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Review Article

Dental Micro-Insurance in Rural India - A Vision for the Future

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ABSTRACT

Over the last 50 years India has achieved a lot in terms of health improvement which includes oral health. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators. To highlight the need of oral health care among poor in rural areas in India through microinsurance. The objective is also to understand and analyse the workings of health insurance by the dental workforce.

Keywords- Microinsurance, Dental Workforce, NGOS

INTRODUCTION

In case of government funded health care system, the quality and access of services has always remained major concern. [1] Unlike most western countries, specific dental insurance plans are not common in India. The nascent health insurance sector in India accounts for a trivial portion of the overall market. Only the very rich, government employees, and some formal sector workers enjoy health insurance and currently only a handful of dental insurance plans are available on a stand-alone basis. A dental plan offers cover against financial hardship due to dental treatments. [2]

Oral health is normally integrated with the general health insurance schemes. Micro-insurance, the term used to refer to insurance to the low-income people, is different from insurance in general as it is a low value product, involving modest premium and benefit package, which requires different design and distribution strategies. It is a form of health, life or property insurance, which offers limited protection at a low contribution hence 'micro'. It is aimed at poor sections of the population and designed to help them cover themselves collectively against risks. [1]

Health Microinsurance

Micro-insurance for the poor is a relatively recent phenomenon in India. The strength of Indian economy is the rural community and it deserves to be well. India has shockingly small organized private sector-less than 10 million workers. Today, with falling agricultural prices and increasing healthcare expenses the poor in unorganized-sector cannot access the micro-insurance in their own. [2]

Approximately 3 billion people worldwide, i.e. half the people on the planet survive on $2 a day. More than one billion or less survives on half that amount or less, which is the World Bank's definition of the severest poverty. Most citizens of the

developing world are in the informal sector and are self-employed. The International Labour Organization estimates that nearly 60% of Latin America and two-thirds of Africa's non-agricultural employment is in the informal sector. In India, nine out of ten workers are in the informal sector, contributing to 60% of net domestic product and 70% of income. [3]

The rural population in India is one of the largest in the world with 72 percent of India's total population was classified as rural and it is estimated that approximately 29 percent of the Indian population lives below the poverty line (World Bank 2003). This figure accounts for more than 290 million people, or nearly 25 percent of the world's poor population. The poor are concentrated in rural areas in the North India, where they are predominantly engaged in agricultural activities. [1] A large number of people in rural areas suffer from dental problems like dental caries, gingivitis, fractured teeth, and orthodontic problems.

Dental health in is among the lowest priorities in our country where most of the money is spent on survival and living. Public spending on preventive dental health services has a low priority over curative health in the country as a whole. [2] In fact, Indian public spending on dental health is amongst the lowest in the world whereas its proportion of private spending on dental health is one of the highest. The urgent need is to transform the public health system into an accountable, accessible and affordable system of quality services. [3] Also there is lack of knowledge and working of the insurance sector on the part of oral health care providers.

The private sector of health care - private clinics, hospitals/health institutions is largely unregulated pushing the cost of health care up and making it unaffordable especially for the poor section of the society in both rural and urban areas. It is also accepted that more than 75% of the population in the country go to the private sector, quacks and others. [3,13]

During the five years plans in India many State governments have provided health programmes to the poor. In spite of these efforts to improve health it must be stated in India as in other developing countries, the health services provided are hardly more than a token service because of resources restrains, insufficient facilities and spiraling cost of treatment. [4] In other words, the cost of health care should be within the means of the individual and the State and with the equitable facility where equal degree of health service is rendered to the needy persons irrespective of caste, sex, creed, etc. This is even more true for dental services in rural areas. [5]

In the past insurance as a prepaid risk managing instrument was never considered as an option for the poor. The poor were considered too poor to be able to afford insurance premiums. Often they were considered uninsurable, given the wide variety of risks they face. However, recent developments in India, as elsewhere, have shown that not only can the poor make small periodic contributions that can go towards insuring them against risks but also that the risks they face (such as those of illness, accident and injury, life, loss of property etc.) are eminently insurable. [2]

Micro Health Insurance (MHI) is defined as a type of health insurance where accessibility to essential health services is made available to individuals and families, who are unable to afford formal health insurance schemes, through affordable premiums and low prices for health services. Health risks such as illness, accident or injury, which require households to incur medical treatment costs, are some of the most common concerns to low-income households. Risk pooling over a large number of people through health insurance schemes can provide at least partial protection against these health risks at an annual cost that is within the household budget. [6]

In India, many households fall below the poverty line every year because of a health shock – consequently, health

microinsurance is considered the most important protection mechanism for low income households that are particularly susceptible to health shocks because of their low saving buffer and poor living conditions. [7]

Since 2005 the Government in India has launched an impressive array of measures to extend social security, in particular to the rural poor. Some of the most important ones are the proposed National Social Security Scheme for Unorganized Workers, the proposed Unorganised Labour and Agricultural Workers (Welfare) Bill, the National Rural Health Mission and the National Rural Employment Guarantee scheme. [8]

Historically in India, a few micro-insurance schemes were initiated, either by nongovernmental organizations (NGO) due to the felt need in the communities in which these organizations were involved or by the trust hospitals. These schemes have now gathered momentum partly due to the development of micro-finance activity, and partly due to the regulation that makes it mandatory for all formal insurance companies to extend their activities to rural and well-identified social sector in the country. [9]

In a recent review of these schemes, access to health care in rural areas is being given priority. Over the last decade, the lack of technical expertise has been instrumental in establishing micro-insurance training centres in India - six by 2006, encouraged by donors and the insurance industry. [10]

Microinsurance delivery models

One of the greatest challenges for microinsurance is the actual delivery to clients. Methods and models for doing so vary depending on the organization, institution, and provider involved. In general, there are four main methods for offering microinsurance - the partner-agent model, the provider-driven model, the full-service model, and the community-based model. [11] Each of these models has their own advantages and disadvantages.

- **Partner agent model:** A partnership is formed between the microinsurance scheme and an agent (insurance company, microfinance institution, donor, etc.), and in some cases a third-party healthcare provider. The microinsurance scheme is responsible for the delivery and marketing of products to the clients, while the agent retains all responsibility for design and development. In this model, microinsurance schemes benefit from limited risk, but are also disadvantaged in their limited control.
- **Full service model:** The microinsurance scheme is in charge of everything; both the design and delivery of products to the clients, working with external healthcare providers to provide the services. This model has the advantage of offering microinsurance schemes full control, yet the disadvantage of higher risks.
- **Provider-driven model:** The healthcare provider is the microinsurance scheme, and similar to the full-service model, is responsible for all operations, delivery, design, and service. There is an advantage once more in the amount of control retained, yet disadvantage in the limitations on products and services.
- **Community-based/mutual model:** The policyholders or clients are in charge, managing and owning the operations, and working with external healthcare providers to offer services. This model is advantageous for its ability to design and market products more easily and effectively, yet is disadvantaged by its small size and scope of operations.

During recent years community-based health insurance (CBHI) has emerged as a possible solution. CBHI is typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources. Such schemes

are generally run by trust hospitals or nongovernmental organizations (NGOs). [12]

DISCUSSION

Health insurance is considered the most complex type of insurance to administer because traditional economic problems of moral hazard and adverse selection are compounded by the need for a quality, reliable health service provider. [13] The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for profit insurers for the purchase of custom designed group insurance policies. [14] However, the coverage of such schemes is low. A review by Bennett, Cresse et al. indicates that many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes. [9]

From the good and bad practices of micro-insurance practiced in different parts of the world and as experienced in Indian scenario it can be seen that doing business in rural areas is not a smooth road though some of the life and health schemes are success stories and have attracted the attention of insurers, regulator and international organizations like International Labor Organization. The experience so far however has been that most of informal schemes typically serves the upper quartile of poor people. [6] As dental workforce in India is generally unaware of the insurance models being offered for the dental treatments, this sector needs to be understood and implemented.

The dominant health microinsurance delivery approach in India is the partner-agent model. The idea is for mainstream insurance companies to partner with microfinance institutions (MFIs) and NGOs. An alternate approach is community-based insurance. But for a sector like health microinsurance, where the need and demand is substantial, diverse approaches and mutual understanding between insurance provider and oral health worker are needed.

CONCLUSION

Oral healthcare in India is in a state of enormous transition. Increased health consciousness among the majority of the classes, price liberalization, reduction in bureaucracy, and the introduction of private healthcare financing is driving the change. Numerous challenges exist for expanding oral health care in India especially in rural sector of India. The biggest challenge of the present time is the need for dental health providers to serve the rural population with care and also understanding the insurance sector. There is a lack of an organized system for monitoring oral health care services needed for the underprivileged.

The demand and supply may influence the ability of the dental workforce to adequately and efficiently provide dental care to an Indian population growing in size and diversity. Dental micro insurance can be used as an essential part of the oral health programmes to provide a better guidance tool for the dentists and a better oral health care to all, especially to the weaker sections of the society.

REFERENCES

1. Ahuja R, Guha-Khasnobis B. Micro-insurance in India: trends and strategies for further extension. Indian Council for Research on International Economic Relations, (ICRIER), New Delhi, Working Paper. 2005 Jun (162).
2. Verma V. The role of Micro Finance in sustainable finance employment and poverty alleviation.
3. Banerjee Nandita. Healthcare For All Through Micro-Insurance. The Journal Of Insurance Institute Of India, Vol. No. 32; 2006: 34-53
4. Devadasan N, Ranson K, Van Damme W, Acharya A, Criel B. The landscape of community health insurance in India: an overview based on 10 case studies.

Health Policy. 2006 Oct 31;78(2):224-34.
5. Auluck Ajit. Oral Health of Poor People in Rural Areas of Developing Countries. J Can Dent Assoc 2005; 71(10):753–5.
6. Ahmed MU, Islam SK, Quashem MA, Ahmed N. Health Microinsurance.
7. Maleika M, Kuriakose AT. Microinsurance: extending pro-poor risk management through the social fund platform.
8. Van Ginneken W. Social security and the global socio-economic floor: Towards a human rights-based approach. Global Social Policy. 2009 Aug; 9(2):228-45..
9. Ranson MK. Community-based health insurance schemes in India: a review. National Medical Journal of India. 2003 Mar 1;16(2):79-89.
10. Soors W, Devadasan N, Durairaj V, Criel B. Community health insurance and universal coverage: multiple paths, many rivers to cross. World health report. 2010.
11. Chandhok GA. Insurance-A tool to Eradicate and a Vehicle to Economic Development. Int J Financ Econ. 2009(24).
12. Ranson MK, Sinha T, Chatterjee M, Acharya A, Bhavsar A, Morris SS, Mills AJ. Making health insurance work for the poor: learning from the Self-Employed Women's Association's (SEWA) community-based health insurance scheme in India. Social Science & Medicine. 2006 Feb 28;62(3):707-20.
13. Anita J. Emerging Health Insurance in India–An overview. In10th Global Conference of Actuaries Feb 2008 (pp. 81-97).
14. Than Sein U. Regional overview of social health insurance in South-East Asia. In Regional overview of social health insurance in South-East Asia 2004.

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