# Family Health Protection Plans for India - A Health Insurance Model.

Prasanta Mahapatra, Samatha Reddy

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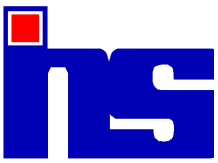

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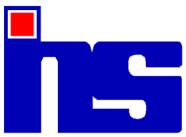

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## 2021 Reprint Note:

At the time of original publication in 2003, the Institute of Health System was located in HACA Bhavan, Hyderabad, AP - 500 004, India. In June, 2014, the Telangana State (TS) was formed out of Andhra Pradesh, with Hyderabad as the State Capital. In November 2021, the Institute of Health Systems shifted to its present location in Sivananda Rehabilitation Home Campus, Kukatpally, TS 500072. This reprint incorporates the new address of the Institute. There is no other change in content of the report originally published in 2003.

# Contents

# Preface

The Government of India (GOI), Ministry of Health and Family Welfare, Department of Family Welfare commissioned the IHS to develop a Family Welfare Linked Health Insurance Policy. In the course of developing the policy and reviewing health insurance literature from various countries, we realized that developing a health insurance policy limited to acceptors of permanent family planning methods (sterilization) may not be ideal. Hence the policy is developed as a " Community Health Insurance and Family Protection Plan" (CHIFHP), which is open for all individuals in India.

This report consists of two parts. Part one provides the CHIFHP policy document as it was submitted to the Government of India for its consideration. Part one of the document has six sections. Each section is a combination of review of literature and our policy recommendations. Review of literature took considerable amount of time. Data necessary to formulate a health insurance policy is not readily available in India. Pooling of information both from Indian publications and other countries was a big task. Literature and data from other countries has been referred to many a times. In Section I (Population Coverage), we recommend targeting all residents of an area with a premium structure that incorporates graded state subsidy for various low income families. In the second section (benefit package and entitlement to benefits), we have outlined three different benefit packages. Our preference is for a combination of ambulatory primary health care and hospital access services. Section three deals with delivery of health services to the insured persons through existing health care infrastructure. We anticipate that the implementation of the insurance scheme will eventually stimulate further growth of required infrastructure. A combination of provider payment mechanisms are recommended in section four. Details of the premium structure are discussed in the fifth section. The final section gives an overview of financing the community health insurance policy.

Part two consists of background papers on various health insurance schemes being implemented in India. The Union Finance Minister announced the Health Insurance Scheme around the same time when we were finalizing the CHIFHP document to be submitted for GOI. We have highlighted some important issues about the implementation of

the Health Insurance Scheme announced by the Union Finance Minister in a brief note. As part of developing the policy we were asked by the Dept. of Family Welfare, GOI to study the health insurance schemes being implemented in India, like ViMOSEWA, Ahmedabad, Gujarat and the Swablamby Swasthya Yojana (SSY), Ratlam, Madhya Pradesh. A comprehensive note on VimoSEWA was prepared based on the available literature through various publications on the scheme. A team of two from IHS visited Ratlam district to study and understand the implementation of SSY. Detailed field notes on the Ratlam visit is included in the report. We had an overview of Arogya Raksha Scheme being implemented in Andhra Pradesh for the family planning acceptors (permanent method) as part of our previous work. We studied it further, out of our own interest in the context of health insurance policy development. We compared these three schemes, ViMOSEWA, SSY and Aarogya Raksha, to understand their benefit package, implementation procedures etc. We are impressed and inspired by the SSY scheme of Ratlam and it has contributed for developing the CHIFHP recommended by us.

We would like to acknowledge our gratitude to all those who have facilitated in preparation of this report. The Ratlam District Administration has been kind enough to allow us to study SSY scheme. Our special thanks to Shri. Manoj Jhalani, Director, Panchayat Raj, Madhya Pradesh; Shri Prabhat Parashar, District Collector; Shri. JK Jain, Addl. District Collector, Ratlam; all members of Indian Red Cross Society, Ratlam Branch especially Mr. Mohanlal Makhvana; and community members whom we interacted in the Ratlam District. We would like to thank Dr. Amarendar, Medical Officer, PHC Yadagirigutta for his cooperation during our quick visit to the PHC. We also thank all the ANMs of the PHC, Private Medical Practitioners and the community members whom we interacted in Yadagirigutta. We thank M/S New India Assurance for providing us information on Aarogya Raksha Scheme. We have benefited from the " Workshop on Health Insurance - Challenges and Options" conducted by the MOHFW and WHO at New Delhi on 3-4 Jan, 2003. The insights of Prof. William Hsiao and experiences shared by public health officials, bureaucrats and researchers from all over the country was very useful. We thank Ms. Shruti Misra, Research Fellow for her contribution in the SSY study. Our thanks to Ms. Mary Nancy, Research Assistant and Bhagirath Gop, Research Associate for helping us in data collection. Our thanks are due to Dr. CK George, Faculty for his comments and suggestions on the draft

documents. We thank Ms. Kavitha, our Librarian in helping us procure books and make them available for literature review.

Our special thanks to Shri JVR Prasada Rao, Secretary, Dept. of FW for his support and encouragement. We convey our appreciation and gratitude to Ms. Sujatha Rao, Joint Secretary for her sustained interest in our work. We also thank Ms. Shubra Singh, Deputy Secretary, Dept of FW for her support. Our thanks are due to Shri. AR Nanda, Executive Director, Population Foundation of India and Mrs. Meenakshi Datta Ghosh, Additional Secretary and Project Director, NACO who were instrumental in initiating this study when they were in the Department of Family Welfare.

03 June, 2003

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# Executive Summary: Highlights of Community Health Insurance and Family Health Protection (FHP) Plans for India.

## I. Population Coverage:

We recommend a community health insurance scheme targeting all residents of an area with a premium structure that incorporates graded state subsidy for various low income families. The health insurance coverage will be available to a community, if it guarantees that at least 75% of its constituent families will purchase the policy.

## II. The benefit package and entitlement to benefits:

Our preferred policy includes comprehensive ambulatory and primary health care. The first component Primary Ambulatory care consists of Out Patient services and First Aid, Immunization and Access to Public Health Programs, Dental and Eye care, Lab services, Drugs and Referral Services. The Hospital Access component would provide facilitation and advocacy services to access Govt. Hospitals and Health Care Institutions (HCI), Supply / cost reimbursement of medicines and materials and Emergency hospitalization treatment There will be a financial cap of Rs 30000 / annum/ family on the cumulative value of medicines, materials and reimbursement.

## III. Organisation of health services:

These policies are designed to work through existing health care infrastructure and eventually stimulate growth of required infrastructure. The above component services covered by these policies will be delivered through; (a) the clinics, (c) public hospitals, (d) private nonprofit hospitals, (e) private for-profit hospitals (f) participating pharmacies, and (g) diagnostic facilities. Clinics set up by practitioners of Indian Systems of Medicine can also participate. Primary Health Centers (PHCs) can participate but will have to compete with private not for profit and for profit clinics.

A participating clinic must satisfy the required quality of service standard. The quality of service standards will be as prescribed by the concerned mutual health organisation and may be based on a minimum quality of service standard prescribed by the concerned state public health authority.

## IV. Provider payment mechanisms:

A combination of provider payment mechanisms is recommended. Primary Ambulatory Care, Facilitation and advocacy services to access Govt. Hospitals and HCIs and access to major medical relief from public or charitable sources is through Capitation fee to participating clinic nominated by the policy holder. Supply / cost reimbursement of medicines and materials is by Price per item mechanism and emergency hospitalization treatment is by Case payment based on a schedule of diagnoses.

The ambulatory primary care component should be provided through a clinic with a subsisting participation agreement. Arrangement for provision of the hospital access, access to catastrophic illness relief funds, and major medical expenses access services will vary. The service organisation may chose to directly provide all of these services and subcontract parts of it. We anticipate that, in some areas, there may be a scope to enlist support of local social service organisations, or social workers.

## V. Cost estimation and cost control

Major determinants of health insurance costs are; (a) demand for services by the covered population, (b) cost of production or price of medical care, (c) transaction costs of the insurance. The following premium structure is recommended.

| Family situation | Rate / Annum |
|---|---|
| Basic enrollment premium for individual or family with upto 3 members | 600 |
| Additional premium for family members exceeding three. | 220 |

Total premium for a three member household works out to Rs. 660 / annum. In practice, the insured families will consist of one, two and three member families. Our conjecture is that the actuarial average may work out to about Rs. 600 / family / annum. More accurate actuarial average can be computed only after some experience about the composition of covered families is available. A family will be enrolled only if premium is paid for all members of the household in which the family lives. Thus if two or more families share live in a single household, both families have to enroll.

We propose that these community health insurance schemes be operated through mutual health insurance firms. The insurance function played by nonprofit mutual health insurance firms, coupled with the capitation based provider payment system, it is anticipated,

that it will keep administrative costs down. Accordingly we propose that the administrative cost of mutual health insurance plans be limited to 10% of premium income.

## VI. Financing community health insurance:

We propose a system premium subsidy graded according to the income. For the poor families a range from 75 to 90% subsidy, for Low Income Families 50%, for Middle Income Families 20% and for High Income Families no subsidy is recommended. The actual subsidy will depend on situation in each state, their finances and decisions by respective state governments.

# Part - 1:

# The Proposal.

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# Community Health Insurance and Family Health Protection (FHP) Plans for India.

## I. Population Coverage:

### A. Families with income below the poverty line:

1. All families living below the poverty line (BPL). The poverty line is fixed on the basis of consumption expenditure required to meet minimal food and clothing. The poverty line, in India, is defined by inverse interpolation of per capita total expenditure that average households actually incur while meeting the normative calorie requirement for the respective category (Dubey and Gangopadhyay, 2002). Thus, there is no normative medical and health expenditure built into the poverty line. The inverse interpolation based on normative food basket and observed consumption pattern of households ensures that average medical and health expenditure incurred by the households consuming food below the normative level is built into the poverty line definition. Recently the Finance Minister, in the 2003-04 budget speech, has proposed to introduce a health insurance scheme for the poor (Times News Network, 2003). The scheme proposes to cover hospitalization costs upto 30000 rupees per annum for an annual premium of Rs365 / person. Families below the poverty line will be eligible for a 100 rupee subsidy per person. However, many operational difficulties have to be overcome for successful implementation of a comprehensive health insurance scheme (Jain 2003).
2. One restriction over and above the below poverty line status, from the Family Welfare Program perspective, is to require adoption of family planning measures. Ideally, from this perspective, adoption of any family planning measure including spacing methods should be sufficient. However, administrative feasibility is an issue. Families adopting permanent measures such as tubectomy or vasectomy are easily classified. Inclusion of those who adopt spacing measures, may give scope for administrative leakage in the sense that some families who are not actually practicing spacing methods, may manage to get in. These arguments probably weighed in the National Population Policy (GOI, 2000), which has clearly specified that couples below the poverty line, who undergo sterilisation with not more than two living children, would be eligible for a family welfare linked health insurance scheme. However, since the "family planning adoption" criterion is to be superimposed on the "below poverty line" criterion, there will be a built in cap on the potential leakage due to false declarations about adoption of spacing methods. More over an inclusive "family planning adoption" criterion recognising the spacing methods will be consistent with the "target free" approach (Khan and Townsend, 1999). Furthermore, improvements in infant mortality, and overall family health status has been found to contribute towards adoption of fertility control measures.

### B. Health Insurance Coverage for Community Risk Rating:

1. Relative merits of different forms of health insurance were discussed in the seminar on health insurance in November, 1999 by the Government of India and the World Bank (Peters, Ramana and Sujatha Rao, 2000), and more recently in the Workshop on Health Insurance at New Delhi, 3-4 January 2003, organised by the GOI and WHO.

2. Community rating of health risks is preferred because of its usefulness to promote solidarity concept and to keep the incidence of adverse selection and cream skimming down. Adverse selection and cream skimming have been found to substantially contribute to health care cost escalation. Hence social insurance and community-based insurance options are preferred over private voluntary health insurance.
3. Garg (2000) has summarised for the National workshop mentioned above, key features of social and community health insurance schemes, which are reproduced below.
    i. Social Insurance: This scheme can provide universal coverage and can ensure equity in finance if premiums are graded according to incomes. Costs and quality of care can be controlled through payment mechanism to the provider. Moral hazard could be minimised by introducing supplementary payments for expensive treatment. Compulsory and lifetime enrollment can help to reduce the risk of adverse selection. Supply side limitations can be influenced through provider payment mechanisms. Consumer redress mechanisms can ensure good quality care at the cheapest rates. In India, the social insurance is limited to only a small proportion of people in the organised sector and to central government employees. With a large rural and informal sector, social security approach will have its inherent problems. There will be problems in assessing the incomes of people and collection premiums from small, unregistered firms and from those in the unorganized industries and rural sector, just as there are problems in collecting income tax. Further, the consumer redress mechanism will not function effectively because of a large percentage of illiterate population.
    ii. Community Insurance: Community financing can complement formal social security schemes that cover regularly employed or self employed, particularly in rural communities. These are ‘soft compulsory’ implying that there is a local pressure on individuals to take a cover and also the term of insurance is long so that insurance funds could be planned as if the insurance is compulsory (Ensor 1997). Community based insurance schemes are important as they cover primary care, which is difficult for private insurance to administer. Another advantage of the community-based schemes is that they have low administrative costs and most of the expenditure is on providing drugs and paying doctors. For community schemes to sustain, the demand should be from within the community. Funds have to be locally managed and benefits and premiums should also be decided at the local level for people to trust the scheme. Inherent problems visualised in these schemes are low coverage, poor cost recovery and limited ability to protect the interest of the poorest both in terms of access and financing. Also, these schemes are based on the demand on the demand for those services / facilities for which there is local demand and not on professionally perceived needs.
4. The International Labour Office (ILO) Medical Care and Sickness Benefit Convention, 1969 provides that at least 75% of economically active population or at least 75% of residents should be covered in a Social health insurance scheme. In all cases, the spouse and children of insured persons must be covered. Below poverty line families constitute between 10 to 40% of population in different parts of the country. Targeting any health insurance scheme only to the poor will mean that only about 10- 40% population in any geographic area can be covered giving rise to the problem of adverse selection. Adding permanent sterilisation requirement will further reduce coverage among the poor. Moreover, a health insurance scheme designed only for the

poor goes against the solidarity principle. The Employees State Insurance (ESI) eligibility is yet another potential criterion for target group definition. Currently, the maximum monthly wage for ESI coverage is fixed at Rs. 6500 (ESI, 1997). As mentioned earlier solidarity principle is widely held as a valid ethical basis of addressing health care policy.

**C. Recommended community based health insurance coverage model:**

1. Thus we recommend a community health insurance scheme targeting all residents of an area with a premium structure that incorporates graded state subsidy for various low income families.
2. Community enrollment:
   i. The health insurance coverage will be available to a community, if it guarantees that at least 75% of its constituent families will purchase the policy.
   ii. Communities will include all constitutional local bodies such as the Gram Panchayat, and municipality, but not limited to them. Other formal and informal communities will also be eligible. For example; employer affiliated groups, women self help groups etc..
3. Subscription by families living in an enrolled community:
   i. To purchase the Community Health Insurance Policy a family should be the constituent of at least one enrolled community. If a family happens to be simultaneously a constituent of more than one enrolled communities, then such a family will have the option to indicate any one of the said communities.
   ii. Low income families will be entitled to graded subsidy as described below.

**D. Income lines for health and housing (ILH):**

1. There is one important problem with all of the above criteria primarily based on the poverty line. The expenditure now allocated towards medical and health care by below poverty line family is usually inadequate to meet the need. Thus many families with income marginally above the poverty line, when faced with high medical and health expenditure would end up below the poverty line. It is well known that many lower middle class people are not able to afford the cost of medical care. Health and housing are the next order of need of families as their income goes above the poverty line. Research in the US shows that families with income less than twice the poverty line account for a majority of the uninsured (Economic Report of the US President, 2002, p.160). Hence it is desirable to adopt the concept of a low income line for health and housing.
2. The Housing Development Corporation (HUDCO) assigns families into the following four income classes to target its housing loans.
   i. The Economically Weaker Section (EWS) with household income of Rs. 2,500 per month or less.
   ii. The Low Income Group (LIG) with household income not more than Rs. 5,500 per month. This is slightly less than the current ESI eligible income limit of Rs. 6500 per month.
   iii. The Middle Income Group (MIG) with household income not more than Rs. 10,000 per month.
   iv. The High Income Group (HIG) with household income more than Rs. 10,001 per month.
3. It is recommended that Government of India should periodically fix income lines for health and housing. The monthly income limit for employees social insurance eligibility and low income housing finance should be synchronized. We recommend

the a technical group on income lines for health and housing be set up jointly by the planning commission, the ministries of health, housing and labour to develop the technical basis for computation of these income lines and their periodical updates. A permanent official mechanism should be put in place for updating of the income lines for health and housing. We recommend the following income lines for health and housing as a starting point.

Table 1: Income lines for Health and Housing

| Income Category for Health and Housing | Recommended Definition | Recommended Health Insurance Premium Subsidy |
|---|---|---|
| Poor Families | Official Poverty Line for food subsidy or targeting of anti poverty programs | High State Subsidy 75 - 90% |
| Low Income Families | An income figure around the current official Low Income Limit for Housing Finance (Rs5500/mo) and salary limit for ESI coverage (Rs6500/mo). | Substantial State Subsidy or Mandated Employer Contribution. About 50% |
| Middle Income Families | Families with monthly income more than low income limit but with no taxable income. | Marginal subsidy equivalent to health insurance premium subsidy enjoyed by income tax paying families through income tax concessions. About 20%. |
| High Income Families | Families with income above the Official Low Income Limit for Housing Finance | Subsidy available through income concessions for health care expenditure. |

**E. Coverage of States and Districts:**

Wiesmann and Jutting (2001), based on a review of about 48 community based health insurance schemes in rural Sub Saharan Africa, identify three important fields contributing to the success of such health insurance schemes. These are; (a) scheme design and management, (b) availability and behaviour of health care providers, and (c) community characteristics. Scheme design and management issues are addressed elsewhere in this document. The other two aspects, namely availability of health care providers and community characteristics, imply that, ceteris paribus, a well designed health insurance scheme is likely to succeed in certain areas and may not establish well in certain other areas, depending on availability of health care providers and community characteristics. The scheme designed by us envisages some degree of competition among primary ambulatory care providers. This will be feasible only if there is scope for multiple clinics. All over the country there are primary health centres which may, if the respective state governments grant them operational autonomy, compete to serve the proposed community based health insurance policy holders as a clinic. However, public sector primary health centres acting as clinics can not provide the required

provider competition alone. Additional clinics in the private nonprofit and for-profit sector should be available to give choice to policy holders. Thus Wiesmann and Jutting's (2001) observation about the importance of health care provider availability for success of health insurance schemes sounds reasonable. Mahapatra and others (2002), based on a study of the private health sector in Andhra Pradesh, found strong correlation between the Centre for Monitoring Indian Economy (CMIE) infrastructure development index and private hospital bed capacity. Much of these private hospital beds are actually in small nursing homes of 1-10 beds (Mahapatra, 1998). These are potential candidates to serve as clinics for the health insurance scheme designed here. In addition, private hospitals and nursing homes are known to be closely associated with clinics. So areas having substantial private sector nursing homes are likely to have more number of private clinics, some of which may qualify and be willing to serve as the clinics to deliver ambulatory medical care to health insurance policy holders. Wiesmann and Jutting (2001) observe that widespread absolute poverty among potential members can be a serious obstacle to the implementation of any form of health insurance. If people are struggling for day to day survival, they are less willing to pay advance premium for possible use at a later date.

Hence, we propose that these community health insurance plans be implemented at the district level in a phased manner. In the first phase, districts with high infrastructure development, lower levels of poverty and higher levels of literacy should be taken up. In addition, scope for development and sustenance of Mutual Health Organisations (MHO) that will be responsible for management of the health insurance scheme is also important. The public sector health centres, and hospitals will continue to be the primary source of health care for most of the local population living in less developed districts. In subsequent phases, the community based health insurance schemes can be extended to other districts commensurate with socioeconomic and infrastructure development. Actual phasing of districts is ideally decided at the state level. Phasing should also be flexible, so that emerging opportunity if any can be tapped to introduce community health insurance schemes. Key criteria for inclusion of districts in earlier phases should be based on an overall assessment of the probability of success and sustainability of health insurance schemes.

## II. The benefit package and entitlement to benefits:

We have first conceived of two levels of health care coverage, namely; (a) ambulatory primary care, and (b) hospital access services.

### A. Ambulatory Primary Care:

1. Out patient consultation including clinical examination and ambulatory medical care.
2. First aid; wound cleaning and dressing services including removal of foreign bodies, suturing of clean wounds, abscess drainage etc..
3. Injection services for ambulatory treatment with small volume parentrals.
4. Primary eye care including diagnosis and treatment of Conjunctivitis, eye lid infections, removal of conjunctival foreign body, Vitamin A deficiency; first aid and referral.
5. Dispensed primary medicines free of charge, and other essential medicines subject to 30% co payment.
6. Referral services including information about location, appropriateness and access procedures of hospitals and health care institution and specialists.
7. Access point for services provided by Public Health Authorities such as; (a) Immunisation (b) Contraceptives (c) Ambulatory treatment under disease control programs.
8. Ante natal care.
9. Prophylactic dental treatment including dental hygiene advice, dental examination and advice and scaling.
10. Primary laboratory services including routine tests of blood, urine and stools, plain X ray and collection and dispatch of samples to referral laboratory.

Most participating clinics should be able to provide bulk of the ambulatory medical and primary health care services at serial 1-6, on walk in basis during regular clinic hours. The clinic would act as access point for services provided by public health authorities according to the cycle and periodicity to be mutually developed by the concerned local health authorities and the clinic. For example, immunisation services would be available on certain days, and directly observed anti tuberculosis treatment may be delivered on another day of the week. The specific days of the week for such services will, naturally, vary according to local practices and the clinics convenience. Ante natal, and dental care may also be delivered on certain day of the week. This will encourage clinics to affiliate with suitably skilled personnel, in case the primary care physician does not feel comfortable enough to deliver these services. Some clinics will have their own laboratory and some may out-source these services from another laboratory / clinic or hospital. Most clinics will probably out-source X-ray services. However, the clinic will have to pay for these services from out of its capitation receipts.

**B. Hospital Access Services:**

1. Facilitation, assistance and advocacy to access Government Hospitals and Health Care Institutions (HCIs).
2. Direct settlement of user fees charged by public hospitals and health care institutions.
3. Supply or cost reimbursement of medicines and materials required but not available in government hospitals.
4. Cost of treatment in designated non profit hospitals and health care institutions.
5. Direct settlement or reimbursement of the cost of dispensed medicine, cost of diagnostic tests performed outside the public or designated non profit hospitals subject to 30% co payment by the policy holder. Reimbursement will be limited to price of generic drugs where available and rates of diagnostic test set by appropriate public agency or the insurer.
6. Emergency treatment in any hospital.
7. If treatment is not available in the first referral hospitals stated in clause 2 & 3 above, service charges of speciality / tertiary referral hospitals.
8. In case of major medical conditions/ catastrophic illnesses requiring very high expenditure, facilitate application to State or Charitable sources of medical assistance. There will be a financial cap of Rs 30000 / annum on the cumulative value of

medicines, materials and reimbursement stated in clause 2-7 above. The medicine (drugs), material (therapeutic) included in the appropriate formulary will only be admissible. Appropriate formulary will be the hospital/health care institution formulary approved by the mutual health organisation, where such a formulary is not available, the formulary of mutual health organisation and if neither the above two are available, the list of essential drugs approved by state government, central government or WHO as the case may be.

Three alternative policies, giving different benefit packages, have been developed. These alternative policies, numbered 1-3 are given in the annexure 1- 3. The following table summarizes, the benefit package of each policy.

Table 2: The benefit package and entitlement to benefits in three Family Health Protection (FHP) Plans.

| The benefit package | FHP1 | FHP2 | FHP3 |
|---|---|---|---|
| Primary Ambulatory Care: | | | |
| Out Patient services and First Aid | ✓ | ✓ | |
| Immunization and Access to Public Health Programs | ✓ | ✓ | |
| Preventive Dental and Eye care | ✓ | ✓ | |
| Diagnostic tests for ambulatory care. | ✓ | ✓ | |
| Drugs and Referral Services | ✓ | ✓ | |
| Hospital Access and Services Upto Rs30000 / family / annum | | | |
| Facilitation and advocacy services to access Govt. Hospitals and Health Care Institutions | ✓ | | ✓ |
| Supply / cost reimbursement of medicines and materials, | ✓ | | ✓ |
| Emergency hospitalization treatment | ✓ | | ✓ |
| Catastrophic Illness & Major Medical Expenses | | | |
| Facilitate access to major medical relief from public or charitable sources. | ✓ | | ✓ |

We have given three alternative health insurance policies. Comprehensive ambulatory medical and primary health care is the foundation for two of the three policies. Although, the Primary Health Centres (PHCs) were originally set up to provide both curative and preventive services, the curative service component is least reliable and is a major source of popular dissatisfaction with these centres. However, some public health officials and policy executives do argue that the PHC is meant to provide primary medical care. Hence government should not pay for primary medical care again through a health insurance scheme. The third alternative policy proposed by us will find favour with this school of thought. But our reason for including this third alternative is to provide a lower cost alternative to the government in case enough finances are not available.

Our preference is for the first policy consisting of comprehensive ambulatory primary care and access to first referral hospital services. The second policy covering ambulatory primary care is our second preference.

## III. Organisation of health services:

### A. Overview:

These policies are designed to work through existing health care infrastructure and eventually stimulate growth of required infrastructure. Various component services covered by these policies will be delivered through; (a) the clinics, (c) public hospitals, (d) private

nonprofit hospitals, (e) private for-profit hospitals (f) participating pharmacies, and (g) diagnostic facilities. The role of each of these component institutions is described below.

**B. The Clinics:**

Note that the ambulatory primary care is the foundation of the two policies preferred by us. We envisage that this ambulatory primary care services will be provided by the participating clinics. A participating clinic is defined as an ambulatory medical care facility having a contract with the Mutual Health Organisation to deliver ambulatory primary care services to the MHO's policy holders.

1. Public, private nonprofit, and private for-profit ambulatory medical care facilities will all be eligible to participate, provided they satisfy the required quality of service standards.
2. Automatic participation by public sector clinics will not be allowed. On the other hand, a public sector health care institution will have to satisfy the quality of service standards and in addition demonstrate evidence of its operational autonomy[1].
3. The clinic may have registered medical practitioner from any system of medicine including Indian systems of medicine and homeopathy as the primary care physician. The clinic will be expected to clearly state the system of medicine practiced by the primary care physician. Policy holders will decide once a year, which clinic to register.
4. The clinics will compete with each other by seeking policy holder options in their favour. It is hoped that, unpopular clinics will eventually get voted out by the policy holders annual option to choose a clinic from among the participating clinics in the area.
5. A participating clinic must satisfy the required quality of service standard. The quality of service standards will be as prescribed by the concerned mutual health organisation and may be based on a minimum quality of service standard prescribed by the concerned state public health authority. A draft minimum quality of service standard for clinics is enclosed at annexure-4.
6. A MHO may use credible third party accreditation status information, in addition to its in house quality assurance system, to determine initial and continuing satisfaction of quality of service standards by a clinic. It will be desirable for governments to encourage appearance of voluntary accreditation services to improve the quality assurance environment for the health sector.

[1] The operational autonomy requirement of public sector clinics is to ensure that a participating clinic is in a position, to locally utilize the capitation fee received by it to provide services to the policy holders registered by it for primary ambulatory care. It may be argued that a private nonprofit or for-profit clinic, which is branch of a large organisation or firm, would be subject to central control as is a public sector clinic. This is possible in case of private health care chains. As of now, such chains are not very prevalent in India. Almost all private for-profit and nonprofit health care facilities in India, enjoy reasonable degree of operational autonomy. We view the societies registered by governments as public sector institutions. Many such societies are subject to centralized control as are government facilities. Hence, de-facto autonomy of these de-jure autonomous institutions needs to be established on a case by case basis.

**C. The Hospitals:**

The first referral hospital services will be accessed from the public and selected nonprofit (which term includes voluntary and charitable) hospitals. These would be mostly public hospitals. The hospital access component in the benefit package is to facilitate access to the public hospitals. Only emergency treatment in private hospitals is considered to be eligible.

**D. Public hospitals:**

It is envisaged that the bulk of first referral hospital services can be accessed from the public hospital network. The public hospitals are duty bound to provide free service to the poor. A good part of the health sector resources are allocated to these hospitals on the ground that they would provide free services to the poor. Some may argue that the quality of services in public hospitals is not as good as it is in private hospitals. Hence the poor, covered by state funded health insurance scheme should not be denied access to private hospitals. It turns out that evidence in support of this argument is lacking. On an average, and ceteris paribus, there is no difference in quality of services by private and public hospitals or nonprofit hospitals. On the other hand, private hospitals are more likely to be sources of provider induced demand. One of the important factors, why poor are unable to access the public hospital services is that they are unable to meet marginal costs of accessing these services. For example; purchase of drugs not available in the public hospital, surgical materials, and more recently user charges levied by some public hospitals. By restricting the first referral hospital services component to be delivered through the public hospitals, we are actually seeking to keep the cost of the insurance policy down. Since the policy holder will be assisted with required social work and advocacy support and will have access to funds to meet any additional costs arising during the course of hospitalization, this policy will stimulate better utilization of the public hospitals. Experience from the Swablamby Swasthya Yojana in Ratlam district of Madhya Pradesh suggests that this a feasible strategy. (Mahapatra and Reddy, 2003). A detailed report is enclosed as annexure 5.

**E. Private nonprofit hospitals:**

In addition, we have provided for payment of costs of treatment in nonprofit hospitals. Since most nonprofit hospitals work with some amount of volunteer workforce (salary costs of non profits have been found to be comparatively lower than the public hospitals) and have access to some capital subsidy by way of donated land, building and / or equipment, cost of treatment in these hospitals is likely to be less than private for-profit hospitals. In many

districts there are very active nonprofit hospitals with excellent reputation of social service. The recommended policy allows for selection of such hospitals where policy holders may avail hospital services.

These community health insurance schemes have been designed, with a liberal health care coverage package and very modest premium cost. One of the ways these plans seek to manage the coverage is by accessing already subsidized public hospital services or low cost charitable hospital services for the health insurance policy holders. So the enlistment of nonprofit hospitals by the mutual health insurance firm has substantive implications for viability of the scheme. The nonprofit charitable hospitals have to be carefully chosen, so that the scope for provider induced care is minimised. Some non profits are strategically organised as such to claim tax benefits, and other government support. The MHO has to follow appropriate administrative practices for enlistment of non profits that include primarily altruistic or service oriented non profits and exclude strategically organised non profits. Other relevant criteria for enlistment of nonprofit hospitals would be; (a) good organisational governance, (b) social service track record, (c) high incidence of low income and underprivileged clientele served by the hospital, (d) lower service tariff compared to customary and usual for-profit tariff for similar health care services, and (e) adherence to high quality of service standards.

**F. Private for-profit hospitals:**

Policy holders may meet with accidents or suffer from such other calamities. Accessing public or the enlisted nonprofit hospitals in such emergencies may not be feasible on account of various factors. For example, a private for-profit hospital may be available near by and accessing such a hospital to mitigate the impact of an accident or injury would be the most sensible thing to do. In such cases, the plans allow for settlement of cost of emergency treatment in private for-profit hospitals.

**G. Participating pharmacies:**

1. Covered people referred to first referral hospitals would require access to drugs and therapeutics not available in those hospitals. In case of large public hospitals, the health mutual may operate a special drug store. In case of smaller public hospitals, where incidence of referred clients is less, it may not be cost-effective to maintain dedicated medicine stores. For example, in Ratlam district of MP, the SSY maintains a drug store in the District hospital. SSY covered people attending this hospital go to this counter to seek access to the hospital and to get drugs and therapeutics indented by the hospital for outside purchase. But no such drug stores are maintained in sub district hospitals (Mahapatra and Reddy, 2003). In such cases, a network of

participating private drug stores located closer to the public hospitals will be useful. The Mutual Health Organisation should identify and enter into Pharmacy Participation Agreements (PPA). The agreement should provide for regular stocking of the drugs and therapeutics included in the health mutual hospital formulary, price concession to the health mutual, responsiveness to the health mutual clientele, etc..

**H. Diagnostic facilities.**

1. Simple diagnostic tests and X-rays required for ambulatory primary care will be the responsibility of the participating Clinics. A clinic may either provide for these investigations, in house, or out-source them from private or public diagnostic facilities.

**I. Community service providers:**

1. It is expected that the Mutual Health Organisation will provide social workers who will enable policy holders requiring hospitalization to access public or designated nonprofit hospitals. In case, however the MHO is unable to play this role or there are more effective social activist organizations available in an area, they may be engaged by the MHO to provide the public hospital access service. The community service providers have to be voluntary or nonprofit institutions.

**J. The Mutual Health Organisation (MHO):**

1. These fiduciary nonprofit health insurance organizations will underwrite the risk and issue health insurance policies.
2. MHOs may arise from an existing public or nonprofit hospital base, community health or other social service organisation, or may appear first and then develop affiliations with health care providers.
3. To minimise scope for conflict of interest, a Trustees, or Director of MHOs should not have any financial or proprietary interest in any forprofit health care provider, medical and health equipment supplier, pharmaceutical concern or such other suppliers largely dependent on business from the health care sector in the area of operation of the MHO.
4. About two to three MHOs should be encouraged in each district or a region.
5. MHOs will compete in enrollment of communities and affiliated groups. A community can enroll with any one MHO only. Communities can review their enrollment with a particular MHO once in three years.
6. Although, India does not have many mutual health organizations as of now, enough civil society formations and voluntary health care delivery efforts exist to facilitate development of mutual health organizations. The MHOs have to be carefully developed and should be governed by people with demonstrated potential for fiduciary trusteeship, and commitment of social work. Special institutional and consultancy support will be required for organisation and monitoring of the MHOs. The supporting institutions should have a program to enable the MHOs to gradually be self sufficient and manage its own affairs.

## IV. Provider payment mechanisms:

**A. Recommended provider payment mechanisms:**

A combination of provider payment mechanisms is recommended.

Table 3: Recommended provider payment mechanisms.

| The benefit package component | Basis of Provider Payment[1] |
|---|---|
| **Primary Ambulatory Care:** | |
| Out Patient services and First Aid<br>Immunization and Access to Public Health Programs<br>Dental and Eye care<br>Lab services<br>Drugs and Referral Services | Capitation fee to participating clinic nominated by the policy holder. |
| **Hospital Access and Services Upto Rs30000 / family / annum** | |
| Facilitation and advocacy services to access Govt. Hospitals and Health Care Institutions, | Capitation fee |
| Supply / cost reimbursement of medicines and materials | Price per item |
| Emergency hospitalization treatment | Case payment based on a schedule of diagnoses. |
| **Catastrophic Illness & Major Medical Expenses:** | |
| Facilitate access to major medical relief from public or charitable sources. | Capitation fee |

[1] Note: For description and interpretation of terms under this column refer to chapter - 8 in Normand Charles; Weber Axel WHO; ILO Social Health Insurance. A Guidebook for Planning.; Geneva: WHO, 1994.

The ambulatory primary care component should be provided through a clinic with a subsisting participation agreement. Arrangement for provision of the hospital access, access to catastrophic illness relief funds, and major medical expenses access services will vary. The service organisation may chose to directly provide all of these services and subcontract parts of it. We anticipate that, in some areas, there may be a scope to enlist support of local social service organisations, or social workers.

**B. Quality of health care services:**

1. All policies provide for annual nomination by policy holders, of clinics for ambulatory primary care services. This is designed to facilitate demand side pressure on quality of services. If a clinic is not responsive to its registered clientele, then it would run the risk of loosing many of the clients in subsequent years.
2. Policy holders will have the option to chose from a panel of clinics who have a continuing participation agreement with the service organisation. The process of empanelment of clinics and execution of participation agreement will have built in mechanism to assure that the clinics satisfy minimum structural, process and outcome standards. This empanelment process will then help assure the policy holders a minimum medical facilities and technical quality of care.

## V. Cost estimation and cost control

Major determinants of health insurance costs are; (a) demand for services by the covered population, (b) cost of production or price of medical care, (c) transaction costs of the insurance.

### A. Demand for Services:

Major determinants of demand for health care include; (a) population health status and burden of disease, (b) cash price of healthier, (c) transportation and access costs, (d) waiting time, etc.. The effect of population health status and burden of disease on demand for health care is difficult to predict. Rich or educated people clearly enjoying better health status are known to demand more medical care. Socio-economically poor people carrying a higher burden of disease most often do not demand as much medical care as the educated, rich and well informed (Murray and Chen, 1992; Murray, 1996 p24-27). On the other hand factors like price, access cost, and waiting time have predictable influence on health care demand (Besley, 1989; Leopold and Langwell, 1979). The proposed health insurance coverage will reduce the cash price, and is also likely to reduce access costs, and waiting time. The net effect of all these will be to increase usage of health care, which will of course be limited by the supply side capacity of health care providers in an area.

Table 4: Healthcare Usage per Person Year - Some Empirical Estimates.

| Source | Study Year | Population | OP Visits | Hospital Adm. | Health Visits | Dental Visits |
|---|---|---|---|---|---|---|
| NCAER, 1998 | 1993 | All India Sample | | 0.10000 | | |
| NSS-52nd Round | 1995 | All India Sample | 1.02 | 0.02000 | | |
| NCAER (2000) Survey in Ahmedabad. | 1999 | SEWA | 2.15 | 0.06000 | | |
| | | ESIS | 1.83 | 0.07000 | | |
| | | Mediclaim | 0.92 | 0.02000 | | |
| Bhaskaran and others, 2000. | | Manipal - Medicare Scheme. | 1.45 | 0.15000 | Included in OP Visits | |
| Rand Health Insurance Exp.[1], USA. | 1974-1982 | Free plan | 3.77 | 0.13300 | 0.790 | 1.330 |
| | | 25% coinsurance | 2.96 | 0.11000 | 0.640 | 1.060 |
| | | 50% coinsurance | 2.83 | 0.09900 | 0.720 | 0.970 |
| Philippines [2] Institute of Dev. Studies, Survey. | 1,991 | No Insurance | | 0.01312 | | |
| | | Social Insurance | | 0.13150 | | |
| | | Universal Coverage | | 0.13480 | | |

[1] Rand Health Insurance Experiment estimates from Newhouse, 1993, pp.100.

[2] Estimate by Gertler & Solon, 2000 using data from Philippine Inst. of Dev. Studies (Solon et al, 1997).

To estimate demand for services by the covered population, we start with observed levels of health care usage reported by various studies (Table 4). The NCAER survey of 1993, and the NSS 52nd round give reported utilization of ambulatory and hospital care by largely uninsured population. All other estimates are for people enjoying some form of health insurance coverage. The NCAER study in Ahmedabad gives observed demand for health care by people covered by different health insurance schemes such as the VimoSEWA by SEWA, Employees State Insurance Scheme, and the Mediclaim policy holders of the general insurance corporations. The VimoSEWA insurance is operated by the well known Self Employed Women's Association (SEWA). This is a reputed self help nonprofit organised by women. The Medicare scheme in Manipal, Karnataka is operated by the Kasturba Hospital since 1972. The bottom three rows give estimates from the Rand Health Insurance Experiment in the USA. This was a randomised social experiment using 15 different health plans to estimate effect of variations in insurance plan on demand for health care. Estimates for three health insurance plan are shown in the Table 4. The Free plan means that policy holders do not have to pay any amount over and above the premium. The coinsurance policies require that policy holders pay a percentage of charges for services over and above the premium. The 25% coinsurance plans means that covered families have to pay 25% of the service charges, and the 50% coinsurance plan means that they have to pay 50% of service charges. The Rand Health Insurance study provides estimate of dental visits and preventive health care visits. The Manipal Medicare scheme includes coverage for dental care. The paper by Bhaskaran and others (2000) describing data from this scheme does not give a separate estimate of dental or preventive care visits. So we assume that the estimate of 1.45 OP visits per person year includes dental and preventive care visits. Outpatient visits and hospital services availed by the American population covered under the Rand Health Insurance plans are clearly higher than the figures reported from India. This is plausible, in view of the greater medical care supply capacity in the US. For our purposes, to compute the cost of proposed health insurance schemes, we assume 1.5 OP visits / person year, 0.075 hospital admissions / person year, and 0.3 preventive or public health program related encounters / person year. The preventive and public health program related ambulatory care encounters would include immunizations, directly observed treatment for tuberculosis, etc.. The general out patient visits would include visits for preventive eye and dental care.

**B. Price of medical care:**

Table 5: Marginal Cost (Price) of Healthcare Episodes.

| Source | Study Year | Population | OP Visits | Hospital Adm. | Pblc Hospl - Av. Out of pocket Exp. |
|---|---|---|---|---|---|
| NCAER, 1998 | 1993 | All India Sample | 103 | 1,121 | 494 |
| NSS-52nd Round | 1995 | All India Sample | | 3,562 | 2,218 |
| NCAER, 2000 | 1999 | Ahmedabad | | | |
| | | SEWA | 214 | 2,586 | 4,045 |
| | | ESIS | 161 | 1,411 | |
| | | Mediclaim | 686 | 4,045 | |
| Mahapatra & others | 2000 | Pvt. Health Care Institutions in AP. | 41[1] | 3, 574[2] | |
| Bhaskaran and others, 2000. | 1999 | Manipal - Medicare Scheme. | 173 | 4,031 | |

[1] Mean charge by general outpatient visits. Range between 5-200 rupees.

[2] Mean charge for admissions involving caesarian sections.

Mean charge or cost of an outpatient visit estimated from various sources fall into three distinct classes. The mean charge for general outpatient contact reported by Mahapatra and others (2002) from a study in Andhra Pradesh is the lowest at rupees 41 per visit. But this estimate does not include other costs such as drugs, laboratory investigations, etc.. The NCAER, SEWA, ESIS and Manipal Medicare estimates range from rupees 103 - 214 / ambulatory visit. The NCAER survey asked for all costs incurred by the household towards out patient treatment and hospital treatment. The other three are insurance schemes providing for coverage of diagnostic and medicine costs. Hence these estimates appear to include the cost of diagnostic services and medicines as well. The average Mediclaim in Ahemdabad was about rupees 686 per episode. This is distinctly higher from other estimates. Many factors contribute to inflation of Mediclaim costs. Firstly, this is a voluntary health insurance scheme with large scope for provider induced demand, and moral hazard. Secondly, the per episode cost estimate is based on a smaller denominator of those people who chose to raise a claim for out patient visit. Considering the high transaction costs of filing and processing of a claim, Mediclaim policy holders will generally be reluctant to claim for all outpatient visits unless the financial cost is substantial. We have seen earlier in Table 4 that the average out patient visits reported by Mediclaim respondents was comparatively smaller than that reported by SEWA and ESIS clients. Thus in most of the low cost outpatient visits by Mediclaim respondents is not reported, the average cost per out patient visit will be overestimated. So we turn to other estimates in Table 5 to arrive at a plausible marginal cost

of an outpatient visit. The NCAER all India survey was done quite some time ago, in 1993. All other surveys were more recent around 1999 - 2000. Hence we give a higher weightage to these numbers. Another important consideration is the applicability of these marginal cost estimates to the proposed health care delivery system. The provider payment system adopted by most of the schemes contributing to these estimates is largely fee for service, except of course the ESI. We have proposed a capitation based system of ambulatory care. The transaction costs of a capitation based system would be comparatively lower than a fee for service based system. The Manipal Medicare is more like the ESI, since most of the service is provided by the Kasturba hospital and its outpatient facilities. Considering all these factors we provisionally adopt an unit cost of rupees 100 per out patient visit.

**C. Administrative cost of health insurance:**

1. Rules 17-E of the Insurance Rules, 1939 limits the administrative expense in general insurance business to between 35 and 20%. (Insurance Laws, 2001)
2. We propose that these community based health insurance schemes be operated through mutual health insurance firms. The insurance function played by nonprofit mutual health insurance firms, coupled with the capitation based provider payment system, it is anticipated, will keep administrative costs down. Accordingly we propose that the administrative cost of mutual health insurance plans be limited to 10% of premium income. We have provided for a 10% administrative cost (insurance overhead) for computation of premium. There is some supporting evidence about the feasibility of a 10% administrative cost cap. For example; the average administrative costs of Minnesota Health Plans in the USA for the year 2001 (Minessota Department of Health, 2002) was 9.4%. The US Health Security Act, 1994 premium estimates allowed for 13% administrative costs, of which 4% was to be transferred to regulators to support medical research and regional health administration (American Academy of Actuaries, 1994). So the net administrative costs allowed for health plans was 9%. The Philippine Medicare spends about 12% on administrative overhead costs (Gertler and Solon, 2000, p26). This social insurance system pays the hospitals on the fee-for-service system, that is known to involve more transactions. If we take into consideration the fact that the community based health insurance system proposed by us, will pay providers on a capitation basis and hence the administrative costs should be less than what is observed in the Philippine Medicare System.

**D. Premium Estimate:**

1. Average cost per person:

Table 6: Average cost per person

| Service component | Visits / Person Year | Rate | Amount |
|---|---|---|---|
| Out patient visits + Diagnostic ser. | 1.5 | 80 | 120 |
| Health Visits | 0.3 | 20 | 6 |
| Hospital | 0.07 | 1,000 | 70 |
| Sub total of service costs | | | 196 |
| Insurance overheads (Adm costs) | | 0.1 | 19.6 |
| Total Premium / Person | | | 215.6 |

2. Annual Premium per Family: The following premium structure is recommended.

| Family situation | Rate / Annum |
|---|---|
| Basic enrollment premium for individual or family with upto three members. | 600 |
| Additional premium for family members exceeding three. | 220 |

3. Total premium for a three member household works out to Rs660 / annum. In practice, the insured families will consist of one, two and three member families. Our conjecture is that the actuarial average may work out to about Rs600 / family / annum. More accurate actuarial average can be computed only after some experience about the composition of covered families is available.
4. A family will be enrolled only if premium is paid for all members of the household in which the family lives. Thus if two or more families share live in a single household, both families have to enroll.

## VI. Financing social health insurance:

**A. Current Levels of Medical expenditure and households' ability to pay:**

The National Sample Survey (NSS) on household consumer expenditure gives details of the monetary values of consumption of various items classified as (a) food and (b) non food (NSSO, 2001). These surveys provide national and state level estimate of monthly per capita expenditure (MPCE) by economic status of the household, which is also identified by the MPCE. Households are assigned to 12 MPCE classes representing increasing levels of household income. Medical expenses is covered under the non food component in two different categories (a) medical institutional, medical treatment undergone as an inpatient and (b) medical non institutional, ambulatory care. Medical expenses include expenditure on medicines and medical goods including family planning appliances, payments made for medical treatment, and expenses incurred for clinical tests. Table 7 shows estimate allocations by rural households on medical expenses, as a percentage of total monthly per

capita consumption expenditure. These estimates from the latest five rounds of the NSS, show that poorer households allocate about 3% of their consumption expenditure on medical care. The average allocations on medical expenses by all households was between 5-6% of consumption expenditure. Most of these expenses are on ambulatory medical care. There is a slight increasing trend of household allocations for medical care.

Table 7: Household allocations for medical expenses. % of consumption exp. spent on medical out patient (Med-OP) and hospitalization (Med-IP) care.

| NSS Round[1] | Year of Survey | Poor Households | | | All Households | | |
|---|---|---|---|---|---|---|---|
| | | Med-OP | Med-IP | Total | Med-OP | Med-IP | Total |
| 51st | 1994-95 | 2.62 | 0.3 | 2.92 | 3.78 | 1.20 | 4.99 |
| 52nd | 1995-96 | 2.65 | 0.12 | 2.77 | 3.36 | 0.71 | 4.07 |
| 53rd | 1997 | 3.35 | 0.2 | 3.55 | 4.13 | 1.58 | 5.70 |
| 54th | 1998 | 2.66 | 0.17 | 2.82 | 3.86 | 1.60 | 5.45 |
| 55th | 1999-00 | 3.09 | 0.46 | 3.56 | 4.72 | 1.37 | 6.09 |

[1] All data is from NSSO publications for respective rounds: 51st- 1995, July Tb 3-4, Appendix Pg A4-A5; 52nd - 1998, September, Tb 3-4, Appendix Pg A4-A5; 53rd - 1998, October, Tb 3-4, Appendix Pg A4-A5; 54th - 1999, June, Tb 3-4, Appendix Pg A4-A5; 55th - 2001, May, Tb 5R, Appendix Pg A 233, Tb 5U, Appendix Pg A266.

Table 8 shows estimate of per capita expenditure on medical care by rural households in India, in 1999-2000, from the 55th round of the NSS. Poor households were spending, in the year 2000, about 10-15 rupees per month per capita on medical care expenses. Thus annual medical care expenditure by the poor households in rural areas would range from 120-180 rupees per capita. Most households in rural areas have between 4-5 members. Thus an average rural household was spending about 480 - 900 rupees per annum on medical care expenses. This figures gives us an idea of amount of money that a poor household may be able to pay for a comprehensive health insurance coverage. The slight increasing trend, anticipated improvements in economic growth rate, and availability of a comprehensive health insurance coverage may all contribute to a further increase in the household allocation for health care. We use this information below in our financing recommendations.

Table 8: Monthly per capita expenditure on medical care by households in rural areas of India in 1999-00.

| MPCE | | House holds | | Persons | | Monthly Per Capita Expenditure (MPCE) | | | |
|---|---|---|---|---|---|---|---|---|---|
| Class | Cl. Limit | % | Cum % | % | Cum % | Total | Med-OP | Med-IP | Med-All |
| 1 | 225 | 4.4 | 4.4 | 5.21 | 5.21 | 190.98 | 4.29 | 0.55 | 4.84 |
| 2 | 255 | 4.2 | 8.6 | 5.01 | 10.22 | 241.82 | 6.24 | 1.05 | 7.29 |
| 3 | 300 | 8.7 | 17.3 | 10.01 | 20.23 | 278.69 | 8.21 | 1.22 | 9.43 |
| 4 | 340 | 9 | 26.3 | 10.01 | 30.24 | 321.04 | 11.09 | 1.66 | 12.75 |
| **5** | **380** | **9.3** | **35.6** | **10.31** | **40.55** | **360.83** | **12.86** | **1.96** | **14.82** |
| 6 | 420 | 9.2 | 44.8 | 9.71 | 50.26 | 399.9 | 15.34 | 2.71 | 18.05 |
| 7 | 470 | 10 | 54.8 | 10.21 | 60.47 | 445.49 | 17.53 | 3.56 | 21.09 |
| 8 | 525 | 9.6 | 64.4 | 9.31 | 69.78 | 496.74 | 21.58 | 4.93 | 26.51 |
| 9 | 615 | 11.1 | 75.5 | 10.31 | 80.09 | 566.62 | 25.76 | 7.35 | 33.11 |
| 10 | 775 | 11.3 | 86.8 | 9.91 | 90 | 686 | 37.46 | 11.17 | 48.63 |
| 11 | 950 | 6.1 | 92.9 | 5 | 95 | 851.58 | 49.07 | 16.89 | 65.96 |
| 12 | >950 | 7.1 | 100 | 5 | 100 | 1,344.76 | 100.45 | 45.78 | 146.23 |
| | All | 100 | 100 | 100 | 100 | 486.16 | 22.94 | 6.66 | 29.6 |
| Poor | | 35.6 | 35.6 | 40.55 | 40.55 | 294.2 | 9.36 | 1.41 | 10.77 |

[1] Source: NSS 55th Round Report No.457(55/1.0/3), NSSO 2001. Columns 2 & 3 from Table - 1R at page A-17, Columns 4-6 from Table - 5R at page A-233.

[2] The poverty line for rural areas has been estimated as Rs.229.14 per capita expenditure at 1993 prices. Adjusted for inflation, this corresponds to Rs359.57 per capital at 1999-00 prices.

**B. Recommended financing of social health insurance scheme:**

1. We propose a system premium subsidy graded according to the income line for health and housing discussed earlier. For the poor families a range from 75 to 90% has been shown. The actual subsidy will depend on situation in each state, their finances and decisions by respective state governments.

| Income Line for Health and Housing | Reco. Health Insurance Premium Subsidy |
|---|---|
| Poor Families | 75-90% |
| Low Income Families | 50% |
| Middle Income Families | 20% |
| High Income Families | None |

2. In rural areas, premium collection cycle should be set locally by the MHO to coincide with peak cash income season. The MHOs should operate multiple premium collection cycles tailored to match high cash income periods of enrolled communities.
3. Enrolled communities are expected to work with their respective members for timely payment of health insurance premium. MHO should work with respective communities to tailor community specific premium payment procedures.
4. On average, a poor family of about four persons will spend about Rs 205 per annum to purchase the health insurance cover. We have shown above a poor family, on average, is currently allocating about 480 - 900 rupees per annum towards medical expenses. Thus there will be a balance of about 275 - 695 rupees per annum from

current levels of medical expense. This amount will cover for the 30% co-payment for drugs and medicines, envisaged in the various family protection plans.

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Mutual Health Organisation logo

**Parivar Swasthya Yojana/ Family Health Protection Plan - 1**

# Health Insurance Coverage

1. Policy Holder: Policy #

Name: _____

W/o, S/o _____

Hamlet / Street _____

Village / City _____

Taluq/Mandal _____

District _____

State PIN

Policy Holder Photograph

Specimen Sign/ Thumb Impression:

Additional Policy Holder Identifiers:

Family Members Covered:

| Name | Sex | Age | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Affiliated Community/Group:

| 3. The Mutual Health Organisation: | 4. The Clinic |
|---|---|
| Name and Business Address: | Clinic Name, Business Address: |
| Premium Payment details: | Participation Agreement # |
| Period of coverage: | |

Where as; the above policy holder seeks coverage for health care services, premium has been paid as above, the policy holder has opted in favor of the above clinic, and the said clinic has a continuing participation agreement with the above mutual health organization; Now; The Clinic will claim capitation from the mutual health organization in accordance with its participation agreement, undertakes to provide the policy holder and family members ambulatory primary health care services listed below for a period of one year, without additional fee, service charge etc. except for copayments specifically provided for in this policy; and guarantees continued enrollment with out any reference to medical conditions but subject to exercise of option by the policy holder, as well as continuation of the participation agreement.

## Ambulatory Primary Care

1. Out patient consultation including clinical examination and ambulatory medical care.
2. First aid; wound cleaning and dressing services including removal of foreign bodies, suturing of clean wounds, abscess drainage etc.
3. Injection services for ambulatory treatment with small volume parentrals.
4. Primary eye care including diagnosis and treatment of Conjunctivitis, eye lid infections, removal of conjunctival foreign body, Vitamin A deficiency; first aid and referral.
5. Dispensed primary medicines free of charge, and other essential medicines subject to 30% co payment.
6. Referral services including information about location, appropriateness and access procedures of hospitals and health care institution and specialists.
7. Access point for services provided by Public Health Authorities such as; (a) Immunisation (b) Contraceptives (c) Ambulatory treatment under disease control programs.
8. Ante natal care.
9. Prophylactic dental treatment including dental hygiene advice, dental examination and advice and scaling.
10. Primary laboratory services including routine tests of blood, urine and stools, plain X ray and collection and dispatch of samples to referral laboratory.

Provided that:

a. Services at serial 1-6 will be on walk in basis during regular clinic hours.
b. Services at serial 7-9 may be provided by appointment.
c. Some of the laboratory services may be outsourced by and at the cost of the clinic from with in reasonable distance and
d. Interpretation will be subject to the definition of terms etc. of the Parivar Swasthya Yojana.

And; the mutual health organization undertakes to pay agreed capitation to the opted clinic, and if for any reason the clinic becomes inoperative, to arrange for an alternative clinic to satisfy balance of the coverage period, provide the following hospital access services and guarantees policy renewal without any reference to medical conditions, but subject to payment of premium.

## Hospital Access Services:

1. Facilitation, assistance and advocacy to access Government Hospitals and Health Care Institutions (HCIs)
2. Direct settlement of user fees charged by public hospitals and health care institutions.
3. Supply or cost reimbursement of medicines and materials required but not available in government hospitals.
4. Cost of treatment in designated non profit hospitals and health care institutions.
5. Direct settlement or reimbursement of the cost of dispensed medicine, cost of diagnostic tests performed outside the public or designated non profit hospitals subject to 30% co payment by the policy holder. Reimbursement will be limited to price of generic drugs where available and rates of diagnostic test set by appropriate public agency or the insurer.
6. Emergency treatment in any hospital.
7. If treatment is not available in the first referral hospitals stated in clause 2 & 3 above, service charges of speciality / tertiary referral hospitals.
8. In case of major medical conditions/ catastrophic illnesses requiring very high expenditure, facilitate application to State or Charitable sources of medical assistance.

Provided that the:

a. cumulative value of medicines, materials and reimbursement stated in clause 2-7 above in respect of all persons covered by this policy does not exceed Rs. 30000 / annum.
b. The medicine (drugs), material (therapeutic) included in the appropriate formulary will only be admissible. Appropriate formulary will be the hospital/health care institution formulary approved by the health insurance firm, where such a formulary is not available, the formulary of health insurance firm, as if neither the above two are available, the list of essential drugs approved by state government, central government or WHO as the case may be.
c. Interpretation will be subject to the definition of terms etc. of the Parivar Swasthya Yojana.

Seal:

Signature, Name & desgn.
of the Issuing Authority:

Place:

Date:

---

Clinic Assignment Slip:

Policy #:

To The Mutual Health Organisation: I have opted in favor of the following clinic to avail ambulatory primary health care services for me and my family members. I will have the option to either continue with the same clinic or choose a different clinic for subsequent years.

Clinic Name, Business Address:

Policy Holder's Name
Signature/ Thumb Impression:

Participation Agreement # :

Date:

Mutual Health Organisation logo

**Parivar Swasthya Yojana/ Family Health Protection Plan - 2**

# Health Insurance Coverage

1. Policy Holder: Policy #

Name:

W/o, S/o

Hamlet / Street

Village / City

Taluq/Mandal

District

State PIN

Policy Holder Photograph

Specimen Sign/ Thumb Impression:

Additional Policy Holder Identifiers:

Family Members Covered:

| Name | Sex | Age | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Affiliated Community/ Group:

| 3. The Mutual Health Organisation: | 4. The Clinic |
|---|---|
| Name and Business Address: | Clinic Name, Business Address: |
| Premium Payment details:<br>Period of coverage: | Participation Agreement # |

Where as; the above policy holder seeks coverage for health care services, premium has been paid as above, the policy holder has opted in favor of the above clinic, and the said clinic has a continuing participation agreement with the above mutual health organization; Now; The Clinic will claim capitation from the mutual health organization in accordance with its participation agreement, undertakes to provide the policy holder and family members ambulatory primary health care services listed below for a period of one year, without additional fee, service charge etc. except for copayments specifically provided for in this policy; and guarantees continued enrollment with out any reference to medical conditions but subject to exercise of option by the policy holder, as well as continuation of the participation agreement.

## Ambulatory Primary Care

1. Out patient consultation including clinical examination and ambulatory medical care.
2. First aid; wound cleaning and dressing services including removal of foreign bodies, suturing of clean wounds, abscess drainage etc.
3. Injection services for ambulatory treatment with small volume parentrals.
4. Primary eye care including diagnosis and treatment of Conjunctivitis, eye lid infections, removal of conjunctival foreign body, Vitamin A deficiency; first aid and referral.
5. Dispensed primary medicines free of charge, and other essential medicines subject to 30% co payment.
6. Referral services including information about location, appropriateness and access procedures of hospitals and health care institution and specialists.
7. Access point for services provided by Public Health Authorities such as; (a) Immunisation (b) Contraceptives (c) Ambulatory treatment under disease control programs.
8. Ante natal care.
9. Prophylactic dental treatment including dental hygiene advice, dental examination and advice, scaling
10. Primary laboratory services including routine tests of blood, urine and stools, plain X ray and collection and dispatch of samples to referral laboratory.

Provided that:

a. Services at serial 1-6 will be on walk in basis during regular clinic hours.
b. Services at serial 7-9 may be provided by appointment.
c. Some of the laboratory services may be outsourced by and at the cost of the clinic from with in reasonable distance and
d. Interpretation will be subject to the definition of terms etc. of the Parivar Swasthya Yojana.

And; the mutual health organization undertakes to pay agreed capitation to the opted clinic, and if for any reason the clinic becomes inoperative, to arrange for an alternative clinic to satisfy balance of the coverage period and guarantees policy renewal without any reference to medical conditions, but subject to payment of premium.

Seal:

Signature, Name & desgn.
of the Issuing Authority:

Place:

Date:

Annexure - 2

Clinic Assignment Slip: Policy #:

To The Mutual Health Organisation: I have opted in favor of the following clinic to avail ambulatory primary health care services for me and my family members. I will have the option to either continue with the same clinic or choose a different clinic for subsequent years.

---

Clinic Name, Business Address:

Policy Holder's Name
Signature/ Thumb Impression:

Participation Agreement # :

Date:

Mutual Health Organisation logo

**Parivar Swasthya Yojana/ Family Health Protection Plan - 3**

# Health Insurance Coverage

Policy Holder: Policy #

Name:

W/o, S/o

Hamlet / Street

Village / City

Taluq/Mandal

District

State PIN

Policy Holder Photograph

Specimen Sign/ Thumb Impression:

Additional Policy Holder Identifiers:

Family Members Covered:

| Name | Sex | Age | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

2. Affiliated Community/ Group:

3. The Mutual Health Organisation:

| Name and Business Address: | Premium Payment details: |
|---|---|
| | Period of coverage: |

Where as; the above policy holder seeks coverage for health care services and premium has been paid as above; Now; the mutual health organization undertakes to provide the following hospital access services and guarantees policy renewal without any reference to medical conditions, but subject to payment of premium.

## Hospital Access Services:

1. Facilitation, assistance and advocacy to access Government Hospitals and Health Care Institutions (HCIs)
2. Direct settlement of user fees charged by public hospitals and health care institutions.

3. Supply or cost reimbursement of medicines and materials required but not available in government hospitals.
4. Cost of treatment in designated non profit hospitals and health care institutions.
5. Direct settlement or reimbursement of the cost of dispensed medicine, cost of diagnostic tests performed outside the public or designated non profit hospitals subject to 30% co payment by the policy holder. Reimbursement will be limited to price of generic drugs where available and rates of diagnostic test set by appropriate public agency or the insurer.
6. Emergency treatment in any hospital.
7. If treatment is not available in the first referral hospitals stated in clause 2 & 3 above, service charges of speciality / tertiary referral hospitals.
8. In case of major medical conditions/ catastrophic illnesses requiring very high expenditure, facilitate application to State or Charitable sources of medical assistance.

Provided that the:

a. cumulative value of medicines, materials and reimbursement stated in clause 2-7 above in respect of all persons covered by this policy does not exceed Rs. 30000 / annum.
b. The medicine (drugs), material (therapeutic) included in the appropriate formulary will only be admissible. Appropriate formulary will be the hospital/health care institution formulary approved by the health insurance firm, where such a formulary is not available, the formulary of health insurance firm, as if neither the above two are available, the list of essential drugs approved by state government, central government or WHO as the case may be.
c. Interpretation will be subject to the definition of terms etc. of the Parivar Swasthya Yojana.

Seal:

Signature, Name & desgn.
of the Issuing Authority:

Place:

Date:

Annexure - 4

# Quality of service standards for the clinics delivering Ambulatory Primary Care.

## I. Premises:

**A. Clinical Facilities:**

1. At least one general purpose Consultation, Examination and Observation room. The room should have a minimum floor area of 80 square feet, excluding toilets, and cupboards. The room should have; (a) an examination table, (b) a writing desk, (c) furniture to seat the patient and an attendant, (c) a wash basin with continuous water.
2. At least one Treatment room for minor surgery, first aid, etc. Floor area of the Treatment room should at least be 120 sft. Provision for dressing table, hand wash, etc.
3. A support area, centrally located with respect to the consultation and treatment rooms, and to facilitate visual control of entrance to the clinic. This area should have space for provisions, supplies, drug distribution station, etc. This area is to accommodate, paramedical, allied health and / or health care business support personnel. Should have hand wash facility.
4. A laboratory consisting of at least 120 sft floor area. Requirement may vary, if laboratory services are out-sourced, by the clinic.

**B. Conveniences:**

1. At least one toilet for patients and their attendants. It should have Indian squatting type commode. Additional toilets, depending on the level of patient attendance. Additional toilets may have Indian, European or hybrid commodes.
2. Drinking water facility for patients and their attendants.
3. Patient waiting area.

**C. General:**

1. The premises must have adequate sanitation and drainage facilities. All wash basins, wash areas and toilets should have drainage connected to a sewer system. The drainage pipes and joints should be free of leaks.
2. Must have adequate water supply. Piped water supply system with adequate overhead storage, enough to meet at least one days requirement, should be available. The plumbing system should be free of leaks.
3. Clean storage. Separate room or closet for storing sterile and clean supplies.
4. Locked storage for biologicals and drugs.
5. Sterilizing facilities. On site and / or off site provision for sterilization of equipment and supplies, and use of disposables as appropriate.
6. Soiled holding. Provision for separate collection, storage and disposal of soiled materials.

## II. Health Care Professionals, Staffing and Affiliation:

**A. Health Care staff:**

1. Primary Care Physician (PCP):
   i. At least one full time medical practitioner, holding a valid registration to practice.

ii. The clinic should clearly state through its client documentation, sign posting, reception and enquiry, about the system of medicine practiced by its primary medical practitioner.
iii. Disqualification:
    a. Medical doctors holding post graduation or higher degree of specialization other than pediatrics, family medicine, general medicine, and community medicine will not be counted as general physician[1].
iv. The PCP should be resident within a reasonable distance such that the travel time to and from the clinic is less than half an hour. Travel time is to be reckoned with respect to the mode of conveyance ordinarily used by the PCP.
v. The Primary Medical Practitioners must acquire and maintain continuing medical education credits prescribed by their respective professional councils.
vi. In addition, to the Primary Care Physician, irrespective of the system of medicine practiced by him / her, must;
    a. Attend and satisfactorily complete Continuing Medical Education of at least two weeks duration, on Ambulatory Care aspects of Public Health and Disease Control Programs, at least once in three years; and
    b. Receive and satisfy Continuing Medical Education on Preventive Eye Care and Preventive Dental Care of one week duration each at least once in six years.

2. Substitute Primary Care Physician:
    i. The clinic should have arrangement with a general physician or a physician exchange service to substitute for the PCP during periods of absence on account of illness, pregnancy, vacation or continuing education.
3. Additional Primary Care Physician: If there is sufficient demand among the clinic's clientele for services of a professional practicing a system of medicine not offered by the primary medical practitioner, the clinic should arrange for such a practitioner on a visiting basis at appropriate regularity.
4. Consulting physicians:
    i. The Clinic should have affiliation with at least two specialists for consultation. The consulting affiliation should be reinforced by periodic meetings between the specialists and the primary care physician.
    ii. The Clinic should maintain professional liaison with casualty medical officers, and specialists in the first referral hospitals to which patients from the clinic are commonly referred. This liaison should facilitate sharing of clinical information about referred cases, tele consultations between the primary care physician and attending specialists in the first referral hospitals. The referral linkage and professional liaison should be reinforced by periodic meeting between the primary care physician and the attending specialists in the referral hospitals. It will be desirable to maintain such professional liaison with as many specialists as feasible. At the least, the clinic should demonstrate evidence of continuing professional liaison with at least two specialists from among the hospitals to which the clinic commonly refers its patients.

[1] A doctor, specializing in an area that does not usually call upon practice of family physician skills will not be well suited to play the role of a family physician. There is a scope for bias in differential diagnosis of conditions lying outside the area of study of the specialist. More over, even if a specialist is extraordinary and competent enough to play the role of a family physician, there is likely to be a question of client confidence about suitability of a specialist to perform the role of a general practitioner. Hence the disqualification.

**B. Health care Support Staff:**

1. At least one full time equivalent paramedical / allied health support person such as a nurse, auxiliary nurse, nursing assistant, pharmacist, and pharmacy assistant, or dental hygienist.

**C. General support staff:**

1. At least one full time equivalent health care business support person such as secretary, Medical receptionist, Medical office assistant, Medical billing clerk, Medical records clerk, and Medical aid clerk.

## III. Equipment, Furniture, and Material Resources:

**A. Furniture:**

1. The clinic should have the required furniture to facilitate consultation, examination and treatment activities in respective areas.
2. These will include;
   i. Office Table, Chairs, and Examination Tables, as required.
   ii. Storage shelves for clinic requisites, and
   iii. Bulletin boards to hold frequently required telephone numbers, and such other reminders.

**B. Equipment:**

1. The clinic should have the required equipment to facilitate examination, diagnosis and treatment activities in respective areas.
2. A current, accurate, unique inventory should be kept of all equipment in the clinic, regardless of the equipment's ownership or purpose.
3. Each piece or type of equipment listed in the inventory should have written equipment testing procedure, and user guidelines.
4. Each piece of equipment should be tested prior to initial use and at least once a year thereafter. Such testing should be documented.
5. Individuals who use and / or operate the equipment should receive orientation and refresher training. These orientation and training activities should be documented, giving details of the dates of orientation, name(s) of person given orientation, and Name(s) of trainers.
6. The treatment room should be equipped for first aid.
7. The clinic's equipment should include;
   i. Appropriate sterilisation facility to ensure regular supply of sterile materials for clinical examination patients, dressings and other materials required in the treatment room.
   ii. Equipment for rapid sterilisation of instruments and materials used in the treatment room.
   iii. Clinical diagnostic and test equipment as appropriate.
8. The clinic should have enough supply of disposable syringes needles and collection and administration sets required for administration of injections and management of emergencies.

Annexure - 4

## IV. Quality of Care and Responsiveness:

**A. Quality of Professional Care:**

The clinic should have policy and a mechanism of its enforcement to ensure that its health care professionals and support personnel follow high standards of practice in their respective profession. In particular:

1. The physicians should follow systematic history taking and clinical examination, supplemented, where necessary, by appropriate diagnostic procedures, laboratory and radiological studies, to arrive at an accurate clinical impression, or working diagnosis.
2. Treatment should be consistent with clinical impression or working diagnosis. Available, professional practice guidelines should be followed as far as feasible. Prescriptions and treatment plan should first exhaust drugs and therapeutics in applicable formulary.
3. The physicians should use the facility of consulting physicians affiliated to the clinic, whenever the situation requires.
4. Instructions to and education of patients and attendant, if any, regarding the prescribed treatment including use of medicines and other therapies.
5. Appropriate, accurate and complete medical record entries should be made.
6. The clinics to be capable of providing initial evaluation, support or stabilisation of patients in emergencies. In case, referral to hospital is needed, the clinic should establish contact with concerned institution over telephone, fax, etc. and facilitate quick admission.

**B. Access & Sign Posting:**

1. Entrance to the clinic should be separate, so that patients need not go through other activity areas and there is no unrelated traffic within the clinic area.
2. Appropriate signs should be posted in the neighborhood, at the entrance and within the clinic area to direct new patients to the clinic.
3. A description of the clinic hours, holidays, intake system for appointment holders, walk-in patients, handling of emergency after clinic hours. These details should be made available through written fact sheets / flyers and should be prominently displayed for reference by visiting patients and their attendants. Support staff should be trained to draw client attention to the clinic hours and after hour access procedure.
4. A mechanism to inform clients, the names and access telephone numbers of primary care physician, substitute primary care physician, and additional primary care physician, if any.

**C. Telecommunication Access:**

1. The telephone acts as a means of access for people outside the Clinic. The clinic should have at least one telephone to receive calls and place calls to the referral Health Care Institutions (HCIs), part time and affiliated health care professionals. Separate telephone for dial in and dial out will be preferred.
2. The Primary Care Physician, Substitute Physician and Additional Primary Care Physician, if any, should all have should have a dedicated residential telephone for off hour and emergency accessibility to the clinics clientele.

**D. Medical Record:**

1. The clinic should maintain a medical record system that allows for prompt retrieval of information. Separate medical records should be maintained for each individual

client. Medical records of clients belonging to the same health insurance policy should be linked together.

2. Timely and adequate transfer of appropriate patient care documents and information when clients are referred for hospitalisation or care by specialists.
3. Timely and adequate transfer of appropriate patient care documents and information when a family registers with another clinic.
4. Except as required by law, clinical, financial, and social data of patients contained in medical records should be kept confidential and should not be disclosed or shared without specific approval of the concerned patient.

## V. Pharmacy:

1. The clinic should either have its own drug store to dispense primary and essential medicine to its client and / or have an affiliation with a pharmacy for this purpose.
2. The affiliated pharmacy, if any, should be located very close to the clinic within a distance of 100 yards.

## VI. Laboratory:

1. The clinic should either have its clinical laboratory to provide primary laboratory services such as routine tests of blood, urine and stools, collection and dispatch of samples to referral laboratory.
2. Alternatively, the clinic may out-source some or part of the laboratory services from an affiliated laboratory. The affiliated laboratory should be located within reasonable distance of the clinic.

## VII. X-Ray:

1. The clinic should either have facility for plain X-ray or out-source the same from an affiliated radiology service.

## VIII. Legal status and governance:

1. The clinic should have a legal status independent of its promoters, owners, or managers.
2. In case of sole proprietary firms;
    i. The proprietor, should be a health care professional, such as a medical doctor, or allied health care professional, such as a nurse, pharmacist, whose full time service in the clinic is required. Such health or allied health care professional should have a valid registration from the relevant professional council, and
    ii. the proprietor should be working full time in the clinic.
3. In case of partnership firms;
    i. Each partner, should be a health care professional such as a medical doctor, or allied health care professional, such as a nurse, pharmacist, whose full time service in the clinic is required. Such health or allied health care professional should have a valid registration from the relevant professional council, and
    ii. At least one of the partners should be working full time in the clinic.
    iii. Other partners may work full or part time.
    iv. A substitute primary care physician or additional primary care physician may be partners in the clinic.
4. In case of a franchise;
    i. There should be a valid franchise agreement between the franchisor and the franchisee.

   ii. The franchise agreement should be consistent with the standards and quality assurance requirement of a participating clinic.
   iii. Structural, process and functional standards of service, supported by the franchise may be taken into consideration by the mutual health organisation to assess suitability of a clinic to participate.
5. Voluntary and nonprofit organisation
   i. May be societies registered under the relevant society registration act, public trusts under the relevant public trust law, or nonprofit companies registered under the companies act, and
   ii. Should maintain their nonprofit status under section 12 of the Income Tax Act.
6. The clinic should have an independent bank account to handle its receipts and expenditure.

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Annexure - 5

# The Swablamby Swasthya Yojana. A Community Based Health Insurance Experiment in Ratlam District, Madhya Pradesh, India.

**Prasanta Mahapatra[1], Samatha Reddy[2]**

In this paper we report about the genesis, operation and impact of the Ratlam Swablamby Swasthya Yojana (SSY).

## I. Materials and Methods:

Most of the methods are the rapid assessment procedures (RAP). RAP was used to understand the successes and problems related to the implementation of the Swablamby Swasthya Yojana.

### A. Key Informants interview:

Key informant interview were used to find out the implementation and operational issues of the SSY. We first met the key player for envisaging the SSY and the architect of the scheme Mr. Manoj Jhalani, then District Collector, Ratlam, and now Director, Panchayat Raj, Govt. of MP to understand the genesis of SSY. Other important persons like (a) Present District Collector of Ratlam (b) Addl. Collector of Ratlam (c) Members from the Indian Red Cross, Ratlam Branch (d) Tahsildars (e) Store Keepers etc. were interviewed. Each of them had a key role to play in the implementation of SSY at different levels.

### B. Participant Observation:

This method was used to observe the patient in flow at the district drug stores. This gave an insight into the socio cultural context of the households that are accessing the facility. We interacted with the patients or attendants who visited the drug stores during the hospital out patient hours to understand the utility pattern of the scheme.

### C. Conversation:

We conversed with the beneficiaries of the SSY during the filed visits to understand their perspectives about the scheme, its implementation etc.

[1] Director, The Institute of Health Systems, Hyderabad
[2] Faculty, The Institute of Health Systems, Hyderabad

Annexure - 5

## II. Background and Genesis:

Many a times Collectors, other public administrators, and peoples' representatives have to deal with petitions from the poor and needy seeking assistance for treatment of serious illness. Mostly, the petitioner is unable to meet the cost of treatment. Empathetic public administrators may tap discretionary sources to satisfy such requests. But these are usually inadequate to meet full cost of treatment or satisfy the request of all poor and needy people. Manoj Jhalani was the Collector of Ratlam in 1999 . Jhalani was very concerned about the inability of poor people suffering from serious illness, to access appropriate treatment. He believed that suffering and premature death on account of untreated illness merely for lack of funds to meet cost of treatment would be considered inhuman in any society.

The MP State Sickness Assistance Fund Act[3], 1997 (SAF) allows for financial assistance to poor families for catastrophic illnesses where treatment cost exceeds Rs25000. Treatment costs up to a maximum of Rs1.5 can be paid from out of the SAF. But the SAF does not provide for serious illness, where treatment cost is less than Rs.25000. The SSY was Mr. Jalani's response to mitigate this problem and was designed to fill this gap. This was a spontaneous response to frequent appeals from poor households mostly coming from rural areas and seeking assistance to meet costs of medical care. The scheme was introduced through the Ratlam branch of the Indian Red Cross Society (IRC-Ratlam). The IRC-Ratlam was chosen since this provided a convenient institutional base for collection of donations and premium referred to as membership contributions by the scheme. The Ratlam SSY was introduced in April 1999 and started functioning from June, 1999. Membership of the SSY is open to all people living in rural areas of the Ratlam district. Family is considered as a unit and membership fee is based on socio economic status of the family. Families having a person suffering from chronic diseases fall under different premium structure.

## III.Features of SSY:

This scheme was introduced for rural households to meet additional costs of medicines and treatment not available in public hospitals.

[3] This Act actually regulates drawl of financial assistance from the Prime Ministers relief fund and such other relief funds. Specific budget program is usually not there. It is understood that as a result there are long queues and a large back log.

Annexure - 5

**A. Population Coverage:**

Ratlam district has a rural population of around 8.5 lakhs as of 2001 census. Table 1 shows the number of households that are covered under SSY scheme. It can be noted that the households that enrolled under the scheme decreased from the year 1999 to 2002.

Table 1 : Population coverage under SSY 1999-2002

| Year | No. of Households |
|---|---|
| 1999- 2000* | 7049 |
| 2000-2001 | 5459 |
| 2001-2002 | 5370 |

The financial year for SSY is from October to November. * From July 1999-Nov 2000

Data related to the socio economic conditions of the households enrolled in SSY are not available at the district level. We tried to analyse data from the drug distribution register maintained at the district drug store, so as to get a beneficiary profile who are accessing the services at the district level. Table 2 gives the number of beneficiaries who has accessed the district store. This may not accurately depict the true beneficiary profile.

Table 2: No. of beneficiaries in different socio economic classes who are accessing services at the District Hospital

| | Sep 2002 | | | Oct 2002 | | |
|---|---|---|---|---|---|---|
| | BPL | APL | Total | BPL | APL | Total |
| SC | 7 | 37 | 44 | 3 | 21 | 24 |
| ST | 28 | 12 | 40 | 21 | 4 | 25 |
| OBC | 29 | 43 | 72 | 21 | 36 | 58 |
| General | 27 | 43 | 70 | 22 | 22 | 44 |
| Total | 91 | 135 | 226 | 67 | 83 | 151 |

From the above data it shows that people from OBC and other castes are accessing the services at the district hospital more. With in this group, above poverty line people are utilizing the services more when compared to below poverty line people. Schedule tribes below the poverty line are utilizing the services more when compared to the number of Schedule caste beneficiaries. Schedule caste below poverty line beneficiaries are very low compared to other castes. A more detailed analysis is required to see the beneficiary profile of the SSY. Below we have given a brief description of the population coverage in two tahsils of Ratlam district.

1. Coverage in Sailana Tahsil:

Sailana Tahsil has around one lakh population and 242 habitations. Sailana is a tribal block. There are around 8000 below poverty line families in this area. There are four Primary

Health Centers (PHCs) and one Community Health Center (CHC) in the Sailana Tahsil. The records and registers related to SSY are not readily available at the Tahsildar office. It was noted that a separate register is being maintained for SSY beneficiaries recently. Village wise beneficiaries list is available at the Panchayat office. These list from various villages are filed at the Panchayat office. The CHC has the SSY drug store. Table 3 gives the beneficiary coverage under SSY in Sailana Tahsil. Socio economic bifurcation of the beneficiaries are not readily available.

Table 3: Beneficiary coverage in Sailana Tahsil

| Year | No.of Households enrolled |
|---|---|
| 1999 - 2000 | 2,578 |
| 2000 - 2001 | 705 |
| 2001 - 2002 | 2,125 |

The Medical officer at the CHC Sailana mentioned that migration and draught are the main reasons for dropouts in the beneficiaries. He mentioned that the health workers and other health personnel do propagate about the scheme and take a active role in enrolling the beneficiaries.

One of the beneficiary in Sailana rural ward, when asked about the scheme mentioned that she had to run around the tahsildar's office to get the card. After the card was available to her she had to go to the district hospital as the required treatment was not available at the CHC. She once again visited DH, but did not go with the card and hence she had to buy the medicines. She said that running around for the card is a difficult task. Another beneficiary said that he was availing the services that are provided under this scheme and he is satisfied with it. The third beneficiary we spoke to mentioned, that he has taken the card, but did not use till now as no one in his house fell ill. But still would prefer to continue because of the benefits provided under the Scheme.

2. Coverage in Jaora Tahsil:

Jaora is around 35 kms from Ratlam. It has a Civil Hospital (Area Hospital). At the Janpat (Panchayat Office) the details of each year were filed as the panchayat karmi gives it. The Tahsildar office maintains a register of the beneficiaries who are enrolled. The cards that are incompletely filled were also signed by the Tahsildar. The details of the card members are supposed to be verified by the Tahsildar and then it has to be issued. But complete verification was not done by the Tahsildar level.

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The Civil Hospital in Jaora has a SSY drug store. Beneficiaries of SSY did not visit the drug store from July 2002. The Medical Officer of the hospital mentioned that people from long distances would not come to the hospital just to get the drugs being given at the SSY store. He said that the transportation charges would be high to reach the hospital. He mentioned that the scheme has to be implemented through all the PHCs so that people would be able to avail the benefits of scheme.

The beneficiaries of the Borda village in Jaora tahsil, which is around 2 km from the Jaora town are not fully aware of the benefits given in the scheme. The details of the family members are not entered in the SSY card. The village panchayat karmi who was supposed to enter the details is not aware that the details has to be filled in the card. The beneficiaries were also not aware that the scheme is entitled for all the family members. It was also noted that most of the beneficiaries who enrolled did not access much benefits from the scheme.

**B. Benefit package:**

The benefit package of SSY includes:

1. Supply of drugs and surgicals that are not available in the public hospitals:
   Most of the drugs are purchased by generic name. Some drugs not available under generic name are bought with specific company name. They call these as "ethical drugs". The prices of generic drugs are much less than the MRP shown on the drugs. However they write the MRP of the drugs in the drug distribution register to compute the total disbursement against the maximum coverage limit of the scheme There are 13 drug stores under the SSY. The store keepers at the respective institutions maintain two different type of registers (a) Drug distribution register (b) Stock Register. The drug distribution register is maintained with the details of the patient like age, caste, economic status , name of the disease, etc. The register also has a column for the type and cost of the drugs provided to the patient. The cost of the drugs that are filled in this column is the Maximum Retail Price (MRP) i.e. the market price for which it is available in the retail medical stores. The IRC would procure the drugs at a much lesser price.

2. Reimbursement of treatment costs in emergency in any hospital:
   The beneficiaries of the SSY are reimbursed for any health costs incurred by them in emergency. The patients are reimbursed through demand draft or the hospitals that treated the patients are reimbursed directly. Around four lakh rupees has been reimbursed over the past

three years on account of medical costs. Table 4 shows the hospitals that were reimbursed for treating SSY beneficiaries.

Table 4 : Hospitals reimbursed for treating SSY beneficiaries

| City | HCI |
|---|---|
| Ratlam | Jain Divakar Hospital |
| Bombay | Tata Memorial Hospital |
| Baroda | Gayathri Nursing Home |
| Baroda | Baroda Heart Institute & Research Center |
| Indore | Maharaja Yashwant Rao Hospital |
| Indore | Dr. C.B Swami Sridhar |
| Indore | Rajat Varma Union Hospital |
| Ahmedabad | U.N Mehta Institute of cardiology |
| Ahmedabad | Civil Hospital |
| Ahmedabad | Cancer Hospital |
| Navsari, Gujarat | Rotary Eye Institute |
| Mumbai | K.E.M |

**C. Organization of Health Services:**

The Public Health Care Institutions (HCI) are the primary providers of the health care services. These are supplemented with the drugs and surgicals that are not available in the public HCIs thorough the special drug stores. There are 37 HCIs that fall under the scheme of which 12 has the SSY drug stores. Out of 31 PHCs only 6 PHCs has the drug stores. It is mentioned by the IRC that non availability of Medical Officers at the PHCs is the main reason for not establishing a drug store at these PHCs. Table 5 gives the number of public HCIs and drug stores availability under the SSY.

Table 5: Public HCIs and SSY drug store availability

| Type of HCI | No. of HCIs | SSY drug store |
|---|---|---|
| PHC/ Mini PHCs | 31 | 6 |
| Civil hospital | 2 | 2 |
| Community Health centre | 3 | 3 |
| District Hospital | 1 | 1 |

It is noted that most of the patients come to the DH for treatment. CHCs and PHCs does not seems to be having much of the clientele. It was mentioned that the most of the facilities are available in the DH and hence patients prefer to visit DH. This can also be noted from the Table 6 below that the expenditure on drug distribution is more in the district

drug store. Availability of Health Care Professionals, especially docotors at the PHC and CHCs are mentioned to be a problem in other sub districts hospitals.

Table 6 shows the drug stores functioning under the SSY and the amount expended in drug distribution as per the MRP.

Table 6: Drug stores under the SSY showing drug distribution expenditure

| | 1999- 2000 | 2000-2001 | 2001-2002 | Total |
|---|---|---|---|---|
| District Store, Civil Hospital Ratlam | 550325 | 878134 | 584844 | 2013303 |
| Civil Hospital, Alote | 26402 | 2629 | | 29031 |
| Civil Hospital, Jaora | 100759 | 17167 | 11729 | 129656 |
| Community Health Center, Bajna | 83195 | | | 83195 |
| Community Health Center, Sailana | 44710 | 6724 | 7467 | 58901 |
| Community Health Center, Namli | 11815 | | | 11815 |
| Civil Dispensary, Tal | 14990 | | | 14990 |
| Primary Health Center, Piploda | 15130 | 1471 | | 16601 |
| Primary Health Center, Bardia Goyal | 1927 | | | 1927 |
| Primary Health Center, Bilpank | 11674 | | | 11674 |
| Primary Health Center, Kharnakala | 65452 | | | 65452 |
| Mini PHC, Raoti | 32181 | | | 32181 |
| Mini PHC, Ringnod | 23142 | | | 23142 |
| | 981702 | 906125 | 604040 | 2491868 |

1. District drug store:
   The district drug store at the District Hospital, Ratlam has two drugs store keepers employed under SSY. Both the drug distribution and stock registers are maintained by these store keepers. The drug distribution registers is maintained up to date in the district drug store. The daily distribution of the drugs are tallied on a day to day basis and entered in the stock registers. The stock received and distributed to various stores are maintained at the district drug store stock register. The stock is distributed to the sub stores by the district store keepers and details are entered in the stock register.

2. Sub district drug store:
   The sub district drug store is maintained by the compounder of the respective Health Care Institution (HCI). No separate store keeper is employed to maintain the sub stores under the SSY. The sub district drug store keepers come once in month or bimonthly to the district drug store to collect the medicines. They pick up the required number of drugs as per their requirement. Regular reporting system from the sub stores is not established. The sub district store keeper do not submit reports on a monthly basis. If the IRC committee members

happens to visit any of the drug stores they would check the registers. Regular stock verification is not being done at the sub district stores. IRC members expressed that they are not able demand much from these people are they are not being paid any additional amount or honorarium for maintaining the SSY drug store.

i. Sub district store at Community Health Centre (CHC) Sailana: In CHC Sailana a separate cupboard is maintained to store the SSY drugs. The nurse maintains the drug distribution register and the compounder maintains the stock register. These registers are being poorly maintained. The stock register maintained by the compounder had a last entry in July 2001.
ii. Sub district store at Civil Hospital, Jaora: The Civil Hospital in Jaora has a SSY drug store. It has been noted that availability of the drugs in the store is sufficient. But beneficiaries of SSY did not visit the drug store from July 2002. There was no entry in the drug distribution register from 26th July 2002. The compounder mentioned that he would visit the district stores once in 4-5 months to the to collect the drugs. It has been long that he went to collect the drugs, as utility of drugs is low, due to poor turn out of the SSY beneficiaries.

**D. Provider Payment Mechanisms:**

The Panchayat Secretary/ Karmi tries to identify the beneficiaries of the SSY at the village level. He is the key player to disseminate about the scheme details to the beneficiaries and enroll them in the SSY. The SSY cards are printed and distributed to the Tahsils by the IRC. The Tahsildar inturn distributes them to the Panchayat Karmi. The SSY card has to be filled by the Karmi with the details of the Head of the Family, family members, age, caste. If the family is under Below Poverty Line (BPL), then the BPL number has to be included. The Karmi maintains a register with the year wise details of the SSY card holders. The Panchayat Karmi collects the premium amount from the families. The premium amount and the filled in SSY cards are submitted to the Tahsildar. The premium amount is then sent to the Panchayat office and the CEO of the Panchayat issues the receipts for the same. After receiving the receipts from the Panchayat office, the Tahsildar signs the SSY card after validating the details given on the card. A register is to be maintained at the Tahsildar office and at the Panchayat Office with the details of the Head of the family, socio economic status etc. The Panchayat Karmi collects the receipts and the SSY cards and hands them over to the respective beneficiaries. Generally enrollment is done in the months of September and October. For year 2002-2003, it was extended till November end. The collected amount is sent to the IRC and then drugs are purchased and distributed accordingly.

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**E. Premium structure :**

The SSY scheme mobilises finances from multiple sources. These are; (a) membership fees, i.e. Premium to avail services under the scheme, (b) donations from philanthropists, (c) reimbursement claims from other government programs. The annual membership fee (premium) is based on the family income. The membership fee is fixed on the basis of the principle that poor pay lower premium and rich pay more. Family is the basic unit of membership. Head of the family, spouse, children and dependent parents are covered for treatment costs upto Rs25000 per annum. Table 7 shows the premium structure of SSY.

Table 7: SSY Premium structure

| Member's Socioeconomic Status | Annual Fee |
|---|---|
| Below the poverty line (BPL) | |
| Scheduled Caste (SC or Tribe (ST) | Rs 50 |
| Others | Rs 100 |
| Having a person suffering from any chronic disease. | Rs 1,000 |
| Above the poverty line | |
| Minimum premium | Rs 200 |
| Having a person suffering from any chronic disease. | Rs 2,000 |

In addition to the membership fee, the IRC-Ratlam raises additional funds by donation from philanthropists. Certain government programs and schemes allow for payment of treatment costs to underprivileged population. When a SSY member, who is other wise eligible for assistance under another government program, avails medical care, an effort is made by the SSY to claim reimbursement of treatment costs from other programs. SSY amount is being deposited in the SBI as a fixed deposit, and the interest is also further deposited into the account

**F. Financing the community based insurance:**

The first year of implementation had generated maximum amount of revenue. Around 60% of the revenue in the first year came in the form of donations. The following two years did not receive any donations. The premium collected in the first year of implementation is also much higher than the other two years. The interest on the deposits remained a source of revenue through all three years. It is noted that over the three years amount from the premium is decreasing. The first year had maximum premium as it also included the beneficiaries who were taken in on a pilot basis of six months. Table 8 shows the revenue generated by SSY.

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Table 8: Revenue generated for SSY from 1999-2002

| | 1999- 2000 * | 2000-2001 | 2001-2002 | Total |
|---|---|---|---|---|
| Donation | 2588948 | - | - | 2588948 |
| Membership fee | 2347882 | 620300 | 400369 | 3368551 |
| Interest on deposits | 123817 | 259627 | 227790 | 611234 |
| Medicines donated | 200000 | - | - | 200000 |
| Total | 5260647 | 879927 | 628159 | 6768733 |

The financial year for SSY is from October to November. * From July 1999-Nov 2000

Funds are utilized to supplement care provided by government hospitals and health care institutions. Table 9 gives the expenditure statement of the SSY.

Table 9 : Expenditure statement of SSY

| | 1999- 2000 | 2000-2001 | 2001-2002 | Total |
|---|---|---|---|---|
| Purchase of medicine | 868681 | 465258 | 250392 | 1584331 |
| Reimbursement to patient | 29175 | 350930 | 48203 | 428308 |
| Equipment purchase | 300000 | | | 300000 |
| Stationary | 74849 | 38700 | 26367 | 139916 |
| Furniture | 13900 | | | 13900 |
| Store keeper | 20836 | 37355 | 44000 | 102191 |
| Miscellaneous | 85570 | | | 85570 |
| Award to field workers who encouraged FP | | 48500 | | 48500 |
| Bank Charges | | 443 | 150 | 593 |
| Total | 1393011 | 941186 | 369112 | 2703309 |

Maximum amount i.e. around Rs. 16 lakhs has been spent on purchase of medicines. Administrative costs for three years is around 3.4 lakh rupees which is around 13 percent on the total expenditure.

## IV.Administration and Management:

The SSY committee is chaired by the Collector of the Ratlam district and the additional collector is the Office In charge of IRC. The members of the committee meet at least once in three months and also as and when there is any need. Issues related to the implementation, drug procurement, reimbursement of expenditure to the patients etc. are reviewed and finalized in these meetings. Drugs are purchased once in a year on basis of

tender. The office bearers opens the tenders and short lists the suppliers and final decision is taken by the Collector. The detail list of office bearers is given in appendix- 1.

The Indian Red Cross Society (IRC) Ratlam branch acts as a Mutual Health Organisation. It was envisaged that the SSY would not spend much of its financial resources on the human resources. Hence the responsibility to implement SSY was given to IRC, with its readily available network, infrastructure and human resources.

## V. Impact of the scheme:

The scheme aims to increase the access to public hospitals thorough provision of drugs and surgicals. It was observed that the people are accessing the district hospital more as medicines and surgicals that are not available in the DH is being provided by the SSY drug store. There was a demand for these kind of stores at the sub district hospitals and PHCs.

### A. Monitoring and Evaluation:

There is no monitoring system in place at any level of implementation. A general audit is done at the district level for accounting purposes. No reporting system exist from the sub district level to the district level i.e. IRC. No feedback mechanism has been noted from the district to sub district level and vice versa.

It is noted that the ANMs are not being involved either in motivating the beneficiaries or in any other activities related to SSY. The involvement of the other health personnel also seems to be lacking.

### B. Replicability:

If the scheme has to be replicated following issues need to be looked at:

1. Socio economic profile of beneficiaries: Understanding the socio economic profile of the beneficiaries would enable to further plan the replicability of the scheme. It would aid to develop strategies that would be adopted to reach the target beneficiaries.
2. Financial viability: If we try to increase the number of beneficiaries would we be able to meet the demand of medicine supply i.e. the main source of expenditure, is noted as the main concern. Understanding the utility pattern of the drugs and epidemiological profile would help us arrive at the financial viability of the scheme.

### C. Services to be rendered: Drug store approach

The major service being provided under SSY is distribution of drugs and it is also restricted to only few HCIs. It would be beneficial to provide other services like advocacy for referral cases etc. Now also advocacy is being done in an adhoc manner at the IRC, Ratlam.

**D. Awareness:**

Awareness about SSY seems to be lacking. Even the card holders are not able to tell about the benefits that they would have under the scheme. It is more a routine procedure that the village karmi fills in the card and hands it back to the beneficiary collecting the membership fee. In one of the village the Village karmi was not sure of the amount to be collected for the above poverty line SC/ST families.

**E. Other Observations:**

It was evident that the Collector was very keen to implement the SSY effectively. There seems to be apprehensive about the financial burden that would be added to the implementation, if the coverage is increased. They are also concerned about the present approach of covering all the rural people in the scheme. They would like to aim more at the needy people who are in real need for the scheme benefits. They are contemplating on these issues to strengthen the SSY.

IRC, Ratlam works under a limited vision. They are not keen to spend money on human resources. Management and administrative skills are lacking at the IRC. As SSY is one of the program they implement under IRC, they have a blanket approach for all the schemes. There are not able to focus on monitoring the scheme at all levels.

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SSY Appendix-1: Details of the office bearers

| Current Office bearers of SSY | |
|---|---|
| Shri. Prabhat Parashar, IAS | Collector & Chairman |
| Dr. ML Gupta, Chief Medical Officer | Vice Chairman (I) |
| Shri. Anil Jalani | Vice Chairman (II) |
| Shri. Kailash Joshi | Secretary |
| Shri.Shabbir Dawsan | Treasurer |
| Shri. B.S Rawal, Retd.Dy. Collector | Hony. Asst. Secretary |
| Shri. Mohanlal Makwana | Hony. Joint Secretary |
| Shri. J.K Jain, Add. Collector | O.I.C Red Cross |
| Shri. Sushil Nahar | Member |
| Shri. Gyanshinghji | Member |
| Dr. Jagdish Khandelwal | Member |
| Dr. Padam Ghate M.D | Member |
| Shri. Babulal Paliwal | Member |
| Shri. Pannalal Jain | Member |
| Shri. Saradar Hardayal singh | Member |
| Smt. Usha Jain | Member |
| Shri. Susil Munat | Member |
| Shri. Lalit Dakh | Member |

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# Part - 2:

# Background Papers.

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# Note on important issues about implementation of Health Insurance Scheme announced by the Union Finance Minister

The announcement of a health insurance scheme by the Union Finance Minister has raised hopes among many. However, doubts remain about operationalization of the Finance Ministers vision. The information about the "community universal health insurance scheme" announced by the Union Finance Minister suggests that this is a group insurance variant of the Mediclaim.

There are certain problems that need to be addressed for successful implementation of the insurance scheme. Firstly, we need to recognize that the public sector general insurance companies are offering what are called private voluntary health insurance schemes. Hardly any country in the world relies on voluntary health insurance to achieve its public health goals. In the United States of America, where voluntary health insurance schemes are some what in vogue, bulk of the voluntary health insurance schemes are offered by nonprofit mutual health insurance organizations, with affiliation to groups of hospitals. These are the Blue-Cross and the Blue-Shield. Some may argue that our General Insurance Companies (GIC) are publicly owned and hence can be treated as non profits. But this may change after disinvestment. Another contrast is the lack of domain knowledge on health care. The Blue Cross and Blue Shields were set up by group of hospitals. Hence they were strongly footed to some health care delivery knowledge. The primary domain of our GIC's is Marine and fire insurance. These are quite different from what is required for health insurance

Secondly, by community health insurance scheme, we mean community rating of risks. For example, the present proposal allows option to cover parents. A community risk rating system will not allow for such options. By universal coverage we mean NHS like universal coverage of all resident population by health care. It may not be feasible for us to straight away go for universal coverage. But community rating of risks will be feasible.

Thirdly, the administrative overhead of a voluntary health insurance scheme is very high. The IRDA allows for about 35 to 20% over head. We believe the scheme announced by the FM allows for about 25% administrative overhead (10% for business acquisition + 5% for claims processing and + 10% for intermediaries). Our estimate is that claims processing and insurance administration overheads will take about 10%. We feel there is no reason to

allocate 10% for business acquisition. If this is a universal and community health insurance scheme, where is the need for sales agents to sell the policies? This is one reason why voluntary health insurance schemes are expensive. On the other hand promoting nonprofit mutual health insurance organizations will help keep the administrative costs within 10%. Experiences elsewhere in the world support this view. Allowing for about 35% administrative expenses and grant of a 100 rupee premium subsidy per family essentially means that the government will be subsidizing the Insurance company administrators to operate a high cost profit oriented health insurance business. There will not be any money left from this 100 rupee subsidy to pass on to the poor. Although the FM's intention is to provide subsidy to the poor, the scheme may end up doing the opposite.

Fourthly, system of administration of subsidy has a bearing on the market. Traditionally, thus far, GOI have directly released subsidy or premium to the GIC companies. That system will further reinforce our suspicion about the likelihood of the subsidy going towards administration cost, instead of passing on to pay for health care costs of targeted families. Instead, giving vouchers to the target families and letting them encash it at the time of purchase of policies may be a better idea.

We believe that these provide feasible alternatives to implement the FM's vision of community health insurance and move towards universal coverage.

# VimoSEWA: A note on the health insurance scheme of the Self Employed Women's Association (SEWA)

The Self Employed Women's Association (SEWA) is a labour union of women working in the informal sector. Established in 1972, SEWA now has around 4 lakh members. It was started in Gujarat and has expanded to Madhya Pradesh, Uttar Pradesh, Delhi, Bihar and Kerala. SEWA's goals are to organize women to achieve full employment and self reliance. Full employment includes work and income security, food security and social security, health care, shelter and insurance. Self reliance is both in terms of economic viability and in terms of women's control over management and decision making. The four major categories of workers in informal sector are (a) Home based workers (b) Vendors (c) manual laborers and service providers (d) producers. SEWA provides its beneficiaries support services like legal service, capacity building of members, Health Care, child care and insurance.

The insurance scheme known as VimoSEWA, was set up in 1992. The historical roots of this scheme can be traced way back to 1978 when the Life Insurance Corporation (LIC) agreed to linkup with SEWA Bank to cover SEWA members for life insurance. Then only natural death was covered. VimoSEWA has a combined life and non life insurance scheme. The nonlife component includes catastrophic insurance designed to undertake risk exposure of women workers. The scheme has a novel premium payment design consisting of (a) a traditional annual premium component and (b) an optional fixed deposit component. Those who opt for the fixed deposit extension to the premium increase their risk coverage. The health insurance part of the scheme covers hospitalization, maternity and occupational illness costs upto a maximum of 2000, 5500 or 10,000 depending on the scheme. The catastrophic insurance component includes accidental death, accidental death of husband, house and assets coverage. The life insurance component covers natural death.

The following are the details of the premium and risk coverage under VimoSEWA:

Table 1: Premium details of the VimoSEWA scheme

| | Scheme I | Scheme II | Scheme III |
|---|---|---|---|
| **Members Insurance** | | | |
| Annual Premium | 85 | 200 | 400 |
| Fixed Deposit* | 1,000 | 2,400 | 4,800 |
| **Risks Covered** | | | |
| Hospitalization | 2,000 | 5,500 | 10,000 |
| Life Insurance | | | |
| Natural Death | 3,000 | 5,000 | 10,000 |
| Non life Insurance | | | |
| Accidental Death | 40,000 | 40,000 | 40,000 |
| Accidental death of husband | 15,000 | 15,000 | 15,000 |
| House & assets insurance | 5,000 | 10,000 | 20,000 |
| **Husbands insurance** | | | |
| Annual Premium | 55 | 150 | 325 |
| Fixed Deposit* | 650 | 1,800 | 4,000 |
| **Risks Covered** | | | |
| Hospitalization | 2,000 | 5,500 | 10,000 |
| Life Insurance | | | |
| Natural Death | 3,000 | 5,000 | 10,000 |
| Non life Insurance | | | |
| Accidental Death | 25,000 | 25,000 | 25,000 |

* Interest from this fixed deposit (FD) is used as premium. Special incentives like Maternity benefit of Rs 300, Reimbursement of denture expenses and hearing aid of Rs. 600 and Rs. 1000 respectively are also given for FD linked members.

The VimoSEWA started with around 50000 women who insured themselves. As of 2002, a total of 72000 women are insured. Around 18000 of these women have subscribed for the "husband option". Thus total persons insured in 2002 were 90000. VimoSEWA obtains reinsurance from general insurance companies who are required to abide by the IRDA, Obligations of Insurers to Rural Social Sectors Regulations, 2000[1] SEWA insurance program has multiple partners including Life Insurance Corporation (LIC), National Insurance Corporation (NIC) and German Technical Cooperation Agency (GTZ) . LIC provides the complete coverage for natural death and partial coverage for accidental death.

[1] Every insurer, who begins to carry on insurance business after the commencement of the Insurance Regulatory and Development Authority Act,, 1999, shall, for the purposes of Secs. 32-B and 32-C of the Act, ensure that he undertakes the obligations, during the first five financial years. The Insurance Regulatory and Development Authority (Obligations of Insurers to Rural Social Sectors Regulations, 2000.)

NIC partially covers accidental death of one/ both the life partners and also provides health and asset insurance. The maternity benefit (applicable only for fixed deposit holders) and administrative costs comes out of the core fund of Rs 1 crore established by GTZ in 1992.

Table 2: Coverage provided by VimoSEWA partners

| Provider | Description of Coverage |
|---|---|
| LIC | Natural death of the member |
| | Accidental death of the member |
| NIC | Accidental death of the member |
| | Accidental death of the spouse |
| | Sickness |
| | Loss of assets |
| GTZ | Maternity benefit, from the core fund established in 1994 |

VimoSEWA functions as a cooperative and the workers themselves take up the activities like (a) manage services through local teams lead by the women leader called as "aagewans" (b) promote coverage by educating and disseminating information on insurance (c) decide on claims and ensure their rapid disbursement (d) decide on premium structure, new products and policies and (e) recently negotiating with insurance companies. The "aagewans" are given orientation training on the concept of insurance so as to promote VimoSEWA more effectively. The coverage of the SEWA health insurance program includes hospitalization, maternity, occupational health related illnesses and other gynecological ailments. It also covers life and asset insurance.

VimoSEWA plans to expand its coverage and introduce children's health insurance and offer family insurance package. It is envisaged that all members would be covered for cataract operations. It is also planned to introduce maternity insurance for all insured.

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# Aarogya Raksha: A Family Welfare Linked Health Insurance Scheme in AP

To encourage adoption of tubectomy and vasectomy, a family planning linked health insurance scheme was launched by the Government of AP in 1999. The scheme aims at providing insurance for acceptors of sterilization. The main benefit of this health insurance is hospitalization services through tie up hospitals. Households below the poverty line only are eligible. The period of coverage under the insurance scheme is 5 years from the date of sterilization operation. The eligibility criteria are:

1. Acceptance of sterilization operation,
2. Not more than two children and
3. Family income is below the poverty line.

The scheme covers (a) Hospitalization, along with drugs, diagnostic services etc. for upto Rs. 2000 per claim and upto Rs. 4000 per annum (b) Catastrophic insurance benefit of Rs. 10000 for single child and Rs. 5000 per child for two child families. This is admissible in case of accidental death, grievous injury or incapacitation of a child. The policy holder can avail the services in any of the enlisted private hospitals.

The New India Assurance company is the insurer. Premium is paid by the Family Welfare department. The insurance company has tied up with various private hospitals in Andhra Pradesh to serve the policy holders. As on February 2002, the insurer had tied up with 556 private hospitals. These tie up hospitals directly claim reimbursement from the insurer for providing the hospitalization treatment to the policy holders.

A pre signed, numbered certificate is prepared by the insurance company and made available to the District Medical and Health Officer (DMHO). The DMHO inturn affixes his/her signature and distributes the certificates to the Family Welfare Service Centers (FWSC). According to the implementation guidelines every FWSC is expected to stock certificates required for atleast six months. But in practice it may not always be available. For example, it was found that in Yadagirigutta PHC the issue of policy certificates was delayed due to non availability of the stock. The Medical Officer counter signs the policy certificate and issues to the eligible beneficiary. A list of private tie up hospitals in the district is to be provided to the policy holder along with the certificate. We found in Yadagirigutta PHC that this was indeed the case.

Table 1 gives an overview of the Aarogya Raksha scheme implementation in AP. There are teething problems at almost every stage. Although the government has paid premium for four lakh policies, about 2 lakh policies were actually distributed to eligible beneficiaries. The tie up hospitals are new to the system of insurance claims. Hence we cannot be sure if the claims rate shown in Table 1 will remain the same in the long run. In all probability claims rate is likely to increase. If Government had paid premium accordingly to the number of policies actually distributed, the total premium could have been 1.5 crore rupees. The average annual claim rate based on the initial two years rate is about 17 lakhs rupees. If this were to hold for five years total distribution will be about 85 lakhs rupees. This is within the premium value of 1.5 crores. If we assume that the annual claim will be same as observed in the second year then total disbursement will be about one crore, which is also below the total premium of 1.5 crores. If we assume that the claims with increase at the rate of about 30% as has happened in first to second year . The total disbursement will be about 137 crores, which is also within the 1.5 crore premium. The Insurance will be left with about 13 lakhs rupees for administration cost.

Table 1: Overview of Family Welfare Linked Aarogya Rakshya Health Insurance in AP

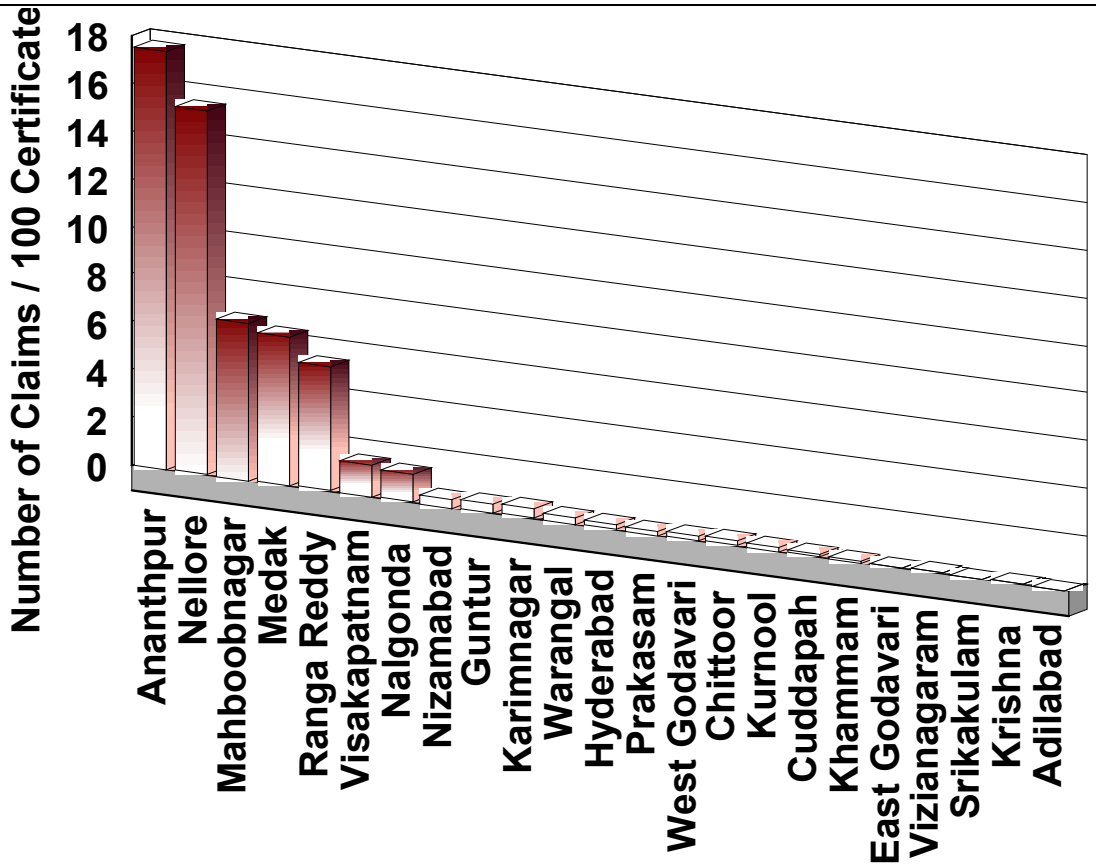
| Year | Premium Paid (Lakh Rupees) | Potential Policy Holders | Policies distributed [3] | Tie up hospitals[3] | Claims Settled[4] | | |
|---|---|---|---|---|---|---|---|
| | | | | | No. | Amount | Av. Claim Amount |
| 1999-00 2000-01 | 150[1] | 2,00, 000 | 1, 62,169 | 368 | 2, 217 | 14, 45,668 | 652 |
| 2001-02 | 150[2] | 2,00, 000 | 44, 168 | 556 | 3, 034 | 20, 47,146 | 675 |
| Total | 300 | 4,00, 000 | 2, 06,337 | 556 | 5, 251 | 34, 92,814 | 664 |

[1] GO Rt. No 95, dated 21-01-1999. [2] GO Rt.No. 712 dated 06-7-2000. [3] Policies distributed and tie up hospitals is till Feb 2002. [4] Claims settled is till Dec 2002.

## Implementation at the district level:

District wise situation of the number of claims per 100 certificates distributed is given in Figure 1. There is more number of claims per 100 policy certificate distributed in Anantapur district followed by Nellore district. The claim rate is lowest in Adilabad district.

Figure 1: District wise utilization of health insurance benefits




District wise distribution of certificates, number of tie up hospitals and the claims details are given in Table 2. There is wide variation in the distribution of insurance certificates among the districts, from 3152 in Hyderabad to 12956 in West Godavari. Maximum number of claims of 2011 was from Anantapur district, where as Adilabad district had only one claim. No specific pattern evolved when infrastructure development index is compared to number of claims in a district. We explored if the level of infrastructure developed in a district had any relationship with the number of claims. The Pearson correlation coefficient between Centre for Monitoring India Economy (CMIE) infrastructure development index and number of claims per 100 certificates was -0.2. The claim rate in many districts is very low. It is probably due to delayed learning about the benefits of the health insurance coverage. The tie up hospital owner/manager in the districts are perhaps yet to see the revenue potential offered by the insurance scheme. The policy holders in these districts are not demanding services from tie up hospitals probably due to lack of awareness.

Table 2: District wise distribution of certificates and claims

| District | Infrastructure Devp. Index* | Certificates distributed | Tie Up Hospitals | No.of Claims | Claims/ 100 Certificates |
|---|---|---|---|---|---|
| Ananthpur | 83 | 11,421 | 37 | 2,011 | 17.61 |
| Nellore | 114 | 8,223 | 25 | 1,259 | 15.31 |
| Mahboobnagar | 66 | 5,824 | 23 | 387 | 6.64 |
| Medak | 102 | 8,759 | 10 | 551 | 6.29 |
| Ranga Reddy | 77 | 9,229 | 23 | 484 | 5.24 |
| Visakapatnam | 96 | 11,000 | 34 | 154 | 1.4 |
| Nalgonda | 104 | 7,011 | 20 | 84 | 1.2 |
| Nizamabad | 118 | 8,070 | 25 | 38 | 0.47 |
| Guntur | 107 | 12,931 | 30 | 60 | 0.46 |
| Karimnagar | 113 | 9,748 | 32 | 44 | 0.45 |
| Warangal | 100 | 9,625 | 16 | 30 | 0.31 |
| Hyderabad | 154 | 3,152 | 20 | 9 | 0.29 |
| Prakasam | 90 | 9,042 | 31 | 23 | 0.25 |
| West Godavari | 122 | 12,956 | 22 | 30 | 0.23 |
| Chittoor | 108 | 9,597 | 18 | 22 | 0.23 |
| Kurnool | 74 | 9,338 | 16 | 19 | 0.2 |
| Cuddapah | 100 | 4,734 | 20 | 8 | 0.17 |
| Khammam | 86 | 7,193 | 20 | 11 | 0.15 |
| East Godavari | 109 | 12,147 | 29 | 9 | 0.07 |
| Vizianagaram | 92 | 9,000 | 26 | 6 | 0.07 |
| Srikakulam | 108 | 9,000 | 16 | 6 | 0.07 |
| Krishna | 125 | 11,589 | 42 | 5 | 0.04 |
| Adilabad | 77 | 6,748 | 21 | 1 | 0.01 |
| AP | 104 | 206,337 | 556 | 5,251 | 2.54 |

* Infrastructure Development Index is for 1995 taken from CMIE, 2000.

Table 3 gives the hospital wise claim disbursement in three districts. It can be seen that the hospital wise claim percentage is ranging from 38 to 64 percent. Of the claim amount being disbursed in these districts the hospitals are claiming around 43, 52 and 55 percent in Anantapur, Mahboobnagar and Medak districts respectively. In Bharati Nursing Home of Anantapur district and Vijaya Nursing Home of Mahboobnagar district the average claim amount is almost similar to that of state average of Rs. 664. In Naresh Poly Clinic, Medal district the average claim amount is Rs.982, which is higher than the state average.

Table 3: Hospital wise claim disbursement in three districts.

| Hospital Name | District | Total Policy holders | Claimant Policy Holder | | Claims | | Claim Amount | | Av. Claim Amt |
|---|---|---|---|---|---|---|---|---|---|
| | | | No. | Dist % | No. | Dist % | Amt | Dist % | |
| Bharati Nur.Home | Anantapur | 11, 421 | 273 | 2.4 | 767 | 38 | 4, 69,762 | 43 | 693 |
| Vijaya Nur.Home | MBNagar | 5, 824 | 86 | 1.5 | 179 | 46 | 1, 22,774 | 52 | 686 |
| Naresh Poly Clinic | Medak | 8, 759 | 202 | 2.3 | 352 | 64 | 3, 48,616 | 55 | 982 |
| State Average | | 206,337 | | | 5,251 | | 34, 92,814 | | 664 |

# Implementation of Aarogya Raksha Scheme at the Primary Health Centre level - Visit to Yadagirigutta PHC:

To understand the implementation of the Aarogya Raksha scheme, we visited the Yadagirigutta PHC on 28th Dec, 2002. The PHC was selected based on the following criteria (a) Convenience of the location of the PHC (b) Our familiarity with the PHC Medical officer. Yagadiri Gutta PHC is around 70 km from Hyderabad. So it was convenient for us to visit this PHC. Secondly, the PHC Medical Officer of Yadagiri Gutta was familiar to us. This Medical Officer had participated in a three day workshop conducted by the IHS on an earlier occasion. To select the participants for this workshop each of the 22 District Medical and Health Officers (DMHOs) in the state were requested to nominate five “ideal typical” PHCMOs from their respective districts. The following criteria was suggested to identify the PHCMOs: (a) Comprehensive understanding of RCH services and programs (b) Understanding of Women and Child health problems (c) Effective management of PHC activities (d) Usually resides at head quarters (e) Good communication and managerial skills and (f) Proactive, enthusiastic and dedicated to service. The institute got a list of 110 PHCMOs i.e. five PHCMOs from each of the 22 districts. A random sample of 20 PHCMOs was drawn from this list. The Yadagirigutta MO was one among them.

## Discussion with Medical Officer, Yadagiri Gutta PHC:

The PHC Medical Officer, Yadagiri Gutta mentioned that the Private medical practitioners are not showing interest in the scheme. The main reason he mentioned is the lengthy administrative procedure for claim reimbursement. He stated that after submitting the claims, reimbursement is also taking lot of time. He felt that if the administrative procedures are simplified the Private practitioners may show interest. Talking about the policy holders

perspective, he mentioned that they complain that the Private practitioners are not showing any interest. He stated that if ambulatory care is provided through the scheme, then it would be beneficial. While taking about the nature of tie up hospitals he stated that the tie up hospitals list should be updated regularly. He felt that new hospitals and specialty hospitals like pediatric hospitals need to be included by the insurance company as tie up hospitals.

## Discussion with Medical Officers of the Private tie-up hospitals, Bhongir:

There are two tie up hospitals under Aarogya Raksha scheme in Bhongir. These are the nearest private tie up hospitals to the Yadagiri Gutta PHC. The two hospitals are (a) Mamata Maternity and Nursing Home (b) Ashwini Maternity and Surgical Nursing Home. We spoke to the Medical Officers incharge of these hospitals.

### Dr. J. Amarendar, Mamata Maternity and Nursing Home:

Dr. J. Amarendar mentioned that the concept of the Aarogya Raksha scheme is good. They enrolled to be a tie up hospital in the scheme. He stated that there are problems in implementation of the scheme. As of now they took up only two cases under the scheme. The administrative procedures are too laborious. They need to appoint a separate person to take care of documentation and related procedures of the scheme. Of the two claims they have filed, only one was reimbursed. The first claim was rejected and they did not follow it up. The reimbursement for the second claim came after two months of submission of the claim. They lost enthusiasm to be part of the scheme due to too much of documentation work that is required to claim the reimbursement and also the time taken to get the reimbursement. He informed that most of the policy holders of the scheme come for ambulatory care . As they are not able to provide ambulatory care under the scheme most of the policy holders feel dejected. He mentioned there are instances where in they rejected the patients due to the implementation difficulties of the scheme. He felt that if the administrative procedures are simplified and ambulatory care is included then the scheme would be successful.

### Dr. Radha Krishna Murthy, Aswani Maternity and Surgical Nursing Home:

Dr. Radha Krishna Murthy mentioned that they have treated around six patients under the scheme. In the year 1999, two cases were treated but only one case was reimbursed. The

insurance company did not mention the reason for rejecting the claim. After that he was disinclined to admit the Aarogya Raksha scheme policy holders. Again in 2002 he admitted around four cases, and claims were filed in July 2002 and three of them was reimbursed in December 2002. For these three cases he received around Rs. 3300, an average of Rs. 1100 per case. It is more than the State average of around Rs. 664 per case. He stated the there is too much of paper work involved. Documents like prescription, case sheets, diagnostic details, bills, discharge summary etc. need to be sent along with the claim. He said that this takes lot of their time and they generally do not have time to file all these details and hence are not enthused to admit the policy holders. Even if they admit, they still have an apprehension whether the claims will be reimbursed or rejected. Due to this also they hesitate to admit the policy holders. He said once he got the reimbursement of the previous cases he started to admit some other policy holders under the scheme. He stated that if ambulatory care is included in the scheme more number of patients would be benefited.

## Discussion with ANMs, Yadagirigutta PHC:

The two ANMs met by us told that the policy holders are not able to access the services from the tie up hospitals as they provide only hospitalization services. They felt that the scheme should also cover ambulatory care. During the first year of implementation, i.e. 1999 most of the policy holders went to seek ambulatory care from these tie up hospitals. As these hospitals refused to provide ambulatory care for free of cost the scheme had a negative impact. The policy holders used to come back to the ANMs or to the PHC and told them that the scheme was not useful. As it was affecting the credibility of the ANM in the field, they stopped distributing the certificates in 2000 and 2001. Due to pressure from higher authorities i.e. DMHO and Commissioner Family Welfare, they again started to distribute the certificates in 2002.

## Discussion with the Aarogya Raksha scheme policy holders in Masoipet Subcenter, Yadagirigutta PHC, Dated 28-12-2002:

| Details of the policy holder | Record note of discussion |
|---|---|
| Errupula Kalamma<br>W/o E. Ramulu<br>Date of tubectomy:<br>08-4-2002 | ANM told her about the scheme. The insurance certificate was given after 6 months, due to short supply of certificates from insurance company. List of tie-up hospitals were also given with the card. She is aware about the uses of the insurance card and the list of tie up hospitals. She did not utilize the scheme as no one was hospitalised. |
| Veeravelli Shobarani<br>W/o V. Venkatachary<br>Date of tubectomy:<br>22-12-1999 | Certificate was distributed after 2 months, due to shortage of supply from insurance company. She knew about the benefits of the scheme and named one tie-up hospital. But she was not clear about the type of treatment that is covered under the scheme. She did approach the tie up hospital when she fell ill. As it was an out patient case the tie up hospital rejected to give treatment free of cost. She took the treatment and paid for the same. |
| Padakanti Varalakshmi<br>W/o. P. ChandraMouli<br>Date of tubectomy:<br>21-3-2000 | She do not have the Aarogya Raksha certificate. But the ANM said that she has given the certificate to the policy holder. She is not aware of the scheme. She visits a private doctor in Bhongiri if she falls ill. |
| Sindham Mangamma<br>W/o. Narasimha<br>Date of tubectomy:<br>05-07-1999 | One month after the operation she received the Aarogya Raksha certificate along with the list of tie up hospitals. The delay is cause due to shortage of certificates. She came to know about the scheme through ANM. But she is not clear about the scheme, its benefits and about the tie up hospitals. She did not avail any benefits as there was no serious illness in the family. For minor illnesses she goes to a RMP doctor in the village. |
| Oruganti Sabitha<br>W/o O. Kistaiah<br>Date of tubectomy:<br>16-9-2002 | Due to non availability of the certificates it was given after two months of the operation. ANM and the MPHS told her about the scheme. She knew about the benefits under the scheme and named one tie up hospital. Usually she would approach RMP or a medical shop in the for minor ailments. Did not avail the scheme till now. |
| Taduri Padma<br>W/o T. Parasuramulu<br>Date of tubectomy:<br>30-8-1999 | ANM gave the certificate after a month. She did not know about the benefits of the scheme and the tie up hospitals. She suffered from stomach ache and fever and was admitted in a private nursing home in Bhongir. For minor ailments they visit the RMP in their village. |
| Giri Reddy Lakshmi<br>W/o G. Narasimha Reddy<br>Date of tubectomy:<br>09-08-1999 | She was given the certificate after a month from the date of her tubectomy. She do not know about the scheme, its benefits and the tie up hospitals. She generally goes to PHC if she has any illness. She suffered from a boil on her genitalia and approached a private doctor in the village and paid around Rs.2000. |

## Discussion with the Aarogya Raksha policy holders in Gundlapalli Sub center, Yadagirigutta PHC, Dated 28-12-2002:

| Details of the policy holder | Record note of discussion |
|---|---|
| Kari Lakshmi<br>W/o K. Palani<br>Date of tubectomy: 26/10/2002 | ANM and PHCMO told about the scheme. Distribution of certificate was delayed for one month due to shortage of supply. List of tie-up hospitals were also given along with the card. She is aware about the benefits of the scheme. Did not utilize the scheme as they did not fell ill. |
| Gundlapalli Usha Rani<br>W/o G. Venkateswarulu<br>Date of tubectomy: 11/10/1999 | After one week of the operation she received the certificate with list of tie up hospitals. She knows about the benefits of the scheme, but do not know about the tie up hospitals. Till now she and her children did not suffer any major illness. For minor illness she visits private nursing home, which is not a tie up hospital. |
| Kairamkonda Saroja<br>W/o Surya Prakash<br>Date of tubectomy: 17/05/1999 | She received the Aarogya Raksha Certificate with the list of tie up hospitals on the same day of sterilization operation. She knows about the scheme and its benefits. She did not use the certificate as there was no need. For minor illness she visits the Yadagirigutta PHC. |
| Dorbala Lalitha<br>W/o D. Nagaraja Sharma<br>Date of tubectomy: 17/5/1999 | She received the certificate after one week from the date of tubectomy. She knows about the benefits of the scheme and the list of tie up hospitals. For most of the ailments they visit private hospitals in Hyderabad. Did not use the scheme as there was no major illness. |
| Boga Varalakshmi.<br>W/o B. Shekar<br>Date of tubectomy: 9/8/1999 | She received the certificate after one week from the date of tubectomy. MPHS told about the scheme. She knows about the benefits of the scheme and the list of tie up hospitals. For most of the ailments she visits Yadagirigutta PHC. |

Discussions with the stake holders in this PHC revealed various difficulties in implementation of the scheme such as (a) Lack of awareness of the health insurance benefits (b) ambiguity about admissibility of ambulatory care and frustration due to non coverage of the same (c) reluctance of the tie up hospitals to honor the policy certificate etc..

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# Three Recent Health Insurance Schemes in India - Arogya Rakshya, VimoSEWA, and The Swablamby Swasthya Yojana

**Prasanta Mahapatra[2], Samatha Reddy[3]**

## Aarogya Raksha - A Family Welfare Linked Health Insurance Scheme in AP

To encourage adoption of tubectomy and vasectomy, a family planning linked health insurance scheme was launched by the Government of AP in 1999. The main benefit of this health insurance is hospitalization services through tie up hospitals. Households below the poverty line only are eligible. The period of coverage under the insurance scheme is 5 years from the date of sterilization operation. The eligibility criteria are:

1. Acceptance of sterilization operation,
2. Not more than two children and
3. Family income is below the poverty line.

The scheme covers (a) Hospitalization, along with drugs, diagnostic services etc. for upto Rs. 2000 per claim and upto Rs. 4000 per annum (b) Catastrophic insurance benefit of Rs. 10000 for single child and Rs. 5000 per child for two child families. This is admissible in case of accidental death, grievous injury or incapacitation of a child. The policy holder can avail the services in any of the enlisted private hospitals.

The New India Assurance company is the insurer. Premium is paid by the Family Welfare department. A pre signed, numbered certificate is prepared by the insurance company and made available to the District Medical and Health Officer (DMHO). The DMHO inturn affixes his/her signature and distributes the certificates to the Family Welfare Service Centers (FWSC). According to the implementation guidelines every FWSC is expected to stock certificates required for atleast six months. But in practice it may not always be available. For example, it was found that in one of the PHC the issue of policy certificates was delayed due to non availability of the stock. The Medical Officer counter signs the policy certificate and issues to the eligible beneficiary.

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The insurance company has tied up with various private hospitals in Andhra Pradesh to serve the policy holders. As on February 2002, the insurer had tied up with 556 private hospitals. These tie up hospitals directly claim reimbursement from the insurer for providing the hospitalization treatment to the policy holders. A list of private tie up hospitals in the district is to be provided to the policy holder along with the certificate.

Table 1 gives an overview of the Aarogya Raksha scheme implementation in AP. There are teething problems at almost every stage. Although the government has paid premium for four lakh policies, about 2 lakh policies were actually distributed to eligible beneficiaries. Discussions with the stake holders in one PHC revealed various difficulties such as (a) Lack of awareness of the health insurance benefits (b) ambiguity and frustration about lack of coverage for ambulatory care (c) reluctance of tie up hospitals to honor the policy certificate, etc..

Table 1: Overview of Family Welfare Linked Aarogya Rakshya Health Insurance in AP

| Year | Premium Paid (Lakh Rupees) | Potential Policy Holders | Policies distributed[3] | Tie up hospitals[3] | Claims Settled[4] | | |
|---|---|---|---|---|---|---|---|
| | | | | | No. | Amount | Av. Claim Amount |
| 1999-00 2000-01 | 150[1] | 2,00, 000 | 1, 62,169 | 368 | 2, 217 | 14, 45,668 | 652 |
| 2001-02 | 150[2] | 2,00, 000 | 44, 168 | 556 | 3, 034 | 20, 47,146 | 675 |
| Total | 300 | 4,00, 000 | 2, 06,337 | 556 | 5, 251 | 34, 92,814 | 664 |

[1] GO Rt. No 95, dated 21-01-1999. [2] GO Rt.No. 712 dated 06-7-2000. [3] Policies distributed and tie up hospitals is till Feb 2002. [4] Claims settled is till Dec 2002.

## VimoSEWA - An health insurance scheme of the Self Employed Women's Association (SEWA)

The Self Employed Women's Association (SEWA) is a labour union of women working in the informal sector. Established in 1972, SEWA now has around 4 lakh members. It was started in Gujarat and has expanded to Madhya Pradesh, Uttar Pradesh, Delhi, Bihar and Kerala. SEWA's goals are to organize women to achieve full employment and self reliance. Full employment includes work and income security, food security, social security, health care, shelter and insurance. Self reliance is both in terms of economic viability and in terms of women's control over management and decision making. The four major categories of workers in the informal sector are (a) Home based workers (b) Vendors (c) manual

laborers and service providers (d) producers. SEWA supports its members by providing legal service, building their capacity, health care, child care and insurance.

The insurance scheme known as VimoSEWA, was set up in 1992. The historical roots of this scheme can be traced way back to 1978 when the Life Insurance Corporation (LIC) agreed to linkup with SEWA Bank to cover SEWA members for life insurance. Then only natural death was covered. VimoSEWA is a combined life and non life insurance scheme. The nonlife component includes catastrophic insurance designed to undertake risk exposure of women workers. The scheme has a novel premium payment design consisting of (a) a traditional annual premium component and (b) an optional fixed deposit (FD) component. Special incentives like Maternity benefit of Rs 300, Reimbursement of denture expenses and hearing aid of Rs. 600 and Rs. 1000 respectively are also given for FD linked members. The health insurance part of the scheme covers hospitalization, maternity and occupational illness costs upto a maximum of 2000, 5500 or 10,000 depending on the scheme. The catastrophic insurance component includes accidental death, accidental death of husband, house and assets coverage. The life insurance component covers natural death.

Table 2: VimoSEWA schemes available to Self employed women members of SEWA

| | Scheme I | Scheme II | Scheme III |
|---|---|---|---|
| **Member's Insurance** | | | |
| Annual Premium | 85 | 200 | 400 |
| Fixed Deposit | 1,000 | 2,400 | 4,800 |
| **Risks Covered** | | | |
| Hospitalization | 2,000 | 5,500 | 5,501 |
| Life Insurance | 3,000 | 5,000 | 10,000 |
| General Insurance | | | |
| Accidental Death | 40,000 | 40,000 | 40,000 |
| Accidental death of husband | 15,000 | 15,000 | 15,000 |
| House & assets insurance | 5,000 | 10,000 | 20,000 |
| **Husband's Option** | | | |
| Annual Premium | 55 | 150 | 325 |
| Fixed Deposit | 650 | 1,800 | 4,000 |
| **Risks Covered** | | | |
| Hospitalization | 2,000 | 5,500 | 10,000 |
| Life Insurance | 3,000 | 5,000 | 10,000 |
| Gen. Insurance: Accidental Death | 25,000 | 25,000 | 25,000 |

The VimoSEWA started with around 50000 women who insured themselves. As of 2002, a total of 72000 women are insured. Around 18000 of these women have subscribed for the "husband option". Thus total persons insured in 2002 were 90000. VimoSEWA obtains reinsurance from general insurance companies who are required to abide by the IRDA, Obligations of Insurers to Rural Social Sectors Regulations, 2000[4] SEWA insurance program has multiple partners including Life Insurance Corporation (LIC), National Insurance Corporation (NIC) and German Technical Cooperation Agency (GTZ) . LIC provides the complete coverage for natural death and partial coverage for accidental death. NIC partially covers accidental death of one/ both the life partners and also provides health and asset insurance. The maternity benefit (applicable only for fixed deposit holders) and administrative costs comes out of the core fund of Rs 1 crore established by GTZ in 1992.

VimoSEWA functions as a cooperative and the workers themselves take up the activities like (a) manage services through local teams lead by the women leader called as "aagewans" (b) promote coverage by educating and disseminating information on insurance (c) decide on claims and ensure their rapid disbursement (d) decide on premium structure, new products and policies and recently (e) negotiating with insurance companies. The "aagewans" are given orientation training on the concept of insurance so as to promote VimoSEWA more effectively. The coverage of the SEWA health insurance program includes hospitalization, maternity, occupational health related illnesses and other gynecological ailments. It also covers life and asset insurance.

## The Swablamby Swasthya Yojana. A Social Health Insurance Experiment in Ratlam District, MP.

A health insurance scheme was introduced in Ratlam district of MP for rural households to meet additional costs of medicines and treatment not available in public hospitals. The scheme was introduced by the then District Collector of Ratlam. This was a spontaneous response to frequent appeals from poor households mostly coming from rural areas and seeking assistance to meet costs of medical care. The Swablamby Swasthya Yojana (SSY) was started to mitigate this problem.

[4] Every insurer, who begins to carry on insurance business after the commencement of the Insurance Regulatory and Development Authority Act,, 1999, shall, for the purposes of Secs. 32-B and 32-C of the Act, ensure that he undertakes the obligations, during the first five financial years. The Insurance Regulatory and Development Authority (Obligations of Insurers to Rural Social Sectors Regulations, 2000.)

The MP State *Sickness Assistance Fund Act*, 1997 (SAF) allows for financial assistance to poor families for catastrophic illnesses where treatment cost exceeds Rs25000. Treatment costs up to a maximum of Rs1.5 lakhs can be paid from out of the SAF. But the SAF does not provide for serious illness, where treatment cost is less than Rs.25000. The SSY was designed to fill this gap. The scheme was introduced through the Ratlam branch of the Indian Red Cross Society (IRC-Ratlam). The IRC-Ratlam was chosen since this provided a convenient institutional base for collection of donations and premium referred to as membership contributions by the scheme. The Ratlam SSY was introduced in April 1999 and started functioning from June, 1999. Membership of the SSY is open to all people living rural areas of the Ratlam district. All the residents in the rural areas of the district are eligible. Family is considered as a unit and membership fee is based on socio economic status of the family. Families having a person suffering from chronic diseases fall under different premium structure. The Indian Red Cross Society (IRC) Ratlam branch is the implementing agency. It was envisaged that the SSY would not spend much of its financial resources on the human resources. Hence the responsibility to implement SSY was given to IRC, with its readily available network, infrastructure and human resources.

The SSY scheme mobilizes finances from multiple sources. These are; (a) membership fees, i.e. Premium to avail services under the scheme, (b) donations from philanthropists, (c) reimbursement claims from other government programs. The annual membership fee (premium) is based on the family income. The membership fee is fixed on the basis of the principle that poor pay lower premium and rich pay more. Family is the basic unit of membership. Head of the family, spouse, children and dependent parents are covered for treatment costs upto Rs. 25000 per annum.

Table 3: SSY Premium structure

| Member's Socioeconomic Status | Annual Fee |
|---|---|
| Below the poverty line (BPL) | |
| Scheduled Caste (SC) or Tribe (ST) | Rs 50 |
| Others | Rs 100 |
| Having a person suffering from any chronic disease. | Rs 1,000 |
| Above the poverty line | |
| Minimum premium | Rs 200 |
| Having a person suffering from any chronic disease. | Rs 2,000 |

In addition to the membership fee, the IRC-Ratlam raises additional funds by donation from philanthropists. Certain government programs and schemes allow for payment of treatment costs to underprivileged population. When a SSY member, who is other wise eligible for assistance under another government program, avails medical care, an effort is made by the SSY to claim reimbursement of treatment costs from other programs. SSY amount is being deposited in the SBI as a fixed deposit, and the interest is also further deposited into the account.

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# Comparative statement of SSY, SEWA and Arogya Raksha Schemes for economically poor households

| Feature | SSY | SEWA | | | Arogya Raksha |
|---|---|---|---|---|---|
| | | I | II | III | |
| Target Group | Rural Households: Entire Family | SEWA Woman + Husband option | | | FP Acceptor + 2 Children |
| Annual Premium | 100 | 190[1] | 426[1] | 989[1] | 15[2] |
| Health Care Coverage | | | | | |
| Services | Hospitalization: Drugs | Hospitalization. | | | Hospitalization |
| Providers | Public HCI | Private HCI | | | Private HCIs |
| Amount | 25,000 | 4,000 | 11,000 | 20,000 | 4,000 |
| Catastrophic Insurance | | | | | |
| Acc. Death-Self | | 65,000 | 65,000 | 65,000 | 10,000 |
| Acc. Death - Husband | | 15,000 | 15,000 | 15,000 | |
| Natural Death | | 6,000 | 10,000 | 20,000 | |
| House & Assets | | 5,000 | 10,000 | 20,000 | |
| Subscriber base | 5,370 | 72,000 | | | Unknown[3] |

[1] Premium + 3% net return on the fixed deposit. We have used net return on capital (real interest rate) of 3% after discounting for inflation. (Nominal interest = 9%, Inflation = 6%, real interest = 3% ). Thus we have assumed a net return of 3 %.

[2] We have taken a simple average of the one time premium of Rs75 / acceptor / five years. Since coverage cards are distributed to only about 50% of persons for whom premium is paid by the government, the de-facto premium works out to more than Rs. 30 / annum.

[3] Premium is paid by Govt of AP for 206337 persons based on number of sterilization operations. But health insurance coverage certificates are not distributed to all. Only 50% have received cards. No estimate of gap between time of payment of premium and time of distribution of card is available. Hence difficult to estimate the net subscriber population. It will be safe to say that this is less than 50% i.e. Less than 1.00 lakh persons.

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# Field notes from Ratlam District

**Samatha Reddy[5], Shruti Misra[6]**

## Context of the visit:

A health insurance scheme was introduced in Ratlam district of MP for rural households to meet additional costs of medicines and treatment not available in public hospitals. The scheme was introduced by the then District Collector of Ratlam. This was a spontaneous response to frequent appeals from poor households mostly coming from rural areas and seeking assistance to meet costs of medical care. The Swablamby Swasthya Yojana (SSY) was started to mitigate this problem. Early success of the SSY was noticed by people and at the state and national level. Accordingly, The Secretary, Family Welfare, Government of India asked the IHS to study the Ratlam experience while developing a Family Welfare linked health insurance plan. To understand the scheme further, Dr. Mahapatra, Director, IHS met the architect of the scheme Mr. Manoj Jhalani, then District Collector, Ratlam, and now Director, Panchayat Raj, Govt. of MP.

This visit to Ratlam district was to gain first hand information from the implementation site. Earlier Mr. Manoj Jalani had introduced the Institute to Mr. Prabhat Parashar, District Collector, Ratlam. The visit was organized with approval from the Ratlam district administration. The Institute had informed Commissioner Health, Govt. of MP about the visit. The IHS team Ms. Samatha Reddy and Ms. Shruti Misra has visited Ratlam in this context from 26th - 30th November, 2002. The following is the field notes and the record note of discussions we had with various officials during our visit to Ratlam. We kindly acknowledge the district administration for the support and cooperation they have extended during our stay in Ratlam.

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# Indian Red Cross Society, Ratlam

We made four visits to the Ratlam District branch of the Indian Red Cross Society (IRC). Our aim was to understand the SSY implementation process, collect relevant documents and data.

The first visit was on 26-11-2002. We interacted with Mr. Mohanlal Makwana, Hony. Joint Secretary, IRC, Ratlam. Mr. Makwana explained us about the implementation of SSY. He gave us a folder containing (a) note on SSY implementation (b) SSY beneficiary card (c) format of drug distribution register (d) format of stock register (e) SSY prescription slip (f) appeal made at the beginning of the scheme (g) Poster about SSY etc.. He mentioned that the SSY is based on drug distribution at the designated public hospitals. He stated that SSY got most of its revenue in the first year of its implementation from donations by individuals, industries etc.. Explaining the details of the SSY card he said that it is issued for a period of one year and membership fees depends upon the socio economic status of the households such as Schedule Caste (SC), Schedule Tribe (ST), Below Poverty Line (BPL) etc.. The SSY committee members meet at least once in three months. The decisions about procurement of drugs, reimbursement etc.. are finalized in these meetings. Drugs are purchased once in year. There are two store keepers at the district drug stores. These store keepers take care of issues, receipts and stock maintenance of the drugs. Most of the drugs are purchased by generic name. Some drugs not available under generic name are bought with specific company name. They call these as "ethical drugs". The prices of generic drugs are much less than the MRP shown on the drugs. However they write the MRP of the drugs in the drug distribution register to compute the total disbursement against the maximum coverage limit of the scheme. We asked about the transactions between the sub district stores and the district stores. He informed that specific information is not available. They do not pressurize the sub district drug store keepers to report regularly as they are not being paid to do the SSY work. Hence he felt the transactions between district and sub district stores are not many.

Explaining about the records and registers maintained at the Tahsil and Panchayath level, Mr. Makhwana mentioned that the Tahsildhar would maintain a register with some minimum details of the household like head of the family, village, BPL number etc.. Enrollment of beneficiaries is done in the months of September and October in each year, but this year it was extended till November end. If a family wants to enroll after the enrollment dates, they would be given benefits only for the remaining period of the year. For example if

the deadline for enrollment is 30th November, 2002, then the scheme would be valid from 1st Dec 2002 to 30th Nov. 2003. So if the beneficiary enrolls some time after 30 Nov, 2002, say Jan 2003 then also the coverage would be till 30th Nov 2003 only.

We asked why most of the expenditure is concentrated at the district stores. He informed that most of the beneficiaries come to District Hospital as they feel that they would get better treatment in the district hospital. We asked if any reimbursement is being claimed from other government vertical programs. He mentioned that no reimburse is being claimed from the vertical programs.

Our second visit was on the same day, post lunch . By then we had gone thorough the material given to us by the IRC in the morning. We raised the following questions (a) where is the amount of the SSY being deposited (b) availability of data on bifurcation of the beneficiaries (c) honorarium paid to the district drug store keeper (d) why is the amount that was spent on reimbursement in the 2000-2001 is high (e) what is the reason for health workers being given cash awards for Family Planning motivation through SSY. We noted down the list of major donors of the SSY in the first year of its implementation.

In response to the questions Mr. Makhvana mentioned that the SSY amount is being deposited in the SBI as a fixed deposit, and the interest is also further deposited into the account. Stating the availability of data on beneficiaries he said that it may not be available at the Tahsil level also. He mentioned that the store keeper is being paid Rs. 2500/ and Asst. store keeper Rs. 1500/. Talking about the reimbursement to the patients he stated that the beneficiaries are reimbursed for treatment that was taken in other public and private hospitals which are not under SSY. Since there were many beneficiaries who treated outside SSY hospitals in the year 2000-2001 the amount reimbursed was high in that year. The health workers were given monetary awards on instructions from the then Collector Shri Manoj Jalani, as he wanted to appreciate the health workers in their efforts on Family Planning.

The third visit was on 28-11-2002. The data on the hospitals that were reimbursed for treating SSY beneficiaries was collected. We also collected the data of the patients who were reimbursed for the medical costs, the details are given in Annexure 1. When asked about if any reimbursement is being claimed from the vertical programs, Mr. Makhvana said that they are not getting any reimbursement for these programs. Following is the list of hospitals that has been reimbursed.

Hospitals reimbursed for treating SSY beneficiaries

| City | HCI | No. of cases referred | Approximate Reimbursement | | |
|---|---|---|---|---|---|
| | | | Year 1 | Year 2 | Year 3 |
| Ratlam | Jain Divakar Hospital | 1 | - | 1,200 | - |
| Bombay | Tata Memorial Hospital | 1 | - | 10,000 | - |
| Baroda | Gayathri Nursing Home | 1 | - | 2,500 | - |
| Baroda | Baroda Heart Institute & Research Center | 1 | - | 25,000 | - |
| Indore | Maharaja Yashwant Rao Hospital | 4 | - | 34,601 | - |
| Indore | Dr. C.B Swami Sridhar | 1 | - | 2,200 | - |
| Indore | Rajat Varma Union Hospital | 1 | - | 5,000 | - |
| Ahmedabad | U.N Mehta Institute of cardiology | 2 | 5,000 | 5,000 | - |
| Ahmedabad | Civil Hospital | 1 | - | 5,000 | - |
| Ahmedabad | Cancer Hospital | 1 | - | 10,000 | - |
| Navsari, Gujarat | Rotary Eye Institute | 1 | - | 2,000 | - |
| Mumbai | K.E.M | 1 | 25,000 | - | - |

In the fourth and final visit on 29-11-2002, we had a debriefing meeting and shared our observations with the SSY team in the Red Cross Society. We also collected some data on HCIs and population etc..

## District Drug store, District hospital, Ratlam

Most of the data on beneficiaries came from the district drug stores. We visited the store around three times in various contexts. The first visit on 26-11-2002 was to familiarize about the functioning of the drug store. We met Mr. Hitesh Ranawat, store keeper. Mr. Ranawat explained to us about the functioning of the drug store. He showed the drug distribution register and stock maintenance register that are maintained in the stores. He mentioned that day wise drug utility is maintained in the drug distribution register, with details of the patient. Stock utility is maintained in the stock register. Stock distributed to the sub stores is also maintained in the stock register at the district stores. He said they would do a day wise tally of the drugs that are being utilized and enter into the register. The registers are maintained well. When asked about the procurement, he said that they would give the requirement to the IRC and the drugs are procured once in an year. Surgical items are also being distributed to the SSY beneficiaries.

During the second visit on 27-11-2002, we collected and entered the data of SSY beneficiaries visited the DH in the month of September, 2002. The data was taken from the drug distribution register at the district stores.

In the third visit on 28-11-2002, we interacted with the beneficiaries who visited the stores. The details of the discussions with the beneficiaries is given in the Annexure 2. All the seven beneficiaries we interacted are new entrants. We also collected the data of the beneficiaries in the month of October.

Beneficiary profile accessing services at the district hospital

| | Sep 2002 | | | Oct 2002 | | |
|---|---|---|---|---|---|---|
| | BPL | APL | Total | BPL | APL | Total |
| SC | 7 | 37 | 44 | 3 | 21 | 24 |
| ST | 28 | 12 | 40 | 21 | 4 | 25 |
| OBC | 29 | 43 | 72 | 21 | 36 | 58 |
| General | 27 | 43 | 70 | 22 | 22 | 44 |
| Total | 91 | 135 | 226 | 67 | 83 | 151 |

# Visit to Sailana Tahsil:

We visited Sailana Tahsil on 27-11-2002. The purpose of the visit is to understand the field level functioning of the SSY scheme from various aspects like role of revenue depart, role of health department and perspectives of the beneficiaries.

## Janpad office, Sailana Tahsil

In Janpad office we met Mr. R.P Bhadrasen, Janpad Officer and Mr. G.R Patidar, Tahsildar. Mr. Bhadrasen mentioned that Sailana Tahsil comes under tribal area and there are around 242 habitations and one lakh population. He gave us year wise household and population coverage under SSY. When asked about the socio economic details of the beneficiaries, they stated that the information is not readily available. They gave us the recent year, i.e. 2001-2002 caste wise beneficiaries number. Other details were not readily available

## Community Health Centre (CHC), Sailana

We visited the SSY drug store at the CHC Sailana. A separate cupboard is maintained for the SSY. The duty nurse showed us the drug distribution register maintained by her. She said that as soon as she gives drugs to SSY beneficiaries she enters it in the register. She mentioned that the stock register is maintained by the compounder and he is the one who gets the drugs from the district store as per the requirement stated. Dr. Sailaish, Medical Officer, PHC Sakravada mentioned that there are four PHCs under Sailana CHC. None of these PHCs has a SSY drug store. Hence if the beneficiaries in these PHCs want to avail the drugs distributed by the SSY, they have to come to the CHC at Sailana. Dr. Chowdary, MO, CHC Sailana mentioned that he is quite happy about the scheme as it is a good scheme and poor people can really make full use of it, but he said that full awareness about SSY is lacking. He mentioned that availability of doctors and drugs at PHCs is a constraint. The patient has to travel 40-50 km to reach the CHC, so inspite of traveling so far patients prefer going to local doctor. He said that this is one of the reason for the decline in the number of patients in the SSY. He mentioned that draught and migration are the other causes for beneficiaries not enrolling in the SSY.

### Discussion with the SSY Beneficiaries in Sailana Rural ward:

| Details of the beneficiary | Record note of discussion |
|---|---|
| Kali Bai, 65 Y, SC | She is registered from last year. She visited the hospital for her daughters delivery. She had the expired SSY card at that time. She had to make several visits to Janpad office to get a new card. The card was not available on time and she had to pay for the treatment. |
| Sarpanch, 30 Y, Sailana Rural ward | He informed that he makes sure that the BPL families are enrolled in the SSY. He also pays the premium for the needy from the funds available at his disposal. But he feels that still people are not aware of the scheme and the benefits. |

# Visit to Jaora Tahsil:

We visited Jaora Tahsil on 29-11-2002. Our purpose to visit Jaora is similar to that of our visit to Sailana.

## Janpad Office, Jaora Tahsil

The Janpad officer Mr. Vinod Kumar Chauhan gave us the details of the beneficiaries enrolled in the scheme from some villages. He said beneficiaries details based on socio economic class is not readily available. We gave him a format to be given for the four Karmis from different villages who came to the Janpath. We expressed our desire to speak to some of the beneficiaries from some of the villages. He assigned a karmi of Barbodna village to take us there.

### Discussions with the SSY Beneficiaries in Barbodna Village, Jaora Tahsil

| Details of the beneficiary | Record note of discussion |
|---|---|
| Bhinlo Bai, 65 Y, OBC | She has card since three year but still not avail any of the facility from the SSY. She is consulting some private doctor for her illness and she is unaware of the facilities provided by SSY. |
| Rukmani bai, 55 Y, SC | She is suffering from skin disease and using the drugs provided by the SSY and is satisfied of the services provided by the SSY. |
| Pratap Singh, 70 Y, General | He is suffering from lumps in the throat and availing the facilities. He mentioned that he has been asked to renew his card for the operation to be conducted. His card expired by the time he went for the treatment. |
| Bhawar singh, 65 Y, General | He or his family members did not happen to visit the hospital. |
| Muntikha, 45 Y, OBC | Her granddaughter is handicapped and hence they have enrolled in the SSY. They are also availing the services and happy with drugs provided by the SSY. |
| Lilabai, 60 Y, SC | She did not visit the hospital and is not aware of the facilities provided by the scheme. |
| Radhe Shyam, 50 Y, General | He had card in the previous year, but did not avail any benefits and hence did not renew this year. |

## Civil Hospital, Jaora

We met Dr. R Mandwaria, Medical Officer and Mr. Digpal Singh Yadav, compounder and SSY store keeper in the hospital.

Dr. R Mandwaria mentioned that SSY is a good scheme, but accessibility for the beneficiaries to come to the CH is difficult. The beneficiary has to come all the way to CH, to get the medicines. He felt that if the drug stores are established at the PHC level then it would be beneficial and can increase the enrollment.

Mr. Digpal Singh Yadav mentioned that there is a steady decline in the patients over the past three years because of lack of access to the civil hospital. He suggested that if drug stores are also maintained at the PHC then the SSY would be more successful. He showed us the drug store. The store is maintained well. But there were very few SSY drugs, when asked the reason he said that very few patients are coming from past 5 months. He showed the drug distribution register and the last drugs were distributed in July 2002. As there is no consumption he is not even collecting the drugs from the district SSY drug stores. He mentioned if he is need of any medicine for SSY beneficiary he provides it from the CH pharmacy stock and then replenishes from SSY, after he gets the stock from SSY. He mentioned that in the beginning of the SSY, it was promised that the SSY drug keepers would be given Rs. 500 as a honorarium but is not given. He said it would be good if some kind of honorarium is given so that they feel motivated to work.

## Tahsildhar Office, Jaora

Tahsildhar was not available for discussions. Registers and data was not readily available. Met the administrative staff and informed to provide village wise beneficiary level data to the IRC.

# Discussion with Chief Medical Officer, District Hospital, Ratlam

I had a discussion with CMO, Ratlam on 27-11-2002. The purpose of the visit was to understand the role of health department in the implementation of SSY. Dr. ML Gupta, CMO has mentioned the best part of the SSY is the involvement of the Revenue department to

enroll the beneficiaries as people are more receptive to revenue department. He said in the District hospital most of the cases are referred cases from other hospitals as far as SSY beneficiaries is concerned. When asked about the role of health workers in the implementation of the SSY scheme is stated that they play a advocacy role. He mentioned that he attends the SSY committee meetings once in three months and also in drug purchase.

## Discussions with Mr. J. K Jain, Addl. Collector / Office In charge, Indian Red Cross Society (IRC), Ratlam

In our first visit with Mr. Jain on 26-11-2002 we briefed him about the purpose of our visit. He then gave us a briefing on Swawlamby Swasthya Yojna (SSY). He mentioned that SSY covers treatment up to Rs. 25,000. He mentioned about another insurance scheme called Rajya Bimari Sahayata Nidhi, which covers an amount of Rs. 25000 to Rs. 1.5 lakhs. He stated that the Rogi Kalyan Samithis which are formed are functioning effectively. These samithis has the financial autonomy. He then asked about functioning of Public Hospitals in AP. We mentioned about our HPA and PSS studies. He then asked about the main reason for unsatisfaction and about availability of drugs and supplies in the public HCIs. I mentioned that interpersonal skills of the health care professionals (HCPs) is one of the important cause. He mentioned that they also need human resource support for improving the service delivery in public HCIs. He stated that NGOs could play an important role to improve the health care delivery especially as laisoners.

Our second interaction with him was on the final day of our visit i.e., 29-11-2002 to share our observations and findings. We mentioned that the District store is the major activity point. Sub stores are not functioning due to low beneficiary turn out. We suggested about the need for Management Information systems . Mentioned about the poor feedback mechanism from sub district level to the district level. We stated that as for as the distribution of drugs is concerned it is being done well. Mentioned about the low awareness levels in Jaora Tahsil. We asked about the involvement of other government vertical programs and if any reimbursement is being claimed from those schemes. He informed that they are contemplating about this issue and would like to implement it in future.

## Shri. Prabhat Parashar, Collector and Chairman , Swablamby Swasthya Yojna, IRC, Ratlam

Shri. Prabhat Parashar was busy during the first three days of our visit. We met him on the fourth and final of our visit i.e., 29-11-2002. He asked us about general impressions on the SSY. We mentioned the observations we shared with Mr. JK Jain. We stated that the SSY looks more like a drug store approach. He also acknowledged the same. We mentioned that there are four areas which has to be looked at (a) Management Information systems (b) replicability (c) Services provided (d) Awareness. Mentioned to him that information flow and feedback mechanism has to be streamlined. Also mentioned that socioeconomic profile of the beneficiaries who are benefiting from the scheme has to be looked at. We stated that disease pattern analysis of the patients who are taking the drugs would also help us in planning the strategies for replicability. We mentioned that to look at providing more services, like advocacy services, referral transport services etc.. than just providing drugs. Awareness levels at all levels, i.e. both the implementors and beneficiaries has to be improved. We suggested that better marketing of the scheme has to be done so that the rural people will be aware of it’s benefits. We mentioned that availability of drugs through PHC's can also be looked at.

He asked us if the scheme will be viable for long run or not, can it run on membership fees or will require donations for. Replying to his question we mentioned that the concept of the scheme is good, but for replicability on a large scale we have to look at the above mentioned points first and then plan accordingly. He also mentioned that he is trying to address the issue of drug store approach and trying to look at other services like providing lab facilities etc.. in the scheme.

## Annexure 1: Details of the patients reimbursed for medical care through SSY

| Details of the beneficiary | Date | Amount |
|---|---|---|
| Gova, Jaora | 20-8-1999 | 2,000 |
| Heeralal, Barkhedi | 1-10-1999 | 20,000 |
| Mayadevi Pandey | 1-10-1999 | 2,000 |
| Mrs. Sanjaykumar | 15-10-99 | 2,475 |
| Narayan Porwal | 1-2-2000 | 1,000 |
| Smt. Shakuntala | 14-2-2000 | 1,200 |
| Ram Prasad, Mavta | 28-2-2000 | 25,000 |
| Smt. Shakuntala | 29-2-2000 | 2,500 |
| Kumari Lalita, Laparia | 16-11-2000 | 25,000 |
| Smt. Sunita Wagh, Ratlam | 29-3-2000 | 2,500 |
| Shri. Kailash Kumari | 17-4-2000 | 1,100 |
| Nadra, Ratlam | 31-3-2000 | 2,500 |
| Dinesh, Minawada | 30-6-2000 | 10,000 |
| Subhash goyal, Ratlam | 2-8-2000 | 5,000 |
| Maksood, Ratlam | 17-4-2001 | 2,000 |
| Ramu, Berda | 3-5-2001 | 1,000 |
| Prahlad Ranawat | 16-4-2001 | 1,000 |
| Dharamchand | 23-6-2001 | 2,601 |
| Smt. Mamta Soni | 5-7-2001 | 2,650 |
| Nagu | 1-3-2002 | 1,685 |

## Annexure 2: Discussions with the beneficiaries at the district drug store on 28-11-2002.

| Details of the beneficiary | Record note of discussion |
|---|---|
| Tasleem, 25 Y, General, APL | This is the first time they have enrolled in SSY and also this is the first time she is availing the scheme. Her child is suffering from fever and cough. She said that the drugs provided under SSY is of help. When asked about would she further continue with the scheme next year, she said that it would depend on her husbands decision. When asked about how did she know about the SSY, said that the Panchayat Karmi has told about it and her neighbors and relatives also has the card. |
| Radhe Shyam, 30 Y, SC, BPL | Both his father and wife is admitted in the hospital. His father is suffering with septic wound on his leg and wife has some post partum complication. This is the first time he enrolled in the SSY. His village is far and takes around Rs. 20/ person for the travel. |
| Ganga Bai, 45 Y, SC | She is also a new member. Her daughter in law is admitted for the delivery. She comes from Barbodna Village which is around 15-20 km from Ratlam. She said that the village karmi has told about the scheme. |
| Pooja, 5 Y, OBC | Her father told that village sachiv informed about SSY and told him to register for this scheme. They are from Bagrod village. The child is suffering from cold and cough. This is the first time they enrolled in the scheme. |
| Kailash singh, 45 Y, OBC | Kailash singh has also registered this year in SSY. He is a chronic patient of tuberculosis and belongs to sailana village which is 20 km. away from Ratlam. He is quite happy about the scheme because the drugs provided to him is very costly and with this scheme he is able to get the drugs free of cost. |
| Arjun, 22 Y, OBC, BPL | Arjun enrolled this year. He belongs to Rayanapara. The village sachiv told him about the scheme. |
| Shyanabaino, 27 Y, SC, BPL | Her husband told that he is satisfied by the services. Shyanabaino is admitted for her delivery. She belongs to Hatwara village. They enrolled in the scheme this year. |