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SERIES: SOCIAL PROTECTION WORKING PAPERS

INDIA

**“ANSWERING THE HEALTH INSURANCE
NEEDS OF THE POOR: BUILDING UP
TOOLS FOR AWARENESS, EDUCATION
AND PARTICIPATION”**

New Delhi, May 29 – 31, 2006



WORKSHOP REPORT

SUBREGIONAL OFFICE FOR SOUTH ASIA, NEW DELHI

India

“Answering the Health Insurance Needs of the Poor:
Building Up Tools for Awareness, Education and Participation”

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Workshop Report

International Labour Organization
Subregional Office for South Asia
New Delhi

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INDIA: Workshop Report: "Answering the health insurance needs of the poor. Building up tools for awareness, education and participation"

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ACRONYMS

ANC	Ante-Natal Care
AMIN	Asia Micro-Insurance Network
ASM	Arthik Samata Mandal
BPL	Below Poverty Line
CBO	Community Based Organization
CGAP	Consultative Group for Assisting the Poorest
CHC	Community Health Centre
CINI	Child in Need Institute
CMP	Common Minimum Programme
CSR	Corporate social Responsibility
CYSD	Centre for Youth & Social Development
DHAN	Development of Humane Action Foundation
EPFO	Employees' Provident Fund Organization
ESIC	Employee's State Insurance Corporation
FP	Family Planning
GNK	Gram Niyojan Kendra
Gol	Government of India
GTZ	German Technical Cooperation
HIV/AIDS	Human Immune Virus / Acquired Immune Deficiency Syndrome
HFF	Healing Fields Foundation
ILO	International Labour Organization
IRDA	Insurance Regulatory and Development Authority
MFI	Micro Finance Institution
MH&FW	Ministry of Health & Family Welfare
MIS	Management Information System
MoLE	Ministry of Labour & Employment
MOU	Memorandum of Understanding
NCEUS	National Commission for Enterprises in the Unorganized Sector
NOAPS	National Old-Age Pension Scheme
OPD	Out Patient Diagnosis
PHC	Primary Health Centre
PNC	Post-Natal Care
PPP	Public-Private Partnership
PREM	People's Rural Education Movement
RCH	Reproductive and Child Health
SBMA	Shri Bhuvneshwari Mahila Ashram
SHEPERD	Self Help Promotion for Health and Rural Development
SHG	Self-Help Group
STEP	Strategies and Tools against social Exclusion and Poverty
STI	Sexually Transmitted Infection
TOR	Terms of Reference
TPA	Third Party Administrator
UHS	Universal Health Insurance Scheme
USAID	United States Agency for International Development
VHC	Village Health Committee
WHO	World Health Organization

I. INTRODUCTION

1. INTERVENTION RATIONALE

Access to quality health care services remains a distant dream for many in India. Although several studies and surveys showed that health care was the social protection priority need of the poor, it is estimated today that some 950 million people remain excluded from this benefit. To bridge such a huge gap still requires the intervention of many more actors, especially at the community level where the particular needs of the various excluded groups may be identified and taken into account while designing appropriate health insurance initiatives.

In recent years, some new major actors such as micro-finance institutions, private insurance companies and private health providers have entered the social protection field and may now be found actively engaged in various micro-insurance experiences. However, these new interventions so far have not resulted in significant improvements on the health front. On the one hand, being considered as a more complex product, health insurance has not attracted among insurance providers all the attention it deserved as demonstrated by the still very limited number of systems and products made available (the 2006 national inventory update prepared by ILO identified 51 organizations involved in the provision of health micro-insurance, covering a total of 5 million people). On the other hand, the purchase response observed among the various target groups failed to reach the overall expected figures which proved to be further negatively affected by high drop-out rates at the end of the first enrolment period.

One major concern is that there is still a huge shortage of organizations actively involved in the provision of both insurance products and support services at the community level. The insurance concept has still to gain its ground among many intermediary organizations engaged in health programmes or other development activities at the grassroots level.

Another major concern is that there is still an important mismatch between the health insurance products currently made available and the basic requirements of the poor. Found predominantly supply-driven (through the intervention of all insurance companies, both public and private), these products, in their design as well as in their implementation, often fail to address the real problems faced on a day-to-day basis by the poor (type and scope of benefits, cashless services, easy-payment mechanisms...).

Also, the knowledge related to on-going health insurance experiences remains very limited, which may prevent some new actors to play a role in what they still consider as an uncharted territory. With the exception of some case studies undertaken by international organizations such as ILO, GTZ and CGAP, there is not much documentation available providing detailed information on the schemes' operational mechanisms (enrolment modalities, policy provisions, service delivery model, financial arrangements, etc...) and performances (coverage, renewal rate, cost containment measures, service satisfaction, etc...).

Finally, there is a widespread lack of the various technical tools that need to be used by the health micro-insurance schemes in order to achieve their objectives in terms of efficiency, impact and sustainability. Most needed in particular, are the tools that may contribute to the better understanding of insurance principles and mechanism as well as those that can enhance the access to quality health care services.

Hence the need to launch a new promotion programme, combining knowledge development, capacity building and advocacy activities that could encourage new interventions adopting a stronger demand-driven approach and social perspective in the design and implementation of efficient health micro-insurance schemes for the poor.

Building on their previous collaboration experience, Plan International (India), the Centre for Health and Social Sector Studies (CHSSS) and ILO/STEP have now decided to strengthen their partnership in developing together this new promotion programme.

Since 2000, PLAN India is actively supporting the promotion of community-based health micro-insurance schemes that could address the priority needs of the poor segments of the population. The organization is currently working at two levels. At the grassroots level it provides technical and financial support to some 15 local NGOs spread over 7 states involved in the setting up of health micro-insurance schemes. At the policy decision level, PLAN is interacting with the Ministry of Health in order to promote innovative health insurance strategies relying on the active participation of organized groups.

Established in Hyderabad, CHSSS has been very active in the field of research linked to health financing mechanisms, including health micro-insurance. In 2004, it conducted a first joint ILO/Plan case study on the health insurance experience developed in Orissa by one of Plan partner organizations (PREM), which triggered a series of additional studies and culminated in a comparative analysis commissioned by ILO/STEP, aiming at recognizing the best practices among 12 health micro-insurance schemes operating in India.

Recognizing a major importance to the social protection issue, ILO has already identified the “extension of social protection to all” as a top priority in its Decent Work Country Programme, and accordingly engaged, together with STEP, a wide program to develop more evidence-based knowledge on health micro-insurance and to share it with all key actors (government, social partners, civil society organizations, community-based organizations...) in order to encourage and facilitate the design and implementation of new national strategies and programmes addressing the health social protection needs of the poor.

2. OBJECTIVES

The objective of the joint initiative was to contribute to the promotion and development of health micro-insurance schemes that can affectively address the specific social protection requirements of the poor. To achieve this goal, the initiative will first target a group of health insurance practitioners working at the grass-roots as well as some other organizations preparing their own health insurance initiative in order to share the practical experience and knowledge that is required for the preparation of various technical tools to enhance awareness, education and participation among the population groups targeted by their interventions.

As a second outcome, various relevant materials documenting health micro-insurance experiences developed in India will be published and widely disseminated among various organizations already involved or willing to play an active role in the promotion of health micro-insurance schemes committed to better answer the social protection needs of the poor.

The first activity planned under the joint initiative was to organize a technical workshop in New Delhi (May 29-31). The workshop “Answering the health insurance needs of the poor: Building up tools for awareness, education and participation” had the following main objectives:

- Review with participants the existing and missing tools related to health micro-insurance
- Enhance the technical capacity of participants to design necessary tools adapted to the local context and target groups
- Develop with participants a series of education tools that could contribute to a wider and better understanding of health insurance principles and mechanisms

- ❑ Explore with participants the possibility of introducing new efficient management information systems and health insurance software in their scheme
- ❑ Encourage participants to participate actively in the Asian Micro-Insurance Network (AMIN)
- ❑ Organize with participants an agenda for the joint development of additional tools

3. OPENING ADDRESSES

Dr. Nalini Abraham, Country Health Advisor, Plan International (India) welcomed the dignitaries and the participants to the workshop. She highlighted the initiatives Plan had taken in this regard. She also mentioned about the steps taken by Plan in mentoring NGOs in micro-health insurance (MHI) by sponsoring trips to various pioneering MHI schemes, in India to learn from their experience.

Mr. Bruno Oudmayer, Country Director Plan International (India) inaugurated the workshop. He dealt with the need for Micro-health insurance in India considering the inability of the poor to spend for health. He also mentioned about Plan's efforts in micro-health insurance. He stressed the need for capacity building among the NGOs who are involved in health insurance. This being the main objective of the present workshop he wished the workshop all success while inaugurating it.

4. KEYNOTE ADDRESS

Ms. Leyla Tegmo-Reddy, Director, ILO Subregional Office, delivered the following keynote address:

Dear Participants,

It gives me great pleasure to attend this technical workshop jointly organized by ILO, the Centre for Health and Social Sector Studies and Plan International (India) which aims to address one of the most important challenges faced by many countries today: how to guarantee to all citizens an appropriate level of health care in terms of access, quality and opportunity, regardless of ability to pay.

It is increasingly being recognized that good health is an essential condition for productivity and social and economic growth in India. Good health and its natural corollary – defence against illness – is fundamental to every man, woman and child. India, however, has still to work towards the gradual development of efficient social protection provisions to match these needs. Although there have been much gains on the health front, the promise of providing health protection to all has not been fulfilled.

It is estimated today that only 10% of the total population enjoys some level of health protection in India, while most of the informal economy workers and their families are left without any kind of social protection benefits. The weakest segments of the population and among them, the most disadvantaged groups are left facing on a day to day basis health risks they are not prepared to cope with. Illness emerges everywhere as the most prominent economic stress for poor households. It may affect all members of the family and it may happen often. Illness not only affects them because of the cost of medical care, but also because of the loss of a household's income when the earning member of the family falls ill. The high probability of being affected by this risk may inhibit the development initiatives of the poor, forcing them into the liability trap and preventing them to play an active role in the mainstream social and

development programmes. Being not protected, they are kept in a continuing cycle of vulnerability and poverty. Having no access to social protection services, they are also deprived of a fundamental human right.

The concept of social protection has evolved over time. It is particularly true in India, where the magnitude of the challenge to extend social protection to all, which may appear daunting to many, requires innovative solutions. Any solution however and especially regarding health care, should adhere to the fundamental principle of national solidarity, which means that social protection benefits to individuals in need, have to be provided by the society as a whole, by means of a redistribution of income in order to achieve better social justice and social equity, as stated in the following definition: “Social protection represents a guarantee, by the entire community to all its members, for the maintenance of their standard of living or at least of tolerable living conditions by means of redistribution of income based on National Solidarity. In other words, the concept of social protection in its broadest sense should be understood to mean the support provided to the individuals by the society to enable him/her to attain a reasonable standard of living, and to protect the same from falling into indebtedness due to the occurrence of any contingency”.

In recent years, the poor performance of public sector using supply side financing has led to increasing interest in demand side financing as a possible health financing option to influence the demand for health services as well as to increase the access of the poor to health services. With this new focus, the introduction of health micro-insurance has been seen as an innovative mechanism that could contribute to a significant improvement of the health status of the poor and especially the poor women. Many civil society actors willing to contribute to the reduction of the vulnerability of the poor have already stepped in to develop multiple schemes.

The schemes that have been set up for poor communities vary widely in size and structure. They also vary widely in terms of who organizes and manages them: community based organizations (cooperatives, women’s groups, micro-entrepreneurs associations, etc), NGOs, trade unions, employer’s organizations, health providers, local governments, etc. There are already numerous cases where micro-finance institutions have established micro-insurance schemes in addition to their more classic services of savings and loans, often in recognition that one of the important causes for lack of repayment of loans is impoverishment due to illnesses and costs of obtaining health care. Today, some of the schemes designed and implemented in India are already among the largest in the world and as such have succeeded to generate a wide interest among the international community.

Given their small-scale decentralized and participatory nature, community-based health insurance schemes have an important potential to focus on the specific interests and needs of the target groups relying on active solidarity mechanism. They can be easily connected with existing institutions to which these workers have already adhered (such as cooperative movements, self-help group federations and trade unions extending their reach to informal economy workers).

Experience, however, shows that these health micro-insurance schemes still face specific problems as regards their financial sustainability due to the limited contributory capacity and small risk pools. In addition, they often cover a very small part of the un-protected population. Great difficulties to extend geographic and socio-occupational outreach and increase membership are often linked to insufficient experience learning and information sharing, inadequate management skills and inappropriate information systems. It is also quite apparent that there is a widespread lack of the various technical tools that need to be used by the health micro-insurance scheme in order to achieve their objectives in terms of efficiency, impact and sustainability.

Overcoming these constraints clearly requires the intervention, in a coordinated way, of many actors willing to contribute to the extension of health protection to all. Indeed, the present workshop provides a very good example of how efficient partnerships in this field can be successfully implemented. Associating health micro-insurance practitioners operating in several states, an international NGO supporting community-based organizations in their various development initiatives, a centre active in the field of research linked to health financing mechanisms and the ILO committed to promote the broad decent work concept in India appears to be the best way to identify the real constraints affecting the development of health micro-insurance, and accordingly, come up with the appropriate strategies.

Obviously enough, all solutions cannot be found at the end of the day. The present workshop should be seen as a very first step towards achieving concrete results and significant impact. Under the framework of its Decent Work Country Agenda, ILO has identified the extension of social protection as one of its priorities and as such is committed to support new initiatives that can bring together all the key stakeholders willing to contribute to this effort. The three partner organizations also share the view that in order to move forward the present collaboration should be developed far beyond the organization of a 3-day technical workshop. Additional activities need to be identified and carried out. However, the successful implementation of any follow-up activity will ultimately depend on the willingness and commitment of all community-based and support organizations attending this workshop to play a more active role aiming to fully address the health protection needs of the presently excluded groups.

With these words, I would like to convey my deepest gratitude to Plan International (India) and Centre for Health and Social Sector Studies for their active collaboration in making this event possible and wish all participants a very fruitful workshop.

II. PROCEEDINGS

DAY 1

Session 1: An Overview of the Present Situation and Development Perspectives

Mr. Marc Socquet in his presentation highlighted that social protection is a fundamental human right and that according to a 1952 definition medical care is one of the nine contingencies listed by the ILO for which social support is required. He further pointed out that although the informal economy, which employs 370 million unorganised sector workers in India, contributes 63% of the country's GDP, workers in this sector have no social protection including protection for health. He brought to notice that the recently submitted report of the National Commission on Enterprises in the Unorganised Sector has recommended that the Government should provide health coverage for the unorganized sector workers in India. He presented the details of this report in a subsequent session.

Using the UNDP statistics he brought out clearly that 80% of India's population lived on less than US\$ 2 and that therefore the contributing capacity of the people was very limited. A study in this regard showed that the contributable capacity declined as the amount expected increased. He therefore emphasized the need for the Government to take care of the health and social protection of India's vast population in the unorganized sector. He concluded this session by pointing out that social security should also be seen as an empowerment instrument and a social inclusion mechanism.

Ms. Stanzin Dolkar presented on the inventory of micro-insurance schemes that the ILO maintains. According to its recent update there are 58 health micro-insurance schemes in India, which cover 5.1 million persons. She also presented slides, which showed the distribution of health micro-insurance schemes by different variables. It was shown that most schemes use the partner-agent model and offer a single risk coverage and also that they are more prevalent in the Southern part of India and next to it in the Western part.

Mr. Alex George mentioned that private expenditure constitutes 78.7% of health expenditure in India. Almost the whole of private expenditure is out of pocket expenditure, which amounts to a whopping 98.5% of it. Increase in the use of private hospitals for Inpatient (IP) care in rural areas from 39% observed in the 42nd round of NSS in 1986-87 to 50% in the 52nd round in 1995-96, and in urban areas from 38% to 53%, (NSSO 1998) is also draining the meagre resources of the poor. A substantial 36.8% population below the poverty line in rural areas and a still higher 43.9% of them in urban areas used private hospitals. This has to be seen against the average hospital charges per day incurred by people below the poverty line in public hospitals, which was only Rs.11.7 as opposed to a more than seven times high Rs.87.7 in private hospitals. People are compelled to use the private sector for their health needs due to the shortcomings or dysfunctioning of public health facilities in various areas.

In the absence of concrete data, health insurance coverage in India is variously estimated by different researchers between to 3%-10% of the population consisting mainly of employees in the organised sector and their families. On the contrary workers in the informal and unorganised sectors of the economy, constituting 93.3% of the workforce.

Against this background the Central Government in the 2003-04 budget announced a micro-health insurance scheme covering health care costs up to Rs.30, 000 per person per annum, accident cover for Rs.25, 000 and a maximum of Rs.750 for loss of wages at the rate of Rs.50 per day. The amount of annual premium was fixed at Rs. 365 for one person (Re.1 per day), Rs.547.5 for a family of five (Rs.1.5 per day) and Rs.730 for a family of seven (Rs.2 per day). Families below the poverty line were eligible for a subsidy of Rs.100 per annum towards

their premium. This scheme was envisaged to be operated by the four public sector insurance companies, through NGOs and was targeted to enrol 50 lakh families.

The 2004-05 Union Budget restricted the scheme to families below the poverty line and more than doubled the subsidy. As per this a subsidy of Rs.200 was offered for the individual premium of Rs.365, Rs.300 for the premium of Rs.547.5 for families of five and Rs.400 for the premium of Rs.730 for seven member families. A new scheme with a health cover of Rs.10,000 for a premium of Rs.120 per annum was introduced for members of Self Help Groups (SHG).

Due to various reasons only 4.17 lakh families with a population of 11.62 lakh could be covered in the first year as against a target of 50 lakh. Probably due to the restricting nature of the policy and poor awareness of the policyholders, claims of only Rs. 28 lakh were settled out of a premium collected of Rs.19 crores. These schemes run by the four public sector general insurance companies have not been able to reach the poor in any substantial manner. In 2003-04 it reached only 11408 BPL families till May 2004, and in the second year, it reached only around 34,000 families till 31st January 2005 and have an extremely low claims ratio. At the same time recently, several state Governments have also introduced this scheme with some modifications.

There are many NGO / CBO initiatives to provide health insurance to the poor such as the VHS and ACCORD in Tamil Nadu, Yashaswini and Karuna Trust in Karnataka, Vimo-SEWA in Gujarat, RAHA in Chattisgarh, the Students Health Home in West Bengal, PREM-Plan in Orissa to name a few. Some of these schemes are precursors to Government activity in this field. They have been able reach a wider coverage in their operational areas and a better claims ratio, though many of them depend substantially on subsidies.

Alex George pointed out that India's health insurance scene presented both challenges and possibilities. On the one hand India faces the challenge of high out of pocket expenditures leading to impoverishment and an extremely low coverage of health insurance, which leaves out the informal sector. On the other hand India also has large social movements with vast social bases and strong historical roots through which MHI could be rooted. These are the movements of adivasis, dalits, co-operatives, women's organisations, SHGs, informal sector trade unions and the NGOs and CBOs.

Session 2: Health Micro-insurance for the Poor: Learning from Experience

In this session several MHI schemes, which were invited to share their experience in MHI, presented their observations. The schemes that presented were: ACCORD, SHEPERD, and DHAN Foundation from Tamil Nadu, Healing Fields Foundation from Andhra Pradesh, UpLift Health Foundation from Maharashtra and Asha Kiran Society from Orissa. These presentations were not based on any pre-fixed format, which has helped the presenters to feel free to present the noteworthy features of their respective schemes. The presentations in this respect are also included in the Appendix to this report along with other technical papers.

Session 3: Setting up a Health Micro-insurance Scheme: Looking at the Process and Conditions of Success

Opening this session, Mr. Marc Socquet pointed out that subsidies were indeed needed in the case of health micro-insurance schemes if they are expected to meet the comprehensive health protection needs of the target groups. He recalled the statistics that was presented in a previous session, which indicated that 80% of the people lived on less than US\$ 2 a day,

which translates into a very weak contributory capacity.

Subsidies he said were of two types: viz., Direct subsidies which are a part / addition to the premium itself and indirect subsidies to meet administrative costs of the scheme. Mr. Socquet, later made a comparative analysis of two of the largest schemes operating in India viz., VimoSEWA, which has a membership of 174,000 and longer history and Yeshaswini, which though of more recent origin has a membership of 1.4 million. There is indirect subsidy in VimoSEWA, while there is direct subsidy in Yeshaswini. Although both schemes have adopted very different operational modalities, they experiment with a similar strong adverse selection, suggesting that when planning to expand their coverage over an important population, health micro-insurance schemes should try to cover whole families through an automatic enrolment process.

Session 4: Panel: Sharing Plan's Experience in Health Financing

NGOs of Plan International (India) presented their experience in MHI in this session. These organisations were PREM-Plan and CYSD from Orissa, ASM-Plan and Samskar-Plan from Andhra Pradesh, Myrada from Karnataka, Seva Mandir from Rajasthan, SBMA from Uttaranchal and GNK from Uttar Pradesh. Among the Plan schemes PREM-Plan with a membership of 87,000 is one of the largest MHI schemes in the country. Details of all the MHI schemes in the Plan International (India) network are mentioned in the Appendix.

DAY 2

Sessions 5 and 6: The Need for Awareness/Education Tools

This day was mostly devoted to studying and modifying the educational and contracting tools, which were distributed as part of the technical notes on the workshop. For working on the educational tools the participants were divided into two rural and one urban groups. The groups either modified the settings and dialogues of the cartoon strips for health insurance education that were distributed to them or created anew similar strips to suit specific social settings. The original cartoon strips covered the following issues:

Tool 1.	The health risk and its consequences...
Tool 2.	Access to quality health care...
Tool 3.	Health care... but at what cost?
Tool 4.	Health insurance advantages

The need to create specific cartoon strips adapted to the local context and target groups requirements was further highlighted in the final discussions amongst the groups when presenting their proposals.

Session 7: The Need for Baseline Survey Tools

An important element of the setting up process of any health micro-insurance schemes is to carry out various base line surveys to collect the necessary data that will be used for the design of mechanisms adapted to the specific context and specific requirements of the target groups. This process generally includes household surveys, Focus Group Discussions and health provider surveys. Due to lack of time, it was not possible to organize work groups to look at some questionnaires used for these purposes. The survey tools used in this regard are given in the Appendix.

Mr.Goswamy, made a presentation based on his experience with the health insurance industry. He presented a scheme meant for children for adults within 18-70 years and children from 3 months to 18 years, which he had conceptualised. The scheme he said would cover hospitalization, minor surgeries, critical illnesses and hospitalization including major surgeries and deliveries – normal as well as caesarian. It is envisaged to operate through the Government health facilities and also use the private facilities with a ceiling limit. This scheme he emphasised was his own conception and not of the Government.

In the process of his presentation he also mentioned about the cost escalation practices employed by some health providers. For example the private hospitals admitted patients who had insurance cover in deluxe rooms when other rooms were available and also conducted several unnecessary tests and examinations on them.

Session 8: The Need for Contracting Tools

The contracting documents used by Healing Fields Foundation, UpLift Health and MD India, which is a Third Party Administrator were studied and discussed by the participants. By studying these documents participants realized the need for contracting tools in their schemes and how best they can draft one, which suited their requirements. The contracting tools used in this regard are given in the Appendix.

DAY 3

Session 9: The Need for Management Information Tools

Uplift set up a new micro-insurance information package namely SYSLIFT Mutual Fund Management System, which is used for decision making, people orientation, understanding financial operations and store members' data. It includes mutual fund management system, monitoring tools, records, reports and business plan.

It offers the following facilities: Data Model including Policies, Persons, Families, Socio economic information, 5 Levels of portfolio consolidation (from Community to Federation), 3 Types of policies, Extensive Claim Information Management, Health Events chosen from the ICD (WHO), Bills or Expenses sorted per hospital. It generates various reports and has the potential for statistical studies. It helps in verifying the policy status and in validating, cancelling policies.

Though SYSLIFT is meant for community based organizations gathered together under the umbrella of UpLift Health Federation, UpLift is willing to share it with other community based organizations, who won't sell it commercially. The interested organizations are expected to bear the installation and training costs for operationalising the software.

Main objectives of Healing Fields Foundation's Management Information Tool are member profiling, risk profiling, transaction operations, disaster management, knowledge management and auxiliary tools. Medicine rates are recorded in the electronic format so that prices of most of the medicines are known. The tool uses data codes to classify diseases under ICD-10. The tool maintains online application. A resource centre is also set up to facilitate its operation.

HFF has profiled Individual / Group health risks. These include Common ailments, Chronic ailments, Critical ailments, Life style ailments, etc and the strategies to be followed. It has computerized and networked its transaction operations. These include Online Workflow application, Connecting all stakeholders seamlessly, Online dashboards, Enrolment, Authorizations and Claims transactions

HFF has set up a Web enabled Resource Center, Best practices Knowledge base, and an MIS Department for specialty reports. HFF's reports are portable to Excel and SPSS file formats. For discussion with partner organizations Monthly partner dashboard reports are used.

Session 10

Mr. SP Goswamy presented on the new scheme introduced by MoHFW, which offers insurance protection for female sterilisation. According to this scheme launched on 29th November as part of RCH II, the Government assures a payment of Rs.1 lakh for any death due to sterilization, Rs. 30,000 for death with one month of sterilization and Rs.20, 000 for any complications within 60 days. For failure of contraception after conducting sterilization an amount of Rs. 20,000 is offered. The Government has allocated Rs.9 crores for this scheme, which is being administered by the Oriental Insurance Company. Claimants have to put up their claims with the QA committees at the district levels, constituted under the scheme. So far however there has been only two claims from the state of Chattisgarh.

Mr. Onishi focused his intervention on demand side financing using voucher as an essential tool. He mentioned that one of the main objectives of the Maternity Voucher Scheme is to ensure access to quality health facilities to pregnant women. Direct subsidies are available

through the vouchers given to the target group i.e. pregnant women. Chiranjeevi is one such health voucher schemes, which is run by the Gujarat Government aimed at bringing down the maternal and infant mortality rates in the state. This scheme has become very popular in Gujarat. In this connection Mr. Onishi also pointed out that while 10% of the Caesarian operations are conducted by private doctors under this scheme, only 2% Caesarians are carried out by public doctors. It clearly indicates a higher Caesarian rate in the private sector.

Ms. Dolkar introduced the newly set up Asian Micro-Insurance Network (AMIN) to the participants. About 300 micro-insurance schemes have already been identified within the region. These schemes already cover some 8.2 million population for health insurance and 5.2 million for life insurance. Main functions of the network will be to share information and experience, to build up technical capacities and to enhance advocacy both at the national and regional level. Ms. Dolkar mentioned also that there are 24 permanent members in AMIN representing 7 countries.

Session 11

The NCEUS has submitted its report recently to the Government of India. Considering the far-reaching nature of the Commission's recommendations and its topicality Mr. Socquet made a presentation on the NCEUS report. This Commission defines unorganized sector workers as those workers who are getting less than Rs.6500 as monthly income. The Commission recommends to provide health and life cover and pension to 300 million unorganised workers who constitute 23% of India's population who are Below Poverty Line (BPL).

It recommends in general a contribution of Re.1 per day from the worker, employer and the Government. Thus constituting a premium of Rs.3 per day aggregating to Rs.1095 per year. For those workers in the BPL category the Central Government will pay the worker's contribution. In the case of unidentifiable employers or self employed the Centre will pay three fourth of the employer's contribution and remaining one fourth has to be paid by States. The Government's contribution will be also shared between Centre and states in 3:1 ratio. Of the premium collected Rs.380 is set apart for Health, Maternity & accidental Death; Rs.150 is kept aside for life cover, while pension or PF is provided Rs.565.

The commission recommends a hospitalization cover of Rs.15000; Maternity cover of Rs.1000 and accident cover of Rs.25000. Loss of wages due to sickness will be compensated at the rate of Rs.50 per day for a maximum of 15 days. This health scheme is to be run through the public sector insurance companies. The Life cover of Rs.15,000 is to be provided through the LIC and the Postal Life Insurance. The Universal Health Insurance scheme, is already offering a cover of Rs. 30,000 for hospitalization for BPL persons. However it subsidises only 55% of the premium and does not cover maternity. It appears that needs to be better co-ordination between the scheme offered by this commission and the UHIC.

For the Above Poverty Line a Provident Fund with interest @ 10% will be paid. For the BPL persons a pension of Rs.200 per month is to be paid from the age of 60 onwards

Session 12

Mr. Socquet initially presented various statistics on the magnitude of population below the poverty line in India based on various estimates. According to nutrition requirement there are 278 million people constituting 26% of the population who are BPL. As per UNDP 35% of population live on less than US\$ 1 per day, while 80% live on less than US\$2 per day. In such a situation of poverty people have little to pay for insurance. The formal economy workers and

their families are entitled to health insurance through a compulsory scheme provided by the Employees' State Insurance Corporation (ESIC).

He then made a comparison of the formal and informal economy worker each with an income of Rs.2000. He showed that while the formal economy worker by paying just 1.75% of his wages was also benefiting from the contributions of the employer to the tune of 4.75% and the Government 12.5% On the contrary the informal economy worker had no such employer or Government contribution to his/her micro-insurance premium. The whole amount had to be paid by him. The total amount of premium contribution for the formal economy worker from the three sources amounted to Rs.1680 per annum, while in the case of the informal economy worker, if we take the VimoSEWA example had to pay Rs.300-400 for a family premium. In the case of the formal economy worker the administrative cost of the scheme was borne by the Government. On the contrary the informal economy worker had to pay for administrative costs, the TPA's charges, the Insurance company's charges and also the service tax. All these further reduced the meager amount available for claims to the informal economy worker.

The scheme for formal economy workers did not involve any adverse selection as whole families were covered. This scheme is unlikely to be affected by over-prescription also as it is run through the scheme's own hospitals. On the contrary the micro-insurance schemes, which give some amount of health protection to the informal economy workers, suffer from uncontrolled adverse selection as many of them cover individuals and not families. They also suffer from over-prescription as they are mainly depending on the private sector unlike the ESIC scheme, which has its own hospitals.

Ms. Jalaja pointed out that India has not done badly after independence in reducing infant mortality, increasing life expectancy, eradicating small pox and eliminating leprosy. At the same time she mentioned that three types of illnesses affect the country. The traditional diseases of Malaria and TB continue. In addition diabetes and cardiovascular diseases have emerged and HIV-AIDS is posing a major threat. It is in this context that the Gol is making massive investments in the RCH II and the NRHM.

The NRHM aims at providing 'universal quality health care'. It has also identified that lack of ownership of health facilities among the people and lack of community involvement are two main reasons why Government health investments have not produced the desired results. Hence decentralization to the district and from the district to the village level is emphasized in NRHM. Community monitoring and accountability to the community are also key aspects of NRHM. PHCs will be looked after by the Gram Panchayats and CHCs by the Block Panhayats.

The ASHA (Accredited Social Health Activist) under NRHM has to be from the local communities. They are expected to link the community to the Government health facility. She will work in collaboration with the ANM in the Sub Centre and the AWW in the Angan Wadis. Intersectoral convergence of nutrition, sanitation and education is also emphasized under NRHM.

Ms. Jalaja expected health insurance to complement the public provision against this background of increasing Government expenditure in health. She closed her brief speech by calling upon health activists to come up with constructive and creative proposals on various aspects of health delivery including health insurance. The Government she said will be open to act on such proposals. She also urged the NGO community to put pressure on the Government health system. Ms. Jalaja was appreciative of the increasing interest in health in states such as Uttar Pradesh and Bihar, which have been showing poor health indicators. She particularly mentioned about a campaign against Japanese Encephalitis in Uttar Pradesh in which 25 lakh children were immunized.

Ms. Ganga Murthy presented a brief summary of the major recommendations of the National Commission on Macro-economics and Health with which she had associated. The Commission recommends a three-tier package of health delivery, which included a core package, basic package and secondary package.

The core package will cover all vector-borne diseases, TB, leprosy, HIV/AIDS (excluding treatment) and other STDs, childhood diseases, preventive and promotive health education including immunization against vaccine-preventable diseases, antenatal and postnatal care of mothers, family planning and information dissemination on all vital health matters, nutrition, water, sanitation and female literacy. The basic package consists in addition to the above, surgery and treatment for hypertension, diabetes, respiratory diseases such as asthma and injury. The core and basic packages will be provided by the Government. Together with services included in the Core Package and the Basic package will cover nearly 85–90% of the health needs of the people and, if implemented well, will substantially reduce both household spending and disease burden. Community Health Insurance is recommended to complement the Core Package through Village Health Units.

Secondary care package consists of treatment for vascular diseases, cancer and mental illness in addition to referrals from the CHC that needs to be handled at district hospitals. An insurance based financing system is recommended for secondary care. For executing the secondary care package, the commission recommends the merger of ESIS and CGHS and reconstituting it as the Social Health Insurance Corporation of India (SHIC).

The Commission has estimated a cost of Rs.1160 per capita for this three-tier package. Of this the core and basic package would cost Rs.150 and Rs.310 respectively, which are recommended to be met completely by the Government. The secondary package would cost Rs.700 per capita, for which health insurance is thought of an alternative financing mechanism, to complement Government investment in this regard.

III. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

The technical workshop was highly successful in highlighting the importance of adapted tools at the various development stages of any health micro-insurance scheme. A review of some good examples of existing tools proved very helpful in encouraging the participants to develop the various specific tools that are required for the setting up, management and development of their health micro-insurance scheme.

The workshop also allowed the participants to better understand the wide diversity of approaches and methodologies that could be used for the promotion of efficient and sustainable health micro-insurance schemes. It became quite clear to all that given the diversity of on-going initiatives as well as the diversity of actors involved, the need to exchange more information, experience and technical knowledge was of the utmost importance. In this regards, the participants expressed their interest to play a more active role in the Asian Micro-Insurance Network (AMIN) as well as in any other similar collective initiative referring to the particular Indian context.

The workshop was also instrumental to provide to all participants a broader perspective regarding the social protection strategies and mechanisms that could be used to extend health protection to each and every citizen. In this perspective, they could better understand the importance of linking up their own local experience with the various policies, strategies and programmes developed at the central or state level to extend social protection and to combat poverty and social exclusion.

Finally, the workshop also allowed the participants to realize that in the present context, the real challenge in the near future will be to ensure that the voices of the presently excluded groups will be clearly heard when designing new wide health insurance strategies and programmes for the poor. Over the last few years, it was recognized that many government initiatives taken either at the central or at the state level have failed due to insufficient knowledge of the real needs of the poor and lack of social dialogue.

To take up this challenge requires the enhancement of the communities' capacity to defend their own interest and accordingly, to plan and organize interventions better adapted to the local context and particular expectation of their members. Hence, the need for the participants to promote and support an empowerment and social inclusion process relying on strong community-based approach.

RECOMMENDATIONS

As a major outcome of the workshop the participating organizations willing to support the community-based approach already decided to come together and to organize themselves into a wider "platform" allowing for all organizations sharing the same principles to develop a closer collaboration on all health micro-insurance issues.

Based on the various discussions developed during the proceedings, the organizations agreed on the following first activities to be implemented:

1. To encourage other organizations sharing the same principles to participate in this new collective initiative
2. To encourage the active participation of all community-based organizations in the design and implementation of health protection schemes adapted to the particular needs of their members

3. To adopt a broader perspective when dealing with health protection, which should not be restricted to curative aspects, but also include the promotion and education components
4. To look beyond insurance mechanisms at other demand-side health financing mechanisms such as vouchers schemes and health savings
5. To plan with all organizations a wide effort to generate more evidence-based information on existing experiences at the community level and to document the best practices
6. To promote and develop a multi-partnership approach with all other actors from the public and private sector willing to contribute to the extension of a better protection for the poor
7. To initiate and organize a regular interaction with public departments involved in policy decisions
8. To link up with the various new protection initiatives taken by the Central and State Government
9. To recommend the adoption of a rights-based approach and social perspective when looking for appropriate health protection solutions
10. To advocate for the waiver of service tax applied to micro-insurance products for the poor

APPENDIX

ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA) TECHNICAL WORKSHOP:

“Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and Participation”

New Delhi, India Habitat Centre, May 29-31, 2006

WORKSHOP AGENDA

Day 1. May 29 – Building Up Tools: Identifying the Priority Needs...

- | | |
|---------------|---|
| 09-09.30 | Registration of Participants |
| 09.30 – 10.00 | Opening Session <ul style="list-style-type: none">□ Welcome Address: Ms. Nalini Abraham, Country Health Advisor, Plan International (India)□ Introductory Remarks: Mr. Bruno Oudmayer, Country Director, Pan International (India)□ Keynote Address: Ms. Leyla Tegmo-Reddy, Director, ILO-Subregional Office□ Workshop Objectives, Expected Outcomes and Review of Workshop Agenda: Mr. Marc Socquet, Social Protection Specialist, ILO-Subregional Office |
| 10.00 – 10.30 | Tea Break |
| 10.30 – 11.30 | Session 1. Health Micro-Insurance in India: An Overview of the Present Situation and Development Perspectives <ul style="list-style-type: none">□ How to Answer the Health Insurance Needs of The Poor? (Mr. M. Socquet)□ What do we Know?: A Review of the Health Insurance Schemes Operating in India (Ms. S. Dolkar)□ Development of The Sub-sector: The Challenges Ahead (Mr. A. George) |
| 11.30 – 12.30 | Session 2. Health Micro-Insurance for the Poor: Learning from Experience
Presentations from: <ul style="list-style-type: none">□ ACCORD/Ashwini- DHAN Foundation□ Healing Fields Foundation (HFF)□ Self-Help Promotion for Health and Rural Development (SHEPERD)□ Uplift Health□ Asha Kiran Society |
| 12.30 – 13.00 | Questions and Answers |
| 13.00 – 14.00 | Lunch |

- 14.00 – 14.30 **Session 3.** Setting Up of a Health Micro-Insurance Scheme: Looking at the Process and Conditions of Success (Mr. M. Socquet)
- 14.30 – 16.30 **Session 4.** Panel: Sharing Plan's experiences in health financing Panel participants:
- ❑ People's Rural Education Movement (PREM)
 - ❑ ASM
 - ❑ CYSD
 - ❑ Samskar
 - ❑ Seva Mandir
 - ❑ GNK
 - ❑ Myrada
 - ❑ SBMA
- 16.30 – 16.45 Tea Break
- 16.45 – 17.15 Open Discussion
- 17.15 – 17.30 Closing Session

Day 2. May 30 – Building Up Tools: Addressing the Priority Needs...

- 09.00 – 09.15 Summary of first day Activities – Introduction to day's Activities
- 09.15 – 10.45 **Session 5.** The Need for Awareness/Education Tools – 1
Group Work: Building Up Awareness/Education Tools
- 10.45 – 11.00 Tea Break
- 11.00 – 13.00 **Session 6:** The Need for Awareness/Education Tools – 2
Group Work: Building Up Awareness/Education Tools
- 13.00 – 14.00 Lunch
- 14.00 – 14.45 Group Work Report and Discussion
- 14.45 – 15.00 Presentation from Mr. S.P. Goswamy· Sharing and Experience with the Health Insurance Industry
- 15.00 – 15.15 **Session 7:** The Need for Baseline Survey Tools
- 15.15 – 15.30 Tea Break
- 15.30 – 16.45 **Session 8:** The Need for Contracting Tools
Group Work: Building Up Tools for Contracting Health Services
- 16.45 – 17.15 Group Work Report and Discussion
- 17.15 – 17.30 Closing Session

Day 3. May 31 – Building Up Tools: Preparing For More...

- 09.00 – 09.15 Summary of second day Activities – Introduction to day's Activities
- 09.15 – 10.15 **Session 9.** The Need for Management Information Tools Presentations from:
- ❑ Uplift Health
 - ❑ Healing Fields

10.15 – 10.30	Questions and Answers
10.30 – 10.45	Tea Break
10.45 – 11.30	<u>Session 10.</u> The Need for Information/Experience Sharing Tools <ul style="list-style-type: none"> □ Innovative Mechanisms: Family Planning Insurance Scheme (Mr. S.P. Goswamy) □ Demand-Side Financing: Maternity Health Voucher Schemes (Mr. H. Onishi) □ Networking: Asia Micro-Insurance Network (AMIN) Activities (Ms. S. Dolkar)
11.30 – 12.00	Questions and Answers
12.00 – 12.30	<u>Session 11.</u> Building Tools: Moving Forward... <ul style="list-style-type: none"> □ National Commission for Enterprises in the Unorganized Sector: The Social Security Report (Mr. M. Socquet)
12.30 – 12.45	Plenary Session: Discussion on a Follow-up Agenda
12.45 – 13.45	Lunch Break
13.45 – 15.45	<u>Session 12.</u> Interaction with Ministry of Health <ul style="list-style-type: none"> □ Objectives and Functioning of the National Rural Health Mission: Ms. S. Jalaja, Additional Secretary, Ministry of Health and Family Welfare □ Main Recommendations of the National Commission on Macro-Economics and Health: Ms. Ganga Murthi, Economic Advisor, Ministry of Health and Family Welfare □ Towards an All-Inclusive Social Health Insurance Model (Mr. M. Socquet) Plenary Session: Exploring New Possible Collaborations and Partnerships With MoH&FW and other Key Actors
15.45 – 16.00	Summary of Activities And Outcome
16.00 – 16.15	Closing Remarks
16.15	Break-Up Tea

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4. List of Support Documents

SESSION 1

Health Micro-Insurance in India: An Overview of the Present Situation and Development Perspectives

Technical Paper 1.1	Extension of Social Protection: Overview of the Present Situation
Technical Paper 1.2	Extension of Social Protection in India: The Contribution of Health Micro-Insurance Schemes
PWP Presentation 1	How to Answer the Health Insurance Needs of the Poor?
PWP Presentation 2	Health Micro-Insurance Schemes in India
PWP Presentation 3	Development of MHI Sub-Sector: The Challenges Ahead

SESSION 2

Health Micro-Insurance for the Poor: Learning from Experience

PWP Presentation 1	ACCORD – AMS – Ashwini Community Health Insurance Scheme
PWP Presentation 2	DHAN Foundation Community Health Insurance Programme
PWP Presentation 3	Self-Help Promotion for Health and Rural Development
PWP Presentation 4	Healing Fields Foundation
PWP Presentation 5	Uplift Health Community Based Health Mutual Fund
PWP Presentation 6	Asha Kiran Prepaid Rural Health Care Scheme: Experience with the Bonda Tribe

SESSION 3

Setting up of a Health Micro-Insurance Scheme: Looking at the Process and Conditions of Success

PWP Presentation 1	Setting up a Health Micro-Insurance Scheme: Looking at the Process and Conditions of Success
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SESSION 4

Panel: Sharing Plan's Experiences in Health Financing

PWP Presentation 1	ASM Primary Health Care Promotion Scheme
PWP Presentation 2	CYSD Community Health Financing Programme
PWP Presentation 3	GNK
PWP Presentation 4	Myrada Swasthya Suraksha Yojane Health Insurance
PWP Presentation 5	People's Rural Health Promotion Scheme
PWP Presentation 6	RNCH Samskar
PWP Presentation 7	SBMA People Health Security Fund
PWP Presentation 8	Seva Mandir Experience in Health Financing

SESSION 5

The Need for Awareness/Education Tools – 1-2

Technical Paper 5.1	Building up Tools: The Health Risk and its Consequences...
Technical Paper 5.2	Building up Tools: Access to Quality Health Care Services...

SESSION 6

The Need for Awareness/Education Tools – 3-4

Technical Paper 6.1 Building up Tools: Health Care... But at What Cost?

Technical Paper 6.2 Building up Tools: Health Insurance Advantages

SESSION 7

The Need for Baseline Survey Tools

Technical Paper 7.1 Examples of Baseline Survey Tools

SESSION 8

The Need for Contracting Tools

Technical Paper 8.1 Examples of Contracting Tools

SESSION 9

The Need for Management Information Tools

PWP Presentation 1 Uplift Health Tools

PWP Presentation 2 Healing Fields Foundation Tools

SESSION 10

The Need for Information/Experience Sharing Tools

Technical Paper 10.1 Extension of Social Protection in India: The Social Security Bill – 2006

Technical Paper 10.2 Extension of Social Protection in India: Taking the Lead in Experience Sharing and Networking

Technical Paper 10.3 Extension of Social Protection in India: ILO/STEP Studies Related to Demand-Side Financing

PWP Presentation 1 Asia Micro-Insurance Network (AMIN)

PWP Presentation 2 Demand-Side Financing: Maternity Health Voucher Scheme

PWP Presentation 3 Towards a National Health Insurance Strategy: Need for More Evidence Based Knowledge

PWP Presentation 4 National Commission for Enterprises in the Unorganized Sector: The social Security Report

SESSION 11

Moving Forward...

Technical Paper 11.1 Extension of Social Protection in India: Jharkhand: An Experiment...

SESSION 12

Interaction with Ministry of Health & Family Welfare

PWP Presentation 1 Addressing the Social Justice Issue

4.1. Technical Papers

Session 1: Health Micro-Insurance in India: An Overview of the Present Situation and Development Perspectives

TP 1.1
TP 1.2

Extension of Social Protection in India: Overview of the Present Situation
Extension of Social Protection in India: The Contribution of Health Micro-Insurance Schemes

Session 5: The Need for Awareness / Education Tools – 1-2

TP 5.1
TP 5.2

Building up Tools: The Health Risk and its Consequences
Building up Tools: Access to Quality Health Care

Session 6: The Need for Awareness / Education Tools – 3-4

TP 6.1
TP 6.2

Building up Tools: Healthcare... but at What Cost?
Building up Tools: Health Insurance Advantages

Session 7: The Need for Baseline Survey Tools

TP 7.1

Building up Tools: Examples of Baseline Survey Tools

Session 8: The Need for Contracting Tools

TP 8.1

Building up Tools: Examples of Contracting Tools

Session 10: The Need for Information / Experience Sharing Tools

TP 10.1
TP 10.2

Extension of Social Protection in India: The Social Security Bill – 2006
Extension of Social Protection in India: Taking the Lead in Experience Sharing and Networking

TP 10.3

Extension of Social Protection in India: ILO/STEP Studies Related to Demand-Side Financing

Session 11: Moving Forward

TP 11.1

Extension of Social Protection in India: Jharkhand... An Experiment

**ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP:**

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New Delhi, India Habitat Centre, May 29-31, 2006

ABSTRACT

- To this day, it is estimated that some 90% of the whole population does not benefit from any kind of social protection
- Although they contribute to 63% of the GDP, informal economy workers still do not benefit from the wealth they contribute to generate
- According to the latest UNDP Human Development Report, 80% of the population lives with less than 2 US a day
- Having to cater for all their basic needs, this amount does not allow them to pay for all their protection needs
- Among these needs, social protection in health is clearly the top priority of the poor
- India is recognized today as having taken the lead in trying to extend social protection to the excluded groups
- Several instruments are currently being tested, including welfare funds, subsidized insurance products and micro-insurance schemes
- To be fully successful, these mechanisms must rely on the active participation of the presently excluded groups...

SESSION 1

**HEALTH MICRO-INSURANCE IN INDIA: AN
OVERVIEW OF THE PRESENT SITUATION
AND DEVELOPMENT PERSPECTIVES**

TECHNICAL PAPER NO 1.1

**EXTENSION OF SOCIAL
PROTECTION IN INDIA:**

**OVERVIEW OF
THE PRESENT
SITUATION**



INTRODUCTION

To this day, India is still striving to reduce a huge poverty phenomenon affecting most of its population. 370 million people are still living under the below poverty line, and if we look at the population earning less than 2 US\$ a day, we come to a staggering total of 855 million who can barely access the essential services they need to survive. The spectacular economic achievements of the last decade have not generated more work (jobless growth). The informal economy is still on the rise, regrouping to this day 93% of the whole labour force. Most of these workers do not have any access to social protection benefits. To this day, only some 10% of the whole Indian population does enjoy some level of social protection, while some 950

India Human Development Factsheet

Population	1,071 million
HDI	127th
HPI	58th
Income less than \$1 per day	371 million
Income less than \$2 per day	855 million
Total Labour Force	406 million
Informal Economy LF	370 million

million are left excluded. The informal economy workers, who contribute to some 63% of the GDP, still cannot benefit from the additional wealth they have contributed to generate.

1. OVERVIEW OF FORMAL SOCIAL SECURITY SYSTEMS

1. Employees' State Insurance Scheme (ESIS)

Launched in 1948, ESIS provides free medical care but also cash benefits towards loss of wage due to sickness, maternity protection, permanent or temporary disablement, survivors' benefits and funeral expenditure. It is basically a compulsory social security system targeting employees of non-seasonal power using factories with 10 or more employees and non-power using factories employing 20 or more. The maximum monthly wage limit is Rs. 7,500. Employers and employees contribute respectively 4.75 and 1.75% of the salary. ESIC currently covers some 7.1 million workers, but has been plagued by high desertion rates, many workers preferring to enrol in other schemes providing better benefits. Its present network of health care facilities is generally found undermanned, ill-equipped and underused. In August 2005, ESIC launched a new programme providing new unemployment benefits to the former employees covered by its other activities. Legal barriers still prevent ESIC to extend its benefits to informal economy workers and the poor quality of the services provided through its own network of health care facilities does not make it attractive enough.

Employees' State Insurance Scheme	
Establishment	Year 1948
Application	Power using factories
employing 10 or more	
Contribution	1.75% by workers 4.75% by employer Gov: 12,5% med/benefits
Threshold of Contribution	Rs. 7,500
Number of workers cover.	7,1 million
Number of people covered	31 million
Contingencies covered	Health Care Sickness benefit Maternity Benefit Disability Funeral expenses
Administration : Employees State Insurance Corporation	

Rajiv Gandhi Shramik Kalyan Yojana (Unemployment Allowance)	
Establishment	Year 2005
Application	Workers covered by ESIS
Contribution	Minimum 5 years to ESIS
Benefit	50% of previous salary
Duration 6 months	
Administration: Employees' State Insurance Corporation	



2. Employee's Provident Fund Organization (EPFO)

Created in 1952, The Employee's Provident Fund caters for the needs of establishments with 20 or more workers. To this day this compulsory scheme provides both old-pension benefits and a provident fund together with same disability benefits to some 39 million workers. The scheme does not benefit from any kind of

Employees' Provident Fund	
Establishment	Year 1952
Application	Establishments with 20 or more workers in any of 180 industries
Contribution	12% by workers 12% by employer 1,1% adm.cost by employer
Treshold of contribution	Rs. 5,000
Number of workers cover	39 million
Rate of interest	9,5%
Contingencies covered	Old-age pension Provident fund
Administration : Employees State Insurance Corporation	

Government subsidy. In January 2004, EPFO launched on a pilot basis in 50 districts the “Unorganized Sector Workers’ Social security Scheme” which combined an accident insurance, old-age pension and the benefits provided under the Universal Health Insurance Scheme. The scheme targeted all informal economy workers with an income lower than Rs. 6,500. The monthly premium to be paid was: Rs. 50 for the age group of 18 to 36, Rs. 100 for the age group of 36 to 50, with a matching contribution from the employer and a contribution from the government set at 1,16% of the monthly wage. Due to its very high price (Rs. 100 to 200 per month), the scheme failed to attract informal economy workers. At the end of its first year, only 3,500 workers had enrolled.

3. Central Government Health Scheme (CGHS)

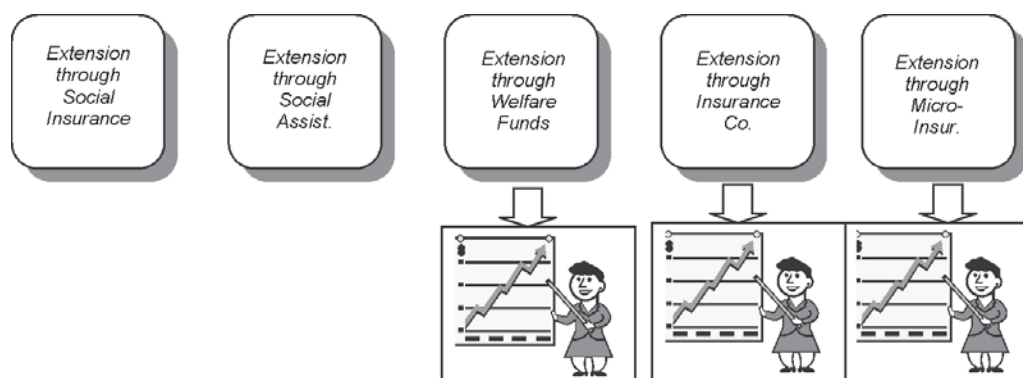
Introduced in 1954 as a contributory plan, the CGHS was aimed at providing comprehensive medical care to central government employees (both in service and retired) and their families to replace the cumbersome and expensive system of reimbursement. The contribution by the employees is, however, nominal (maximum of Rs. 50 per month). The total number of beneficiaries is estimated today at 4 million.

4. State-Owned Managed Health Care Facilities

The Government provides health services to most of the state-owned departments such as Railways, Defence, Police, Mining and Education services. These departments have set up their own system of dispensaries, hospitals and personnel and the services are provided free of charge.

2. REVIEW OF SOCIAL PROTECTION EXTENSION MECHANISMS

Among the various mechanisms that can be used to extend social protection to all, three have recently demonstrated a rapid increase and a higher development potential in terms of both scope and coverage.



1 Extension Through Welfare Funds

Welfare Funds clearly remain in the opinion of many policy makers the best way to extend social protection to various categories of informal economy workers. Although not all operational, the number of welfare funds is steadily increasing (10 new WF created in the last 5 years), and amounts now to a total of 62 schemes distributed among 14 states.

2 Extension Through Insurance Companies' Interventions

1. Public Insurance Companies

All public insurance companies were already traditionally involved in the promotion of several products targeting the disadvantaged segments of the population. The most important health

insurance product introduced in 1986, remains the Medici-claim product. It is a flexible plan whereby the premium varies according to the insured sum as well as to the age of the group concerned. Medici-claim policy only covers hospital care and domiciliary hospitalisation and is subject to several exclusions and coverage limits.

The public insurance companies were also advantaged in the sense that they may offer several products including a subsidy component financed by the Central Government. Such is the case with the Universal Health Insurance Scheme (UHS) which was designed and launched by Ministry of Finance in July 2003. From the outset, it was aimed at answering the health requirements of the poor and very poor people and as such included a subsidy component. Its declared target was to cover a Below Poverty Line (BPL) population of 10 million across all India in its first year of operation. Failing to achieve this goal, the Government of India decided in Year 2 to increase the subsidy and to restrict its availability to the sole BPL population.

2. Private Insurance Companies

Due to the very high capital requirement imposed on private insurance companies for entering the Indian market limited this new intervention to 20 companies, 12 working in the life insurance sector and 8 operating in the general sector. All these companies have to comply with the social obligations issued by the Insurance Regulatory and Development Authority (IRDA) in 2002, obliging them to devote some part of their business towards the disadvantaged segments of the population. Some companies, such as ICICI Lombard have already succeeded to reach an important fragment of the excluded groups (total of 700,000 people covered by various health insurance schemes).

3 Extension Through Micro-Insurance Schemes

Micro-insurance schemes have proliferated in recent years across all India, operating first as in-house schemes. The recent intervention of private insurance companies encouraged many of them to adopt the partner-agent model in order to transfer the risk to the insurance companies. A third generation of micro-insurance schemes is currently on the move with the new extension initiatives taken by various states.

3.

OVERVIEW OF THE NEW POLICY FRAMEWORK

The willingness of the central government to enhance the efficiency and extend the coverage of social protection benefits to all is illustrated by the recent initiatives as regards the necessary legal framework for both formal and informal sector workers. Although the government has made significant efforts on extending social protection for all, the overall coverage remains very limited. Most informal economy workers remain exposed to the multiple risks affecting on a day-by-day basis their working and living conditions, and inhibiting their development initiatives. Taking the example of health protection which remains the first social protection priority need of the workers, the various extension initiatives only succeeded so far to cover some 24,5 million (2,5% of the whole population).

Recent Public Policy Interventions since 1995

1995	National Social Assistance Scheme
	• National Old-age Pension Scheme
	• National Maternity Benefit Scheme
	• National Family Benefit Scheme
2002	Social Obligations for Insurance Companies
2003	New Pension Scheme
2004	Universal Health Insurance Scheme
2005	Rajiv Gandhi Shramik Kalyan Yojana (Unemployment Insurance)
2005	National Rural Employment Guarantee Act
2005	National Social Security Draft Bill
2005	Micro-insurance regulations
	<i>Schemes in blue are for informal economy workers.</i>

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ABSTRACT

- Although still at an infancy stage, health micro-insurance is growing fast in India
- 51 organizations, mostly NGOs have been identified as involved in the provision of health micro-insurance to the poor
- 60 schemes are already fully operational and many others are preparing their initiative
- Total number of schemes has doubled over the last four years
- Some of these schemes have already become the largest ones in Asia
- All together, these schemes already cover some 5.1 million people
- A majority (60%) of the schemes has tied up with insurance companies
- A majority of the schemes operate in rural areas
- Most schemes (81%) offer a single risk health insurance product
- Two third of the schemes are related to micro-finance activities
- Almost all schemes rely on voluntary enrolment
- Health micro-insurance remains far more developed in the Southern part of India...

SESSION 1

**HEALTH MICRO-INSURANCE IN INDIA: AN
OVERVIEW OF THE PRESENT SITUATION
AND DEVELOPMENT PERSPECTIVES**

TECHNICAL PAPER NO 1.2

**EXTENSION OF SOCIAL
PROTECTION IN INDIA:**

**THE CONTRIBUTION OF
HEALTH MICRO-
INSURANCE SCHEMES**

INTRODUCTION

In recent years, health micro-insurance has emerged in India as an essential tool for removing the financial barriers allowing to an easier access to quality health care services. Wider awareness of the existing social protection gaps as well as the growing demand for adapted benefits emanating from the excluded groups have led to the active involvement of multiple actors of the civil society and to a rapid proliferation of various health micro-insurance schemes across the country.

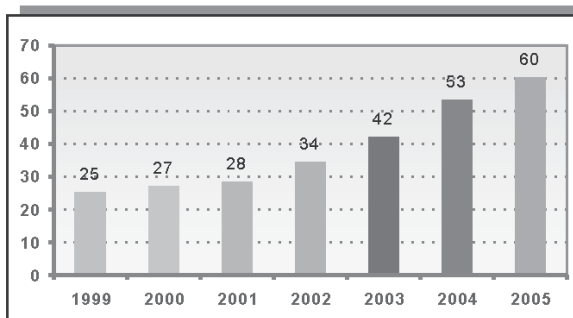
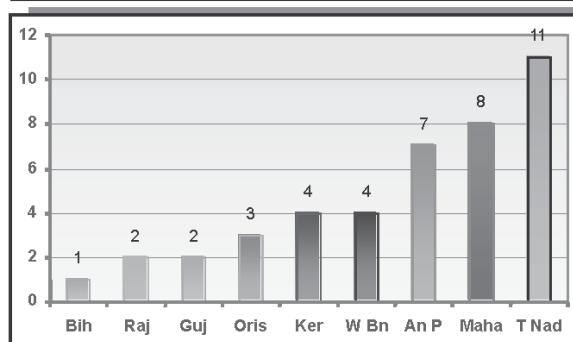
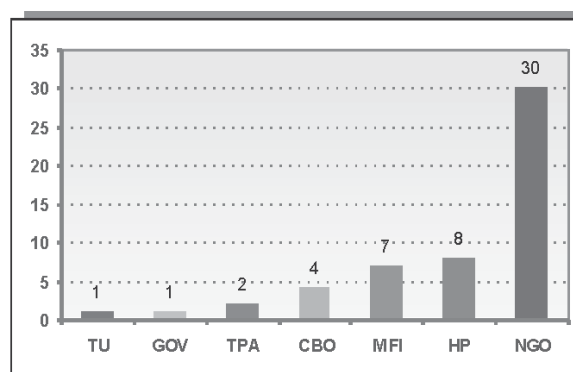
A first national inventory prepared in 2003-2004 by ILO/STEP provided detailed information related to each micro-insurance scheme while highlighting the main characteristics of the experiments developed at the country level. As such, it contributed both to the knowledge development process among micro-insurance practitioners who might find useful to adopt some of the innovative features already tested by others as well as to advocacy activities that still need to be strengthened in order to extend social protection to all. Based on a 2005 update of this inventory, the present document provides an overview of the various health micro-insurance schemes currently found operational in India as well as a very first assessment of their present and potential contribution to the overall extension strategies still to be fully designed at the national level.

1. HEALTH MICRO-INSURANCE AT A GLANCE

As regards the ownership profile, NGOs remain by far the main actors involved in India in the promotion of health micro-insurance schemes. While already working at the grassroots level, these organizations are generally better prepared to design tailor made health insurance products to suit the priority needs and contributory capacity of their target groups. Since most of the NGOs also implement a micro-finance component, health insurance related to micro-finance, when adding the fully specialized MIs, account for two third of the schemes.

One distinctive pattern of the health micro-insurance schemes operating in India is their stronger concentration in the south which clearly relates to the wider presence and coverage of both micro-finance activities and private health care facilities in this part of the country.

The steady growth of the health micro-insurance sub-sector has taken a faster pace over the last 5 years. The new inventory update which by far never pretended to be exhaustive, could already document 60 schemes which is more than twice the number operating in 2001.



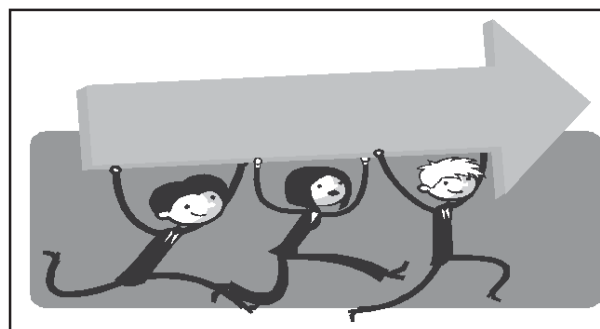
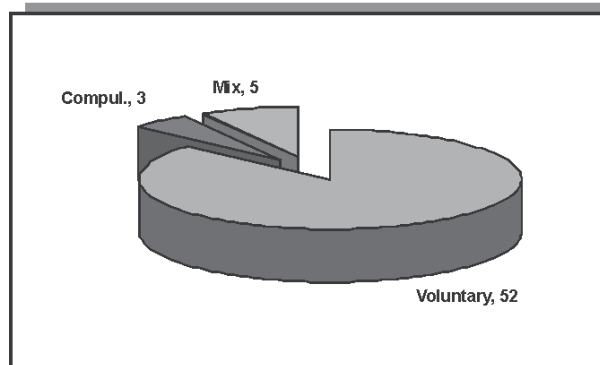
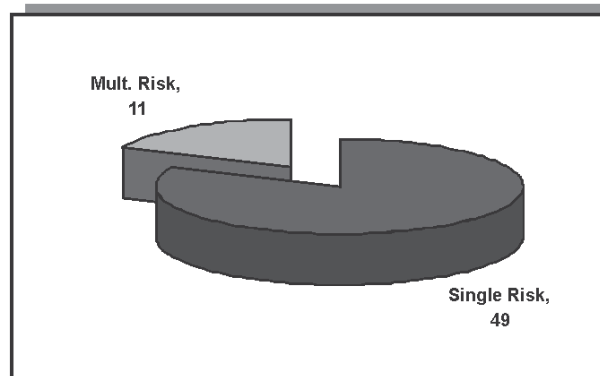
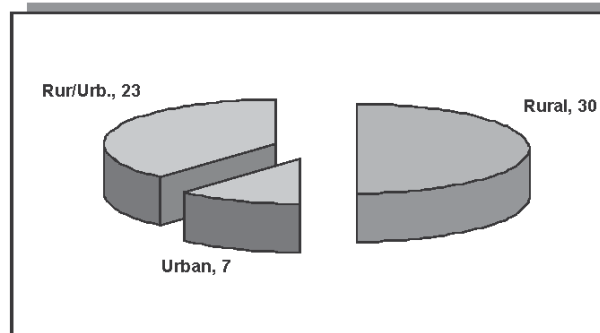
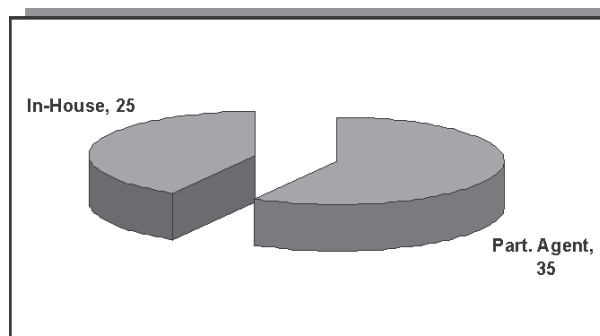
As regards the type of scheme, the partner-agent model has already become predominant in spite of a very late (4 years back) intervention of the private companies in the insurance market, and is quickly gaining more ground on the in-house model that was first to emerge.

While most health micro-insurance schemes are found providing services to groups operating in rural areas, 37% of the schemes have extended their coverage to members living in both rural and urban areas.

Another distinctive feature of the schemes operating in India is that some (20%) have opted for a composite risk package, while the number of schemes offering a single health insurance product remains far higher. The recent micro-insurance regulations issued by IRDA, which encourage the bundling of life and non-life products, may result in many more schemes adopting the composite risk packages in the near future.

With few exceptions (all linked to micro-finance activities) most schemes do rely on a voluntary enrolment which implies that they have to re-engage each year promotional activities that increase administrative costs and accordingly, reduce the allocations going for the payment of benefits provided under the scheme.

Based on the figures provided by the last inventory update, the various health micro-insurance schemes operating in India have already succeeded to enroll a total of 5.1 million. Given the fact that many other schemes must have escaped the exercise, the present total figure could probably be much higher and probably top the 6 million mark.



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ABSTRACT

- Although still at an infancy stage, health micro-insurance is growing fast in India
- Insurance remains an alien concept for many
- It is quite different from many spot transactions poor people are used to. Purchasing a “protection” needs to be carefully explained
- Health insurance is far more difficult to explain than life insurance
- Hence the need to develop a series of education materials on health micro-insurance
- The first element of this series looks at the health risk and its possible consequences:
- Poor people usually do not prepare against health risks
- When a health problems occurs it also directly affects your work and income
- It may generate unexpected level of expenditures
- You are usually left alone to cope with the problem
- Reverting to loan sharks is not a good solution
- It may make you unable to repay a loan
- Once defaulting on a first loan, you will not have another chance
- You may have to sell some assets to cope with expenses
- It may be serious enough to make you lose your business

SESSION 5

**THE NEED FOR AWARENESS / EDUCATION
TOOLS - 1**

TECHNICAL PAPER NO 5.1

**BUILDING UP
TOOLS:**

**THE HEALTH RISK AND
ITS CONSEQUENCES...**

INTRODUCTION

In recent years, health micro-insurance has emerged in India as an essential tool for removing the financial barriers allowing to an easier access to quality health care services. Wider awareness of the existing social protection gaps as well as the growing demand emanating from the excluded groups have led to the active involvement of multiple actors of the civil society and to a rapid proliferation of various health micro-insurance schemes across the country. However, the further development of this sub-sector is still hindered by the lack of appropriate basic education materials. Insurance principles and mechanisms are still not clearly understood by the various population groups who never experimented before with a collective protection mechanism.

No real effort has ever been undertaken so far to develop appropriate tools aiming to ensure the full understanding of health insurance, which can be developed using very different models and operational modalities. This effort could not be expected from insurance companies using the partner-agent model. They usually hardly know the expectations and particular requirements of the target groups. Neither are the various NGOs and MFIs involved in some in-house health micro-insurance schemes able to allocate the time and resources for this purpose. The present lack of tools may already be responsible for the high drop-out rates observed in many schemes at the end of each insurance year, which affects any plan to scale up and extend social health protection benefits to more people in need. Hence, the need to develop a series of education materials related to the various aspects of health micro-insurance.

THE PROPOSED SCENARIO – TOOL NO 1

<u>Objectives</u>	<ul style="list-style-type: none">● Illustrate the negative effects of a health problem on a professional activity● Illustrate the various problems faced when being ill-prepared when confronted to a health problem● Illustrate the possible consequences when unable to repay a loan due to a sickness problem
<u>Proposed Setting</u>	<ul style="list-style-type: none">● Rural environment (since 70% of workers are operating in rural areas)
<u>Proposed Actors</u>	<ul style="list-style-type: none">● Young woman (A), home-based worker with a 5-6 year old child
<u>Proposed Scenes</u>	<ul style="list-style-type: none">● In the street (village)● At her home● At the hospital● With several shopkeepers
<u>Illustrations</u>	<ul style="list-style-type: none">● 20 to 24 (max.)

DESCRIPTION	SCENARIO – MESSAGES
PROPOSED SCENARIO	
1 A, standing on the market place, looking at a small building with a board “savings and credit co-operative”	I am a member for so long, but never thought to ask for a loan. Would it be possible to get one? (Thinking: working hard on a sewing machine)
2 Sitting in the office with the manager. He shows her papers, they discuss...	The manager: Let me explain on what conditions we can give you a loan...

- | | | |
|----|---|--|
| 3 | At evening, in her house, working on the table, preparing her loan application...in front of her, a paper with two columns: Expenditures and income... | I have to plan everything carefully... |
| 4 | In front of the manager again, he reads a paper, she looks worried (she is waiting for his reaction to her proposal) | What do you think? Is it acceptable? |
| 5 | The manager seems satisfied, he smiles and shows her the counter where the cashier is giving some money to a client | The manager: it is a good project, you have to sign the loan form and then we will give you the money... |
| 6 | At the same place: A is in front of the cashier who hands over the money | The cashier: You have to observe the repayment schedule... |
| 7 | Other location: A is in a shop and shows to the shop assistant a sewing machine standing on a shelf | A. This one is expensive ... but I need a good and reliable one... |
| 8 | In another shop: A chooses various fabrics to make clothes | A. Give me that one too... I pay cash |
| 9 | In her house, A is buys working with her new sewing machine, behind her, two clothes have already been completed. On the wall behind her, we see a calendar : we are in March | A: I have to get more orders... |
| 10 | Same place: but behind her on the calendar, we see April, there is a pile of clothes behind her | A: Now, I am doing fine... I have almost too many customers... You have only to work hard to succeed... |
| 11 | Same place: in front of her, money on the table, notes and coins, she is counting money and in front of her, we see three boxes: food, clothes and loan repayments | A: I need to organize and put each day some money in each box... |
| 12 | Same place: A dreams, all the money has been put in the three boxes... she looks happy... | In her dream, we see a box called Health with a cross on it... and instead, we see many people eating at her place... she prefers to organize a party... |
| 13 | A is at the savings and credit cooperative and hands over to the cashier some money... she is repaying her loan on time. The manager is besides her and looks happy... | The manager: It's very good, I see that you are very serious and always on time with your instalments... |
| 14 | A is at her house again, her little boy lying in his bed... he is sweating and looks bad... A is kneeling beside him holding his hand | Do not worry. It is probably nothing and we will go and see the doctor tomorrow... |

- | | |
|--|---|
| 15 A is in the hospital, her child is in a bed, the doctor diagnoses him... a nurse is nearby taking notes... | The doctor: It is serious, he will have to stay here...we have to be sure it isn't get worse... |
| 16 A is at a pharmacy, buying medicines | A: I didn't know that it was so expensive... |
| 17 A is at her home again, in front of her on the table, only some coins left...she is holding her head in her hands, she looks worried... | A: What will I do? I have still some bills to pay to the doctor and I have already spent all my money... |
| 18 A is in front of a neighbour, asking her for some money... | The neighbour: I am really sorry but I cannot lend you that amount... |
| 19 A is in front of the manager of the savings and credit co-operative, asking him to extend her credit... the manger looks worried... | The manager: I am sorry but I cannot give you another loan... you still owe us a lot of money on the first one |
| 20 A is now standing in a shop, asking for a loan from the moneylender... in front of her, a fat man is sitting, clearly, he is not sad hearing her story | A: I relay need Rs. 1,000
The moneylender: I only can lend you Rs. 500, and you will have to give me Rs. 1,000 in two months |
| 21 A is at her house again, in front of her, the thee boxes are now empty, there are just two coins on the table | A: And now, I cannot even repay my loan on time... what am I to do? |
| 22 A is at the same shop where she bought her sewing machine... which is in front of her on the counter, she is bargaining with the owner, trying to get the best price for it | A: Please, give me more money, it is almost new. I only bought it two months ago...
The owner: That means that it is old to me... sorry, I cannot give you more than that... |
| 23 A at her home: She is hiding and crying... we see the manager of the savings and credit co-operative in front of her door, he looks really angry and waves some papers... | A: I should have thought of the possibility of getting sick... I should have saved some money and put it in a "health" box... |

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- Insurance remains an alien concept for many
- It is quite different from many spot transactions poor people are used to. Purchasing “protection” needs to be carefully explained
- Health insurance is far more difficult to explain than life insurance
- Hence the need to develop a series of education materials on health micro-insurance
- The second element of this series looks at the issues of accessibility and quality of healthcare services :
- Public health posts are sometimes located far away
- Transportation to get there may be a problem and there are costs attached to it
- Opening hours may not be observed all the time
- Staff is usually not attentive to patients’ plight
- Health posts are usually undermanned and the doctor may come late... or not at all
- Infrastructure may be in poor condition
- Essential medicines are usually lacking
- There is some evidence that some clients are better treated than others...

SESSION 5

**THE NEED FOR AWARENESS / EDUCATION
TOOLS - 2**

TECHNICAL PAPER NO 5.2

**BUILDING UP
TOOLS:**

**ACCESS TO QUALITY
HEALTH CARE...**

INTRODUCTION

In recent years, health micro-insurance has emerged in India as an essential tool for removing the financial barriers allowing to an easier access to quality health care services. Wider awareness of the existing social protection gaps as well as the growing demand emanating from the excluded groups have led to the active involvement of multiple actors of the civil society and to a rapid proliferation of various health micro-insurance schemes across the country. However, the further development of this sub-sector is still hindered by the lack of appropriate basic education materials. Insurance principles and mechanisms are still not clearly understood by the various population groups who never experimented before with a collective protection mechanism.

No real effort has ever been undertaken so far to develop appropriate tools aiming to ensure the full understanding of health insurance, which can be developed using very different models and operational modalities. This effort could not be expected from insurance companies using the partner-agent model. They usually hardly know the expectations and particular requirements of the target groups. Neither are the various NGOs and MFIs involved in some in-house health micro-insurance schemes able to allocate the time and resources for this purpose. The present lack of tools may already be responsible for the high drop-out rates observed in many schemes at the end of each insurance year, which affects any plan to scale up and extend social health protection benefits to more people in need. Hence, the need to develop a series of education materials related to the various aspects of health micro-insurance.

THE PROPOSED SCENARIO – TOOL NO 2

<u>Objectives</u>	<ul style="list-style-type: none">● Underline the different problems that can be faced when trying to access healthcare services● Illustrate the various problems when trying to get quality health care services● Demonstrate the vulnerability and weakness, when exposed all alone to some health problem
<u>Proposed Setting</u>	<ul style="list-style-type: none">● Rural environment (since 70% of workers are operating in rural areas)
<u>Proposed Actors</u>	<ul style="list-style-type: none">● Young pregnant woman (B), with another young child
<u>Proposed Scenes</u>	<ul style="list-style-type: none">● At the market place (village)● On the road● In front of the health post
<u>Illustrations</u>	<ul style="list-style-type: none">● 20 to 24 (max.)

PROPOSED SCENARIO

DESCRIPTION	SCENARIO – MESSAGES
1 B holds a small restaurant shack... she is seen serving some clients (sitting and standing)...	B: I don't feel too well today...
2 B lies in her bed, an old lady is beside her and make her drink something, she looks worried... we see through the window that it is night	The friend: You will have to visit the health post tomorrow morning...

- | | |
|--|---|
| 3 B leaves her home, holding a bag, she waves to her friend who is staying at her home to take care of her child, who is crying... | The friend: Don't worry, he will be fine...will see you tonight |
| 4 B is waiting on the roadside... the bag at her feet... the sun is already high in the sky... it is hot | B: Already one hour that I wait here... |
| 5 B is discussing with the driver of a truck ... he waves saying No... | B: You are asking for too much... I don't have much money |
| 6 B is now sitting at the back of the truck... she feels uncomfortable, it is hot and dirty, smoke from the truck is getting at her... | B: He could have been nice and let me sit beside him in the truck... |
| 7 B left at a crossroad in the countryside, the truck in the distance, a small path in front of her with a board saying Health Post – 5 Km | B: I didn't know that it was that far... and it's hilly too... |
| 8 B arriving in front of the health post, she is tired, she holds her belly... we see that the building is not well kept | B: I was already not well... and now I am exhausted as well... I just hope it won't take too long |
| 9 B coming in front of the door, on the terrace we see a queue of patients waiting...some of them are waiving her to go to the end of the queue | A patient: go to the back, you are the last to come... |
| 10 At the door we see a nurse sitting at a table, the door is still locked... a paper on the wall says: opening hour at 8.30. On the clock on the wall: 9.10. The first patient shows the clock to the nurse | The patient: It's always the same thing... the doctor is always late |
| 11 In front of the door, a car is stopping, the doctor finally arrives... It is now 9.30 on the clock | A patient: Finally, here he comes... |
| 12 The doctor (big man with a stethoscope) opens the lock with a big key... | A patient: I just hope he already read the newspaper and that we will start working immediately |
| 13 In the queue, two men are discussing | First patient: lat time, I had to pay more for the same service...
The second: It's normal, everything gets more expensive over time |
| 14 In front of the door, the nurse is discussing with a patient handing over a chicken... the nurse says no, she wants money | The nurse: Sorry, too may chicken this month already... |
| 15 In another part of the queue, an old lady is trying to get some water from a tap on the wall... but no water coming out... | |

- 16 In another part of the queue, a young girl child looks through the window at the room... it looks dirty, one leg is missing from the bed, a spider web in a corner...
- 17 B also looks through another window... she sees the doctor in front of a cupboard (containing the medicines).. it is almost bare
- 18 In front of the door, a couple is coming out of a car, they are well dressed, the nurse stands up to welcome them The nurse: Your wife does not feel well?... I am calling the doctor immediately
- 19 Same place, the doctor is with them, all smiles, and ask them to come in The doctor: Please come in, I will attend to you immediately...
- 20 In the queue again, we see now B sitting in third position in the queue, quite near the door B: All the day lost in waiting... hope now that it will be my turn soon
- 21 B in second position, behind an old man, she is looking at the doctor who has come out with the big key in his hand B: What is he doing?...
- 22 B is discussing with the doctor and shows him the clock on the wall: 17.15, the doctor is leaving B: But it is too early to close...
The doctor: Sorry, but I am too tired now... come back tomorrow
- 23 From afar, we see the health post in the dark, some people are still waiting on the terrace, others are eating in front of the building...they are clearly going to spend the night there
- 24 B is sitting in a small group on the terrace, she is listening to a women who raises her finger The women: Long ago it was different... We see in her dream, the health post when it was new and well kept...

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ABSTRACT

- Insurance remains an alien concept for many
- It is quite different from many spot transactions poor people are used to. Purchasing a “protection” needs to be carefully explained
- Health insurance is far more difficult to explain than life insurance
- Hence the need to develop a series of education materials on health micro-insurance
- The third element of this series looks at the issue of affordability
- Quality healthcare services come with a price
- Many different services are charged to the patient
- The full treatment of an illness may be much longer than expected
- You never know in advance the total cost that will have to be paid
- Some people could simply not afford to pay
- This may wipe out all your money, deplete your assets and even your professional tools
- Better to be prepared and be able to cope with such a risk
- Introduction of the health insurance concept...

SESSION 6

**THE NEED FOR AWARENESS / EDUCATION
TOOLS - 3**

TECHNICAL PAPER NO 6.1

**BUILDING UP
TOOLS:**

**HEALTHCARE... BUT AT
WHAT COST?**

INTRODUCTION

In recent years, health micro-insurance has emerged in India as an essential tool for removing the financial barriers allowing to an easier access to quality health care services. Wider awareness of the existing social protection gaps as well as the growing demand emanating from the excluded groups have led to the active involvement of multiple actors of the civil society and to a rapid proliferation of various health micro-insurance schemes across the country. However, the further development of this sub-sector is still hindered by the lack of appropriate basic education materials. Insurance principles and mechanisms are still not clearly understood by the various population groups who never experimented before with a collective protection mechanism.

No real effort has ever been undertaken so far to develop appropriate tools aiming to ensure the full understanding of health insurance, which can be developed using very different models and operational modalities. This effort could not be expected from insurance companies using the partner-agent model. They usually hardly know the expectations and particular requirements of the target groups. Neither are the various NGOs and MFIs involved in some in-house health micro-insurance schemes able to allocate the time and resources for this purpose. The present lack of tools may already be responsible for the high drop-out rates observed in many schemes at the end of each insurance year, which affects any plan to scale up and extend social health protection benefits to more people in need. Hence, the need to develop a series of education materials related to the various aspects of health micro-insurance.

THE PROPOSED SCENARIO – TOOL NO 3

<u>Objectives</u>	<ul style="list-style-type: none">● Underline the unpredictable character of health problems● Review the different aspects and cost elements of a sickness episode● Highlight the high and unexpected costs attached to the treatment of a sickness episode
<u>Proposed Setting</u>	<ul style="list-style-type: none">● Semi-rural environment (important village)
<u>Proposed Actors</u>	<ul style="list-style-type: none">● Young man (C), about thirty years old● His wife (D)
<u>Proposed Scenes</u>	<ul style="list-style-type: none">● In his shop at the market place● At his home● At the hospital
<u>Illustrations</u>	<ul style="list-style-type: none">● 20 to 24 (max.)

PROPOSED SCENARIO

DESCRIPTION	SCENARIO – MESSAGES
1 C in his shop, at the market place, he repairs shoes...he talks to a customer... many people in the street	The customer: I need them this evening
2 C sitting in his shop, holding his belly... he is sweating and clearly in pain	C: What's wrong with me?...I don't feel well...

- | | |
|--|--|
| 3 C closes his shop (still in daylight, market place is still animated behind him) | C: Impossible to go on working with this pain... |
| 4 C at his home, sitting at the table... nearby, his wife (D) is putting some clothes in a bag... | D: It looks serious, we have to see the doctor immediately |
| 5 C and D are at the health facility, a nurse show them where to sit to wait for the doctor... three other patients are already waiting | The nurse: Just a few minutes... I'll tell the doctor to come and see you |
| 6 C is with the doctor, sitting on a bed, without shirt, the doctor looks at his tongue and his throat... | The doctor: I don't like too much the colour of it... |
| 7 Same room, the doctor is now putting his stethoscope on his chest | The doctor: Yes, I can hear we have a problem here... |
| 8 Same room, the doctor takes his tension... The doctor: | You need an injection, it won't hurt you and it will ease your pain... |
| 9 Same room, the doctor but C is now lying on the bed looking behind his shoulder at the nurse who is preparing an injection.... | The doctor: But I need to make some tests to confirm my diagnosis... |
| 10 Same room: C is again sitting on the bed, clearly in pain... the doctor looks at him, he seems worried... the nurse gives C a small container | The doctor: It looks serious... we will have to keep you here for the next days
The nurse: Sorry, but we need you to urinate for some additional tests... |
| 11 The nurse is opening a room with three beds, left and right beds have already a patient... middle bed is free... she shows the room to C, the room looks well kept | The nurse: You will stay here... don't worry, we will take good care of you |
| 12 Same room: C is now lying in his bed, the three patients look at the nurse entering with a trolley... food is coming... behind C on the wall, we see a calendar with one day circled first day in the health facility | |
| 13 Same room: The doctor is back, and examines one of the other patients... through the window, we see that the night has fallen | |
| 14 Same room: The nurse is coming again with her trolley, but bringing medicines (plenty of it) this time... it is the morning... on the calendar, we see now two days circled... she is giving C something to swallow | The nurse: Take this, it has to be taken four times a day... |

- 15 Same room: Visiting hours. D is near her husband, she points out the various medicines on his bed table... on the calendar, we now see that it is his fourth day at the health facility
- 16 Same room and time: The patient on the left side is also with his wife... the patient on the right side remains alone... the doctor is entering with some papers in his hand
- 17 Same room and time: The doctor is speaking to the patient on the right side, he is reading his papers... the patient is opening his mouth, while listening to the doctor telling him what he has to pay...
- 18 Same room and time: The doctor is still reading his papers to the patient on the right side... the patient holds his head, he is sweating...
- 19 Same room and time: The doctor is now in front of C and D, starting to tell them about what they will have to pay... we see on the right side of the room, the patient jumping through the window (he decided to leave without paying)
- 20 Same room and time: The doctor is still going through the bill to pay... C and D are both gaping, clearly amazed by everything that goes into a bill...
- 21 Same room and time: The doctor is still going through the bill to be paid...
- 22 Same room and time: Same situation... D is staring to cry...
- 23 Same room and time: The doctor is now standing in front of the patient on the left side... the patient and his wife listen to him, both are smiling...
- 24 Same room and time: The doctor has finished telling them about their bill... the patient on the left side, still smiling, shows a card to the doctor... C and D are looking at him, not understanding his reaction...
- D: Do you have to take all this? This must be expensive?
- C is thinking about the money he will have to pay, all their savings will be gone...
- C is sweating... C is thinking about the pig he will have to sell to settle their own bill...
- C is thinking about his ship and tools... they will probably have to sell that too...
- On the card, we can read: Health micro-insurance scheme: membership card...

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- It is quite different from many spot transactions poor people are used to. Purchasing a “protection” needs to be carefully explained
- Health insurance is far more difficult to explain than life insurance
- Hence the need to develop a series of education materials on health micro-insurance
- The fourth element of this series looks at the characteristics and advantages of a health micro-insurance scheme
- It regroups the women who were involved in the first elements of the series
- Together with another woman already member of a health insurance scheme, they review the most important services provided by the scheme
- How does it work?
- Who can be a member?
- Where to go when in need of health services?
- What is there to pay?
- What about the quality of services?
- This discussion attracts the interest of many others...

SESSION 6

**THE NEED FOR AWARENESS / EDUCATION
TOOLS - 4**

TECHNICAL PAPER NO 6.2

**BUILDING UP
TOOLS:**

**HEALTH INSURANCE
ADVANTAGES**

INTRODUCTION

In recent years, health micro-insurance has emerged in India as an essential tool for removing the financial barriers allowing to an easier access to quality health care services. Wider awareness of the existing social protection gaps as well as the growing demand emanating from the excluded groups have led to the active involvement of multiple actors of the civil society and to a rapid proliferation of various health micro-insurance schemes across the country. However, the further development of this sub-sector is still hindered by the lack of appropriate basic education materials. Insurance principles and mechanisms are still not clearly understood by the various population groups who never experimented before with a collective protection mechanism.

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THE PROPOSED SCENARIO – TOOL NO 4

<u>Objectives</u>	<ul style="list-style-type: none">● Show the necessity to organize a collective mechanism to better cope with health problems● Introduce the concept of a community-based health micro-insurance scheme● Highlight the various advantages of enrolling into a health micro-insurance scheme
<u>Proposed Setting</u>	<ul style="list-style-type: none">● Semi-rural environment (important village)
<u>Proposed Setting</u>	<ul style="list-style-type: none">● Semi-rural environment (important village)
<u>Proposed Actors</u>	<ul style="list-style-type: none">● Young woman A (tool N0 1)● Young woman B (tool N0 2)● Young woman D, spouse of C (tool N0 3)● Older woman E (new actor)
<u>Proposed Scenes</u>	<ul style="list-style-type: none">● Group of people discussing at the market place, the group gradually attracts more and more people
<u>Illustrations</u>	<ul style="list-style-type: none">● 20 to 24 (max.)

PROPOSED SCENARIO

DESCRIPTION	SCENARIO – MESSAGES
1 A, B and D discuss at the market place	B: Hello A, I learned that you were sick? A: Yes, you too I learned? And what about your husband D? D: He is better now, but it cost us a lot of money

- | | | |
|----|--|--|
| 2 | A, B and D are now sitting and drinking tea in front of the market place... E, a friend of D is now sitting with them | D: I told you about my friend? She also had some health problems in the past, like all of us... |
| 3 | Same situation: The four women are discussing... | E: Yes, we all know how health problems can be difficult to cope with... but now we organized ourselves and found a solution. We are members of a health insurance scheme...
B: What is that? |
| 4 | Same situation: The four women are still discussing with animation... a fifth woman standing behind them, has stopped and listen to them | E: It is a group of persons who unite to help each other to cope with health problems, it is based on solidarity principle and insurance mechanism whereby everyone has to pay a small premium |
| 5 | Same situation: B looks discouraged... | B: But we have already organized a small emergency fund in the past, it didn't work...some people didn't pay their due and when we needed it most, there was no money left in the kitty |
| 6 | Same situation: We see the fifth woman waving to another to come and listen to the group... | E: No, the system is different, the scheme covers only services that have been pre-determined and also the scheme is organized and managed so that we know that the benefits will be provided when we need them |
| 7 | Same situation: Two women are now standing behind the group | A: But, if we don't fall sick, does the scheme pay back our contribution?
E: No, it is a solidarity system... everyone is contributing but only those who are sick are benefiting from the protection offered by the scheme |
| 8 | Symbol: A group of people holding a roof over their heads, to illustrate the protection provided by the scheme | E: Each member has to understand that in enrolling in the scheme, they protect all members of the scheme... this means pooling the resources and sharing the risks... |
| 9 | Same situation as in 7: | B: What are the benefits provided by the scheme?
E: Those that the members have determined as top priorities... those may be different in various schemes |
| 10 | New illustration: A health post: three women and a man are waiting in front of a nurse... on the door nearby, a board: doctor | E: In some cases the scheme covers OPD services |
| 11 | New illustration: A patient in a bed at the hospital | E: In some cases the scheme is covering hospitalization costs |

- | | |
|--|---|
| 12 New illustration: A pregnant lady in a bed, holding her belly... | E: The scheme may also provide a maternity protection |
| 13 New illustration: A woman leaves a pharmacy, with a bag of medicines... | E: The scheme may cover the cost of medicines |
| 14 Same situation as in 9: But the two women who were listening are now sitting with the group, and three others are also listening | D: Who can be member of the scheme?
E: Everyone who pays the one-time enrolment fee, the yearly premium and observes the scheme's regulations |
| 15 New illustration: A whole family | E: Each member can protect the members of his/her family... |
| 16 Same situation: One of the women who had stopped to listen is raising her hand to ask a question... | The woman: Are the members allowed to visit any health provider?
E: No, the scheme selects some good and trustworthy health providers that can provide the best services |
| 17 New illustration: Three representatives of the insurance scheme sitting in front of a doctor signing a document: Agreement | E: Then the scheme is concluding an agreement with these health providers that determine the services to be provided as well as the costs attached to these services |
| 18 Same situation as in 14 | B: But then... are the services for free?
E: No, the scheme is still paying the health provider... but at lower costs as determined in the agreement |
| 19 Same situation... but now there are some 10 people listening to the group... | D: What happens when we go and see the doctor?
E: Then there is nothing to pay... the scheme will take care of the bill |
| 20 Same situation | A: Do we know how our contributions are used in the scheme? |
| 21 Same situation | B: How many members may enrol into the schemes
E: As many as possible, so that the risks are better spread among many... |
| 22 Same situation | A: So, it is a solidarity system to overcome the health problems that may affect some of the members...
B: To avoid the financial burden when falling sick...
D: And at the same time, improving the quality of health care services... |
| 23 Same situation: the four women in the first group smile, they have understood the principles and mechanism of a health micro-insurance scheme | One woman who was listening: It is a very good idea...
Others in the group: Yes! |

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ABSTRACT

- Planning the setting up of a new health micro-insurance scheme has to be carefully prepared
- The necessary feasibility study is a process that consists of various phases and many different activities
- One of the most important phases is the one aiming to collect and analyze all reliable information and data on which the next design phase and the whole exercise will have to rely
- Once the procedures for this data collection have been decided, it is generally found necessary to build up some tools that need to be adapted to the local context
- Most used tools include questionnaires for household surveys and for in-depth interviews, guidelines for focus group discussions and technical discussions, and another set of questionnaires for the mapping of health providers and analysis of their infrastructure and service delivery capacity
- Some efficient tools have already been developed by other organizations and can be easily adapted...

SESSION 7

THE NEED FOR AWARENESS / EDUCATION
TOOLS - 4

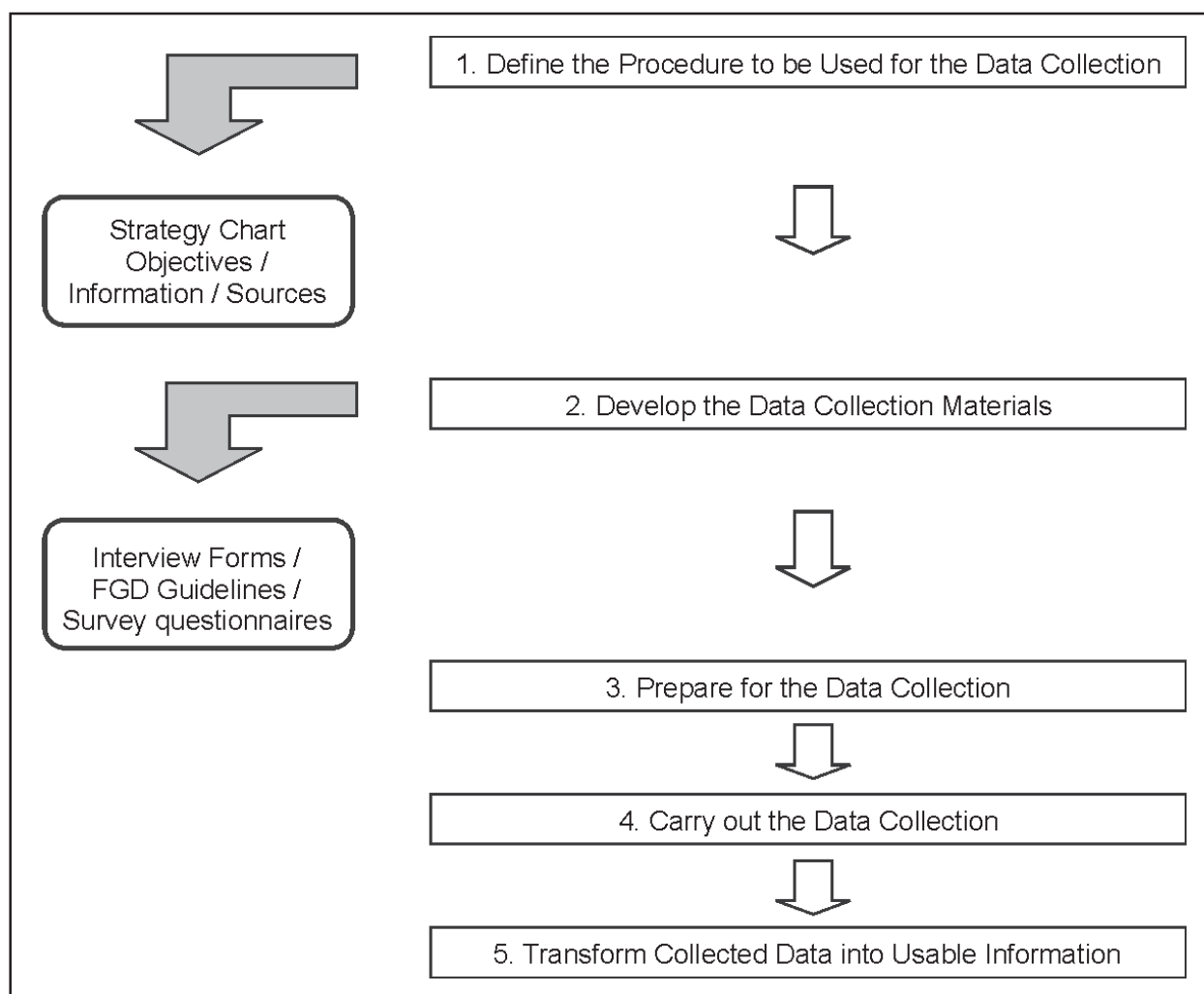
TECHNICAL PAPER NO 7.1

**BUILDING UP
TOOLS:**

**EXAMPLES OF
BASELINE SURVEY
TOOLS**

INTRODUCTION

The design of a new health insurance scheme has to be carefully prepared and a full feasibility study, preferably with the active participation of the targeted community has to be carried out. This whole process covers several phases and activities. The first phase of the feasibility study covers the data collection and analysis and usually consists of the following 5 activities. Once the procedure to be used for the data collection has been decided, some practical tools have generally to be created in order to gather the comprehensive data and reliable information that will be the basis for the next important phase of the process: the scheme design.



1. EXAMPLES

The tools presented below were prepared in relation to the following activities:

- Guidelines for Focus Group Discussions organized in the framework of a wider survey among cooperative societies members in order to identify their social protection priority needs (Surveys developed in the following 10 states: Andhra Pradesh, Chattisgarh, Gujarat, Jharkhand, Karnataka, Kerala, Maharashtra, Orissa, Tamil Nadu and Uttaranchal)
- Household Survey Questionnaire used in Jharkhand to prepare a state-level health insurance initiative targeting the BPL population
- Health Provider Questionnaire used in Jharkhand to prepare the same



**FOCUS GROUP DISCUSSION
GUIDELINES:
IDENTIFYING THE SOCIAL
PROTECTION PRIORITY NEEDS OF
COOPERATIVE MEMBERS**

1. Identification of Cooperative Society

- 1 Name of the cooperative society:
- 2 State:
- 3 District:
- 4 Date of creation:
- 5 Main activity:

2. Identification of Group Members

- 6 Number of persons in the group:

Number of Women	Number of Men
- 7 Age of persons in the group:

Women				Men			
< 30	30-40	40-0	> 50	< 30	30-40	40-50	> 50
- 8 Family composition:

Single	1 Ch.	2 Ch.	3 Ch	4 Ch.	5 Ch.	6 Ch.	>6
- 9 Occupational status:

Number of Women	Number of Men

 - o One occupation
 - o Several occupations
- 10 Main occupational classification:

Number of Women	Number of Men

 - o Full-time wage formal sector
 - o Full-time wage inform. Sector
 - o Wage labour in agriculture
 - o Self-employed
 - o Small farmer
 - o Part-time casual labour
 - o Unemployed
 - o Others
- 11 Social status:

Number of Women	Number of Men

 - o Scheduled caste
 - o Scheduled tribe
 - o Other backward classes
 - o

12 Member of the co-operative
Since:

Number of Women				Number of Men			
< 1 y	1-5 y	6-20y	>20 y	< 1 y	1-5 y	6-20y	<20 y

3. Risk Awareness

13 Do you have savings?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

14 If yes, for what purpose?

- ☐
- ☐
- ☐
- ☐

Number of Women		Number of Men	

15 If some savings were made to protect against risks, discuss these risks and the protective role of savings

Comments:

.....

.....

.....

.....

16 List the risks you are facing?

- ☐
- ☐
- ☐
- ☐

Number of Women		Number of Men	

17 Health problem in family in 2005

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

18 Death in family in 2005?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

19 Natural disaster in 2005?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

20 Belongings lost in 2005?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

21 Riots/violence in 2005?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

22 Other shocks suffered in 2005?

- ☐
- ☐
- ☐

Number of Women		Number of Men	

23 Money lost due to risks in 2005?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

- 24 Ask and discuss some real examples of costly risk-related expenditures that were recently met

Example 1:

.....
.....

Example 2:

.....
.....

- 25 Taking the example of a health problem, identify with the participants the various expenditures they may face and estimate the costs they will have to bear Comments:

Comments:

.....
.....
.....
.....
.....

- 26 Taking the example of a death in the family, identify with the participants the various expenditures they may face and estimate the corresponding costs they will have to bear Comments:

Comments:

.....
.....
.....
.....
.....

- 27 Try to classify the main risks:

- ☐
☐
☐
☐
☐
☐

Number of Women	Number of Men

4. Risk Behaviour

- 28 Can one prepare against risks?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

- 29 Identify ways to get prepared?

- ☐
☐
☐
☐
☐

Number of Women	Number of Men

- 30 Taking the example of savings, discuss with participants the limitations of this risk preparation mechanism

Comments:

.....
.....
.....
.....
.....

- 31 Identify ways to respond to risks

- ☐
☐
☐
☐
☐

Number of Women	Number of Men

32 Best ways to answer to risks?

- o Reduce other expenses
- o Selling assets/livestock
- o Taking an extra job
- o Taking a loan
- o Asking for family's help
- o Asking for friends' help
- o Put children to work
- o Other.....

Number of Women	Number of Men

Comments:

.....

33 Taking the example of loans, discuss with participants the limitations/problems of this risk answer strategy

34 Is it better to answer alone?

Number of Women	Number of Men
Yes:	No:

Number of Women	Number of Men

Comments:

.....

35 Any outside support possible?

- o Cooperative
- o Community as a whole
- o Non Governmental Org
- o State government
- o Central government
- o Companies/Private sector
- o Other.....

36 Taking the example of the cooperative, discuss the type of support that it could possible provide?

Comments:

.....

37 Taking the example of the community, discuss the type of support that it could possibly provide?

Comments:

.....

38 Taking the example of NGOs, discuss the type of support that they could possibly provide?

39 Taking the example of the government, discuss the type of support that it could possibly provide?

Comments:

.....

.....

.....

.....

.....

40 Based on the above, discuss the necessity to get organized collectively to get the necessary support

Comments:

.....

.....

.....

.....

.....

5. Insurance Understanding

41 Knowledge about insurance?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

42 Giving a simple definition of insurance, ask the participants if they can provide some examples of available insurance products?

Examples

.....

.....

.....

.....

.....

43 What risks can be covered?

- o
- o
- o
- o

Number of Women		Number of Men	

44 Who can provide insurance?

- o
- o
- o
- o

Number of Women		Number of Men	

6. Risk Protection Experience

45 Ask the participants to describe the social protection mechanism that has already been initiated through the cooperative

Comments:

.....

.....

.....

.....

.....

46 When did the scheme start?

.....

47 Objectives of this scheme?

- ☐
- ☐
- ☐

Number of Women		Number of Men	

48 Were you involved in the design of this scheme?

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

49 Are you covered by the scheme

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

50 Are you satisfied with the services provided by the scheme

Number of Women		Number of Men	
Yes:	No:	Yes:	No:

51 Discuss with participants the current limitations of the scheme and the possible ways to improve it

Comments:

.....

.....

.....

.....

52 Would you prefer?

- ☐ Improve the present scheme
- ☐ Set up a new scheme
- ☐ Both

Number of Women		Number of Men	

7. New Possible Initiatives

If there is an interest to start a new scheme....

53 Main protection need?

- ☐
- ☐
- ☐

Number of Women		Number of Men	

54 Deciding on a priority need, discuss with participants the benefits they would look for and the best way to get organized to make them available

Comments:

.....

.....

.....

.....

55 Discuss with participants the amount of contribution they would be willing to pay to get that protection

Comments:

.....

.....

.....

.....

56 Discuss with participants the most appropriate mechanisms that could be used for the payment of this contribution

Comments:

.....

.....

.....

.....



HOUSEHOLD SURVEY QUESTIONNAIRE:

SETTING UP A HEALTH INSURANCE SCHEME IN JHARKHAND

Explain the objective of the survey:

This survey is conducted by the Ministry of Health, Family Welfare, Medical Education and Research, Government of Jharkhand to better understand the health problems faced by families in the state of Jharkhand. The answers of the interviewees will facilitate the design and implementation of a new social protection scheme for the Below Poverty Line population which aims at improving the access of poor families to quality health care services while minimizing the financial burden in case of sickness.

Do not insist if the person refuses to answer the question.

Date of Survey :	Entry Number :
Name of researcher :	Function of researcher :

District :

Block :

Village/City :

Area (rural/urban) :

Name :

Age :

Gender :

Literate / Illiterate :

Main occupation :

Family Size :

Nr. Men	Nr. Women	Children		Person in Charge	
		Nr. Boys	Nr. Girls	Who?	Age?

- Which are the main difficulties faced by you in daily life? (Choose the 3 top priorities).

<input type="radio"/> Food	<input type="radio"/> Education of children	<input type="radio"/> Health and medicines
<input type="radio"/> Housing / Construction	<input type="radio"/> Land	<input type="radio"/> Access to drinking water
<input type="radio"/> Clothing	<input type="radio"/> Ceremonies	<input type="radio"/> Others.....
- Yearly Family Income:Rs
- Yearly Family Expenditure:.....Rs
- How much of your yearly savings/budget is spent on health?.....Rs
Percentage of total budget (%).....

5. Since last January how many illnesses (besides pregnancy) have there been in the household?.....
6. Since last January how many pregnancies have there been in the household?
7. Please provide the age, gender and kind of illness that occurred in the household since last January

	Illness 1	Illness 2	Illness 3	Illness 4	Illness 5	Illness 6	Illness 7
Age							
Gender							
Minor Illness							
Major Illness							

8. What are the most prevalent diseases in your household (name 3 to 5 most common diseases)?:

	Women	Men	Children
Fever			
Cold / Cough			
Stomach Ache			
Head Ache			
Tooth Ache			
Diarrhea			
Gastroenteritis			
Skin Disease			
Stone			
Accidents, Fracture			
Snake Bite			
Respiratory Disease, Chest Pain			
Asthma, Bronchitis			
Pneumonia			
Dysentery			
High Blood Pressure / Hypertension			
Hepatitis A			
Hepatitis B			
Japanese Encephalitis			
Meningitis			
Malaria			
Typhoid			
Cholera			
Sexual Transmitted Diseases			
Uterus Problems			
Complicated Delivery			
Chronic Diseases (TB, Cancer, Leprosy...)			
Others, such as:			

9. Which Treatment did you undergo for last illness case ? Age:.....Gender:.....

	ocation*	Name Inst.	Tot. Exp.	Reason**	Hospitaliz.
No Treatment					
Traditional Healer					
Untrained Doctors/Practitioners					
Home, by TBA or traditional midwife					
Health Sub-Centre					
Primary Health Care Centre					
Community Health Centre					
Private Clinic					
Government Hospital					
Private Hospital / Nursing Home					

* Location: Name of the village/city where the doctor, TBA, (sub) health post or hospital is located, used by sick person

** Reason: Indicate why this type of health care is chosen by using the following codes:

1. = Problem of money
2. = Support is sufficient to treat the health problem
3. = No means of transportation
4. = Other reason

10. How did you find the money to pay for treatment?

- | | |
|---|---|
| <input type="radio"/> Money at Home / Savings | <input type="radio"/> Loans or Paid by Friends / Neighbours |
| <input type="radio"/> Money Lender | <input type="radio"/> Paid by Family |
| <input type="radio"/> Selling of Goods (Jewellery, Assets, Land...) | <input type="radio"/> Credit of a savings & credit system |
| <input type="radio"/> Selling of Labour | <input type="radio"/> Traditional loan system |
| <input type="radio"/> Selling of Livestock | <input type="radio"/> Other, such as: |

11. How much did you spend on drugs alone? Rs

12. How far is the nearest sub-centre? (walking hours)hours

13. How far is the nearest facility with a doctor? (walking hours)hours

14. Whether this facility is public or private?.....

15. What do you think about the services provided by this facility?

	Very good	Average	A little	Very bad	Do not know
A. Sufficient staff					
B. Qualified staff (competent)					
C. The ill people are well received					
D. The ill people are well taken care of					
E. The services are expensive					
F. The centre is well equipped					
G. You have confidence in the staff					

16. On average, how much did you pay for the visit at this facility?.....Rs
17. How much did you spend on transportation /coming and going)?.....Rs
18. In your opinion, which facilities provide the best services?
☐ Private facilities ☐ Public facilities
19. During which month of the year is your income the highest?
☐ January ☐ July
☐ February ☐ August
☐ March ☐ September
☐ April ☐ October
☐ May ☐ November
☐ June ☐ December
20. Has it ever occurred that you did not have the money in the family to treat minor illnesses?
☐ YES ☐ NO Reason:.....
21. Has it ever happened that a very serious illness in your family could not be treated at a hospital because of lack of money?
☐ YES ☐ NO Reason:.....
22. Has it ever happened that a sick person in your family died because you did not have the money to take care of him/her?
☐ YES ☐ NO Reason:.....
23. Are you interested to participate in a health insurance mechanism?
☐ YES ☐ NO
 IF NOT, END OF THE QUESTIONNAIRE
24. If Yes, what kind of services would you want to be covered by the insurance mechanism?
☐ Medicines ☐ Hospitalization at a private clinic/ nursing home
☐ Common diseases ☐ Delivery (regular)
☐ Consultations at a medical hall ☐ Delivery (complicated)
☐ Consultations at health sub-centre/ PHC centre ☐ Surgery
☐ Consultations at a private clinic / nursing home ☐ Laboratory
☐ Consultation at a hospital ☐ Radiology
☐ Hospitalization at a PHC centre ☐ Operation
☐ Hospitalization at a government hospital ☐ Others, such as:.....
25. For how many people in your family would you like to contribute?.....
26. How much would you be willing to contribute per person and in which period of the year?
- | Frequency
per person | Contribution per person | Frequency | Contribution per person |
|--|-------------------------|---|-------------------------|
| <input type="radio"/> Every week:.....Rs | | <input type="radio"/> Every four months:.....Rs | |
| <input type="radio"/> Every month:.....Rs | | <input type="radio"/> Half Yearly:.....Rs | |
| <input type="radio"/> Every three months:.....Rs | | <input type="radio"/> Yearly:.....Rs | |



HEALTH PROVIDER SURVEY QUESTIONNAIRE:

SETTING UP A HEALTH INSURANCE SCHEME IN JHARKHAND

1. Identification of Health Provider

- 1 Name of the establishment:
- 2 Full address:
- 3 Contact details:
- 4 Date of creation:
- 5 Type (public/private):
- 6 Catchment area (urban/rural):

2. Buildings and Equipment

- 7 Building (owned/rented):
- 8 Services/Wards

	Yes	No	Nr. Rooms	Nr. Beds
General medicine				
Maternity (gynaecology & obst)				
Minor surgery				
Major surgery				
Emergency ward				
Paediatric ward				
Neo-natal				
Day hospital				
Prevention unit				
Radiology				
Laboratory				
Nursing unit				
Psychiatric ward				
Psychological ward				
Traumatology				
Other (specify)				

9 Health Equipment

	Yes	No	Nr. Rooms	Nr. Beds
Delivery kit				
Delivery tables				
Respirator				
Oxygen mask				
Oxygen bottle				
Incubator				
Incinerator				
Sterilizer				
Foetal Stethoscope				
Refrigerator				
Radiology apparatus				
Other (specify)				

3. Health Personnel

10 Type of personnel (full-time)

	Number	Nr. Female	Nr. Male
Generalist			
Surgeon			
Radiologist			
Anaesthetist			
Epidemiologist			
Vaccinator			
Midwife			
Nurse			
Other (specify):			

11 Helpers (part-time)

	Number	Nr. Female	Nr. Male
(specify):			

4. Administrative Personnel

12 Type of personnel (full-time)

	Number	Nr. Female	Nr. Male
General administrator			
Finance officer			
Accountant			
Supply officer			
Clerks			
Drivers			
Other (specify):			

5. Administrative Equipment

13 Type of equipment

	Yes	No	Number	Status
Computer				
Printer				
Photocopier				
Scanner				
Typewriter				
Fax machine				
E-mail				
Telephone				
Cell phone				
Ambulance				
Other cars				
Other (specify):				

6. Main Health Activities

14 Overall frequentation evolution

	2001	2002	2003	2004
Total Number of patients				

15 Seasonal frequency (2004)

	J	F	M	A	M	J	J	A	S	O	N	D
% of overall activities												

7. Utilization Rates

16 Outpatient services (2004)

	Number of consultations			
	Men	Women	Children	Total
Common diseases				
Infectious diseases				
Obstetrics				
Family planning				
Paediatrics				
Gynaecology				
Minor surgery				
Major surgery				
Sexually Transmitted Infections				
Geriatrics				
Psychiatry				
Accidents, Emergencies				
Other (specify)				

17 Hospitalization services (2004)

	Number of cases			
	Men	Women	Children	Total
Common diseases				
Infectious diseases				
Obstetrics				
Family planning				
Paediatrics				
Gynaecology				
Minor surgery				
Major surgery				
Sexually Transmitted Infections				
Geriatrics				
Psychiatry				
Accidents, Emergencies				
Other (specify)				

18 Overall bed occupancy

	2001	2002	2003	2004
Overall bed occup. Rate (%)				

8. Referral Systems (2005)

- 19 How many referred to you?
- 20 Who referred them?
- 21 Why referred to you?
- 22 How many referred by you?
- 23 Where referred to?
- 24 Why referred by you?

9. Medical Services

25 Price list of main services

	Current Price	Date applied	Previous price	Date applied
Consultation with generalist				
Consultation with specialist				
Uncomplicated delivery				
Complicated delivery				
Emergency				
Transport (ambulance)				
Blood test				
Radiology				
Minor surgery				
One day bed occupancy				
Other (specify)				

26 Availability of main drugs (2005)

	Generic	Specialty	Qty. used	Source Proc.
1.				
2.				
3.				

	Generic	Specialty	Qty. used	Source Proc.
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

27 Shortages on drugs? (2005)

.....

28 Reasons for shortage (2005)

.....

.....

29 Prices applied to main drugs (2005)

	Specifications	Current price	Date applied	Prev. price
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

30 Overall cost of drugs

	2001	2002	2003	2004
Cost of drugs in total billing (%)				

10. Other Services

31 Other services provided to clients (2005)

	Numb. Benef.	Conditions attached to benefits/Functioning
Health education classes		
Health camps		
Domiciliary services		
Vaccination		
Free contraceptives		
Fidelity cards		
Special discounts		
Credit mechanisms		
Other (specify)		

11. Health Status of Clients

32 Average vaccination report (2005)

	% of women fully immun.	% of children fully immun.	% of men fully immun.
Measles			
BCG			
Diphtheria			
Tetanus			
Polio			
Meningitis			
Hepatitis			
Typhoid			
Other (specify)			

33 Overall health status

	Good	Fair	Poor	Very Poor
Overall health status of clients				

12. Response to Specific Problems

34 Response to specific clients' problems

Description	Nr (2004)	How to deal with it?
A patient comes to give birth but has no money		
A patient cannot pay for prescribed drugs		
A patient is admitted as an emergency after accident but family cannot pay		
A patient cannot pay for necessary surgery		
A patient does not come for check-up after surgery due to lack of money		

13. Main Advantages of the Establishment

35 Main advantages of establishment recognized by staff

	(1 = The strongest advantages)			
	1	2	3	4
The only health structure nearby				
Quality of services				
Reputation of medical staff				
Low prices				
Medicine always available				
Cheap medicine				
Good medical records				
Individual follow-up				
Minimum waiting time				
Cleanliness				
Good communication system				
Transportation facilities				
Easy payment mechanisms				
Other (specify)				

14. Main Problems of the Establishment

36 Main problems recognized by staff

	(1 = The biggest problems)			
	1	2	3	4
Ensure timely payment by clients				
Provide new expected services				
Attract new clients				
Keep clients in the long run				
Find necessary drugs				
Organize reliable statistical data				
Organize management system				
Recruit highly committed staff				
Maintain highly committed staff				
Provide regular training for staff				
Obtain subsidies				
Keep expenditures low				
Achieve financial sustainability				
Maintenance of equipment				
Other (specify)				

15. Insurance Mechanisms Knowledge

In 2003, the Government of India launched the Universal Health Insurance Scheme which aimed to cover mostly the low-income people. The premium was set at Re. 1 per day (Rs. 365 per annum) for an individual and at Rs. 1,5 per day (Rs. 548) for a family up to 5 persons. The scheme provided a coverage for hospitalisation expenses up to Rs. 30.000. BPL families were entitled to receive a subsidy of Rs. 100. Recently, the new Government increased this subsidy for BPL individuals and families.

37 Do you have a good knowledge of this Universal Health Insurance Scheme?

Yes ☐ No ☐

All insurance companies (both public and private) are already offering health insurance products that have been especially designed to address the needs of the unorganised sector workers. These products cover various health risks and may be purchased by individuals or by groups.

38 Do you have a good knowledge of the various health insurance products provided by these insurance companies?

Yes ☐ No ☐

Various Health Providers have already designed and set up micro-insurance schemes that provide a specific coverage against some health risks. In Karnataka, a network of health providers has been organized to provide the specific services provided to cooperative societies' members. The Yeshasvini health insurance scheme covers today some 1.4 million people.

39 Do you have a good knowledge of the Yeshasvini scheme?

Yes ☐ No ☐

16. Insurance Experience

40 Did you ever try to set up an insurance mechanism in your establishment?

Yes ☐ No ☐

41 If yes, explain your experience

.....

.....

.....

.....

.....

.....

.....

17. Interest in Participating in State's New Social Protection Initiative

42 Would you be interested in participating in a new wide scale health insurance scheme for the BPL population?

Yes ☐ No ☐

**ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP:**

**“Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and Participation”**

New Delhi, India Habitat Centre, May 29-31, 2006

ABSTRACT

- The type of relationship to be developed with a health provider is of the utmost importance for any health micro-insurance scheme since it relates to its main function: the delivery of healthcare services
- It is essential to look carefully at the best mechanism to adopt when tying up with a health provider willing to be associated to the scheme
- The final agreement should always take the form of a formal arrangement
- There are different levels and types of contracting
- Since health insurance is the only insurance sub-sector where you don't have to suffer first the damage, the loss or the cost, the provision of cashless services is the most common type of contracting arrangement
- This financial mechanism should be complemented by other personal services provided to the members
- More sophisticated arrangements, although proving more efficient in dealing with the over-prescription risk still remain the exception in India...

SESSION 8

THE NEED FOR CONTRACTING TOOLS

TECHNICAL PAPER NO 8.1

**BUILDING UP
TOOLS:**

**EXAMPLES OF
CONTRACTING TOOLS**

INTRODUCTION

Any health micro-insurance scheme should develop some partnership arrangement with a health provider. Although the extent of this partnership may vary from one scheme to another, the terms and conditions for the provision of agreed services should be clearly stipulated in a formal agreement. Although the choices may be more restricted in the case of health insurance schemes operating in rural areas, contracting types and levels should be thoroughly considered and before implementing the insurance activities.



Franchising

Full Ownership

Managed Health Care

Treatment Protocols

Capitation Mechanism

Network Standards

Cashless Services

Special Discounts

Service Delivery Improvement

Patient Support Services

Types of Contracting Arrangements

The insurance scheme determines the terms and conditions other franchised units can operate

The insurance scheme owns and manages its own facility (ies)

Each illness episode is discussed with the health provider and common decisions are taken regarding the best treatment to apply

Each sickness episode is examined. Acts and costs related to each element are decided

A common cost is pre-defined for all members and accordingly paid in advance to HP

In addition to cashless services, fixed discounted prices are determined and applied by all network hospitals

Cashless services are provided by the health provider. Regular (often, monthly) invoices are sent to and settled by the scheme

Special discounts are agreed and applied for various services and interventions

Collective non-financial arrangements targeting the members of the scheme (help desk, delays reduction, special privileges, quality services)

The agreement only covers some individual support services provided to a patient (personal visit, assistance for hospital papers, help to accompanying members of the family...)

2. EXAMPLES

Good examples of agreements signed with health providers include the following:

- ☐ Memorandum of Understanding – Uplift Health
- ☐ Memorandum of Understanding – Healing Fields Foundation
- ☐ Memorandum of Understanding – MDIndia Healthcare Services (P) Ltd

1. UpLift Health

UpLift Health Network Partnership MOU



UpLift Health Network Partnership Memorandum of Understanding

Subject	UpLift Health
Project	Health Care Provider's Name
Topic	Memorandum of Understanding

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1. Objective of this MOU

This Memorandum of Understanding (MOU) defines the rapport and relationship established between the two signatories.

It is the intention of the parties to co-operate and to share their knowledge, experience and best practices in order to provide quality health care services to the poorest sections of the society in a professional manner thereby improving the overall efficiency of health care delivery system.

2. Parties to this MOU

Health Care Provider's Name with business address located at Address, near Landmark CITY 411009, India represented by its administrator authorized by the Health Care Provider's Name Board of directors/Administration to sign this present MOU, hereafter referred to as the Health care provider.

UpLift health represented by with its office located at landmark Appts. Flat No. 14 BJ road, Sadhu Vaswani Circle, Pune-411001.

3. Parties to this MOU witness

Whereas, each of the Parties to this MOU share the UpLift Health mission:

'To make quality health care available, accessible and affordable to the urban poor'

Whereas, the Health Care Provider's Name, is a registered medical service/care provider having a good reputation and strong social commitment.

Whereas, the Health Care Provider's Name, is willing to be a member of UpLift Health network of Health care providers and to implement the guidelines hereunder defined.

Since this MOU will not be considered as legally binding, the said parties by this presence hereby agree in good faith to be committed to the duties and responsibilities herein stated.

4. Duties and Responsibilities

4.1 Health Care Provider's Name Duties

Health Care Provider's Name agrees to the following:

4.1.1 UpLift Health is a community based health mutual fund

Health Care Provider's Name authorities recognise UpLift Health as a Community based health mutual fund for the slum dwellers of Pune and not as an insurance company.

Members of UpLift Health can avail Health Care Provider's Name services defined in this MOU.

4.1.2 Health Care Provider's Name Identifies UpLift Health Members

On the basis of the UpLift Health I-Card presented on the spot or at the latest the next day.

In order to recognise the I-Card, a sample is attached to this MOU.

Health Care Provider's Name will recognise the valid UpLift Health Identity Card to give the assured benefits to the members of UpLift Health community health fund.

The authenticity and validity of the I card will depend on

- The Health Lift/UpLift Health stamped/printed
- The start date and the end date of the policy
- The photograph of the policyholder and his dependents.

Referral letters may be issued by UpLift Health members' organizations in order to facilitate the guidance (a sample is attached to this MOU.) The counter foil of the referral letter will be given back to the member patients, duly filled.

The reception, enquiry counter, diagnostic facilities and casualty staff will be familiarised with the referral form and I-card.

4.1.3 Health Care Provider's Name Provides access to quality health care at all times

Health Care Provider's Name will at all times extend its cooperation and services to UpLift health members.

The patient will be assured of quality diagnostic, therapeutic and nursing care facilities under all circumstances.

The patient's right to information and to make an informed choice would be integral to quality care.

These basic rights will be honoured irrespective of the paying capacity of the patient.

The UpLift Health member patient's welfare, once the patient has been referred to the Health Care Provider's Name will solely be the responsibility of the Health Care Provider's Name.

The Health Care Provider's Name shall take utmost care while rendering health care services to the UpLift Health members so that negligence (acts of commission or omission) are avoided at all costs.

The consequences of the treatment modalities decided by the doctors in the Health Care Provider's Name shall be the responsibility of the Health Care Provider's Name and as such would be explained to UpLift Health member patient.

The UPLIFT HEALTH FEDERATION will at no point interfere in the management of medicolegal cases. These would be dealt with by the Health Care Provider's Name according to the policy of the Health Care Provider's Name. The consequences of the actions taken by the Health Care Provider's Name will be the responsibility of the Health Care Provider's Name.

Health Care Provider's Name will inform UpLift Health representatives of any patient who has been discharged against medical advice as soon as the patient decides to do so.

4.1.4 Health Care Provider's Name provides cashless facility to the members when they are eligible

When provided with a letter inviting to do so, signed by UpLift Health member organization, Health Care Provider's Name shall provide care without requesting any funds to the patient, but by sending the bill to UpLift Health member organisation.

Health Care Provider's Name shall provide all information regarding the costs of the care provided to the patients since they will have to bear the costs from their saving accounts with the organization.

4.1.5 Health Care Provider's Name providers Concessional Treatment to UpLift Health Members

The schedule of fees and concessions given to UpLift Health members

No	Category	Routine Charges	Concessions for UpLift Health Members
1	OPD : General First consultation Follow up	60 40	50 30
2	OPD: Speciality First Consultation Follow up	100 60	90 50
3	IPD: General		10% concession on total bill (excludes medicines prescribed during admission, implants, food served, telephone bills, ambulance)
4	IPD: General ICU		10% concession on total bill (exclusions same as above)
5	Investigations (OPD) Laboratory indone at the hospital Radiology (X ray, USG) ECG		10% concession at all times (including Sundays, holidays and emergencies)
6	Physiotherapy		10% concession on the bill during work hours.

For deserving UpLift members hospitalised in general ward or general ICU, an additional 10% concession on the total bill will be considered. The above exclusions will be valid for this concession also.

This concession will be given only after a discussion between Health Care Providers Name administrator, Uplift health Doctor and project co-ordinator of the NGO.

The UpLift Health doctor may write this request on the referral form.

Major sugery cases may be considered for additional concession on merits of case.

The same concessions would be applicable to UpLift Health members who seek further treatment at Health Care Povider's Name after being advised so at health check up camp conducted by Health Care Provider's Name.

The payment of bills will be the responsibility of the patient.

UpLift Health will not be responsible for non-payment of bills.

Health Care Provider's Name will deal with such case of non-payment of bills, according to Health Care Provider's Name policy as if they were not UpLift Health members.

4.1.6 Health Care Provider's Name provides an access to UpLift Health member patients' records

Health Care Provider's Name will give UpLift Health Doctor access to upLift patient's records during and after hospitalisation, according to the consent given by the policyholder on the UpLift health enrolment form.

The permission in each case will be given by the Health Care Provider's Name Administrator depending on the merit of the case.

4.1.7 Health Care Provider's Name facilitates communication between treating physician and UpLift Health doctor

The UpLift Health Doctor will be able to communicate with the treating physician regarding the member patient's illness and treatment choices.

To facilitate this Health Care Provider's Name authorities will circulate information regarding UpLift Health among the resident, consultant and panel doctors of the hospital.

4.1.8 Health Care Provider's Name will refer UpLift members within the UpLift Health Network

Health Care Provider's Name agrees to refer UpLift Health member patients to UpLift Health Network hospitals for any diagnostic or therapeutic purposes not available at the hospital.

This would also be done in cases where the financial condition of the patient warrants shifting to a cheaper but quality care provider.

Health Care Provider's Name will inform UpLift Health representatives the necessity of such a decision and where the member patient is to be shifted.

Health Care Provider's Name will take due care and caution while shifting the patient from Health Care Provider's Name to any other health care provider.

Health Care Provider's Name responsibility shall be considered complete only when the patient is carefully handed over to the other health care provider's incharge physician.

In case the member patient refuses to be shifted to any other health care provider, Health Care Provider's Name will inform the UpLift Health representatives of the same. In such cases joint efforts would be made by Health Care Provider's Name and UpLift Health to convince the member patient of the same.

4.1.9 Health Care Provider's Name will keep separate record - keeping for UpLift Health Patients

Health Care Provider's Name agrees to separate record keeping for UpLift Health patients. This will be done by stamping the case records with UpLift health rubber stamp provided by UpLift health.

This will enable a periodic review of the association by both the parties.

4.1.10 Health Care Provider's Name supports preventive health and provides resource persons for health activities within the community

Health Care Provider's Name would on behalf of the doctors agree to conduct health check up camps and health talks within the community.

The schedule of the health activities will be mutually decided on by Healthcare Provider and UpLift Health representatives.

The conducting doctor will check and advice the participants for proper follow up treatment of their ailments.

The health activities will be conducted in the spirit of UpLift Health mission for improving the health status of the poor in the urban slums.

4.1.11 Health Care Provider's Name follow the Quality Charter

Health Care Provider's Name at all times will follow the guidelines in the quality health care charter in dealing with UpLift Health members.

This will lead to quality assurance to the member patients and will lead to improved relations between Health Care Provider's Name and communities at large.

Health Care Provider's Name undertakes to sign and abide by the Quality charter and to promote the same among its doctors.

Health Care provider's Name will not take any decision modifying the herein covered activities' nature without discussion with UpLift health.

4.2 UpLift Health federation duties

UpLift Health federation agrees to the following

4.2.1 Presenting the Health Care Provider's Name as a quality health care provider

UPLIFT HEALTH FEDERATION will present Health Care Provider's Name as a bonafide quality healthcare provider to its member organisations and thus to the communities.

The field staff of UPLIFT HEALTH MEMBER ORGANISATIONS will promote the various diagnostic and therapeutic facilities available and the Health Care Provider's Name as reliable and affordable.

4.2.2 Insist on Using the Health Care Provider's Name services

UPLIFT HEALTH FEDERATION will insist that the UPLIFT HEALTH MEMBER ORGANISATION refer their member patients to Health Care Provider's Name during any health crisis whenever their member is located in Health Care Provider's Name's area or requires specifically a service that only Health Care Provider's Name can propose.

UPLIFT HEALTH FEDERATION will regularly and periodically review the number of referrals to the Health Care Provider's Name and their follow up done by the UPLIFT HEALTH MEMBER ORGANISATION field staff.

A report of this will be sent to the Health Care Provider's Name after every review.

The UPLIFT HEALTH FEDERATION will commit to utilise the services and concessions given by the Health Care Provider's Name for achieving the goal of UpLift health.

At no point will the permission to access the UpLift health community health fund member patient's records be misused and patient's privacy will be respected at all costs.

The UPLIFT HEALTH FEDERATION commits to use this facility only to further assist the treatment of the patient and prove the authenticity of the claims.

4.2.3 Facilitating new member organisations to refer patients to Health Care Provider's Name

UPLIFT HEALTH FEDERATION will introduce a new member organisations to the Health Care Provider's Name as soon as the organisation is part of the UPLIFT HEALTH FEDERATION.

UPLIFT HEALTH FEDERATION will guarantee the bonafide intentions of the new member organisations to work within the framework of this MOU.

UPLIFT HEALTH FEDERATION will insist that the new member organisation uses the service of Health Care Provider's Name in the same spirit as of the MOU.

4.2.4 Liaison between member organisations and Health Care Provider's Name

UPLIFT HEALTH FEDERATION will be the liaison between the UPLIFT HEALTH MEMBER ORGANISATION and the Health Care Provider's Name.

Only UPLIFT HEALTH FEDERATION representatives shall conduct all the necessary and relevant negotiations with the Health Care Provider's Name on behalf of the UpLift Health community health fund member partners of the UPLIFT HEALTH MEMBER ORGANISATION.

All the extra concession or benefits would be negotiated through UPLIFT HEALTH FEDERATION representatives only.

This will help channelise the communication between UPLIFT HEALTH MEMBER ORGANISATION, UPLIFT HEALTH FEDERATION and Health Care Provider's Name.

There would be no interference from the representatives of UpLift Health Federation or its Member Organisations in deciding the treatment modalities for the member patient.

Any course of action taken in good faith for the benefit of the patient by Health Care Provider's Name and communicated to UpLift Health representatives would be acceptable to UpLift Health Federation and its Member Organisations.

4.2.5 UpLift health Federation will ensure that the cashless bills are paid to Health Care Provider's Name

UPLIFT HEALTH FEDERATION will be the liaison between the UPLIFT HEALTH MEMBER ORGANISATION and the Health Care Provider's Name in case of any delay in paying the organisation's bills.

4.2.6 Helping the Health Care Provider's Name in out reach services

UPLIFT HEALTH FEDERATION commits to help the Health Care Provider's Name in organising any outreach services in the UPLIFT HEALTH MEMBER ORGANISATION areas of operation, as long as this is done in the spirit of the UpLift Health mission (to provide quality health services to the poorest sections of the society).

4.2.7 Support in fund raising

UPLIFT HEALTH FEDERATION will support the medical social department in raising funds to finance costly treatment for deserving UpLift Health community health fund members.

Only in genuine cases this cooperation may be extended to raise funds for non-UpLift health member.

4.2.8 Train the UpLift Health Member Organizations' staff for

- Promotion of the Health Care Provider's Name as quality health care provider in the communities,
- Insisting that the UpLift Health members use the Health Care Provider's Name services,
- Introducing resource persons in Health Care Provider's Name
- Sending patients with I cards and referral letter
- Follow up of the referred patients
- Organising and follow up of health activities within the community
- Undertake to use the Health Care Provider's Name services concessions in good faith

UpLift Health will not take any decision modifying the herein covered activities' nature without discussion with Health Care Provider's Name.

5. Review

Health Care Provider's Name will facilitate periodic reviews to be done by UpLift Health staff for assessing the services utilisation by the community members.

Health Care Provider's Name will give cooperation in this review so that the problems faced by both the parties can be solved amicably.

6. Reports

UpLift Health Member Organisations will keep a record of the referrals done to the Health Care Provider's Name.

These would be matched with the hospital's records to assess the utilisation of services by the community members.

A record would also be kept of the beneficiaries of the health activities conducted by the UpLift Health Member Organisations' field staff.

7. Time Frame and Signatures

The MOU takes effect on _____ till _____ unless amended or modified by mutual agreement of the parties prior to its termination.

In Witness whereof, the parties, through their respective representatives, hereunder acknowledge and sign this MOU this _____ day of _____ 2005 in the office of the Health Care Provider's Name.

Name	Designation / Name	Signature
Health Care Provider's Name		
UpLift Health		

3. Healing Fields Foundation



MEMORANDAM OF UNDERSTANDING – FOR HOSPITALS

This Memorandum of Understanding is executed on this _____ Day of _____ 2005.

BETWEEN

Healing Fields Foundation represented by Chief Operating Officer, Mr P Murali Srinivas S/O P Appa Rao aged 35 years and having their office at 2nd floor. Plot No. 60, Nagarjuna Hills, Punjagutta, Hyderabad – 500082, here in after called Party of First Part which expression shall mean and include his heirs, legal representatives, successors and assignees. Healing Fields Foundation is a not for profit society under the Andhra Pradesh (Telengana Area) Public Societies Registration Act, 1350 Fasli (Act 1 of 1350 F)

AND

_____ is represented by its _____, _____ S/O _____ aged _____ years and having their medical facility at _____, herein after called Party of Second Part which expression shall mean and include his heirs, legal representatives, successors and assignees.

1. Healing Fields Foundation (Healing Fields) is a not for profit organization aiming at making quality healthcare accessible and affordable to all people in India, particularly the poor, underprivileged and marginalized population by leveraging on knowledge in healthcare and healthcare management to reduce wastage in the system and to promote optimum utilization of resources. In this, Healing Fields aims to work closely with other NGOs, private sector, the government and semi-government sectors. In this regard, Healing Fields entered into MOU with various Insurers licensed by the Insurance Regulatory Development Authority (known as IRDA) of India.
2. _____ is established in the year of _____ to render Medical Services to people in the surrounding areas of _____ with qualified Medical Professionals on consideration. The Medical services include medical and surgical treatment.
3. The Party of First Part has entered into arrangements with NGOs to enroll eligible members with the insurer, to whom the Party of First Part is required to arrange and manage certain healthcare services.
4. The Party of First Part has entered into arrangement with several hospitals and had established a network of hospitals for providing identified healthcare services to the Members of the Party of First Part.

5. The Party of Second Part agreed to extend identified services to insured members of the Party of First Part and follow the guidelines mentioned in annexure – A
6. The Party of Second Part agreed to extend cashless treatment to the extent of 75 per cent of the Disease Limit Amount as specified in Annexure – A.
7. The Party of First Part desires to enter into this agreement with the Party of Second Part to ensure that the healthcare services specified in Annexure – A (the “Identified Services”) are provided as per prescribed rates in Annexure – A to its members.
8. The Party of Second Part desires to enter into this MOU with the Party of the First Part to provide such services to its Members by becoming a Part of the network hospitals of the Party of the First Part.
9. Both Parties for mutual benefit and valid consideration have agreed to the above on the below mentioned terms and conditions.

Now this Memorandum of Understanding witnesses as follows:

10. Members of the Party of First Part shall present a photo identity card issued by the Party of First Part to the eligible members, to enable them to avail of any, Identified Services, from the Party of Second Part.
11. The Party of First Part will appoint a Facilitator for a group of network hospitals. The designated facilitator for the hospital belonging to the Party of Second Part will assist the Party of Second Part in identifying eligible the member. The facilitator will further coordinate between the Party of the Second Part and the office of Party of First Part for authorization to the hospital for extending cashless treatment up to 75 per cent of the prescribed Disease Limit Amount as prescribed in Annexure – A, to the eligible members.
12. The Party of Second Part shall provide either a closed or upon office with a desk to seat the hospital Facilitator, appointed by the Party of First Part, and make available a Fax Machine for communication to the health office of the Party of First Part.
13. The Party of Second Part shall admit eligible members, upon the production of the photo identity card issued by Party of First Part or referral letter duly signed by the authorized signatory of Part of First Part. For the purpose of this understanding, a person (member) is eligible, upon producing a valid ID card, issued by the Party of First Part, and availability of sum assured with such members, towards coverage of hospitalization expenses for the identified services for which the member desires to get admitted, which is prescribed in the Annexure - A.
14. The Party of Second Part shall ensure that no member is required to make a deposit of any amount as a pre-condition for admission. If the admission has been made only on the basis of a Photo-Identity card, the Party of Second Part shall inform the local/nearest Party of First Part office personnel within a period of 12 hours from the time of admission.
15. Upon the admission, a member shall be entitled to avail the Identified Services as mentioned in Annexure – A or such facilities as communicated by Party of First Part to the Party of Second Part from time to time. The Party of Second Part should provide Identified Services on an urgent and preferred basis. The Party of Second Part further agrees not to collect any amount towards accommodation/room/bed charges, surgeries, pharmacy, doctor consultations, and lab investigation from the hospitalized member.

16. The Party of Second Part will provide Identified services to Members of Party of First Part will pre-authorization approval which is given by the Part of First Part. Incase of emergency, the Party of Second Part should start treating the member and should take approval within 12 hours from time of admission of member.
17. The Party of Second Party should ensure to collect signature of the member upon discharge on Claim Form, Co-Pay bill and in any other documentation as required by the insurer's terms and conditions for processing claims
18. A co-payment of 25 per cent of the bill amount will be recovered from the patients by the Party of Second Part and which will be informed to the patient at the time of discharge by the Party of Second Part.
19. The Party of Second Part shall not include all non-medical expenses like registration fee, admission fees, telephone charges, food bills of attendants; ambulance charges, toiletries etc in claim bills and shall be recovered from the member at the time of discharge.
20. The Party of Second Part agrees to submit, completed invoice and bills with detailed breakup of miscellaneous, consumables, pharmacy charges and a copy of the case sheet discharge summary, investigation reports in original, co-pay receipt signed by patient and any other documentation as required by insurer's terms and conditions for processing claims within THREE working days to the Party of First Part.
21. The Party of Second Part agrees to submit any claims strictly according to the Disease Limit Amount rates of the Identified services specified in Annexure – A, as the total cost of hospitalization.
22. The Party of Second Part shall be paid by the insurer within 225 working days from the date of delivery of completed documents to the office of the Party of First Part.
23. The responsibility of submitting completed claim documents lies on the Party of Second Part. The Party of Second Part's claim document will be processed by Third Party Administrator appointed by the insurer.
24. The Party of First Part will not have any liability if a claim gets rejected due to the fault of the Party of Second Part.
25. This Memorandum of Understanding shall come into force from the date hereof. Either Party may terminate this Memorandum of Understanding upon 30 days notice in writing to the other Party. However, the obligations already undertaken and pending shall be discharged by Party of Second Part despite termination.
26. In case the Party of Second Part does not honor or accept the members Identity Card or fails to extend identified services or deficiency of service or any guidelines not been properly followed which both the Parties have agreed upon, the Party of First Part has the right to terminate this Memorandum of Understanding immediately, after giving due notice in this behalf, to Party of Second Part.
27. The Party of First Part will initially conduct an orientation program for the Party of Second Part's identified staff at the beginning of agreement period on the admission guidelines, claims processing procedure and other guidelines issued by the insurer. The Party of Second Part shall thereafter be responsible for communicating the guidelines to its new staff on a regular basis.

28. The Party of Second Part shall display all recognition and promotional material in their premises supplied by the Party of First Part, in areas of high visibility and shall assist and cooperate with the Party of First Part in the promotion of the services provided by Party of First Part.
29. A Discount of _____ per cent on Out-patient consultation fee shall be offered to the members of Party of First Part members by the Party of Second Part in acknowledgement of the goodwill generated by this Memorandum of Understanding.
30. For mutual convenience, on all transactional issues, the Party of First Part will be represented by their 'Operations Manager – Transaction Process' and the Party of Second Part will be represented by its _____.
31. To handle all other issues the Party of First Part will be represented by their 'Medical Management Manager' and the Party of Second Part will be represented by its _____.
32. The Party of Second Part agrees that it shall be responsible in any manner whatsoever for any claims, arising from any deficiency in service or any failure to provide identified service.
33. The Parties agree that the terms and conditions of this Memorandum of Understanding are confidential and shall not be disclosed to any third Party without prior written consent from the non-disclosing Party, unless such disclosure is required by law.
34. All disputes or differences arising between the Parties hereto in interpreting the terms and conditions and subject matter of this agreement or the respective rights and duties there under present shall be referred to the sole jurisdiction of the civil courts in Hyderabad

IN WITNESS WHEREOF, the Parties have caused this Memorandum of Understanding to be executed by their respective duly authorized representatives.

3. MDIndia Healthcare Services (P) Ltd



MDIndia
Health care Services (P) Ltd.

Memorandum of Understanding Between MDIndia Healthcare Services (P) Ltd. and Healthcare Provider

This memorandum of Understanding made atthis..... day of.....

Between

MDIndia Healthcare Services (P) Ltd, a company incorporated under the Companies Act 1956 and having its Registered Office at 261/2/7 Silver Oaks Park, Baner Road Pune – 411 045 India or its associate company bearing the logo of MDIndia Healthcare Services (P) Ltd. Herein referred to as MDIndia Healthcare Services (P) Ltd., (which expression, unless it be repugnant to the context or meaning thereof, shall deem to mean and its successors and assigns) of ONE PART.

And

....., and having its Registered Office at..... hereinafter referred to as PROVIDER. (with Hospital Registration NO..... and total beds.....) which expression, unless it be repugnant to the context or meaning thereof, be deemed to mean and include its successors and assigns of the OTHER PART

Whereas

MDIndia Healthcare Services (P) Ltd., is n IRDA Licensed “Third Party Administrator (License NO 005), providing healthcare related services to its beneficiaries and clients and for these purposes MDIndia Healthcare Services (P) Ltd. Has created a network of service providers. is desirous to join the said network of providers and is willing to extend medical facilities and treatment to its members covered under such healthcare management plan on the agreed terms and conditions.

Now this agreement witnessed that:

ARTICLE 1: EFFECTIVE DATE

1.1 The Parties hereby agree that the effective date of the Agreement shall be the date on which the agreement is signed

ARTICLE 2:

2.1 The Provider shall treat MDIndia Healthcare Services (P) Ltd. Beneficiaries in a courteous manner and with good business practices.

2.2 The Provider will extend priority admission facilities to the beneficiaries.

- 2.3 The Provider will have his facility covered by proper indemnity policy including error, omission and professional indemnity and agrees to keep such policy in force during tenure of the Agreement.
- 2.4 The Provider shall ensure that best medical treatment/facility is extended to the beneficiary.
- 2.5 The Provider shall endeavor to have an officer in the administration department assigned for insurance / contractual patients and the officers will have to lease the various types of medical benefits offered by the different insurance plans.
- 2.6 The Agreement is subject to the detailed schedule submitted by the Provider, which has to be agreed by MDIndia Healthcare Services (P) Ltd.
- 2.7 The Provider shall allow MDIndia Healthcare Services (P) Ltd. Official to visit the beneficiary and also check the indoor papers/treatment being given to the beneficiary & whether the patient is happy with the services or not. MDIndia Healthcare Services (P) Ltd. Shall not interfere with medical treatment of the patient. Access to billing, medical records and indoor papers will be allowed to MDIndia Healthcare Services (P) Ltd. As and when necessary or asked for.
- 2.8 The Provider agrees to comply with statutory requirement and follow the law of land. The Provider shall also agree to comply with future requirements of insured like standardized billing, ICD-10 coding etc. In case the Provider doesn't have such facility at their end, they shall agree to get such things out-sourced by the outside agent at their own cost.
- 2.9 The Provider agrees to have medical audit/bills audit on periodical basis and when necessary with MDIndia Healthcare Services (P) Ltd. Audit team.
- 2.1 The Provider agrees to display their status of being a preferred provider of MDIndia Healthcare Services (P) Ltd. At their reception/admission desks along with the display and other materials supplied by MDIndia Healthcare Services (P) Ltd for the ease of MDIndia Healthcare Services Ltd.
- 2.11 The Provider will instruct their attending consultant to keep the beneficiaries only for the required number of days for treatment and carry out only the required investigation & treatment for the ailment, for which he is admitted. Any other incidental investigation required by patient for his benefit, are not payable by insurer/TPA and the consultant will have to inform the patient that he will have to bear the cost of the same.

ARTICLE 3. IDENTIFICATION OF BENEFICIARIES

- 3.1 The beneficiaries will be identified by the Provider on the basis of an ID card issued to them bearing the logo and the wordings MDIndia Healthcare Services (P) Ltd. It may also bear the name of the Insurance Company. The ID card shall have photograph of the beneficiary. In certain cases where ID card doesn't have photograph, the beneficiary will provide a photo ID proof such as Voter ID Card, Passport, Driving License, PAN Card and Employer ID Card (only applicable for Government organizations and Public Limited Companies), along with MDIndia Healthcare Services (P) Ltd. ID card.
- 3.2 For the case of beneficiary, the provider shall display the recognition and promotional material, network status and procedures for admission supplied by MDIndia Healthcare Services (P) Ltd. At prominent location, preferably at the reception and admission counter and Casualty/Emergency departments. A Provider also needs to inform their reception and admission counter regarding the procedures of admission and obtaining Pre-authorization as per the Article 4 clause 4-3.

- 3.3 It is advisable to take a photocopy of the ID card, to be submitted later with the bill or to keep as proof of the beneficiary being treated.

ARTICLE 4 : PROVIDER SERVICES ADMISSION PROCEDURE

A) OUTPATIENT SERVICES

Provider will provide out patient services on the basis of pre-authorization, subject to the amount and required services mentioned in the authorization letter. The Provider will ensure the identity of the beneficiary before imparting the services.

B) PLANNED ADMISSION

- 4.1 Request for hospitalization on behalf of the beneficiary may be made by the provider/ consultant attached to the provider, or beneficiary himself after obtaining due details from the treating doctor in the prescribed format "Request for Authorization Letter" (RAL). The RAL needs to be faxed to the 24-hour helpdesk at MDIndia Healthcare Services (P) Ltd. Telephone number/contact details of treating physician and the beneficiary needs to be mentioned, as it would ease the process in the cases where the symptoms are vague or if effective diagnostic is not arrived at. The medical team of MDIndia Healthcare Services (P) Ltd. would get in touch with treating physician/beneficiary, if necessary.
- 4.2 MDIndia Healthcare Services (P) Ltd. Guarantees payment only after receipt of RAL and the necessary medical details. Only after MDIndia Healthcare Services (P) Ltd. has ascertained the eligibility of coverage shall issue the Authorized Letter (AL).
- 4.3 In case the ailment is not covered or given medical data is not sufficient for the medical team of helpdesk to confirm the eligibility, MDIndia healthcare Services (P) Ltd. can deny the Authorization.
- 4.4 Denial of Authorization (DAL)/guarantee of payment is by no means denial of treatment. The Provider is requested to deal with each case as per their normal rules and regulations.
- 4.5 AL will mention the amount guaranteed, class of admission, eligibility of beneficiary or various sub limits for rooms, boarding, nurses, surgical fees etc. as per the benefit plan of the insured. Provider must see that these rules are strictly followed.
- 4.6 The guarantee of payment is given only for the necessary treatment cost of the ailment covered and mentioned in the request for hospitalization. Non-covered items like telephone usage, relative's food, hospital registration fees etc. must be recovered directly from the insured. Any investigation carried out at the request of the patient but not forming the necessary part of the treatment must also be collected from the patient.
- 4.7 The AL normally mentions the amount, which is requested at the time of request for hospitalization or the total sum available. Therefore in event of cost of treatment going above the guaranteed amount, the Provider may check the availability of further limit with MDIndia Healthcare Services (P) Ltd.
- 4.8 In case the sum available is considerably less than the estimated treatment cost, Provider should follow their normal norms of deposit/running bills etc. MDIndia Healthcare Services (P) Ltd. upon receipt of the bills and documents would release the guaranteed amount.
- 4.9 Certain beneficiary may have "No Coverage Restriction" as mentioned in their card, in case of comprehensive coverage. However their sum insured could be limited

- 4.1 MDIndia Healthcare Services (P) Ltd. will not be liable for payments in case the information provided in the “Request for Authorization Letter” and subsequent documents during the course of authorization is found incorrect or not disclosed.

C) EMERGENCY ADMISSION

- 4.11 In case of a vehicular accident, if the victim was under influence of alcohol or inebriating drugs, since the insurance does not cover this, no AL will be issued. It is mandatory for the Provider to inform the cause of emergency to MDIndia Healthcare Services (P) Ltd. in order to issue AL.
- 4.12 In case of other emergencies, the Provider shall call the helpdesk of MDIndia Healthcare Services (P) Ltd. for authorization. MDIndia Healthcare Services (P) Ltd. may continue to discuss the case with the treating doctor till conclusion of eligibility of coverage is arrived at. Provider in the meanwhile may consider treating the patient by taking a token deposit or as per their norms.
- 4.13 If AL is issued after ascertaining the coverage, Provider should refund the amount if taken, barring a token amount to take care of non-covered expenses. Post emergency, patient must be transferred to the room, which he is eligible for as per his health plan, which would be mentioned in the AL.

ARTICLE 5. FEE SCHEDULE

- 5.1 Provider has to submit the fee schedule in the format designed by MDIndia Healthcare Services (P) Ltd. Or in their own Format
- 5.2 Provider should also separately list package charges.
- 5.3 Such package charges must be inclusive of stay, medicines, consumables, surgical fees, operation theatre etc. No additional payment would be entertained unless the medical team of MDIndia Healthcare Services (P) Ltd. agrees with the treating consultant for any deviation.
- 5.4 Certain expensive consumables like stent, catheters etc. may be replenished by MDIndia healthcare Services (P) Ltd. and if the provider agrees to rework the bill.
- 5.5 Any revision in the fee schedule will be submitted to MDIndia Healthcare Services (P) Ltd. at least 15 -30 days prior to the effective date. MDIndia Healthcare Services (P) Ltd. reserves the right to discontinue the contract after assessing the revised fee schedule.
- 5.6 In case MDIndia Healthcare Services (P) Ltd. is not intimated regarding the revision, then it will pay for the services as per the agreed schedule of fees.
- 5.7 Provider agrees that the schedule of fees submitted is the lowest and if any other schedule of fees during the tenure is found lower, Provider will refund such additional charges levied on MDIndia Healthcare Services (P) Ltd.
- 5.8 Provider would be happy to give a further discount on schedule of fees as given below:
- | | |
|--------------------------|--------|
| 1. Bed Charges |% |
| 2. OT Charges |% |
| 3. ICU/CCU Charges |% |
| 4. Investigation Charges |% |

5.	Consultation Charges%
6.	Nursing Home%
7.	Surgery Charges%
8.	Medicines / Drugs%
	OR	
9.	Package Discount%

ARTICLE 6. DUTIES / CHECKLIST FOR THE PROVIDER AT THE TIME OF PATIENT DISCHARGE

- 6.1 Original discharge card, original investigation reports, all original prescription & pharmacy receipt etc. must not be given to the patient. These are to be forwarded to billing department who will compile the same and forward along with the bill to MDIndia Healthcare Services (P) Ltd.
- 6.2 In case the patient requires the discharge card / reports, he/she can be asked to take photocopies of the same at their own expenses.
- 6.3 The discharge card / summary must mention the duration of ailment, stay and duration of other disorders like hypertension or diabetes and operative notes in case of surgeries. The clinical details should be sufficiently informative.
- 6.4 Signature of the patient / beneficiary on final hospital bill including doctor's daily visit charges, surgical fees etc. must be obtained.
- 6.5 Claim form of the insurance company / MDIndia must be presented to the beneficiary for signing and identity of the patient needs to be ascertained.

ARTICLE 7 : BILLING PROCEDURE

- 7.1 Final bill should be submitted to MDIndia Healthcare Services (P) Ltd. preferably in the format as submitted in MDIndia "Provider Servicing Kit".
- 7.2 The bills must be as per the agreed schedule of charges. Any higher amount will be deducted from the bill amount.
- 7.3 Any non-covered treatment / investigation cost must be recovered from the patient.
- 7.4 The final docket for onward submission to MDIndia Healthcare Services (P) Ltd. for immediate payment must contain the following:
 - ☐ Copy of MDIndia Healthcare Services (P) Ltd. ID card with legible ID number
 - ☐ Copy of Authorization Letter with beneficiary's signature
 - ☐ Signed claim form
 - ☐ Original final bill with detailed break up of miscellaneous consumables and other charges
 - ☐ Original and complete Discharge Card mentioning duration of ailment and duration of either disorders like hypertension or diabetes if any
 - ☐ Original Investigation reports with corresponding prescription / request
 - ☐ Pharmacy bill, if supplied by hospital with corresponding request

- ☐ Any other documentary evidence, statutory under law
- ☐ Status of deposit if any, by beneficiary
- ☐ Any other related documents

ARTICLE 8 : PAYMENT TERMS AND CONDITIONS

- 8.1 MDIndia Healthcare Services (P) Ltd. agrees to pay all the eligible claims within 30 days of the receipt of bill at their head address office in Pune.
- 8.2 In case certain billed items are not correlated with corresponding report, such amount will be deducted from the final bill. However, the Provider may send these reports within 90 days of receiving the payment to get the deducted amount. Due reasons for deductions, if any will be given at the time of settlement of the bills.
- 8.3 The Provider can instruct MDIndia Healthcare Services (P) Ltd. to pay the amount separately to its vendor's like pharmacies, diagnostic centers, ICD-10 coding vendor etc.
- 8.4 Payment will be done by "At par payable" Cheque of nationalized bank.
- 8.5 Payment and bank deposition would be construed as due receipt, if a Provider agrees to send a stamped receipt of the payment received immediately on receipt of the Cheque.

ARTICLE 9 : LIMITATIONS OF LIABILITY AND INDEMNITY

- 9.1 MDIndia Healthcare Services (P) Ltd. will not interfere in the treatment and medical care provided to its beneficiaries. MDIndia Healthcare Services (P) Ltd, will not be in any way held responsible for the outcome of treatment of care provided by the Provider.
- 9.2 MDIndia Healthcare Services (P) Ltd. shall not be liable or responsible for any acts of omission or commission of the Doctors and other medical staff of the Provider.
- 9.3 The Provider shall alone be liable to pay any costs, damages and / or compensation demanded by the beneficiary for poor, wrong or bad quality of the test report or treatment given to the beneficiary by the Provider while executing any assignment of MDIndia Healthcare Services (P) Ltd.

ARTICLE 10 : CONFIDENTIALITY

- 10.1 The Provider undertakes to protect the secrecy of all the data of MDIndia healthcare Services (P) Ltd. beneficiary and trade or business secrets of MDIndia Healthcare Services (P) Ltd. and shall not share the same with any unauthorized person for any reason whatsoever with or without any consideration.

ARTICLE 11 : TERMINATION

MDIndia Healthcare Services (P) Ltd. shall reserve the right to terminate the Agreement without notice if:

- 11.1 The Provider violates any of the terms and conditions of this Agreement, or
- 11.2 Increases fee schedule without prior notice, or
- 11.3 MDIndia Healthcare Services (P) Ltd. comes to know of wrong and fraudulent practices, or
- 11.4 MDIndia Healthcare Services (P) Ltd. observes cases of over stay and other provisioning without adequate explanation

The Provider can terminate the Agreement

11.5 After giving 90 days notice to MDIndia Healthcare Services (P) Ltd.

11.6 Either party reserves the right to inform public at large along with the reasons of termination of the Agreement by the method which they deem fit.

ARTICLE 12 : NON EXCLUSIVITY

12.1 MDIndia Healthcare Services (P) Ltd. reserves the right to appoint any other provider for implementing the packages envisaged herein and the Provider shall have no objection for the same.

ARTICLE 13 : OTHER SERVICES OF MDINDIA HEALTHCARE SERVICES (P) LTD.

13.1 Provider is free to choose MDIndia Healthcare Services (P) Ltd. to provide other various services on agreed financial terms which are outside the contract between the insurer and insured and hence outside the preview of regulation. These services could include replenishment of certain consumables, imparting web space or web portal, software data entry and coding services etc.

ARTICLE 14 : JURISDICTION

14.1 Any disputes / claim arising out of this Memorandum of Understanding are subject to Administration and Jurisdiction of Pune Courts

14.2 In case of any dispute or differences arising out of this Memorandum of Understanding, each party may as soon as practicable give to other party notice in writing of the existence of such questions or disputes specifying its nature and the point of issue. If the parties cannot resolve the matters by a mutually acceptable solution within 15 (fifteen) business days, the said dispute or difference shall be referred to and settled by arbitration under the provisions of the Arbitration & Conciliation Act, 1996 or any other reenactment or modifications thereof.

14.3 The sole Arbitrator shall enter upon the reference immediately and within 30 working days from its constitution pass the final award. The time of 30 days contemplated may be extended by mutual consent of both parties in writing.

14.4 The venue of the Arbitration shall be Pune and the arbitration shall be carried out in English language only.

14.5 The Arbitration decision will be final, irrevocable and binding on all parties. The decision shall also determine the expenses of the Arbitration and the Party shall bear them or the proportion of such expenses to be borne by each party.

14.6 Any Amendment in the clauses of the Agreement can be effected as an addendum, after the written approval from both the parties.

In witness thereof this Agreement was executed by or on behalf of the parties the day and year first before written.

Signed and delivered by the within named:

Provider Signature

Witness Signature

MDIndia Healthcare Services (P) Ltd. signature

Witness Signature

ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA) TECHNICAL WORKSHOP:

**“Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and Participation”**

New Delhi, India Habitat Centre, May 29-31, 2006

ABSTRACT

- The National Commission for Enterprises in the Unorganized Sector (NCEUS) was established in May 2004 by the Government of India
- Its terms of reference included the preparation of proposals to extend social security benefits to unorganized sector workers
- In May 2006, the Commission submitted to the Government its social security report
- The proposal planned to extend a minimal social protection to 300 million informal economy workers
- This target was to be reached in a 5-year time span
- The benefit package included the following: medical care, maternity protection, sickness benefits, life insurance, pension and provident fund
- Contributions to finance this plan were to come from the worker, the employer and the Government (Central and State)
- Contribution for BPL workers will be fully paid by the Central Government
- The implementation of the scheme will also involve the various civil society organizations...

SESSION 10

**THE NEED FOR INFORMATION /
EXPERIENCE SHARING TOOLS**

TECHNICAL PAPER NO 10.1

**EXTENSION OF SOCIAL
PROTECTION IN INDIA**

**THE SOCIAL SECURITY
BILL - 2006**

INTRODUCTION

The National Common Minimum Programme (CMP) of the United Progressive Alliance (UPA) which was formed after the general elections in April/May 2004 was announced on 27 May 2004. It set out the major policy orientations adopted in order to enhance sustainable development in India. In the spirit of the Alliance, it referred in its preamble to the welfare of farmers, agricultural workers and weaker sections of the society and strongly stated a commitment to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, particularly in the unorganized sector who constitutes 93% of the labour force. To follow up this commitment, the Government established a National Commission to examine the major problems facing the various enterprises operating in the informal economy.

In August 2005, the National Commission published an ambitious plan (The Unorganized Sector Workers Social Security Draft Bill) aiming to provide a minimum level of social protection benefits to some 300 million informal economy workers.

This proposal could be viewed as paving the way towards a nation-wide social security system based on the national solidarity principle. Almost one year later, in May 2006, the Commission released its report on Social Security for unorganized workers which included a revised version of this Bill complemented this time with detailed recommendations relating to its implementation mechanisms and financing requirements.

The present document presents this important Bill and provides an overview of the main features, provisions and practical measures recommended by the Commission in order to bring it into existence.

1. NATIONAL COMMISSION FOR ENTERPRISES IN THE UNORGANIZED SECTOR

The National Commission for enterprises in the unorganized sector was set up with a clear mandate on September 20, 2004 in the wake of the CMP resolutions. The broad terms of reference given to the Commission were as follows:

- Review the status of unorganized/informal sector in India including the nature of enterprises, their size, spread and scope, and magnitude of employment
- Identify the constraints faced by small enterprises with regard to freedom of carrying out the enterprise, access to raw materials, finance, skills, entrepreneurship development, infrastructure, technology and markets and suggest measures to provide institutional support and linkages to facilitate easy access to them
- Suggest the legal and policy environment that should govern the informal/unorganized sector for growth, employment, exports and promotion
- Examine the range of existing programmes that relate to employment generation and suggest improvement for their redesign
- Identify innovative legal and financing instruments to promote the growth of the informal sector
- Review the existing arrangements for estimating employment and unemployment and examine why the rate of growth of employment has stagnated in the 1990s
- Suggest elements of an employment strategy focussing on the informal sector

- Review labour laws, consistent with labour rights, and with the requirements of expanding growth of industry and services, particularly in the informal sector, and improving productivity and competitiveness, and
- Review the social security system available for labour in the informal sector, and make recommendations for expanding its coverage

2. UNORGANIZED WORKERS SOCIAL SECURITY BILL

The new version of the proposed Bill included the following major changes:

Proposed Bill, 2005	Proposed Bill, 2006
Under Definitions	Under Definitions
j) "Self employed worker"... subject to a monthly earning of Rs. 5,000...	j) "Self employed worker"... subject to a monthly earning of Rs. 6,500...
k) "Unorganized sector" means all private unincorporated enterprises including own-account enterprises engaged in any agriculture, industry, trade and / or business	k) "Unorganized sector" consists of all unincorporated private enterprises owned by individuals or households engaged in the production or sale of goods and services and operated on a proprietary or a partnership basis and employing less than 10 persons
l) "Unorganized sector worker"	l) "Unorganized worker"...
m) "Wage worker" ... with a monthly wage of not more than Rs. 5,000...	m) "Wage worker".... or workers employed by households including domestic workers, with a monthly wage of not more than Rs. 6,500...
Under Chapter II	Under Chapter II
1. By this Act, the Central Government shall formulate a scheme to be called National Social Security Scheme for the unorganized sector workers consisting of the following national minimum social security benefits:	1. By this Act, the Central Government shall formulate a scheme to be called National Social Security Scheme for the unorganized workers consisting of the following national minimum social security benefits:
I. Old age pension to all workers above the age of 60 years	I. Health benefits in the form of health insurance for self, spouse and children below the age of 18 years, sickness benefits, and maternity benefits for women workers or spouse of men workers
II. Health insurance for self, spouse and children below the age of 18 years	II. Life insurance to cover natural and accidental death

III. Maternity benefits for women workers or spouse or men workers; and

IV. Insurance to cover death and disability arising out of accidents

III. Old age security in the form of old age pension for BPL workers above the age of 60 years and provident fund cum unemployment insurance benefit to all other workers

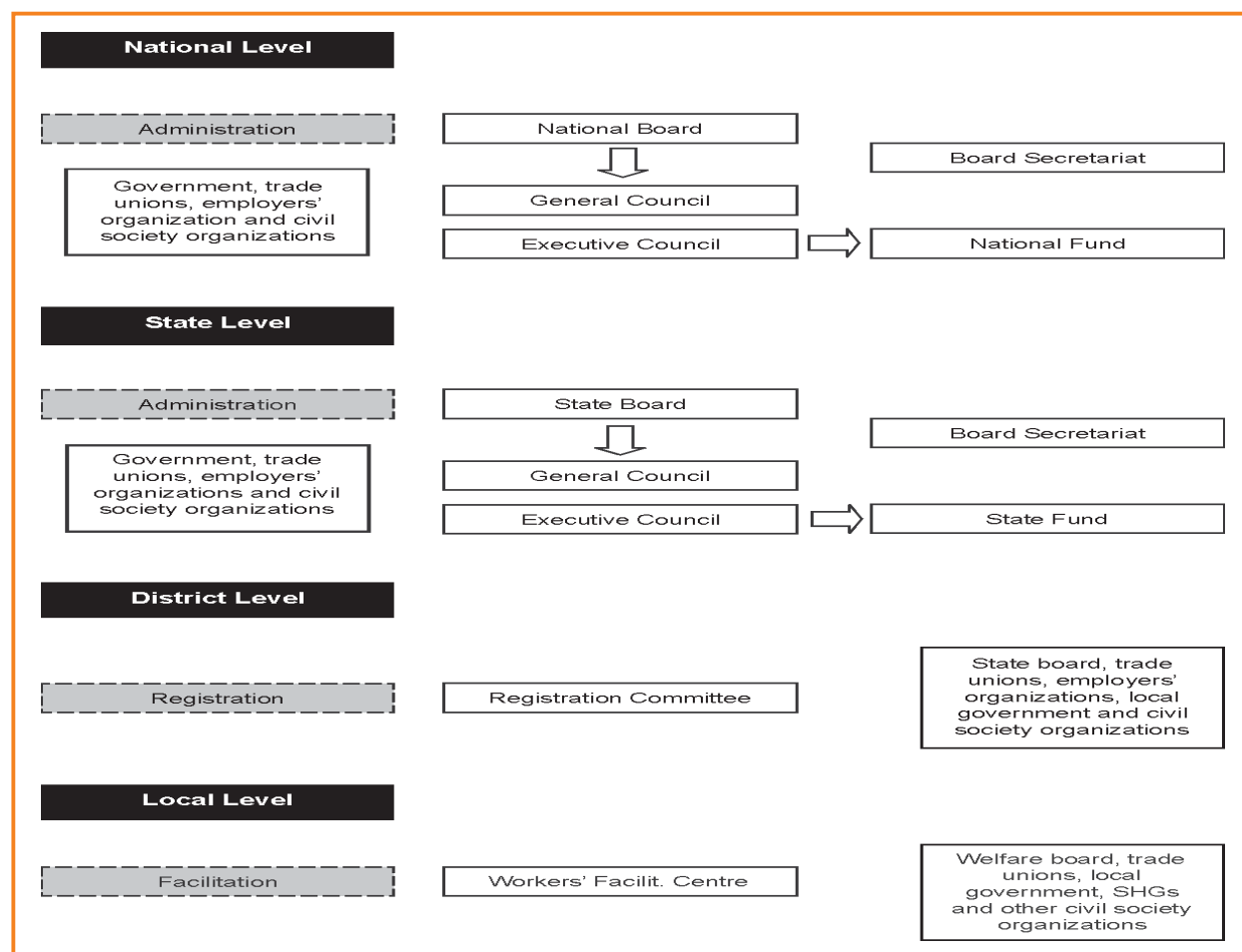
The major stipulations relating to the contributions to be paid remained unchanged.

Under Chapter III

5. Contributions from workers, employers and governments for the specified national minimum social security shall be as under:
 - I. Re. 1 per day by the worker, provided that for those below the poverty line the contribution shall be made by the Central Government
 - II. Re. 1 per day, per worker, by the employer, provided that where the employer is not identifiable, the contribution shall be shared by the Central Government and the respective State Government in the ratio of 3:1
 - III. Re. 0.75 per worker, per day, by the central Government, and Re. 0.25 per worker, per day by the State Government

3. IMPLEMENTATION MACHINERY

The new version of the proposed Bill included the following major changes:



4. IMPLEMENTATION ARRANGEMENTS

Chapter 9 of the Report on Social Security for the unorganized workers provides detailed information on the various implementation arrangements. The following recommendations deserve to be highlighted:

9.0 The National Social Security Scheme proposed by the Commission is based on defined contributions. These contributions are meant to be utilized as premium for insurance to cover (a) sickness, (b) life insurance, and (c) old age security. As per the defined contribution, of Rs. 3 per worker per day (contributed equally by the worker, employer and the Government), a sum of Rs. 1,095 will be available per worker per day. This may be split into three premiums: sickness and maternity, life insurance and old age security. In the scheme of things suggested by the Commission, it will be the responsibility of the State Social Security Boards to negotiate with the concerned insurance agencies, with the help of the National Social Security Board, and decide on how best to apportion the contribution and secure the best possible deal. The Commission has suggested a division consisting of Rs. 380 for sickness and maternity cover and Rs. 150 for life insurance and Rs. 565 for old age security. These figures were arrived at in consultation with insurance agencies.

Health and Maternity Insurance Cover

9.1 The Commission suggests an annual premium of Rs. 380 per worker based on preliminary discussions with public sector insurance agencies. A single policy is expected to cover a typical family of five members. The minimum benefits presently stipulated are:

- a) Hospitalization cover up to Rs. 15,000
- b) Maternity benefit of Rs. 1,000 (maximum) per delivery
- c) Personal accident cover in the event of death of earning head of family (Rs. 25,000) and
- d) Sickness cover for the registered worker during hospitalization (Rs. 50 per day for a period of 15 days)

9.2 The National Board and the State Boards may negotiate with the insurance agencies to ensure the above-mentioned minimum health and maternity benefits. As of now, there are four general insurance agencies in the public sector with different health insurance policies.

9.5 ... Although the experience of the general insurance agencies with regard to health insurance services is rather limited, the Commission's discussions revealed that they may be willing to consider a fixed policy (as opposed to annual policy) for a longer period say, five years provided the claim-to-premium ratio does not exceed a certain maximum, say 70 per cent in a year. In case the claim is less than this ratio, the insurance agencies are willing to offer a lump sum discount to the concerned State Boards. Alternatively, however, if the claim ratio exceeds this ceiling, the insurance agencies will have to be compensated by the State Boards.

9.10 The social security identity cards issued to the worker/family shall allow him/her to avail of the prescribed facilities on the basis of either a cashless system or reimbursement of expenses. The Commission is of the opinion that a cashless system is the more appropriate one for the unorganized workers...

- 9.11 The Commission has recommended the insurance route for covering the health care requirements of the workers not as a substitute to the existing services provided by the public health care institutions. In fact, by providing risk cover for hospitalization, we expect the insurance system to work as an incentive to the designated public health care institutions to strengthen their infrastructure and provide the needed services if they are allowed the chargeable element of the cost of treatment of the registered workers.

Life Insurance

- 9.12 The suggested annual premium for life insurance is Rs. 150 per worker per annum. This is expected to provide a benefit of at least Rs. 15,000. The benefit could be negotiated with insurance agencies.
- 9.13 Given the fact that the Department of Post (DoP) has considerable experience in marketing and servicing Postal Life Insurance schemes at costs that are lower than insurance agencies, it should be possible to secure a better deal for the unorganized workers with defined contributions through the Department. Moreover, the Department of Posts has a network of infrastructure in the form of Post Offices that number more than 150,000 connecting all localities in rural and urban areas in the country. This should strengthen the delivery of services in every nook and corner of the country... The DoP was permitted to introduce a Rural Postal Life Insurance (RPLI) scheme in 1995 offering five different insurance schemes. The aggregate number of active insurance policies served by the Department of Posts (as on 31.03.2004) is 4.87 million that includes 2.67 million RPLI policies....
- 9.15 In order to enable the Department of Posts to come out with a suitable scheme, the Commission recommends that the Department be allowed to design a new insurance product, if necessary, in the form of a group insurance scheme.

Provident Fund for Contributing Workers

- 9.17 As observed in para 9.0, a premium of Rs. 565 is available per worker per year for old age security, either in the form of pension or contribution towards Provident Funds. The Commission has considered both these options for all workers and has recommended a Provident Fund for all registered workers above the poverty line and a pension for old aged (60+) workers in BPL households.
- 9.18 The calculations of the Commission show that even if one were to consider pensions at Rs. 2,400 per year (i.e. Rs. 200 per month) to contributing workers, this would depend upon the age of entry of workers into the scheme. The Commission's discussions with the Life Insurance Corporation (LIC) suggest that the return on investment could be between 5.5 to 6% per annum, which is a conservative estimate. This is mainly due to the restrictions on the type of investment as per the Insurance Regulatory and Development Authority (IRDA). This will fall short of Rs. 200 for those workers entering scheme at around age 39 and above; while less conservative estimates (assuming a return of 10%) show that this age will be around 43. This would mean that those workers above the age of around 40 years would not be in a position to secure a minimum pension of Rs. 200 per month.
- 9.19 Taking the above into account, the Commission recommends the institution of a Provident Fund for the contributing informal workers who are above the poverty line (estimated at 77%). This will ensure that all those who contribute will get a terminal benefit on completion of 60 years of age.

- 9.2 The Commission further recommends that the workers be given an option, on attaining 60 years of age, to take either the accumulated corpus in their PF or purchase an annuity. This will give an option to those who are desirous of having an old age pension.
- 9.21 In addition, the Commission also recommends that the PF may also be designed as an Unemployment Insurance by permitting the workers to withdraw up to half of his contribution depending on the period of unemployment. However, a minimum lock-in period of ten years is recommended.
- 9.22 Discussions with Unit Trust of India revealed that a PF scheme can be managed by a mutual fund organization. However, the mutual fund organization will not be in a position to guarantee a minimum return as per the regulations of the SECURITIES AND Exchange board of India. However, the experience of the last several years suggests that the annual return has been well above ten per cent.
- 9.23 The Commission therefore recommends a minimum guaranteed return of ten per cent to the workers under the proposed PF. This is to ensure that the unorganized workers, who are much poorer than the workers in the organized sector, get a return higher than the Employees Provident Fund. If the proposed PF experiences a short-fall, it will have to be covered by the State Boards. To make this operational, the mutual funds should transfer the excess realization of promised 10 per cent to State Boards. If the accumulated sum on that account falls short of the outgo on account of a minimum 10 per cent return to the employees in any year, the National Social Security Fund (NSSF) will provide for the difference. The State Boards may declare bonus for the workers every five years if there is a balance left on this account.

Old Age Pension for Poor (BPL) Workers

- 9.24 For poor workers, it is desirable that they are entitled to a minimum level of protection regardless of the year of inception of the scheme and number of years of their contribution. In the case of BPL workers, the Commission has suggested a premium of Rs. 565 per worker per annum towards old age security of unorganized workers.
- 9.25 The Commission has carefully considered the various options through which a minimum level of protection may be available to all aged poor workers. It has noted that the Government of India already funds the National Old Ages Pension Scheme (NOAPS) under which destitute old-aged persons, above the age of 65 years are being provided a monthly pension of Rs. 200. The Central allocation for the scheme has been enhanced to Rs. 1430 crores in the 2006-2007 Budget and the Finance Minister has considered it desirable that States use additional resources to enhance the pension to Rs. 400 per month.
- 9.28 The Commission recommends payment of a minimum pension of Rs. 200 to all the poor (BPL) aged unorganized workers on completion of 60 years of age. This can be done by expanding the NOAPS, which at present is confined only to those above 65 years and are identified as destitute.

5. FINANCIAL REQUIREMENTS

The following tables provide an overview of the main financial requirements attached to the scheme.

Individual Contribution Distribution

	Worker	Employer	C. Gov.	S. Gov.	Total
BPL	0	0	912,50	182,50	1,095
APL – Without Employer	365	0	547,50	182,50	1,095
APL – With Employer	365	365	273,75	91,25	1,095

Extension Targets

(In Crore – X 10 million)	2006-07	2007-08	2008-09	2009-10	2010-11
Total NO of Workers	6	12	18	24	30
BPL workers	1.38	2.76	4.14	5.52	6.9
APL workers	4.62	9.24	13.86	18.48	23.1

Expected Costs – Health and Life Insurance for All

(In Crore – X 10 million)	2006-07	2007-08	2008-09	2009-10	2010-11
Contrib: Rs. 530 per worker	3,180	6,360	9,540	12,720	15,900
Of Which:					
• APL Workers Contribution	816	1,632	2,449	3,265	4,081
• Government Contribution	2,362	4,725	7,087	9,449	11,811
o Central Gov.	1,834	3,668	5,501	7,335	9,169
o State Gov.	528	1,057	1,585	2,114	2,642

Expected Costs – Old Age Security

1. Provident Fund - APL

(In Crore – X 10 million)	2006-07	2007-08	2008-09	2009-10	2010-11
Contrib: Rs. 565 per worker	2,610	5,221	7,831	10,441	13,052
Of Which:					
• APL Workers Contribution	870	1,740	2,610	3,480	4,351
• Government Contribution	1,742	3,483	5,225	6,967	8,709
o Central Gov.	1,306	2,613	3,919	5,225	6,532
o State Gov.	435	871	1,306	1,742	2,177

2. Old-Age Pension - BPL

(In Crore – X 10 million)	2006-07	2007-08	2008-09	2009-10	2010-11
Pension: Rs. 2,400 per year	3,244	3,292	3,340	3,387	3,434
Of Which:					
o Central Gov.	3,244	3,292	3,340	3,387	3,434
o State Gov.	0	0	0	0	0

**ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP:**

**“Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and Participation”**

New Delhi, India Habitat Centre, May 29-31, 2006

ABSTRACT

- Micro-insurance schemes are now proliferating all across Asia
- Some 300 schemes operating in 10 countries have already been identified
- Health insurance has a clear lead with some 8.2 million insured followed by life insurance with 5.3 million
- With so many actors and initiatives there was an urgent need to set up a mechanism allowing for the regular exchange of information, experience and tools
- In 2005, STEP decided to support the setting up of a regional network: AMIN
- AMIN fosters in Asia the social protection challenge: “From Local Initiatives Towards National Solidarity Systems”
- Amin activities focus on Knowledge Development, Capacity Building and Advocacy
- 24 most active organizations representing 7 countries are permanent members of AMIN
- Over 600 Associate and Contact members are registered with AMIN
- India and the Philippines are recognized as the first micro-insurance countries in Asia

SESSION 10

THE NEED FOR INFORMATION /
EXPERIENCE SHARING TOOLS

TECHNICAL PAPER NO 10.2

**EXTENSION OF SOCIAL
PROTECTION IN INDIA:**

**TAKING THE LEAD IN
EXPERIENCE SHARING
AND NETWORKING**

INTRODUCTION

Micro-insurance schemes serve one of the crucial needs of the community. Far more than a simple financial arrangement, they have to be seen as an efficient empowerment instrument and as a social inclusion mechanism.

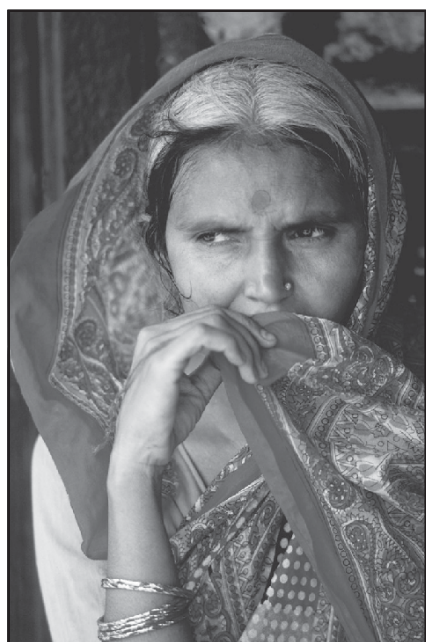
Micro-insurance schemes have the potential to ensure that equity-based, gender-sensitive, comprehensive, affordable and viable social protection services can reach out to the various excluded groups and most disadvantaged groups of the population.

In order to effectively contribute to the ambitious role of providing social protection to all, the various micro-insurances operating in Asia have now joined hands in undertaking a new regional initiative that could enhance all actor's technical capacities while helping them to come up more efficiently with the issue of extension of social protection at the policy level in each concerned country.



1. BACKGROUND

In Asian developing countries, it is clear that many other actors than the State have a role to play and evidence already suggests that new forms of collective promotion of interest such as micro-insurance schemes addressing the priority needs of the members may be the first and



necessary step for the design and implementation of efficient nation-wide systems of social protection. Facing the huge gap of social protection a wide diversity of civil society actors (cooperatives, women's group, trade unions, micro-finance institutions, NGOs, micro-entrepreneurs association, etc.) have already begun to experiment with innovative solutions to meet their needs.

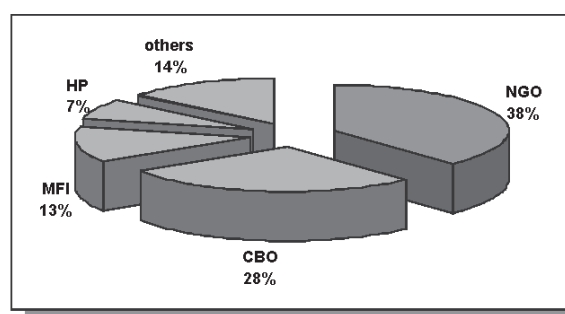
Various micro-insurance schemes that were tailor made to answer the needs of their members are found to be proliferating in all countries. Some of these schemes have already succeeded in linking up with insurance companies, banking institutions, health providers and even pharmaceutical companies. In some Asian countries such as India where there is now a critical mass of membership based schemes and where these have started to organise into networks, it is already apparent that micro-insurance has already increased the voice of the excluded groups and is beginning to influence the policy and legal context that governs social protection.

However, and although having already successfully demonstrated their positive effect at the local level, these multiple micro-insurance schemes remain often isolated and insufficiently documented, resulting in the fact that they are still not taken into account into national policies, strategies and programmes that could achieve a widespread positive impact on the excluded groups. Another related concern, is that being not linked with national systems of social protection, these schemes still cannot rely on effective national solidarity redistribution mechanisms. Hence, the social protection challenge that remains to be taken up in Asia: **"From local initiatives towards national solidarity systems"**.

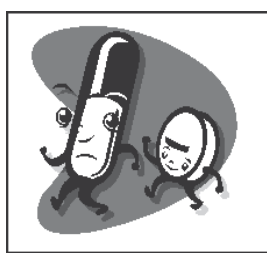
2. MICRO-INSURANCE IN ASIA

Ownership Profile

Most micro-insurance schemes operating within the region are reported as having been initiated by NGOs (38%), but wide disparities may be observed among the various countries, such as in the Philippines where CBOs are predominant or in India, where both MFIs and health providers are now playing a major role...

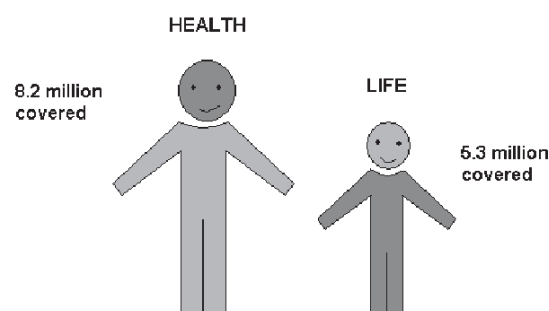


Overall coverage



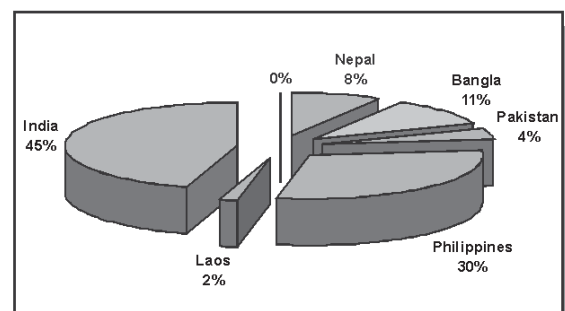
The importance of health, being the social protection priority need of the poor in developing countries, is reflected in the emphasis put on this risk by most micro-insurance schemes.

India, Bangladesh and the Philippines have been the most successful in covering already huge segments of population...



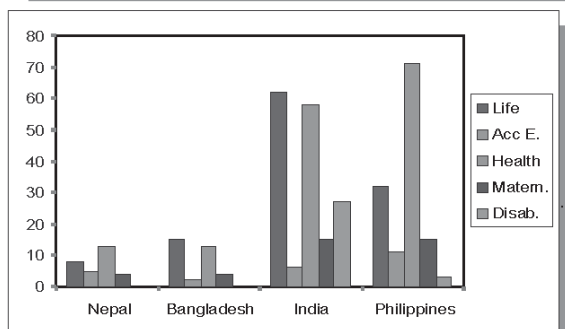
Number of Schemes

So far close to 300 schemes have already been identified and enlisted in AMIN network. India and the Philippines register today the most numerous experiences accounting together for a total of 73% of existing schemes...



Risk Coverage

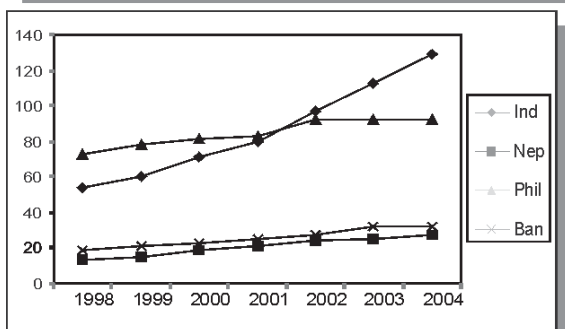
Insurance products covering a wide range of risks including life, health, maternity protection, disability, livestock, housing, old-age pension, etc have been made accessible to the poor in various countries. Philippines had the highest number of health schemes, with a total of 71, but India is catching up at a fast pace...



Growth



Growth of micro-insurance is to be seen everywhere but has recently taken a big leap in Pakistan and has been quite rapid. In India starting at 54 schemes in 1998, rising to 129 in 2004 and already covering 7 million people...



3. ASIA MICRO-INSURANCE NETWORK (AMIN)

1. Description

AMIN AT A GLANCE

24 Permanent Members Representing 7 Countries

Bangladesh, Cambodia, India, Nepal, Pakistan, the Philippines, Sri Lanka

Some 300 schemes Operating in 10 Countries

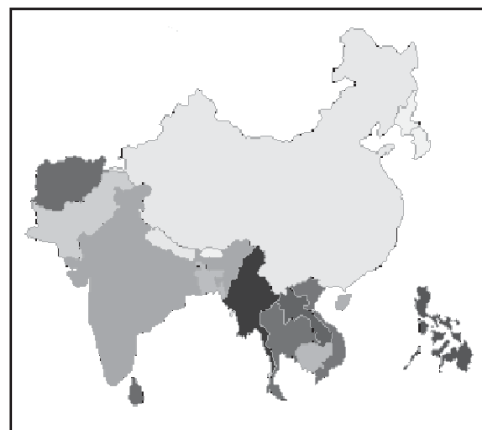
Identified and documented

Some 600 Associate Members

Informed on any activity and event

Some 40 Major Reference Materials

Inventories, studies and case studies conducted within the region



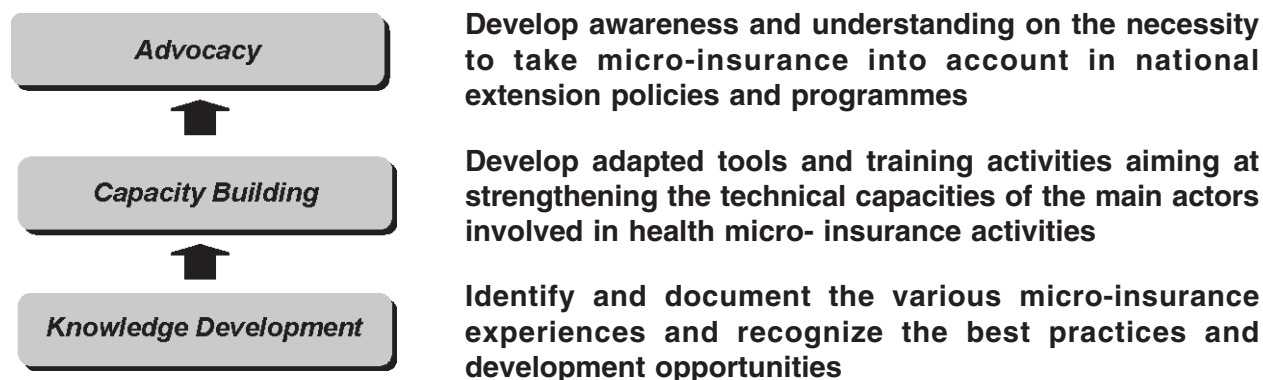
2. Objectives

AMIN has the following main objectives:

- ☐ Set up an efficient mechanism allowing for the regular sharing of information and experience among practitioners from different countries
- ☐ Develop the documentation process of various on-going micro-insurance initiatives, innovations and achievements
- ☐ Build up new technical capacities for the various actors involved in micro-insurance activities
- ☐ Strengthen the collaboration and active partnership among the various membership-based micro-insurance schemes
- ☐ Highlight and clarify issues, challenges and opportunities related to the contribution of micro-insurance schemes to the extension of social protection
- ☐ Organise new initiatives aiming to create a wider awareness and a stronger commitment on the need to extend social protection

3. Activities

AMIN activities are organized according to the following bottom-up approach:



Main activities planned for 2006 include the following:

- ☐ Production of AMIN promotional brochure

- ☐ Production of four newsletters
- ☐ Organization of various e-mails forum
- ☐ Update of national inventories
- ☐ Promotion and adaptation of health micro-insurance training guides
- ☐ Production of additional case studies on health micro-insurance schemes
- ☐ Organization of technical workshops with various partner organizations

4. AMIN Permanent Members

24 Organisations are already represented in the core group of permanent members set up by AMIN.

1	Bangladesh	<input type="checkbox"/> Grameen Kalyan (GK) <input type="checkbox"/> Bangladesh Rural Advancement Committee (BRAC) <input type="checkbox"/> Delta Life Insurance Company Ltd.
2	Cambodia	<input type="checkbox"/> Groupe de Recherche et d'Echanges Technologiques (GRET) <input type="checkbox"/> Cambodian Organization for Assistance to Family and Welfare (CAAFW)
3	India	<input type="checkbox"/> All India Association for Micro Enterprise Development (AIAMED)- Emmanuel Hospital Association (EHA) <input type="checkbox"/> DHAN Foundation <input type="checkbox"/> Self Help Promotion for Health and Rural Development (SHEPERD) <input type="checkbox"/> Indian Association for Savings and Credit (IASC) <input type="checkbox"/> Self-Employed Women's Association (SEWA) <input type="checkbox"/> Narayana Hrudayalaya Asia Heart Institute <input type="checkbox"/> PLAN International <input type="checkbox"/> Family Health Plan Ltd. (FHPL) <input type="checkbox"/> SKS Microfin Pvt. Ltd (SKS)
4	Nepal	<input type="checkbox"/> General Federation of Nepalese Trade Unions (GEFONT) <input type="checkbox"/> B.P. Koirala Institute of Health Services (BPKIHS) <input type="checkbox"/> Public Health Concern Trust (PHECT-Nepal)
5	Pakistan	<input type="checkbox"/> Kashf Foundation <input type="checkbox"/> National Rural Support Programme
6	Philippines	<input type="checkbox"/> Coop Life Mutual Benefit Services (CLIMBS) <input type="checkbox"/> PAKISAMA Mutual Benefit Association
7	Sri Lanka	<input type="checkbox"/> Sanasa Almao Insurance Company Ltd. <input type="checkbox"/> Yasiru Mutual Provident Society Ltd.

**ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP:**

**“Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and Participation”**

New Delhi, India Habitat Centre, May 29-31, 2006

ABSTRACT

- There is growing evidence that India has taken the lead in developing innovative health demand-side financing mechanisms
- Since 2004, ILO has been active in documenting some of these initiatives that could contribute to the extension of health protection to all
- Following a global study on public-private partnership initiatives four case studies on innovative health financing mechanisms were carried out
- As a follow-up, ILO/STEP provided regular technical support to Yeshasvini, the largest health micro-insurance scheme operating in Asia
- Case studies and in-dept analysis of other health micro- insurance schemes were also conducted
- New case studies looked at maternity voucher schemes in West Bengal and Gujarat, at a broad health protection scheme for school children in Andhra Pradesh and at the linkage with banking institutions in West Bengal
- ILO is also supporting the new health insurance scheme targeting the BPL population in the state of Jharkand...

SESSION 10

**THE NEED FOR INFORMATION /
EXPERIENCE SHARING TOOLS**

TECHNICAL PAPER NO 10.3

**EXTENSION OF SOCIAL
PROTECTION IN INDIA:**

**ILO/STEP STUDIES
RELATED TO
DEMANDSIDE HEALTH
FINANCING**

INTRODUCTION

While facing a still huge social protection gap, India has already clearly taken the lead in experimenting with various innovative strategies and mechanisms aiming to provide various health protection benefits to excluded groups. This far-reaching extension experience could also benefit to other countries facing a similar health exclusion phenomenon.

Adopting this broader perspective, ILO has already engaged in a series of studies related to the various demand-side financing models developed in India in the health sector. These studies will be widely disseminated in order to encourage and facilitate their adoption and replication in other countries to move forward their own social protection extension agenda.

2. STUDIES



The Government of India has clearly stated its support to new initiatives aiming “to forge public-private partnerships in the widest range of activities in order to leverage private sector resources and skills for the development of the nation”. In recent years, this policy resulted in an increasing number of new experiences based on this principle aiming at extending social protection to the weaker sections of the population. These experiences have already been recognized as covering a wide range of social protection requirements, using various partnership arrangements at all levels (national, state, local). This diversity of experiences offered good grounds for documenting the knowledge acquired and lessons learnt with regard to “public-private partnership initiatives” (PPPI) in the health sector.

The main objective of the study will be to document and to assess the impact of the various public-private partnership initiatives contributing to the extension of social protection to the poor and excluded groups of the population. While reviewing the existing partnership initiatives, the study will categorize those in main categories, provide guidelines for the selection of case studies and carry-out in-depth analysis of the most interesting experiences. Based on a broad review of the different experiences and major findings of the case studies, the study will highlight the best practices and recommend the efficient measures that can be applied for new partnership initiatives aiming to extend social protection benefits to the various excluded groups.



In 2005, a broad new movement emerged with the initiatives taken by various states aiming to extend social protection in health to wide segments of the unorganized sector labour force. This new generation of health insurance schemes promoted at the state level generally relies on an important subsidy component. While many states are still drawing their plans, some of these initiatives have already succeeded to cover important segments of the population. The design and implementation features of these various initiatives as well as their development perspectives deserved to be thoroughly analysed in the light of their possible contribution to the overall social protection extension effort.

The main objective of the study will be to carry out a comparative analysis on the new health insurance schemes promoted by some 10 states in India. The analysis will provide detailed information on the various aspects related to their design and implementation process. Among the main aspects to be examined, the financing mechanisms, the partnership arrangements and the long-term sustainability conditions will be of major importance. The analysis will assess the relevance, efficiency and development potential of these various schemes and highlight the best practices that could facilitate the further development of state-level health insurance initiatives.



Over the last years, micro-insurance schemes have proliferated all over India with most initiatives choosing to tie up with insurance companies. While a wide diversity of insurance products has been made available to the poor, health insurance is still found lagging behind in terms of the number of schemes and scope of benefits provided, resulting in the fact that access to quality health care remains a distant dream for many. In order to foster new initiatives in that field, it was found necessary to carry out first a comparative in-depth analysis of various health micro-insurance schemes aiming not only at identifying the best methodologies and practices but also at recognizing the existing gaps in answering the health protection needs of the disadvantaged groups.

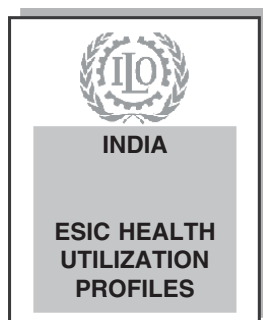
The study aims at analysing the organization, functioning, performances and development perspectives of 12 health micro-insurance schemes carefully selected in order to represent the various methodologies that can be used to provide health insurance benefits to the poor. The study will identify the best practices related to their design and implementation as well as the conditions allowing for their successful development/scaling up or replication in other locations thus encouraging new interventions in that field. The study will analyse the current contribution of these products to the overall goals of providing comprehensive, equitable and quality health care services to the poor. It will further recommend the best ways to link up these local schemes with the new public health insurance initiatives and look at the broader policy issues conditioning their long-term development.



In the wake of 2004's elections, the new Government took a strong stand towards extending health protection benefits to the presently excluded groups of the population. This commitment not only resulted in various initiatives taken at the national level but also inspired a new momentum observed at the state as well as at the local level. These new initiatives were found increasingly relying on the promotion of new partnerships with the multiple organizations involved in micro-insurance activities at the grassroots level. This recent trend deserved to be fully documented in order to further promote the linkage between local and national initiatives in the health sector.

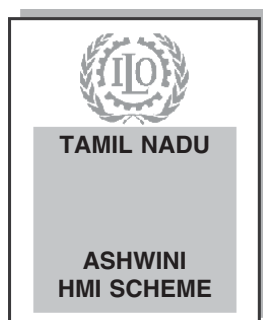
The main objective of the study will be to document the process adopted by the new Government to foster some new developments

in the field of health protection. The study will also demonstrate the effect of policy decisions on encouraging new extension initiatives at various levels



While health micro-insurance schemes may apply very different development models, they are generally found facing the following similar constraints: high claims incidence ratio, pervasive adverse selection, high drop-out rate and evidence of over-prescription. Health micro-insurance being fairly recent, there is still no long-term perspective providing some information and guidance on the various mechanisms that can be used to overcome these constraints. Hence the need to look at ESIS experience which also caters for the social protection needs of the lower-income group of the population.

The main objective of the study will be to analyse the health service utilization profile under the Employees' State Insurance Scheme in select states (Tamil Nadu, West Bengal, Karnataka and Gujarat), to highlight the trends over the last few years and to compare all information and data with the current specific experiences developed by some health micro-insurance schemes operating in the same states.



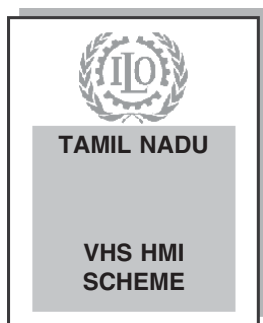
Ashwini, an NGO based in Gudalur has designed and set up in 1992 a health insurance scheme providing a comprehensive coverage to the Adivasi people. The scheme relies on a three-tier healthcare delivery system consisting of village health workers, regional health sub-centres and a central integrated hospital. Using a participatory approach, the scheme succeeded to convince the local population to adhere to the very new concept of health insurance and to stabilize the membership while the scheme evolved over time towards achieving sustainability.

The objective of the study will be to fully document this community-based experience applying a model where the insurance mechanism is only one component of a wider health development programme.



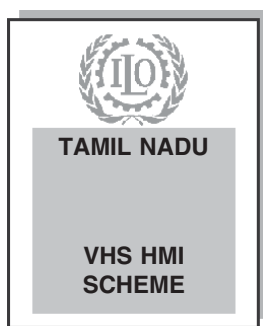
Karuna Trust launched in 2002 in Karnataka an innovative public-private partnership initiative aimed at improving the access of poor and low-income people to public medical care through an insurance scheme. Three public and three private agencies were involved in this health insurance scheme which was later revised, fine-tuned and extended to other regions.

As part of a series looking at public-private partnership initiatives contributing to the extension of social protection to the excluded groups, the objective of the case study will be to fully document this experience and to analyse the process through which the partnership arrangements were designed, organized and implemented.



Initiated in the 90s in Chennai, Tamil Nadu, to take up the challenge of improving the health care of the poorest segments of the population, the ONG Voluntary Health Services succeeded to develop an efficient partnership with both the Central and State government. VHS conceptualised and nurtured a new model comprising of (a) a system of mini-health centres based on community participation and (b) a referral hospital providing a wide range of health services, both relying on a form of health insurance.

As part of a series looking at public-private partnership initiatives contributing to the extension of social protection to the excluded groups, the objective of the case study will be to fully document this experience and to analyse the process through which the partnership arrangements were designed, organized and implemented. The study will also interview representatives of the various partner organizations, highlight the lessons learned and explore the possibility of replicating this partnership experience.



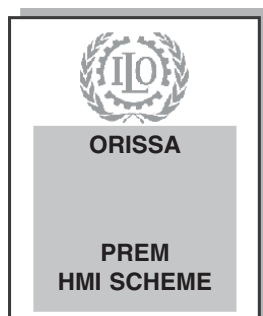
The Vivekananda Foundation, which is a coalition of nine like-minded voluntary organisations operating in Karnataka, was willing to take over the management of several PHCs, in order to address the health needs of the population, and to set up a model of efficiency that could be replicated. The public-private partnership which was initiated in 1996 aimed at improving the access of poor people to quality health care services, through an arrangement transferring the management responsibility of a public primary health facility, located in a poor tribal region, to the NGO.

As part of a series looking at public-private partnership initiatives contributing to the extension of social protection to the excluded groups, the objective of the case study will be to fully document this experience and to analyse the process through which the partnership arrangements were designed, organized and implemented. The study will also interview representatives of the various partner organizations, highlight the lessons learned and explore the possibility of replicating this partnership experience.



Initiated in early 2003 in the state of Karnataka and targeting the poor farmers regrouped in co-operative societies, the Yeshasvini micro-insurance scheme was designed to cover only the most expensive segment of the health expenditures spectrum: the surgical interventions. In its first year of operation, the scheme already succeeded to become the largest health micro-insurance scheme in the world with some 1.6 million insured. The scheme also provides today one of the best examples of efficient public-private partnership in health between a state government, rural co-operatives, private and public health providers and a Third Party Administrator (TPA). From the perspective of providing quality health care services to poor segments of the population, the scheme was highly successful. From a financial perspective however the scheme shows no sign of having reached some level of stability and is affected by a strong adverse selection effect resulting in a challenging upwards trend payout.

The objective of the in-depth analysis will be to provide a comprehensive assessment of the evolution and present situation of the scheme, and determine the efficient answer strategies that should be applied to strengthen the partnership mechanisms and ensure the scheme's viability and long-term sustainability.



People' Rural Education Movement, an NGO based in Bherampur is involved since 1980 in many local development support activities to the benefit of Adivasi and Scheduled Caste. Embedded in a wider health promotion programme, PREM initiated in 2002 a health insurance scheme which succeeded to cover some 108,000 people. This in-house scheme utilises the public health facilities and has tied up with a wide network of Village Medicine Depots run by trained volunteers in order to ensure a doorsteps availability of essential medicines. Over the last three years, the scheme has proved to be most effective in ensuring a better ownership feeling amongst its members. This scheme has shown noteworthy progress in all its endeavours and potential for growth.

The objective of the study will be to fully document this community-based experience applying a model where the insurance mechanism is only one component of a wider health development programme.



There is growing evidence in India that vulnerable groups have poor access to public health services particularly maternal health services due to both supply side and demand side barriers. The poor performance of public sector using supply side financing has led to increasing interest in demand side financing as a possible health financing option to influence the demand for health services as well as to increase the access of the poor to health services. With this new focus, the introduction of health vouchers covering the whole sequence of maternity-related health care services has been seen as an innovative mechanism that could contribute to a significant improvement of the health status of poor women. Since 1999, while partnering with both public and private health facilities, the urban branch of CINI (Children in Need Institute) has developed this innovative approach to provide maternity protection to poor women living in the slums of Kolkata.

The objective of the case study will be to fully document this health maternity voucher scheme. The study will analyze the various aspects related to the organization and functioning of this experience at its various development stages as well as highlight its present impact and performance. In a broader perspective, the study will also identify the possibilities and conditions for the replication of the scheme or for its promotion through other demand-side financing mechanisms such as health **micro-insurance schemes**.

The micro-insurance scheme called VimoSEWA, having tied up with both public and private insurance companies, proposes a composite insurance product, covering simultaneously: life, accidental death,



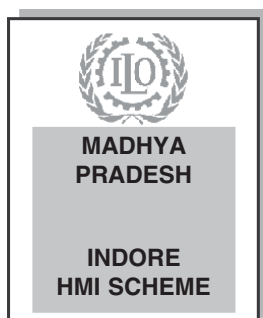
assets, health care and maternity benefits. Over the last five years, VimoSEWA succeeded to extend its membership from 35.000 to 174.000 people. Linking with SEWA Bank, it also devised an easy payment mechanism which allowed for the premium to be paid out of interests earned by the policyholders on their fixed deposits. The scheme plans to evolve into an independent cooperative insurance company answering the protection needs of the poor.

The objective of the in-depth analysis will be to provide a comprehensive assessment of the evolution and present situation of the scheme, and determine the efficient answer strategies that should be applied to ensure the scheme's viability and long-term sustainability.



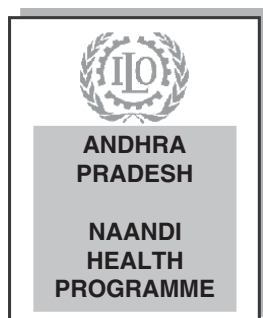
The Government of Jharkhand considers health to be central to sustainable development. Recognizing the improvement of the health status of the disadvantaged groups of the population as a top priority it has pledged to "provide quality health care services to the last person of the last household of the last village". To fulfil this promise, the government has formulated a comprehensive and integrated health policy based on a new social development vision that relied on the active involvement of all segments of the population and on the development of active partnerships with the civil society and the private sector. The health directions adopted by the government also included the promotion of a new social protection scheme aiming at improving the access to quality health services for all. In a first phase, the scheme targeted the entire Below Poverty Line group which accounts for some 54% of the whole population.

The objective of the study is to fully document the design phase of the new social protection extension initiative called "Sarv Awasthya Mission" taken by the government of Jharkhand. While looking at the whole process through which the scheme came into existence, the study will highlight the human-rights approach, the social perspective and the consultative mechanisms that were applied which resulted in various innovative features brought to the final version of the scheme. The study will also provide detailed information on the various institutional and partnership arrangements upon which the successful implementation of the scheme will rely in order to encourage the further replication of this model in other states.



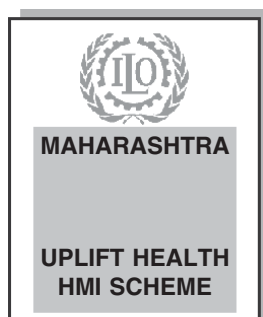
In 2003, the Municipal Corporation of Indore in Madhya Pradesh decided to develop a new insurance plan to provide a comprehensive hospitalization coverage to its senior citizens. The leading public insurance company, New India decided to take up the challenge and appointed a Third Party Administrator, MDIndia Healthcare Services to the task of designing and implementing a scheme that targeted the highly risk-prone population group aged between 60-80 years. The scheme proved quite successful in the last two years, extending its benefits to some 49,000 people and showing impressive performance indicators, clearly linked to a close partnership developed with a network of private health providers.

The objective of the in-depth analysis will be to provide a comprehensive assessment of the evolution and present situation of the scheme, and determine the efficient answer strategies that should be applied to ensure the scheme's viability and long-term sustainability. In a broader perspective, the study will also identify the possibilities and conditions for the replication of the scheme in other municipalities in Madhya Pradesh as well as in other states.



Over the last two years, Naandi Foundation has partnered with the Ministry of Health & Family Welfare, Government of Andhra Pradesh for the development of a pilot scheme providing a comprehensive medical cover to young children enlisted in Government primary schools. The scheme has set up out-patient clinics in key schools as well as a base hospital with special wards including intensive care wings for in-patient care. Having already provided promotive, preventive and curative healthcare services to 49,000 children in Hyderabad, Naandi has recently initiated a similar scheme in Udaipur with the active support of Government of Rajasthan.

As part of a series looking at public-private partnership initiatives contributing to the extension of social protection to the excluded groups, the objective of the case study will be to fully document this experience and to analyse the process through which the partnership arrangements were designed, organized and implemented. The study will also assess the financing issues, providing evidence of the full costs to be borne for the provision of these comprehensive services in order to facilitate a far-fledged replication of this health protection model in other states.



Uplift Health adopted the mutual approach to initiate its health micro-insurance scheme in Pune in 2003. Having succeeded to enrol some 16,000 people, the scheme is now fully owned and managed by its community-based member organizations. Uplift Health developed sophisticated tools including a state of the art management information system that can be used by other schemes sharing the same mutual principles and vision, and is now extending its reach to the whole state and beyond.

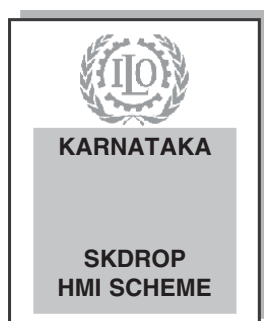
The objective of the study will be to fully document this mutual society experience, to review the various tools that have been made available, and to highlight the various services that the scheme may provide to others.



Having initiated since 2003 a health micro-insurance scheme covering now some 16,000 people, Healing Field Foundation evolved towards playing a wider role and soon emerged as a new key actor in the micro-insurance sub-sector. Healing Field adopted broader objectives aiming to improve accessibility, affordability and quality of healthcare services for BPL families while developing into a model of a viable and sustainable support agency for all stakeholders.

The objective of the study will be to fully document the process through which this health micro-insurance scheme was designed and

implemented, to review the various tools that have already been produced and to highlight the various technical assistance and training services that this new type of intermediary organization could provide to other health insurance schemes in the near future.



The health micro-insurance scheme initiated in 2003 in Karnataka by Sri Kshetya Dharamsthala Rural Development Project relied on a very widespread community-based movement already involved in micro-finance activities supported by a strong banking linkage. Having tied up with ICICI Lombard in year II, the scheme succeeded to increase its membership to some 400,000 in year III, up from 196,000 in the previous year.

The objective of the study will be to fully document this community-based experience, to highlight the conditions having allowed it to become one of the largest health insurance schemes operating in India and to assess the possibility of having the specific operational mechanisms applied in this scheme, being replicated in other locations.

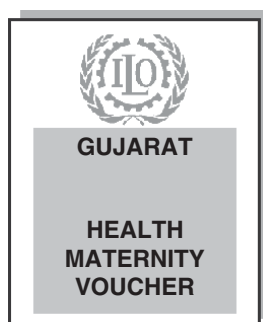
In December 2004, a new kind of health micro-insurance scheme emerged in Karnataka with a private-private partnership between an insurance company and health providers being extended to a pharmaceutical company which provided some essential drugs at rock-bottom prices to the members of the scheme. Another distinctive feature of this scheme that enrolled some 60,000 people was to cover both OPD and hospitalization services, the latter using the same provider network established for the Yeshasvini scheme.

The objective of the case will be to fully document this new experience which could evolve towards a model being replicated in other states under similar partnership arrangements with other pharmaceutical companies.



CARE is running one of the largest micro-finance programmes in the country, targeting women self-help groups scattered in remote areas. Most of these groups have already tied up with banking institutions which made available additional financing resources. In West Bengal, these local community-based organizations have already succeeded to organize themselves in second-tier federations that have added to their classic financial services such as savings and loans, new health insurance services. The regular savings organized through the local groups may be utilized for the payment of the insurance premium. Given the fast proliferation of these organizations across the country, some benchmarks should be determined in relation to the use of savings to prepare and respond to health risks affecting these disadvantaged groups of the population.

The objective of the study will be to look at how micro-savings, organized along the methodology currently being used for the promotion of most self-help groups, and complementing loan activities can play an active role in contributing to the reduction of the health vulnerability affecting poor women and their families.



The Ministry of Health and Family Welfare, Government of India, recently launched in 10 states a new pilot scheme aiming at providing maternity protection to Below Poverty Line women through a system of vouchers. At about the same time, the ministry of Health & Family Welfare, Government of Gujarat decided to initiate its own maternity voucher scheme which already succeeded to cover some 11,000 safe deliveries in a period of 5 months.

The objective of the study will be to fully document the maternity voucher experience launched in Gujarat and to compare the main features of this scheme with the one designed at the central level. Looking at the broader and still grim maternity protection situation in India, the study will also analyze how maternity voucher schemes could effectively contribute to the improvement of some essential health care indicators and how the various on-going experiences could be linked to other demand-side financing mechanisms such as health micro-insurance schemes which are now proliferating all across India.

**ILO/STEP – CHSSS - PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP:**

**“Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and Participation”**

New Delhi, India Habitat Centre, May 29-31, 2006

ABSTRACT

- The Government of Jharkhand has recently taken a new social protection initiative that could pave the way towards a broader system that could encompass the whole population
- In a first phase the health insurance scheme targets the whole BPL population estimated to be 14 million strong (50% of the population)
- The scheme relies on an active partnership with the private sector
- Major industrial groups operating in Jharkhand will contribute to the financing and management of the scheme (private-public partnership)
- The scheme will tie up with private health providers and encourage them to invest in remote areas
- The scheme will be operated through a IMO (Insurance Management Organization)
- It will promote the active participation of the population
- It will provide a comprehensive coverage and will be the first all-inclusive health insurance scheme
- It will progressively evolve into a universal scheme...

SESSION 11

MOVING FORWARD...

TECHNICAL PAPER NO 11.1

**EXTENSION OF SOCIAL
PROTECTION IN INDIA:**

**JHARKHAND:
AN EXPERIMENT ...**

INTRODUCTION

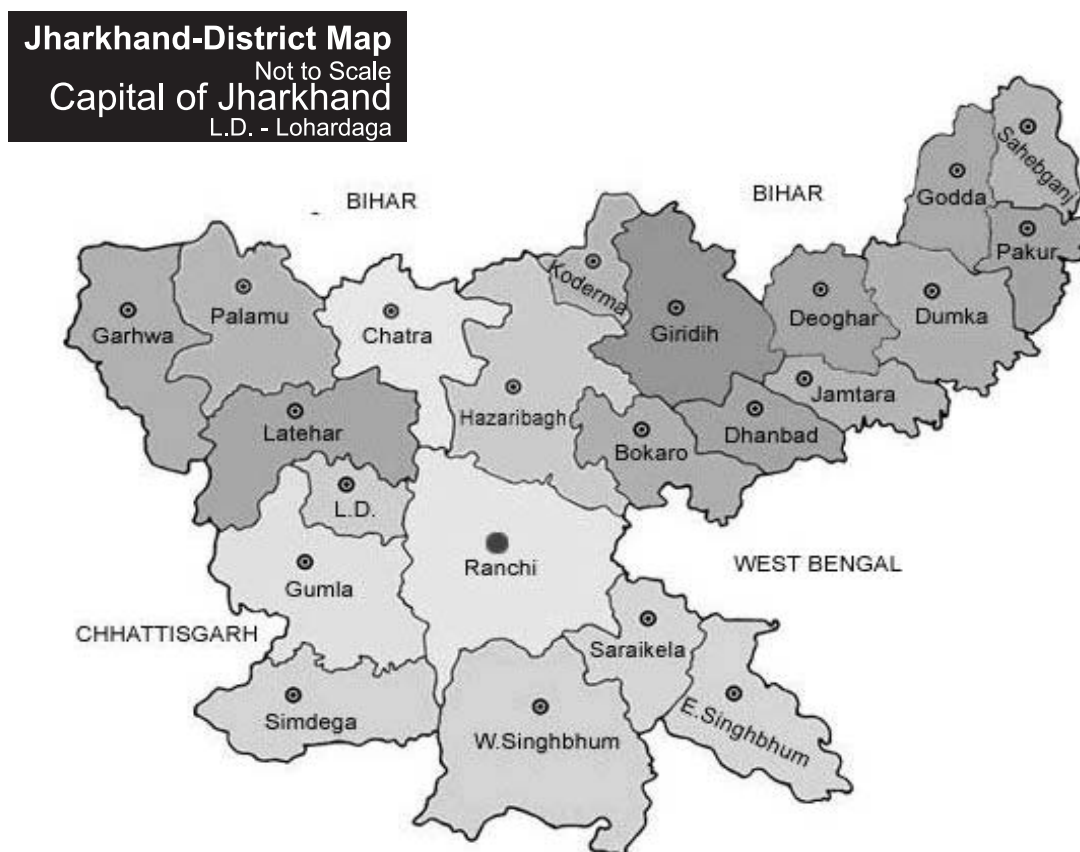
In August 2005, a delegation from Jharkhand contacted the International Labour Organization and requested its technical support for the design and setting up of a new health insurance schemes that was planned to cover the whole Below Poverty Line population of the state. Upon receipt of a first concept paper prepared by the Ministry of Health & Family Welfare and the Health Society of Jharkhand, ILO carried out a first preliminary assessment mission in Jharkhand in September 2005.

As a result of the first interaction with all stakeholders concerned, new orientations were adopted as regards the design of the health insurance scheme and further ILO technical assistance was planned. Follow-up activities allowed for the progressive shaping up of the scheme's implementation process and operational modalities. As compared to other recent state-level initiatives, the integrated health care system to be developed in Jharkhand clearly adopted distinctive innovative features allowing it to pave the way towards a broader programme that could ultimately encompass the whole population. As it stands today, the Jharkhand's experience may already serve as a good example for replication in other states looking at ways to address the health insurance needs of the excluded groups.

The present document provides brief information on the new Jharkhand health insurance model while highlighting the consultative process that was adopted to bring it into shape.

1. BACKGROUND

Carved out of Bihar, the state of Jharkhand came into existence in November 2000. Its population has been estimated to be 26,9 million, predominantly rural (78%). Jharkhand is one of the poorest and most backward states in the country with low per capita income (half of the



national average), some 54% of the population living below the poverty line and with 28% of the population belonging to scheduled tribes. Literacy rate is also very low, particularly among women (40%). The state consists of 22 districts, 33 sub-divisions and 211 blocks, distributed over an area of 28,000 square km.

Health indicators in Jharkhand are among the worst in the country. Infant mortality is high: of every 1000 live birth, 71 children die before they reach year 1. Maternal mortality rate is also high: 504 per 10,000 live births (more than the national average) 75% of the total deliveries are made without proper medical assistance. Nearly 75% of women suffer from anemia and 40% of women are malnourished More than 20% of children suffer acute diarrhea and acute respiratory infections Less than 10% of children of all age are fully immunized. About 85% of women have not heard about HIV/AIDS

The state is still suffering from a very large health infrastructure deficiency. The following table shows the Importance of the existing gap.

	Needed	Existing	Gap	% of Gap
Community Health Centers	231	31	200	86%
Primary Health Centers	1,387	533	854	62%
Health Sub-Centers	5,548	3,495	2,053	63%

At the same time, Jharkhand has some of the richest deposits of iron, coal and manganese in the world, has 40% of the natural resources of the country, and is one of the most industrialized regions.

2. HEALTH: A STATE PRIORITY

Jharkhand's government has taken a strong stand to improve the overall health situation and has already taken an impressive set of measures according to this development priority. A state health policy, a population and reproductive and child health policy and a drug policy have been recently elaborated and adopted. The Jharkhand Health Society and the Jharkhand State AIDS Control Society have been established to help the Ministry of Health and Family Welfare to address health issues. In addition, the Government of Jharkhand recently took the following initiatives:

- Recruitment on contract basis of 2,400 medical officers and 2,200 paramedical
- Organization of a first catch-up round
- Setting up of Village Health Committees (VHC)
- Promotion of the concept of Village Health Workers (Sahiyya)
- Mapping exercise of all local NGOs involved in health activities and charity/faith-based hospitals operating in the state
- Setting up of a State Fund for Medical Assistance for Below Poverty Line Population with a yearly allocation of 1.9 million \$ (2002)
- Doubling of health budget in order to bridge the infrastructure gap (2004-2005)

“The mission of Ministry of Health and Family Welfare, Government of Jharkhand, is to provide quality healthcare services to the last person of the last household of the last village in the state and thus ensuring a Healthy Jharkhand and a Happy Jharkhand”

P.P. Sharma, Chief Secretary



3. THE ANSWER STRATEGY: “SARV SWASTHYA MISSION”

As an appropriate strategy to the present situation, government of Jharkhand developed the “Sarv Swasthya Mission” broad concept which aimed at providing quality health care services at all levels, with effective referral mechanism. While organizing a health insurance coverage for the poor marginalized population, the Mission was also conceived as developing a new vehicle to enhance public and private sector investment in remote and left out areas of the state. The overall objectives of the Mission were set as follows:

- To improve access to health care among the poor
- To protect the poor from indebtedness and impoverishment resulting from medical expenditures by spreading the health shocks among the community
- To access health care with dignity by community
- To encourage health-seeking behaviour by offering comprehensive health care with minimal co-payment at the time of the services
- To ensure availability of affordable quality health care services
- To enhance the feeling of ownership of the health program among all participants/ stakeholders, including the community
- To enhance the private sector investment for delivery of primary health care services in the state

While adopting these objectives, it was clear from the outset that the Mission intended to rely on the following major principles:

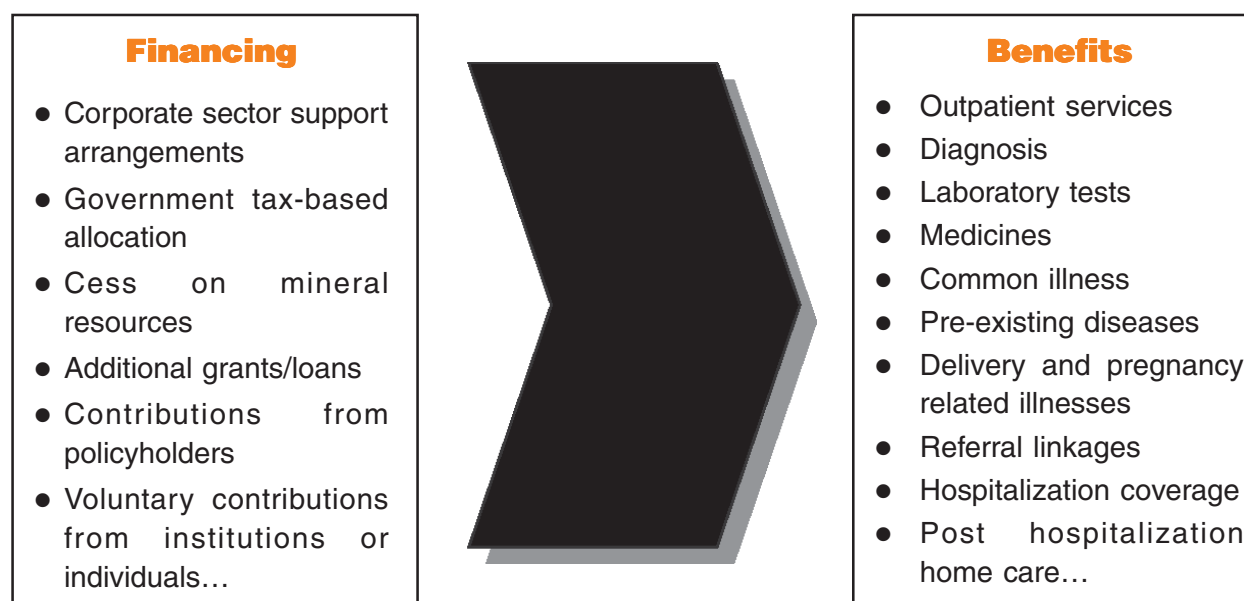
PUBLIC-PRIVATE PARTNERSHIP

EMPOWERMENT

COMPREHENSIVE HEALTH PROGRAMME

SUBSIDIZED INSURANCE COMPONENT

One of the innovative features of the planned scheme was to involve on a long-term basis all industrial groups in the financing of the insurance component under the Corporate Social Responsibility (CSR) principle. In August 2005, the Government of Jharkhand signed an agreement with TATA industrial Group whereby TATA will allocate for the next 30 years a yearly contribution of Rs. 250 million (5.6 million US) to the health insurance scheme. The Government plans to conclude similar agreements with all other industrial groups operating in the state and also to levy a cess on some mineral products to further increase the necessary resources.

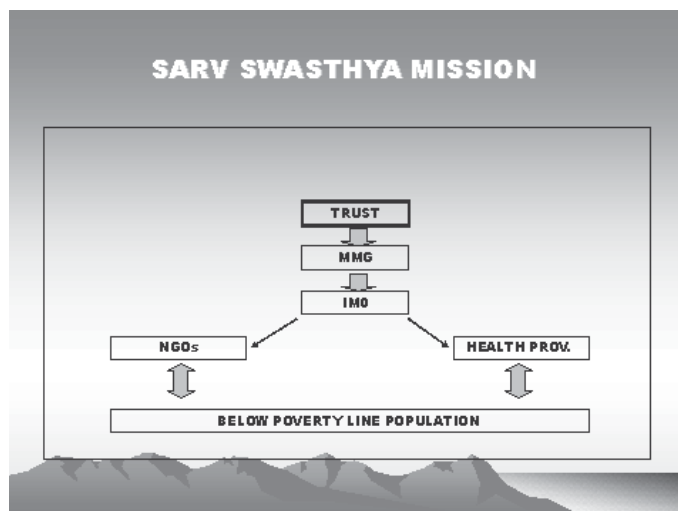


4. EVOLUTION OF THE INSURANCE SCHEME

The design of the scheme evolved in accordance with the broad consultative process that was set up. In addition to the various meeting organized with Ministry of Health and Jharkhand Health Society, the consultations were extended to the following organizations:

- | | |
|--|-------------------------------|
| • Major public and private sector stakeholders | Round Table (22.09) |
| • Insurance companies | Information review (20.10.05) |
| • Third Party Administrators | Round Table (02.12.05) |

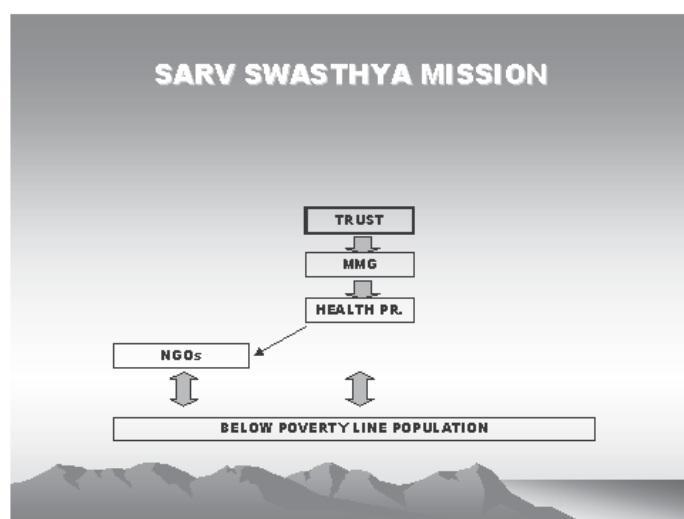
As a result, the original design of the scheme progressively underwent the following major changes:



August 2005

« **Partner-Agent Model** »

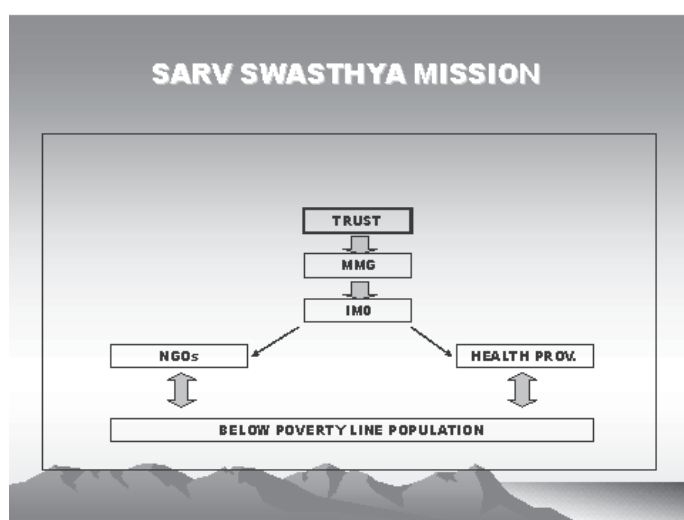
- ❑ The Mission Management Group ties up with an insurance company
- ❑ The intervention of a Third Party Administrator contracted by the insurance company allows for the provision of cashless services to the BPL population...



September 2005
(before first mission)

« **Full Provider Model** »

- ❑ The Mission Management Group ties up with the various health providers willing to play a role in the insurance scheme
- ❑ Using a capitation method, these health providers cover all members in their catchment area...



September 2005
(after first mission)

« **Insurance Management Organization Model** »

- ❑ The Mission Management Group contracts the services of a specialized agency
- ❑ The agency takes over all responsibilities related to the administration of the insurance component...

At the same time, the consultative process resulted in the adoption of the following new principles applying to the operational modalities of the insurance scheme:

AUTOMATIC ENROLMENT

In order to avoid adverse selection, the scheme has to rely on a automatic enrolment mechanism (the first in India)

ALL-INCLUSIVE COVERAGE

The scheme will also cover the groups at risk and people living with HIV/AIDS (the first in India)

TOWARDS UNIVERSAL COVERAGE...

The scheme will progressively be extended to the whole population of the state (the first in India)

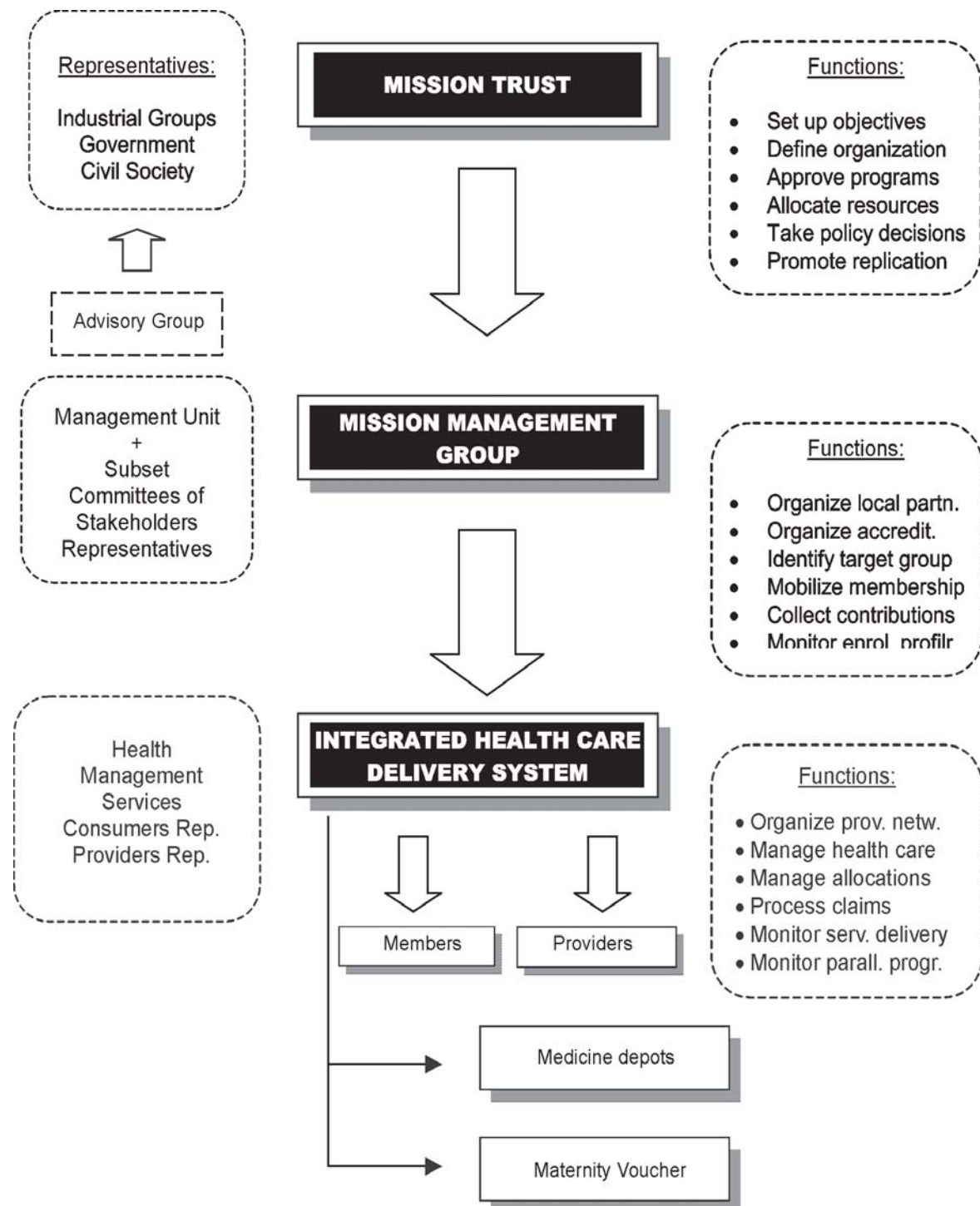
The following Third Party Administrators (out of a list of 25 fully licensed TPAs) responded to the Ministry of Health invitation and participated in the round table organized in early December.

N0	Designation	Lic. N0	Address	Public Partners	Private Partners
1	Parekh Health Management Ltd	002	Mumbai		Cholomandalam ICICI Lombard Royal Sundaram
2	MD India Healthcare Services Ltd	005	Pune	National Insurance Oriental Insurance New India Insur. United India Insur.	Ifco Tokio
3	Heritage Health Services Ltd	008	Kolkata	National Insurance Oriental Insurance	
4	Universal Medi-Aid Services Ltd	009	New Delhi	National Insurance New India Insur.	
5	Family Health Plan Ltd	013	Hyderabad	United India Insur. National Insurance New India Insur.	Reliance General ICICI Lombard
6	Raksha Ltd	015	Haryana	National Insurance New India Insur. Oriental Insurance	
7	TTK Healthcare Services Ltd	016	Bangalore	National Insurance New India Insur. Oriental Insurance	Reliance General ICICI Lombard
8	Med Save Health Care Ltd	019	New Delhi	New India Insur. United India Insur. National Insurance Oriental Insurance	
9	Genins India Ltd.	020	Noida	National Insurance Oriental Insurance	
10	Bhaichand Amoluk Insurance Services Ltd.	022	Mumbai	New India Insur.	

All participants expressed an interest for the unique configuration of the planned scheme and confirmed their willingness to be associated in its implementation. At the same time, the technical discussions in various groups resulted in the adoption of further refinements to the overall design of the proposed scheme.

SARV SWASTHYA MISSION TOWARDS A SOCIAL HEALTH INSURANCE SYSTEM...

PHASE I TARGET: 14 MILLION PEOPLE... (WHOLE BPL POPULATION)



5. NEXT STEPS...

The following activities will have to be carried out in the coming months:

Date	Activity	ILO Support
1 st Quarter 2006	Round Table with Health Providers	SRO
	Elaboration of Questionnaire: Health Provider Survey	SRO
	Elaboration of Questionnaire: Household Survey	SRO
	Utilization of Questionnaire among Health Providers	SRO
	Finalization of the Questionnaires and Launching of Surveys	SRO
	Drafting of TOR: Study: Health Facilities/Utilization of Services	SRO
	Drafting of TOR: Study: Documentation of the Design Phase	SRO
	Drafting of Workshop Programme: Health Insurance Mechanisms	SRO
	Round Table with Industrial Groups	-
	Establishment and First Meeting of the Trust	-
2 nd quarter 2006	Study: Health Facilities/Utilization of services (national consultant)	SRO
	Study: Documentation of the Design Phase (national consultant)	SRO
	Round Table with NGOs/Support agencies	SRO
	Technical workshop: Health Insurance Mechanisms (MoH&FW staff)	SRO
	First ILO Technical Assistance Mission	HQ
	Second Round Table with Selected TPAs	SRO-HQ

Reference Materials

1. Health Policy - Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2002, 25 pages
2. Population and Reproductive and Child Health Policy - Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2002, 15 pages
3. Drug Policy - Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2002, 8 pages
4. Essential Drugs List – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2004, 76 pages
5. Drug Formulary – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2004, 381 pages
6. Standard Treatment Guidelines for Medical Officers – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2004, 259 pages
7. Concept, Assessment and Evaluation: The First “Catch Up Round, 1st to 31st July, 2004 – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2004, 238 pages + Annexes
8. NGOs in Jharkhand’s Health Sector – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2004, 264 pages
9. State Project Implementation Plan (PIP) 2005-2010: Reproductive and Child Health II – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2005, 230 pages + Annexes
10. State Fund for Medical Assistance for Below Poverty Line Population: 2004 Report – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2005, 406 pages
11. Operational Guidelines for Village Health Committees (VHC) and Sahiyya – Ministry of Health, Family Welfare, Medical Education & Research, Government of Jharkhand, 2005, 43 pages
12. Sarv Swasthya Mission: Health Insurance in Jharkhand: A Concept Paper (Version 1) – Health Society of Jharkhand, August 2005, 17 pages
13. Sarv Swasthya Mission: Health Insurance in Jharkhand: A concept Paper (Version II) – Health Society of Jharkhand, October 2005, 18 pages

4.2 PWP Presentations

Session 1: Health Micro-Insurance in India: An Overview of the Present Situation and Development Perspectives

- PWP 1.1 How to Answer the Health Insurance Needs of the Poor?
- PWP 1.2 Health Micro-Insurance in India
- PWP 1.3 Development of HMI Sub-Sector: The Challenges Ahead

Session 2: Health Micro-Insurance for the Poor: Learning from Experience

- PWP 2.1 ACCORD–AMS – Ashwini Community Health Insurance Scheme – Tamil Nadu
- PWP 2.2 DHAN Foundation Community Health Insurance Programme – Tamil Nadu
- PWP 2.3 Healing Fields Foundation – Andhra Pradesh
- PWP 2.4 Self-Help Promotion for Health and Rural Development (SHEPERD) – Tamil Nadu
- PWP 2.5 Uplift Health – Maharashtra
- PWP 2.6 Asha Kiran Prepaid Rural Health Care Scheme: Experience with the Bonda Tribe – Orissa

Session 3: Setting Up of a Health Micro-Insurance Scheme: Looking at the Process and Conditions of Success

- PWP 3.1 Setting up a Health Micro-Insurance Scheme: Looking at the Process and Conditions of Success

Session 4: Panel: Sharing PLAN's Experiences in Health Financing

- PWP 4.1 ASM Primary Health Care Financing Scheme
- PWP 4.2 CYSD Community Health Financing Programme
- PWP 4.3 GNK
- PWP 4.4 Myrada Swasthya Suraksha Yojane Health Insurance
- PWP 4.5 People's Rural Health Promotion Scheme
- PWP 4.6 RNCH Samskar
- PWP 4.7 SBMA People Health Security Fund
- PWP 4.8 Seva Mandir's Experience in Health Financing

Session 9: The Need for Management Information Tools

- PWP 9.1 Uplift Health Tools
- PWP 9.2 Healing Fields Foundation Tools

Session 10: The Need for Information / Experience Sharing Tools

- PWP 10.1 Asia Micro-Insurance Network (AMIN)
- PWP 10.2 Demand-Side Financing: Maternity Health Voucher Scheme
- PWP 10.3 National Commission for Enterprises in the Unorganized Sector: The Social Security Report
- PWP 10.4 Towards a National Health Insurance Strategy: Need for More Evidence Based Knowledge

Session 12: Interaction with Ministry of Health & Family Welfare

- PWP 12.1 Addressing the Social Justice Issue

**SESSION
1**

**PWP
1.1**



**ILO/STEP –CHSSS – PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP**

**« ADDRESSING THE HEALTH INSURANCE NEEDS OF THE POOR:
BUILDING UP TOOLS FOR AWARENESS, EDUCATION AND
PARTICIPATION »**
New Delhi, 29 -31 May, 2006

**HOW TO ANSWER THE HEALTH
INSURANCE NEEDS OF THE POOR?**

INTERNATIONAL LABOUR ORGANIZATION (ILO)
STRATEGIES AND TOOLS AGAINST SOCIAL
EXCLUSION AND POVERTY (STEP)



**MICRO-INSURANCE:
A RIGHTS-BASED APPROACH ...**

- **SOCIAL PROTECTION IS A FUNDAMENTAL HUMAN RIGHT (1948)**
- **EACH GOVERNMENT SHOULD PROVIDE SOCIAL PROTECTION TO EACH AND EVERY CITIZEN**
- **UNDER ILO'S DEFINITION NINE MAJOR BENEFITS SHOULD BE COVERED BY SOCIAL PROTECTION SYSTEMS (MEDICAL CARE, SICKNESS BENEFITS, UNEMPLOYMENT BENEFITS, OLD AGE BENEFITS, EMPLOYMENT INJURY BENEFITS, FAMILY BENEFITS, MATERNITY BENEFITS, INVALIDITY BENEFITS, SURVIVOR 'S BENEFITS)**
- **IN INDIA TODAY, ONLY 10% OF THE POPULATION ENJOYS SOME LEVEL OF SOCIAL PROTECTION BENEFITS**
- **WHILE 370 MILLION INFORMAL ECONOMY WORKERS CONTRIBUTE TO SOME 63% OF THE GDP, MOST OF THEM REMAIN EXCLUDED FROM SOCIAL PROTECTION SYSTEMS – THEY DO NOT BENEFIT FROM THE WEALTH THEY CONTRIBUTED TO GENERATE**
- **MICRO-INSURANCE IS ONE OF THE INSTRUMENTS THAT CAN BE USED TO COMBAT SOCIAL INJUSTICE**



**INDIA: A UNIQUE MICRO-INSURANCE
EXPERIENCE...**

- **THE BIGGEST CHALLENGE: HOW TO EXTEND SOCIAL PROTECTION BENEFITS TO ALL?**
- **A WIDER DIVERSITY OF RISKS (WEATHER, ASSETS, CROP ...)**
- **A WIDER DIVERSITY OF ACTORS (INS. COs, BANCASSURANCE ...)**
- **A WIDER DIVERSITY OF INNOVATIONS (RISK PACKAGES) AND OPERATIONAL MECHANISMS**
- **SOME OF THE LARGEST MICRO-INSURANCE SCHEMES IN THE WORLD**
- **SOME MICRO-INSURANCE SCHEMES HAVE ALREADY REACHED AN IMPORTANT DEVELOPMENT LEVEL (SEWA, YESHASVINI ...)**
- **VARIOUS LINKAGE EXPERIENCES INCLUDING A SUBSIDY COMPONENT (REDISTRIBUTION MECHANISM)**
- **MULTIPLE NEW INITIATIVES AT THE STATE LEVEL**
- **A NEW AMBITIOUS EXTENSION PROGRAMME: TO COVER 300 MILLION INFORMAL ECONOMY WORKERS (NATIONAL COMMISSION DRAFT BILL - 2006)...**



MICRO-INSURANCE PRIORITY NEEDS OF THE POOR

- 1 ☺ **HEALTH CARE :**
 - ☐ A STRONG DEMAND FOR TOTAL COVERAGE (WHOLE CARE VS RARE CARE)
 - ☐ QUALITY IS A MAJOR CONCERN
- 2 ☺ **MATERNITY PROTECTION**
 - ☐ NEED FOR A BROADER RCH PERSPECTIVE
- 3 ☺ **OLD AGE PENSION**
 - ☐ A NEW BUT FAST INCREASING DEMAND
- 4 ☺ **LIFE**
 - ☐ A STRONG DEMAND FOR MATURITY BENEFITS (CASH BACK SERVICES)
- 5 ☺ **ACCIDENTS**



HEALTH MICRO-INSURANCE: ESTIMATED PRESENT COVERAGE

	NO BENEF
MEDICLAIM	9,000,000
WELFARE FUNDS	7,000,000
MICRO-INSURANCE SCHEMES	6,000,000
UNIVERSAL HEALTH INSURANCE SCHEME	700,000
TOTAL	22,700,000
% OF POPULATION	2%



HMI ORGANIZATION: THROUGH ORGANIZED GROUPS...

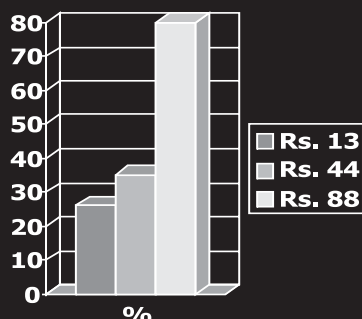
- RELY ON ORGANIZED GROUPS BASED ON STRONG SOLIDARITY MECHANISMS (COOPERATIVES, SELF -HELP GROUPS, INFORMAL ECONOMY TRADE UNIONS, LOCAL ASSOCIATIONS ...)
- CONTRIBUTE TO THE FURTHER EMPOWERMENT OF THESE GROUPS





STEP

HEALTH MICRO-INSURANCE: THE EXCLUDED GROUPS ...



⊕ **PLANNING COMMISSION
DEFINITION: VALUE OF
A SPECIFIED NUTRITION
REQUIREMENT**

- 26%
- 278 MILLION

⊕ **UNDP DEFINITION: LESS
THAN 1 US/DAY/PERSON**

- 35%
- 374 MILLION

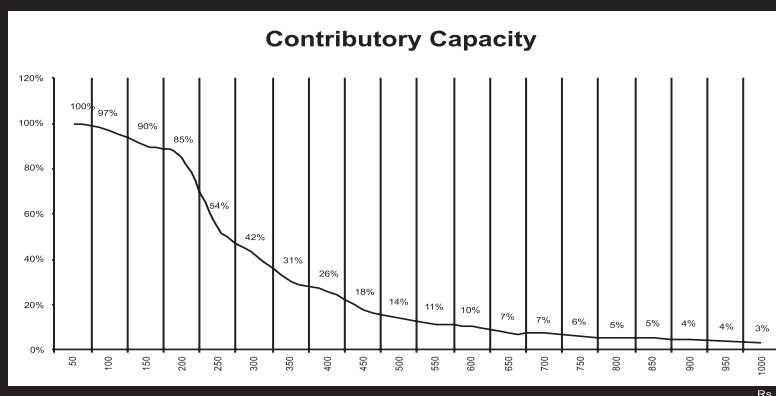
⊕ **UNDP ANALYSIS: LESS
THAN 2 US/DAY/PERSON**

- 80%
- 855 MILLION



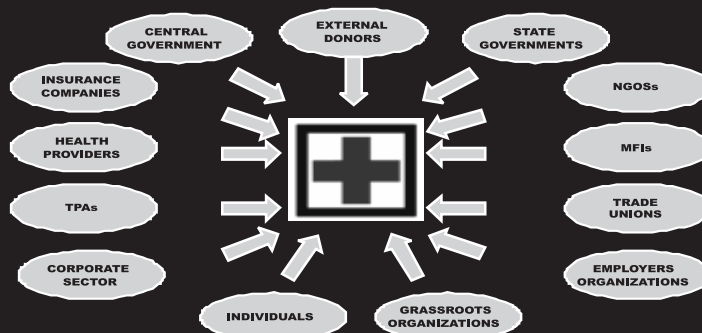
STEP

HEALTH MICRO-INSURANCE: NOT ENOUGH PAYING CAPACITY ...



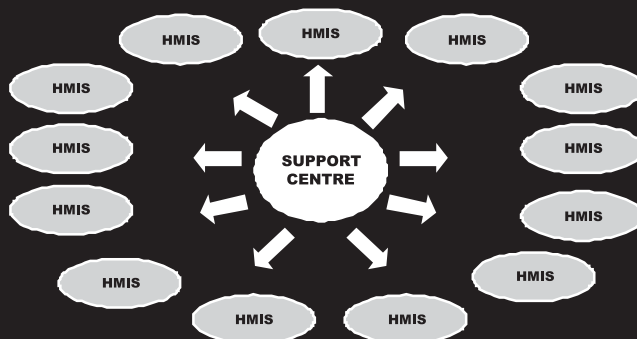
STEP

HEALTH MICRO-INSURANCE: THE NEED TO SHARE THE BURDEN ...

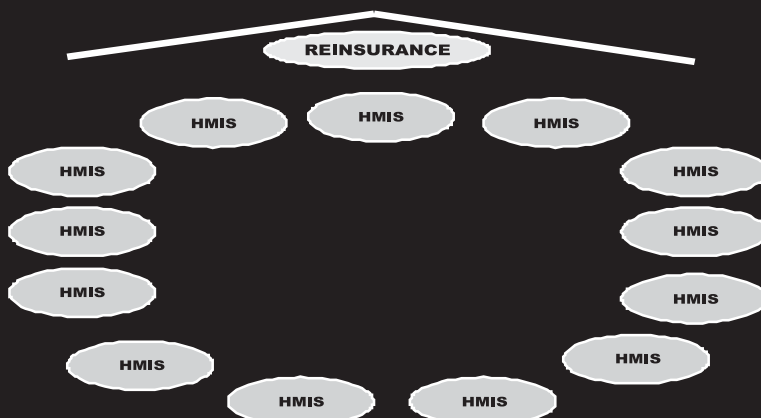




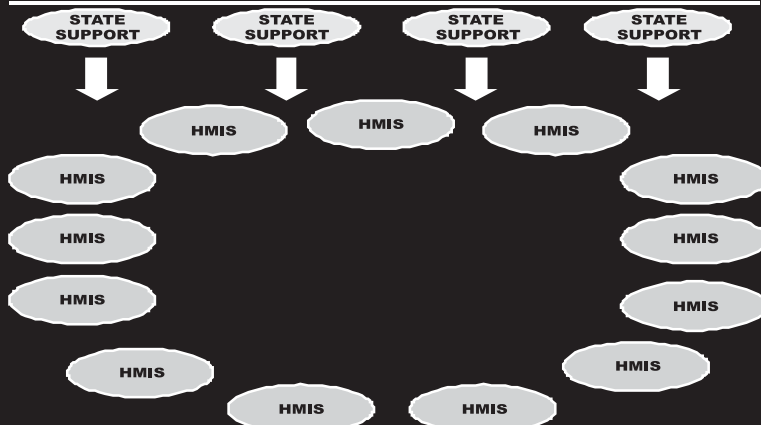
HMI INNOVATIONS: PROVIDING SUPPORT SERVICES



HMI INNOVATIONS: ADDING A REINSURANCE MECHANISM



HMI INNOVATIONS: TAPPING INTO NEW RESOURCES



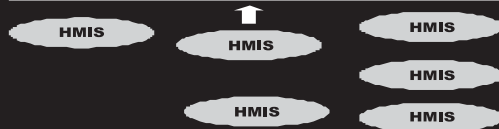


HEALTH MICRO-INSURANCE: THE NEW STRUCTURAL TRENDS

FIRST GENERATION: IN-HOUSE MODEL

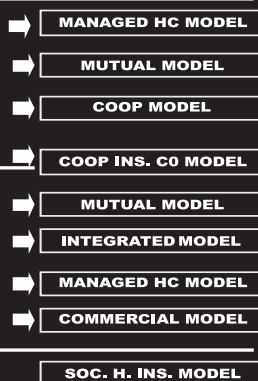


SECOND GENERATION: PARTNER-AGENT MODEL



THIRD GENERATION: STATE LEVEL MODEL

TOWARDS...



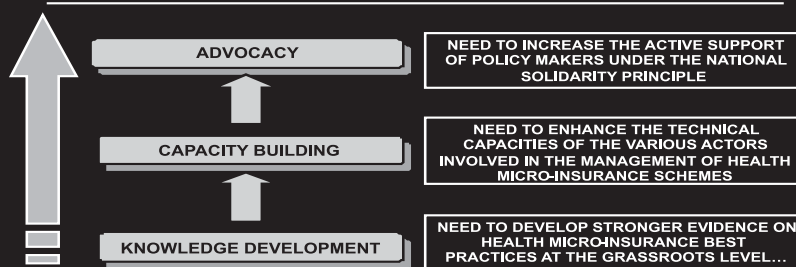
HEALTH MICRO-INSURANCE: STILL A LIMITED KNOWLEDGE ...

- LIMITED INTERVENTIONS...
- LIMITED LEVEL OF EXPERIENCE...
- LIMITED SCOPE OF EXPERIENCE...
- LIMITED SCOPE OF BENEFITS...
- LIMITED KNOWLEDGE...
- LACK OF AWARENESS AND UNDERSTANDING ...
- LACK OF TECHNICAL CAPACITIES ...
- LACK OF EXPERIENCE SHARING ...
- LACK OF ACTIVE ADVOCACY...
- LACK OF (RELIABLE) DATA ...



HEALTH MICRO-INSURANCE: MORE ADVOCACY IS NEEDED ...

«THERE IS NO ADVOCACY WITHOUT EVIDENCE, HENCE,
THE NEED TO DEVELOP MORE KNOWLEDGE AMONG ALL
ACTORS THROUGH ACTIVE NETWORKS»





FROM MICRO TO MACRO: THE WAY FORWARD ...

- **START WITH HEALTH MICRO-INSURANCE AS A STAND-ALONE PRODUCT**
 - THE PRESSING NEED OF THE DAY – MORE COMPLICATED
- **ADDRESS THE SPECIFIC PROTECTION NEEDS OF ORGANIZED GROUPS**
 - COMPREHENSIVE ADAPTED BENEFIT PACKAGE – EASY PAYMENT MECHANISMS ...
- **SET UP A NETWORK OF HEALTH PROVIDERS (PRIVATE/PUBLIC)**
 - CONCESSIONAL TARIFFS AND INTERVENTION REGULATIONS ...
- **ORGANIZE ACCREDITATION/ MANAGEMENT/MONITORING SYSTEMS**
 - ENSURE THE PROVISION OF QUALITY SERVICES ...
- **ENSURE SUSTAINABLE FINANCIAL SUPPORT**
 - LONG-TERM PUBLIC/PRIVATE PARTNERSHIP ARRANGEMENTS AND FINANCIAL SUPPORT ...
- **ENHANCE EMPOWERMENT AND SOCIAL INCLUSION**
 - MEMBERS SHOULD BE ABLE TO «VOTE WITH THEIR FEET» - NEW COLLECTIVE RESPONSIBILITIES...



JUST A FEW WORDS TO REMEMBER...



**EFFICIENT AND SUSTAINABLE
HEALTH INSURANCE FOR THE
POOR HAS TO RELY ON A
MULTI-PARTNERSHIP
APPROACH...**

THANKS ...

**SESSION
1**

**PWP
1.2**



**ILO/STEP-CHSSS-PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP:**

**“ Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and
Participation”**

**HEALTH MICRO-INSURANCE IN
INDIA**

INTERNATIONAL LABOUR ORGANIZATION (ILO)



**MICRO-INSURANCE IN INDIA:
THE NATIONAL INVENTORY**

- IN 2004 ILO/STEP PUBLISHED THE VERY FIRST NATIONAL INVENTORY OF MICRO -INSURANCE SCHEMES IN INDIA
- THE INVENTORY CONTRIBUTED TO THE KNOWLEDGE DEVELOPMENT PROCESS AMONG THE MICRO -INSURANCE PRACTITIONERS WHO MIGHT FIND IT USEFUL TO ADOPT SOME OF THE INNOVATIVE MECHANISMS ALREADY TESTED AS WELL AS TO ADVOCACY ACTIVITIES
- THE INVENTORY DOCUMENTED A WIDE VARIETY OF MICRO - INSURANCE PRODUCTS COVERING A RANGE OF RISKS
- ALSO HIGHLIGHTED IN THE INVENTORY WAS THE HEALTH PROTECTION GAP. AMONG THE 51 MICRO -INSURANCE SCHEMES, ONLY 29 WERE COVERING HEALTH RISKS
- ILO/STEP IS INVOLVED IN PRODUCING THE UPDATE VERSION (2005) OF THE INVENTORY. THE SOON TO BE PUBLISHED INVENTORY PROVIDES AN OVERVIEW OF THE MAIN CHARACTERISTICS OF EACH SCHEME



**HEALTH MICRO-INSURANCE:
AN OVERVIEW OF PRESENT
SITUATION**

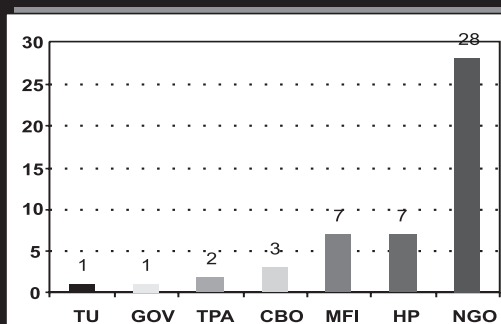
- HEALTH MICRO -INSURANCE HAS EMERGED IN INDIA AS AN ESSENTIAL TOOL TO AN EASIER ACCESS TO QUALITY HEALTH CARE SERVICES
- WIDER AWARENESS OF HEALTH PROTECTION GAP AND GROWING DEMAND FOR ADAPTED BENEFITS EMANATING FROM THE EXCLUDED GROUPS HAVE LED TO ACTIVE INVOLVEMENT OF MULTIPLE ACTORS OF THE CIVIL SOCIETY
- VARIOUS INNOVATIVE HEALTH MICRO -INSURANCE SCHEMES HAVE PROLIFERATED RAPIDLY ACROSS THE COUNTRY
- MATERNITY PROTECTION IS FAST BEING RECOGNISED AS PRIORITY NEED FOR WOMEN



HEALTH MICRO-INSURANCE: OWNERSHIP PROFILE



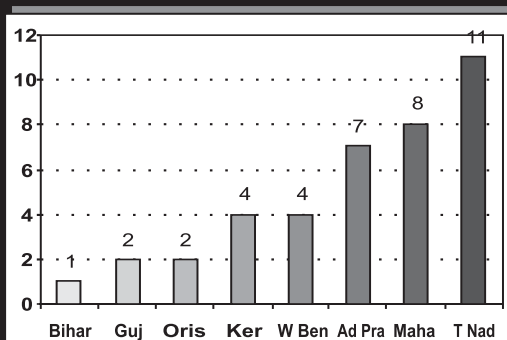
- 51 organisations have been identified as involved in the provision of health micro-insurance to the poor
- NGOs have taken a clear lead in promoting HMIS
- At the grassroots level, these organisations design tailor made health insurance products to suit the priority needs and contributory capacity of their target groups



HEALTH MICRO-INSURANCE: STATEWISE DISTRIBUTION OF HMI SCHEMES IN INDIA



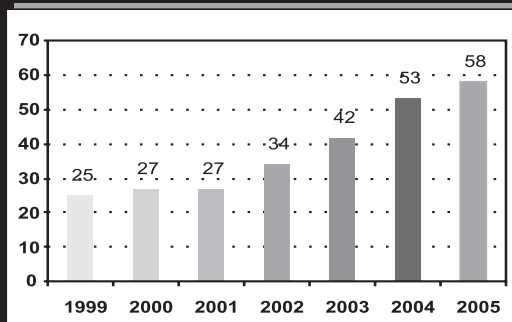
- One distinctive pattern of the health micro insurance scheme is their stronger concentration in the south of India
- Evidently, this reflects on the wider presence and coverage of both micro-finance activities and private health care facilities in this part



HEALTH MICRO-INSURANCE: EVOLUTION PROFILE



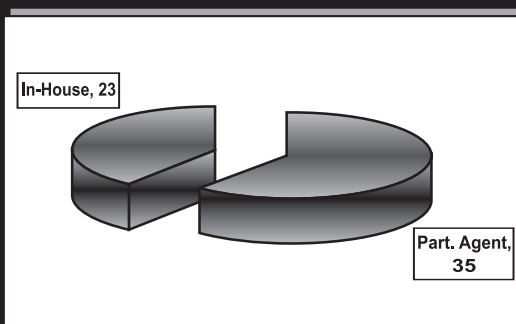
- Fast paced growth of health micro insurance in the last 5 years
- So far some 58 schemes have been documented.
- Schemes have grown twice in number since 2001





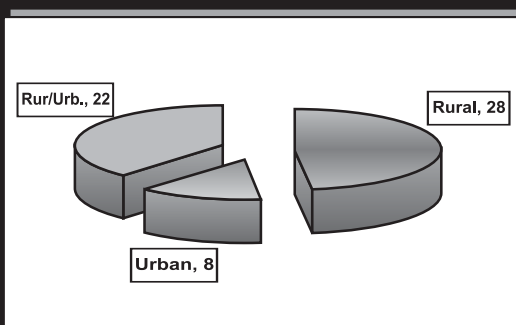
HEALTH MICRO-INSURANCE TYPES OF SCHEMES

- Despite late intervention, the partner-agent model has quickly become pre-dominant as compared to the in-house model that was the first to emerge



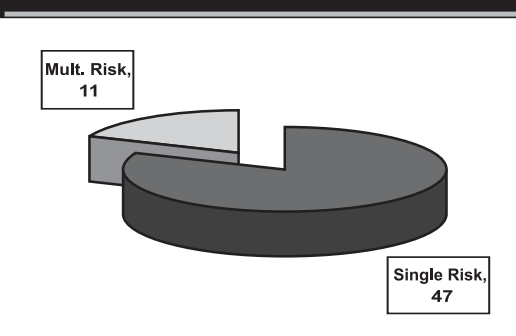
HEALTH MICRO-INSURANCE: AREA OF INTERVENTION

- Most health micro-insurance schemes are extended in rural areas
- 37% schemes extended coverage to member living in both rural and urban areas



HEALTH MICRO-INSURANCE: RISK PACKAGE

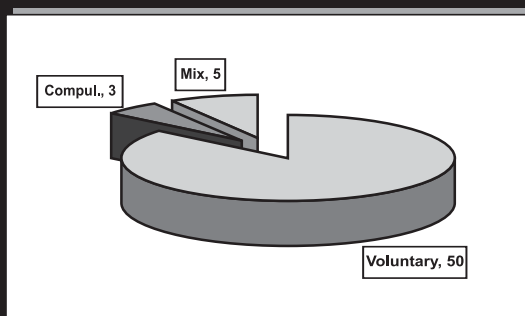
- Some 20% of schemes have opted for composite risk package while the number of schemes offering a single health insurance product remains far higher
- The recent IRDA regulations may result in more schemes adopting composite risk package





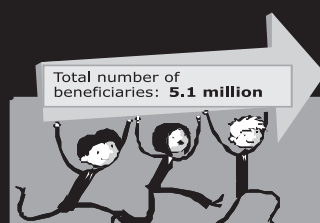
HEALTH MICRO-INSURANCE: TYPE OF MEMBERSHIP

- Most schemes rely on a voluntary enrolment
- 5 schemes are both voluntary and compulsory and another 3 compulsory schemes



HEALTH MICRO-INSURANCE: OVERALL COVERAGE

- Based on the figure provided by the last inventory update, the various health micro insurance schemes operating in India have already succeeded to enroll a total of 5.1 million
- Given the fact that many other schemes must have escaped the exercise, the present total figure could probably be much higher and probably top the 6 to 6.5 million mark



SESSION
1

PWP
1.3

Development of MHI Sub Sector: Challenges Ahead

Alex George

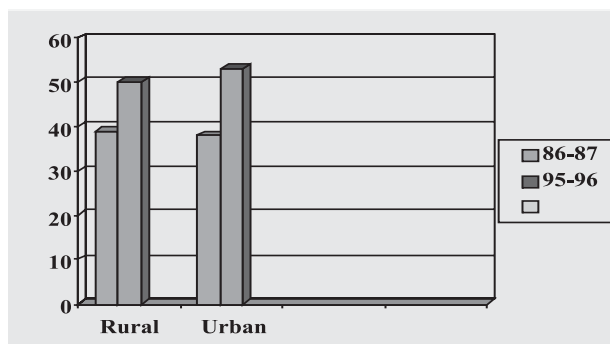
Centre for Health & Social Sector Studies
Secunderabad

High Out of Pocket Expenditure

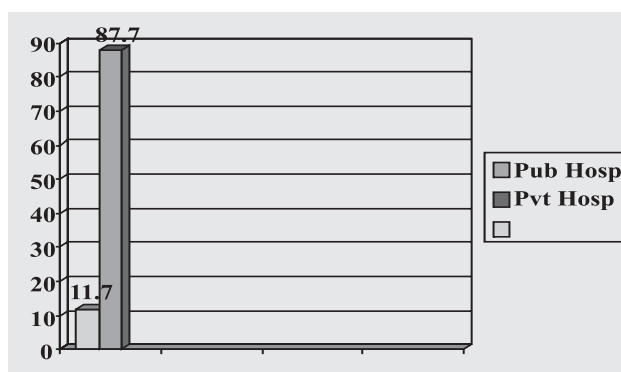
- Private Expenditure constitute 78.7% of health expenditure in India
- 98.5% of Private Expenditure is Out of Pocket Expenditure

(WHO 2005, World Bank 2005)

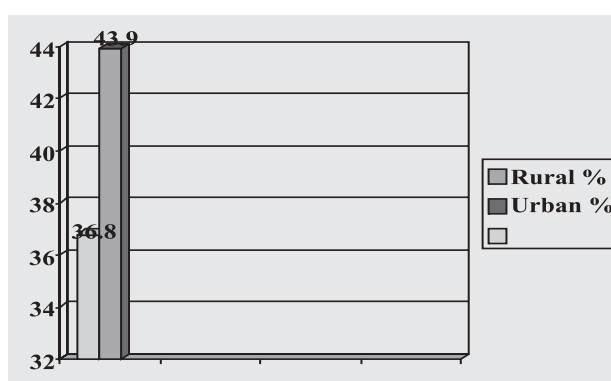
Increasing Use of Pvt. Health Sector: In patient Care 42nd to 52nd Round NSS : 1986-87 to 1995-96



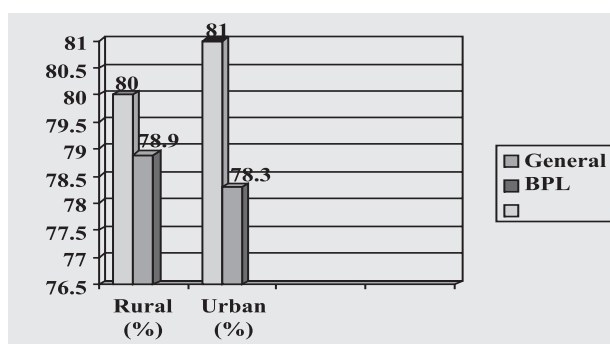
Average Hospitalisation Expenses Per Day: Public and Private (Rs.)



Use of Private Sector by BPL



Use of Private Sector in Outpatient Care



Poor Compelled to Use Private Sector:

- Due to shortcomings and dysfunctioning of public facilities
- Absenteeism of doctors/ staff, lack /inadequacy of drugs & supplies, dysfunctional equipment, inappropriate timings etc.

Result of High Spending for Health by Poor

- Mortgage or sell family property / jewellery
- Take loans at exorbitant interests
- Both Leading to further impoverishment

Poor Coverage of Health Insurance in India

- Roughly 3% to less than 10% of the population ie. employees in Organised Sector only are covered by health insurance
- CGHS, Railways, Defence, ESIS and Private Insurance

Poor Coverage of Health Insurance in India

- Roughly 3% to less than 10% of the population ie. employees in Organised Sector only are covered by health insurance
- CGHS, Railways, Defence, ESIS and Private Insurance

Poor Health Insurance Coverage in Informal Sector: Reasons cited

- No written job contract or pay roll ; identification difficult
- Irregular employment. So not possible to use wages as a means of contribution
- Many Self employed or poor peasants with irregular income
- Illiteracy : communication problems

Scheme Offered in Central Budgets 2003-04 and 04-5

Benefits (Rs.)	Premium (Rs)	Subsidy for BPL:(Rs)
Health: Rs.30000 per person per annum	Indiv: 365	200
Accident: Rs. 25000	Fly-5: 547.5	300
Loss of Wages : Rs.750	Fly-7: 730	400

Scheme modifications

- In 2004–05 the scheme was restricted to Below Poverty Line population.
- Subsidy for BPL which was Rs.100 was increased to the levels mentioned above.
- A new scheme for SHG members with a health benefit of Rs. 10,000 and premium of Rs. 120 was introduced.

Performance of Central Scheme

- In 2003-04 only 4.17 lakh families with population of 12 lakhs were enrolled against a target of 50 lakh families
- BPL enrollment in 2003-4 just 11408 families!!
- In 2004-05 after restricting to BPL enrollment was still only 34000 families!!
- Claims Ratio in 2003-04 was just 1.47%

Reasons cited for poor performance

- Disinterest of Public Sector Insurance companies expected to market the scheme
- Lack of propaganda
- Lack of awareness among target population
- Problems in certifying BPL status
- Scheme not covering existing illnesses
- No QA norms for health facilities put in place

NGO-CBO Experience in MHI

- NGOs linked to CBOs have been running MHI schemes with larger membership from their target areas, better community participation and claims ratios.
- Some earlier schemes in this regard are the Students Health Home, Voluntary Health Services, RAHA, VimoSEWA and ACCORD. Several others have come up more recently.

CONCLUSION: (1)

- The challenge to give support to the poor for Out of Pocket Expenditure mainly due to the high cost of Private health care and
- The need to cover India's vast informal sector remains.

CONCLUSION: (2)

- But India also has large social movements with vast social base and strong historical roots through which MHI could be rooted.
- These are the movements of adivasis, dalits, co-operatives, women's organisations, SHGs, informal sector trade unions and the NGOs&CBOs.

CONCLUSION: (3) CAUTION!

- MHI should be only a financing mechanism to help the poor to meet the mounting health care costs
- It should not become a means to reduce public investment in secondary and tertiary care as most of the present MHI schemes are using private facilities.

**SESSION
2**

**PWP
2.1**

THE ACCORD – AMS – ASHWINI COMMUNITY HEALTH INSURANCE SCHEME

Dr. N. Devadasan MBBS, MPH
Institute of Public Health
Bangalore.

Introduction

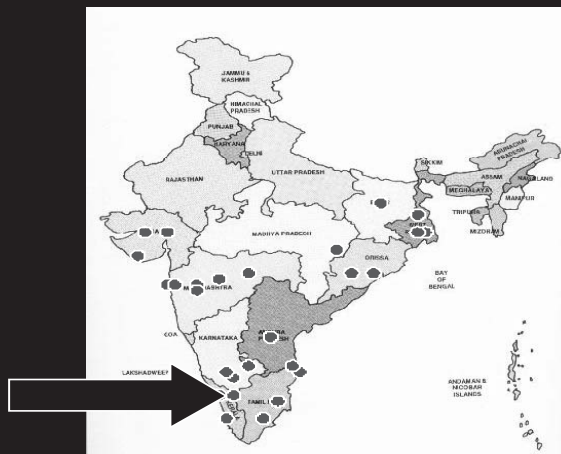
Context

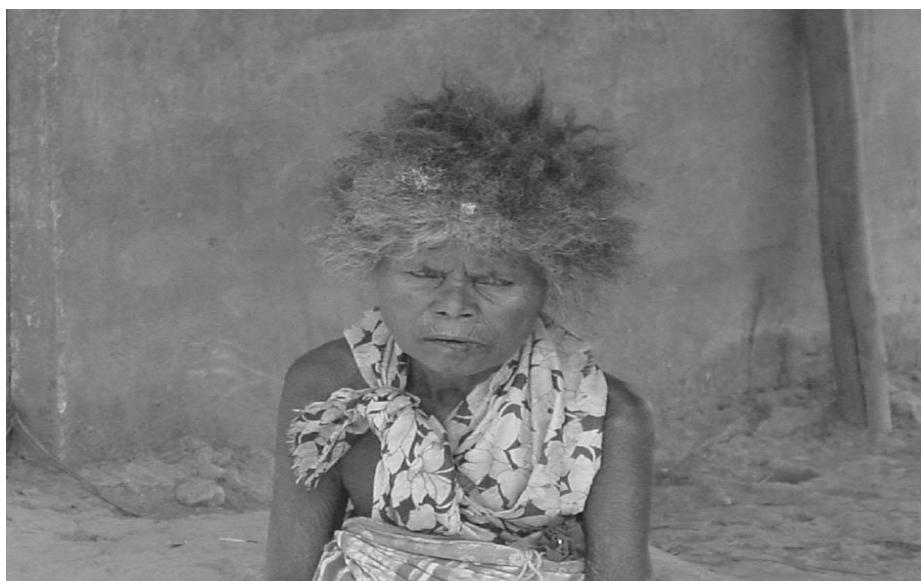
Design

Performance

Discussion

Gudalur, Nilgiris, TN.



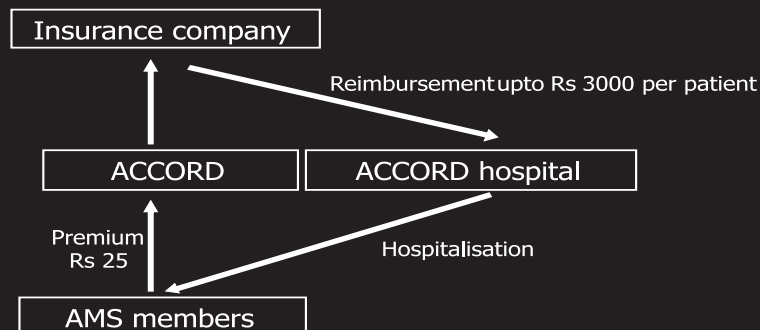


The Health Insurance package

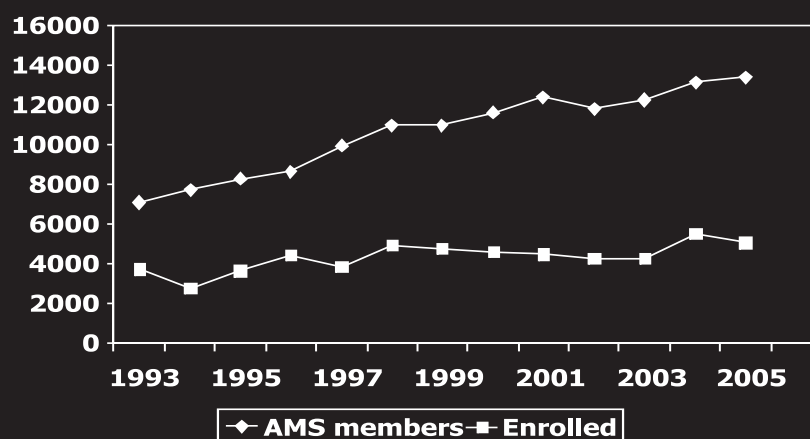
■ REASONS FOR STARTING INSURANCE

- ☐ **INCREASING ACCESSIBILITY**
- ☐ **SOLIDARITY**
- ☐ **COMMUNITY OWNERSHIP**
- ☐ **MOBILISING RESOURCES**

The ACCORD CHI



Enrolment



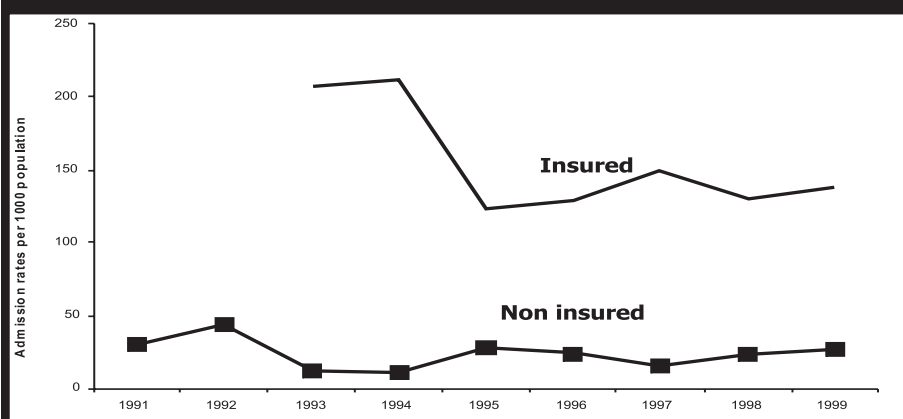
Reasons for not enrolling

- Hospital too far away – other hospitals nearby
- Have had problems with ACCORD / AMS
- Relationship with the community is poor
- Other people discourage – 'free treatment
- Not enough insurance education - No illness in the past, so why pay?
- Premium not affordable – especially large families
- Premium collection is not user friendly

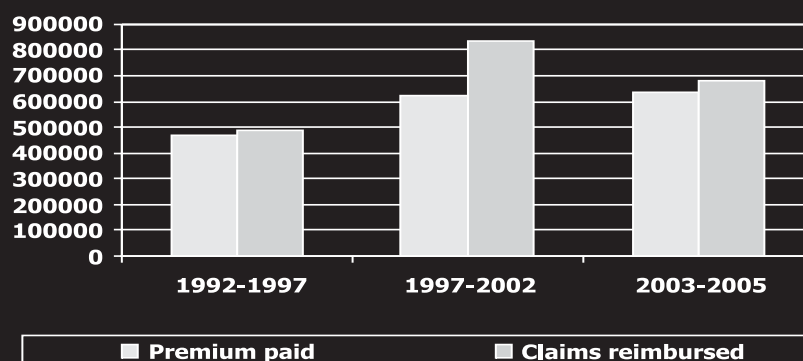
Benefit package

- Free Hospitalisation cover – only at ACCORD hospital. Non insured have to pay cost of medicines.
- Initially most pre-existing diseases, deliveries etc were excluded. Later, with successful negotiations, we were able to minimise exclusions. Currently only mental illnesses are excluded.
- Primary care including OP provided for insured and non-insured free of charge from other resources

Utilisation of services



Financial performance over the years



Lessons learnt

- THE POOR ARE INSURABLE.
- But they need subsidies
- There should be a need for health insurance.
- CHI is not just about selling a product. It is also about servicing the product. Without this health insurance will not succeed.
- Communities are capable of managing a health insurance programme.
- Community health insurance, if organised properly can increase access to health care.

Lessons learnt

- Keep premiums affordable and benefit packages acceptable
- Provide good quality care
- Need to have a good database for monitoring the programme
- Keep administration to the minimum – preferably a cashless system.
- Give regular feedback to the community

Lessons learnt

- Minimise adverse selection by
 - Enrolling large units eg. Families, SHGs etc;
 - Having a definite collection / waiting period
- Minimise moral hazard by
 - Developing a referral system
 - Insisting on standard treatment guidelines and using a case based payment for hospitals.
- NGOs will need technical and managerial inputs
- LISTEN TO THE COMMUNITY

CONCLUSIONS

- Remember that health insurance is a complex financing mechanism.
- Health insurance can be used as a mechanism to empower the patient community' and strengthen solidarity.
- There are a few pre-requisites that need to be in place before initiating health insurance programmes

Some resources

- Website www.comhealthins.org
- eGroup – IGHPM@yahoogroups.com
- Institute of Public Health – Training programme

**SESSION
2**

**PWP
2.2**

DHAN Foundation

DHAN Foundation

Community Health Insurance Programme

DHAN Foundation

Genesis and evolution of community based insurance in DHAN's programmes

- 1992 Funeral expenses
 - Rural : Appanthiruppathy
 - Urban : Tiruppathy
- 1997 Community based life risk management programme in Kadamalai, Appanthiruppathy and Alanganallur
- 2000 Community based health risk management programme in Kadamalaigundu

DHAN Foundation

Genesis and evolution of community based insurance in DHAN's programmes

- 2005 Community based life risk management programmes in Pudur & Gangai
 - Funeral expenses & emergent hospitalisation expenses in 20 federations
 - Old age people mutual risk solutions at Appanthiruppathy
- 2006 Whole life mutual risk solutions in six federations

Philosophy

- Self help and mutuality are the basis for effective community action.
- Mutuality is more appropriate for community based insurance programmes as people with common problems together solve their own problems.
- Mutual solutions are people driven, people owned and people managed.

Need for community health insurance programme

- ❑ Remote area
- ❑ Interior habitations
- ❑ Poor access to health care
- ❑ Low levels of affordability
- ❑ Absence of health insurance products from mainstream insurance companies that suit the need of the people.

Unique features of community health insurance programme

- Designed by people.
- Revision of programme design by people at the end of each year.
- Covers primary, secondary and tertiary health care.
- Community hospital with beds , pharmacy and clinical facilities to provide primary and secondary health care.
- Nine referral hospitals for secondary and tertiary health care

Experience of community health insurance programme

- Able to meet the claims from inception till date.
- Reserves have been built up over years.
- Over 3000 families (13000 persons) are covered.
- Community runs health insurance programme as a graduated programme after life insurance programme resulting in sharing of risks across.

Designing mutual insurance programme

<i>Sl.No.</i>	<i>Need</i>	<i>Solutions</i>
1	Meeting the education expenses of children	savings, credit
2	Meeting the marriage expenses of daughter/s	savings, credit
3	Livelihood	savings, credit
4	Life risks	Mutual solutions, commercial insurance
5	Health risks	savings, Mutual solutions, commercial insurance
6	Risk to assets	Mutual solutions, commercial insurance
7	Lack of support during old age	Mutual solutions, commercial insurance, pension products

A Judicious mix of micro savings, micro credit and micro insurance would meet the requirement of risk addressal and development.

Member Administration of mutual programmes

Member administration commences from member enrollment till the contribution amount reaches the federation mutuals

Member Administration

Functions	Role of Kalanjiam
Selection of eligible members	Only eligible members are enrolled Responsibility: Group leaders
Application with proof is obtained	Obtention Responsibility: Field staff
The eligible contribution is collected	Collection Responsibility: Field Staff
The Contribution amount reaches the federation through cluster with in 3 days	Remitting Responsibility: Group leaders
Member base line creation	Collection of data Responsibility: People staff
Member enrollment	Enrolling all eligible members Responsibility: Governance

Member Administration

Functions	Role of Federation Mutuals
Selection of eligible members	Ensuring by cross checking & test check Responsibility: Federation Mutuals President, Professional
Application with proof is obtained	Verification Responsibility : Field Staff
The eligible contribution is collected	Verification Responsibility: Field Staff
The Contribution amount reaches the federation through cluster with in 3 days	Ensuring Responsibility: Federation Mutuals president, Professional
Member base line creation	Monitoring and consolidation Responsibility: Federation Mutuals Associate, Professional
Member enrollment	Ensuing all eligible members are covered Responsibility: Governance, Professional

Member Administration

Functions	Role of People Mutuals
Selection of eligible members	Capacity building, literacy programme to members, training to leaders & people staff Systems evolution and putting in place Ensuring the eligibility a members and proper application and appropriate contribution are collected Collecting MIS, consolidation and monitoring
Application with proof is obtained	
The eligible contribution is collected	
The Contribution amount reaches the federation through cluster with in 3 days	
Member base line creation	Technical support Ensuring collection of data from all federations and creating a data base for calculating mortality and morbidity rates
Member enrollment	Periodical review

Product Administration of mutual programmes

Product administration commences from the receipt of application and contribution amount by the federation mutuals.

Product Administration

Function	Role of Kalanjiam	Role of Federation Mutuals	Role of People Mutuals
Receiving applications and the relevant contribution amount	Submission to Federation Mutuals Responsibility: People staff and Governance	1.Verifying 2.Accounting in bank Responsibility: Federation staff and Secretary	Establishing systems & half yearly auditing
Issue of certificate of membership and handing it over to members with in 7 days.	Receiving the certificates from Federation mutuals and handing it over to members Responsibility: People staff and governance	Issue of certificates with in 3 days Responsibility: Secretary, Professional	Establishing systems
MIS on the programme	Submission of data Responsibility: People staff	Monthly to PM Responsibility: Secretary, Professional	Monitoring review and support Capacity building

Benefit Administration of mutual programmes

Benefit Administration commences from the credit of contribution amount in the bank account

Benefit Administration

Function	Role of Kalanjiam	Role of Federation Mutuels	Role of People Mutuels
Reaching of the information of happening of a risk with in 24 hours to Federation Mutuels	Sending the message Responsibility: Group leaders	Acting on the message Responsibility: Governance, Professional	Establishing systems
Releasing funeral expenses of Rs.3000 with in 24 hours in case of death	Receiving the amount Responsibility: Group leaders	Disbursing the amount Responsibility: Governance, Professional	Establishing systems
Verification of benefit application & releasing benefit amount with in 30 days	Assistance in applying for benefit Responsibility: People staff and Group leaders	Processing the application Responsibility: Governance, Professional	Establishing systems

Benefit Administration

Function	Role of Kalanjiam	Role of Federation Mutuels	Role of People Mutuels
Releasing the benefits and ensuring that it reaches the affected	Follow up Responsibility: Governance	Ensuring prompt benefits disbursement and due delivery. Responsibility: Treasurer, Professional	Establishing systems
Investment of funds	-	Appropriate investments to get optimum yield and maintaining adequate liquidity Responsibility: Treasurer, Professional, Programme Associate	Establishing systems
Monthly report of the programme to Federation Board to People Mutuels	Submission of data Responsibility: People staff	Collection and consolidation of data Responsibility: Professional	<ul style="list-style-type: none"> Monitoring, scrutiny support quarterly review half yearly financial auditing

Challenges

- Baseline creation
- Evolving need based solution in tune with the affordability.
- Solvency building for sustainability.
- Making mutuels self reliant.
- MIS and software systems.
- Legal space for mutual insurance.
- Reinsurance for mutual insurance.

**SESSION
2**

**PWP
2.3**

ILO WORKSHOP

SHARING OF HEALTH INSURANCE EXPERIENCE OF SHEPHERD & SSAFE FOUNDATION



Place : New Delhi

Date : 29.05.06

Email : shepherddevorg@sify.com (or)

ssafe.india@gmail.com

⇒ **Poverty is the main source of ill health 1.3 billion people live on less than a dollar.**

⇒ **Poor are much more susceptible to disease due to lack of access to clean water and sanitation, medical care, information about preventive behaviors and adequate nutrition.**

⇒ **Poor lack knowledge on health, no money to spend, and long distance of hospitals.**

⇒ **80% of modern medical facilities are concentrated in the cities.**

⇒ **75% of Indian population lives in rural India & 75% of the doctors practice among the 25% of urban population**

⇒ **90% of the disease can be managed at primary and secondary level hospitals.**

⇒ **Doctors are moving from service to commercial nature.**

↪ **Corruption in Health Care**

<u>Type of Hospital</u>	<u>Bribe as % of total Hospital Expenses</u>
Government	13%
Corporation /	38%
Mission & Charity	11%
Private	6%

↪ **In India the health man power is**

Physician / 1000 population	= 1
Nurse / 1000 population	= 0.9
Midwife / „	= 0.2
Hospital / „	= 0.7

↪ **SHEPHERD Safety Net on Health**

- * **40% of internal loans, were used for hospital expenses.**
- * **Conducted feasibility study with the support of Insurance Company.**
- * **Our 3 p's approaches**
 - Prevention – Medical Camps**
 - Protection – Health Insurance**
 - Promotion – Health Education**

↪ **Our Products & Services in Social Security**

	<u>Apr'06</u>
(a) Food Security	18,600
(b) Life Security	10,454
(c) Health Security	10,454
(d) Assets Security	10,454
(e) Sugam Fund	140
(Emergency Health Fund)	

↪ **Premium collection and claim settlement by way of cheque to surabi A/C.**

↪ **Service charges are collected from the members for operations.**

↪ **Our Health Insurance coverage 10,454**

Our New Initiatives :-

✳ **Cashless treatment agreement with 4 hospitals for our members.**

✳ **Special medical camps for Diabetic, Gynecology & Cancer.**

✳ **Emergency Health Fund– Sugam Fund for (Not Covered in Insurance)**

- (a) Emergency hospital admission**
- (b) Transport cost to hospital**
- (c) After discharge, medicine cost**
- (d) Delivery upto 2 children**
- (e) Any minor operations**

Operational Issues :-

(i) Insurance companies are keen in premium collection than claim settlement (timely) (or) assisting in medical camps.

**(ii) The health insurance conditions such as (a) 30 days waiting period
(b) Exclusion of pre-existing diseases
(c) Certain diseases will not be covered in the first year.**

Learnings :-

- * Men are keen to enroll in health insurance than women.**
- * Pre existing conditions (on & off Tonsil case) rejection leading to disintegration of surabhi.**
- * After rejection women are raising a point that, why insurer didn't do medical test (or) screening before enrollment.**
- * Women expects that portion of premium should be refunded when there is no claim for 3 years.**

*** Cashless treatment is working well, but some cost of the hospital need to be collected from patients such as registration, amenities etc.**

*** Reimbursement approach– gives choice to members to take treatment from any hospitals. But financial constraints– solved thro' surabhi.**

*** Before we send health insurance claim papers, we have claim processing committee with grass root leaders & medical doctor for verification.**

*** If claim is rejected, we used to visit the surabhi and explain the reasons why it was rejected.**

*** We received 51 health claim with in the financial year 2005-06. The health issues has been clarified as Heart diseases, Diarrohea, Jaundice & Fever, Reproductive Tract Infection, Urinary Infection, Pelvic-inflammatory infection, Hydrocele, Acute peptic ulcer, Leg fracture, Snake bite, Hysterectomy, Tonsil, Fibroid in uterus, Uterus removal, Lower Abdomen pain, Enteric fever, paralysis etc.**

*** Women are expecting that out-patient treatment cost need to be covered in health insurance claim.**

*** Some Doctor's are giving the bills in letter head (or) white sheet?**

*** Chronic disease (Diabetic, Cancer) members expect timely financial support for regular treatment.**

*** In two cases, women brought bills of husband treatment and asking us to include in her health insurance eligibility.**

*** One women under went abortion, but requesting the staff to get health insurance claim.**

*** Another case, mother was sick and taking treatment. The son who is around 32 years old consumed all the leftout medicine purchased for her kept in the family. He was admitted in ICU for 4 days, as if it will improve his health condition?**

*** Service tax 10 to 12% is a real burden on the poor.**

*** To obtain death certificate from Government Officer (VAO) minimum Rs.350 to 500 need to be paid as corruption.**

- ✳ **Our insurance workers need adequate training, in order to train the surabhi members and address the issue.**
- ✳ **Health awareness is lacking in rural areas.**
- ✳ **Commercial hospitals are coming to villages in the name of free medical camps to catch people.**
- ✳ **In some cases members expect that the surabhi leaders must take them to hospital for treatment also. But not by her husband?**

NGO / MFI's Attitude :-

- (i) Life coverage is easy and protection to loan amount. So, it is nothing but loan linked insurance.**
- (ii) MFI's are Interested in inhouse insurance programme.**
- (iii) MFI's are giving very less attention on health insurance because of complication.**
- (iv) MFI's are Assisting commercial hospitals for service charge collection to sustain the NGO.**

Future Direction :

- ↳ **Enrolling 25,000 families in HI during 200607.**
- ↳ **Our health education & social security inputs, to all level surabhi, mahasurabhi leaders.**
- ↳ **Promoting health collectives among link minded organisation for learning & sharing of experiences.**
- ↳ **Marketing division need to be developed for family package.**

SESSION 2

PWP 2.4



Breaking the Cycle of Despair

Mukti K Bosco
Healing Fields Foundation
Hyderabad



Objectives

Healing Fields Foundation 's focus is to improve accessibility, affordability of quality healthcare BPL families.

The main objectives are to 'Reduce household expenditure on healthcare, particularly hospitalization expenses and to Create a viable and sustainable model for all stakeholders '



Steps in planning Health Insurance Service Healing Fields Experience

- Baseline survey
- Hospital expenditure
- Disease profile
- Ambulatory care expenses
- Loan Pattern to meet hospital expenses.
- Willingness to pay premium
- Affordability to pay for Health Insurance



Key Findings from Healing Fields Survey

- Women want cover for entire family
- Average Family Income Rs.2000 pm
- 80% of healthcare expenditure is from out of pocket
- Willing to contribute between Rs. 250-Rs. 300 per annum towards Health Insurance
- Want premium financing
- Confusion with money back policy of Life Insurance
- Want hospitalization of common, frequent illnesses to be covered
- Only 2% of the surveyed population had surgeries



Health Insurance Product

With collaboration with HDFC CHUBB the following product was developed specially for Healing Fields

- Members pay 363/- per annum to cover entire family of five.
 - Health Insurance: Rs 285/- for Rs.20,000/ cover
 - Personal Accident Benefit: Rs 35/-
 - Service Tax: Rs 33/-
 - Regn fee to HFF: Rs 10/-



Service Delivery

- DRG – limit for rates based on disease profile, treatment protocols & scientifically worked out rates
- Rating of Hospitals
- Networking of Hospitals
- Facilitator
- Documentation
- Medical Management
- Health Education



DRG – some illnesses covered

- Normal Pregnancy and Childbirth
- OP conditions like Fracture, Diarrhea etc
- GE, Typhoid, VID, Fever of unknown origin etc
- Other Fractures, poisoning, accidents etc
- In the second year Hysterectomy is also included



Rating & networking of Healthcare providers

- Availability of basic infrastructure
- Ensure quality care
- Uniformity in delivery of services
- Uniformity and transparency in fee



Why Facilitator?

Documentation

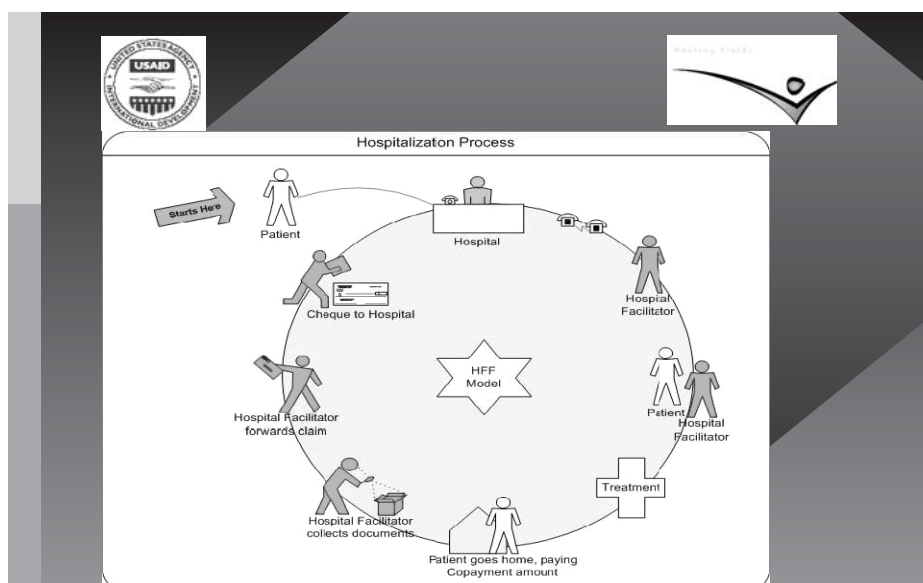
- Speedy and efficient Pre authorization
- Admission procedure
- Second medical opinion with the MM team
- Collection of documents at the time of discharge

Follow up

- Medication
- Post Hosp care
- Health Education

Reduction in Moral Hazards

Effective Dealing with Hospital rejections and referrals



A drop in the Ocean Snap shot from one of the Groups

- Total hospitalization expenditure from Insurance - Rs.70,746
- Out of Pocket expenditure as copay – Rs.17,687
- Loan taken from SHG-NIL

Snapshot

- Incident rate is 1.3 %
- Claims ratio is 43%
- Claim settlement time is 7 to 10 days
- 65% renewal rate in the I phase



Second Year of the Policy

- ✓ Post hospitalization medicines up to Rs.300/
- ✓ Pre-hospitalization investigation charges are covered if admitted within 10 days
- ✓ Wage compensation to the insured is hiked by 100% and is now applicable from the 3rd day of admission in the hospital.
- ✓ Hysterectomy (with specific guidelines) is added to the list of diseases, but applicable only after 2nd and 3rd medical opinion only.



Health Provider

- Subsidy for OPD has increased
- Hospitals coming forward to be part of network
- Health Providers promoting Health Insurance among the villages they are serving
- Upgradation of services



Health Education...

- Preventive & Promotive education vital
- Pilot covering 50 villages in on the job training of Health animators.
- Identified 200 villages to couple Health education with HI



Challenges

- Premium Financing
- Awareness
- Health Education
- Disability
- Old age Pension
- Skewed Market forces



Way Forward....

- Profit Share ☺
- Stop Loss Insurance ?
- Re Insurance ?

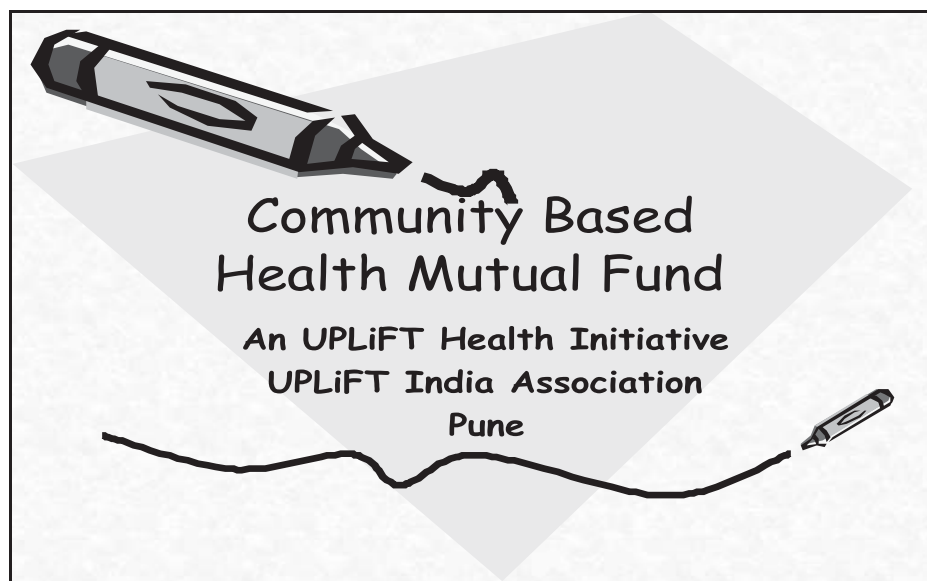


Way forward

- Capacity Building
- Health Education with Health Insurance
- Surveillance
- Data Data Data

**SESSION
2**

**PWP
2.5**



What made us design a CBHMF model ?

Our Needs	Market realities
<ul style="list-style-type: none">• Affordable product for our partners• Guidance to quality care with discounts• Impact on health and health behaviour• Local management with transparent procedures	<ul style="list-style-type: none">• No low cost product• Non transparent procedures• No guidance towards quality care• Health not a concern• Profit for Insurance Company

The slide includes illustrations of two black markers at the bottom left and one black marker at the top right, with a wavy line drawn next to it.

Impact of sharing: Big Number Law

- Lesson 1 → Being together it Can not be worse than being alone.
- Lesson 2 → The more we are together, the cheaper the security margin becomes.
- 2 Choices for Pooling:
Model N°1: Individually dependants of an Insurer ?
Model N°2 : All Together responsible of each other?

The slide includes illustrations of two black markers at the bottom left and one black marker at the top right, with a wavy line drawn next to it.

Model N2- Community Based Health Mutual Fund

- Community based
 - Health
 - Mutual Fund

One for all, All for one



Community Needs Approach



Product designed
according to
Communities
CAPACITY TO PAY
And
Expressed Health
Care needs



Collective Strategy

Collective
enrolments
CHECK
Adverse
selection



Community Management



Policy Guidelines
APPROVED by
Community
Directors



Community Management

Monthly
Committee
meetings to
DISCUSS
funds status
, claims review



Community Ownership

Fund Account
jointly in the
name of
Community and
the voluntary
organization



Community Decision

Claims DECIDED
by Community in
their houses in
small groups
according to
norms laid in
the fund



Health-Curative Care Support

☺ 24X7 helpline available

Network Doctor to provide guidance to members, 20-40 calls a day

☺ Concessional OPD (30-40%)

Tie-up with general practitioners for OPD, 6 in Pune, 6 in Marathwada

☺ Recognize other systems of medicine



Curative Care Support

☺ Medicines, Surgical items at discounted price

☺ Referral and Guidance Services

Referral chit to members through branches located in Slum Pockets, Arogyasakhis who are in need of care to Network hospital, follow-up of referrals

☺ Towards Uplift Health Care Network at discounted rates

Tieup with 60 health care providers including Multispecialty Hospitals, Maternity clinics, Diagnostic labs, Pathology labs, Medicine shops

Linkages with agencies involved in AIDS counseling and rehabilitation



Health -Preventive Promotive Care

- Monthly health checkup camps by specialist and generalist doctors
- Health talks (special focus on reproductive health)
- Health committee , seasonal mapping of diseases, action plan
- Nutrition programme being designed for members in Rural Marathwada



Mutual Product -Revised

- 100Rs/person/per year
- +100Rs if alcoholic/addict
- +100 if whole family not covered
- Family defined as both spouses with their children ,more can join
- No Age limit



Benefits of Mutuality-Monetary

PRIVATE HCP

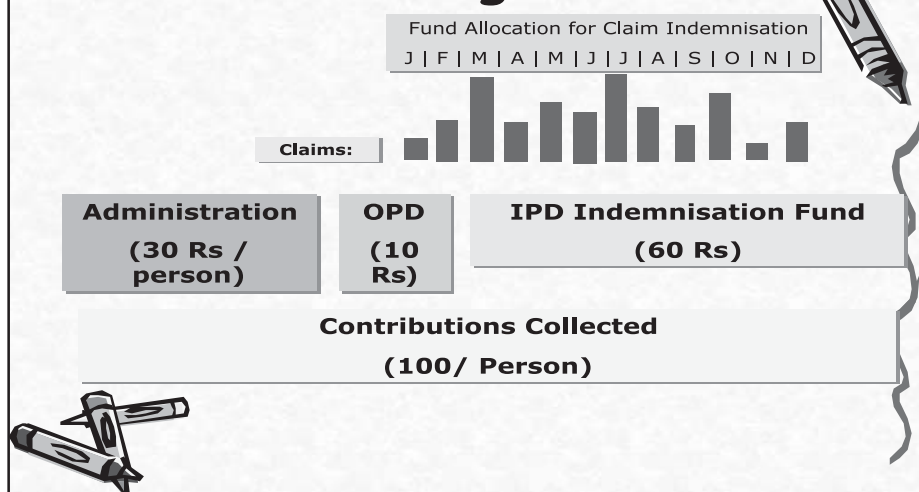
- 80% Reimbursement max up to 10000Rs
- Wage loss of 60Rs/day up to 15 days

PUBLIC HCP

- Reimbursement up to 80% of hospitalization expenses
- Wage loss of 75Rs/day up to 60 days



Funds Management



Claim Settlement Process

1. Declaration to field worker/Arogyasakhi or through phone (Any time)
2. Guidance toward Most appropriated and fairly priced quality health care provider
3. Cure
4. Claim file preparation and validation by a doctor
5. Local Claim committee validation along with doctor or coordinator (education /instruction of the claim)
6. Claim decision
7. Claim reimbursement

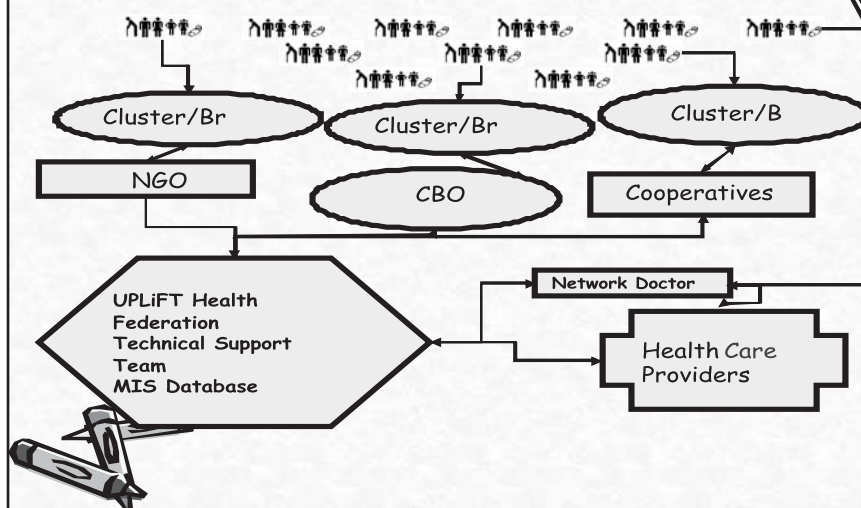
UPLiFT Services

- Product design ,
- Sustainability Planning
- Benchmarking
- Systems Setup -operations, accounting
- MIS,Software Support
- Tools -Monitoring, Reporting, Promotions
- Training support
- Network Doctor
- Claim servicing
- Helpline
- Health care Network

Uplift Health Federation - Mutual Partners

- In Pune City -Urban Slums since June 2003
- With Annapurna Pariwar Vikas Samvardhan APVS
- Parvati SwayamRozgar PSW
- In Rural areas - Latur, Osmanabad, Solapur since Feb 2006
- With three federations supported by Swayam Sikhsan Prayog SSP
- MIS support to Buldhana Urban Cooperative Credit Society, BUCCS since Jan 2006

How are we organized



SESSION
2

PWP
2.6

Asha Kiran
Prepaid Rural Health Care Scheme (PRHCS)
Lamtaput, Koraput District, Orissa

Experience with the Bonda Tribe

Ashita Abraham
Asha Kiran Society

The Bondas

- The Bondas live in Khairput Block, Malkangiri dt. Orissa and are scheduled as a Primitive Tribal Group (PTG) with a reputation of being hostile and difficult group to work with
- They have a stagnating population of about 5500, practice shifting cultivation and have very low literacy rate
- High morbidity and high maternal and child mortality
- Their isolation and society's fear of their violent ways have excluded them from basic rights of health care and education

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

2



May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

3

Background

- **1991**: Asha Kiran Society started health and holistic development work in Lamtaput block of Koraput district (Orissa). Secondary level, Asha Kiran base hospital set up.
- **1993**: Network of 185 Community Health Volunteers and 15 Community Development Organisers established covering the Block
- **1994-96**: Mobile clinics for the Bondas started at base markets and trips into hills to build rapport
- **1997**: Medical doctor and teacher couple start staying in Dumripada village in the upper Bonda hills, running a clinic and preschool
- **2000**: Moved to disused government building given by District Collector

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

4



May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

5

Background ...

- **2001**: Prepaid Rural Health Care Scheme started in Lamtaput block (50,000 pop.)
- **2002**: Asha Kiran – Action Aid Bonda Community Health & Development Project started. Community Health Workers trained.
- **2003**: Project extended to cover 6 villages with a population of 2207.
- **2003**: Prepaid Scheme extended to the Bonda hills (5,500 pop.)

Even though a fully equipped secondary referral hospital was set up, offering quality low cost care, the very poor still came too late for medical care or even died because they did not have money to pay. Many had to sell cattle or mortgage land to pay their bills. The sad episode of a young daughter being sold off to pay for the mother's medical expenses so traumatised the staff that it triggered action to start the prepaid scheme.

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6

Objective of PRHCS

- To help households who cannot avail of ready cash all the year round to access timely, quality health care at affordable cost.

Low cost quality care provided through

- Bulk of care at community and peripheral clinic level
- Rational drug use
- Low cost prescriptions (CDMU)
- Rational diagnostics
- Protocol driven care
- Low overheads (salaries of staff, basic clean amenities)
- Staff with a calling and commitment to serve the poor

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7

Health Priorities

1. Malaria
2. Acute Respiratory Infections
3. Diarrhoeal Diseases
4. Child birth related morbidity and mortality in mother and child
5. Malnutrition

$$\text{Priority} \propto \frac{M \times I \times V}{C}$$

where

M=Magnitude of the problem

I=Importance in terms of severity of effect

V=Vulnerability to control

C=Cost of control in the project area

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8

Details of PRHCS

- Year 1 & 2: 2001-03
 - Village-wise enrolment: Requirement – 75% households.
 - All members of household must register
 - Enrolment window: Jan. to Mar. (after harvest)
 - Premium: Rs.25 / child and Rs. 50 / adult limited to Rs. 200 / household
 - Fee for treatment by CHW & Mobile Clinic – Re.1
 - Fee for OPD registration & treatment – Rs.5
 - Fee for inpatient (medical) – Rs.50
 - Surgeries and deliveries – Rs.100

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

9

Details of PRHCS ...

- Year 3: 2003-04
 - Village-wise enrolment dropped since solidarity was absent in larger villages
 - Enrolment only for BPL Card Holders or on certification by Community Development Organiser to ensure that the poorest are not excluded
 - Premium: Rs.25 / child and Rs. 50 / adult limited to Rs. 200 / household
 - Fee for treatment (OPD, IPD, etc.) – 25% of total cost

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

10

Details of PRHCS ...

- Year 4 (2004-05) onwards
 - Enrolment only for BPL Card Holders or certification by Community Development Organiser
 - Premium: Rs.25 / child and Rs. 50 / adult limited to Rs. 200 / household
 - Fee for treatment (OPD, IPD, Medicine) – 25% of total cost
 - Fee for treatment (Surgeries & Deliveries) – 50% of total cost (Expenses for institutional deliveries can be claimed from the govt. by clients)

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

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Details of Bonda PRHCS

- Started in 2003-04
- Enrolment open to all
- Premium: Started at Rs.10 / child & Rs. 15 / adult. Presently, Rs. 25 / child and Rs. 30 / adult
- Free treatment - OPD, IPD, Medicine, Surgeries & Deliveries
- User fee paid by Action Aid

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

10

Financial Implications of PRHCS on Health Care Provider (AKH)

Operational Data on Comprehensive Program

	2005-06	2004-05	2003-04	2002-03
No. of household cards	461	359	295	176
No. of insured	2321	1654	1375	951
No. of Secondary Hospital Visits	1378	891	784	335
Premium Collection (Rs.)	74900	59275	48660	15220
Cost of Hospital Care (Rs.)	240078	183612	155390	74522
Fees from patients (Rs.)	69773	45903	38750	16980
Contribution by Asha Kiran Hospital (Rs.)	95405	78434	67980	42322
Free treatment to poor (Rs.)	883599	798448	385707	223657

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

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Operational Data of Bonda PRHCS

	2004-05	2005-06	2006-07
No. of household cards	150	172	198
No. of insured	605	728	845
No. of adults	382	426	491
No. of children	223	302	354
No. of clinic visits	1890	1942	
No. of Secondary Hospital Visits	22	42	
Premium Collection	Rs. 10,985	Rs. 20,330	Rs. 23,435
Cost of medicines at clinic by Action Aid	Rs. 29,652	Rs. 27,808	
Cost of referrals	Rs. 39,327	Rs. 22,725	
Subsidy from action Aid for gap in premium	Rs. 12,040	Rs. 7,030	7,965
Fees for patients paid by Action Aid	Rs. 10,394	Rs. 6,812	

May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

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Operational Data of Bonda PRHCS

	2005-06	2004-05
Premium collected/Person	Rs. 27.93	Rs. 18.16
Visits to Health Centre/Person	2.67	3.12
Visits to Hospital /Person	0.06	0.04
Cost of Medicines at Clinic/Visit/Person	Rs. 14.32	Rs. 15.69
Cost of Medicines at Clinic/Person	Rs. 38.20	Rs. 49.01
Cost of Hospitalisation/Person	Rs. 50.23	Rs. 102.08
Subsidy/Person	Rs. 57.21	Rs. 86.09
Percentage Households using clinic atleast once	88.37	88.67
Percentage Households using hospital atleast once	17.44	10.67

Notes: 1. Only direct cost of medicines at the clinic is included. No consultation fees nor other overheads are recovered.
2. For referrals services too, only direct costs are considered.

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Lessons Learnt

- Even the Bondas with a largely cashless economy (bartering for basic needs is common) are willing to contribute to their health care in cash or in kind
- They are gradually able to comprehend and participate in a pre payment plan
- The Bondas had limited access to modern health facility till the 24 hour clinic became operational in their area in 2001

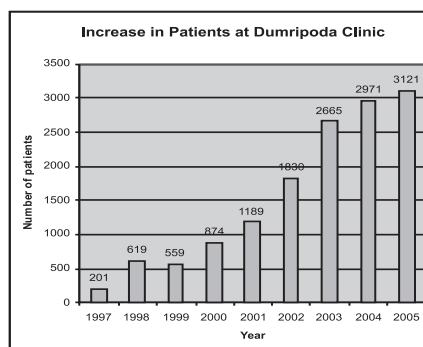
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Lessons learnt

- Health seeking behavior has seen a marked change since then
- Institutional deliveries and surgical services are being utilised
- Lives are being saved especially pregnant women and children
- This has been possible through a substantive subsidy from AKS and AA



May 29, 2006

Prepaid Rural Health Care Scheme, Asha Kiran, Lamtaput, Orissa

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**SESSION
3**

**PWP
3.1**



**ILO/STEP – CHSS – PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP**

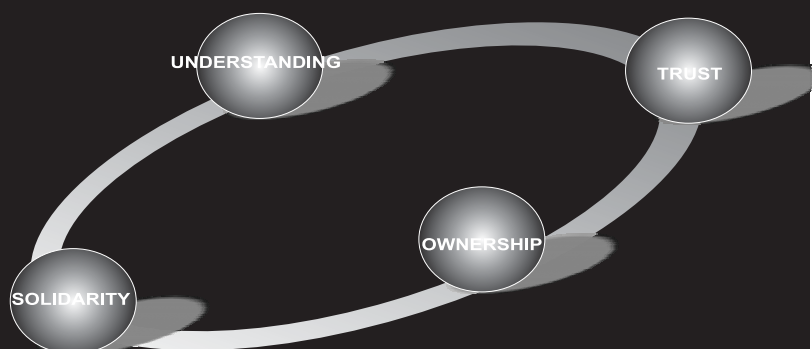
**« ADDRESSING THE HEALTH INSURANCE NEEDS OF THE POOR:
BUILDING UP TOOLS FOR AWARENESS, EDUCATION AND
PARTICIPATION »**
New Delhi, 29 -31 May, 2006

**SETTING UP A HEALTH MICRO - INSURANCE
SCHEME: LOOKING AT THE PROCESS AND
CONDITIONS OF SUCCESS**

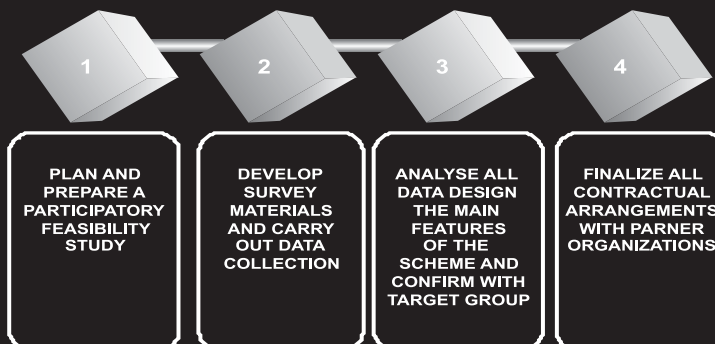
INTERNATIONAL LABOUR ORGANIZATION (ILO)
STRATEGIES AND TOOLS AGAINST SOCIAL
EXCLUSION AND POVERTY (STEP)



**HEALTH MICRO-INSURANCE:
THE CORE PRINCIPLES...**



**HEALTH MICRO-INSURANCE:
THE FEASIBILITY STUDY**





HEALTH MICRO-INSURANCE: THE OPERATIONAL MECHANISMS ...

- IN-HOUSE VERSUS PARTNER - AGENT MODEL
- SINGLE RISK VERSUS RISK PACKAGE
- VOLUNTARY VERSUS COMPULSORY
- INDIVIDUAL ENROLMENT VERSUS FAMILY ENROLMENT
- FIXED ENROLMENT PERIOD VERSUS ANY TIME ENROLMENT
- UP-FRONT PREMIUM PAYMENT VERSUS EASY PAYMENT MECHANISMS
- TIE UP WITH HEALTH PROVIDER VERSUS INDEPENDENT MODEL
- CAHLESS SERVICES VERSUS REIMBURSEMENT
- CO-PAYMENT VERSUS FREE ACCESS TO SERVICES
- IMMEDIATE ACCESS TO SERVICES VERSUS PRIOR AUTHORIZATION
- DIRECT SUBSIDY VERSUS INDIRECT SUBSIDY

.....



LEARNING FROM EXPERIENCE: VIMOSEWA / YESHASVINI HMI SCHEMES

THE SCHEMES

VimoSEWA

TARGETS SEWA MEMBERS
(700,000 STRONG)

COVERS HOSPITALIZATION
COSTS UP TO RS. 2,000

MANAGED BY
A TRUST

YESHASVINI

TARGETS CO-OPERATIVE
FARMERS
(8 MILLION STRONG)

COVERS SURGICAL
PROCEDURES UP TO
Rs. 100,000T

MANAGED BY
A TRUST



LEARNING FROM EXPERIENCE: VIMOSEWA / YESHASVINI EXPERIENCES

THE SIMILITUDES

VimoSEWA

INDIVIDUAL ENROLMENT

VOLUNTARY

LIMITED SCOPE H. BEN

HIGH NUMBER OF INSURED
174,000

HIGH ENROLMENT OBJECTIVE
300,000

NO CO-PAYMENT

YESHASVINI

INDIVIDUAL ENROLMENT

VOLUNTARY

LIMITED SCOPE H. BEN

HIGH NUMBER OF INSURED
1,473,000

HIGH ENROLMENT OBJECTIVE
3,000,000

NO CO-PAYMENT



LEARNING FROM EXPERIENCE: VIMOSEWA / YESHASVINI EXPERIENCES

THE DIFFERENCES

VimoSEWA	YESHASVINI
PARTNER-AGENT MODEL	IN-HOUSE MODEL
RISK PACKAGE	SINGLE RISK
LIMITED LEVEL H. BEN	HIGH LEVEL H. BEN
NO TIE UP WITH H. PROV.	TIE UP WITH HEALTH PROV.
REIMBURSEMENT	CASHLESS
FREE ACCESS TO H. SERV.	PRE-AUTHORIZ. REQUIRED.
NO TPA	TPA



LEARNING FROM EXPERIENCE: VIMOSEWA / YESHASVINI EXPERIENCES

THE DIFFERENCES

VimoSEWA	YESHASVINI
NO TPA	TPA
NO EASY PAYMENT MECHANISM	EASY PAYMENT MECHANISM
NO ADDITIONAL BENEFITS/DISCOUNTS	ADDITIONAL BENEFITS/DISCOUNTS
NO IMPROVEMENT IN TERMS OF ACCESS AND QUALITY	IMPROVEMENT IN TERMS OF ACCESS AND QUALITY
INDIRECT SUBSIDY	DIRECT SUBSIDY



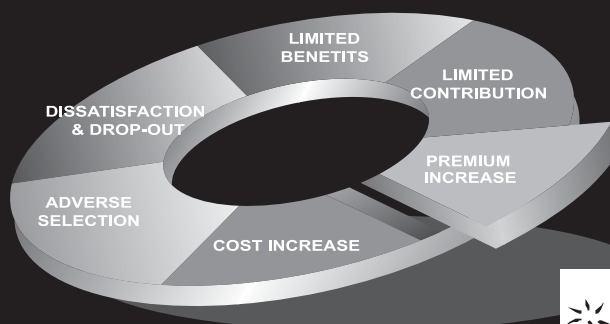
LEARNING FROM EXPERIENCE: VIMOSEWA / YESHASVINI HMI SCHEMES

THE RESULTS

VimoSEWA	YESHASVINI
HIGH CLAIMS INCIDENCE (4.2%)	HIGH CLAIMS INCIDENCE (1.8%)
HIGH ADVERSE SELECTION	HIGH ADVERSE SELECTION
HIGH CLAIMS RATIO (180%)	HIGH CLAIMS RATIO (97%)
MODERATE DROP (42%)	HIGH DROP-OUT RATIO (57%)
HIGH ADMINISTRATION COSTS	LOW ADMINISTRATION COSTS



HEALTH MICRO-INSURANCE: AVOIDING THE WORSE SCENARIO ...



HEALTH MICRO-INSURANCE: LOOKING AT SOME SOUND PRACTICES

- **INSURANCE PLANS COVERING ONLY HOSPITALIZATION EXPENSES SHOULD LINK UP WITH WIDER HEALTH PROGRAMMES IN ORDER TO PROVIDE ADDITIONAL BENEFITS TO INSURED**
- **BETTER TO OFFER A BROADER PROTECTION ON ONE PRODUCT THAN LOWER PROTECTION ON EACH ELEMENT OF A PACKAGE**
- **FAMILY COVERAGE IS FAR BETTER THAN INDIVIDUAL COVERAGE AND SHOULD BE OFFERED FROM DAY 1**
- **A CO-PAYMENT MECHANISM IS GENERALLY AN EFFECTIVE MECHANISM TO REDUCE MORAL HAZARD AND CLAIMS INCIDENCE**
- **A PRE-AUTHORIZATION MECHANISM MAY BE EFFECTIVE FOR REVIEWING THE CASES IN ORDER TO CURB A HIGH CLAIMS RATIO PROFILE**
- **BETTER TO INTRODUCE CAPS ON SOME HEALTH SERVICES THAN TO INCREASE THE PREMIUM RATE**
- **CASHLESS SERVICES SHOULD BE PROVIDED THROUGH A DETAILED CONTRACTUAL ARRANGEMENT WITH HEALTH PROVIDERS**



HEALTH MICRO-INSURANCE: CHALLENGES AHEAD...

- **SCALING UP: A BUMPY ROAD INDEED...**
 - YESHASVINI 700,000 MEMBERSHIP DROP IN YEAR III
- **INSURANCE EDUCATION FRONT: NOT MUCH TO SEE YET ...**
 - URGENT NEED FOR EDUCATION PROGRAMMES AND TOOLS ...
 - HEALTH INSURANCE: MUCH MORE COMPLICATED TO EXPLAIN THAN ANY OTHER INSURANCE PRODUCT ...
- **RENEWAL RATES: STILL VERY LOW ...**
 - TOP MARK SEEMS TO BE AROUND 50%?
- **ADVERSE SELECTION: STILL VERY HIGH**
 - SEWA INCIDENCE RATIO: FROM 2 TO 4 PERCENT
 - YESHASVINI INCIDENCE RATIO: FROM 1 TO 18 PER THOUSAND
- **EXCLUSION CLAUSES: STILL PREDOMINANT ...**
 - PREGNANCY-RELATED ILLNESSES (A CHOICE ?)
- **AND WHAT ABOUT THE ULTIMATE GOAL: QUALITY IMPROVEMENT? ...**
 - WHERE IS THE EVIDENCE ?



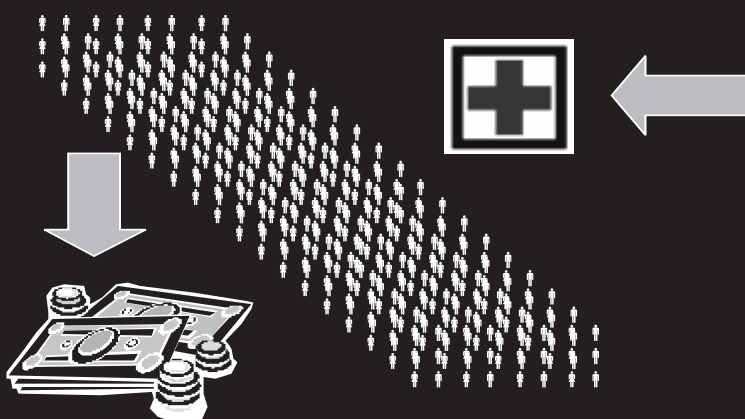


HEALTH MICRO-INSURANCE: TOWARDS SELF-RELIANCE?

SCHEMES	Nº OF BENEFIC.	TYPE OF SCHEME	TYPE OF COVERAGE	TYPE OF BENEFIT	TYPE OF SUBSIDY
YESHASVINI	1,473,000	IN-HOUSE	TER.	CASHL.	DIRECT
SEWA	174,000	P.AGENT	SEC.	REIMB.	INDIRECT
VHS	124,000	P.AGENT	PR/SEC	CASHL.	INDIRECT
KARUNA	118,000	P.AGENT	PR/SEC.	REIMB	IND/DIRECT
PREM	108,000	IN-HOUSE	SEC.	CASHL/REIM	INDIRECT
AROGYA	60,000	P.AGENT	SEC.	CASHL.	INDIRECT
H.FIELDS	16,000	P.AGENT	SEC.	CASHL/REIM	INDIRECT
UPLIFT	16,000	IN HOUSE	SEC.	REIMB.	INDIRECT
ASHWINI	12,000	P.AGENT	PR/SEC	CASHL.	IND/DIRECT



HEALTH MICROINSURANCE: IMPROVING ACCESSIBILITY? ...



HEALTH MICRO-INSURANCE: EXTENDING THE PARTNERSHIPS ...





ASIA MICRO-INSURANCE NETWORK (AMIN)

300 SCHEMES...
SO FAR ...



OBJECTIVES :

- SET UP AN EFFICIENT MECHANISM ALLOWING FOR THE REGULAR SHARING OF INFORMATION AND EXPERIENCE AMONG MICRO - INSURANCE PRACTITIONERS
- DEVELOP THE DOCUMENTATION PROCESS ON MICRO - INSURANCE INITIATIVES, INNOVATIONS AND ACHIEVEMENTS
- BUILD UP TECHNICAL CAPACITIES OF MICRO-INSURANCE ACTORS
- STRENGTHEN COLLABORATION AND PARTNERSHIP AMONG MICRO - INSURANCE SCHEMES
- HIGHLIGHT AND CLARIFY ISSUES, CHALLENGES AND OPPORTUNITIES RELATED TO THE CONTRIBUTION OF MICRO-INSURANCE TO SOCIAL PROTECTION EXTENSION



INTERNATIONAL ALLIANCE FOR THE EXTENSION OF SOCIAL PROTECTION

ILO, ISSA, AIM,
IHCO, WIEGO, ICA,
ICMIF

OBJECTIVES:

- ACT AS A GLOBAL CLEARING HOUSE FOR ALL ISSUES RELATED TO SOCIAL PROTECTION
- IDENTIFY, DOCUMENT AND SUPPORT ORIGINAL AND INNOVATIVE EXTENSION APPROACHES
- DEVELOP OVERALL CONSENSUS ON KEY EXTENSION ISSUES AND BEST PRACTICES
- BRING TRANSFERABLE INNOVATIONS AND REGIONAL EXPERIENCES TO THE INTERNATIONAL LEVEL
- PLAY AN ADVOCACY ROLE TO ENCOURAGE NEW EXTENSION INITIATIVES AT THE INTERNATIONAL LEVEL

**SESSION
4**

**PWP
4.1**

Anthyodaya Primary Health Care Promotion Scheme

Presented by:

ASM-Plan, Vijayawada (PU# 6036)



WHO WE ARE -THE BACK GROUND

Arthik Samata Mandal (ASM) made its beginning with the interventions in Relief and Rehabilitation of Cyclone and Tidal Wave of 1977 in Krishna District of Andhra Pradesh.



WHAT WE ARE NOW

ASM has departed from the status of relief and rehabilitation to an integrated development agency particularly aimed at helping the most disadvantaged communities (Tribals, Weavers and Dalits) with emphasis on women and children.





OUR VISION

Sustainable development, which emerged, as concept of Gram Swaraj is positive philosophy of life and an idea, which emphasises on the rational distribution of resources, decentralized economic and political system and simple life style.



OUR MISSION

The central aim of the ASM is to work with deprived communities and to make them self reliant and self sufficient model villages through mutually integrated programs.



OUR OBJECTIVES

- To impart and promote scientific secular, democratic and cosmopolitan outlook
- To make them better citizen by facilitating to realize their responsibilities
- To discharge their duties socially, economically, educationally and culturally in the society.

Area of operation

ASM is working in Krishna, Nalgonda East and West Godavari districts of Andhra Pradesh. Vulnerable communities include Lambadas (scheduled tribe), scheduled castes, weavers and economically backward communities

MAJOR INTERVENTIONS SINCE 1996:

- Creating awareness on rights of the children through child centered programs.
- Reducing malnutrition among children in all the target families
- Improving the quality and sustainability of child education programs with all stakeholders and Department of Education, A.P
- Improving the functional literacy of adolescents/women through vocational skills and training.

Contd...

MAJOR INTERVENTIONS SINCE 1996:

- Mother and child care, reproductive health of adolescents
- To empower communities to take action against HIV/AIDS to promote responsible sexual behavior.
- Protecting the health and nutritional status of adolescent girls and to prevent all forms of abuse.
- Motivating women to realize their potential and organize themselves to address issues collectively in the form self help groups (SHGs).

Contd...

MAJOR INTERVENTIONS SINCE 1996:



- Imparting vocational skills training to enable adolescents/women to become economically independent and to facilitate better employment opportunities.
- Enabling poor household to increase their income through improving productivity, and skills training.
- Providing poor households with basic services of safe water, sanitation, health, and alternative energy source.
- Improving financial services for the poorest of the poor by way of creating a habit of savings.
- Establishing community health funds as means to make primary health care affordable, available, accessible and

Highlights of our Program and Projects



- Federating Self Help Groups into Micro Finance Institution.
- Anthyodaya Educational Committee
- Federating all Village Education Committees (VECs) into Project Level Education Committee to sustain all educational programs.

School Health Committees



Formation of School Health committees
for achieving measurable changes in
knowledge attitudes and behavior



What is School Development Program?

- “School Development Program” is about all round development of child.
- To make school as a community centre
- To involve community and participate in development of education.



Anthyodaya Primary Health Care Promotion Scheme which is other wise called as Micro Health insurance



Issues:

- Health is a critical factor in development:
- ill health affects productivity
- Poverty causes ill health setting up a vicious circle of increasing poverty and sickness. The ability of people to make a living depends on their capacities.
- Lack of skills, knowledge, resources cause ill health in poor.
- Sickness induced loss of earnings which has been found to be the highest among the poor

Vision

- Subsidizing the premiums for poor
- Providing technical assistance to improve their management capacity
- Links with formal health care networks

OBJECTIVES OF THE SCHEME

- To subsidize the medical care of the members at primary, secondary and tertiary level.
- To encourage people 's participation in health care services.
- To encourage people to be a caring community and contribute towards the medical care of their fellow beings through membership fee.
- To reduce exploitation of moneylenders.

Membership Issues:

- Annual membership fee is Rs. 25/- per individual.
- Duration of membership is One year (January 1st to December 31st)
- During the membership time, member can avail health services up to Rs.2,000/-. However this may change time to time based on community opinion.
- In case a member availed his/her health services up to the maximum limit i.e. Rs 2000/- before the expiry of membership, he/she may re-join the scheme again by paying Rs.25/- for the rest of the duration.
- Any member join in the Scheme at any point of time at pro-rata basis for the balance of the expiry period.



Services will be provided at
three levels:

- 1) Primary level – Village/Thanda
- 2) Secondary level– COPD/FO
- 3) Tertiary level – Suryapet and Beyond



- Memberships are not transferable .
- Membership is void if the member seeks traditional/ RMPs services without intimating the respective PHWs.
- Each member will have photo identity card / family membership book.
- Renewals must be made fifteen days before Dec 31st every year.
- Membership expires every year by Dec 31st.
- If a member discontinues after one year and would like to re-join he/she has to pay Rs.25/- for each year for being non-member.

Membership Management

- Village/ Thanda Level: PHWs, CHVs (under the supervision of PHWs), and Village/ Thanda Health Committees.
- Formation and Strengthening of 'Village Health Committees' is the responsibility of concerned SMs and CCs under the supervision of Program Manager/CPMEO.
- Management of scheme will be the responsibility of 'Village Health Committees'.

Membership Management

- Community Level: VHCs and CHVs
- Cluster Level: PHWs and CCs/SMs
- FO level: GUH Coordinator and Program Manager (Apex body)

There are three levels of services available to the community. These include: primary level, secondary level and tertiary level. Following are the details of services available at each level

Service providers at Primary Level:



- Cases registration PHWs and CHVs
- Diagnosis by PHWs
- Medicines by PHWs. May be at a latter stage this will be done by CHVs
- Follow ups by CHVs at Village Health Pharmacies.
- All the Referral Reports must be prepared by PHWs every two days and submitted to the concerned CCs for approval
- Overall responsibility and supervision in by GUH coordinator

Services at Primary Level:



- First Aid
- Simple ailments like fever, headache, cold, stomach ache, and any other seasonal ailments
- No injections and antibiotics are allowed at this stage
- Only simple medicines will be provided at this level. In future aurvedic and homeopathic medicines will be considered
- Duration of treatment is for 2 -3 days only. If the patient situation doesn 't improve, he/she must be referred to secondary level without any further delay.
- Service value of Rs 100/- will be provided at this level.

Secondary Level: COPD



- Service provider at this level GUH coordinator along with COPD staff.
- Injections and Antibiotics are allowed at this stage
- Treatment begins with referral/case sheet/letter from concerned PHW
- Registration, diagnosis, prescriptions and preparing case report is the responsibility of the GUH coordinator and COPD staff
- Simple lab tests will be conducted at COPD level

Secondary Level Services: COPD

- Health Check ups, treatments up to Rs. 500/-.
- Based on COPD Doctor's examination/advise, the case will be referred to the concerned panel specialist doctor/hospitals either in Suryapet or out side the Suryapet

Tertiary Level: Suryapet and Out side Suryapet

- Services at this level include specialist consultations/ hospitalization at Suryapet or outside the Suryapet.
- Responsible persons at this level are GUH coordinator, Program Manager and Project Director
- Panel of Doctors/hospitals within and outside the Suryapet are yet to be identified
- Service value at this level is up to Rs. 1500/-
- The Services also provided through transportation/ Ambulance.





MIS



- Membership enrollment tracking through in - house built software PHP.
- Day-to-day utilisation of services by members at three levels.
- Tracking of disease patterns.
- Inventory of medicine usage by Village Health Pharmacies.
- Sharing of Software generated reports with Community on monthly basis.
- Tracking of health support maximum benefit level.

Fund Management

- Community level collections by VHCs under the supervision of local CHV.
- Cluster level collections/ disbursements by PHWs under the supervision of CC/SM.
- Collected amount being deposited by Apex body (at present in MACTS Account) under the guidance of PU Core team.
- All financial matters are being discussed and monitored by PU level peoples institutional representatives.

Awareness campaigns towards “Primary Health Care Promotion Scheme”

Gaps

- Due to the lack of proper understanding of the scheme people are not taking membership for all family members.
- Linkage development with other institutions to be strengthened.
- Advocacy and importance on PHP by families and communities.

Learnings



- Strengthening of Village Health Pharmacies.
- Periodic trainings of Community Health Volunteers
- Periodic Trainings to Village Health Committees.
- Sustainability of Village Health Pharmacy maintenance
- Creating demand for utilization of existing government health services.
- Networking with Micro Health Insurance institutions.
- The membership fee is being used as corpus fund for future utilization in micro health insurance scheme.

Sustainability of Scheme



- ✓ PU is aiming to build capacities among the communities towards continuous functioning of the primary health promotion scheme to support CHVs and VHPs.
- ✓ Every year contributions and membership fees will be deposited as a corpus fund.
- ✓ PU will reduce the support after 3 years and makes to utilise the community funds.
- ✓ Village Health Committees will be trained on the maintenance of the village health pharmacies.
- ✓ PU level Apex body will execute the entire PHP scheme.

Phase-out Strategy



- ☐ PU will facilitate the executive body in terms of funds management.
- ☐ PU support program implementation and monitoring with Apex body.
- ☐ PU will reduce from the facilitation role giving more responsibility to community as a main functional role.
- ☐ The entire program will be handed over to Apex body.

SESSION
4

PWP
4.2

cysd

Community Health Financing
Programme

A Challenge to secure the needy



Background

Perticulas	Thakurmunda	Saharapada
Outpatients	22,393	17,974
Population	80000	79022
Patient-	28%	23%



Population ratio

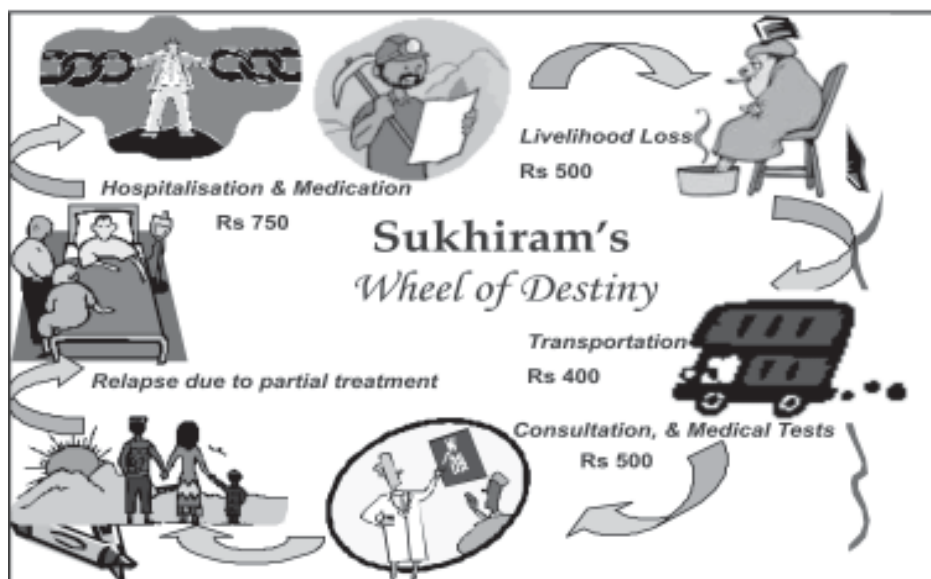
Approx 95% of the chief wage-earners within the households, work in the agriculture & daily labor

Direct contraction

Roughly 4% of them contract the disease of different kinds.

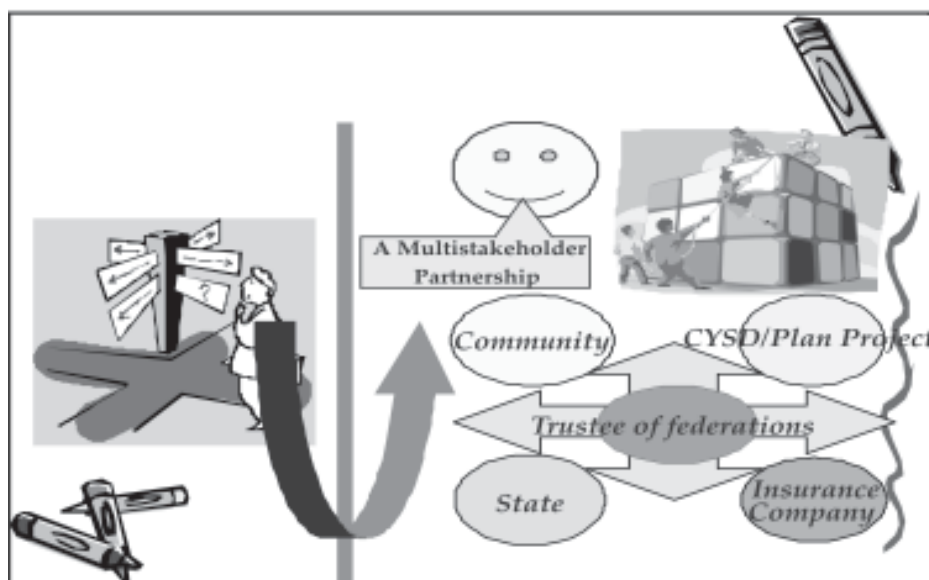
Secondary contraction

•The wife and other members in the family have 50% chance of contraction



Government

- Partially subsidized the insurance premium
- Spent money in the PHC architecture
 - But falling short of funds to repair the X -ray machine at the centre
 - Unable to increase the no. of beds in the PHC
- Sukhiram still unhappy



Required Work plan

Phase I	Reducing the losses due frequent diseases through preventive mechanisms
Phase II	Creation of Community Fund for low -medium impact diseases transferred to Federations & high impact risks like death risk is transferred to Insurance Companies
Phase III	Introduction of community health financing programme.

Details - Phase II

Phase 2

Creation of community fund with per household(husband wife and two child) contribution of Rs. 280 & Rs. 70 on individual basis.

- Will create a community fund in the long run
- Cover treatment and transportation costs
- Up to Rs. 2000 for hospitalization

Key Benefits

Likes of Sukhiram can manage the risk within Rs. 70 in the first year as against a cost of Rs.2000

Proposed Health financing Programme

- Services reaches the whole community in one shot
- Community expected to buy the services every year
- Commissions can be earned by the CHW 's & SHG members.
- commensurate with the ability to pay a particular membership

Stakeholder Roles

Advisor (CYSD/ PLAN Project)

State/PHC

- Providing institutional support
- Facilitating mutual utilization and management of state health infrastructure with people's organisations wherever required

Community

- Participating through monetary contributions and peer monitoring
- Cooperating with SHG federation for effective programme administration

Insurance Company

- Meeting specific demands of community for insurance products
- Backing the customized products through efficient services

CYSD/PLAN Project

- Playing the role of a public healthcare service provider

Stakeholder Rewards

Advisor (CYSD/ PLAN Project)	State/PHC
	<ul style="list-style-type: none"> • Result-oriented expenditure; greater focus on preventive aspects • Scope for delegation of responsibilities for effective outreach
	Community
	<ul style="list-style-type: none"> • Better healthcare services; greater sense of ownership & security • Larger potential to demand transparency and accountability
	Insurance Company
	<ul style="list-style-type: none"> • Covers only those risks that are fit to be covered by it • Sustainable relationship with communities through better service
	CYSD/Plan Project
	Enhancement of resources for better delivering healthcare services <ul style="list-style-type: none"> • Due compensation for services rendered; direct contribution towards community wellbeing; increased social visibility

Objectives

- To provide a forum for discussion of problems related to health.
- Asset creation and capital formation at the community level.
- Strengthening the capacity of CBO 's to manage community based health care activities ,thus ensuring programme sustainability and contributing towards better health of the community members.

Target Group

1. **Self Help Group Members**
2. **All community members (Individual/ Families)**

Membership Benefit

Primary Health Cover through HEALTH POST

- The members covered under the programme would receive free medical treatment at the village level. Each member would have to pay a fee of Rs. 5 during each visit and would receive free medication for his/her ailment; this fee is applicable for 3 visits for the same ailment within one week.
- The diseases covered under this programme are, INJURY, ENT, COLIC, DISPEPSIA, GASTRITIS, PILES, EPILEPSY, FRACTURE - O, LUMBAGO, FRACTURE - Surgical (femur, tibia, ribs), MALARIA, PNEUMONIA, BOILS, ECZEMA, SCABIES, SKIN ALLERGY, URTICARIA, WOUNDS, BRONCHITIS, TONSILLITIS, BURN URINE, DISMENORRHEA, LUCORRHEA, POLYMENORRHEA, RENAL COLIC, STERILITY

Secondary Health Cover through HOSPITALIZATION

Under the secondary health coverage the members can avail two options

- 1) Get treated at Salim Nursing Home in Karanjia, the bills including medicine costs will be settled directly by the authority in accordance to the upper limits set under the programme.
- 2) Get treated at Sub-Divisional hospital in Karanjia, since the consultation & hospital charges are free, other out of pocket expenses would be settled on actual basis. The bills including medicine costs will be settled by authority in cash as per the upper limits set under the programme.

Maximum liability per individual is Rs.2000

- The Hospitalization cover has an upper limit of Rs.2000 per member per year. The upper limit for number of days to be hospitalized in a year is 5.
- **Clarifications:** (Total claim amount is Rs 2000 including hospitalization Cost. If hospitalization goes beyond 2000 one has to pay excess amount from his own pocket)
- In either cases transportation would have to be arranged by the patient and would be payable up to a maximum of Rs.300. Food expenses would be paid to a maximum of Rs. 50/day or the actual whichever is lower.

Exclusions

- The cover does not include chronic ailments.
- Pre-existing illnesses are specifically included.
- Coverage shall commence 30 days from the payment of contribution.
- Age group is within 1 to 50 years for individual basis
- The scheme is a mutual fund with limited liability.

Membership Fee. & Documents Required.

- # Rs. 280/- for one family of four member (Husband, Wife, and two child)
- # Rs. 70/- for additional one member of a family (Excluding Husband, Wife, and two Child).

Claim Process

- Members will approach the health post and show the membership card.
 - Authorized person (health post assistant) will examine details and issue of claim form on payment of Rs 5.
 - Patient will approach authorized nursing home or hospital of the trust along with claim in case of hospitalization.
 - Patient will approach Doctor of CYSD along with claim form in the respective health post.
 - Dr will examine the status of the patient and extend the treatment (advice and some medicine). s/he will write the details in the claim form i.e. the type of diseases, what type of claim with details as it is in the format like X-ray, pathological tests required etc. the patient at her own cost would do the pathology and other tests if required.
- Next time if that patient comes then another claim form will be issued until his/her limit exhausts.
- Secondary and Tertiary cover:
 - If the patient would require hospitalisation, s/he would be referred to the authorized nursing home or Hospital. The patient would accordingly be given a claim form, which s/he would submit completely filled up along with the claim. On scrutiny, the claim amount would be released.



• **Role of Community Health Volunteers in the health post.**

- o Will issue claim form to patients.
- Will coordinate with the Doctor.
- Will collect database and coordinate with the other departments like X-ray, pathology etc at the end of the week and will make the payments to the respective departments.
- Will monitor the type of claim in case of a specific type of increasing claim.
- Will monitor the financial status at the end of the week.



• **Role of CYSD Authorized Doctor**

-

Will examine whether patient is eligible to get claim or not.

Suggests and educate the patients about necessary precautions to be taken in case of some diseases of repeating nature .So that asking rate of that type of diseases will be lower in the future.

Joining of New Members:



- Admitted on payment of subscription
- Health declaration form would be required for new joiners

Renewal:

- The membership can be renewed before the date on which the existing membership comes to an end.

Features:



- Affordable (Cheapest community health financing programme)
 - Easy Documentation
 - No Medical Tests
 - Simple Forms builds a long term relationship
 - We work together to reach out the needy through affordable community health financing programme)
- Quick claim settlement



Summary

- We would successfully achieved our objective during the next 5 financial years with the help of active support and co-operation from like minded federations.
- Now, we are looking forward to tie up with more such federations to create awareness and increase accessibility of health financing programme for the rural mass.
- We need your Valuable suggestions and support to meet the challenge.

**SESSION
4**

**PWP
4.3**

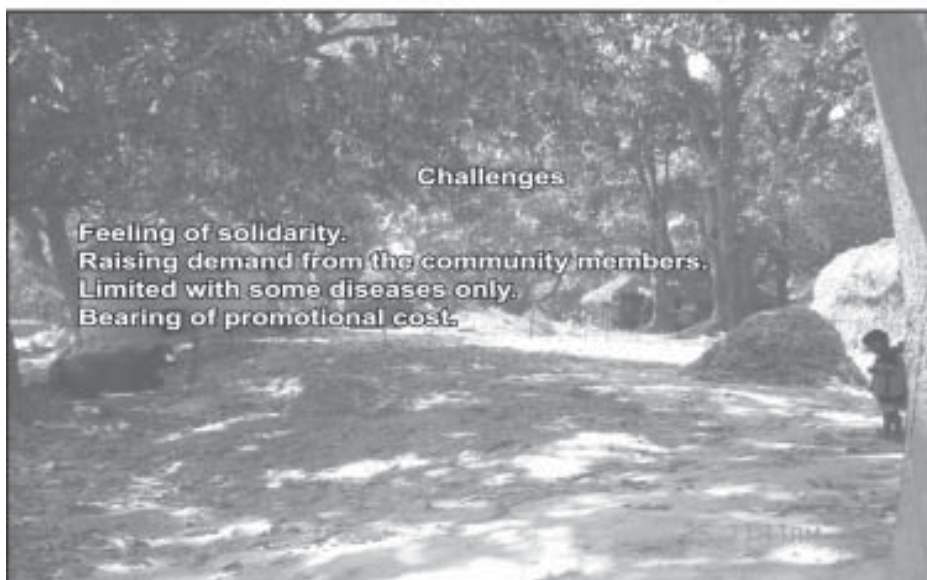
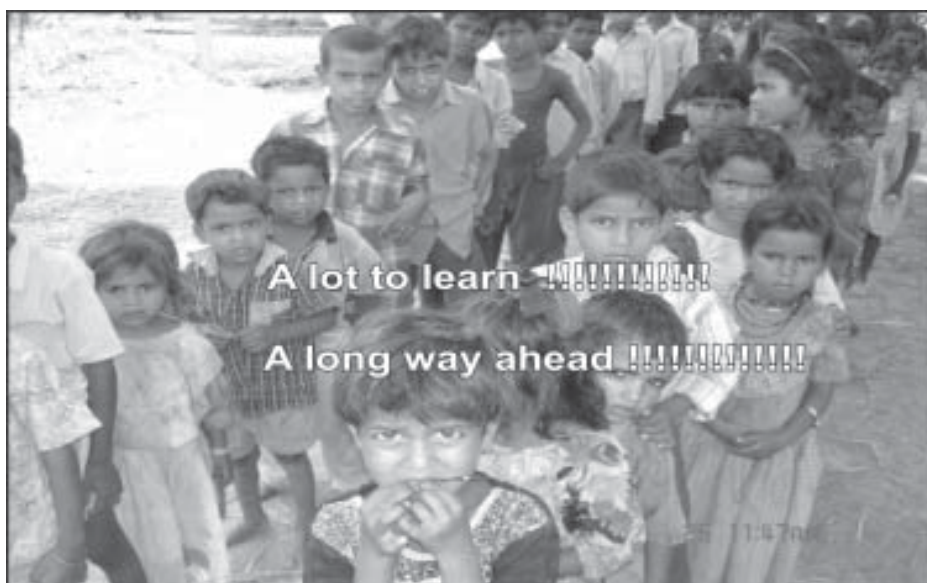


GNK- Plan is working within 75 communities at Ratanpur and Laxmipur block of District Maharajganj (UP). The area is located at the Himalayan foothills and it is in the humid and fertile Tarai plains. The northern boundary of the area is the international boundary of Nepal. South, East and West are bordered by Gorakhpur, Deoria and Basti districts respectively.

Micro health insurance Programme in GNK-Plan was initiated in 2003-2004 with 13 communities within 1399 families and 9246 population. Presently the programme is being implemented within 16 communities. All 16 communities are most backward. Even in 3 communities in rainy season we need to go via Nepal. communities there are no road communication.

MHI activities: At a glance

Details	2003-2004	2004-2005
No of families covered	266	397
No of population covered	1411	2121
Female covered under this scheme	672	1028
Male covered under this scheme	739	1086
Amount deposited by members	29710	46635
Amount supported by GNK-plan	29710	41053
Total amount accumulated in each year	59420	87688
Benefit taken by community members	0	4000
Balance at the end of the year	59420	131113
No of persons benefited	0	30
No of persons dropped	0	43
No of persons joined	266	174





**SESSION
4**

**PWP
4.4**

**MYRADA/PLAN H.D.KOTE PU
(6023)**

**SWASTHYA SURAKSHA YOJANE
(Health Insurance)**

By

Swamy Vivekananda Youth Movement in
Partnership with ORBIS India, New Delhi and
MYRADA/Plan H.D.Kote Project

What is Swasthya Suraksha Yojane?

Innovative project to provide health facilities to
community at minimum cost

Enrollment through Self Help Affinity Groups

- Person should be the resident of H.D.Kote Taluk
- Person insured should be a member or the family member of a sAg
- Annual subscription should be made through sAg

ಕಲೆ ಮೋಜಿನೆಂಬುದು ಯಾವ ನೋಂದಾವಣೆಗೆ ಅರ್ಹವೆ
ನೋಂದಾವಣೆಗೆ - ಸೂಕ್ತವು. ಮುಂತು.

- ❖ ನಿಮ್ಮ ಮಗ್ಗುಲವೆಂಬುದೇ ಹಾಸ್ಯಕರವಾಗಿರುತ್ತದೆ
- ❖ ನಿಮ್ಮ ಆತ್ಮವು ನಿಮ್ಮ ಮನಸ್ಸಿನಲ್ಲಿ ಬಿಡುಗಡೆಯಾಗುವುದಾಗಿರುತ್ತದೆ
- ❖ ಸ್ವಪ್ನವು ಸುಖದ ಸಂದೇಶವಾಗಿರುತ್ತದೆ
ಆದರೆ ಹಾಸ್ಯವು ಮನಗಾಂವು
- ❖ ನಿಮ್ಮ ಹಾಸ್ಯವು ಬಿಡುಗಡೆಯಾಗುವುದಾಗಿರುತ್ತದೆ
- ❖ ಸುಖದ ಮನಸ್ಸು ಸೋಗುವುದಾಗಿರುತ್ತದೆ.

- Doctors consultation and some facilities of SVYM Hospital will be provided free of cost for the persons who are covered under medical insurance

- SVYM provides special treatments such as delivery, surgery etc. on concessional rates
- Referral facilities are available for further treatments in other hospitals
- Awareness on health to insured members of sAgs
- Home visits by health volunteers
- Awareness to community through campaigns

ಈ ಧರ್ಮವು ಧರ್ಮವು ಸೌಖ್ಯವೇನು?

- ♦ **ଅନୁରାଗ** ଅର୍ଥାତ୍ ସ୍ନେହ ବା ପ୍ରେମର ସମ୍ପର୍କ ଥାଏ।
- ♦ **ଅନୁରାଗ** ହେଉଛି ଆତ୍ମା ଓ ମନର ସମ୍ପର୍କ।
- ♦ **ଅନୁରାଗ** ହେଉଛି ଆତ୍ମା ଓ ମନର ସମ୍ପର୍କ।
- ♦ **ଅନୁରାଗ** ହେଉଛି ଆତ୍ମା ଓ ମନର ସମ୍ପର୍କ।
- ♦ **ଅନୁରାଗ** ହେଉଛି ଆତ୍ମା ଓ ମନର ସମ୍ପର୍କ।

- Rs.60/- per person per annum
- Payment should be made in one installment to the hospital by the sAg

- Enrollment of all the family members in the scheme is compulsory
- Membership should be renewed every year
- If the person takes an insurance for 2 or 3 years discount in premium is offered

ವಾರ್ಷಿಕ ಶುಲ್ಕ ಎಷ್ಟು

- 1 ಕುಟುಂಬ ಪ್ರತಿಕ್ಷೇಪ 60 ರೂಪಾಯಿಗಳು
- 2 ಮನೆಯಲ್ಲಿ ಮಗುವು ಹುಟ್ಟಿದಾಗ ಸೇವೆಯಿರುವವರಿಗೆ ಕುಟುಂಬ
ಪ್ರತಿಕ್ಷೇಪ
- 3 ಕುಟುಂಬ ಎಲ್ಲರೂ ಕುಟುಂಬದಲ್ಲಿರುವವರು
- 4 ಪ್ರತಿಕ್ಷೇಪ ಕುಟುಂಬದಲ್ಲಿರುವವರಿಗೆ
- 5 ಒಟ್ಟು 2 ಅಥವಾ 3 ಮಕ್ಕಳು ಹುಟ್ಟಿದಾಗ ಮಗುವು ಹುಟ್ಟಿದಾಗ
ಕುಟುಂಬ ಪ್ರತಿಕ್ಷೇಪ

ಅವಲಂಬನೆಗೆ ಮಾರ್ಗದರ್ಶಕವಾಗಿ

- 1. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ ಮನೆಯ ಪ್ರಕೃತಿಯು
- 2. ದೀಪ್ತ ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 3. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 4. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 5. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 6. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 7. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 8. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 9. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ
- 10. ಪ್ರಕೃತಿಯು ಹಾಗೂ ಪ್ರಕೃತಿಯ ಮನೆಯ

•Vehicle facility to women who undergo delivery in the hospital and for surgery cases (restricted to H.D.Kote Taluk only)

Österreichische Staatsanwaltschaft

- * 1. OGA Wien - 10
- * 2. OGA Linz - 30
- * 3. OGA Salzburg - 30
- * 4. OGA Innsbruck - 30
- * 5. OGA Graz - 30
- * 6. OGA Wien - 10
- * 7. OGA Linz - 30
- * 8. OGA Salzburg - 30
- * 9. OGA Innsbruck - 30
- * 10. OGA Graz - 30
- * 11. OGA Wien - 10
- * 12. OGA Linz - 30
- * 13. OGA Salzburg - 30
- * 14. OGA Innsbruck - 30
- * 15. OGA Graz - 30

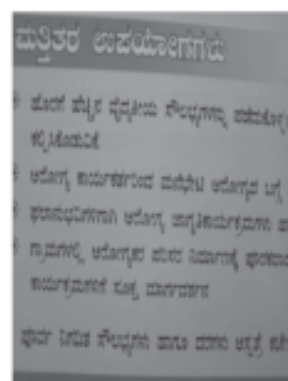
Facilities available on concession

Contd...

- Treatment in hospital such as dressing etc. (10%)
- Physiotherapy (10%)
- Ayurvedic Treatment (10%)

Other Facilities

- Linkage facility for further medical treatments
- Home visit by health volunteers and providing information on health
- Health awareness programs and training to insured persons
- Providing information to rural community on healthy environment and programs



How to Enroll?

- Through the Self Help Affinity Groups promoted by MYRADA/Plan



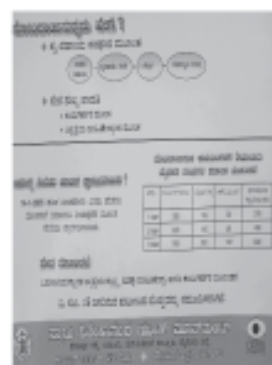
- Direct Enrollment

Through the volunteers

Through the information centres of the hospital

Concessions to families enrolled through sAgs promoted through MYRADA/Plan

Period	Premium per family of 5 persons	MYRADA / Plan	SVYM	Insured
1 Year	300	100	0	200
2 Years	600	100	50	450
3 Years	900	200	100	600



When did the services start?

On 14.01.2005 by conducting two deliveries at the hospital on concessional rates

Details of members enrolled and membership fees collected

	2004-05	2005-06
# of members enrolled	3343	488
Membership Fees Collected	200,580	29,280
MYRDA/PLAN Contribution	60,000	Yet to release

**SESSION
4**

**PWP
4.5**

People's Rural Health Promotion Scheme



One for all & All for one..

**PEOPLE'S RURAL EDUCATION MOVEMENT (PREM)
ORISSA STATE, INDIA**

PEOPLE'S RURAL EDUCATION MOVEMENT

- ❖ Since 1984
- ❖ Orissa, Andhra Pradesh, Tamil Nadu & Pondicherry
- ❖ 8,000 villages

NETWORK OPERATION

- ❖ 172 NGOs at 25 districts in Orissa
- ❖ 50,00,000 people

PEOPLE'S RURAL HEALTH PROMOTION SCHEME

- ❖ 500 Tribal villages in Gajapati District
- ❖ Fully developed CBOs
- ❖ Pilot Project

GAJAPATI DISTRICT, ORISSA

- ❖ Tribals 53%
- ❖ Endemic area
- ❖ Government facilities do not arrive
- ❖ Search for alternative approach to provide health care
- ❖ Study of
 - (i) Nilagiri Tea Garden (ACCORT)
 - (ii) Ambikapur (RAHA)
- ❖ Adoption of the local conditions

PROBLEM

- PREM's expenditure for referral medical care per year recorded Rs. 15,00,000
- How to provide medical care in inaccessible areas and at the same time raise funds to support for treatment
- Majority of the population in the project area do not have resources to meet the expenses

EXPERIMENT

- Tribals have rich social tradition of 'One for all and all for One' and 'Caring and Sharing' common resource mobilization for individual consumption is a part of the tribal culture.
- Three tiered delivery system to provide healthcare at the village, local PHC and referral cases to district hospitals

PILOT PROJECT

- ❖ Implemented in 500 villages with 1,00,000 members.
- ❖ In the process each of the members paid Rs. 20 per year
- ❖ A sum of Rs. 20,00,000 collected per year where as Rs. 15,00,000 spent for healthcare facilities
- ❖ Corpus is created with balance amount of Rs. 5,00,000 per year from membership fees and returns from investments.

CURATIVE ACTIVITIES

➤ VILLAGE LEVEL

Education & Supply of Appropriate Medicines from village Pharmacy by trained workers

➤ PHC LEVEL

Treatment of members referred by the village SHGs

➤ DISTRICT AND MEDICAL COLLEGE LEVEL

Treatment of the members recommended/referred from sector level

PROCEDURE FOR MEMBERSHIP REGISTRATION

Rural Health Promotion Scheme Report Generator

Location Code : MOI 001 M01

Family Type : FC

Report Type : Receipt

Generate Close

Computerized Receipt cum Identity Card

PEOPLE'S RURAL HEALTH PROMOTION SCHEME Utkal Mahila Sanchaya Vikash Mandapali, Berhampur-760007 Annual Membership Rs. 20/- (Jan to Dec 2003)	PEOPLE'S RURAL HEALTH PROMOTION SCHEME Utkal Mahila Sanchaya Vikash Mandapali, Berhampur-760007 Annual Membership Rs. 20/- (Jan to Dec 2003)
Membership # F 002333 / 01 Name : NAYAN CHAND NAYAK Sex : M DOB(dd mm yyyy) 25 12 1989 Family Type : FC Location Code : MOH001 M01 Village Name : DENGASARGI Amount Collected by Date : _____ Member's/Guardian's Signature	Membership # F 002333 / 01 Name : NAYAN CHAND NAYAK Sex : M DOB(dd mm yyyy) 25 12 1989 Family Type : FC Location Code : MOH001 M01 Village Name : DENGASARGI Amount Collected by Date : _____ Member's/Guardian's Signature

Computerized Print of Individual Receipt cum Identity Card in duplicate

One will be given to the member at the time of enrollment

Second will be kept as office copy

It will be renewed every year by putting a renewal stamp

TREATMENT EXPENSES PER MEMBER

- ❖ Expenditure upto 3,6000
- ❖ Exceptional case Rs 15,000 or more are spent / even referred to corporate hospitals

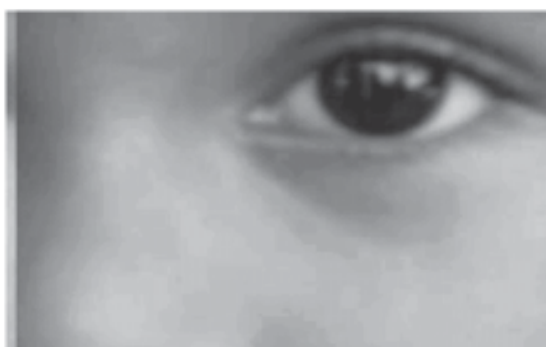
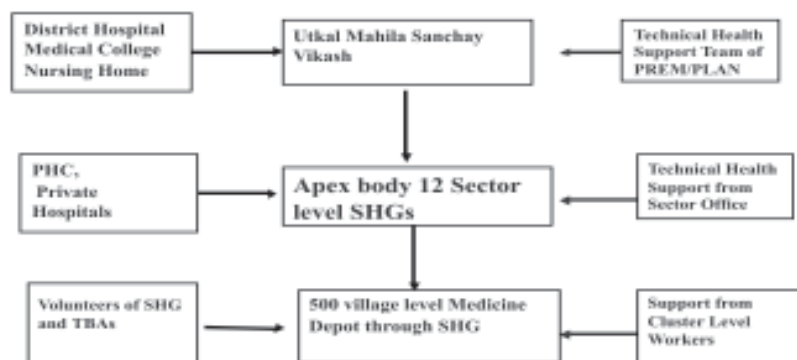
SCALING UP

- ❖ Training & management support is given by Plan International
- ❖ It is 3 years old can be reach sustainability within next 2 years
- ❖ Proposal to scale up 1,00,000 people to 5,00,000 people.
- ❖ Strengthen the federation level pharmacies by weekly visit by qualified doctors
- ❖ Better use of traditional medicines
- ❖ Payment of a sum of Rs. 20,000 upon death of a member

OUTCOMES

- Bring medical services for healthcare to the door steps
- Women reserve their rights on healthcare of the members of the family
- Immunization of the entire population becomes a reality
- IMR and MMR decreases
- Government organizations became more active and responsive
- Accessibility of the marginalized communities to urban hospitals

HEALTH PROMOTION SCHEME PROJECT STRUCTURE



All the members of the family including the babies are enrolled.

**SESSION
4**

**PWP
4.6**



SAMSKAR -Plan International (India), Nizamabad Project



SAMSKAR began its work with a three -generation plan. For, social reform cannot sustain itself (to that extent any kind of reform/social transition) unless three generations are covered – first generation of direct victims, second generation of direct witnesses and the third generation of people free from stigma as well as memory.



SAMSKAR -Plan International (India), Nizamabad Project



Keeping this fundamental understanding in view, the organisation always devises plans for reform -oriented development interventions and in the process concentrates on child and women empowerment, education, livelihood promotion, advocacy, research, basic health needs of the reformed families. Planning is continuous subject to interim needs and changes juxtaposed with ongoing monitoring and evaluations.



SAMSKAR -Plan International (India), Nizamabad Project



Implementation Procedure of Health Insurance Policy

The Project deals with the medical problems of the people at three different levels.

- Primary Level
- Secondary Level
- Referral Level



Primary Level:

All the common ailments and routine health problems will be treated by the health promoters at grassroots level.

Secondary Level:

Health complications of medium range would be referred to VHWs who in turn forward them to the local sub -centres and nature cure hospital established and run by the project. Since the project doctors visit these centres with an unfailing periodicity, most of the medium level health problems will be treated here.



Referral Level:

It is purely referral level where the project medical officers would suggest patients with chronic medical problems to the district level or even bigger level medical institutions where facilities for treating cases of accidents and medical emergencies are available



- The project tries to evolve a three -pronged structure to deal with the medical problems within the project area.
- The insurance policy is juxtaposed with regular and routine health interventions of the medical personnel of the project.
- This enables people, over a period, to depend less on the project (in respect of common ailments) and look into insurance coverage in respect of chronic diseases and medical emergencies.



Implementation Strategy:

- The enrolment will start from March 1st and ends on 31st March.
- The collection time will be extended upon the community request for 10 more days.
- The project is having separate committee (5 community members from project health committee and two members from hospital) to execute the Health Insurance, for which members would get elected from the CBOs of each cluster.
- The CBO capacity building programme will be launched simultaneously, so that the committee can monitor the insurance scheme effectively.



Terms & Conditions:

- Primary and secondary level health services will be rendered at free of cost.
- Each member will be given an identification card and passbook
- Each person will be provided with medicines worth Rs.300/-
- The project will not pay more than Rs.2,000/- per head for surgical interventions/hospitalisation. Rest of the charges should be borne by the families



Programme Highlights

- Number of villages covered : 53
- No.of persons covered :4820 – 1st year
- No.of persons covered : 5340 – 2nd year
- Program Started on : May 2005
- Membership fee : Rs.25/- – 1st year
- Membership fee : Rs.30/- – 2nd year
- Subscribed Amount : Rs.1,20,500/-
- Expenditure incurred : Rs.5,20,812/-



- Renewal Rate : 76%
- Networking with the Government has to be done
- Claim ratio is 8%
- Bringing all Muslim community into the scheme is a challenge

**SESSION
4**

**PWP
4.7**

(SBMA/Plan UTTARKASHI)

WELCOMES

ALL DELEGATES

**PHSF
(People Health security Fund)**

Objectives

- * Awareness among women Group to help each other to ensure better health.
- * Aware to MMD's for generate sources at village level for their health aspects.
- * Utilization of fund at emergency Health problems.(Inter loaning)in community.

Objectives

- Complete quality immunization achieved with the help of MMD(Mother & Child)
- MMD worked as pressure group for adopting Better health and hygienic practices by community.
- Better utilization of money and proper documentation skill development.

Summary at a Glance

SBMA/Plan Uttarkashi

- Total Gram Panchayats ----- 77
- Total Village ----- 140
- Total MMD ----- 133
- Total MMD supported by PHSF-----53
- Total Proposed MMD for PHSF---- 50
(Fy. 06)

Fund Status (PHSF)

SBMA/Plan Uttarkashi

- Total Fund Released for PHSF –3,36000/-
- Total Purposed fund (Fy06)-----4,00000/-
- Total fund generated by MMD– 10,30000/-
- Approx. inter loaned amount-- 7,00000/-
- Aprox.Benefited families----- 530

PHSF Strategy

- Cluster level meetings for Formation of MMD.
- Cluster level orientation program for MMD strengthen and PHSF concept.
- Skill development of MMD on Documentation and account keeping.

PHSF Strategy

- PU level orientation/Training on documentation/Account keeping and PHSF concept.
- Regular monitoring of MMD by Quarterly monitoring format and field visit.
- Selection of MMD for PHSF.

Selection criteria of MMD for PHSF

- Formation of MMD by proper channel .
- MMD having their account in recognize bank.
- They have their own bylaw's ,incorporated local bylaw's /Inter loaning pattern/amount limit/ Time period/ interest Rate etc.

Selection criteria of MMD for PHSF

- MMD working as pressure group for 100% immunization.
- MMD playing an important role to aware community for 100% birth registration with birth certificate.
- MMD playing an important role to aware community for better health and hygienic practices.

Selection criteria of MMD for PHSF

- MMD playing an important Role to promote community for Safe/Institutional delivery.
- Proper documentation maintaining.
- Organize regular meetings by MMD.
- Regularly participating different meetings/Trainings organized by Govt./NGO's regarding MMD strengthen .

Success story MMD Sald Uttarkashi

- village Sald situated at Bhatwari Block, Distt. Uttarkashi.
- It has 135 families and 1050 population.
- It far from Uttarkashi 07Km by jeep road.
- At June 2004 diarrhea spread at whole village.
- Total human losses were 6 by diarrhea at sald village.
- At a time maximum poor families required help (Money) for their treatment. (Approximate 20 family)
- MMD sald saved the life of 35 person.
- MMD Sald Help all of them by providing money from MMD's account i.e. Rs.11000/-
- All families return money to MMD after relief .
- It is a realistic use of PHSF provided by SBMA/Plan.

**SESSION
4**

**PWP
4.8**

Improving access of communities to quality health care: Seva Mandir's experience in Health financing

*New Delhi
May 29, 2006*



The context-

- Tribal communities in the region live in scattered habitations; hilly terrain makes access difficult and time-taking.
- Communities living in extreme poverty, burden of ill health and morbidity very high.
- Care-seeking most often from unqualified providers, cost of care high.
- Limited availability of qualified health providers; Govt. health services irregular, unpredictable - for both preventive, and curative services.
- Hospitals providing In -patient care located at large distances, accessing transport services during an emergency difficult and expensive.



Health Program - thrust areas

- Improving availability of basic health services at the community level-
 - Building up capacity of village functionaries, as TBAs and VHWs.
 - Networking with Government functionaries
- Improve the ability of the communities to seek care from health facilities, by addressing the gaps found (cost of travel, treatment costs, etc.)



Community Cluster Fund for EOC

- Initiated in 2001, with the objective of making available a fund at cluster level to provide support to the community for Obstetric emergencies and nutrition.
- Program initiated across 24 villages in 2002, up scaled to 100 villages in Seva Mandir's work area in 2003



CCF for EOC - Implementation

- Each cluster provided with a fund of Rs. 10,000 by Seva Mandir, every year for 3 years.
- Local village committees (GVC) made responsible to administer the funds in the beginning, responsibility passed on to a special women's committee constituted at the village level.
- Funds given to the community as per the needs, as an interest free loan; norms for disbursement and repayment decided by the community.



CCF - utilization

- CCF well received, reaching out to more than 1300 women over a period of 3 years (2002- 2005)

Utilization of CCF (2002- 05)

Year	Purpose of fund usage			
	Nutrition	Transport	Treatment	Total
2002- 03	121	20	28	169
2003- 04	202	56	42	332
2004- 05	561	57	234	852



CCF - key learnings and concerns

- Availability and flexibility of funds
 - In most cases, funds made available to the beneficiaries quickly.
 - Repayment mechanisms worked out at the cluster level, permitting these to be stylized to fit the economic means of each individual.
- In places, CCF also helped to strengthen linkages with Government and Private service providers.



Learnings---

- Repayment: Low repayment on CCF was a chronic problem, found across most clusters. Repayment rates higher in -
 - Clusters having a strong women's committee
 - Where a committee was formed to separately regulate the transactions from the fund.
- Reason for utilization: Nearly 70% of the utilization was for nutrition, and not for seeking emergency Obstetric care, for which the fund had been primarily designed.
- Prevailing unmet need: Even with the fund, half of the women still reverted to private funding sources, which charge at least some rate of interest.



Learnings---

- Knowledge gaps: within the community regarding the availability, and the purpose for the fund.
- Access issues, delaying the initiation of treatment in the event of emergencies.
- Supply side concerns: Insufficient, irregular support from the health providers.
- Modifications/ alterations, brought in the funds in places.



Coupon program

- Initiated in 2004, with the objective of strengthening linkages between health service providers and beneficiaries, and to build up accountability of service providers.
- Program initiated in November 2003, across 156 villages in Seva Mandir's work area- covering 317 TBAs and 242 village health workers.



Coupon program- Implementation

- Beneficiaries provided coupons/ vouchers for services provided by the TBAs and the VHWs; coupons distributed by the zonal staff, based on demand put forth by the health paraworker
- Community made aware of the coupons, and the purpose.
- Vouchers claimed by the VHWs and the TBAs from the beneficiaries on provision of services, and redeemed from the village fund/ zonal office.
- Each coupon having a unique code such that via data entry services provided to each beneficiary can be tracked.



Coupon program- beneficiaries reached

Beneficiaries reached, Coupon Program (2004 - 06)

Year	No. of children immunized	No. of home deliveries	Institutional deliveries
2004 - 05	2856	3614	260
2005 - 06	2767	3323	470



Coupons: Key learnings, concerns

- Coupons have helped in tracking the performance of the VHW, and the status of the various health services to some extent.
- In places, coupons have enabled the community to demand services from the TBAs and the VHWs.



Coupons: Key concerns

- Distribution of coupons
- Dependence on a third person for provision of services, and for payment.
- Difficulties in the verification of the beneficiaries of the various services.
- Coupons leave out/ do not compensate for the additional services provided by the VHWs.
- Limited awareness within the communities regarding the program.



The way forward---

- Initiatives on Community based health insurance being explored
 - Covering the major health needs of the community
 - Addressing the gaps/ concerns with the previous scheme
 - With active participation and ownership from the community.



**SESSION
9**

**PWP
9.1**

Management Information Tools

Uplift Health

1

WHY MIS?

Information - Core of Micro-Insurance.

Used For –

- Decision Making
- People orientation- Health status
- To track & understand - Financial operations
- To store members' data

Since all this is essential for running
"Health Mutual Fund"

2

INCLUDES WHAT?

List of Tools Used –

1. Syslift – Mutual Fund Management System
2. Monitoring Tools
3. Records
4. Reports
5. Business Plan

3

SYSLIFT - MFMS

The Health Mutual Fund
Management System

4

1. SYSLIFT - MFMS

- ✧ The first software developed by ITB for Micro Insurance Units.
- ✧ It is meant for community based organizations gathered together under an umbrella of UpL i ft Health Federation.
- ✧ SQL Based Flexible tool for Data Management.



- ✧ It is used to Monitor the Micro-Insurance Port-folio.

5

INTRODUCTION TO SYSLIFT

It includes the following facilities:

- ✧ Security: Login with password and various possible user roles.
- ✧ Data Model including Policies, Persons, Families, Socio economic information
- ✧ 5 Levels of portfolio consolidation (Cty – Fed)
- ✧ 3 Types of policies.
- ✧ Extensive Claim Information Management:
 - Health Events chosen from the ICD (WHO)
 - Any Bill or Expenses are sorted per Hospital
- ✧ Various reports and Wide potential for statistical studies.

INTRODUCTION TO SYSLIFT

It includes the following facilities:

- ✧ Policy Validation, Cancellation and Termination buttons - under role of controller.
- ✧ These are nothing but 3 policy status- Open Policy, Expire Policy, Cancel Policy And Revert Policy to open Status.
- ✧ Claim Status – Open claim, Encoded, Enquiry, Ready for settlement, Close.
- ✧ Includes the link of Crystal Reports given to the Syslift. E.g. OR, EPR, PDR, HCC Reports.
- ✧ Parameters to be set for the Report.

7

USES OF SYSLIFT

3 Important uses of Syslift:

- ✧ Data Management
- ✧ Reporting
- ✧ Analysis

8

OUR ROLE

- ✧ **Installation**
- ✧ **Maintenance** – Proper configuration, Monitoring, Back- up procedures, Back office set-up, to validate data entry and rectify the mistakes.
- ✧ **Up gradation & additions** – New specifications – ITB, Testing, Upgrade new versions, Need identification of reports, Design & installation of reports.
- ✧ **Trainings** – Data Encoders, COs, MDs.
- ✧ **Integration & standardization**

9

2. MONITORING TOOLS

• Promotion Monitoring Tool

Parvati Swayamrojgar

Coordinator's weekly input & monitoring tool

Month:

Branch:

Quantitative Monitoring:

New IMF/ST enrolments per week

(For each next week, Coordinator should select cases & fix visit target from IOP master list, weekly collection statement, Loan list, health camp attendance sheet etc)

Week	CM No	Policy	Target for the month	Number of families visited		No of forms filled	Number of new full paid this month	Full paid forms recorded in IOP	Comments
				Target	Actual	Actual			
1 st week	1	IOP							
	2								
	3								
	4								
	5								
2 nd week	1	IOP							
	2								
	3								
	4								
	5								

10

2. MONITORING TOOLS

• Claim Control Tool

APVS-Swasthyapurna Claims Data - 2004

Sr. no.	HCO	Month	Policy No.	Claim NO.	Ex.	Name of Claimed	Policy Type	Date of Submission of papers at Branch	Date of submission of papers to HO	Date of submission to Fed doctor	Illness	Illness/ Emergency	Name of the Hospital	Private/Low cost/ Network	Date of return by Fed doctor
---------	-----	-------	------------	-----------	-----	-----------------	-------------	--	------------------------------------	----------------------------------	---------	--------------------	----------------------	---------------------------	------------------------------

data - 2005.

Date of return by Fed doctor	Reasons for delay	Total expenses	Comments Given by Network Hospital	Amount paid to the Hospital	Claim amount recommended by Fed doctor	Claim Category recommended by Fed doctor	Claim % Sanctioned by group	Date of Claim Settlement	Amount settled	Remarks
------------------------------	-------------------	----------------	------------------------------------	-----------------------------	--	--	-----------------------------	--------------------------	----------------	---------



11

3. RECORDS

- Partners Recovery Book
- Petty Cash Book
- Receipts
- Meeting Minutes Book
- Promotion Register



12

4. REPORTS

- **Syslift Tech Report**

Health Mutual Fund Monthly statistics	ACCOUNTING PERIOD		MOO		MONTH
	Accumulated	Percent	MOO	MOO	
	2003	2004	2005	2006	MOO
Policies Issued this month (New + Renewed)	541	749	1,337	677	50
Contributions collected this month (New + Renewed)	111,256	148,960	251,890	135,560	26.4%
Written Contributions for Policies Starting this month	185,656	182,191	246,350	133,860	36.4%
Net of total policies starting this month	518	44	1	1	0.0%
Net of renewed policies starting this month	8	2	285	213	10.0%
Renewal Ratio	9%	63%	63%	17%	63%
Net of new policies starting month	418	442	890	628	5.0%
Net of on-going policies	518	444	1,340	980	1.36%
Net of total policies starting this month	518	2,543	4,482	3,166	4.4%
Net of on-going policies	2,047	2,543	4,129	3,569	4.5%
Contribution to the agent from new premium %					4.5%
Written Contributions allocated to the HMF claims fund	86,526	94,356	126,149	79,488	10.8%
Unearned Contributions allocated to the HMF claims fund	30,763	81,516	117,387	132,528	18.8%
Unearned Premium Amount	55,729	52,371	70,133	72,960	67.6%
Net of Claims this month	4	38	95	24	0.0%
Unearned Amount of HMF claim allowed this month	19,364	66,864	71,826	47,761	2.9%
Claim Ratio	100%	77%	14%	136%	1.0%
12 months Claim Ratio	89%	79%	48%	89%	87%
12 months Frequency Ratio	6.87%	6.12%	0.12%	0.12%	0.12%
Unearned Fund Balance (plus beginning)	12,424	39,813	79,362	85,867	35.6%
12 Months Pure Contribution (Claim Amount per member)	660.35	2.00	2.00	300.00	0.0%

- Nbr of Enrollments
- Collected Funds, Reserves
- Earned Premium
- Claim Ratio

13

4. REPORTS

- **Service Report**

- Nbr of References, Guidance, Admin Support
- Amt Saved thanks to References, Guidance, Admin Support
- HCC Data



5. BUSINESS PLAN

Includes –

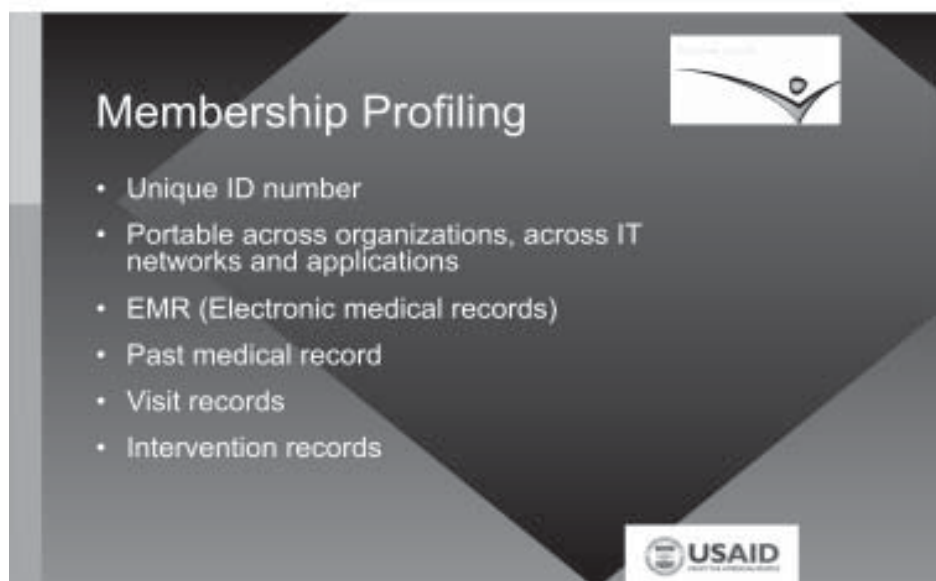
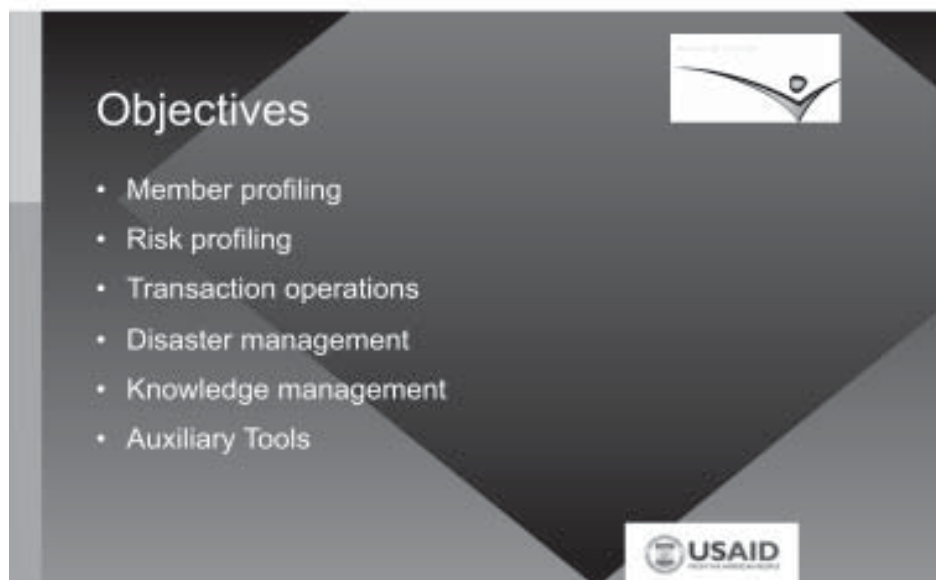
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- Operation Budgets
- Targets
- Achievements
- Sustainability Ratio



**SESSION
9**

**PWP
9.2**



Dynamic Risk Profiling



- Individual / Group health risks
 - Common ailments
 - Chronic ailments
 - Critical ailments
 - Life style ailments, etc
- Strategies
 - Risk transfer & Insurance
 - Risk mitigation



Medical Management



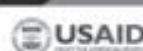
- DRG and rates
- Unique ID no for Providers & rating
- Electronic Medical Records
- Health Indicators tracking
- Using data code sets ICD-10 and CPT-4, electronic data exchange HL-7 using X12 formats.



Transaction Operations



- Work flow application (Online)
- Connects all stakeholders seamlessly
- Online dashboards
- Process mapping (Offline)
- Enrollment, Authorizations and Claims transactions



Knowledge Management



- Resource Center (Web enabled)
- Best practices K-base
- Reports portable to Excel and SPSS file formats
- Monthly partner dashboard reports
- MIS Dept for specialty reports



Other Tools






- Activity based cost (ABC) computations
 - Direct
 - indirect
- Hospital rating
- Disaster mitigation
- Insurance promoter (s) performance
- Preventive & Promotive program management




**SESSION
10**

**PWP
10.1**

ILO/STEP-CHSSS-PLAN INTERNATIONAL (INDIA) TECHNICAL WORKSHOP:

“ Answering the Health Insurance Needs of the Poor:
Building up Tools for Awareness, Education and
Participation”



**FROM LOCAL
INITIATIVES
TOWARDS
NATIONAL
SOLIDARITY
SYSTEMS**

Amin

ASIA MICRO INSURANCE NETWORK (AMIN)




INTERNATIONAL LABOUR ORGANIZATION (ILO)





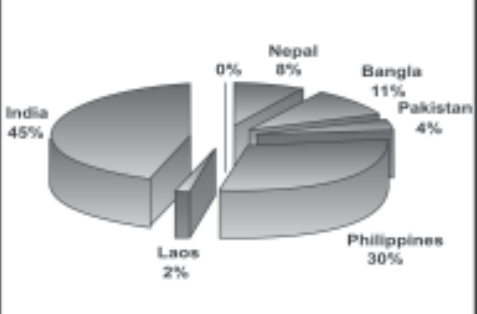
MICRO INSURANCE IN ASIA : A NEW REGIONAL INITIATIVE

- MANY COUNTRIES IN ASIA ARE STILL FACING A HUGE SOCIAL PROTECTION GAP
- MOST INFORMAL ECONOMY WORKERS OPERATING IN ASIA STILL DO NOT BENEFIT FROM ANY KIND OF SOCIAL PROTECTION MECHANISM
- IN SOUTH ASIA, FIVE COUNTRIES HAVE MORE THAN 90% OF THE WHOLE LABOUR FORCE EXCLUDED FROM SOCIAL PROTECTION MECHANISMS: INDIA, BANGLADESH, NEPAL, PAKISTAN AND AFGHANISTAN
- MICRO-INSURANCE IS ONE OF THE INSTRUMENTS THAT CAN BRIDGE THE SOCIAL PROTECTION GAP
- MICRO-INSURANCE CAN BE SEEN AS AN EFFICIENT EMPOWERMENT INSTRUMENT AND AS A SOCIAL INCLUSION MECHANISM
- TAILOR MADE MICRO INSURANCE CAN BE SEEN PROLIFERATING ACROSS ASIA

MICRO-INSURANCE ASIA: NUMBER OF SCHEMES

- So far close to 300 schemes have already been identified and documented across all Asia
- India, Bangladesh and Philippines have been the most successful in covering already huge segments of population as compared to other Asian countries

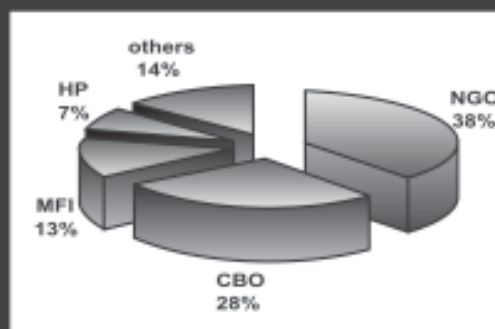


Country	Percentage
India	45%
Philippines	30%
Bangladesh	11%
Pakistan	4%
Nepal	8%
Laos	2%
Others	0%



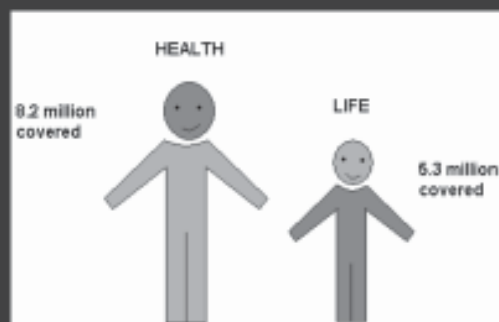
MICRO-INSURANCE IN ASIA: OWNERSHIP PROFILE

- Some 38% of documented micro - insurance schemes are initiated by NGOs
- However in Philippines CBOs are predominant
- India is a fine example of multiple actors like the NGOs, CBOs, HP, MFI, TU and GOV playing a major role



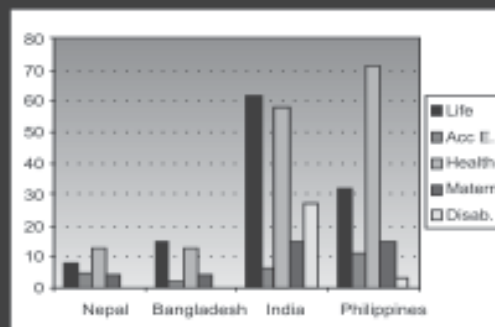
MICRO-INSURANCE IN ASIA: OVERALL COVERAGE

- Most micro insurance schemes recognise health insurance as the priority need of the poor
- Life insurance accounts for the second priority well ahead of other risks such as: accidents, livestock, assets ...



MICRO-INSURANCE IN ASIA RISK COVERAGE

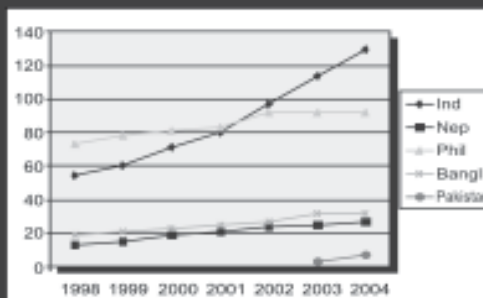
- Asian schemes are already covering wide diversity of risks as compared to other regions
- Maternity protection is also growing fast in Asia
- Philippines has the highest number of health schemes with a total 71, but India is fast catching up





MICRO-INSURANCE IN ASIA: GROWTH OF SCHEMES

- Rapid growth of micro-insurance is to be seen especially in Pakistan where 10 schemes were promoted since 2003
- India has the fastest growing profile with the number of schemes already doubled in the last 4 years

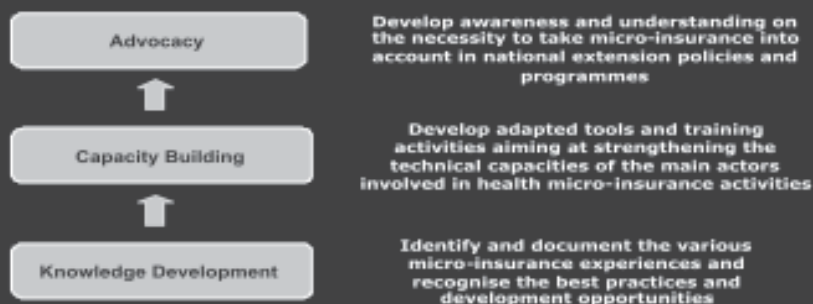


ASIA MICRO INSURANCE NETWORK: AMIN AT GLANCE

- 24 Permanent members representing 7 countries: Bangladesh, Cambodia, India, Nepal, Pakistan, the Philippines, Sri Lanka
- Some 300 schemes operating in 10 countries
- Some 290 Associate members
- Some 40 reference materials: inventories, case studies and studies



ASIA MICRO-INSURANCE NETWORK: THE BOTTOM UP APPROACH





ASIA MICRO-INSURANCE NETWORK: MAIN OBJECTIVES

- SET UP AN EFFICIENT MECHANISM ALLOWING FOR THE REGULAR SHARING OF INFORMATION AND EXPERIENCE AMONG PRACTITIONERS FROM DIFFERENT COUNTRIES
- DEVELOP THE DOCUMENTATION PROCESS OF VARIOUS ON-GOING MICRO-INSURANCE INITIATIVES, INNOVATIONS AND ACHIEVEMENTS
- BUILD UP A NEW TECHNICAL CAPACITIES FOR THE VARIOUS ACTORS INVOLVED IN MICRO-INSURANCE ACTIVITIES
- STRENGTHEN THE COLLABORATION AND ACTIVE PARTNERSHIP AMONG THE VARIOUS MEMBERSHIP-BASED MICRO-INSURANCE SCHEMES
- HIGHLIGHT AND CLARIFY ISSUES, CHALLENGE AND OPPORTUNITIES RELATED TO THE CONTRIBUTION OF MICRO INSURANCE SCHEMES TO THE EXTENSION OF SOCIAL PROTECTION
- ORGANISE NEW INITIATIVES AIMING TO CREATE A WIDDER AWARENESS AND STRONGER COMMITMENT ON THE NEED TO EXTEND SOCIAL PROTECTION



ASIA MICRO-INSURANCE NETWORK: MAIN PLANNED ACTIVITIES

- Production of AMIN promotional brochure
- Production of four newsletters
- Organization of various e-mails forum
- Update of national inventories
- Promotion and adaptation of health micro-insurance training guides
- Production of additional case studies on health micro insurance schemes
- Organization of technical workshops with various partner organizations



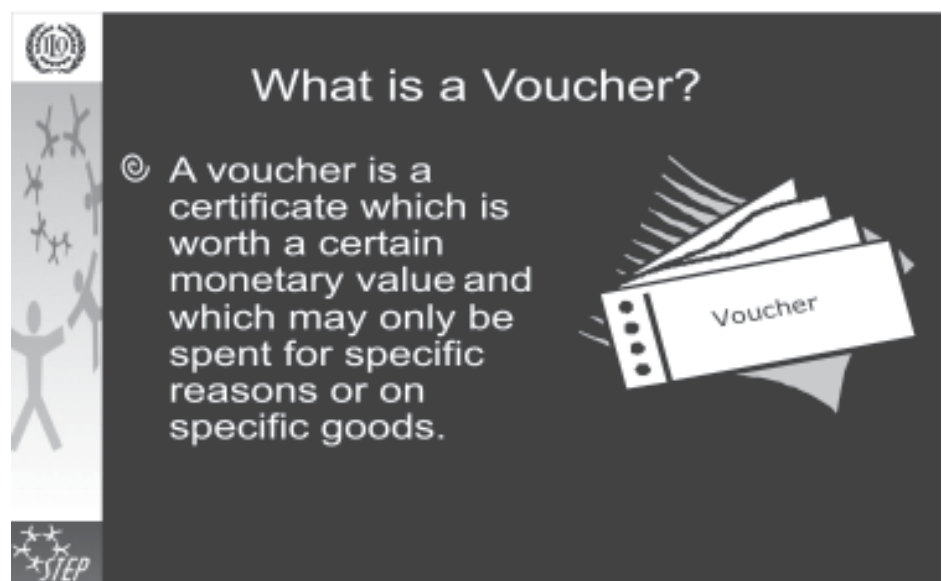
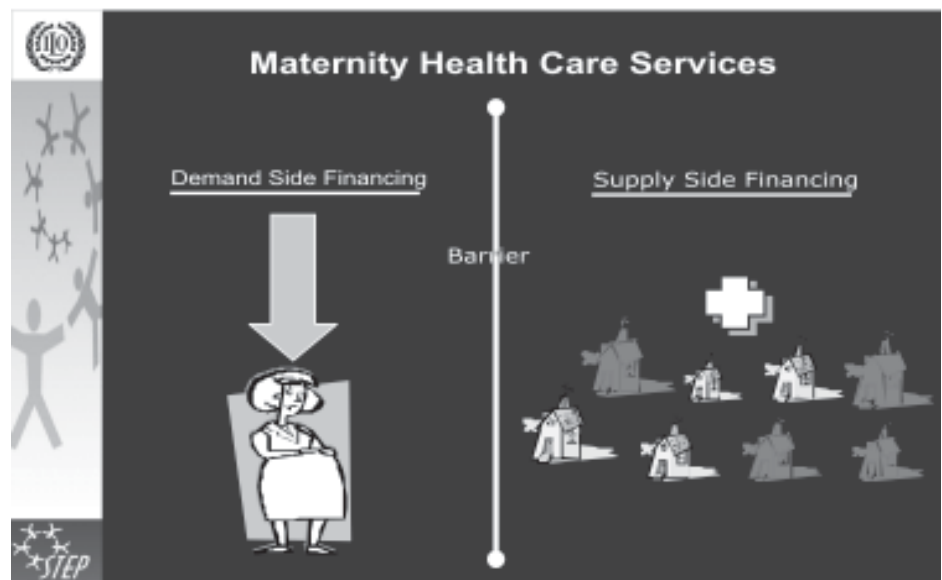
ASIA MICRO-INSURANCE NETWORK: PERMANENT MEMBERS

- | | |
|---------------|---|
| • BANGLADESH | • Grameen Bank |
| • CAMBODIA | • Bangladesh Rural Advancement Committee (BRAC) |
| • INDIA | • Groupe De Recherche et D'Echanges Technologique (GRET) |
| | • All India Association For Micro-Enterprise Development (AIAMED) |
| | • Emmanuel Hospital Association (EHA) |
| | • DHAN Foundation |
| | • Self Help Promotion for Health and Rural Development (SHEPERD) |
| | • Indian Association for Savings and Credit (IASC) |
| | • Self-Employed Womens Association (SEWA) |
| | • Narayana Hrudayalaya Asia Heart Institute |
| | • PLAN International |
| | • Family Health Plan Ltd. (FHPL) |
| | • SKS Microfin Pvt. Ltd (SKS) |
| • NEPAL | • General Federation of Nepalese Trade Unions (GEFONT) |
| | • B.P. Koirala Institute of Health Services (BPKIHS) |
| | • Public Health Concern Trust (PHECT-Nepal) |
| • PAKISTAN | • Kashf Foundation |
| • PHILIPPINES | • National Rural Support Programme |
| • SRI LANKA | • Coop Life Mutual Benefit Services (CLIMBS) |
| | • PAKISAMA Mutual Benefit Association |
| | • Sanasa Alimao Insurance Company Ltd. |
| | • Yasiru Mutual Provident Society Ltd. |



**SESSION
10**

**PWP
10.2**





What is demand side financing?

- © Demand side financing directs subsidies to the target group
- © Voucher is a form of demand side financing
- © Voucher is "a subsidy that grants limited purchasing power to an individual to choose among a restricted set of goods and services."



Objectives

- © To ensure the pregnant women to access to quality health facilities
- © To provide maternity health care regardless their income level
- © To encourage poor women to visit health care facilities during the whole sequence of maternity period
- © To give them a chance to choose health facilities
- © To decrease maternal and infant mortality rates
- © To change the health behavior



Characteristic

- © Subsidies to consumers based on personal or household characteristics
- © Consumer's choice of receiving specific services from a range of health providers, not from a single provider
- © Providers' competition to attract more consumers holding voucher
- © Limited value of voucher
- © Payment for services rather than for inputs





Target Beneficiaries



- © Pregnant women
- © Poor and Vulnerable
 - Income: low
 - No productive asset
 - Landless, etc.



Identifying Potential Beneficiaries

- To Visit NGO, community organizations, etc.
- To undertake a household survey to know potential beneficiaries



Determining the Contribution of the Poor

- To Assess their contribution capacities
- To map the health providers who could associate with the scheme
- To analyze with health providers of local health conditions





STEP

Organizing Co-payment Mechanism

- To know if any subsidy might be provided by the Government
- To develop contractual agreements with health providers
- To build up reimbursement mechanism with health providers



STEP

An Example of Benefit Package

- © Maternal health care package
 - 3 Ante-natal Care (ANC)
 - Safe Delivery (up to 2 children)
 - 1 Post-natal Care (PNC) within 6 weeks of delivery
- © Referral services for obstetric complications (e.g. Caesarian)
- © Additional benefits
 - Transport and other costs to voucher holders



STEP

In case of Obstetric Complications

- | | | | | |
|---|---|--|---|--|
| <ul style="list-style-type: none">▪ Designated by Providers▪ Refers complicated cases among the voucher holders to designated referral centers | ➡ | <ul style="list-style-type: none">▪ Designated Referral Centers▪ Providers services to the referred voucher holders | ➡ | <ul style="list-style-type: none">▪ Designated financial institution▪ Reimburses designated referral centers upon evidence of service provision |
|---|---|--|---|--|



Output indicators

- ⊙ Number of poor women who know about the voucher scheme
- ⊙ Number of eligible pregnant women identified and registered
- ⊙ Number of eligible pregnant women who received vouchers
- ⊙ Percentage of eligible pregnant women who received voucher
- ⊙ Number of designated providers
- ⊙ Number of voucher holders who received 3ANC check ups compared with control
- ⊙ Number of deliveries performed by the designated providers
- ⊙ Number of complicated cases that received services compared with control
- ⊙ Time between reimbursement claim and payment
- ⊙ Percentage of designated providers who received payment timely



Health Voucher Schemes in India

⊙ Cini Asha – West Bengal

CINI ASHA is the urban unit of Child In NEED Institute (CINI), a large NGO, which started outskirts of Kolkata to meet the nutritional and health need of newborn children and mothers in the periphery of Kolkata

⊙ Chiranjeevi – Gujarat

Chiranjeevi is a new government programme aiming to effectively bring down the maternal and infant mortality rates.

⊙ Janani Suraksha Yojana – MHFW – GOI

Janani Suraksha Yojana is now under pilot phase in 10 States by way of modifying the existing National Maternity Benefit Scheme. It targets all pregnant women belonging to BPL households and age of 19 years or above and covers up to two live births.

**SESSION
10**

**PWP
10.3**

Towards a National Health Insurance Strategy: Need for More Evidence Based Knowledge

Alex George

**Centre for Health and Social Sector Studies
Secunderabad**

Existing Health Provision

- **Public Health Sector expected to provide free health care (barring user charges) in some states: SCs, PHCs, CHCs, AH, CH, DH, Med. Colleges**
- **For profit Private Sector with clinics and hospitals ranging from NHs to Corporate Hospitals.**
- **NGO sector charging less than private sector and reaching some remote areas, but with a marginal presence**

NCMH Recommendations on Health Insurance for the Poor

- **Core Package and Basic Package which takes care of 85-90% of illnesses & conditions, to be provided free of cost through public health facilities**
- **Secondary Care Package to be financed also through health insurance**

CORE PACKAGE

To be universally made accessible at public cost:

Prevention and Treatment of all vector -borne diseases, TB, leprosy, HIV/AIDS (excluding treatment) and other STDs, childhood diseases. Immunization, Antenatal and Postnatal care, Family Planning and Preventive and promotive health education / information dissemination on all vital health matters, nutrition, water, sanitation and female literacy.

Basic Package

- A basic package consisting, in addition to the above, surgery and treatment for hypertension, diabetes, respiratory diseases such as asthma and injury.
- Surgeries covered include all major surgeries except superspecialty surgeries, eg. cardiac, cancer.

Secondary Care Package

- A secondary care package consisting of treatment for vascular diseases, cancer and mental illness in addition to referrals from the CHC that needs to be handled at district hospitals.
- To be financed by Social Health Insurance

Increasing Public Investment

- **Public funding needs to be stepped up for upgrading and strengthening sub district and district-level hospitals to provide quality care on par with private sector.**
- **To reduce household health expenditure as impoverishment due to medical costs takes place at this level.**

Health Insurance for Sec.Care 1

- **Social insurance implies insuring persons against definite risk and has a broader social objective than self-interest and require certain basic conditions:**
- **Having a gatekeeper like the CHC and a strong referral system**
- **Accreditation of private hospitals.**

Health Insurance for Sec. Care 2

- **Regulations of health insurance products to cover a minimum set of services provided in the secondary care package, based on treatment protocols, and predetermined rates.**
- **Community rated through income-related premiums**
- **Not allowing any exclusion of existing diseases.**

HI to be Mandatory

- **Mandatory health insurance to be achieved over the next 10-15 years in a phased manner.**
- **Mandatory insurance is the only way of obtaining the desired size of the risk pool to keep premiums low and affordable for the poor.**

Social Health Insurance Corporation of India 1

- **Merge ESIS and CGHS and reconstitute it as the Social Health Insurance Corporation of India (SHIC)**
- **SHIC in addition to taking care of Government and Organised Pvt. Sector patients will be a re-insurer to other insurance organisations catering to poor in particular**

Social Health Insurance Corporation of India 2

- **Envisaged as a re-insurance like NABARD (for rural credit), providing funding to health insurance companies / TPAs, cooperative societies / HMOs (like Grameena banks) etc, which could all compete for this pool of funds.**

Social Health Insurance Corporation of India 3

- The package will be implemented through the ESIS and CGHS hospitals which will come under SHIC and also other private & Govt. Hosps. A consolidation of public hospitals (SHIC), will prevent private health providers to charge at the rates they wish and pick and choose patients.

Need for Evidence Based Knowledge 1

- For Monitoring & Evaluation
- For On Course Correction
- To Improve Performance

Need for Evidence Based Knowledge 1

Enrolment	Sensitization campaign, Advertising, Media, Enrolment period, Incentives...
Benefits	Description of benefit package, type of benefit – cashless or reimbursed

Need for Evidence Based Knowledge 2




Pricing & Financing	Premium charged – individual, family/ group -, direct or indirect / hidden subsidy
Operational Mechanisms	Linkage with Insurance Cos, Contracting with service providers, Easy payment mechanisms
Risk Coping	Prevention against moral hazard, adverse selection, over-subscription

Need for Evidence Based Knowledge 3

Managemt. & Monitorg.	MIS: Data Maintained, Statistics Produced & Reviewed
Financial Results	Claim ratio, Cost per person, Administrative costs, surplus / deficit
Performance & Devlpmt.	Results versus targets, renewal rates, Changes additions in scheme, Sustainability

**SESSION
10**

**PWP
10.4**



**ILO/STEP –CHSSS – PLAN INTERNATIONAL (INDIA)
TECHNICAL WORKSHOP**

« ADDRESSING THE HEALTH INSURANCE NEEDS OF THE POOR:
BUILDING UP TOOLS FOR AWARENESS, EDUCATION AND
PARTICIPATION »
New Delhi, 29 -31 May, 2006

**NATIONAL COMMISSION FOR
ENTERPRISES IN THE UNORGANIZED
SECTOR:**




THE SOCIAL SECURITY REPORT
(MAY 2006)

INTERNATIONAL LABOUR ORGANIZATION (ILO)
STRATEGIES AND TOOLS AGAINST SOCIAL
EXCLUSION AND POVERTY (STEP)



TARGETED POPULATION

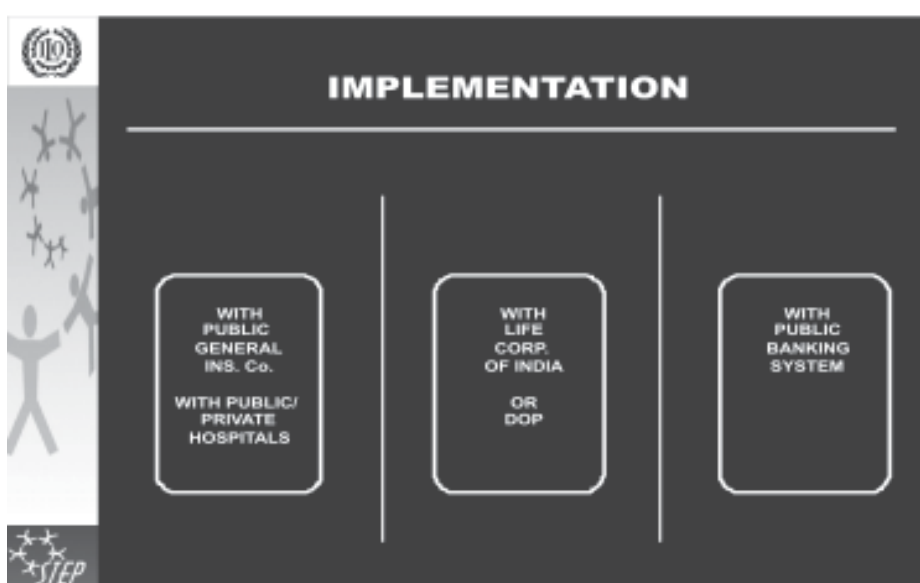
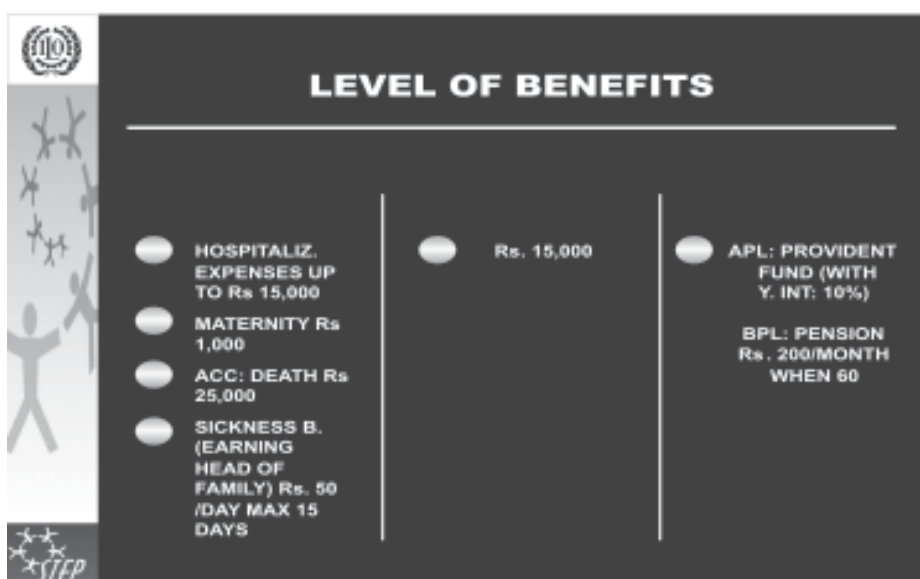
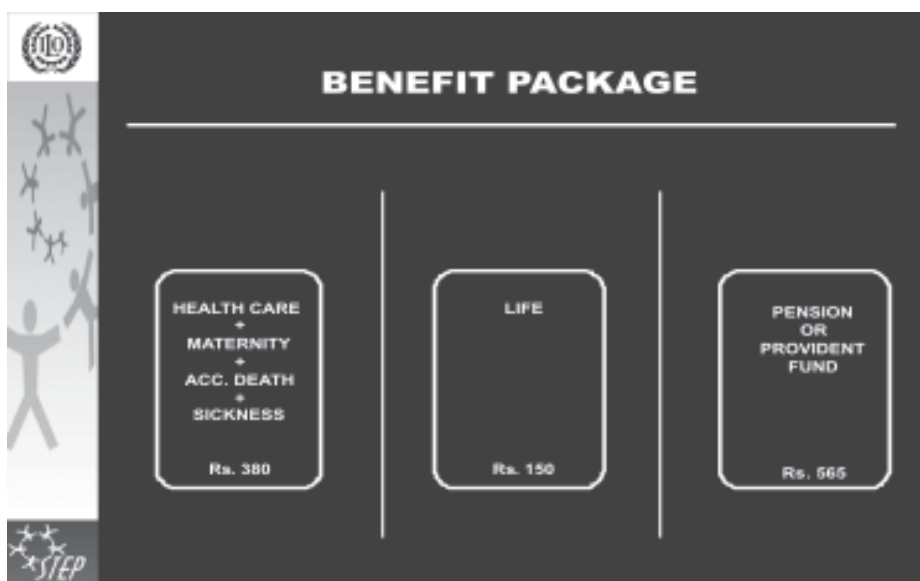
- UNORGANIZED SECTOR WORKERS EARNING LESS THAN Rs. 6,500 PER MONTH
- TARGET: 300 MILLION WORKERS IN 5 YEARS (60 million PER YEAR)
- FAMILY OF 5
- BPL POPULATION: 23% OF TOTAL



CONTRIBUTIONS

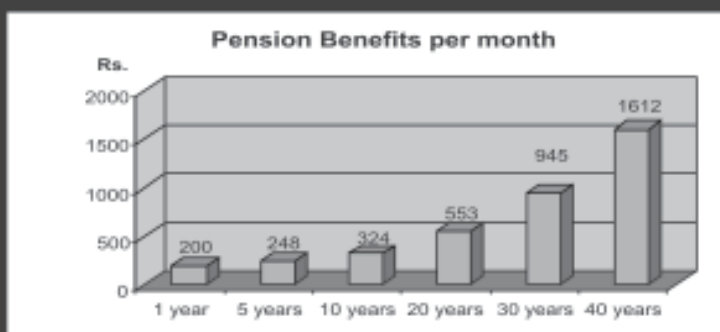
- WORKER: 1 Rs. PER DAY (Rs 365 PER YEAR) – IF BPL, CONTRIBUTION PAID ENTIRELY BY CENTRAL GOVERNMENT
- EMPLOYER: 1 Rs. PER DAY PER WORKER (Rs 365 PER YEAR) – IF NO EMPLOYER, CONTRIBUTION PAID BY CENTRAL GOV – 3/4- AND STATE GOV – 1/4 YEAR
- GOVERNMENT: Rs. 1 PER DAY PER WORKER (Rs. 365 PER YEAR) – 3/4 BY CENTRAL GOV AND 1/4 BY STATE GOV

TOTAL: Rs. 1,095 PER FAMILY PER YEAR

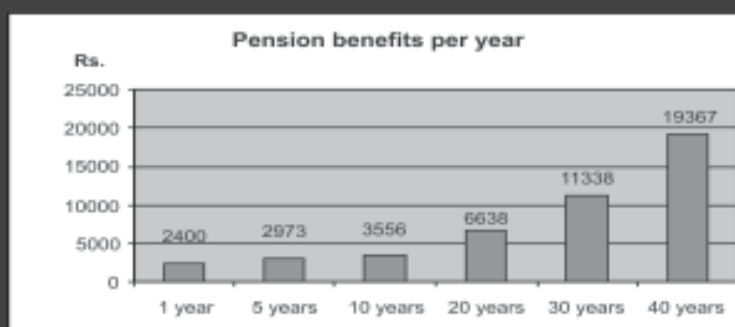




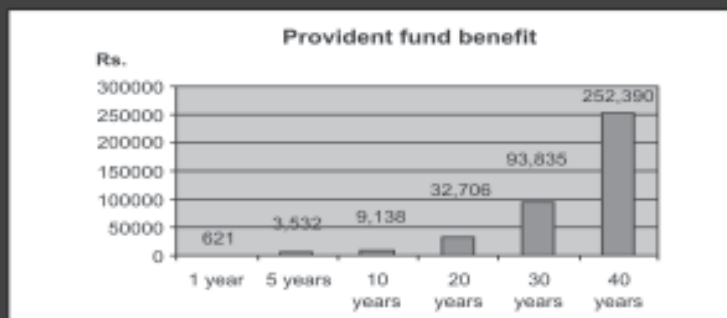
INDEXED PENSION BENEFITS



INDEXED PENSION BENEFITS (2)



Provident Fund Benefit



5. MAIN FEATURES OF THE HEALTH MICRO-INSURANCE SCHEMES OPERATING IN INDIA

No.	Designation	Start Year	Initiator	State	Area of Int.	Sch. Type	Sch.	Risks Covered	Total Ben.	Memb. Type
1	Anisha Microfin Association	2002	MFI	Tamil Nadu	Rural	Partn-Agent	S.I.	Health Care	3,744	Voluntary
2	Kagad Kach Patra Kashi Kari Panchayat	1998	TU	Maharashtra	Urban	Partn-Agent	S.I.	Health Care	4,210	Voluntary
3	Gandhi Samaraka Gama Seva Kendrum	2002	NGO	Kerala	Rural	In-House	S.I.	Health Care	3,567	Voluntary
4	Raigarh Ambikapur Health Association (RAHA)	1980	HP	Chattisgarh	Rural	In-House	S.I.	Health Care, Maternity Prot.	58,334	Voluntary
5	Mayapur Trust-Sri Mayapur Vikas Sangha	2003	NGO	West Bengal	Rural	Partn-Agent	S.I.	Health Care	1,022	VolComp.
6	Kasturba Hospital	1978	HP	Maharashtra	Rural	In-House	S.I.	Health Care, Maternity Prot.	14,390	Voluntary
7	Voluntary Health Services	1961	HP	Tamil Nadu	Rural/Urban	In-House	S.I.	Health Care, Maternity Prot.	124,715	Voluntary
8	Mathadi Hospital Trust	1982	CBO	Maharashtra	Urban	In-House	S.I.	Health Care	110,000	Compulsory
9	Students Health Home (SHH)	1952	GOV	West Bengal	Rural/Urban	In-House	S.I.	Health Care	1,587,890	Voluntary
10	Health Programme of Age Khan Health Services	1995	CBO	Gujarat	Rural	In-House	S.I.	Health Care, Maternity Prot.	5,635	VolComp.
11	Mallur Health Cooperative	1973	CBO	Karnataka	Rural	In-House	S.I.	Health Care, Maternity Prot.	20,000	Voluntary
12	Goelpara	1994	NGO	West Bengal	Rural	In-House	S.I.	Health Care	1,247	Voluntary
13	Seba Cooperative Health Society	-	HP	West Bengal	Urban	In-House	S.I.	Health Care	800	Voluntary
14	Self-Employed Women's Association (SEWA)	1992	NGO	Gujarat	Rural/Urban	Partn-Agent	S.I.	Health Care, Life, Accidental Death, Assets, Maternity Prot.	164,346	Voluntary
15	Nidan	2000	NGO	Bihar	Rural/Urban	Partn-Agent	S.I.	Health Care, Life, Accidental Death, Assets, Maternity Prot.	9,658	Voluntary
16	League for Education and Development (LEAD)	2000	NGO	Tamil Nadu	Rural	Partn-Agent	S.I.	Health Care, Life	4,320	VolComp.
17	Association for Sarwa Sewa Farmers (ASSEFA)	-	NGO	Tamil Nadu	Rural/Urban	Partn-Agent	S.I.	Health Care	20,000	Voluntary
18	Working Women's Forum (WWF)	1983	NGO	Tamil Nadu	Rural/Urban	Partn-Agent	S.I.	Health Care	20,000	Voluntary
19	Society for the Provision of Area Resources (APARC)	1997	NGO	Maharashtra	Urban	Partn-Agent	S.I.	Health Care, Accidental Death, Disability, Assets	2,000	Voluntary

No.	Designation	Start Year	Initiator	State	Area of Int.	Sch. Type	Sch.	Risks Covered	Total Ben.	Memb. Type
20.	Organization for the Development of People (ODP)	1993	NGO	Karnataka	Rural	Partn-Agent	S.I	Health Care, Life, Disability	1,137	Voluntary
21.	Activists for Social Alternatives (ASA)	2003	MFI	Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care	217	Voluntary
22.	Development of Humane Action Foundation (DHAN)	1997	CBO	Tamil Nadu	Rural/Urban	In-House	S.I	Health Care, Maternity Prot.	13,685	Voluntary
23.	Self-Help Promotion for Health and Rural Development (SHEPERD)	1999	MFI	Tamil Nadu	Rural	Partn-Agent	S.I	Health Care	8,540	Voluntary
24.	Action for Community Organization, Development and Rehabilitation (ACCORD)	1990	NGO	Tamil Nadu	Rural	Partn-Agent	S.I	Health Care, Life, disability, Housing, Assets	12,500	Voluntary
25.	People's Rural Education Movement (PREM)	2003	NGO	Orissa	Rural	In-House	S.I	Health Care	108,000	Voluntary
26.	Casp Plan International	2003	MFI	Maharashtra	Rural	In-House	S.I	Health Care	25,000	Compulsory
27.	Yeshasvini Trust	2002	HP	Karnataka	Rural	In-House	S.I	Health Care	1,473m576	Voluntary
28.	Karuna Trust	2002	NGO	Karnataka	Rural/Urban	Partn-Agent	S.I	Health Care, Loss of Income	118,808	Voluntary
29.	Arthik Samatha Mandal (ASM)	2003	NGO	Andhra Pradesh	Rural	In-House	S.I	Health Care	31,627	Voluntary
30.	Emmanuel Hospital Association (EHA)	2004	HP	Uttaranchal	Rural	Partn-Agent	S.I	Health Care, Accidental Death, Disability, Daughters Marriage	800	Voluntary
31.	Self Help Association for Development and Empowerment (SHADE)	1993	NGO	Kerala	Rural/Urban	Partn-Agent	S.I	Health Care	75	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.II	Health Care	4,200	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.III	Health Care	6,865	Voluntary
				Kerala	Rural/Urban	Partn-Agent	S.IV	Health Care	4,325	Voluntary
32.	Indian Association for Savings and Credit (IASC)	2002	MFI	Tamil Nadu, Kerala	Rural/Urban	Partn-Agent	S.I	Health Care	12,911	Voluntary
					Rural/Urban	Partn-Agent	S.II	Health Care	1,200	Voluntary
33.	Family Plan Health Limited (FPHL)	2003	TPA	Andhra Pradesh J&Kashmir	Rural/Urban Urban	In-House In-House	S.I S.II	Health Care Health Care	350,000 200,000	Voluntary Voluntary
34.	Healing Fields Foundation (HFF)	2004	NGO	Andhra Pradesh	Rural/Urban	Partn-Agent	S.I	Health Care, Accidental Death, Disability	15,900	Voluntary
35.	New Life	1995	NGO	Tamil Nadu	Rural/Urban	Partn-Agent	S.I	Health Care Accidental Death, Disability	17,860	Vol/Comp.
36.	Sri Kshettra Dharamsthalia Rural Development Project	2004	NGO	Karnataka	Rural	Partn-Agent	S.I	Health Care	166,000	Voluntary

No.	Designation	Start Year	Initiator	State	Area of Int.	Sch. Type	Sch.	Risks Covered	Total Ben.	Memb. Type
37.	Arogya Raksha Yojana Trust	2004	NGO	Karnataka	Rural/Urban	Partn-Agent	S.I	Health Care	56,411	Voluntary
38.	Youth for Action (YFA)	2004	NGO	Andhra Pradesh	Rural	Partn-Agent	S.I	Health Care, Accidental Death, Disability	2,715	Compulsory
39.	Uplift Mutual Fund	2004	NGO	Maharashtra	Rural/Urban	In-House	S.I	Health Care	16,062	Voluntary
40.	Manipal Health System	2005	HP	Karnataka	Rural/Urban	Partn-Agent	S.I	Health Care	62,500	Voluntary
41.	MD India Healthcare Services	2003	TPA	Madhya Pradesh	Urban	Partn-Agent	S.I	Health Care	49,419	Voluntary
42.	Naandl Foundation	2004	NGO	Andhra Pradesh	Urban	In-House	S.I	Health Care	49,000	Voluntary
43.	Halo Medical Foundation	2004	NGO	Maharashtra	Rural	Partn-Agent	S.I.	Health Care	3,424	Voluntary
44.	BAIF	2002	NGO	Maharashtra	Rural	In-House	S.I	Health Care	1,500	Voluntary
45.	Praghati Grameen Bank Chitr.	2004	MFI	Karnataka	Rural	Partn-Agent	S.I	Health Care	11,320	Voluntary
46.	Seva Mandir	2004	NGO	Rajasthan	Rural	In-House	S.I	Health Care	401	Voluntary
47.	CYSD	2005	NGO	Orissa	Rural	In-House	S.I	Health Care	15,448	Compulsory
48.	Samskar-Plan International (India) Nizamabad Project	2005	NGO	Andhra Pradesh	Rural	In-House	S.I	Health Care	5,303	Voluntary
49.	Myrada	2005	NGO	Karnataka	Rural	In-House	S.I	Health Care	3,831	Voluntary
50.	Bihar Federation of Milk Cooperatives	2004	CBO	Bihar	Rural	Partn-Agent	S.I	Health Care, Accidental Death, Disability	55,000	Voluntary
51.	Welfare Service Organisation	2005	NGO?	Kerala	Rural/Urban	Partn-Agent	S.I	Health Care, Accidental Death, Disability	50,000	Voluntary
52.	Asha Kiran Society	2001	HP	Orissa	Rural	In-House	S.I	Health Care	2,321	Voluntary
53.	Urmul Setu Sansthan	2005	NGO	Rajasthan	Rural	Partn-Agent	S.I	Health Care, Life	18,000	Voluntary
54.	GNK (Gram Niyojan Kendra) -	2004	NGO	Uttar Pradesh	Rural	In-House	S.I	Health Care	2,121	
TOTAL									5,130,918	