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RAHA

MIS

MEDICAL INSURANCE SCHEME

RAHA's SELF FINANCING MEDICAL INSURANCE SCHEME (MIS)

- **The Journey of Raighar Ambikapur Health Association began with the organizing committee meeting on June 8, 1969 in Holy Cross Hospital, Kunkuri, Raigarh dist, Chattishgarh State. The meeting was called to discuss a proposal for a Health Association. With the agreement of the participants RAHA was born.**

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VISION

RAHA envisions a wholesome, sustainable, caring and transformed community of people.

MISSION

1. **To build up local leadership through value – based training.**
2. **To work in partnership with people through an integrated and holistic approach.**
3. **To facilitate preventive, promotive, curative and rehabilitative health care services.**
4. **To promote Alternative System of Medicine.**
5. **To collaborate with like-minded individuals, organisations and government.**

HEALTH CARE SERVICES THROUGH RURAL HEALTH CENTRES

- The Rural Health Centres are established to provide health care services in the most needy areas. The services are provided with the understanding of wholistic health care. The emphasis is on treating the person as a whole and not only the disease.

- RHCs are managed by various church related NGOs. There are certain agreements between RAHA and RHC.

OBJECTIVES

"People's Health in people's Hand"

- To make medical facilities available in the community itself.
- To subsidise 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 from money lenders.

STRATEGY

A movement of people "I AM MY SISTERS/BROTHERS KEEPER"(Genus :4 .9) taking responsibility for each other.

WHO CAN BECOME A MEMBER

Any person (male or female) irrespective of age, caste, colour or creed.

THE MEMBERSHIP FEE

Any person desirous of becoming a member of the scheme shall pay annually a membership fee in kind or in cash equivalent to 2 kg of rice.

DURATION OF MEMBERSHIP

One year.

PRIVILEGES OF MIS MEMBERS ENJOYS

a. **At the Village level:** The VHW gives health education and free treatment on the specified minor sicknesses. For minor ailments they are advised to take home remedies.

b. **At the Rural Health Centre level**: A member enjoys the following privileges:

As Out-Patient –

- Free consultation
- Free medicine (pills) upto Rs.100/- per year

As In-Patient –

- Free consultation
- Fifty percent rebate is given on the total bill
- A pregnant mother, who is an MIS member if admitted for delivery at the Rural Health Centre will be expected to pay only Rs.50/- towards the entire cost of delivery charges.

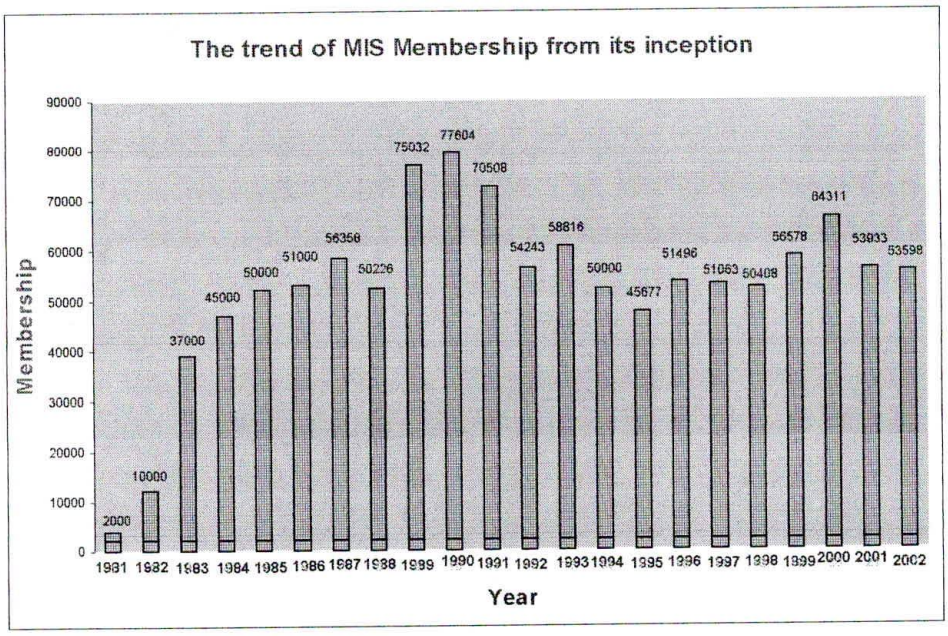
c. **At the Hospital Level**

  - A contribution to the extent of Rs.1,250/- is given on the total treatment per year.
  - Patients contribution towards hospital services is fixed as per the distance.

MEDICAL INSURANCE SCHEME (MIS)

Achievements:

- No. of districts RAHA provides health care services : 4
- No. of Rural Heath Centres coordinated by RAHA : 85
- Medical insurance members benefited : 77,604
- No. of health workers trained and activated : 2200
- No. of TBS trained and activated : 2500
- No. of Traditional Practitioners trained and activated : 850



MEDICAL INSURANCE MANAGEMENT COMMITTEE

The Medical Insurance Scheme is a people's movement. From its inception efforts were made to decentralize the scheme allowing greater participation for the people. The emphasis is on the role of VHW/Dai at the village level and the Rural Health Centre as a secondary level of treatment and support. Now it is considered essential to formally establish Local Committee to administer the scheme at the local level through Medical Insurance Management Committee.

PURPOSE OF THE COMMITTEE

The committee is constituted with a purpose of administering the Medical Insurance Scheme at the beneficiaries level. The committee is an expression of RAHA's purpose of empowering the people to manage their own affairs.

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WILLINGNESS TO PAY FOR RURAL HEALTH INSURANCE THROUGH COMMUNITY PARTICIPATION IN INDIA

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SUMMARY

The main objective of this article is to examine the willingness to pay for a viable rural health insurance scheme through community participation in India, and the policy concerns it engenders. The willingness to pay for a rural health insurance scheme through community participation is estimated through a contingent valuation approach (logit model), by using the rural household survey on health from Karnataka State in India. The results show that insurance/saving schemes are popular in rural areas. In fact, people have relatively good knowledge of insurance schemes (especially life insurance) rather than saving schemes. Most of the people stated they are willing to join and pay for the proposed rural health insurance scheme. However, the probability of willingness to join was found to be greater than the probability of willingness to pay. Indeed, socio-economic factors and physical accessibility to quality health services appeared to be significant determinants of willingness to join and pay for such a scheme. The main justification for the willingness to pay for a proposed rural health insurance scheme are attributed from household survey results: (a) the existing government health care provider's services is not quality oriented; (b) is not easily accessible; and, (c) is not cost effective.

The discussion suggests that policy makers in India should take serious note of the growing influence of the private sector and people's willingness to pay for organizing a rural health insurance scheme to provide quality and efficient health care in India. Policy interventions in health should not ignore private sector existence and people's willingness to pay for such a scheme and these two factors should be explicitly involved in the health management process. It is also argued that regulatory and supportive policy interventions are inevitable to promote this sector's viable and appropriate development in organizing a health insurance scheme.

KEY WORDS: willingness to pay; viable health insurance scheme; community participation; contingent valuation approach

INTRODUCTION

The World Bank's agenda on *Financing Health Services in Developing Countries* (1987), and the recent *World Development Report* (1993), emphasizes the demand side — highlighting health insurance, user fees, and the private sector for strengthening the health sector. This is a major departure from the

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earlier approach which focused on the supply side—public sector spending, costs, management and efficiency—that has dominated the international health finance agenda for many years (Griffin, 1989, 1990). The emphasis on demand is quite understandable as even two decades after *Health For All by 2000 AD* was launched, the non-availability of the necessary finances is a major obstacle to further progress in many developing countries like India (Abel-Smith and Dua, 1988; Abel-Smith, 1992).

In fact, there has been substantial increases in the total plan expenditure in India for health and family welfare in nominal terms, but it has not increased in real terms (Economic Survey, 1997). For example, the total plan outlay for the Sixth Five Year Plan (1980–85) was Rs.6.7 thousand crores, which accounted for only 3.12 per cent of the total outlays of budget during this period. It increased to Rs.14.1 thousand crores; but in real terms it had increased only 0.12 per cent in the Eighth Five Year Plan (1992–97). Health expenditure in relation to the gross national product (GNP) in India was about 0.98 per cent in the Seventh Five Year Plan as compared to 0.91 per cent in the Sixth Five Year Plan. Indeed, the anticipation that governments would increase expenditure on health services to 5 per cent of the GNP was, in most cases, unlikely to be realized. Yet, there is little evidence that donors will increase their aid to the health sector, including in India. Ministries of health are being asked to find their own solutions. This is an unfortunate scenario at the national level.

The situation at the state level seems to be no better. For example, out of the total plan allocation, only 3.30 per cent was the maximum proportion allocated for the health and family welfare sector of the Karnataka state during the last 15 years of planning. It accounted for only a maximum of 0.17 of net state domestic product for the same period. This has resulted in an under-funding situation in the health sector at the state level. This kind of concern has led to substantial debate, in the national and international context about the range of options for financing health care (de Ferranti, 1985; Hoare and Mills, 1986; WHO, 1987; World Bank, 1987; Zschock, 1979). One central option is to introduce a health insurance scheme for improving quality health care services. Health insurance is a risk-sharing approach whereby communities or individuals pool their resources to cover uncertain costly events, which would otherwise be difficult or impossible for individuals to afford at their time of need.

There are several types of health insurance schemes operating in India, through the General Insurance Corporation (GIC) and Life Insurance Corporation (LIC). A central problem of these schemes is that they are biased towards only the salaried class and better-off people, whose resulting distribution of services is often regressive, with middle-income and higher groups benefiting disproportionately. Further, the doctors and hospitals in India are concentrated mostly in the cities, where they are available to the urban middle class but too far away to benefit most of the rural poor.

In this context, it is realized that studying the potential for a viable rural health insurance scheme, through community participation, is an appropriate one. It is also considered as a way of realizing social justice, because it is based on solidarity and cooperation between the well and the ill, the rich and the

poor (Gomaa, 1986). Further, it is presumed that rural health insurance through community participation could bring in more money to pay for better use of health services by all. In the process, more people could possibly choose the health services of the private sector through health insurance, leading to shorter queues at government services and thereby fewer people having to share the limited drugs and other supplies that can be afforded in the government services. The viability of such policy and willingness to pay for it can be justified, *a priori*, on the following grounds:

- it is evident that the rural poor are united by common concerns or events and also represent their problems to administrative bodies through their leaders. Does this mean that this kind of solidarity and cooperative effort of the rural people could provide the basis for the viability of a scheme of rural health insurance through community participation?
- it is also observed from the recent economic reform movement that decentralization at the grass-roots level may increase efficiency in government services (GOI, Eighth Five Year Plan Document, 1992). In this context, would the existing *Panchayati Raj System* become an instrument for eliciting community participation in the health programme, and providing supervision and support to the primary health care infrastructure?
- it is also evident from earlier studies that rural people bypass the supply-constrained government health care services and seek care from the private sector. Does this suggest that people are already paying out of their pockets for health care? Does this give a basis for a scheme whereby private or non-governmental organizations could be the service provider, as these are expanding in almost all parts of the country?
- while the experience of the Sevagram Rural Health Insurance Scheme of Maharastra in India shows the administration of the scheme to be feasible; nonetheless, the question arises whether the existing village administrative background (nearly 60 per cent of the total settlement of India) could feasibly support the administration of the scheme?

Keeping in mind these questions and the importance of resource constraints for financing quality health care services by the government, this study considers whether rural health insurance through community participation in India is a viable alternative policy: (a) to generate and increase financial resources for national health development; (b) to foster efficiency in health care provision; and, (c) to guarantee maximum access to health services for the rural population, and rural poor, in particular. In this context, it is important to observe that once the feasibility of a health insurance scheme is established, it is necessary to then investigate whether the people are willing to accept such a scheme and their willingness to pay for the same?

When economists attempt to infer values, they prefer evidence based on actual market behaviour, whether directly or indirectly revealed. Thus, a technique like the contingent valuation (CV) method — wherein values are

inferred from individuals' stated responses to hypothetical situations — could readily be expected to stir lively debate in academic circles. However, a final set of reasons for economists to care about the contingent valuation debate has less to do with potentially important values. According to proponents of the contingent valuation method, asking people directly has the potential to inform about the nature, depth, and economic significance of these values. Based on this rationale, during the last few years there has been an increased interest in the CV method of measuring willingness to pay for health care technologies (Appel *et al.*, 1990; Donaldson, 1990; Johannesson and Jonsson, 1991; Johannesson *et al.*, 1991a,b, 1993; Johannesson, 1992; Johannesson and Fagerberg, 1992). This study is not a strict replication of these specific studies, since this study adopts a heuristic approach through informal observation and discussion with rural people about their opinions on existing health care services alongside a household survey. It is also important to note that this study first investigates the viability of a rural health insurance scheme through community participation, and finds out whether people are indeed willing to pay for such a scheme.

To repeat: the main objective of this article is to examine the willingness to pay for a viable rural health insurance scheme through community participation in India, and the policy concerns it engenders. The first section of this article has discussed the resource constraint upon providing government health care services and the role of alternative financing. The research approach and data source of this article are discussed in the next part. The third section discusses the descriptive results of the household survey, and the empirical analysis of willingness to pay for a viable health scheme. Finally, by using empirical results, the policy implications are also discussed.

RESEARCH APPROACH

In order to answer the policy questions for organizing a viable rural health insurance scheme through community participation in India, it is necessary to investigate the acceptance of the people regarding such a scheme and the extent to which they are willing to pay for the same. In this context, this study combines two approaches: *viz.*, survey research, and, heuristic/documentary research. The survey research has been designed to analyse rural health care services available through private and voluntary organizations, the cost of their services, and opinions of people on a rural health insurance scheme through community participation. The second approach of heuristic/documentary research is used in order to obtain the opinions of rural people for organizing rural health insurance through community participation. In analysing the survey data and making a comparative study, inter-state experience has also been examined. By comparing the results of the two approaches, it is possible to judge: (a) the viability of a rural health insurance scheme; and (b) willingness to pay for such a scheme. The viability of any programme may be defined as

feasible or practicable in terms of the ways and means of the design. The ways and means of rural health insurance through community participation are determined by: the financial sustainability of the programme; the accessibility of the programme to the rural poor; the referral behaviour of patients in the rural area; and, its administrative feasibility.

Data sources

The study is confined to rural Karnataka State in India. There are 27 028 inhabited villages spread over 19 administrative districts and the total population living in these villages is 26.41 million. The necessary data for analysis were mainly drawn from the household survey in rural Karnataka. The sampling was carried out in three stages. Since socio-economic development is diverse among the districts, it was decided to use a stratified random sample to ensure its representative nature. The districts were stratified into three strata based on the development of districts (i.e. developed, middle order, and backward). In the first stage, six districts were selected out of the three strata (i.e. two districts from each stratum). Within a district, the administrative subunits in the form of taluks exhibited different levels of development. Hence, in the second stage, the taluks were stratified in each district into two strata in terms of their accessibility to health care services, as expressed in the form of hospital beds per thousand population, doctors per thousand population etc., into high accessibility and low accessibility categories. In each of the selected districts, one taluk was selected from each of the two categories. Thus, a total of 12 taluks were selected. In the third stage, one village having a primary health centre (PHC) *and* private/non-government organization (NGO) hospital services was identified. This selection was purposive in the sense that the village was selected to obtain a large community. One or two more villages proximate to the selected village with PHC only were included in the sample. Thus, a total of 36 villages were selected. Taking into consideration the time and resources, it was decided to cover a total of 1000 households. These households were allocated in relation to the number of households in each of the villages. In all, there were 18 298 households. After deciding the number of households for each village, the specific households were selected in a systematic manner by listing them. Depending on the number to be covered, every third or fourth house was selected from a given sample village. It was felt that the female head of the household would be more knowledgeable about the health-related aspects of females and children. Hence, both male and female heads were present during the interview.

FINDINGS

This part examines people's opinions and their validity, through empirical assessment, to a proposed rural health insurance scheme through community

participation, and their willingness to join and pay for such a scheme. It includes the exposure to, and knowledge of, the rural population in the case of insurance/saving schemes, willingness to join and pay, choice of health care provider, and preferences for the components of the proposed rural health insurance scheme.

Exposure and knowledge of rural population on insurance and savings

The survey allowed rural households to answer open-ended questions on their knowledge about insurance and savings schemes. It was expected that the exposure of rural people to insurance and savings schemes may have valid implications for their willingness to join and pay for a rural health insurance scheme. In this context, data on: (a) their exposure to a scheme; (2) whether they have subscribed to a scheme; and, (3) their understanding of the objectives of such schemes were collected. A person exposed to the scheme meant that he has heard about the scheme. Subscribing to the scheme meant that he has heard of, and subscribed to the scheme; and, an understanding of the objectives of such schemes meant that he has heard of, and he has the knowledge of the principles and objectives of the scheme.

Insurance/saving schemes are popular in rural areas. People have relatively better knowledge of insurance schemes (especially life insurance schemes) than savings schemes. The findings (Table 1) reveal that nearly 64.4 per cent of the total sample of households were exposed to life insurance schemes. Among them, nearly 12.2 per cent of the people were subscribing to the scheme. It also revealed that nearly 56.9 per cent of the people had understood the risk-sharing concept of life insurance very well. Though saving schemes were as familiar as life insurance schemes among the rural people, it was found that only 3.39 per cent of the total sample population subscribed to savings schemes. Though the principles and objectives were well understood by the rural households, it was not clear why rural people were not subscribing to the saving schemes. It was, also clear from Table 1 that people had hardly heard about health insurance schemes (2.6 per cent). Perhaps, health insurance schemes by the government-owned (GI) and its subsidiaries (like National Insurance Corporation Limited, the New India Assurance Corporation Limited, the Oriental Insurance Corporation Limited and the United India Assurance Corporation Limited) operating as commercial health insurance schemes in India did not reach the

Table 1. Exposure and knowledge of sample households on insurance/savings schemes (%).

Particulars	Exposed	Exposed and subscribed	Exposed and understood
Life insurance schemes	64.4	12.2	56.9
Saving schemes	64.3	3.9	65.5
Health insurance schemes	2.6	0.0	0.0

rural people. It was also shown from the survey that most people saw health insurance as part of a life insurance scheme.

Willingness to join a proposed rural health insurance scheme through community participation

An understanding of the viability of rural health insurance requires detailed information that can come from an investigation of the willingness to join a rural health insurance scheme. Willingness to join such a scheme is discrete — willing or not willing. Therefore, a suitable estimator was used to explain the qualitative response. The contingent valuation approach, or hypothetical valuation method, was used to reveal rural households' willingness to join and pay a rural health insurance premium through community participation. This technique involves a process of offering a set of hypothetical situations to the respondents and determining how they would react to such situations. It means that estimates are not based on observed or actual behaviour; but, instead, on inferring what an individual's behaviour would be from the answers he or she provides in a survey framework. Although this kind of method may not always provide accurate estimates, it does provide an order-of-magnitude estimate which could be valuable for planning purposes.

The survey results on households' willingness to join the proposed rural health insurance are presented in Table 2. Out of a total of 1000 households, nearly 91.8 per cent said they were willing to join the proposed health insurance scheme, while 0.8 per cent said they were willing to join if most people in the village joined the scheme, and nearly 7.4 per cent of the households said they were not willing to join the proposed scheme. There were some differences among regions regarding willingness to join the proposed scheme. In relative terms, a higher percentage (97.6) of households from Belgaum District were willing to join health insurance, and a higher percentage (19.1) of households from Bangalore Rural District refused to join. However, the differences on willingness to subscribe to health insurance did not vary much (91.5 to 97.6 per cent) across different regions except Bangalore Rural District, where only 76.6

Table 2. Households' willingness to join for proposed rural health insurance by region.

Dcode	Willing	Conditional willing	Not willing
Dcode 1 ($n = 179$)	76.6	1.3	19.1
Dcode 2 ($n = 161$)	91.5	1.1	7.4
Dcode 3 ($n = 111$)	97.4	0.0	2.6
Dcode 4 ($n = 87$)	92.6	1.1	6.4
Dcode 5 ($n = 207$)	97.6	0.5	1.9
Dcode 6 ($n = 173$)	96.6	0.6	2.8
$N = 100$	91.8	0.8	7.4

Dcode 1, Bangalore Rural District; Dcode 2, Mysore District; Dcode 3, Chikmangalore District; Dcode 4, Uttarakannada District; Dcode 5, Belgaum District; Dcode 6, Gulburga District.

Table 3. Willingness to join a proposed rural health insurance by caste.

Caste	Willing	Conditional willing	Not willing
Brn & Ksha ($n = 47$)	87.2	2.5	10.6
Vai & Banaj ($n = 15$)	73.3	6.7	20.0
Linga ($n = 163$)	93.3	0.6	6.1
Okkali ($n = 127$)	88.2	1.6	10.2
KGBBAUDK ($n = 100$)	90.0	0.0	10.0
SC/ST ($n = 227$)	94.3	0.4	5.3
Others ($n = 321$)	92.8	0.6	6.5
$N = 1000$	91.8	0.8	7.4

Brn & Ksha, Brahmin and Kshatriya; Vai & Banaj, Vaishya and Banajiga; Linga, Lingayat; Okkali, Okkaliga; KGBBAUDK, Kuruba/Golla, Badagi, Besta, Akkasaliga, Uppara, Devanga, Kammara; SC/ST, Scheduled caste/Scheduled tribe; others include Christians, Muslims, Jains and Buddhists (religious category).

per cent of the households said they were willing to join the scheme. It was also noted that the differences in willingness to join health insurance did not vary among the different castes, except the Vaishya and Banajiga castes, which reported a lower percentage of 73.3 (see Table 3). It is important to note that the low castes (Scheduled caste (SC)/Scheduled tribe (ST)) recorded the highest percentage (94.3) under the category of willingness to join the proposed scheme.

Willingness to pay for the proposed rural health insurance scheme

The survey included direct questions on each rural household's willingness to pay for health insurance. Households were asked to state the maximum amount of money they could pay. The survey also included questions on reasons for refusing to pay for the proposed scheme. Table 4 shows the survey results of rural households' willingness to pay for health insurance. Out of the total 918 households willing to join health insurance, 86.82 said they were willing to pre-pay a health insurance premium for yearly medical services for themselves or their families. Willingness to pay for the proposed rural health insurance did not differ much among the six different regions' households. It varied between 80.46 and 92.79 per cent of the total households sampled. Households were also willing to pay a maximum amount for the proposed scheme which, on average, was nearly Rs.163.48 per year. It is also noticeable (Table 4) that the average level of the maximum amount people were willing to pay varied significantly from Rs.148.05 to Rs.187.85. It is also important to note that most of the households (41.53 per cent) would pay between Rs.121 and Rs.240. Nearly 32.62 per cent of the households would pay Rs.120 or less, which meant that they would pay Rs.10 per month. A significant number of households (7.90 per cent) were willing to pay between Rs.481 and Rs.600, which amounted to nearly three to four times higher than the average (maximum) amount (Rs.163.48).

Table 4. Willingness to pay for level of proposed rural health insurance scheme by regions (%).

Willing to pay (Rs.)	Region						
	Dcode 1 (n = 179)	Dcode 2 (n = 161)	Dcode 3 (n = 111)	Dcode 4 (n = 87)	Dcode 5 (n = 207)	Dcode 6 (n = 173)	Total (N = 918)
< 120	23.38	31.62	36.89	38.89	32.20	37.58	32.62
121–240	52.60	40.44	34.95	35.71	38.98	41.40	41.53
241–360	11.69	19.12	17.48	14.29	13.56	15.28	15.06
361–480	6.49	2.94	0.00	1.43	3.96	0.64	2.89
481–600	5.84	5.88	10.68	10.00	11.30	5.10	7.90
% of WP	86.03	84.47	92.79	80.46	85.51	90.75	86.82
Average amount willing to pay	148.05	154.66	187.85	150.43	181.30	158.58	163.48

See Table 2 for Dcodes.

The results on willingness to pay in relation to castes are presented in Table 5. Nearly 84.14 per cent of the 227 SC/ST (low caste) households said that they were willing to pay for a proposed health insurance scheme. Vyshyas and Banajigas (high castes) accounted for the lowest percentage (66.67) under the category willingness to pay for the proposed scheme. As already noted, on average, the maximum amount people were willing to pay for health insurance for all castes in the sample area was Rs.163.48. In the case of the higher castes such as Vaishya, Banajiga, Bhramin and Kshatriya it was, on average, between Rs.142.67 and Rs.163.83. In comparative terms, the 'backward' castes like Lingayat and Okkaliga were willing to pay a higher average amount, between Rs.172.60 and Rs.173.35. The low castes like SC and ST were willing to pay Rs.162.18, which was higher than some of the high castes (Vaishya and Banajiga).

Preference to pay for the proposed health insurance scheme

Households' preference for the medical benefits plan was measured in terms of types of illness; and hence, data were collected on medical services desired to be covered by health insurance. Households were told that different types of medical benefits had different costs. This was explained by using a hypothetical method. Types of illnesses/medical care included: (1) hospitalized benefit; (2) non-hospitalized benefit; (3) chronic illnesses benefit; (4) hospitalized and chronic illness benefit; (5) hospitalized and non-hospitalized benefit; (6) chronic illness and non-hospitalized benefit; and, (7) comprehensive medical care benefit. The results are presented in Table 6.

Most households selected a comprehensive medical care benefit, followed by hospitalized, and hospitalized and chronic illnesses care benefit. Out of the

Table 5. Willingness to pay for level of proposed health insurance scheme by castes (%).

Maximum amount (Rs.)	Brn & Ksha ($n = 47$)	Vai & Banaj ($n = 15$)	Linga ($n = 163$)	Okkali ($n = 127$)	KGBBAUDK ($n = 100$)	SC/ST ($n = 227$)	Others ($n = 321$)	Total ($N = 918$)
< 120	55.56	40.00	54.48	50.49	60.01	56.02	56.92	32.62
121–240	25.00	40.00	22.39	29.13	25.71	29.84	23.71	41.53
241–360	8.33	10.00	10.45	7.77	7.14	8.91	7.51	15.06
361–480	0.00	0.00	1.49	5.82	1.43	0.52	3.56	2.89
481–600	11.11	10.00	11.19	6.79	5.71	4.71	8.30	7.90
% of WP	76.60	66.67	82.21	81.10	70.00	84.14	78.82	86.82
Average amount willing to pay	163.83	142.67	173.35	172.60	139.50	162.18	162.88	163.48

See Table 3 for castes.

Table 6. Preference to pay for the different components of the proposed health insurance scheme (%).

Preference	Dcode 1 ($n = 154$)	Dcode 2 ($n = 136$)	Dcode 3 ($n = 104$)	Dcode 4 ($n = 70$)	Dcode 5 ($n = 177$)	Dcode 6 ($n = 156$)	Total ($N = 797$)
Hospitalized benefits ($n = 122$)	12.99	11.03	12.50	12.85	12.43	11.54	15.31
Non-hospitalized benefits ($n = 45$)	1.30	1.47	1.92	1.43	2.26	1.28	5.64
Chronic illnesses benefits ($n = 20$)	9.74	10.29	9.62	10.00	8.47	9.62	2.51
Hospitalized + chronic ($n = 99$)	13.64	14.71	16.35	15.71	15.82	17.31	12.42
Hospitalized + non-hospitalized ($n = 13$)	6.49	7.35	4.81	2.86	5.08	5.77	1.63
Chronic + non-hospitalized ($n = 76$)	1.39	3.68	2.88	1.43	2.26	3.21	9.54
Comprehensive benefits ($n = 422$)	54.55	51.47	51.92	55.71	53.67	51.28	52.95

See Table 2 for Dcodes.

total 797 households who preferred to pay, 52.9 per cent wanted a comprehensive care benefit. This meant that they considered the combination of hospitalized, non-hospitalized and chronic illnesses care benefits as necessary to the entire household. About 15.31 per cent of the total households preferred only hospitalized care benefits and 12.42 per cent opted for hospitalized and chronic illnesses benefits. The combination of other care benefits was reported in only a small proportion of the total sample of households. When the results were broken down by region, there was a similar pattern of preferences emerging.

THE WILLINGNESS TO JOIN AND PAY FOR RURAL HEALTH INSURANCE: FRAMEWORK OF ANALYSIS

Evaluation of the viability and desirability of a rural health insurance scheme through community participation and a population's willingness to pay for such a scheme requires pre-evaluation of the consequences for health care utilization of the rural households and their socio-economic characteristics. Hence, in this context, the CV approach was used. In order to test the validity of the CV method, i.e. whether the hypothesized theoretical relationships are supported by the data (Mitchel and Carson, 1989), the validity was carried out in this study by estimating the theoretically derived regression equations. In this context, the logit estimator was used on the basis of computational convenience. It has also been shown to be consistent with the theory of utility maximization, under certain specifications of the utility function. The following is a brief description.

The proposed logit model was expected to determine the willingness of rural people to join a proposed health insurance scheme. It was presumed that: (1) an individual must decide between some available options; and, (2) the individual chooses one option above the rest if the utility of that option to the individual is greater than the utility of any of the other options. The two options considered in this particular context were willingness to pay and not willingness to pay. It assumed a hypothetical rural health insurance scheme to be available, the details of which were the subject of a briefing collectively in a village gathering, a day before the investigation, and individually to the concerned sample of households at the time of interview. It was assumed that the private/NGO hospitals would be service providers, mainly because the private provider emerged as the people's choice in the rural area (Mathiyazhagan, 1994). The administration and monitoring of the scheme was to be done by the government and the community. In this context, it was expected to test a hypothesis that there is a positive relationship between people's willingness to join and pay for rural health insurance and their socio-economic characteristics. The general framework of the logit model is expressed as follows.

It was assumed that the utility of option i to the jth individual may be expressed by the following equation:

$$U_{ij} = V_{ij} + E_{ij}$$

i.e. utility of the ith option to the jth individual is made up of a *systematic component* or *representative utility* V_{ij}, which was assumed to reflect the individual tastes.

The systematic component V_{ij} was assumed to be a linear function of the characteristics of the individual and attributes of the different options available to him.

$$V_{ij} = \sum_{k=1}^{K} \beta_{ik} S_{ikj}$$

The β values are the weights to each of the socio-economic characteristics of the individual j and the attributes of the options i (S_{ikj}) in the probability of choosing that option. These weights were assumed constant across individuals, but not across alternatives.

It can be demonstrated that if the E_{ij} values are distributed according to the extreme value distribution, then the probability that the option i will be selected from a set of m options, can be expressed by the logit model presented in the following equation.

$$Pr(\textit{selection option } i) = Exp(V_{ij}) / \sum_{m=1}^{M} Exp(V_{ij})$$

Description of variables

In the model, the response of people's willingness (or unwillingness) to join and pay for rural health insurance in a hypothetical situation was considered as a dependent variable. The explanatory variables were classified into four categories. The first consists of the variables that proxy for the risk factors of the decision-making unit. These include demographic characteristics (such as age, size of the family, caste of the respondent) and health-related factors towards physical accessibilities (such as travel time and waiting time). The economic factors such as income, occupation, characteristics of income sources, were also included.

For each categorical variable in the analysis, one category has been selected as a reference category. An estimated coefficient for each of the remaining categories of the variable, indicating the significance of the category's contribution to the probability of reporting that condition (i.e. willingness to join and pay) has been made in the analysis. An odds ratio has been estimated for each category of the factor, that expresses the magnitude of the increased reporting in relation to the reference category. Interaction effects for variables included in the analysis were tested for significance.

RESULTS

The results from the logistic regression analysis lend support to the hypothesis that there is a significant relationship between willingness to join and pay for proposed rural health insurance and social, demographic, economic and physical accessibility of the households in the rural areas. The results are presented in Table 7.

Socio-demographic characteristics

It was found that the family size of households strongly influenced the decision-making process for willingness to join and pay for rural health insurance. It means that larger family sizes have a 119 per cent higher probability of joining and a 27 per cent higher chance of paying for the proposed scheme as compared to small family sizes. However, the caste and age of the respondents were not positive influencing factors in the decision.

In fact, in the case of age, it was found that the older people were lower (35 per cent) in their willingness to join and 64 per cent lower in their willingness to pay for the proposed rural health insurance scheme as compared to younger people. Thus, there is a negative relationship between age and willingness to join and pay for the proposed scheme.

It was also found that there was an inverse relationship between caste and willingness to join and pay for the proposed scheme, except for low caste (SC/ST). The results show that the willingness to join the proposed scheme is 18 per cent lower for backward caste and 13 per cent lower for religious minorities as compared to higher castes. It is important to note that the lower caste (SC/ST) showed a positive attitude towards willingness to join and pay for the proposed rural health insurance scheme. It was estimated that there was nearly a 35 per cent higher chance as compared to the higher castes.

Health status variable

As a group, health status variables cannot be rejected as being insignificant in the choice of health insurance. This is borne out by the likelihood ratio test statistics. The results indicate that variables such as health condition, number of hospital episodes, number of working days lost due to ill-health, are significant determinants of willingness to join and pay for the proposed rural health insurance scheme. In contrast, the variables like health-seeking behaviour by households are not influencing factors upon households' willingness to join and pay for the proposed scheme. People who were sick have a 296 per cent higher chance of willingness to join but only 172 per cent higher willingness to pay for the proposed scheme as compared to people registering no illness at that time. Thus, the probability of willingness to pay for a rural health insurance scheme was found to be less than the probability of willingness to join, which means there is significant difference between willingness to join and to pay for the same.

Table 7. Logistic regression estimates for willingness to join and pay for the proposed rural health insurance scheme.

Explanatory variable	Reference category variable	Willingness to join Odd ratios [Exp(B)]	Willingness to pay Odd ratios [Exp(B)]
I. RISK FACTORS			
(a) *Demographic characteristics*			
(1) Age:	Youthful		
Middle age		0.95	0.76
Old age		0.65	0.36
(2) Family size:	Small size		
Medium		1.71**	1.09**
Large		2.19*	1.27**
(3) Caste:	Higher caste		
Backward		0.82	0.84
SC/ST		0.92	1.35**
Religious		0.87	0.84
(b) *Health status variable*			
(1) Health condition:	No illness		
Illness		3.96*	2.72*
(2) No. of hospital episodes:	One or two times		
Three or more times		0.79	1.32**
(3) No. of working days lost due to ill-health	Less than a week		
More than a week		1.59**	1.36**
(4) No. of times doctor consulted:	One time		
More than one time		0.50	0.58
(5) Source of health care service utilized:	Public health care		
Private health care		1.31**	1.22**
II. ECONOMIC ACCESSIBILITY	Low income		
(1) Annual income:			
Middle income		1.60**	1.42**
High income		2.15*	2.13*
(2) Income flow characteristics:	Monthly		
Daily or weekly		1.10**	1.15**
Irregular/others		0.45	0.66
Threee times in a year		0.63	0.65
Two times in a year		1.58**	1.49**
Once in a year		1.07**	1.43**
(3) Occupational status:	Agricultural and allied activities		
Business and allied activities		0.90	0.85
Labours		0.66	0.64*

(continued)

Table 7. (*continued*)

Explanatory variable	Reference category variable	Willingness to join Odd ratios [Exp(B)]	Willingness to pay Odd ratios [Exp(B)]
III. PHYSICAL ACCESSIBILITY			
(1) Distance between hospital and clients' home	Less than one kilometre		
More than one kilometre		2.96*	2.45*
(2) Travel time to obtain care services:	Less than 0.5 h		
More than 0.5 h		1.13**	1.09**
(3) Waiting time to obtain care services:	Less than 0.5 h		
More than 0.5 h		0.92	0.47
IV. FAMILIARITY OF HEALTH SYSTEM			
(1) Education:	Illiterate		
Formal education		0.85	1.55*
Ancillary statistic:			
-2 Log likelihood ($\delta = 0$)		1006.33	654.74
-2 Log likelihood ($\delta = 1$)		932.04	580.66
Goodness fit (chi-squared test)		110.01	82.26
Degree of freedom		42	42

**Significant at 5 per cent level of significance; *significant at 1 per cent level of significance.

The number of hospital episodes in the household may lead to higher risks in the household. This is consistent with the hypothesis that households more prone to ill-health are more likely to be insured, since they face the greater risk of larger health care costs. It was expected that there would be a positive significant coefficient on the number of hospital episodes. The results indicate that, with the exception of willingness to join, willingness to pay has a positive significant coefficient. It means that households who had three or more hospital episodes in a month may have a higher probability of willingness to pay for the proposed rural health insurance scheme as compared to those who had one or two hospital episodes.

Not surprisingly, the higher the number of days lost to ill-health, the more likely someone is to join and pay for the proposed health insurance scheme. The results indicate that, people who lost more than a week of working days due to ill-health in a month have a 59 per cent higher willingness to join and a 36 per cent higher willingness to pay for the proposed scheme as compared to those who lost less than a week of working days.

The health care provider in the rural areas would play a significant role in the decision to join or pay for any proposed health insurance scheme. It was assumed that those who had a private health care provider were expected to join and pay for a rural health insurance scheme. The estimated coefficients are

significant at the 5 per cent level. The results show that people who used private sources of health care service have a 35 per cent higher chance of joining the proposed health insurance scheme compared to people who only used government sources of health care services. However, those who used private sources of health care services have a 9 per cent lower probability of willingness to pay for the proposed health insurance scheme as compared to a willingness to join.

Economic accessibility

Ability to pay is undoubtedly a major consideration in the decision to insure or not insure. Therefore, it was expected that there would be a positive co-efficient with the real income of households. The estimated coefficients are positive and significant at the 5 per cent level in the case of all income categories (i.e. low, middle and high income). The results indicate that the higher income level households have a higher chance of willingness to join and pay for the proposed scheme. In contrast, coefficients are negative in the case of income flow characteristics such as irregular income. It is important to note that households which receive a regular income daily or weekly have a 10 per cent higher probability of willingness to join and a 15 per cent higher willingness to pay for the proposed rural health insurance scheme as compared to all other categories. This implies that most of the households of labourers and allied agricultural activities have a higher willingness to join and pay for the proposed scheme as compared to business and allied activities. The results suggest that the occupational status of the households is not playing any independent role in the decision-making process on willingness to join and pay for the proposed scheme. The estimated coefficient is negative in the category of occupational status (i.e. business and allied activities).

Physical accessibility

It was assumed that improved access to care was an important indicator for health policy. Distance, travel and waiting time to obtain health care were used as proxies for the physical accessibility of the respondents. It can be seen that the estimated coefficients of physical accessibility are significantly positive in all cases except one variable (i.e. waiting time). This suggests that the longer the distance and travelling time to obtain health care, the greater the willingness to join and pay for the proposed scheme. It is evident that distance between the hospital and the clients' home of more than one kilometre leads to a 196 per cent higher chance of willingness to join and a 145 per cent higher chance of willingness to pay for the proposed scheme as compared to less than one kilometre distance. It also shows that there is a significant difference between willingness to join and pay across these two categories. Those who travel more than 0.5 h to obtain health care have a 13 per cent higher probability of joining the scheme and a 9 per cent higher probability of willingness to pay. It implies that people are willing to pay for health care services if they are brought close

to their house. The waiting time in hospital to obtain care is seemingly not a significant influence on the decision-making process of willingness to join and pay for the proposed scheme.

Familiarity of health system

Educational status was used in the analysis as a proxy for familiarity with the health system for rural people. It is quite reasonable to assume that education may make a significant contribution in the decision-making process on the proposed health insurance scheme. But the coefficient is not significant in the case of willingness to join. It suggests that educated people have a 15 per cent less chance of being willing to join the scheme as compared to illiterates. However, the coefficient is significant in the case of willingness to pay for the proposed scheme. The results indicate that educated people are 55 per cent more likely to pay for the proposed scheme as compared to illiterates.

COMMUNITY PARTICIPATION IN HEALTH-RELATED SERVICES

The proponents of community participation have envisaged self-motivated, rural communities working together with the State to design their own programmes to improve health and development. This grand vision has proved difficult to achieve in practice, particularly in countries and regions without an existing tradition of joint community–government cooperation (Morgan, 1993). However, rural communities in India do have a history of cooperating in social events/common problems such as rural drinking water, street lighting etc. Thus, organization of rural health insurance through community participation is likely to be favoured. In this context, community participation and its role in social services delivery has been conceptualized and stressed in some studies. A United Nations report (1981) reviewed this subject as spontaneous voluntary base-up participation, without external support. But, this type is referred to in the literature as informal (Sherraden, 1991), bottom-up, community supportive (Werner, 1976), social participation (Muller, 1983), or wide participation (Rifkin *et al.*, 1988). It is not isolated to one sector such as health or education, but is part of a larger process of social development intended to foster social equity.

Spontaneous participation may be a deliberate effort to protest at, or to counteract, State policies. At the other end of the concept, induced participation can be sponsored, mandated and officially endorsed. This type is the most prevalent mode to be found in developing countries. Induced participation is called formal, top-down, community oppressive (Werner, 1976), direct participation (Muller, 1983), or narrow participation (Rifkin *et al.*, 1988). Induced forms are not intended to be inter-sectoral, nor to affect the basic character of state–citizen relations. *This study however, favours the spontaneous, bottom-up, view of participation.* It implies that communities voluntarily join together to pay and organize a rural health insurance scheme

that meets their particular needs. In addition, of course, it helps the government to attain *Health for All by 2000 AD* without an undue financial burden.

The proponents of community participation, as contained in this study, visualized self-motivated rural communities working together with the State to design their own programmes to improve health and development. It implies that communities voluntarily join together to pay for and organize the rural health insurance scheme (Tables 2 and 3). In this context, the study found that most rural people were prepared to participate and contribute some amount to such a scheme (Table 4). It is also important to note that most of the households (41.53 per cent) would pay between Rs.121 and Rs.240 (Table 4). Nearly 32.62 per cent of the households would pay Rs.120 or less, which meant that they would pay only Rs.10 per month. A significant number of households (7.90 per cent) were willing to pay between Rs.481 and Rs.600, which amounted to nearly three to four times higher than the average maximum amount (Rs.163.48).

It is interesting to note, moreover, that the Government of India spent about only Rs.90 per capita in the year 1990–91 on state health services, the amount just enough to develop primary health care service (Duggal, 1986b). But the expenditure involved in providing quality health care services worked out to be only Rs.76 per capita year year (Rs.71 for hospital and Rs.5 for door-step services) in the Sevagram project. Hence, it could be justified that if the Government joins forces with the people's willingness to pay for a viable health insurance scheme, it helps the government to provide a quality health care service without an undue financial burden. This could provide a base for a viable health insurance scheme through community participation in India. It has also proved itself in the Sevagram Community Insurance Scheme operated by a voluntary organization in Maharastra State in India (Jajoo, 1993; Deve, 1991; Jajoo *et al.*, 1985).

The empirical evidence of other developing countries also shows that health insurance through voluntary participation can be successful. Countries in this context almost always have some form of voluntary health insurance for their rural populations, while only a few countries have this option for urban citizens. For instance, in China, the rural cooperative insurance approach, based on a decentralized approach to health care, was put into action in 1968 on a voluntary basis. In 1973, this scheme covered approximately 70 per cent of China's 50 000 communes (Hu, 1981). A voluntary prepaid health insurance scheme, called the health card, was introduced for the rural people in Thailand. It was extended and adopted as a national rural health insurance system in 1988 (Hongvivatana and Manopimoke, 1991). It is also evident that 60 per cent of the rural population voluntarily enrolled in health insurance in Zaire's Bwamanda health zone (Kutzin and Barnum, 1992). Recently, a voluntary health insurance scheme for the urban population was set up in Indonesia: a scheme for private employees and their dependants started as a pilot project in 1985 in Jakarta. By 1988, the scheme had been extended to 16 cities in eight provinces (Ron *et al.*, 1990).

CONCLUSION

In a nutshell, the results show that insurance/saving schemes can be popular in rural areas. In fact, people have a relatively good knowledge of insurance schemes (especially life insurance) compared with saving schemes. Most of the people stated they were willing to join and pay for the proposed rural health insurance scheme. However, the probability of willingness to join was found to be greater than the probability of willingness (and ability, doubtless) to pay. Indeed, socio-economic factors and physical accessibility to quality health services appeared to be significant determinants of willingness to join and pay for such a scheme. It is also important to note that, by using the same survey data, it was found that private health care providers emerged as the people's choice. Choice of private health care provider is significantly associated with the socio-economic status and physical accessibility of the people (Mathiyazhagan, 1994). The main justification for the choice of private health care provider and a willingness to pay for rural health insurance can be attributed from the household survey results: the existing government health care provider's services are not (a) perceived to be quality oriented; (b) easily accessible; and, (c) cost effective.

The estimated results are in accordance with the theoretical predictions, and also support the validity of the CV method using the binary responses on willingness to pay for rural health insurance schemes through community participation. It is important that the findings are viewed in the context of India's on-going economic reform and structural adjustment. The economic reforms curtail government spending on social sectors including health, in order to control and stabilize monetary factors. In the light of the findings of the present study, the government may be able to redefine its role in providing health care services and tap the potential of rural households in bearing health care costs. It is also very important to promote the credit system among rural people in villages. This could help to bring a sustainable income to support the insurance scheme. In this context, the role of private organizations/NGOs assumes importance as care providers.

The above findings also assume greater importance in the context of recent constitutional provision for decentralized administration under the Panchayat Raj System (PRS) in India. The local bodies under PRS have the potential for participating in health insurance schemes. Such an arrangement has been found to be effective in the Sevagram Community Health Insurance experience as noted earlier. In this new context, the people will have a greater choice of health care services. The government will be playing the role of monitor and facilitator and not necessarily as financier and provider of health care services. This could provide an alternative framework for designing a viable rural health insurance scheme through community participation in India.

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Health Insurance Systems in Developing Countries

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Contents (1)

- Generalities on health care financing
  - brief history of health care financing in the developing world (focus on SSAfrica)
  - notions of *progressivity* and *regressivity* in financing
- Insurance and solidarity
  - concepts

Contents (2)

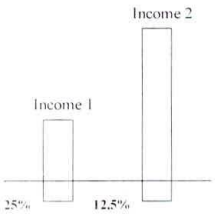
- Mutual aid arrangements
  - typology
  - history and rationale of the development of social health insurance in Western Europe
- Voluntary health care insurance
  - models/terminology
  - discussion of field experiences (DRCongo, Guinea-Conakry)
- Remaining questions and issues...

History of health care financing (1)

- In the 60's: 'free' health care as a constitutional right
- In the 70's and 80's: economic crisis leads to the progressive introduction of out-of-pocket payments (OOP) for health care
- In the 90's: OOP virtually generalised
- Today: growing interest for health insurance

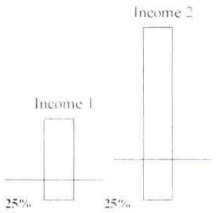
Sent by Dr Nina Unwandt 3/2. Presentation made at Misereor.
In 15/3/04.

Regressive financing



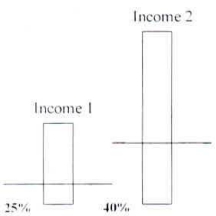
regressivity

Proportional financing



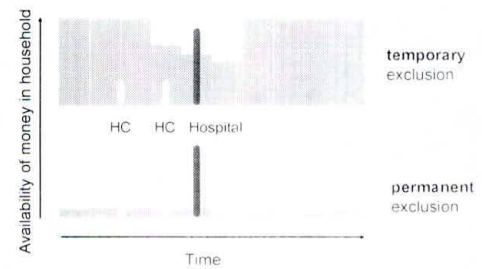
proportionality

Progressive financing



progressivity

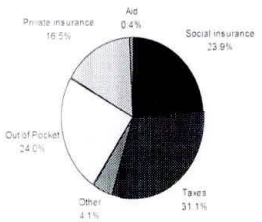
Out-of-pocket payments and (seasonal) exclusion



In 2001, the World spent Int.$3.8 trillion on health care

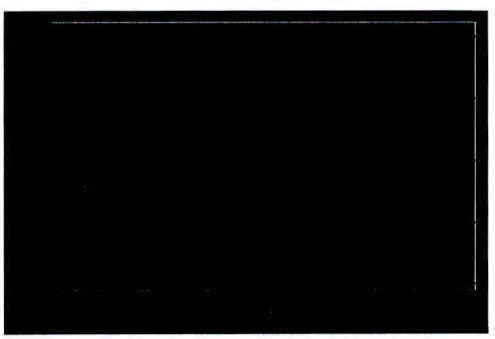
(international dollars estimated at WHO - Timor Leste and Somalia are not included)

Source: National Health Accounts; EIP/FER/FAR, World Health Organization



Proportion of Households with Catastrophic Expenditures vs. Share of Out-of-pocket Payment in Total Health Expenditures (OOP%THE)

OOP as % THE vs.GDP per capita



Insurance (1)

"the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member" (ILO 1996)

Insurance (2)

- Insurance implies the possibility of an 'unbalance' between initial investment and eventual result
- From a purely financial perspective, insurance implies the existence of 'winners' and 'loosers'
- Insurance differs from reciprocity where 'inputs' +/- equivalent to 'outputs'
- Insurance can be blended, to varying degrees, with solidarity

Insurance (3)

Insurance as a *function* versus insurance as a particular *institutional set-up*

(Kutzin, WHO, 1998)

- saveguard access to health care when needed
- protect household's income and assets from the financial cost of expensive medical care

Calculation of premiums

- Basic formula:
  - assumption of *community rating* (as opposed to *risk rating*)
  - P = expected expenditure on benefits + administrative costs + reserve

$$\frac{\text{expected expenditure on benefits + administrative costs + reserve}}{\text{number insured}}$$

Note: expected expenditure on benefits
= f (probability of event occurring under insurance) &
= f (cost of the event)

'Classical' problems in health insurance

- Adverse (or preferential) selection
- Moral hazard
- Cost-explosion

Adverse selection: a problem in voluntary insurance

- Definition: "*those who anticipate needing health care choose to buy insurance more often than others*"
- Adverse selection in health insurance creates a *financial* problem
- How to manage adverse selection?
  - mandatory membership
  - careful design in voluntary schemes (HH membership, limit period of enrolment, waiting period, threshold subscription rate)
- The special case of 'cream-skimming'

Moral hazard (1)

- Definition: "*the tendency of individuals, once insured, to behave in such a way as to increase the likelihood or the size of the risk against which they have insured* " (Mills 1983)
- Moral hazard in insurance creates both a *financial* and *public health* problem

Moral hazard (2)

- Distinction between 'patient moral hazard' and 'provider moral hazard'
- How to manage moral hazard?
  - demand-oriented measures: disincentives to reduce excess demand (e.g. co-payments, fixed indemnity)
  - provider-oriented measures: e.g. change provider remuneration systems, reinforce gate-keeping by first line health services

Cost explosion

Rodwin (1981), in his analysis of the French health care system, wrote that

" if one were to ask, as an intellectual exercise, how to design a cost-maximising health care system, a likely response might be to have a combination of health insurance, fee-for-service remuneration of providers, and minimal state intervention to regulate fees and monitor the volume of services rendered "

Solidarity (1)

" the conscious acceptance of unity and the willingness to accept its implications"
(Dunning, 1992)

- In health insurance solidarity means that people accept - at least implicitely - that the personal 'return' will not necessarily match the initial personal 'investment'
- In the case of mandatory health insurance, the legislator imposes this unequal relationship upon people: solidarity is then institutionalised but nevertheless reversible

Solidarity (2)
the inputs

- Income-solidarity :
  - the rich contribute proportionally more than the poor
  - = vertical equity
- Risk-solidarity :
  - the healthy contribute as much as the sick
  - = horizontal equity

Solidarity (3)
the outputs

- Benefits allocated according to *needs* and not to *merits* (i.e. not a function of the individual inputs made into the system)

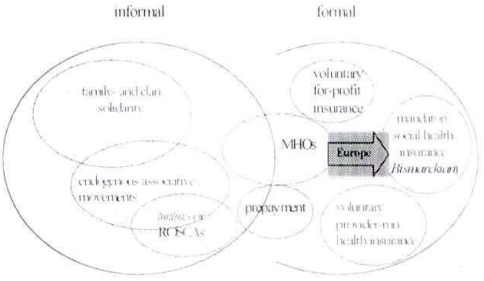
Insurance & Solidarity

- Insurance is a technique
- Solidarity is a value that results from a collective choice made by society

Collective arrangements to cope with individual adversities: a typology of mutual aid systems

- Without insurance
  - systems of family and clan solidarity: moral obligation to help
  - informal mutual aid systems (endogenous assoc. movements, *tontines* or ROSCA's): expectation of reciprocity
  - prepayment systems without sharing (i.e. 'mutualisation') of the risk
- With insurance
  - mandatory insurance systems managed by the State (the *Bismarckian* social health insurance model): insurance *and* solidarity
  - voluntary insurance systems:
    - private finality: insurance *without* solidarity
    - public finality: insurance *with* solidarity

Mutual aid arrangements in the perspective informal-formal



The case of social health insurance in European society : a phased history (1)

- Second half of 19th century
  - 'traditional' mutual aid arrangements (kinship, guilds of 17th-18th century) no longer adequate in rapidly changing environment
  - dynamic of Mutual Health Organisations (MHOs) among workers in context of rapid industrialisation and class struggle
  - benefits mainly of non-medical nature: no effective health care delivery system available at that time
  - considerable management problems (lack of administrative skills, no economies of scale, concentration of risks, etc.): social homogeneity, but poor sustainability

The case of social health insurance in European society : a phased history (2)

- End of 19th - early 20th century
  - mutual aid dynamic coincided with trade union movement
  - gradual take-over by nation-wide, state-controlled, compulsory institutions of social security (see Bismarck regime)
  - increase in coverage and scale accompanied by growing bureaucratisation and professionalisation and by qualitative changes in social relationships
- Compulsory system after World War II
  - post-war momentum throughout the continent

The case of social health insurance in European society : a phased history (3)

- Extension to non-wage earners in the 'golden sixties'
  - sometimes with opposition of workers...
- Recently, shrinkage of the benefit package
  - growing OOP payments
  - issue of choices in health care: what is to be funded collectively? And what is to be individually funded?

Why collective arrangements for individual risks? (de Swaan 1988)

- external effects: i.e. indirect effects of one person's deficiency or adversity for others not immediately affected
  - cfr cholera epidemics in 19th century cities
- extension and intensification of the "chains of human interdependence"
  - state formation led to new bureaucratic networks
  - development of capitalism led to new networks of production/consumption

Social health insurance in Europe

100 years ago...	...and today
low coverage	high coverage
limited State intervention	important State intervention
benefit package: no or little health care	comprehensive package of benefits
small-scale initiatives of relatively limited effectiveness in terms of social protection	nation-wide systems of high effectiveness and with important economies of scale
'overseeable' size and important community control	huge managerial complexity and little community involvement
strong feeling of ownership by community	weak feeling of ownership by the community

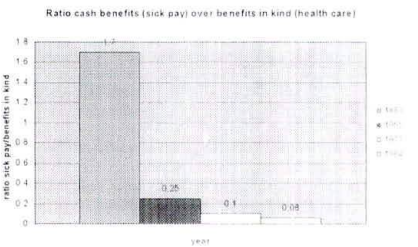
Challenge for European social insurance systems

- Impressive achievements... but at a cost?
  - increasing gap between people's contribution and actual use of that money
  - at the expense of participation and ownership, with, eventually, a gradual 'erosion' of solidarity ?

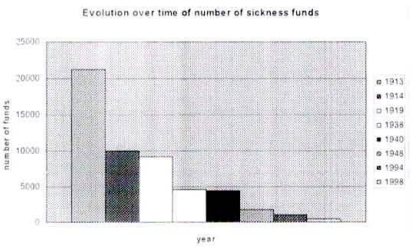
'One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries?'

- Bärnighausen T & Sauerborn R (2002). *Social Science and Medicine*, 54, 1559-1587.

The German Social Health Insurance System



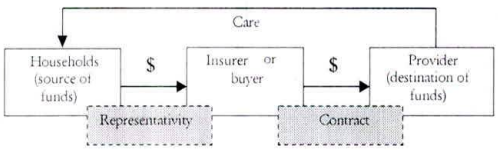
The German Social Health Insurance System



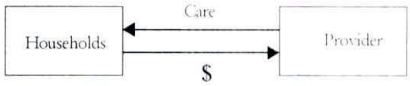
Voluntary health insurance serving a public purpose: different denominations

- **Community based Health Insurance** (CBHI) *or* **Community Health Insurance** (CHI) *or* **Mutual Health Organisations** (MHOs) *or* **Micro-Insurance**
- In French: *Mutuelles de Santé*
- One possible further sub-distinction:
  - Mutualistic or 'Participatory' model
  - Provider-driven or 'Technocratic' model

The mutualistic model:
a purchaser between payer and provider



The technocratic model: the provider also is the insurer



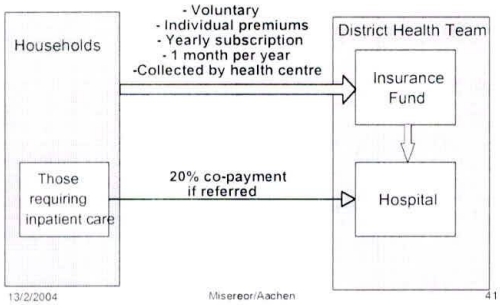
Main features of the two models (1)

- Mutualistic or 'participatory' model
  - small scale
  - selectivity target population
  - predominantly bottom-up planning
  - management by community (member) organisation
  - not necessarily overlap with functional entity of health care delivery
- Provider-driven or 'technocratic' model
  - relatively large scale
  - less social selectivity
  - predominantly top-down planning
  - management by health services
  - usually overlap with functional entity of health care delivery

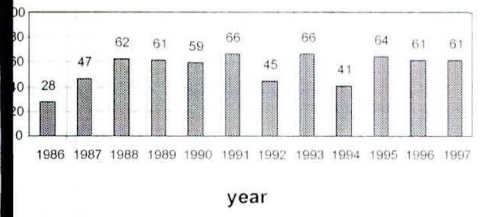
Main features of the two models (2)

- Mutualistic or 'participatory' model
  - intermediate structure between payer and provider
- Provider-driven or 'technocratic' model
  - no such intermediate structure: the provider is also the insurer

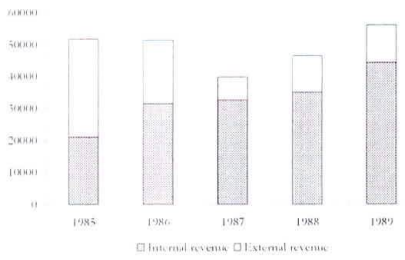
Bwamanda (DRCongo) district: an insurance for hospital care



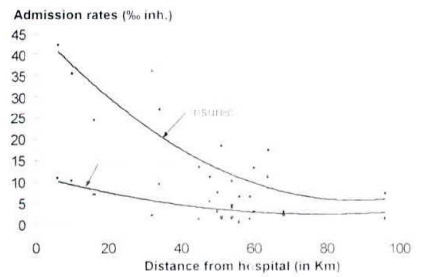
Bwamanda scheme subscription rates (%): a huge interest from the population



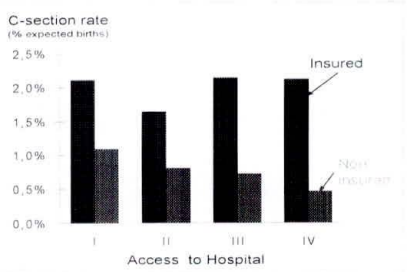
Bwamanda: less dependency from 'external' financing



Bwamanda: spatial analysis of hospital utilisation: all hospital admissions 1993



Overcome distance as a barrier to hospital use ? Caesarean sections 1991-1995



Explanations of this succes story: the crucial importance of **context**

- Reasonably well functioning district health system
- Monopoly position of the Bwamanda hospital
- Substantial external support
  (a.o. remuneration MD's independent from the insurance)
- Monetarisation of the local economy
- Relationship of trust between population and *CDI* project in general, and 'District Health Team' in particular
- Managerial creativity DHTeam

The Mutualistic model

- The *PRIMA* research project in Guinea-Conakry

The context (1)

- mid 80's : the Guinea health care delivery system had virtually collapsed
- launching of centrally led policy of reform
  - development of districts as basic functional units of the (public) health care system
  - user fees at all levels of the district system
  - strong effort of standardisation of clinical decision-making at the level of the first line
  - creation of health committees
  - strong external institutional support (UNICEF)

The context (2)

- 10 years later:
  - people use the system, but ...
  - limited community participation in management decisions
  - growing user dissatisfaction with quality of care supplied in the government health care facilities (rigidity of standardisation, poor staff attitudes)
- ... and also
  - widespread practice of 'over-billings' in the public health care facilities: up to 10 times official flat fee
  - seasonal variation in income in rural Guinea: 50% of households face (partial) financial exclusion from health care

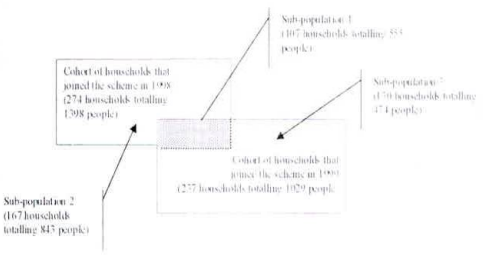
The context (3)

- creation of Mutual Health Organisations (MHOs) : a solution?
  - MHOs: non-for-profit, autonomous, member-based organisations
  - financing of health care through a risk-sharing arrangement (insurance)
- research project *PRIMA* (1996-2000)
  - MOH Guinea, German & Belgian Aid, MMB, ITM
  - test whether MHOs can
    1) improve financial accessibility to health care
    2) weigh on the quality of the supply of health care in the contracted public health services

The MHO *Maliando*

- household as unit of subscription with individual premiums (2$US)
- contract with health centre and hospital
  - free access (except small co-payment) to all care at health centre level
  - free access to emergency obstetrical-surgical care and paediatric care at hospital level
  - free transport to hospital in case of emergency
- coverage of the system
  - 1998: 1400 / 17000 people (8%)
  - 1999: 1000 / 17000 people (6%)

Cohorts of adherents 1998 & 1999



Research question

Why do people behave as they behave?

(See: Criel B. and Waelkens M.P (2003) Declining subscriptions to the *Maliando* Mutual Health Organisation in Guinea-Conakry (West Africa): what is going wrong? *Social Science & Medicine*, Vol. 57, N°7, 1205-1219)

Hypotheses

- (perception of) poor quality of care
- lack of understanding/acceptance of concepts/principles underlying health care insurance
- lack of confidence in the management of the system
- suspicion vis-à-vis 'external' associative movements
- lack of articulation of *Maliando* with existing endogenous movements
- inability to pay the premium

Methods

- focus groups: 3 in each of the 4 sub-populations
  - pop 1: year 1+ year 2+
  - pop 2: year 1+ year 2 -
  - pop 3: year 1 - year 2+
  - pop 4: year 1 - year 2 -
- in total 137 participants
- in total 383 interventions
- 4 validation focus groups

Results

(1) The majority of people - adherents and non-adherents alike - understand and accept the concepts and principles underlying the MHO

- + notion of prevention
- + redistributive effects of insurance
- + need to recruit a large number of people
- + main motivation to join: improved access
- +/- *Maliando* as body representing the members' interests
- - rationale of mandatory subscription of household (control of adverse selection)
- - rationale of co-payments (control of moral hazard)

Results

(2) The specificity of the MHO model, and its complementary character to endogenous associative movements is well recognised

- *Maliando* fills a gap
- Participants clearly identify the divergent purposes between existing schemes and the MHO
- The MHO is perceived as exogenous but well accepted because of its advantages

Results

(3) Suspicion because of previous bad experiences with externally-driven (e.g. the State) and institutionalised / formalised forms of associative movements not an issue

Results

(4) People believe in the integrity of the (financial) management of *Maliando*, but are disappointed because the organisation has not kept promises made concerning the quality of care

- access has improved, but care for adherents is perceived as inferior to (over-billed) non-adherents
- the MHO is not directly held responsible
- … but people reproach *Maliando* for not being able to meet their expectations

Results

(5) A lack of financial resources is a reason for not joining

- for the very poor/ destitute
- but also for large households nobody considers as poor

Results

(6) Better access to health centre care is in practice not considered worth it: a striking conflict between advantages of access and the disappointing quality of the care offered (at the health centre)

"...if we would receive good care, that is a friendly welcome, good products and a fast recovery, I would be ready to join in 2000. If that does not happen, then I am sorry but I am not going to join" (Pop 3)

"...when you go sick to the health centre, you come back home still sick. Neighbours who are not member laugh at you and you feel ashamed. If we, the first members, are not satisfied, the others will never join" (Pop 1)

Main conclusions

- If efforts are made to explain, people can perfectly well understand and appreciate health care insurance
- It is not necessary to design health care insurance schemes that articulate with, or are integrated in existing traditional systems of mutual aid
- The design of insurance schemes should be flexible enough to take into account problems in ability to pay
- A truism: no interest if no value for money
- Hypothesis for further research: there may be rational reasons for health workers not to support, even to oppose the development of MHOs

ITM 2002-2003: Desk-study of CBHI in SSAfrica

- Establish the 'State of the Art' of the CBHI 'movement' in sub-Saharan Africa
- Reflections on a possible research agenda

Two observations

- There is a real problem of access to quality health care and Community Health Insurance (CHI) offers opportunities for better financial access, for promotion of quality of care and responsiveness to the demand, yet subscription rates to CHI schemes remain low
- African communities have developed a variety of associations that mobilise and pool individual resources, yet few such initiatives pay for health care and the promotion of CHI remains largely driven by external organisations

Two questions at the start of this enquiry

- Why so (relatively) little interest for a health care financing model that offers, in theory, a suitable solution to a perceived problem?
- Against a background of vibrant community organisations and associative movements, which are the obstacles to the development of CHI ?

In the literature: a profusion of typologies

- Why?
  - A great variety of schemes
  - Different disciplines involved and different frameworks of analysis handled
  - Two paradigms:
    - the Anglo-Saxon school
    - the Continental European School

	The 'Continental European' school	The 'Anglo-Saxon' school
Region	French-speaking Africa	English-speaking Africa
Prevalent designation	*Mutuelles de Santé*	Community-based Health Insurance
Dominant representation	(1) an association of members (2) created to pool resources for health care (3) and mandated to discuss negotiate with providers	(1) an insurance mechanism (2) to finance health care services
Characteristics emphasised	- Social component - Associative movement - Gains in social capital	- Financial component - Micro-finance - Resource mobilisation
Implementation and management	Bottom-up: by members of the association	Top-down: by providers and or MOH

Towards a single typology?

Manager: *Membership:*	Provider	Members	Separate insurer	Other?
Geographical				
Ethnic origin				
Professional: Formal sector				
Professional: Informal sector				
Existing groups				
Other ?				

Evaluating the performance of CHI schemes: the problematic case of voluntary management

- Demands an important investment in time
- The administrative follow-up expected is that of a computerised world
- Certain tasks are too complex for volunteers
- The number of members has to remain limited
  - because of time constraints of managers
  - for 'social control' to be effective

  => small pool, small benefit package, continuous concern of containing expenses

Causes of low subscription rates

The most important factors seem to be:

- The quality of the health care delivery
- The trust people have in the achievements of the enterprise
- The financial capacity of the target population

Quality of health care delivery

- Quality of care is a condition for the success of the scheme

  (Perceived quality rather than 'objective' quality)
- The scheme may contribute to the improvement of the quality of care

The scheme *may* contribute to the improvement of the quality of care

Three hypotheses:

Quality of care may be improved through 3 levers

- **a financial lever**: a more regular and possibly a higher flow of revenues for the provider
- **a contractual lever**: contractual arrangements established between CHI and provider
- **a socio-political lever**: the power of an organised group of users to express their demand, to increase the responsiveness of the providers, and eventually to weigh on the quality of the care supplied

Trust

- Trust in the competence and integrity of the managers of the scheme
  (e.g. greater distrust when government agents are involved)
- Trust in the chances to achieve the promised results
  (e.g. continuous rotation of health personal increases uncertainty for the future)

Financial capacity: the difficult question of subsidies

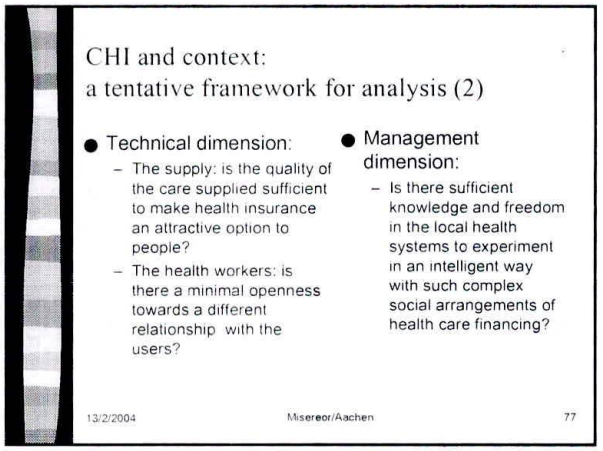
- How best to organise **subsidies**?
  - Destination of subsidies?
    - Subsidise payments of subscriptions of poor members?
    - Subsidise the 'investments' costs of the launching of the scheme?
    - Subsidise the functioning costs of the insurer?
  - Timing of subsidies?
    - From the start on?
    - Or at a later stage?
  - Subsidies by whom?
    - Government? Central and/or local government?
    - Donors?
- Linkages with systems of **Social Assistance for Health Care**?
  - See ITM Workshop 18/12/2003

Final thoughts

- CHI: a value-driven model of organisation of clients > a mere financial arrangement
- CHI and Health Workers: the challenging need for new partnerships that lead to win-win situations
- Need to systematically investigate the contexts in which some CHIs perform well, and contexts in which they don't

CHI and context: a tentative framework for analysis (1)

- Political dimension:
  - Is the development of solidarity-based systems of health care financing really a societal priority?
- Economic dimension:
  - Is the purchasing power of people sufficient to make health insurance a feasible option?
- Social dimension:
  - Is the local social fabric sufficiently strong? And is their enough trust in local leaders, institutions and structures?


CHI and context:
a tentative framework for analysis (2)
Technical dimension:
The supply: is the quality of the care supplied sufficient to make health insurance an attractive option to people?
The health workers: is there a minimal openness towards a different relationship with the users?
Management dimension:
Is there sufficient knowledge and freedom in the local health systems to experiment in an intelligent way with such complex social arrangements of health care financing?
13/2/2004
Misereor/Aachen
77

Slide 1

COMMUNITY HEALTH INSURANCE

KARNATAKA EXPERIENCE

BY

UNDP, KARUNA TRUST, & CENTRE FOR POPULATION DYNAMICS

Slide 2

HRM - Pl. store as Resource file on Health Insurance.

SN
13/10/03

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Partner Organisations

United Nations Development Programme

Ministry of Health & Family Welfare, GOI

Directorate of Health & Family Welfare, GOK

Karuna Trust

National Insurance Co. Ltd.

Centre for Population Dynamics

Models

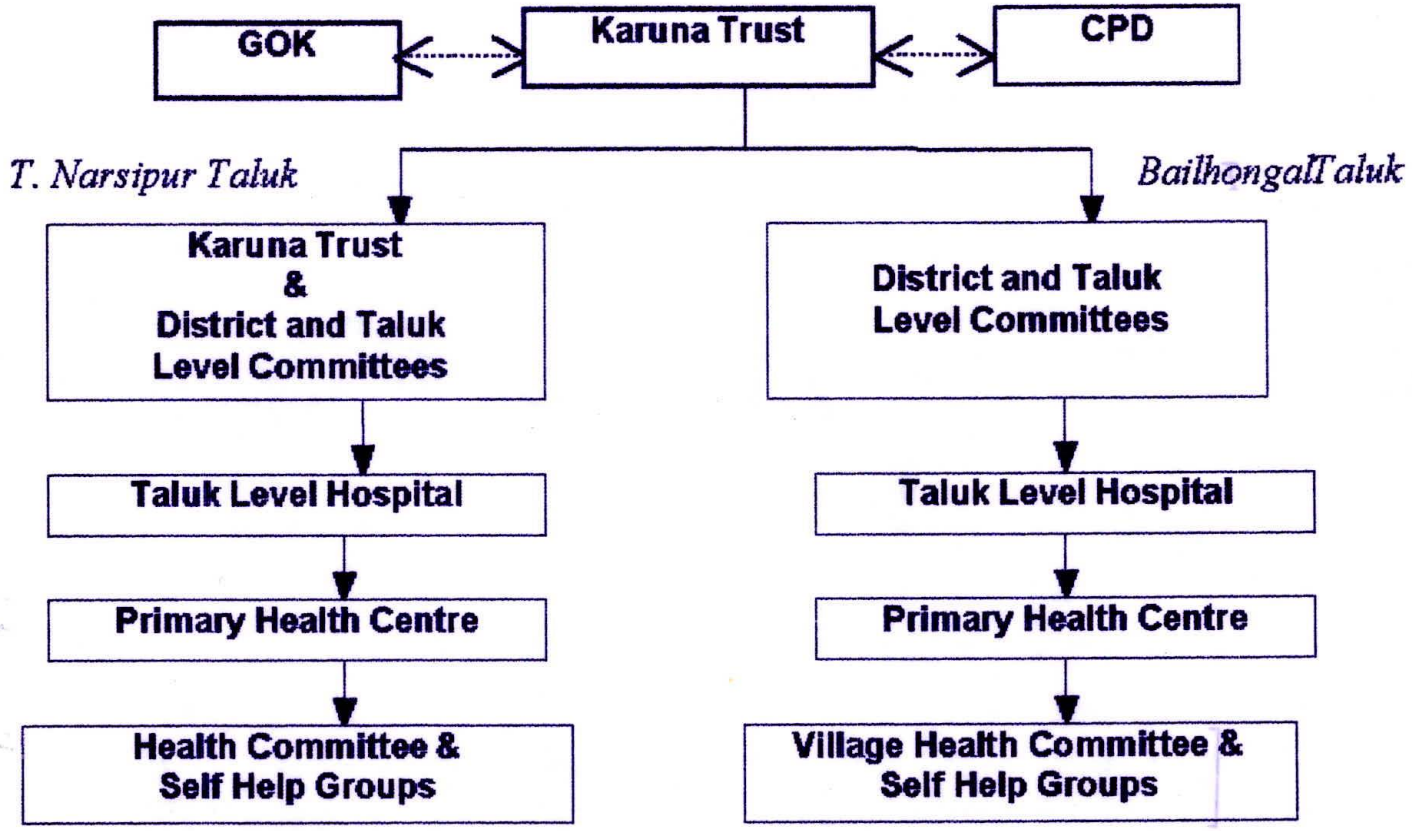
Model I

In T. Narsipur, the scheme would be organized and managed by the Karuna Trust, an NGO

Model II

In Bailhongal the official health personnel would organize and manage the scheme under the supervision of the Chief Executive Officer of the Z.P.

Organization structure of project



Project Implementation Committees

	District Level Committee	Taluk level committee
Chairman	Chief Executive Officer, Zilla Panchayat	Executive Officer Taluka Panchayat
Members	1. Deputy Secretary Administration of the Z.P. 2. District Surgeon 3. Executive Officer Taluk Panchayat. 4. Representative of the NIC 5. Representative NGO-Karuna Trust	1. Administrative Medical Officer General Hospital. 2. Administrative Medical Officer, CHC 3. Child Development Project Officer 4. Representative of the NIC 5. Project Officer, NGO- Karuna Trust
Member Secretary	District Health & FW Officer.	Taluk Health & FW Officer
Permanent Invitees	1. Taluk Health Officer 2. Administrative Medical Officer, General Hospital.	

Salient features of the Scheme

- Oriented towards the poor.
- Community level and family is the unit of membership
- Micro-credit financing for Out-patient care through SHGs
- The premium is Rs. 30 per person per annum for a health insurance cover of Rs. 2500/-.
- The insurance would cover :
  - All inpatient - hospitalization cases.
  - At public health facilities
  - Rs. 50 per day - given directly to the hospital for drugs
  - Rs. 50. per day - given to patient for loss of wages
  - Referred cases also
- The premium :
  - subsidized fully for BPL SC/ST population
  - Partially subsidized for BPL non-SC/ST population
  - Not subsidized for APL population

Salient features of the Scheme (Cont..)

- Revolving fund at health institution –to settle claims immediately.
- Active case finding by the social workers deputed at health centres and field staff.
- Referred cases to any public health institutions anywherel considered.
- Marketing the insurance and claim settlement, documentation etc. done by social workers.
- No exclusion of any diseases
- No waiting period.

Premium Structure and Benefits

	Beneficiaries	Annual Premium amount			Sum assured	Coverage & exclusions			
		Subsidised by Project fund	Users contribution	Total Premium amount		Patient for loss of wage	Hospital for drug charge	User charges	
A	BPL – SC & ST	30	-	30	2500	50	50	Nil	1. Only in-patient expenditure 2.Only Government institutions 3. No exclusions of any diseases
B	BPL Non SC & ST	10	20	30	2500	50	50	Nil	
C	APL	-	30	30	2500	50	50	Actuals	

Knowledge of the public regarding Health Insurance

(in Per cent)

Knowledge	28.28
Source of Knowledge	
Print & electronic Media	24.70
Insurance Agents	20.22
Health Institutions	30.22
Friends/Relatives & Others	24.87
Total	100.00

Perception of the public regarding Health Insurance

Reasons for insuring

Cheapest way to get health/medical care	56.42
Quality of care	20.31
Obligatory	23.27
Total	100.00

Reasons for not insuring

(in Per cent)

Too expensive	18.59
High premium	13.31
Why pay before falling sick	16.25
Low coverage of health services	10.89
Complicated Scheme	13.53
Better to pay for consultation	8.84
No trust in Insurance	14.15
Hassles of claim	4.44
Total	100.00

Willingness to pay premium amount

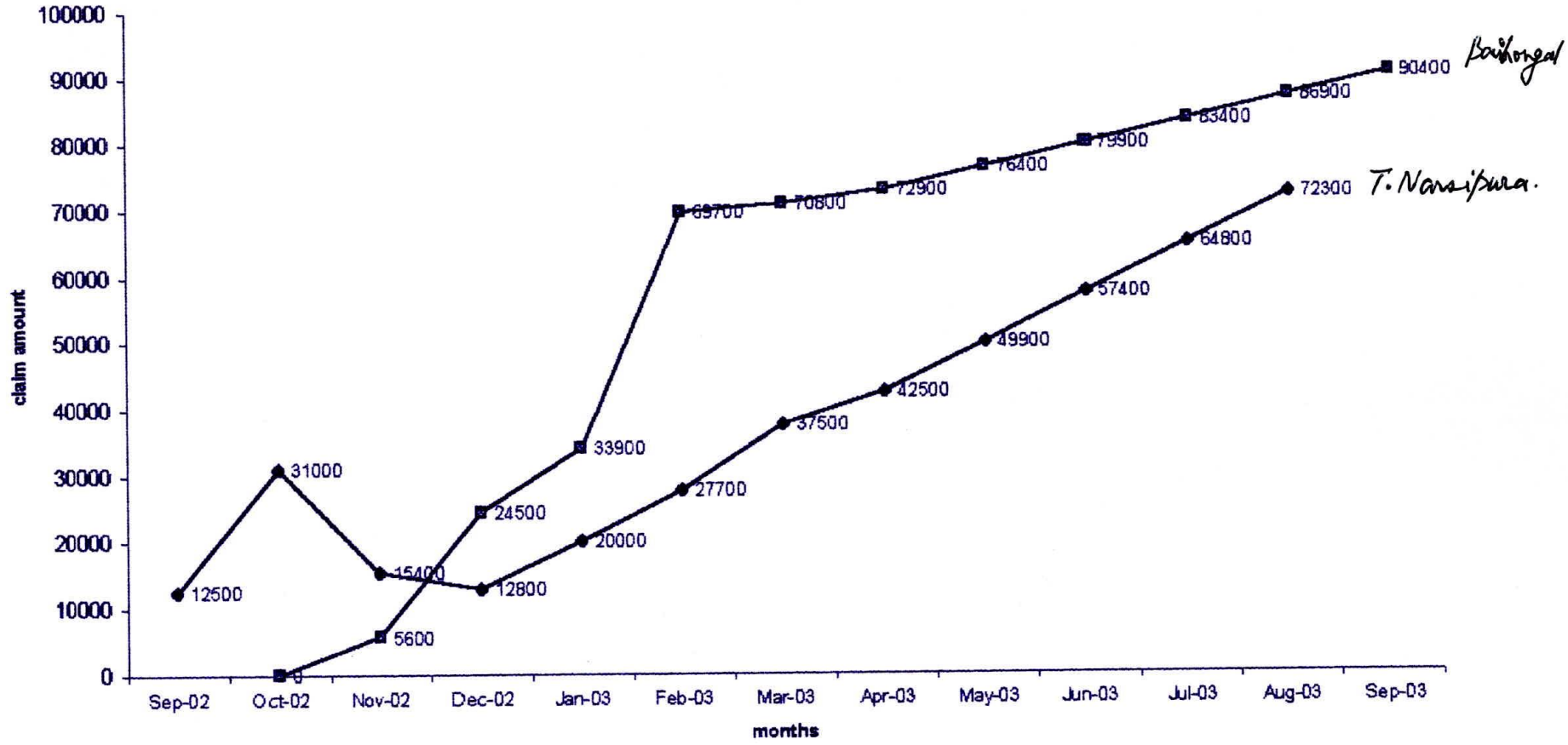
Premium amount in Rupeess/per annum.	%
Less than 50	31.56
50-74	44.14
75-99	6.94
100-149	17.36
Total	100.00

Progress

	T. Narsipura			Bailhongal		
Date of commencement	01.09.2002			01.10.2002		
BPL	Rural	Urban	Total	Rural	Urban	Total
SC & ST	77223	5323	82546	31204	1224	32428
Non SC & ST	2546		2546	20322		20322
Total	79769	5323	85092	51526	1224	52750

	T. Narsipura	Bailhongal
Amount fully subsidized @ (Rs.30) per person	2476380	972840
Amount partially subsidized	25460	304830
Total amount subsidized from UNDP fund	2501840	1277670
Amount collected from BPL Non SC &ST	50920	304830
Total amount paid to NIC	25,66,900	15,82,500
Amount claimed during one year	4,43,800*	6,94,400

Health Insurance claims- T.Narsipura & Bailhongal Taluks



Health Insurance Scheme (HI :Chechady Vally : Mahuadanr : Rap Assessment format for Documentation: -

I. General Information :

1. Clinic/ Hospital : .....
2. Area : .....
3. Informant : .....
4. Designation : .....
5. Working in the area since when ? : .....
6. Date : .....

II. Inforamtion about people/ Villages:-

Sl. No	Name of Village	Total No.of Families	Total Population (Appro-ximate)	No. of Catholic families	Total Catholic population (appro-ximate)	Name of the key personals in village			
						Health Worker	Dais	Compounders	Others (Specify)
1.									
2.									
3.									
4.									
5.									
6.									
7.									
8.									
9.									
10									
11.									
12.									
13.									

Sl. No	Name of Village	Total No.of Families	Total Population (Approximate)	No. of Catholic families	Total Catholic population (approximate)	Name of the key personals in village			
						Health Worker	Dais	Compounders	Others (Specify)
14.									
15.									
16.									
17.									
18.									
19.									
20.									
21.									
22.									
23.									
24.									
25.									
26.									
27.									
28.									
29.									
30.									

III. Information about the Scheme

Sl.No.	Year	Total No. in the Scheme			Total contribution from people for the scheme	Total expenditure on patients of the scheme
		Members	Families	Villages		
1.	1986					
2.	1987					
3.	1988					
4.	1989					
5.	1990					
6.	1991					
7.	1992					
8.	1993					
9.	1994					
10.	1995					
11.	1996					
12.	1997					
13.	1998					
14.	1999					
15.	2000					
16.	2001					
17.	2002					
18.	2003					

IV. Information about the Scheme :-

Sl.No.	Year	Total No. of patients seen in the clinic	**Total No. of Beneficiaries of Health Insurance Scheme**			
			At village level	Clinic level	Hospital level	Total
1.	1986					
2.	1987					
3.	1988					
4.	1989					
5.	1990					
6.	1991					
7.	1992					
8.	1993					
9.	1994					
10	1995					
11.	1996					
12.	1997					
13.	1998					
14.	1999					
15.	2000					
16.	2001					
17.	2002					
18.	2003					

District Health Accounts: An Empirical Investigation

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District Health Accounts: An Empirical Investigation

Economic reforms combined with a resource crunch have compelled planners and policy-makers alike to constantly and frequently take stock of resources available to the vital health sector. Estimations of health sector resources and financial flows accruing to this sector were for a long while limited mainly to public sector alone. This paper attempts a micro-level estimation of health accounts at a district level in the hope of evolving, in due course, a more comprehensive methodology applicable to wider areas such as the state and the country.

V B Annigeri

I Introduction

In the wake of economic reforms, countries across the globe are experiencing a severe resource crunch. This is very much true for the health sector as well as for other sectors. In view of this, policy-makers and planners in the health sector are ntinuously taking stock of resources available to the health sector and seeking ways and means of finding new resource base for this vital sector. Attempts are also on to review allocation patterns and to assess efficiency of prevailing resource use. In the past two decades there have been many attempts, which have tried to estimate health expenditures of an economy both from public as well as private sources. Efforts by Abel Smith (1963, 1967), Griffith and Mills (1982), and Mach and Abel Smith (1983) are considered to be important milestones in this respect.

A careful understanding of financial flows to the health sector seems to have emerged as an important policy tool in the recent times. Earlier attempts in developing countries were restricted to estimation of health expenditures from the public sector only. This was obviously due to data limitations experienced in such countries. In the background of limited availability of resources to the health sector, a judicious use of resources assumes utmost significance. To have a comprehensive picture about health expenditure we must take into account not only public sector spending but private sector contributions in this regard. A analysis of such expenditures with regard to the sources of funds on what uses the funds are made will gives us a form of accounts for the health sector, which may be termed as National Health Accounts.

Both national income accounts and national health accounts are similar, in the sense that what national health accounts describe for the health sector is being done by national income accounts for the economy as a whole. Both these estimates agree to the fact that money payments or transfers should not be double counted and a distinction to be maintained between capital and current expenditures. With regard to the health sector, the national health accounts is a recent addition and in most such developing countries efforts are still in their infancy. Some studies have indicated that the methodology adopted for the estimation of national income accounts may not act as a useful tool for the national health accounts [Foulon 1982, Petre 1983]. It is argued that the categories adopted in the estimation of national income estimates may not be useful for health sector analysis. This may be due to the fact that it is difficult to define what are the constituents of the health sector.

In the present day context, health accounts are in the process of development across the globe. The need for such an accounting has risen due to increased complexity of health care systems and the need to keep track of the resources of the health sector per se.

II Methodological Issues

The conceptual framework for estimating the health accounts emanates from two major attempts namely, (i) one carried out by the OECD group of countries; (ii) and the other one by the Harvard School of Public Health.

OECD Methodology

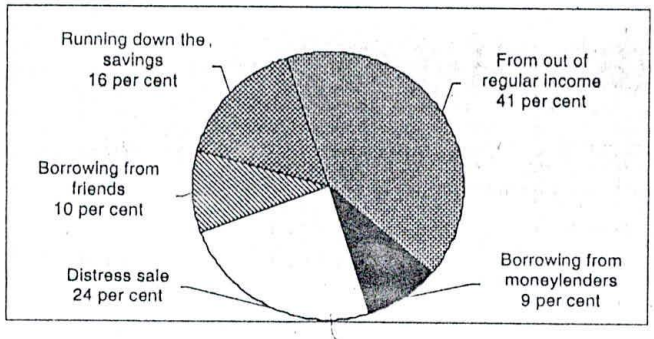
The OECD methodology (2000) broadly concentrates on the following components – health financing; health providers; health care function.

In the financing component, various levels of government are taken separately as well as various other private sources of financing and households. Health care providers include various providers including drug production, hospitals and others. Functions of health care include preventive, promotive, curative and rehabilitative care. Thus the OECD methodology tries to evolve health accounts in a tri-axial format. The methodology seems to be quite exhaustive in its coverage. For a developing country like India, the data to match these requirements may not be easily available, but a beginning needs to be made so that in a years to come we may probably evolve the methodology, which suits specific requirements of our own country.

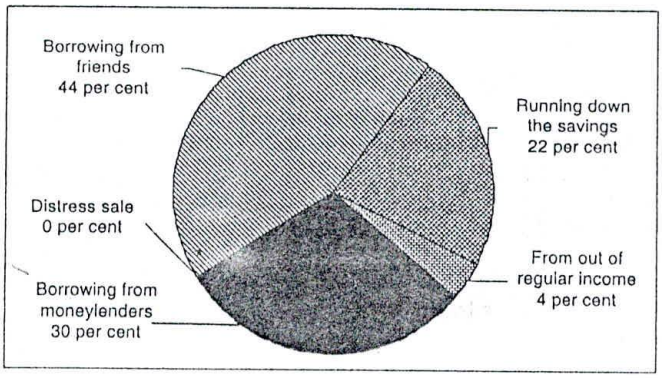
Harvard School Methodology

The methodology states that expenditures on health should be taken as "expenditure on activities whose primary intention (regardless of effect) is to improve health". It excludes large programmes that have health effects, but whose primary goal is not health – for example general food subsidies, housing improvement and large urban water supply projects. Still the debate over what to include in the domain of health expenditures is not conclusive and

Graph 1: Sources of Finance for Medical Care Costs Incurred by Households (Outpatients)



Graph 2: Sources of Finance for Medical Care Costs Incurred by Households (Inpatients)



consensus is likely to emerge once the developing countries start estimating health accounts according to country specific needs.

This methodology considers the flow of funds in the health sector from three angles – (1) source of funds; (2) financing agents; and (3) uses of funds.

Fund sources refer to those entities that provide funds to financing agents. Financing agents are those entities that pay for the purchase of health care services. They may own or operate provider institutions, as the ministry of health does or they may finance services provided by others, as done by private health insurance.

It is important to note that entities can appear at more than one level. For example households (a source) pay premium to insurance companies (a financing agent). However households also act directly as financing agents, purchasing health care services directly from providers. Households can appear at both levels in the flow of fund analysis since they play both roles. The NHA considers this as if households pay part of their expenditures to other financing agents and retain a certain part with themselves as financing agents. This leads to a transfer between columns and rows in the matrices.

The final level of the flow of funds analysis can be categorisation of a variety of 'uses': (i) providers and institutions; (ii) functions or type of health care services; (iii) line items or economic expenditure categories; (iv) regions or geographic, administrative categories and (v) socio-economic categories.

Formulation of flow of funds analysis is complete when the levels are clearly distinguished, all relevant levels and entities included in their appropriate place and well-defined categories of uses have been agreed upon.

III
District Health Accounts (DHA)

In the present study a modest attempt is made to estimate the district health accounts in Karnataka. Ideally health accounts at such a micro level will prove to be more useful in evolving such estimates and also help in strengthening the methodology for its replication at the state and finally for the nation as level. Few issues would assume importance in this regard.

(a) What should be the ideal scope of District Health Accounts (DHA) to begin with?

(b) Should health care services produced in the district and used by residents of other districts to be considered in this regard or not?

(c) Should health care services produced in the areas outside the district but used by the residents of the district be included or not?

(d) What public expenditure items are to be considered in estimating DHA? This is more significant in the background of different approaches adopted by different researchers in the Indian context, for estimating health expenditures.

(e) The same argument also holds good for expenditures made by NGOs and private corporate bodies.

(f) How to reconcile expenditures made by other governmental departments other than health?

Methodology

In the background of these and other issues related to the estimation of DHA, the present exercise has made a modest beginning. The methodology adopted for the current exercise is explained as below:

Public expenditure: Under this category we have considered medical and public health (2210). Though ideally we must also consider expenditures on family welfare, nutrition, water supply and sanitation, child health, and expenditures made by other government departments, in view of resource and time constraints we have restricted ourselves to medical and public health only. Data on public expenditure was collected from different sources in the district.

Private expenditure: In order to capture household expenditures a household survey was conducted in both urban and rural centres. Sample households were chosen in a way as to provide due representation to different socio economic groups as well as geographical regions within the district. Random circulatory method was adopted to select the sample units. A total of 250 households were surveyed and based on the per household expenditure on health (curative), the total household expenditure on health for the district was estimated.

Employees State Insurance (ESI) data regarding contributions made by employers as well as employees was collected.

Table 1: Utilisation of Facilities

Facilities	Utilisation (Per Cent)
Public hospital	35.29
Public health clinic	4.04
Private hospital	13.97
Private doctor	38.24
Private nurse	0.74
Traditional healer	1.10
Others	1.84

Spending on health by departments other than health are also considered. For example, expenditure incurred by jails, police department, railways, state transport corporation, etc. The data sources produced at the end of the report gives in detail the different sources from where the data was collected.

Non-governmental organisations: Two of the NGOs were contacted in the district to gather expenditure data related to health activities.

IV
Results

At the outset we will take a look at the profile of households surveyed. About 13 per cent of households belonged to scheduled caste (SC) and 5 per cent belonged to scheduled tribe (ST). Other backward communities (OBC) constituted about 33 per cent, majority of the households had very low income per month. For example about 40 per cent of the households had income less than Rs 1,400 per month and 28 per cent had income between Rs 1,400 to 2, 500. Of the total households 7 per cent were huts 39 per cent were kutcha houses. Illiterates in the total sample accounted for about 24 per cent and the share of those educated till primary and upper primary levels were 23 per cent and 31 per cent respectively.

These sick people out of the sample, utilised the facilities as given in Table 1.

The table clearly shows that the dependence of the community on private facilities is more in comparison to public facilities.

Financing of Medical Expenditure by Households

Many studies have shown that private resources are quite significant in total health expenditures. But it needs to be examined

Table 2: District Health Accounts of Dharwad (Rs Lakh) for the Year 1997-98

Uses	Total	All Private Funds	Private			Total Government	Government			
			Household	NGO	Others		Union	State	Local	Foreign
Medicines	3615.35	3372.18	3372.18			243.17	85.00	157.17		1.00
Salary	2620.24	708.48		530.49	177.99	1911.76	356.39	1468.64	84.00	2.73
Medical and public health	1209.18	0.00				1209.18		1209.18		
Family welfare	423.45	0.00				423.45	393.17	30.28		
Medical supplies (equipments)	388.78	247.97		42.36	205.61	140.81	0.00	67.33	73.48	0.00
Office exps	168.89	165.44		165.44		3.45		3.44		0.01
Construction and maintenance	165.79	7.18		7.18		158.61	1.25	65.53		91.83
RCH programme	140.77	0.00				140.77	139.63	1.14		
Capital expenditure	89.64	58.13		0.45	57.68	31.51	13.62	1.08	7.12	9.69
ESI contributions	77.44	65.52			65.52	11.92		11.92		
Logistics	74.57	74.10	73.77	0.33		0.47		0.44		0.03
Rehabilitation care	40.25	40.25		40.25		0.00				
Diet	39.01	3.17		3.17		35.84	7.00	28.84		
Leprosy treatment	15.79	0.00				15.79		15.79		
Training	9.89	0.20		0.20		9.69		9.69		
Research expenses	6.52	6.52		6.52		0.00				
Blindness control	5.87	0.00				5.87		5.87		
Malaria programme	3.94	0.00				3.94		3.94		
Power and water	3.42	0.00				3.42		3.42		
Aids control	0.85	0.00				0.85		0.85		
Other	0.10	0.00				0.10		0.10		
Transport	0.00	0.00				0.00				
Total	9099.74	4749.14	3445.95	796.39	506.80	4350.60	996.06	3084.65	164.60	105.29

Table 3: District Health Accounts of Dharwad (Percentages) for the Year 1997-98

Uses	Total	All Private Funds	All Private Funds			Total Government	Total Government Funds			
			Household	NGO	Others		Union	State	Local	Foreign
Medicines	39.73	37.06	37.06			2.67	0.93	1.73		0.01
Salary	28.79	7.79		5.83	1.96	21.01	3.92	16.14	0.92	0.03
Medical and public health	13.29	0.00				13.29		13.29		
Family welfare	4.65	0.00				4.65	4.32	0.33		
Medical supplies (equipments)	4.27	2.73		0.47	2.26	1.55	0.00	0.74	0.81	0.00
Office exps	1.86	1.82		1.82		0.04		0.04		0.00
Construction and maintenance	1.82	0.08		0.08		1.74	0.01	0.72		1.01
RCH programme	1.55	0.00				1.55	1.53	0.01		
Capital expenditure	0.99	0.64		0.00	0.63	0.35	0.15	0.01	0.08	0.11
ESI contributions	0.85	0.72			0.72	0.13		0.13		
Logistics	0.82	0.81	0.81	0.00		0.01		0.00		0.00
Rehabilitation care	0.44	0.44		0.44		0.00				
Diet	0.43	0.03		0.03		0.39	0.08	0.32		
Leprosy treatment	0.17	0.00				0.17		0.17		
Training	0.11	0.00		0.00		0.11		0.11		
Research expenses	0.07	0.07		0.07		0.00				
Blindness control	0.06	0.00				0.06		0.06		
Malaria programme	0.04	0.00				0.04		0.04		
Power and water	0.04	0.00				0.04		0.04		
Aids control	0.01	0.00				0.01		0.01		
Other	0.00	0.00				0.00		0.00		
Transport	0.00	0.00				0.00				
Total	100.00	52.19	37.87	8.75	5.57	47.81	10.95	33.90	1.81	1.16

how this expenditure is financed. In other words it is not enough to say that private sector contributes the major share of health expenditures, but it would be interesting to see how actually households are drawing the money to fulfil their medical needs.

Graphs 1 and 2 make it amply clear as to how the households are able to spend money with help of different sources of finances.

For outpatient care, 24 per cent of the expenditure comes from the distress sale of household articles and 9 per cent through borrowing from money lenders, 16 per cent from dipping into savings. This speaks about the kind of inconvenience households face in meeting their simple outpatient heath care needs.

Money made available for the inpatient care shows that 30 per cent is through borrowing from moneylenders and 44 per cent out of borrowings from friends. Drawing from savings finances 22 per cent of impatient care. These would certainly indicate that episodes of morbidity affect the economic position of the households rather badly. Though households do finance their medical needs, it seems that they undergo a lot of economic pressure to do so. In this background the question of supporting public provisioning of medical care facilities seeks support again.

Table 4: District Health Accounts of Dharwad (Rs Lakh) for the Year 1997-98

Uses	Total Government	Government			
		Union	State	Local	Foreign
Salary	1911.76	356.39	1468.64	84.00	2.73
Medical and public health	1209.18		1209.18		
Family welfare	423.45	393.17	30.28		
Medicines	243.17	85.00	157.17		1.00
Construction and maintenance	158.61	1.25	65.53		91.83
Medical supplies (equipments)	140.81	0.00	67.33	73.48	0.00
RCH programmes	140.77	139.63	1.14		
Diet	35.84	7.00	28.84		
Capital expenditure	31.51	13.62	1.08	7.12	9.69
Leprosy treatment	15.79		15.79		
ESI contributions	11.92		11.92		
Training	9.69		9.69		
Blindness control	5.87		5.87		
Malaria programme	3.94		3.94		
Office exps	3.45		3.44		0.01
Power and water	3.42		3.42		
Aids control	0.85		0.85		
Logistics	0.47		0.44		0.03
Other	0.10		0.10		
Rehabilitation care	0.00				
Transport	0.00				
Research expenses	0.00				
Total	4350.60	996.06	3084.65	164.60	105.29

Table 5: District Health Accounts of Dharwad (Percentages) for the Year 1997-98

Uses	Total Government	Government			
		Union	State	Local	Foreign
Salary	43.94	8.19	33.76	1.93	0.06
Medical and public health	27.79	0.00	27.79	0.00	0.00
Family welfare	9.73	9.04	0.70	0.00	0.00
Medicines	5.59	1.95	3.61	0.00	0.02
Construction and maintenance	3.65	0.03	1.51	0.00	2.11
Medical supplies (equipments)	3.24	0.00	1.55	1.69	0.00
RCH programmes	3.24	3.21	0.03	0.00	0.00
Diet	0.82	0.16	0.66	0.00	0.00
Capital expenditure	0.72	0.31	0.02	0.16	0.22
Leprosy treatment	0.36	0.00	0.36	0.00	0.00
ESI contributions	0.27	0.00	0.27	0.00	0.00
Training	0.22	0.00	0.22	0.00	0.00
Blindness control	0.13	0.00	0.13	0.00	0.00
Malaria programme	0.09	0.00	0.09	0.00	0.00
Office exps	0.08	0.00	0.08	0.00	0.00
Power and water	0.08	0.00	0.08	0.00	0.00
Aids control	0.02	0.00	0.02	0.00	0.00
Logistics	0.01	0.00	0.01	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00
Rehabilitation care	0.00	0.00	0.00	0.00	0.00
Transport	0.00	0.00	0.00	0.00	0.00
Research expenses	0.00	0.00	0.00	0.00	0.00
Total	100.00	22.89	70.90	3.78	2.42

V
District Health Accounts

Based on data collected from the district (both public and private) an attempt was made to develop health accounts for the district (Tables 2 and 3). The matrix of health accounts shows different sources and uses of funds in the district. The government

Appendix A: Explanatory Note on Items of Uses in DHA

	Particulars	Explanations
1	Salary	Salary of officers, staff, DA, TA, interim relief, other allowances, establishment expenses. Accident relief fund. Salary of social workers.
2	Medicines	Drugs and chemicals, medical reimbursement, medicine to poor patient.
3	RCH programmes	Provision of contraceptive/vaccination.
4	Medical supplies (equipments)	X-ray, linen and bedding, instrument and equipment, Hospital equipment, surgical equipment, uniform and shoes.
5	Transport	Expenditure on petrol/diesel.
6	Office expenses	Expenditure on telephone, contingency/ stationery. Contingency.
7	Other	Not defined
8	Diet	Expenditure on food/milk/fruits/eggs/ vegetables.
9	Family welfare	Expenditure on sterilisation/NSV (no scalpel vasectomy).
10	Medical and public health	Expenditure of TB clinics, other govt hospitals, rural health services, school health services.
11	Construction and maintenance	Equipment maintenance, repair and maintenance, improvement, modernisation, expenditure in respect of properties, addition and alteration.
12	Leprosy treatment	Prevention and control of diseases.
13	Malaria programme	Prevention of malaria disease/distribution of medicines/drugs.
14	Logistics	Travelling expenditure.
15	Power and water	Expenditure on energy and water.
16	Capital expenditure	Purchases of vehicle, ambulance.
17	Training	ANM training/NGO training.
18	Blindness control	Prevention and control of blindness.
19	Aids control	National aids control programmes. Awareness to public regarding AIDS.
20	Research expenditure	Expenditure on research.
21	Rehabilitation care	Expenditure on patient rehabilitation.
22	Other	Not defined.

funds have been classified into union, state, local and foreign depending on the flow of resources. In the same fashion, private funds have been classified into household, non-governmental organisations and others (small private firms spending an health care needs). The district health accounts in terms of percentages indicate that all private funds account for about 52 per cent of the resources flowing into the district. Out of this, 37 per cent are contributions by households, 8 per cent by NGOs and about 5 per cent by others. Public resources account for about 47 per cent of which state government spends about 33 per cent, union government spends about 10 per cent and local bodies contribute about 2 per cent. If one looks at the share of uses, it is interesting to note that both state and union governments are spending less on medicines whereas salary assumes greater significance in their spending patterns.

An attempt is also made to evolve the accounts matrix for public resources only (Tables 4 and 5), which show that salary consumes major chunk of resources. The major role in the provision of health services rests with the state government which accounts for about 70 per cent of the total public resources.

Though the DHA estimate has more scope for refinement the present estimates nevertheless give a picture of flow of funds within the health sector of the concerned district. The present exercise of evolving health accounts at the district level can be considered as a beginning. They need to be looked from the point of view of evolving a methodology of developing health accounts at the sub-regional level. But a consensus needs to be arrived at to strengthen the methodology.

Appendix B: Data Sources

I Government
- (1) District Health Office (DHO), Dharwad
  - (a) Salary and non-salary
  - (b) Plan and non-plan expenditure
  - (c) Expenditure on drugs
  - (d) Reproduction and child health (RCH) programmes
  - (e) Capital expenditure on hospital building
  - (f) District leprosy office
  - (g) District malaria office
- (2) District Civil Hospital, Dharwad.
  - (a) Non-plan expenditure
  - (b) Users money and vehicle cost
  - (c) Nurse (ANM) training, (plan)
  - (d) Blindness control – plan and non-plan expenditure
  - (e) Blood bank – AIDS control, plan expenditure
  - (f) Post maternity care centre
  - (g) Leprosy unit.
- (3) Karnataka Institute of Medical Science (KIMS), Hubli
- (4) South Central Railway Hospital, Hubli
- (5) Leprosy Hospital and Rehabilitation Centre, Hubli
- (6) Karnataka Mental Hospital and Rehabilitation Centre, Dharwad.
- (7) District TB Centre, Hubli
- (8) Police Department (expenditure on reimbursement and health unit)
- (9) North-West Karnataka Road Transport Corporation (expenditure on reimbursement and health unit)
- (10) Sub-Jail/Borstal School's Health Unit
- (11) Employees State Insurance (ESI) Office (Employees and employers contribution)

II Local Bodies
- (1) Hubli Dharwad Municipal Corporation (HDMC)

III Private
- (1) Dental Hospital (SDM). Dharwad
- (2) Karnataka Cancer Therapy and Research Institute, Hubli

IV Non-Governmental Organisation
- (1) Karnataka Integrated Development Services (KIDS), Dharwad
- (2) Institute for studies on agricultural and Rural Development (ISARD), Dharwad

V Foreign Funding Agency
- (1) Expenditure of Karnataka Health Systems Development Programmes (KHSDP), Dharwad

Scope for Further Refinements

In the present exercise a modest attempt has been made to present a sources and uses matrix of resources flowing into the health sector at the district level. If this is considered as a beginning, the refinements can be made in future attempts in the areas of (i) health financing component; (ii) expenditure on health by source of funding; and (iii) expenditure on health by provider and source of funding (this has been partly covered in the present study).

Health provider component includes (i) expenditure on health by provider and (ii) expenditure on health by function. In this category different levels of health care institutions act as providers. A careful examination of sources of funds and uses for different levels of institutions would throw more light on the efficient use of resources. Under this category we also need to consider pharmacy/biomedical industries, medical equipment and allied industries and other related industries.

In the context of analysis of health care functions, flow of funds to various functions like preventive, promotive, curative and rehabilitate care, capital formation in health care industries, education, research and training and so on could be included.

Future attempts in estimating health accounts especially in the Indian context must cater to several resources flowing from the non-formal sector where there are many players in the provision of health care services. For example, services of herbal medicine providers, yoga and naturopathy establishments, household expenditure on medicines prepared within the house. Only when such a holistic perspective is taken about health accounts, one can meaningfully evolve 'health accounts' in its true sense. EPW

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Towards an Intellectual Community in India

Amrik Singh

The basic thrust of Ramachandra Guha's article 'The Ones Who Stayed Behind' (*EPW*, March 22, 2003) is that India, like US or even the UK can and should in course of time emerge as an autonomous centre of thought and discourse. This formulation should be seen in a context which is somewhat wider than what Guha has presented. Something about the stae of Indian publishing and its interaction with the emergence and consolidation of an intellectual community in India would in my opinion strengthen the thrust of the argument.

Till about a century ago, the centre of thought and discourse in the English-speaking world was the UK. By the beginning of the last century, the centre had started moving to the US. At the end of second world war, there was no doubt that the US had become its unquestioned leader. The decision to locate the United Nations in New York was an implied recognition of the fact that the US had emerged as a world power and also graduated to become the leading intellectual centre of the world. The USSR was a formidable power no doubt and there was confrontation between these two countries for another few decades. But the US had one unmistakable advantage.

By then, English had emerged as the most important language in the world. However powerful USSR might have been and however productive that country was in a variety of ways, its international acceptance did not measure up to a position of undoubted leadership. Some other factors too were at work but, for obvious reasons, they cannot be gone into here.

A factor which reinforced the American position of leadership was that, even before second world war, there was a systematic attempt on her part to attract talent from all over the world. If there is one country in history which has built herself up on the basis of the identification and pursuit of talent, it has been the US. No wonder the American system of higher education and research had emerged as superior to what obtained in other countries. The invention of the atom bomb was an extraordinary feat of scientific research. Its use over Japan in 1945 might have been a political decision but of this there can be no doubt that both the invention and manufacture of the bomb had been done only in that country.

All these factors combined together to put the US in the forefront. It is not only in the field of Indian studies that the US is ahead of the rest of the world, it is ahead of everybody else in the different branches of regional studies. Guha has referred to the field of south Asian history. But the same can be said in respect of scores of several other fields of enquiry. No more need be said about this issue for it is obvious that, for almost half a century now, the US has been leading the world in accumulating knowledge and producing research in every possible area of knowledge.

Two corollaries of what has been said above need to be spelt out. One, though the UK was at one time the leading country in the field of knowledge in this era of globalisation, it continues to be one of the leading players even now. Several other countries of the world are also beginning to emerge as regional centres. Secondly, it has so happened that, largely because of our population and partly because of the study and dissemination of English for about two centuries in whatever bumbling way it might have been done, India too has emerged as a significant regional power.

In terms of her publishing strength, the UK is miles ahead of India but that is because of the historical legacy of what had obtained in that country before the second world war. Today India is not only the third most important country as far as the publication of books in English is concerned, in a number of other ways India is doing well. This is despite all the negative things that are happening and come in the way of India emerging as a bigger regional power. The weakness of the Indian university system and the relative lack of quality in scientific research are strong negative factors. But it is possible to overcome these problems provided more people think along the lines suggested below.

Some three or four years ago, I published a piece on Science Journals in India. Amongst other things, I had made the point that, despite all the negative factors at work, it is possible to plan the publication of science journals in such a way that about 50 of them are straightaway accepted as internationally comparable. In about a year's time, this number can be taken to 100 or so. In about five years, this number can be doubled, if not trebled. What is required is that a group of people connected with policy-making come together and adopt a plan of action.

This plan of action should survey the entire range of scientific research and identify those areas where Indian researchers are doing well and are currently published in foreign journals. Their numbers might have come down of late but with a little effort the situation can be reversed. During the last 10-15 years, China has forged ahead rapidly. That is because some master minds are at work in that country and there is a plan of action. What we lack is such a plan.

While this proposal was by and large ignored, I tried to interest one of the key policy-makers to see some merit in this approach. The response was not positive. Most people seem to think that India emerging as a regional centre of original research is not a feasible proposition. I do not agree with that perception. So far at any rate they have had the last word.

Social Science Journals

Unlike the field of science, something miraculous happened in the case of the social sciences. One of the leading publishers undertook to publish journals in the social sciences provided the promoters of these journals met two preconditions. One was that they should appear on schedule – a professional obligation – as laid down in the journal itself. Most of the journals published in India do not understand the importance of timely publication. On the contrary, they are casual as well as sloppy in their approach. Secondly, it goes without saying that

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MACROECONOMICS AND HEALTH: AN UPDATE

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MACROECONOMICS AND HEALTH

INTRODUCTION

Since the release of the Report of the Commission on Macroeconomics and Health (CMH) in 2001, several countries have evaluated the recommendations in light of their unique country health and socioeconomic contexts and have embarked on steps to implement policies that would secure health as an essential component of development planning. Countries are approaching the work as a vehicle to assert national health priorities and as another input into reaching the Millennium Development Goals through strategic social sector and economic policy.

A central theme to the follow-up work to the CMH Report as coordinated by WHO is to maintain a country-driven process, with countries assessing their individual situations in order to best develop and implement a long-term Health Investment Plan. Since almost every country has ongoing programmes and mechanisms to reach a variety of health and development goals, the approach taken by each country reflects the programmatic and financial resources (both budgetary and extra-budgetary) at their disposal to integrate development strategies with health priorities. This paper provides a summary of the achievements of countries thus far as they have begun to implement the recommendations of the CMH and describes the early processes and inputs into existing poverty reduction programmes and other national development strategies. This will include a description of country priorities and mechanisms by which pro-poor public policies have been developed, contributing to socioeconomic stability and economic growth.

BACKGROUND

The necessity of integrating health across sectors to create a viable development strategy was established by the findings of the CMH (December 2001). The Commission emphasised the central role of health in securing economic development, identifying the poorest populations as disproportionately affected by disease and the financial hardships caused by disease. The Report concluded that low- and middle-income countries must increase resource allocations to health, and high-income countries must increase their contribution to health in poor countries within a development framework. Equally important to increased health expenditures, the Commission recommended that countries examine their health systems and institutions to identify inefficiencies and limits to the capacity to absorb additional funds and to elucidate the inequities of health provision to the poor.

In parallel, WHO has stressed that Health for All and Primary Health Care (PHC) strategies cannot be successfully implemented without placing them within each country's socioeconomic context. The result is the emergence of an international consensus: socioeconomic growth and development can be achieved only by rigorously promoting the implementation of pro-poor health policies within a developmental framework and financed through a massive scaling up of health investments.

Though health is accepted as an important goal of economic growth and development, economic development alone has not brought about the achievement of national and global health goals. The World Bank reports that though countries are spending one third of their budgets in the health and education sectors, the benefits are primarily experienced by the rich, not the poor (World Development Report, 2004). Several reasons are cited as to why public services are falling short, including the failure of funds to reach the peripheral service delivery level, weak incentives at the local level, and also lack of demand by the poor due to financial, logistical, cultural and educational barriers to access.

Over the last decade, several reports have supported a concerted international effort for scaling up essential interventions for health promotion, disease prevention, treatment, and risk-factor reduction through a coordinated sectorwide approach (World Development Report, 2003; World Health Report, 1999 and 2002). It is widely accepted that a range of interventions exist that, if efficiently and systematically applied, could reduce the burden of disease of the poor.

The CMH Report called for health investments to be placed centrally in countries' development agendas through long-term macroeconomic policies, highlighting the links between health investment and poverty reduction. CMH Working Group 1 states that this "new thinking – that health enhances economic growth - supplements and, to a degree, realigns ideas of the justifications of spending on health, justifications that are based on humanitarian and equity arguments".

THE WORK THUS FAR

In June 2002, the 1st Consultation on National Responses to the Report of the Commission on Macroeconomics and Health (CMH) was convened in Geneva. Representatives from ministries of health, finance and planning from 20 countries came together to translate the recommendations of the CMH Report into concrete actions at the country level towards achieving the Millennium Development Goals (MDGs). The Consultation positioned WHO, inter alia, to support these efforts in countries and to provide opportunities for periodic consultations on the impact of the Macroeconomics and Health (MH) process.

WHO has responded by establishing a Coordination of Macroeconomics and Health (CMH) Support Unit that assists interested countries to analyse their health policies and create fiscally sound strategies. The Support Unit works with WHO and its partners to:

1) help align macroeconomic growth goals towards reducing poverty and improving the health outcomes of vulnerable groups; and

2) support the aims of sustainable growth and development by integrating MH into PRSPs, achievement of MDGs and other national development agendas.

A series of Consultations at the regional level provided countries the forum to share approaches and successes in the MH process. The 2nd Consultation on Macroeconomics and Health, "Increasing Investments in Health Outcomes for the Poor" (October 2003, Geneva), furthered the momentum of the countries. Discussion among ministers of health, planning, and finance, bilateral and multilateral partners, and financing institutions contributed to further focus MH work on improving access to health care and on innovative solutions to address the obstacles that hinder efficient use of financial resources. As expressed in the meeting declaration (see *Annex 2)*, countries identified resource mobilization options, human resource constraints, and the harmonization of donor funding as key issues.

In the two years since the CMH Report was published, approximately 40 countries have taken steps to act on its recommendations with ongoing support by all levels of WHO. The work has been driven by three overarching themes:

- Develop a multisectoral investment plan to improve health outcomes, especially among poor people;
- Strengthen commitments to increased financial investments in the health plan to achieve MDGs and other national goals; and
- Determine how to minimize non-financial constraints to the absorption of greater investments by increasing efficiency and effectiveness.

Given the diversity of health, economic and social situations, efforts to place health in the macroeconomics context must accommodate the health priorities, opportunities and obstacles unique to each country. Specifically, governments are assessing their health priorities and evaluating the cost of providing necessary interventions to the poor, in light of the financing mechanisms available internally and externally and the constraints experienced within the system. Substantial progress is being achieved in many countries that have initiated the CMH follow-up work, which includes advocating for the central role of health in sustainable development, establishing alliances and developing focused economic analyses. The work has demanded a multi-sectoral approach. Implementation must take into account the cross-sectoral interaction of risk factors for disease. Without the complementary improvement of other sectors such as education, water and sanitation, and environment, countries will be unable to optimize investments in health or achieve national health objectives.

In summary, countries have built on existing mechanisms for health investment and policy and systems reform and have used the macroeconomics process to make these activities more central to poverty reduction and economic growth. During the process of developing a long-term Health Investment Plan, several key opportunities and outcomes have emerged within the countries:

- A process to identify and promote country health priorities and health-related MDGs
- The establishment of a cross-sectoral mechanism to further promote priorities and to negotiate and collaborate with bilateral and multilateral partners and donors
- A move to directed evaluations of health financing and resource mobilization options specific to the country social and economic context
- A vehicle to insert health more strongly into PRSPs and other poverty reduction instruments.

HOW COUNTRIES ARE MOVING FORWARD

1. Focus of WHO's Macroeconomics and Health support

Though cost-effective prevention and treatment tools are available for controlling major diseases (e.g. TB, HIV/AIDS, and malaria), insufficient resources, coupled with a diverse range of systemic constraints, continue to obstruct national efforts to reach the poor. WHO supports governments' leading role in the development of pro-poor investments and policies for health to help achieve national targets and the MDGs using the findings of the CMH as a starting point. Substantial progress is occurring in those countries that have initiated CMH follow-up work. This includes promotion of pro-poor strategies, expansion of developmental alliances across sectors and instigation of new research and analysis.

The CMH Report highlights the destructive impact of HIV/AIDS as a unique challenge to growth and poverty reduction. AIDS significantly lowers economic growth and drives more families into deepening poverty, whilst causing great suffering and loss of life. There is a growing disruption to the economic and social fabric that has increased the risk of political and community instability, particularly in low-income countries. The WHO and UNAIDS global initiative ('3 by 5') seeks to provide life-long antiretroviral treatment to 3 million people living with HIV/AIDS in poor countries by the end of 2005. Core principles include urgency, equity and sustainability, and a concerted and sustained action by many partners. MH's integrative approach helps place the response to such socially and economically devastating diseases into a broader context of pro-poor health policy and development. For example, HIV/AIDS initiatives and programmes need to be a part of long-term government socioeconomic reforms, especially concerning the poor, and part of the government's overall health investment plan.

Leveraging the opportunities presented by other sustainable development mechanisms (e.g. Poverty Reduction Strategy Papers and Medium Term Expenditure Frameworks), governments are assisted in building domestic macroeconomic and public sector modelling capacity so they can implement an investment plan for health. As countries attract additional sources of funds, the MH process builds institutional capacity to effectively absorb increased funds and strengthen primary health care. The aim is to extensively increase access by the poor and disadvantaged to essential and cost-effective health interventions, greatly improve health outcomes and contribute to sustainable socioeconomic growth.

Over 40 countries have expressed interest in adapting the CMH Report's findings to their growth and development agendas. The initial focus is to strengthen a country's ability to carry out sound macroeconomic analysis so as to develop evidence-based and equitable health policies. Several countries are designing national Health Investment Plans that scale up cost-effective interventions while addressing the multi-sectoral determinants of health.

2. Relationship to the Poverty Reduction Strategy Papers

The Poverty Reduction Strategy Papers (PRSPs) are broadly based upon the World Bank's Comprehensive Development Framework (CDF) and the Monterrey Consensus[1]. PRSPs encompass five core principles: 1) country-driven, 2) pro-poor and results-oriented, 3) a multisectoral approach, 4) partnership-oriented, 5) sustainable. These match the spirit and thrust of the MH process, which is country-initiated and -directed, based on three themes arising from the CMH Report:

1. Give priority to multisectoral, pro-poor strategies that make health central to sustainable development agendas;

2. Strengthen commitment of all partners to increase significantly the resources invested to improving health outcomes;

[1] The International Conference on Financing for Development, held 18-22 March 2002 in Monterrey, Mexico, formally adopted the Outcome Document (the "Monterrey Consensus"). Developed, developing and transition economy countries pledged to undertake important actions in domestic, international and systemic policy matters.

3. Progressively eliminate non-financial constraints by increasing equity, efficiency and effectiveness of health-related interventions.

The MH approach augments PRSPs by placing health at the centre of development agendas and by identifying and addressing constraints to equitable access. A unique feature of the multi-stakeholder national MH mechanism is that it helps ensure increased investments are coupled with a pro-poor rationale to guide resource allocation and priority setting. Momentum is sustained through regional and country CMH focal points, utilizing a growing network of WHO partners including academia and civil society.

As the recent WHO survey on PRSPs has documented (WHO/HDP/PRSP/04.1), the health component of national strategies to reduce poverty and catalyse sustainable development lack an explicit implementation strategy that targets the poor. PRSP indicators are national aggregates and are often vaguely worded (e.g. "strengthen the capacity of district health workers"). Moreover, PRSPs frequently are additive compilations of sectoral plans, without any systematic way of rationalizing objectives, sequencing reforms and planning for financial sustainability. WHO adds value to the PRSP process, using the findings of the CMH Report, by helping countries craft a health strategy that significantly improves health outcomes, especially for the poor and marginalized segments of the population.

The CMH Report offers an analytical framework that, when used to assess the health components of the PRSP, can provide specific guidance on how to ensure the poor are clearly targeted and truly benefit from the strategies proposed. First, it helps to make a convincing argument to donors and senior political leaders for significantly increased funds for health (both through internal reallocations and by use of external grants). Second, the process uses a cross-sectoral approach to identify and progressively remove systemic barriers to more effective and equitable delivery of health services. Third, by emphasizing that resources should be allocated to preventive and primary health care before curative and tertiary strategies, the CMH Report helps countries put in place concrete steps to achieve the health-related MDGs.

Sixteen countries (Table 1) have both the MH process and PRSPs. In these countries, a MH approach helps focus partners on the need to place health centrally in development, operationalizing the health elements of the PRSP. In addition, the national MH mechanism strengthens high-level dialogues via regular inter-ministerial discussions that are inclusive of civil society and other stakeholders. Nine countries and one sub-regional grouping (CARICOM) do not have a PRSP process. Here the MH process initiates a high-level dialogue similar to that developed by the PRSP. The aim is to generate commitment to a sustainable approach to growth and development, which holds that improved health outcomes are a prerequisite for socioeconomic advancement.

Table 1: Annex: CMH countries with PRSP and HIPC

Region	Country	HIPC Y = Yes	PRSP/ I-PRSP Y = Yes	WB Category[2,3]	Indebtedness[4]
AFRO	Congo, Rep of	Y		LIC	SI
AFRO	Ethiopia	Y	Y	LIC	SI
AFRO	Ghana	Y	Y	LIC	MI
AFRO	Kenya	Y	Y	LIC	MI
AFRO	Malawi	Y	Y	LIC	SI
AFRO	Mozambique	Y	Y	LIC	LI
AFRO	Nigeria			LIC	SI
AFRO	Rwanda	Y	Y	LIC	SI
AFRO	Senegal	Y	Y	LIC	MI
AMRO	Caribbean Community[5]			varies	varies
AMRO	Mexico			UMC	LI
EMRO	Djibouti		Y	LMC	LI
EMRO	Iran			LMC	LI
EMRO	Jordan			LMC	SI
EMRO	Pakistan		Y	LIC	SI
EMRO	Sudan	Y		LIC	SI
EMRO	Yemen	Y	Y	LIC	LI
EURO	Azerbaijan		Y	LIC	LI
EURO	Estonia			UMC	MI
SEARO	Bangladesh		Y	LIC	LI
SEARO	India			LIC	LI
SEARO	Indonesia		Y	LIC	SI
SEARO	Nepal		Y	LIC	LI
SEARO	Sri Lanka		Y	LMC	LI
WPRO	Cambodia		Y	LIC	MI
WPRO	China			LMC	LI
WPRO	Lao PDR	Y	Y	LI	SI
WPRO	Mongolia		Y	LI	MI
WPRO	Papua NG			LI	MI
WPRO	Philippines			LMI	MI

Abbreviations:

LIC	Low Income Country	LI	Less Indebted
LMC	Low Middle Income Country	MI	Moderately Indebted
UMC	Upper Middle Income Country	SI	Severely Indebted

[2] Source: World Bank list of economies (July 2003).

[3] World Bank *income group*: Economies are divided according to 2002 GNI per capita, calculated using the World Bank Atlas method. The groups are: low income, $735 or less; lower middle income, $736 - $2,935; upper middle income, $2,936 - $9,075; and high income, $9,076 or more.

[4] World Bank *indebtedness*: Severely indebted means either of the two key ratios is above critical levels: present value of debt service to GNI (80 %) and present value of debt service to exports (220 %). Moderately indebted means either of the two key ratios exceeds 60 % of, but does not reach, the critical levels. For economies that do not report detailed debt statistics to the World Bank Debtor Reporting System (DRS), present-value calculation is not possible. Instead, the following methodology is used to classify the non-DRS economies. Severely indebted means three of four key ratios (averaged over 1999-2001) are above critical levels: debt to GNI (50 %); debt to exports (275 %); debt service to exports (30 %); and interest to exports (20 %). Moderately indebted means 3 of the 4 key ratios exceed 60 % of, but do not reach, the critical levels. All other classified low- and middle-income economies are listed as less indebted.

[5] Caribbean Community sub-region States comprise 15 members including the former Commonwealth Caribbean, Suriname and Haiti.

3. Relationship to the Millennium Development Goals (MDGs)

The MDGs were endorsed by 147 heads of state in September 2001 at the UN Millennium Summit. At the "High-level Forum on the Health Millennium Development Goals" (Jan 2004) held in Geneva by WHO and the World Bank, it was stated that developing countries will not be able to achieve the health and nutrition MDGs "unless extraordinary actions are taken to improve the coverage and quality of health and nutrition services." During the summit, the experiences of Uganda and Tanzania were reviewed. A key finding was that the "lack of a holistic cross-sectoral view on priority interventions that improve health" significantly weakens planning to achieve health MDGs. And while the PRSPs do address various sectors, the approach is often more additive than integrative, with various sectoral activities lumped together without first undertaking a holistic assessment of overall national priorities and the effectiveness of current expenditures.

The MH process encourages a cross-sectoral dialogue to increase governments' and partners' awareness that a multisectoral analysis is needed to develop a sustainable and comprehensive approach to growth and poverty alleviation. MH research, analysing all factors influencing domestic health outcomes, can be used to redefine narrow sectoral priorities and strategies within a true multisectoral framework. The participatory MH process also helps garner the political commitment to institute an integrative approach to making resource allocations, helping to ensure that primary health care interventions of proven value are adequately funded.

> One Cambodian expert described the relationship in this manner: "While the MDG targets for international development efforts over the next 15 or so years have been fixed, the CMH begins to construct the pathway towards attaining these goals."

4. Linkages and harmonization

Countries need regular and coherent dialogue with donors on what technical and financial support is essential, and how to best match delivery of both to the real absorptive capacity of countries. The MH process, by focusing on harmonization, creates a dialogue amongst major stakeholders as to how they can move from earmarked funding and discrete projects to allocating funds against comprehensive planning and expenditure frameworks, track progress against an agreed set of outcome indicators, and consolidate implementation procedures.

Further, donors and external agents are encouraged to pay more attention to the recurrent costs of investment programmes and to human resource needs. In several countries where the PRSP has been assessed, it was found that too many capital investments are included without adequate sustainability planning. Donor earmarking compounds the problem, since donor priorities end up determining distribution of resources, staff priorities and management time, rather than PRSP implementation being based upon a comprehensive and holistic method to reducing poverty.

To counter this fragmented approach, the MH process advocates for a national coordinating mechanism that could convene high-level representatives from government, NGOs, bilaterals and civil society to assess progress towards improved health outcomes for the poor. It would centre attention on the development of a comprehensive framework for planning and for financing, one that spans the various sectoral plans contained in national poverty reduction efforts, such as the PRSPs. Its purpose would be threefold:

a) To advocate for donors to move from earmarked funding of discrete projects and vertical programmes to allocating funds against a comprehensive expenditure framework;

b) To reduce transaction and administrative costs by harmonizing and streamlining implementation procedures;

c) To track and evaluate progress against a common set of process and outcome indicators.

5. The process of MH at the country level

Support from WHO/HQ

Macroeconomics and Health is a country-initiated and -directed process. After analysing its needs, the government, with facilitation by WHO, compiles the necessary evidence base to mobilize partners and create political support. The resulting high-level political commitment culminates in the development and full implementation of a Health Investment Plan integral to ongoing poverty reduction strategies for sustainable development.

Country requirements are being met by the WHO's mobilization of organizational and partner resources. WHO helps countries access technical support so they can develop an evidence-based investment plan that garners cross-sectoral backing. An important element is the national coordinating mechanism, whether new or added to an existing high-level body, which encourages a pro-poor approach to health policy development. WHO also has a unique integrative role, using its established country-level relationships with partners, NGOs, and donors to place health investment plans within existing development agendas. The outcome is to strengthen and sustain political support and commitment, improve the predictability of donor financing, and develop *and implement* an investment plan to achieve national development goals.

Added value of regional support

The WHO regional offices leverage their close relationships with countries to disseminate the findings of the CMH Report and catalyse a Macroeconomics and Health strategic planning process. Regions identify local and international technical resources and collaborate with HQ to mobilize funds needed to sustain country activities.

African, Eastern Mediterranean and South-East Asian offices incorporated the CMH findings into their regional developmental strategies. AFRO and EMRO have regional concept papers that outline the local relevance and impact of MH and provide a framework for collaborative opportunities with HQ at the country level. EMRO and AFRO operationalized the process via regional workplans containing specific targets for advocacy, policy development and technical products as well as the necessary actions to reach these objectives.

EMRO organized a successful regional consultation in June 2003, while AFRO held a similar meeting in early August 2003. SEARO's meeting occurred on 18-19 August 2003. These provided a venue for the review of national actions and experiences to increase health investments. Countries discussed opportunities and obstacles to Health Investment Plan development, debated options and then outlined individual strategies to put in place a customized process for increased health investments.

Two unique features characterized these three regional intercountry meetings. First, the methodology was innovative in that it brought together senior officials and operational-level directors from ministries of finance, planning and health. The blend of viewpoints allowed a holistic assessment of the actual barriers to scaling up investments in health. Such barriers include low political commitment, weak physical infrastructure, inadequate monitoring and information systems, insufficient human resource capacity, and ineffective social mobilization efforts. Second, the participants were able to outline practical ways to implement a cross-sectoral strategy to addressing constraints, make better allocative decisions, collaborate to attract new sources of funds (e.g. public-private partnerships) and explore innovative financing mechanisms.

6. National Macroeconomics and Health process overview

Initiated and led by government, the MH process reflects the specific opportunities and constraints faced in the domestic health, economic, social and political environments. Based on the experiences of countries that were early adopters of MHS, three phases outline the main outputs and activities of a MHS and offer a sequenced approach to achieving essential objectives. Of the roughly 40 countries in various stages of planning and strategy development, over 30 are categorized as Phase 1 while seven are engaged in Phase 2 activities.

- **Phase I: Preparation**

Activities: Disseminate CMH Report to important stakeholders to analyse its relevance to the current national situation. Promote high-level commitment to the MH process. Identify resources required to embark on planning activities. Define research and technical support needs.

Outcomes: 1) Attain high-level national political commitment to MHS, for example, the development of terms of references (ToR) for a national MH coordinating mechanism. 2) Develop an outcome-oriented work plan outlining activities, linked to a budget and timeline. 3) Develop ToRs for research studies and any technical consultants needed.

Estimated time: 6 months

- **Phase II: Planning**

Activities: Assess the health status of the poor. Determine effectiveness, efficiency and equity of current health-delivery infrastructure. Identify health priorities, outcome gaps and limits in capacity. Evaluate health intervention options based on cost/benefit and cost-effectiveness studies. Perform cost analyses of investment package options.

Outcomes: 1) Sustain cross-sectoral commitment to increasing investments in health as part of the larger development framework, for example, the integration of health outcomes into ongoing PRSP or MTEF processes. 2) Develop long-term Health Investment Plan based on situational and costing assessments. 3) Define an implementation strategy, identifying key stakeholders and how their support will be secured.

Estimated time: 18 months

- **Phase III: Implementation**

Activities: Implement the Health Investment Plan. Ensure effectiveness of mechanisms to monitor the implementation process as well as assess the long-term impact on health outcomes and economic growth. Analyse impact and use this information to refine and optimize resource allocations. Garner political support for implementation and sustain cross-sectoral backing.

Outcomes: 1) Collect and track relevant health and economic indicators. 2) Secure an increase in internal investments for health and (if required) supplemental funding by external donors.

Estimated time: Several years

7. Tracking outcomes

There are two inter-related levels to tracking outcomes in countries employing a MH approach. Administratively, budgets submitted for country and regional CMH-related activities are carefully assessed by the Secretariat to ensure that expenditures are linked to specific outcomes and that outcomes are clearly on the critical path to creating a national Health Investment Plan. WHO then responds to accepted country and regional requests with technical products and financial support. As activities are undertaken, WHO regional and country focal points oversee implementation and monitor achievements of funded workplans. Achievements are conveyed to WHO/HQ using short technical progress reports at the end of each phase (*Annex 1*).

At the country level, the MDGs and national targets provide broad benchmarks to assess progress of poverty alleviation efforts. The country leads the process of developing domestic indicators, with technical support provided by WHO and other development partners. Three complementary approaches help a country track results. First, the CMH Report helps persuade senior decision-makers to support linking pro-poor health policies to specific outcomes defined by the health-related MDGs. Second, workshops, seminars and other mediums foster collaboration between all partners to implement national strategies in a unified manner, agreeing upon a core set of national indicators. Third, provision of resources and products (e.g. end-of-phase Technical Progress Reports) assists the country to use collected data to measure progress of its implementation efforts as well as its advancement towards health-related MDGs. To avoid duplication and needless paperwork, the Secretariat supports streamlined reporting processes and the improvement of current information sources by strengthening existing monitoring systems.

8. Achievements to date

1) Fostering high-level political support

Copies of the report and background papers, translated into multiple languages, have been widely distributed for country review. Many countries (e.g. Ghana, India, and China) held national workshops with essential stakeholders to assess how to incorporate CMH findings into national development strategies. Several countries initiated the MH process through a national launch event, allowing important government officials and other high-profile participants to express publicly their support of the MH process. For example, in India, the Indian National CMH was launched in January 2003 with a keynote address by Dr Jeffrey Sachs of Columbia University. In Sri Lanka, a Macroeconomics and Health event led by the National Health Council and chaired by the Prime Minister resulted in the establishment of a National Commission on Macroeconomics and Health (NCMH).

WHO products

- Technical support for advocacy tools, national workshops, and consultations to secure commitment from politicians and policy-makers. IEC (Information, Education, Communication) products include an "Investing In Health" information booklet, an electronic newsletter and the MH website (http://www.who.int/macrohealth). These maintain support, help disseminate experiences to date and inform additional stakeholders (e.g., development partners, donors, etc.) of progress.

- Seed funds to catalyse and promote a national launch and other activities aimed at securing broad-based support and national commitment.

2) Establishment of high-level national MH mechanism

National cross-sectoral mechanisms support the MH process, usually by expanding the scope of existing coordinating bodies. Occasionally, a national MH commission is established if no better mechanism exists (e.g. Ghana, India and Nepal). Comprised of representatives from multiple ministries including health and finance, the structure of the mechanism is country-dependant. For example, Sri Lanka's NCMH includes representatives from various ministries, the WHO Country Office, UNDP, the private sector and academia. The Commission is co-chaired by the Minister of Health, Nutrition and Welfare and the Minister of Rural Economy and Deputy Minister of Finance. A different structure exists in Ethiopia. Their MH coordination is provided by a newly hired Macroeconomics and Health Country Coordinator (an Ethiopian economist) and by a Technical Working Group operating under the Ministry of Health.

WHO products

- Technical guidelines to design Terms of Reference (ToRs) for domestic MH coordinating mechanisms, with provision of case examples of other countries' coordinating efforts.

- Support to identify and place an in-country focal point, when requested by the country.

- Seed funding to establish the national MH mechanism.

3) Development of outcome-oriented workplans

Linked to a budget and timeline, this plan outlines the activities, outputs, and objectives unique to a country's strategic plan. It includes the identification of resources and support needed to carry out the described activities. Over 20 countries have submitted Phase 1 work plans, and a majority of these have received partial funding. These preparatory workplans pave the way for development of the Health Investment Plan.

WHO products

- Mobilize technical and financial resources necessary for the development and implementation of a realistic and outcome-oriented work plan, budget and timeline.

- Guidelines, templates and outlines to help countries assess gaps in technical expertise they will need for policy development and planning.

- WHO, especially regional focal points, identifies and places local experts by collaborating with universities and regional and national NGOs, and by the selected use of international consultants. Over 21 countries have participated in regional technical meetings, with many also receiving in-country follow-up visits by technical experts.

- Regional workshops to assist country progression, share country experiences and lessons learnt, and develop specific strategies to create and fully implement a plan for investing in health.

4) Assessment of health situation and analysis of health infrastructure

Several countries, including Indonesia and Sri Lanka, have produced country concept papers to adapt the findings to local health, economic and political situations. These concept papers are an initial assessment of the health and health delivery structures of the country.

Countries, in this phase, execute an in-depth epidemiological survey of the causes and risks associated with

morbidity and mortality, disaggregated by income level, ensuring that the conditions most impacting the poor will be targeted. Also, an analysis of the capacity of current health systems to absorb additional funding and assessment of funding gaps for scaling-up of the current health infrastructure and services to the poor is finalized. This provides a basis for sequencing and prioritization of targeted health investments. Indonesia, for example, received funds to prepare an assessment of public health expenditures aimed at assessing the poverty reduction impact of current and proposed spending patterns. Eight countries have now entered this phase of the MH process (Cambodia, China, Ghana, Ethiopia, Rwanda, Mexico, Indonesia, and Sri Lanka).

In this planning stage, countries are identifying the need for experts and institutional technical support to perform such analyses. Technical experts are recruited to assist countries in planning and executing the necessary assessments and analyses. Technical experts will also assist countries in developing important linkages with local and regional partners, such as representatives from the World Bank and NGOs.

WHO products

- Mobilise and coordinate technical support for environmental scanning and the identification of key stakeholders and socioeconomic factors.
- Fund selected research, as well as aid countries to create ToRs for technical and research groups.
- Develop and maintain relationships with academic and development partners to assist in analyses and evaluation at the countrylevel.
- The Earth Institute at Columbia University and the Royal Tropical Institute (KIT) are supporting specific assessment activities in several countries, as well as helping define ways countries can strengthen institutional research and analytical capacity.

5) Development of a Health Investment Plan

Countries will develop investment strategies based on the assessment of options and determine a package of high-priority, cost-effective interventions. A costing analysis of the selected interventions will ensure a sound evidence base on which to develop a long-term Health Investment Plan. Governments are working to foster and sustain cross-sectoral support for the Health Investment Plan. An important management element will be putting into place an internal mechanism for tracking of key outcomes. We expect eight countries to complete this phase by 2005.

WHO products

- Continue to develop and access a pool of experts who can address countries' research needs (e.g., economics, epidemiology, health services research, etc.)
- Will collaborate with countries to identify key economic and health indicators, including health-related MDGs and country-specific health goals (i.e. Healthy Indonesia 2010), by which to track the effectiveness and impact of the investment plan.
- Assist countries in building linkages with development partners, NGOs, donors, and academic institutions to sustain support and integration with ongoing poverty reduction plans and public health projects.

The next section will give some examples of the varied paths to the MDGs being built by countries employing a Macroeconomics and Health Strategy.

Table 2: CMH 2004 Country Progress[14]

WHO Region	Country	CMH Phase	Funding provided	Through end of Phase 2 (tracking MHS process)					
				Initial contact and request for info	Country missions or regional meetings	Follow-up plan, budget submitted[6]	Plan, budget approved	National mechan. created[7]	National mechan. in action
AFRO[8]	Angola	1		Aug 03		Aug 03			
	Botswana	1		Aug 03	Sep 03	Sep 03			
	Congo	1		Aug 03		Sep 03			
	Ethiopia	2	Y	Aug 02	Oct 03	Mar 03	Sep 03	[9]	
	Ghana	2	Y	Jun 02	Apr 03	May 03	Apr 03	Apr 03	
	Kenya	1		Jun 02	Mar 03	Sep 03	May 03	Nov 02	Nov 02
	Malawi	1		Aug 03		Aug 03			
	Mozambique	1		Aug 03	Sep 03	Sep 03			
	Nigeria	1		Aug 03		Aug 03			
	Rwanda	1 2	Y	Jan 03	Mar 03	Aug 03			
	Senegal	1	Y[10]	Aug 03		Sep 03	Sep 03	Sep 03	Nov 03
AMRO	Caribbean Community[11]	1	Y	Dec 02		May 03	May 03	Sep 03	Sep 03
	El Salvador			Jul 03	Sep 03				
	Mexico[12]	2		Jun 02	Jun 02			Jul 02	Aug 02
EMRO	Djibouti	1	Y	Apr 03	Jan 04	Jul 03	Sep 03		
	Jordan	1	Y	Jun 02	Jun 03	Jun 03	Jul 03	Apr 03	
	Iran	1	Y	Apr 03	Jun 03	Jul 03	Jul 03		
	Pakistan	1	Y	Apr 03	Jun 03	Aug 03	Sep 03		
	Sudan	1	Y	Dec 02	Jun 03	Jun 03	Jul 03		
	Yemen	1	Y	Apr 03	Jun 03	Sep 03	Sep 03	Mar 03	
EURO	Azerbaijan			Nov-03	Nov-03				
	Baltic States: Estonia	1		Dec 02	Mar 03				
SEARO	Bangladesh	1	Y	Apr 02	Aug 03	Nov 03	Feb 04	Jul 03	
	India	1	Y	Jun 02	Aug 03	Nov 02	Dec 02	Jan 03	
	Indonesia	2	Y	Dec 02	Aug 03	Sep 03	Mar 03	Sept 03	Sept 03
	Nepal	1	Y[13]	May 03	Aug 03	Oct-03	Mar 04	July-03	Aug-03
	Sri Lanka	2	Y	Jun 02	Aug 03	Feb 03	Mar 03	Jul 02	Dec 02
	Thailand	1		Aug 02	Aug 03	Jan 04			
WPRO	Cambodia	1	Y	Dec 02	Feb 03	May 03	Aug 03		
	China	1	Y	Oct 02	Dec 02	Jan 04	Jul 03	Dec 02	
	Philippines			Aug 03		Sep 03	Jan 04		
	Lao PDR			Sep 03		Jan 04			
	Mongolia			Sep 03		Jan 04			
	Papua NG			Sep 03		Jan 04			

☐ Included in a regional proposal

[6] Only the latest date shown for missions, meetings and funds dispensed, e.g. a Phase 2 date will overwrite the Phase 1 date.

[7] A few countries have developed a National Commission on Macroeconomics and Health as the mechanism for driving this process (e.g. Mexico, Ghana, Sri Lanka, India). Several others are using or considering the use of existing multi-partner/trans-sectoral commissions to manage the MHS process (e.g. Indonesia, Djibouti, Ethiopia, Argentina). In this case, they are rewriting existing ToRs to look at health economics and financing issues within a cross-sectoral framework. In most cases they are also expanding the membership of such committees to include civil society, private sector and other ministries (e.g. Defence & Agriculture in Djibouti).

[8] AFRO worked with Ghana and Ethiopia to disseminate their experiences during the "2nd Consultation on Macroeconomics and Health" (October 2003).

[9] Ethiopia is hiring a CMH country coordinator to work with the Ministry of Health.

[10] Funding provided for support from KIT: Royal Tropical Institute Amsterdam.

[11] Caribbean Community sub-region States comprise 15 members including the former Commonwealth Caribbean, Suriname and Haiti.

[12] Funded by non-WHO resources, primarily internal government resources.

[13] Funding provided for support from KIT: Royal Tropical Institute Amsterdam.

[14] This table only shows those countries that have expressed a strong interest in committing to Phase 1 activities, or those countries already actively pursuing Phase 1 or Phase 2 strategies.

ACHIEVEMENTS THROUGH MARCH 2004

In countries in which the process has moved past initial requests for information, a synopsis is provided of how the Macroeconomics and Health process is catalysing some notable efforts to strengthen cross-sectoral networks linking donors and national leaders.

1. African Region (AFRO)

There is growing interest among WHO African Regional Office (AFRO) member states to implement the CMH recommendations. For example, Ghana and Ethiopia are in the process of developing investment plans for strengthening "close-to-client", or primary health care, systems and extending coverage of essential health interventions. Angola, Botswana, Republic of Congo, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, Rwanda, Senegal, Tanzania and Uganda requested support to engage in a cross-sectoral process leading to multi-year Health Investment Plans.

To augment human resource capacity at the regional level, a regional CMH officer has been recruited. The officer is working collaboratively with other regional CMH contacts and the CMH Secretariat at WHO Headquarters to support local adaptation and ownership of the Macroeconomics and Health process. AFRO has produced a wealth of practical guides and background documents to help countries implement the Macroeconomics and Health (MH) process. Exchanging similar documents between regions has broadened the range of products and resources available for all participating countries.

Fourteen countries attended a WHO AFRO workshop on 4-8 August 2003 in Addis Ababa, Ethiopia. The workshop objective was to support countries in developing a process that will lead to investment plans for expanding coverage of essential public health and health-related interventions that address the most important causes of avoidable morbidity and mortality. Participants from each of the participating countries included: (a) Director of Planning, Ministry of Health; (b) Director of Planning, Ministry of Finance; and (c) WHO Country Office health economist (or National Management Professional). The role of the latter is to ensure follow-up at the country level. The workshop has led to the development of draft Plans of Work for 12 countries, and clearly outlined the steps necessary to advance the CMH follow-up in these countries. By the end of the workshop consensus was established on the importance of Macroeconomics and Health to the countries. Countries developed draft Plans of Action to take the process forward.

A regional concept paper and country guidelines for incorporating MH into poverty reduction efforts have been developed. The current focus of activities at regional level is on human resources and technical support to countries. A critical milestone for regional advocacy efforts was the 53rd Regional Committee (RC) meeting of ministers of health from the 46 countries, which took place 1-5 September 2003 in Johannesburg, South Africa. During the RC meeting, the Ministers of Health and the Regional Director endorsed the recommendations of the Report of the Commission on Macroeconomics and Health (CMH), attaching great importance to the Report's findings. They also commended the AFRO CMH strategy paper "Macroeconomics and Health: The way forward in the African Region" and the resolutions contained within. On the last day of the meeting, the ministers adopted the resolution and paper on Macroeconomics and Health.

Angola

The MH process is beginning to highlight the important links between health and economic development among essential target audiences. A study on 'Public Financing of the Social Sectors in Angola' for the years 1999-2001 was jointly carried out in 2002 by WHO, UNICEF, UNDP and IOM in coordination with the Government of Angola: Ministry of Finance, Ministry of Health, and the Ministry of Education. There exist tangible entry points for implementing the MH process in Angola. Both the Poverty Reduction Strategy Paper (PRSP) and the Medium Term Development Program (MTDP) are being drafted at this time, providing the opportunity to analyse current objectives to see if they address key determinants of health and ensure health

is central to poverty reduction.

Following the AFRO CMH workshop in Addis Ababa, Angola plans to elaborate a structured framework encompassing the CMH findings, key elements of the CMH workshop discussions, and an outline of existing Angolan public expenditure mechanisms in health. This will aim to integrate the MH process into current national development plans and initiatives.

The Republic of the Congo

Epidemiological data shows malaria to be the leading cause of morbidity and mortality among the poor, with other infectious diseases having a large impact (e.g. HIV/AIDS, TB, and vaccine preventable diseases). 15 July 2003 saw the country's draft I-PRSP well received, with World Bank (WB) and donors agreeing to ensure quick access to debt relief through Heavily-Indebted Poor Countries (HIPC) Initiative.

The Republic of the Congo notes that it will require significant and effective international support, both financial and technical, in order to reach the Millennium Development Goals (MDGs). National public sector spending on health has only reached 4.35%, so more advocacy at the highest political levels is needed in order to place health more centrally to the budgetary planning process. An important challenge to be faced, despite new oil revenues forecasted, is the continued heavy scheduled external debt service obligations (currently 46% of government revenue). The economy is poorly diversified and almost entirely export-based. The goal is to increase public health spending to 20% by 2008, and this will be a major part of the Congolese MH strategy.

Ethiopia

The MH process is generating awareness of the important links between health and economic development among essential target audiences. The authorities welcomed a MH approach and the opportunity to establish a Technical Working Group under the Ministry of Health and the country's Central Joint Steering Committee of the Health Sector Development Programme.

A Macroeconomics and Health Country Co-ordinator (MHCC) was recruited in December 2003 to assist the Technical Working Group. The MHCC and Technical Working Group, under the guidance of the Health Minister, will direct research to evaluate the current health care frameworks and the costs of increased health care expenditures. The MH Plan of Action received final approval and endorsement by the Ministry of Health in May 2003. The Technical Working Group has started to assess how the MH process can integrate into the established PRSP. An MH workshop was completed during the Annual Review Meeting of the Health Sector Development Programme II (HSDP) in April 2003.

Ethiopia hosted the Intercountry workshop for CMH for AFRO states in August 2003, giving the government an international platform to share its experiences, whilst exchanging ideas on developing a country-led MH process with other countries. In addition, visits by the Columbia University team and by WHO HQ occurred several times throughout 2003. International experts from Columbia University provided technical expertise in economic and technical analysis to support Ethiopian efforts to carry out needed research and build an effective evidence base for policy development.

Ghana

A high-profile launch of the Ghana Macroeconomics and Health Initiative (GMHI) was held in Accra in November 2002. The Ghana Commission on Macroeconomics and Health (GCMH) is carrying forward the GMHI, analysing the Ghanaian Poverty Reduction Strategy in light of the CMH Report's findings. Six technical papers sponsored by the GCMH were reviewed, investigating cross-sectoral factors affecting health (published in February 2003). Ghana is focusing on three main issues: health insurance, access to water and sanitation, and human resources capacity at village level. A Technical Working Group has investigated performance and outcome gaps in every area of the Ghana PRSP implementation, identifying cross-sectoral causes of health system deficiencies. In one notable outcome of the MH process, analysis has prompted new policies and strategies that aim to increase the capacity of human resources within the health sector.

In Ghana, the MH strategy is positioned to heighten commitment of important ministries that influence the allocation of resources through the national planning process. In addition, Regional Ministers, a potent political force, are being sensitized to the necessity of reassessing current health investments. Moreover,

such downstream political support is necessary to develop the capacity of district managers to design and implement realistic district plans. The predicted increase in the capacity to deliver essential health interventions ties in well with Ghana's establishment of sector-wide insurance schemes. Additionally, MH work supports MDG achievement.

The GMHI has completed several early objectives. This is embodied in three groups of reports: 1) the technical reports commissioned by the GCMH, 2) the consultant's report "Investments in Health to Reduce Poverty and Stimulate Economic Development in Ghana: Findings and Recommendations of the Consultant, December 2002", and 3) the report "Scaling –up Health Investments for Better Health, Economic Growth and Accelerated Poverty Reduction, June 2003". These three documents will form the conceptual basis for the Health Investment Plan, along with other background materials currently in preparation. Completion in early 2004 of this analytical work will allow it to influence the PRSP and budgetary review processes and to help develop national policies optimizing the uptake of new resources and investments.

Kenya

In March 2003, the Columbia team met with the newly appointed Minister of Health, the head of the National AIDS Control Council (NACC) and donor organizations in Nairobi to discuss the potential value of implementing a cross-sectoral plan for increased health investments. The Minister of Health, the NACC and donor groups requested technical assistance to evaluate the financial needs for scaling up health expenditures in Kenya. The President is keenly interested in expanding health prevention and interventions in the country, making this is a pertinent time to engage in a MH process. In July 2003, a Columbia team met with senior health and finance policy makers to discuss options for commencing the MH process and potential linkages between existing health frameworks and PRSPs.

Since the CMH workshop in Addis Ababa, the team led by Ministry of Health 's health economists has focused on consensus building among stakeholders. Toward this objective, briefings have been carried out for: 1) The Permanent Secretary and Director of Medical Services in Ministry of Health, 2) Permanent Secretary Ministry of Planning and Development, 3) the Minister for Health, and 4) Chief Executive for National Hospital Insurance fund and senior management of the Ministry of Health.

The team has also finalized the Plan of Action for Phase 1 for the next 6 months. It aims to link the MH process and subsequent health investments to: 1) the Economic Recovery Strategy (ERS) investment programme; 2) the next National Development Plan (2006-15); 3) the national budgetary process; and 4) and UN Development Assistance Framework Group (UNDAF) workplan.

The Republic of Malawi

Political and socio-economic development is constrained since Malawi is a landlocked, single cash crop agricultural economy with concentrated ownership of assets, limited foreign and domestic investment and a high population growth and density. Malawi participated in the CMH workshops in Addis Ababa, but is still in the preliminary stages of deciding how best to use the findings of the CMH Report. As a Heavily Indebted Poor Countries (HIPC)-I country, the delegation felt that a possible CMH entry point was the reallocation of funds, previously tied to servicing external debt, into the PRSP-defined poverty reduction objectives. The MH process will be located in Ministry of Economic Planning & Development (MOEPD). The MOEPD holds cross-sectoral meetings once a month on development programmes and projects. The other opportunity is that the MOEPD coordinates the activities of the PRSP jointly with Ministry of Finance.

Mozambique

"It is strong health and education services that give people the tools they need to take advantage of expanding economic growth." – Dr. Humberto Cossa, Director, National Directorate of Planning, Ministry of Health.

Mozambique has made significant progress in conceptualising various strategic options for investing in health. In 1999 an Action Plan for the Reduction of Absolute Poverty (Plano de Acção para a Redução da Pobreza Absoluta—PARPA) defined the actions and priorities to be implemented across sectors. PARPA was taken as the basis for the design of the Interim Poverty Reduction Strategy Paper (PRSP). Linkages to the Medium-Term Expenditure Framework (MTEF), giving emphasis to the objective of poverty reduction, are being defined.

The goals of the MH process in Mozambique are to streamline the analysis and evidence of the CMH Report into the national development agenda: Accelerated Economic Growth and Absolute Poverty Reduction.

Mozambique views the Minister of Health as the "pivot of the process", who will lead efforts to assess studies, available data and policy documents so as to formulate a country-specific report on Macroeconomics and Health. Important steps include assessing the interrelationships and the opportunities presented by the "Health Expenditure Review" (PER), the "Expenditure Tracking and Service Delivery Survey", and the "National and Sectoral Medium Term Financing and Expenditure Framework".

Phase 1 of MH work will concentrate on effective advocacy and social mobilization and the use of good communication techniques. The overarching objective is to put into place a solid basis for the design of a long-term investing in health strategy. Ownership building, particularly inclusion of bodies such as 2025 National Development Agenda Council, will be emphasised.

Nigeria

Nigeria accounts for 13% of sub-Saharan Africa's GDP and 55% of West Africa's GDP, so an enhancement of Nigerian socio-economic progress could have tremendous spill-over effects for the continent. Oil and gas account for 20% of GDP, 95% of foreign exchange earnings and up to two thirds of government revenue.[15] A significant window of opportunity currently presents itself to initiate a multi-sectoral process that will generate development of a Health Investment Plan integral to poverty reduction mechanisms. It is important to note that Nigeria is a heavily indebted poor country with severe debt-servicing constraints, even with the nonconcessional rescheduling of Paris Club debts (December 2000). Access to bilateral credits is virtually non-existent, while commercial credit exists only at market rates.

Nigeria's Minister of Health chaired an important session which closed the 2nd Consultation on Macroeconomics and Health, "Increasing Investments in Health Outcomes for the Poor" (28-30 October 2003), synthesizing the various themes of the meeting and helping push forward the draft Declaration from the Consultation. Following this Consultation, the Minister of Finance from Nigeria chaired part of the recently-completed High-level Forum on the Health MDGs, co-sponsored by WHO and the World Bank. Nigeria also chaired a number of sessions at the 53rd Regional Committee which took place in September 2003 in South Africa. Present were 45 ministers of health from the AFRO region who unanimously endorsed the CMH agenda and requested WHO to provide technical support to countries.

Nigeria's MH process is to be directed in the Department of Health Planning and Research of Federal Ministry of Health. This department has a government mandate to coordinate the implementation of the health components of ongoing initiatives such as NEPAD, PRSP, MDG, etc. Social mobilization will be embarked upon concurrently, in partnership with other sectors such as Women Affairs, Water resources, Environment, Agriculture and Education. Various partners (e.g. NGOs, civil society, donors, etc) will be targeted for a comprehensive briefing on the relevance of CMH findings and recommendations to Nigeria. This will spur national ownership of the process and garner the support required to the implement the CMH action agenda.

The Phase 1 objectives comprise two main prongs: 1) to build consensus on the relevance of the findings of and recommendations of the CMH Report at federal, state and local levels, and 2) to set up an appropriate institutional mechanism for moving forward the MH agenda in Nigeria. The latter includes defining linkages to the PRSP efforts and support for establishing National Health Accounts to track the sources and flows of funds to and within the health sector. This includes economic research studies, analysis of intervention options and assessment of financing mechanisms. Once funding is secured, the government will inaugurate a national mechanism to drive the MH process, create a concept paper on MH in Nigeria, and develop the specific operational strategy to integrate relevant CMH findings into long-term health investment strategies.

Rwanda

In March 2003, a team from Columbia University visited Rwanda at the invitation of the President of Rwanda, the Minister of State for HIV/AIDS, and the Executive Secretary of the National AIDS Commission (CNLS). The purpose was to identify how the MH process could be adopted. A PRSP was completed in June 2002, with a priority on rural development and agricultural transformation. The aim was to realize a real annualised GDP growth rate of 6-7% and to reduce poverty from 60% in 2001 to 30% by 2015. The Minister

[15] Source: Foreign Direct Investments December/January issue, 8 December 2003, Financial Times Business.

of Finance and Economic Planning and the Minister of Health both worked with WHO to develop a Macroeconomics and Health Strategy. Initially, the plan will focus on four areas for analysis and research:

1. The potential contribution of community health insurance schemes ('health mutuels') to finance health service delivery and improve access to healthcare in Rwanda;
2. Strategies for enhancing the salary, professional development, and incentive packages of health professionals in the public sector to enable the scale-up and sustainability of public health programmes;
3. An evaluation of spending on major health interventions, and the need to prioritize health care expenditures;
4. The macroeconomic impact of healthcare spending in Rwanda.

Focal points are the Director of PRSP Planning and Monitoring in the Finance Ministry and the Director of Planning for the Ministry of Health. Columbia University has placed an in-country adviser to support these individuals as well as the Secretariat for the National Task Force.

Senegal

On 28 April 2003, the International Monetary Fund (IMF) approved a new 3-year agreement under the Poverty Reduction and Growth Facility (PRGF) mechanism to support Senegal's economic reform program for 2003 to 2005, totalling about US$ 33 million. This is closely articulated with the Senegalese I-PRSP framework and is heavily reliant on wide-ranging structural reforms. At this critical juncture, Senegal wishes to ensure the centrality of essential health interventions, and that macroeconomic analysis carefully looks at health outcomes when deciding upon the shape and nature of proposed structural reforms.

The Ministry of Finance has primary responsibility for defining a global public expenditure control policy. As Senegal moves to full implementation of a MTEF through a PTIP (programme triennial d'investissement public), capital budgetary expenditures will become more scrutinised, especially since they will be linked with the performance based budgeting (PBB), introduced in 2002 to the health and education sectors. Of note, Senegal has identified a reduction in HIV/AIDS growth as a high priority. This implies a substantial public health component to ensure achievement of this objective.

The MH process can provide a strong analytical and evidence-based argument for significantly increased health investments. Phase 1 objectives for Senegal revolved around two main thrusts: wide dissemination of key messages from the CMH Report, and the development of a national and high profile mechanism to manage and sustain the MH process. The country wishes to support the creation of an evidence base showing the impact of various health investment scenarios upon health outcomes, especially for the poor.

United Republic of Tanzania

During the AFRO workshop in Ethiopia, participants from Tanzania and Zanzibar proposed a Framework for CMH Plan of Action covering November 2003 to March 2004. Two principal objectives were identified: 1) to build consensus on the relevance of the findings and recommendations of CMH, and 2) to establish institutional arrangement for facilitating implementation of the CMH recommendations.

Good opportunities exist for sparking strong interest in the MH process. For example, Tanzania will place the CMH Report's findings as an agenda item in the annual health sector review, as well as in the PRSP reviews. Additionally, joint meetings of the Ministries of Health of the Tanzania Mainland and Zanzibar will seek to best coordinate efforts and leverage their various experiences.

Uganda

Several entry points for commencing a MH process were identified by Uganda's participants to the CMH workshop in Addis Ababa. Core on-going processes, for which the mechanism to manage the MH process can be linked, include:

1. Revision of the PRSP (PEAP)
2. Developing Health Sector Strategic Plan II
3. Studies to generate evidence for Health Sector Strategic Plan (HSSP) II, e.g. burden of disease studies
4. National Health Accounts
5. Health systems performance assessment and the Benefit Incidence Analysis
6. Inter-ministerial efforts to improve health and level of funding
7. Health sector working group

The principle outcome sought for the first six months is the forging of a consensus on carrying forward the work on MH at the country level. The objectives are:

- Define the framework and structure for articulating health and development.
- Outline the advocacy package for investing in health.

The MH process will be located in the Prime Minister's (PM's) office, as the PM's mandate will be to coordinate inter-ministerial health financing. The comprehensive approach to health and economic development will be discussed during the upcoming scheduled PRSP review. This will also delineate linkages and potential synergies with the revision of the Poverty Eradication Action Plan (PEAP) and the Health Sector Strategic Plan (HSSP) II development process.

2. The Americas Region (PAHO/AMRO)

PAHO/WHO has suggested opening a dialogue on the implications of the CMH Report for the Americas, initially with a few key regional stakeholders such as the Central American Integration System (SICA), the Andean Health Agency (ORAS), and MERCOSUR.

PAHO's success in the HIV/AIDS strategy to mobilize health investments for anti-retroviral packages has been noted. The importance of having a macroeconomic foundation for managing the health sector has been stressed. At the country level, PAHO/WHO is interested in incorporating National Health Accounts into the local MH process as basic tools. They also feel that the MH-triggered research will contribute to the epidemiological database to assess the burden of disease of the poor and options for cost-effective interventions.

The regional office participated in the 2nd Macroeconomics and Health Consultation, "Increasing Investments in Health Outcomes for the Poor", 28-30 October 2003.

Caribbean Community

The 15 member states that make up the Caribbean Community (CARICOM) have set up a Caribbean Commission for Health and Development. CARICOM includes Antigua and Barbuda, The Bahamas, Barbados, Belize, Dominica, Grenada, Guyana, Haiti, Jamaica, Montserrat, St. Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, and Trinidad and Tobago. On 22 September 2003, the official launch of the CARICOM CHD announced the plan of action and objectives for the Commission. Chaired by the former head of PAHO/WHO, Sir George A. O. Alleyne, this Commission is patterned after the WHO CMH, and is charged with the responsibility of providing guidelines for action to the 15 member states. The overall goal is to "give substance to the Nassau declaration that the health of the region is the wealth of the region and respond to Millennium Development Goals in which health and development are priorities."

A policy framework is being developed to assist the CARICOM member countries in structuring their health and development agendas. This will be accomplished by a clear assessment of all determinants of health, coupled with selected studies on burden of disease and cost-effectiveness analysis. A macroeconomic framework will assess the aggregate returns for areas such as direct foreign investment, tourism and trade that can be expected by a coherent long-term strategy towards investments in health. Research proposed includes papers on the labour market returns to health and inequalities in health and income. Such research will convince senior government leaders of the necessity for increased health investments that are pro-poor.

An 18-month timeline guides the creation of a framework establishing priorities for health financing, including public/private partnerships and the sharing of services. The framework, plus locally developed evidence, will help member states structure their health and development agendas in an interrelated manner, while focusing on provision of pro-poor health services. An important outcome for the Community is partnership building, catalysed by multi-sectoral workshops to be sponsored in the various member states.

The Caribbean Community has obtained donor support for a significant part of their work plan, showing the value of engaging all local stakeholders into the earliest stages of developing a work plan for implementing a MH strategy. PAHO/WHO will be the executing agency and will provided needed technical support in concert with WHO-HQ, using local and regional technical experts when possible.

El Salvador

The Ministry of Health of El Salvador organized the first of a series of three seminars on Macroeconomics and Health in cooperation with PAHO/WHO. Held in May 2003, the first seminar included a presentation of the recommendations of the CMH Report, a presentation on National Health Expenditures in countries of the Latin American and Caribbean (LAC) region and the presentation of detailed studies on Health Accounts from El Salvador. The second seminar (September 2003) focused on health, equity and poverty issues.

The first and second activities are preparatory activities to launch the national MH Commission, which will be the third activity to take place in 2004. El Salvadorian officials are working through the local PAHO office to initiate the mechanisms to get WHO support to:

- sponsor participation of a high-visibility participant at the El Salvador CMH launch; and
- develop a long term MH strategy, using focused technical support and experts working collaboratively with a high-level national mechanism.

Mexico

The Mexican Commission of Macroeconomics and Health (CMMS) was inaugurated in July 2002. Since then, the Commission has scheduled periodic meetings, set up a web site to disseminate the Report findings widely, and outlined plans for forward movement of the process. The WHO/PAHO representative is coordinating the preparation of the proposal. Based on the consensus reached on the priorities and activities for the joint work plan, WHO/PAHO will also work with the Secretariat to assess funding sources. The CMMS continues moving forward towards the completion of a report on the different aspects of the relationship between health and economics in Mexico.

In order to better organize this challenging research project the CMMS was divided into five working groups, each of them coordinated by one of its members. The groups were established based on a careful process in which policy needs were prioritized. Each group will generate a report that would feed the CMMS's final product. The five working groups are the following: (1) Diagnosis of the health status of the Mexican population and of the public health system *vis- à-vis* the achievement of the MDGs, (2) Health, economic development and poverty reduction, (3) Intra and inter sectoral health related public policies, (4) Health insurance and social protection and (5) Global and regional public goods for health in Mexico.

3. The Eastern Mediterranean Region (EMRO)

In WHO's Eastern Mediterranean Region, the Commission on Macroeconomics & Health (CMH) Report was discussed at the 18th Meeting of the Regional Director with WHO Representatives and Regional Office staff in October 2002, with the participation of the CMH Secretariat. Further, EMRO's 26th Regional Consultative Committee (RCC 2002) commissioned work to assess the "impact of economic trends on health care delivery with special emphasis on deprived populations." The 27th RCC meeting (July 2003) noted that an EMRO task force on Macroeconomics and Health was formed and discussions with Headquarters colleagues culminated in a proposal and a plan of action to support poor countries in the region. Moreover, they placed on the 28th RCC agenda (July 2004) another issue relevant to macroeconomics and health: mechanism for prioritization of public health problems in the region and health research priorities.

On 9 June 2003, representatives of the CMH Secretariat participated in an "Experts Consultation to Discuss the Regional Strategy on Sustainable Health Development and Poverty Reduction" in Fez, Morocco. Along with World Bank representatives and other partners, CMH joined a roundtable discussion on strengthening the mechanisms for collaborative vision and integrated work within and outside WHO.

Linked to the Expert's Consultation, the WHO/HQ and EMRO hosted a Meeting to Facilitate the Implementation of CMH in the Eastern Mediterranean Region, 13 - 14 June 2003 in Fez. Themes from the Expert's Consultation fed into the CMH workshop, particularly the drive to build upon Community-Based Initiatives (CBI) and incorporate lessons learnt following the World Bank Development Report (1993) into current efforts for long-term investments in health. Country, Regional and the CMH Support Unit staff came together to draft CMH national plans and a regional MH strategy.

Main themes from workshop discussions stressed that operationalizing MH work requires a solid government commitment to reallocate national budgets and seek additional internal resources for health.

The success of Health Investment Plans will also rely on clear outcome tracking, strong supervision and addressing known constraints realistically by offering practical steps to remove barriers. EMRO supports country strategies that link MH work to WHO initiatives (e.g. Community Based Initiatives, "3 by 5"), as well as with existing national mechanisms such as PRSPs and Sector Wide Approaches (SWAps). Finally, participants agreed that investment plans should show a coherent path towards achievement of the MDGs.

The Regional Concept paper on sustainable development was presented at the Regional Committee (RC) for the Eastern Mediterranean (29 September - 2 October 2003, Cairo). Ministers of Health, other RC delegates and the Regional Secretariat approved the paper, entitled "Investing in Health of the Poor: Regional Strategy for Sustainable Health Development and Poverty Reduction".

In March 2004, a joint WHO mission from CMH and the MDG/PRSP team met with EMRO focal points for sustainable development, Basic Development Needs (BDN) and CMH follow-up. EMRO staff requested that WHO/HQ work with them to develop a more coherent range of analytical and technical tools, which could be made available to WHO country offices. Such tools would help national ministers and WHO representatives (WRs) clarify the strategic linkages needed among various initiatives (such as PRSP, Heavily Indebted Poor Countries (HIPC) Initiative, Global Alliance for Vaccines and Immunizations (GAVI), Global Fund for AIDS, TB and Malaria (GFATM), etc.) and national policies.

Djibouti

The Minister of Health gave a presentation at the 2nd Consultation on Macroeconomics and Health, "Increasing Investments in Health Outcomes for the Poor", 28-30 October 2003. Describing efforts to implement a Macroeconomics and Health strategy, he noted that Djibouti has a poor physical and human resource base. Furthermore, Djibouti has some of the highest rates of poverty, illiteracy, morbidity, and maternal and infant mortality in the world. As the Ministry of Health's allocation has dropped from 5.7% to 4.2% of the total government budget, the Minister places a priority on raising awareness among senior government leaders of the centrality of health to developmental strategies. The country has just commenced the first stage of a multi-year programme to reduce poverty, improve health and other social sector outcomes and spur economic growth and development. The World Bank and USAID have recently agreed to fund health and educational interventions in Djibouti with a total of approximately US$ 50 million over the next three years.

Initial MH efforts aim to insert a strong health component into the World Bank and USAID programmes for restructuring and reform, which accompany the national development plan. Currently, the national macroeconomics steering committee and CMH technical group are being put in place, to be directed by the Health Ministry. As over 50% of the health budget is funded externally, Djibouti finds its national priorities dictated by external donors. Cooperation between the Ministries of Health and Finance is increasing, but the health sector is allotted a very small portion of internally-generated resources.

In October 2003, a member of the Secretariat spent nine days in discussions with the Secretary General for the Ministry of Health and the Director of Budgets for the Ministry of Financing and Planning. This led to revision of the Djibouti work plan and a preliminary situation analysis in which epidemiological and economic data was collected and collated. Additionally, Djibouti was assisted in preparing for their participation at the 2nd Consultation on Macroeconomics and Health in Geneva (28-30 October 2003), where they gave a well-received country presentation on their perceptions of the MH process.

A follow-up visit by a member of the CMH Secretariat as well as by a consultant health economist from EMRO took place in January 2004. The objective was development of a concrete plan of work to draw up a national Health Investment Plan by October 2004.

The Islamic Republic of Iran

The highest levels of the Ministries of Health, Planning and Budget have debated the CMH recommendations. The Deputy Minister for Social Affairs felt that the provision of technical support to analyse existing data, which could then be used to develop an evidence base for pro-poor policies, would be critical for success.

Medical education is integrated under the Ministry of Health, with provincial health ministers also filling the role of medical school deans. Iran is building upon the success of recent poverty alleviation initiatives to increase community involvement in health. One important gap they have identified is the weakness of current

information management systems, which are inadequate for generating an analysis useful to decision-makers. WHO is being requested to aid in identifying IT tools, and the Regional Office and HQ will work with Iran to explore various options to remove this constraint to progress.

In assessing the macroeconomic and political constraints to increasing pro-poor health services, the Deputy Minister for Social Affairs noted that Iran and many other countries are facing opposing inputs: on one side are "neo-classical inputs pushing privatisation and downsizing of public sector services" while on the other side are calls for "increasing investments in health services to the poor, which can only be delivered by the public sector". The resolution of this "political question" needs the involvement of WHO in its role as global advocate for equitable health services.

In June 2003 Iran sent a team to the EMRO CMH meeting that included the Deputy Minister for Social Affairs. Iran notes that a 5-year health & development plan is being finalized now, creating a window of opportunity for ensuring the centrality of health to poverty reduction and sustainable development strategies. The country feels that the basis of such multi-sectoral planning should be reliance on Iran's internal resources, with reallocation based on evidence. These comprise two prime objectives of Iran's Phase 1 work plan for Macroeconomics and Health.

Jordan

The government of Jordan is embarking on a social and economic transformation program of which health is a prominent component. Intersectoral collaboration is also evident in the establishment of the National Committee on CMH with representatives from the Ministry of Planning, Ministry of Finance, and other concerned parties. Health problems such as malnutrition, diarrhoea, infant and maternal mortality, clean water and sanitation and access to a functional referral system and quality care are considered to be impacting the poor disproportionately. Basic essential interventions that have greatest impact on the poor are needed, and this requires a planned intersectoral effort (clean water, adequate sanitation, primary education) with appropriate policies and mobilization of resources to respond adequately and equitably to the health needs of the poor.

The government of Jordan is highly committed to advancing the CMH model by expanding evidence-based essential interventions to all people, including the poor and disadvantaged. Therefore, in December 2002, the Prime Minister has established a high-level National Committee to respond to the CMH initiative, chaired by the Health Minister and including the Minister of Planning and the Secretary General of the High Health Council. A technical committee has emerged and is charged with developing a strategy and plan for health services consistent with the CMH model.

Currently, the High Health Council (HHC) is leading the effort to develop a pro-poor Health Investment Plan in cooperation with a local consultant and the Technical Committee on CMH. The HHC's efforts are directed at the policy and strategy level and aim to improve health system performance and to achieve effectiveness, efficiency and equity in health services in Jordan. A Jordanian team from the HHC, Ministry of Health, Ministry of Planning, and Ministry of Finance, attended all the regional and international meetings on CMH organized by the WHO.

There are plans to establish a country-wide health information system. This will facilitate decision-making and foster cooperation between the different health sub-sectors. The Healthy Villages Program is considered to be one of the successful experiences that can be built upon, because it can effectively meet the needs of the poor in Jordan. Expansion of this program to include more villages is under consideration. The Healthy Village Program is an example of what an intersectoral approach can achieve.

Human resources development is one of the top priorities in Jordan. Two studies to assess the dental and nursing workforce situation in Jordan are underway. These studies are being conducted by the High Health Council in cooperation with consultants from local universities. Another response to the health needs of the poor is development of a universal health insurance program, a topic currently under study in Jordan.

Next steps to implement a National Health Plan:

1. The CMH concepts are rarely disagreed upon and therefore advocacy in this regard is not difficult. However, a national body with a full mandate is needed to maintain momentum and enthusiasm for the MH process.

2. Effort is needed to identify the poor so as to reach them with well-targeted interventions.

3. In order to reach a consensus on a list of essential evidence-based, feasible interventions, technical assistance will be needed during the process.

In Jordan, work to develop a national Health Investment Plan has already started and is expected to be finalized in a few months.

Pakistan

Pakistan has a multi-pronged approach to reducing poverty, based on the Poverty Reduction Strategy Paper (PRSP) and incorporating 1) acceleration of economic growth, 2) governance reforms, 3) expanding social safety nets, and 4) investing in human resources. Health sector investments are viewed as part of the Poverty Reduction Plan, with attention shifting to the provision of primary care and community-based initiatives. The foundation of the current health sector reform process is felt to be improved governance. As the PRSP is already finalized, the objective for Pakistan will be to disseminate the major findings of the CMH Report, translate them into the local macroeconomic context, and use them to define research to construct an evidence base for integrating health into the PRSP. While reaching the MDGs is a high priority, the pressing need is to reach the 45% of the population that currently does not have access to essential health services.

At the EMRO CMH workshop, the WHO Representative (WR) stressed that technical support was more urgently needed than financial support and that increasing local institutional capacity was critical. He felt the entry point for implementing CMH-related findings will be the augmentation of the capacity of countries to carry out strategic thinking and policy analysis that can support a multi-partner, multi-sectoral strategy for health and poverty reduction.

The Secretary of the Ministry of Health made the case that the MH process provides an opportunity to re-examine health strategies from a macroeconomic perspective. He strongly suggested to EMRO colleagues that each health ministry form a distinct "policy development" unit that has high political clout, adequate resources to "conduct macroeconomic analysis for strategic planning", and includes at least one health economist and one political strategist. This will aid in devising policies and strategies that will win support from the most senior levels of government. He also stressed that the chair be the prime minister or president, someone who could break down sectoral walls and foster bold initiatives to strengthen all the determinants of health. The NCMH should also have technical working groups dealing with research, analysis, policy development and implementation. These would be chaired by influential political leaders, respected for their technical ability, and able to take concrete steps to achieve desired outcomes.

Sudan

Sudan is a large country of nearly 32 million inhabitants that must cope with almost 1 million internally displaced people and a rural population of about 10 million. Within the context of severe civil strife and a large trans-national migrant population, long-term strategic health planning must rely on coordinating a diverse network of internal and external partners, aid agencies and other agents. Since the push for primary health care, there has been a marked inability to foster intersectoral collaboration or achieve coordination of various plans even within one public sector. The PRSP is merely one of many UN initiatives, and the government feels some integrated framework to rationalize all these initiatives is needed. They expressed the hope that the CMH focus on building up existing networks and strengthening partner networks will lead to a real cross-sectoral dialogue and participation in poverty reduction efforts.

The WR has pointed out that there is a window of opportunity presented by HIPC funds since the International Monetary Fund has agreed that 100% of these released obligations will be applied to the PRSP. The National Plan for Health Investments will aim to take advantage of this. Senior Ministry officials in delegation (Finance, Health, Social Welfare) discussed and revised the MH workplan.

A joint WHO CMH/PRSP mission visited Sudan in March 2004. Based on feedback from the Ministries of Health and Finance, the team suggested that the government use the momentum provided by the MH process to build upon increased inter-ministerial dialogue and seize the opportunity for more holistic approaches for health sector planning. Furthermore, it could employ a health systems framework to restate key health policy issues, allowing strategic options to be addressed effectively, while reconciling immediate post-conflict activities with broader, more comprehensive development of the health sector.

Yemen

Yemen's Coordinator for the Macroeconomics and Health Program (MHP) attended the EMRO CMH workshop accompanied by the Assistant Deputy Minister for Foreign Affairs from the Finance Ministry and the Director General of Projects from the Ministry of Planning. The team identified the following priority areas for work: 1) the determination of burden of disease of the poor and vulnerable, 2) advocacy, and 3) the creation of a consensus among stakeholders. The health sector reform initiative was identified as an entry point for the MH process. The PRSP process will be the vehicle for operationalizing the MH process, with the Yemen MHP Coordinator maintaining momentum and developing buy-in from influential stakeholders.

The Coordinator of the MHP is located within the Ministry of Public Health and Population. The Ministry has set up an inter-sectoral National Commission on Macroeconomics and Health to adapt the CMH Report to its national strategic priorities.

At the request of the Ministry of Health of Yemen and the WHO Resident Representative of Yemen, a joint PRSP and CMH mission from WHO Geneva visited Sana'a from 9 to 12 March. The objectives of the mission were to assist the Ministry of Health in strengthening its health sector strategy, which will then feed into the PRSP, and to assess the role of the Macroeconomics and Health initiative in supporting this process, as well as identifying areas in which WHO-HQ could provide further support.

The main findings of the mission were that the Health Investment Strategy being developed by the MH process can be an effective tool in linking goals, health systems function strategies and health expenditure plans as well as a tool for advocacy. The team recommended that the MH work focus on:

1) Analysis: Using the three themes of the CMH Report to assess the evolving health sector strategy.

   a) Pro-poor strategies: assess if current and proposed strategies specifically target interventions to improve the health status of the poor (e.g. primary health care (PHC) over tertiary care, and preventive over curative interventions, etc.). Then, assess if the implementation strategy includes a data collection strategy that allows monitoring and evaluation of outcomes and impact on the poor (e.g. are epidemiological data, household health spending surveys and assessment of health facility usage being disaggregated by household income quintiles, etc.)

   b) Greater financing for health. Assessment of the financing gap to look at both options for internal reallocations of funds to health and how external funds can predictably fill gaps. Includes commission of studies to develop a localised impact analysis of the socio-economic benefits of significantly greater investments in health, especially PHC and improving access to essential health interventions among the poor and rural populations.

   c) Removal of system barriers to access by the poor. The primary focus is to stimulate a dialogue on how the various health and health-related sectoral strategies (e.g. education, water, and sanitation strategies) can be harmonized, how local evidence can be used to set priorities, and how the various strategies can be correctly sequenced to sustain achievements. Strategies should explicitly consider how to progressively build up institutional and human resource capacity, using progress towards the MDGs as one way of tracking success.

2) Planning: The MH process works within the Ministry of Health to assess the quality of the evidence base, commission research to fill gaps (two papers are being completed to address these first two points), cost various health strategies, and then determine priorities and sequencing of strategies. This well-costed and evidence-based strategy will be the basis for requests for increased internal allocations and donor support.

3) Implementation: The national CMH team has drafted a Terms of Reference for a coordinating body that can provide input into health sector strategy, advocate for greater public expenditure on health and track the impact over time of the pro-poor elements of health plans. Two short-term objectives, incorporated in the PRSP, are to:

   a) Support National Policy on Essential Drugs and Logistics, including the review and approval of the Essential Drug List and National Treatment Guidelines

   b) Encourage NGOs to participate in provision of health services (e.g. Yemen Family Health Association).

4. The European Region (EURO)

Following the release of the CMH Report, the Regional Director of the WHO European Region decided to set up a special Task Force to assess the relevance of the Report's findings to the Region and propose specific interventions. The Task Force work plan is in line with the implementation of RC52 Resolution on Poverty and Health (EUR/RC52/R7). The first meeting of the EURO Task Force was held at the end of January 2003, in videoconference link with WHO Geneva and the European Observatory on Health Care Systems in Brussels. A strategy was outlined for follow-up and for the assessment of available resources.

Preliminary analytical work of the Task Force has highlighted that:

1) EURO countries, even at the lowest income level, have a health system in place, a tradition of public health, a work force with a higher level of skills and a better developed infrastructure than countries at a comparable level of economic attainment elsewhere;
2) Health data show relatively lower levels of infant, child and maternal mortality and high levels of adult mortality;
3) Predominant health challenges are more complex than in developing countries from other Regions, and include chronic non-communicable diseases, such as cardiovascular disease and injuries, or more difficult infectious diseases, such as multi-drug resistant tuberculosis.

EURO participated in the 2nd Macroeconomics and Health Consultation, "Increasing Investments in the Health Outcomes of the Poor", 28-30 October 2003, in Geneva.

Azerbaijan

A Country-Wide National Workshop on "Poverty and Health" was held in Baku on 19-21 November 2003. The workshop was a joint collaboration between the Ministry of Health of Azerbaijan, the European Regional Office of the World Health Organization (EURO) and WHO Headquarters. The objectives were to:

- Familiarise participants with the notions of investing in health for development;
- Provide an overview of the challenges and successes of integrating health in the PRSP;
- Provide an overview of how different health system functions and technical programmes are changing to better tackle the problems of the poor in Azerbaijan;
- Explore concrete examples of integrating social and economic determinants of population health into policy development.

The workshop blended theoretical and scientific input with practical tools useful for participants involved in decision-making at different levels of policy development in Azerbaijan. Practical experiences and case-studies were utilized.

This occurred within the context of the new Biennial Collaborative Agreement between the Ministry of Health of Azerbaijan and EURO for 2004 to 2005. One priority element of this agreement is the participation of a country representative in a "knowledge forum on pro-poor health action", with the purpose of supporting policy-makers to exchange experience on managing progress towards placing health in the context of poverty reduction strategies and MDGs.

At this time (January 2004) WHO/HQ are collaborating with the WHO country office and Ministry of Health of Azerbaijan to determine the best ways to move forward. One possibility, dependant on funding, is the placement of a short term consultant in Azerbaijan to help with efforts to integrate health into the broader development agenda.

Baltic States sub-regional initiative: Estonia

Estonia is a middle-income country in transition, a new member of the World Trade Organization steadily moving toward a market economy with increasing ties to the West, including the pegging of its currency to the euro. A major goal is accession to the EU, possibly by 2004. The overall health status of the Estonian population has been found to be poor as compared to EU and Nordic countries, for some problems lower than the reference countries of Central Europe. Infant mortality rate is 12.32 deaths/1,000 live births. Among the main health problems affecting Estonia are cardiovascular diseases, chronic liver disease and cirrhosis, alcohol abuse, occupational health and violence-related problems. Tuberculosis and HIV/AIDS are raising particular concern and have contributed to most of the 50% increase in infectious disease mortality since the late 1980s. Lack of estimates of poverty (as well as homelessness) is an obstacle to in-depth analysis of the

links between poverty and health problems, but a 2002 study commissioned by the World Bank and Ministry of Social Affairs of Estonia reached the conclusion that wide inequalities exist and are worsening.

In March 2003, WHO presented its work on the MH approach to a group of decision-makers and officials from the Estonian Ministries of Social Affairs, Foreign Affairs and Finance, academic representatives and international agencies. The Government has expressed an interest in the CMH approach, and a member of the Secretariat gave a presentation on MH strategies entitled, "Investing in Health to Reduce Poverty and Spur Development." Good interactions and dialogue followed the meeting, and Estonia is considering ways to follow up.

5. The South East Asian Region (SEARO)

The Regional Office in South East Asia has been active in communicating to countries the relevance of the CMH Report. SEARO has established a dedicated Working Group to engage in disseminating the Report's findings, making policy decisions regarding implementing its framework in the countries, and providing support to countries in this effort. Inter-ministerial and intersectoral meetings involving donors, development agencies, NGOs, media, and academia, for disseminating the core messages of the CMH Report, preceded the work. A Regional Conference of Parliamentarians on the CMH Report was held in December 2002. The Report was also on the agenda of the recent meeting of the Regional Director with WHO Country Representatives, in April 2003. Earlier, the meetings of Health Secretaries and Health Ministers, held in April and September 2002, had the CMH Report on their agendas.

In conjunction with the above meetings, the Regional Office finalized the Country Guidelines for CMH Follow-up and a related document, Outline for a Strategic Framework and Investment Plan.

In response to country interest and need for support, SEARO organized the Regional Consultation on Macroeconomics and Health for the South-East Asian Region (SEAR). This meeting was held at the World Health House in New Delhi on 18-19 August 2003. The meeting brought together representatives from the Ministries of Health, Finance and Planning from 9 SEAR countries, including Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, and Thailand. Also, East Timor-Leste was represented by the head of the WHO office in that country. Other participants included WHO representatives from HQ, Region and Country level and representatives from the World Bank, Columbia University, and USAID.

The meeting provided the countries a venue to discuss and share experiences and challenges in this process. Also, the countries had an opportunity to work with the WHO offices at all levels to discuss the support needed in terms of advocacy, technical work and building alliances with donor and development partners. Out of deliberations among countries, country status presentations, and outcomes of working groups, several considerations and challenges associated with planning and implementing a MH strategy were identified by the SEAR countries. These issues are the foundation of future coordination of efforts among countries, WHO offices, funding entities, and other partners.

Bangladesh

Bangladesh has made significant strides in improving the health of its citizens over the last two decades, including increasing life expectancy from 48 years to 61 years and decreasing total fertility rate from 6.3 to 3.3. Significant income-based inequality in health and in the provision of health services, however, continues to be an important issue. Bangladesh is currently participating in various poverty reduction and health promotion strategies in partnership with bilaterals, including developing a i-PRSP and receiving funding from the Global Fund for AIDS, TB and Malaria.

In this setting, Bangladesh plans to build on the available data and analyses done in conjunction with these initiatives and to supplement this information with further work on pro-poor planning and policy formation. The government is committed to a pro-poor health strategy that targets resources for priority health objectives and the Essential Services Package (ESP) within its new Health, Nutrition and Population Sector Programme (HNPSP, 2003-2006).

A successful advocacy workshop held by the Ministry of Health and Family Welfare and the WHO-Dhaka office in May 2002 and Ministerial representation at the Regional Conference on Macroeconomics and Health in August 2003 initiated the Bangladesh MH work. Currently, the Ministry of Health and Family Welfare is in the process of establishing a NCMH equivalent - the National Commission on MacroHealth and Poverty Strategy - with the Health Economics Unit of the acting as the secretariat.

A work plan has been developed for the Commission which emphasizes continued advocacy activities linking poverty and health, evaluation of the evidence available for a situational assessment and costing identified essential health interventions.

India

India is spending less than 1% of its gross national product on its health care budget, and private health spending, mostly in the form of out-of-pocket expenditures by families and individuals, accounts for 82.2% of total health expenditures. The 2002 Indian national health policy strongly advocates increased spending by the central government. The policy envisages raising health expenditures from 5.2% of GDP in 2001 to 6% of GDP by 2010, with government health spending increasing from 0.9% of GDP to 2% of GDP.

A well-received presentation on the CMH Report during the 2002 meeting of Health Secretaries and Health Ministers led the Government of India, in January 2003, to establish a National Commission for Macroeconomics and Health (NCMH), co-chaired by the Health and Family Welfare Minister and the Finance Minister. The objectives of the NCMH are to evaluate the impact of increased investments in health on poverty reduction and economic development and to formulate a long-term strategy for scaling-up essential health interventions, with a focus on the poor.

A sub-commission will function as the technical and operational arm of the NCMH, with the chair and Member Secretary already selected and the remaining spots to be filled by 1-2 economists and 1-2 public health specialists. The sub-commission will conduct meetings and hire consultants and experts as necessary.

The work of the NCMH has been slow to commence, but building on the momentum from the 2nd Consultation on Macroeconomics and Health in October, the NCMH technical sub-commission is developing a detailed work plan and budget for 2004, identifying the key issues for India and the resources that will be needed to adequately analyse these issues. The main areas of analyses that will go into the development of a Health Investment Plan include an assessment of the current health financing mechanisms and options for mobilizing additional resources, costing of an essential health services package, the role of the public and private sector in delivery of this package, and the implications of the HIV/AIDS epidemic. Overarching issues include monitoring and accountability, decentralization, inter-sectoral coordination, ensuring equity and economic development.

In coordination with the country, regional and HQ WHO offices, necessary linkages with technical groups and expertise from WHO and other institutions are being made to assist the NCMH in the identified analyses and assessments. The end product of the work of the NCMH sub-commission will be a report by October 2004 that will be the foundation of a Health Investment Plan, and further work will be undertaken to best ensure implementation and long-lasting effects of these recommendations.

Indonesia

In 2000, total spending on health amounted to 1.6% of GDP in Indonesia, or about US$ 8 per person. Additionally, overseas development assistance (ODA) to Indonesia averages US$ 2.3 billion annually, of which only 6% is dedicated to the health sector. Many of Indonesia's most significant health problems – tuberculosis, malaria, infant and maternal mortality, and malnutrition – are problems from which the poor suffer disproportionately. Indonesian children from the poorest families are nearly four times more likely than children from the richest families to die before their fifth birthday.

The government of Indonesia will integrate its health and development initiatives under an overall macroeconomics and health policy framework. The objectives of this framework are to 1) accelerate existing initiatives for pro-poor policy and funding commitments: CGI (Consultative Group of Indonesia, chaired jointly by the Coordinating Minister for Economic Affairs and World Bank), PRSP, etc.; 2) provide focused technical assistance to address systemic issues and integrate pro-poor priorities into policy processes; and 3) increase political commitment for health as a means of poverty reduction and economic development.

Within this framework and in the setting of fiscal decentralization and decreased economic growth, Indonesia aims to improve overall health status through policy development and corresponding financial commitments. To fulfil the health outcomes outlined within Healthy Indonesia 2010 and the MDGs, the Consultative Group on Indonesia Health Working Group, the Government of Indonesia and the donor community have agreed on a shared plan of work consisting of 6 objectives:

1. Reduce financial vulnerability to major medical expenses
2. Optimize the participation of private and NGO health providers in increasing coverage
3. Ensure pro-poor institutional environment under decentralization
4. Ensure sufficient resources to priority health programs (financial)
5. Ensure access for the poor (non-financial constraints), and
6. Ensure accountability by local government.

Indonesia, as part of its MH work, is in the process of completing several important areas of focused research including the completion of a book that conceptualises health and poverty and describes the place of health priorities within the PRSP, a report on costing essential health services, and an assessment of human resource distribution of health care workers. Additionally, studies have been contracted to review decision-making process for sectoral allocation and absorption issues and a review of public health expenditures.

Nepal

Nepal's public expenditure on health as percentage of GDP per capita is approximately 1.06%. The trend has been a slight decrease in health sector allocations as compared to those in other sectors. By contrast, the allocations to the education and water sectors have increased. Investment in health has increased during the last 10 years from 2.1% to 5.2% of the overall government budget. Recent political instability, however, has slowed this trend.

Nepal has improved many national health outcomes, with expansion of Essential Health Care to about 70% of the population. Access to health care facilities and workers in its rural communities has significantly improved. However, geographical variations among other health indicators persist, with rural populations having poorer health outcomes. According to a recent situational analysis prepared by the Royal Tropical Institute (KIT) of Amsterdam, health financing stems mainly from taxes and users fees, with the poor bearing the brunt of these fees. There are significant resource gaps on the road to achieving MDGs.

In response to the CMH recommendations, a Sub-Commission on Macroeconomics and Health (SCMH), part of a National Commission on Sustainable Development, has been formed. The Sub-Commission is chaired by the Ministers of Health and Finance and is comprised of representatives from most of the ministries, the National Planning Commission and the private sector. The WHO Representative to Nepal and the WHO Health Planner have been in close contact with the Sub-Commission. The Sub-Commission has identified key activities and areas of research (including advocacy workshops, epidemiological profile of disease among specific populations, a study on private health expenditures, and developing a coordinated effort for health sector reform and poverty alleviation) needed to move forward the MH process. Some studies that are relevant to the work of the SCMH are being carried out by the Health Economics and Finance Unit of the Planning Division of the Ministry of Health, including pilot projects with Social and Community Health Insurance schemes and studies of private health expenditures.

Nepal has developed a work plan for the SCMH for 2004 and is collaborating with the Royal Tropical Institute (KIT) of Amsterdam to carry forward the initial situational analysis and other technical assistance relevant to the Macroeconomics and Health work.

Thailand

Many in the government of Thailand believe that to achieve better health, a holistic approach, demanding strong support from non-health sectors, is crucial in overcoming health-related problems. The increasing roles of development banks in various structural adjustment programmes, including health, are evident in Thailand. Examples include the trend toward hospital autonomy and the public sector reform initiative.

In response to the CMH Report, the Ministry of Public Health of Thailand has set up a Working Group on Macroeconomics and Health, co-chaired by the Senior Advisor to the Ministry in Health Economics and comprised of 15 experts from the health, economic, and financing sectors. The Working Group has developed a proposal to set up a National Commission on Macroeconomics and Health (NCMH). It has been proposed that the NCMH be jointly chaired by the Health and Finance Ministers. A joint secretariat will be set up comprised of representatives from National Economic and Social Development Board (NESDB) and the Bureau of Policy and Strategy to develop a strategic framework for an investment plan targeting the MDGs.

The MH process for Thailand as defined by the Working Group consists of five steps: 1) Analysis of current situations and trends focusing on the poor and marginalized, 2) Diagnosis and prioritization of the main health problems, 3) Examination and evaluation of selected health interventions for cost-effectiveness and feasibility, 4) Development of a Strategic Framework and Investment Plan; and 5) Advocacy for mobilizing political support for integration of health into poverty reduction strategies. The Working Group has identified study on cost-effectiveness of interventions in the Thailand context in 15 diseases as a priority area of further study.

Sri Lanka

Sri Lanka has had well known and significant successes in the public health arena, including decreasing birth rates and death rates, increasing life expectancy to levels of developed countries and low infant mortality rates and maternal mortality rates. However, there are still significant disease challenges for Sri Lanka. Malaria, TB, and mental illness are on the rise and malnutrition is not under control. Sri Lanka is also addressing current human resources issues, such as a shortage of nurses and paramedics as well as the commitment by the government to absorb all graduating doctors through 2009.

In light of the existing health issues, Sri Lanka is assessing whether it is investing enough in health. Compared to other countries in the region and globally, Sri Lanka's national health expenditure as a percentage of GDP (3.2%) is low. Sri Lanka is currently evaluating various strategies to mobilize funding for health, including the feasibility of private insurance, community financing, ear-marked taxes, and cost-containment strategies.

Sri Lanka formed a National Commission on Macroeconomics and Health (NCMH) in early 2003 to address health sector priorities, including mobilizing funding for health and the shortage of health care workers. The NCMH is co-chaired by the Minister of Health, Nutrition and Welfare and the Minister of Rural Economy and Deputy Minister of Finance and includes representatives from various ministries, the WHO Country Office, UNDP, the private sector and academia. The work of the NCMH is synergistic with Sri Lanka's Poverty Reduction Strategy Paper (PRSP) and Vision 2010 –which formulated an economic development strategy calling for sustained 7 to 9 % annual GDP growth – in developing a long-term policy that highlights pro-poor health and development issues and achievement of the MDGs.

The NCMH is commissioning health financing studies on designing and costing a basic health care package for the poor, human resource planning and issues of decentralization. The NCMH has also commissioned a report entitled "Macroeconomics and Health Initiatives in Sri Lanka".

The NCMH has developed a work plan for 2004, which will culminate in a needs-based ten-year investment plan and report of the NCMH, based on the studies summarised above and others looking at the economic implications of disease and scaling up interventions. Additionally, the Commission will focus on building the capacity for MH work at the central and provincial levels, including a potential National Centre in Macroeconomics and Health.

6. The Western Pacific Region (WPRO)

The recent outbreak of Severe Acute Respiratory Syndrome (SARS) led the Western Pacific Regional Office to devote scarce resources to confronting this grave event. In spite of this, they continue to support strongly the further dissemination of the CMH Report's findings. They are working with member states to increase the uptake of this evidence base into national health policy development and the design of poverty reduction mechanisms. Despite the challenges posed by the SARS outbreak, two states, China and Cambodia, have moved forward substantively with instituting a Macroeconomics and Health process.

In addition, a regional proposal outlining the MH activities and outcomes for governments of Papua New Guinea, Philippines, Lao PDR, and Mongolia has been developed by the country and regional offices.

People's Republic of China

Sparked by a strong expression of interest by the Government for information about MH strategies and the findings of the CMH, the Commission's Report was translated into Chinese in November 2002. Follow-up discussions stimulated authorities to integrate health investment into reform agendas and new developmental policies. Recently, the urgency of investing in health was heightened by the media attention surrounding SARS.

China has made considerable progress in the past 20 years towards improving living standards, including health, as well as reducing poverty and achieving strong macroeconomic growth. Large-scale poverty reduction has been one of China's greatest accomplishments during its economic reform period. Since the early 1980s, GDP growth has averaged 10 % per annum, life expectancy and mortality rates have continued to improve markedly, while some 400 million people have been lifted out of poverty.

In the aggregate, China has made considerable progress in improving its key health indicators in the last 50 years mainly because of the public health emphasis of government spending prior to 1980. For the most part, these gains have been maintained or slightly improved with the early market economy reforms which emphasized provision of fee-for-service rural care and rapid adoption of higher technologies. The improvements, however, mask sharp underlying disparities. Inadequate financing of health services in poor areas and limited access in remote areas, particularly in western China, have resulted in widening disparities in health conditions. Since 1980, the share of villages with Rural Cooperative Medical Systems (RCMS) has declined from about 90% to just 14-15%. Even in urban areas, community health services are under-supplied, while there has been a proliferation of high-cost hospital services.

China's public health spending shrank as a share of GDP (to 1.3%). During the same period patient fees and insurance payments, mainly for non-public health services, rose sharply in both absolute value and their relative importance. External funding by the foreign assistance community remained an important stimulus and source of finance, helping central and local authorities attend to immunization, nutrition, tuberculosis and other infectious diseases, and to emphasize the needs of the poor and creation of public goods in health.

A key constraint to effective delivery of health services includes a decentralized system of inter-governmental finances, exacerbating regional inequalities and the effective delivery of health services. Local governments bear heavy expenditure responsibilities, including for providing health services, which are not matched by adequate own-revenue sources or sufficient government transfers.

Strategic, targeted increases in government spending on the health of the poor will build their capacity for production and increase their ability to contribute to the rural economy. This will help ensure overall socioeconomic stability and create options for sustainable health insurance systems. Health investments can be an important development objective, as it will improve rural health conditions, decrease regional health disparities and, by improving the health of the local workforce, augment the output of the rural economy.

Along with Health Partners in China, the Ministry of Health has set forth an outcome-oriented follow-up to the CMH Report. Chinese authorities are building a local evidence base to systematically link poverty alleviation and health reforms to the UN Development Assistance Framework, especially in conjunction with the UN Theme Group on Health. The CMH process has built momentum among China's policy makers to use the Report's evidence to design national policies that integrate health and economic development. The challenge is to better integrate individual initiatives within an overall policy framework to provide common direction based on the nature of poverty and health in China. The initial analyses undertaken that placed the CMH recommendations in the China context included a study on the sub-provincial linkages on health and local economic growth, a analysis of China's macroeconomic policies (in conjunction with DFID), a study describing the economics of rural health, and an analysis of the effect of migration patterns on health care.

In April 2003, the Ministry of Health and the Chinese Health Economics Institute held a work session to review follow-up activities, strengthening their conviction to develop a Macroeconomics and Health strategy. China participated in the 2nd Consultation on Macroeconomics and Health (October 2003, Geneva) where they presented their overall strategy through a China State Council-backed document entitled "Macroeconomics and Health in China" and led a meeting which enabled Consultation participants to discuss China's experiences and progress made on public health issues. This document identified three main issues: 1) Inadequate health service capacity, 2) Inadequate health services for disease control and prevention; and 3) Incompatibilities between the health management system and the new economic system of the socialist market economy.

China's activities during the 2nd phase have focused on continuing the work already begun, including expansion of the sub-national National Health Accounts analysis and a new studies that will potentially analyse the options for rural health scale-up under the New Cooperative Medical Schemes and analyse community-based social insurance for health. Other work includes the analysis of the effect of SARS-related investments on pro-poor health investments and health system development and the development of the overall MH strategy.

The planned work for China in 2004 will centre on the integration of the studies commenced, the review of the various epidemiological profiles in China and finally to incorporate the evidence collected into a medium-term investment plan. This work will be carried out in cooperation with high-level government participation, WHO offices, local academics and experts and in integration with existing bilateral and multilateral initiatives and projects.

Cambodia

Cambodia has strong interest in implementing the findings of the CMH Report, especially in light of the desire to move purposefully towards the achievement of the MDGs. The Health Strategic Plan of 2002 provides a framework for cohesion among three other important efforts: a medium-term expenditure framework; a monitoring and evaluation framework for analysing cross-sectoral performance; and guidelines for developing annual operational plans for Health Ministry departments. This is enhanced by the Health Sector Support Project, funded by a broad coalition of donors, instrumental in the government's adoption of a long-term Poverty Reduction Strategy for 2003-2005.

Within this dynamic context, the WHO country office built commitment and support for the first health sector review. This led to the Finance, Planning and Health Ministries to debate how to introduce the MH process and ascertain entry points into health policy issues. In February of 2003, Dr. Jeffrey Sachs visited Cambodia and discussed with senior government leaders how the evidence provided by the CMH Report could be localised to achieve substantive outcomes.

On 22 May 2003, the Royal Government of Cambodia and the WHO Country Office jointly drafted the "Proposal on Macro-Economics, Poverty and Health". Government authorities are ready to scale up access of the poor to essential health interventions as defined by epidemiological evidence on Cambodia's burden of disease, especially among the poor and disadvantaged.

With government support strong, the Proposal requested that a National CMH (NCMH) be established, firmly integrated into the overall PRSP process. Chaired by both the Ministers of Health and Finance, and involving influential stakeholders from society, donors and other partners, the Commission will serve to implement a long-term strategy for increased health investments.

from Shakuntala,
enclosed as attachment (from Deccan Herald paper
dt. 23/3/04).
Shakuntala Narasimhan

Com H - 2A.

DH.Cons03042

Medical insurance, right to water, and illness prevention.

World Consumers Day this month brought a gift for citizens, especially for those having (or contemplating) health insurance. The Gujarat High Court has given a judgment directing insurance companies to renew Mediclaim policies on existing terms and conditions, without imposing arbitrary exclusion clauses (which is what insurers were doing, without informing the policy holders who were opting for renewals.)

Fakirbhai Shah's case (described in Insight magazine, published by CERS of Ahmedabad which fought against such exclusion clauses and obtained this judgment) is typical.He had had a health insurance policy for 12 years before he developed kidney failure in 2002, which required him to undergo dialysis four times a day. The insurance company renewed his policy but raised the premium by 300 per cent and also excluded five major diseases including kidney failure. (If whatever illness you are likely to claim for, is excluded, there seems no point in having insurance anyway.) In other cases, the insurance companies refused to renew the policy after the policy holder developed health problems. The Consumer Education and Research Society (CERS) challenged this practice and obtained this judgment forbiding arbitrary and unilateral exclusions of diseases already covered under the existing policy (even if the disease was contracted during the policy period) and also forbiding refusal to renew. The judgment, Insight points out, offers relief to lakhs of policy holders and marks a "turning point for Mediclaim policies". U.P. has also ruled against claim rejections.

Insight advises that consumers having health insurance policies should not accept exclusions at renewal, and fresh policy takers should ask for the licence number and ID of the agent before signing policy documents .There have been instances where the intermediary or agent has failed to forward the documents to the company in time (or messed up the procedures, or suppressed details) resulting in repudiation of claims later on.) Several other suggestions are also listed in Insight (issues dated Jan-Feb 2004 and March-April 2003 – the latter carries an in-depth examination of mediclaim as its cover story).

No one makes a medical claim after undergoing illness and hospitalisation merely to collect money. The average policy holder opts for health insurance only to safeguard himself/herself against unforeseen (and burdensome) expenses related to illness. Prevention of illness has therefore been the focus of two other initiatives launched this month. CERC took up "water as a basic right" as its theme for its consumers day celebrations, focusing on how the provision of clean and safe water must be made a basic entitlement for all of us. Those of us who can afford to buy water (bottled and branded, or from tankers) do not give it much thought but for millions of urban as well as rural dwellers, finding the daily potful of water is a major hassle, and this causes preventable illnesses that take the lives of thousands of children as well as adults. As summer draws near, already there are tell-tale rows of empty pots lined up at public water taps, waiting

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for a few precious drops. While CERC is focusing on municipalities' obligation to organise safe water supply, some urban NGOs are trying to sensitise city dwellers to the need to conserve water as a priority. The Centre for Science and Environment (CSE of Delhi, which hit the headlines last year with its expose on pesticide residues in soft drinks, and has succeeded in forcing the government to look into safety norms) has prepared a short ad spot (shown on TV) which shows citizens collecting rain water in whatever container they find handy, from up-ended umbrellas to pot and pans, so that the precious liquid may not run waste into gutters. Just watch the difference in our water use when the household pump motor burns out and there is no water in the house -- we manage to wash our faces with just a mugful of water, whereas at other times we let the tap flow merrily while we soap ourselves at leisure). Consumers have not only rights and entitlements, but also obligations and duties – in this case, to conserve water.If we made it go round better, there would be less illness in the country.

In a related initiative, the global People's Health Movement (PHA) launched this week a worldwide campaign on citizens' "right to health". Saturday March 20 was designated World Day of Protest against the apathy of governments that spend billions on defence arsenal and exports but neglect basic health and simple, unexpensive outlays that could save lives. Bangalore is one of the hubs of this global campaign to protest against the "blatant violation of international humanitarian laws on people's basic rights". Dr. Ravi Narayan, general secretary of the international People's Health Movement, says that the "World Trade Organisation (WTO) is ... a great threat to health in the world today", because under liberalised trade rules, the rich are getting richer while the poor are getting poorer (with less access to basic health care which is becoming privatised and thereby going beyond the reach of the economically weaker sections).
The three items – PHM, CERC and the Mediclaim judgment -- together highlight what should be a top priority in any governance for and by the people – health, and prevention of illnesses.

* * * *

The **pinch of salt** this time is required to be taken with ads of multinational company LG which has got rapped twice for misleading consumer. Once, by CERC which tested LG refrigerators and found that the capacity fell short of the capacity claimed by the manufacturer for various models (by 11 per cent). CERC went to court asking that Rs 11 crores , the amount by which the company has enriched itself at the cost of the buyers, should be refunded to the customers. The second rapping was from the Advertising Standards Council of India (ASCI) which ruled last month that LG's ad for air conditioners (promising the "Healthiest air in the world") amounts to misleading the public since it cannot be substantiated.The ad has been ordered withdrawn.

Sakuntala Narasimhan

(1000 words)

COMH - 2A.

ASHWINI's Health Care System and the Composite Health Insurance Programme for Adivasis

January 2004

1.0 Introduction

Group Insurance is not a new thing to the Adivasis ! Even now in many adivasi villages, whenever somebody becomes seriously ill and needs to be taken to a hospital, there is a "collection" among all the houses in that village. With this money, they hire a vehicle and come to the hospital in a group. This kind of 'sharing the risk', which is fundamental to any group insurance scheme, had been practiced by the tribals for ages ! However, the modern economic systems and lifestyles made it necessary to fine-tune these traditional practices. This is the basis of the Composite Tribal Insurance Scheme of ASHWINI.

2.0 Genesis of ASHWINI

Though ASHWINI as an independent organisation was started only in 1990, its genesis dates back to 1986 when Stan Thekaekara and his wife, Marie started ACCORD, a Non-Governmental Organisation in Gudalur. Their main objective was to to fight the unjust alienation of the adivasi lands and other human rights violations by organising them as a strong group.

They facilitated the formation of village level sangams and these sangams enabled the adivasi families to prevent any of their land getting encroached by powerful non-tribals of that area or by the Government authorities. More than 200 such village sangams had been formed within two years. These sangams were federated at the taluk level into "Adivasi Munnetra Sangam" which till today remains the representative organisation of the adivasis, fighting for their just rights and striving for the socio-economic development of the adivasi community.

But, it was not only the problem of land. The village sangams again and again brought up the issue of health care. Women were dying during childbirth. Children were suffering from easily preventable diseases. Some intervention was urgently required. But, Stan and Marie were not doctors. They started looking out for some doctors through their contacts. Fortunately, they met two young doctors, Dr.Devadasan and his wife, Dr. Roopa, quite eager to take up the challenge.

3.0 Community Health Programme

Deva and Roopa joined ACCORD in 1987 just after their graduation from the Christian Medical College, Vellore and launched a community health programme in the adivasi villages. The main focus was to train village level Health Workers (HW) selected from the community itself, to identify and prevent illnesses like diarrhoea, to provide immunisation and nutrition to the pregnant women and young children, and generally to improve health awareness among the adivasi community. The team went from village to village, participated in the sangam meetings and regularly monitored the progress of the pregnant women and children.

Within a few years, the preventable deaths among the adivasis (like due to diarrhoea or during childbirth) were more-or-less eliminated. The HWs did a tremendous job in the programme, kept highlighting the health issues in the villages and closely followed-up the individual cases. The immunisation status of the children & pregnant mothers dramatically improved with the launch of

the community health programme. Issues like growth monitoring and nutrition were constantly brought to the notice of the parents by the health workers. Thus far, the health programme consisted entirely of these field activities. In spite of the successful community health programme, there were inevitable cases needing hospitalisation, there were high-risk pregnancies which required the women to deliver in a hospital, and acute cases of diarrhoea and fever among children too needed hospitalisation. Deva and Roopa used to refer such patients to the local Government hospital or to the private clinics.

But the experience with these hospitals was not very encouraging since the care and treatment given to these patients was not satisfactory, the doctors weren't there many times in the Government hospitals, the costs of treatment in private clinics were high (ACCORD subsidised these costs). Deva and Roopa were torn between following a few cases in these hospitals and visiting the villages all over the taluk.

Quite encouraged by the success of the community health programme and the role played by the adivasi health workers, the adivasi community felt that the next logical step would be to start a hospital of our own. There was a heavy demand from the village sangams to start a hospital. But the doctors were reluctant, saying that Hospital is a permanent institution which needs to be run 24 hours a day, all through the year - and for many years. The health team at that time was not equipped to handle such an institution. Moreover, the ACCORD team strongly felt that their intervention had to be time-bound and they will withdraw after a few years when the AMS can take over the initiative of protecting the rights of the adivasis. But, hospital is a permanent form of intervention which cannot be withdrawn. And, in any case, where are the nurses in the adivasi community (another basic philosophy of ACCORD was to identify youth from the community itself to deliver all the services to the people and to train them !) ? And, Doctors ??

4.0 Gudalur Adivasi Hospital

However, the community was strong in its demand and felt that the community health programme needed a hospital of its own to make it much more effective and acceptable to the people. So, they started a search for suitable people. Again as a curious coincidence, there landed up a doctor couple, Shyla and Nandakumar, willing to be part of the health programme. Having the ideal combination of skills as Gynaecologist and Surgeon, they were what the "doctor ordered" and the people were looking for ! Young adivasi girls were identified by the sangams and the new doctors started training them as nurses. Thus was born the "Gudalur Adivasi Hospital" [GAH]. In 1990.

With the establishment of the Hospital, we realised that this intervention is going to continue for a many years, and structurally it has to be different from that of ACCORD or AMS. So, the health programme, activities and the staff were hived off from ACCORD and a separate legal entity called ASHWINI was registered. From then onwards, Ashwini took care of the health issues concerning the adivasis and poor people of this area. While Deva and Roopa continued their focus on the community health programme, Shyla and Nandakumar started training tribal girls as Nurses. It was a major cultural change for the girls - from innocent village life to a three-shifts-a-day routine in the hospital. Training had to start from elementary Maths and English.

These adivasi nurses have come a long way in the next 10 years. They have become experts in conducting deliveries, in assisting the doctors in surgeries, in the general administration of the hospital, in ordering and managing the drug stocks, in designing systems to monitor the performance of the hospital (All the patient details have been computerised after 1996) and in analysing the financial aspects of the hospital management. They are constantly trained and their skills are upgraded to keep up with the growth of the programme.

Today, the Adivasi Hospital is one of the most sought after hospital in the Gudalur valley, not only by the tribals but also by the non-tribals of the local area. Patients are brought from distant villages by ambulance and good quality care is given. As all the staff are from the community and can talk the tribal languages, the tribal patients feel at home. Efforts were constantly made to keep the place culturally acceptable to them and the community gradually adjusted to the change. Today, there are cots in the hospital, they come forward for surgeries and many of them regularly show up for antenatal checkups etc. Some more young doctors came and worked in the hospital for brief periods - the health team getting enriched by the interaction with each of these doctors.

5.0 Sub-Centres

Till 1994, the health programme consisted of preventive care given by the HWs at the villages and curative care provided at the GAH. However, during many interactions with the sangam members, a need was felt to have another intermediate level comprising of a group of villages. The AMS had already divided the sangam villages into eight administrative zones called "Areas" and an Area Centre was coordinating the sangam activities of that particular Area. From 1995 onwards, a health Sub-Centre was started in each of these Area Centres.

These Sub-Centres coordinate the community health programme in the villages of that Area, provide first aid and primary level curative care by dispensing medicines, Screen patients regularly, refer those needing doctor's intervention to Gudalur Adivasi Hospital and follow-up the patients discharged from the Hospital. Initially the senior nurses and health staff took responsibility to manage these sub-centres. Later, a few more adivasi girls were trained specifically to run these sub-centres - They are called "Health Animators". As per the need, they keep shifting between the hospital and the sub-centres, so as to strike a balance between the curative and preventive programmes and to keep their skills sharpened and updated.

6.0 Management

Monitoring and review of the activities, both in the villages and in the hospital are done by the staff themselves in the monthly meetings. Besides, a Working Committee comprising of a few senior nurses and health animators has been constituted. This group looks ahead, takes care of the long term planning, budgeting and other policy issues.

ASHWINI is registered as a Charitable Society under the Tamilnadu State Societies Registration Act. The General Body of the Society is constituted from the senior AMS activists, the adivasi nurses / health animators and the doctors. All the members of the Executive Committee are adivasis. Thus, though ASHWINI is legally an independent identity, it continues to function under the umbrella of the AMS as an institution owned and managed by the adivasis themselves for their own development.

7.0 Breaking the Financial Barrier – The Insurance Scheme

The main objective of the insurance scheme is to break the financial barrier of the adivasi families at the time of illness. We have noticed that lack of liquid cash at the time of illness is one of the most serious barriers to the adivasis, preventing them from getting safe medical care and accessing hospitals. Our challenge was to encourage them to plan ahead and save something for the possible event of sickness in the future. For a community, eking out a day-to-day existence, this was a radical change. Saving for

the future itself was a new thing - leave alone for their health needs. But, we were convinced that this had to be done and hence, pursued our idea with the people relentlessly.

When Gudalur Adivasi Hospital was started in 1990, we discussed with the village sangams about the financial aspects. On the one hand, none of us wanted the hospital treatment to be totally free as this would not be sustainable in the long run. However, on the other hand, it would be difficult for the adivasi patients to pay the entire costs of hospitalisation. Combining this need for resources with the adivasi tradition of sharing, we arrived at the concept of group insurance. Though providing health care through insurance coverage is a very modern idea, we hit upon the same solution, but through a very different route and rationale.

We approached various agencies including some insurance companies. However, the insurance policies existing at that time were targeting primarily middle and high-income people living in the cities. The premiums were high as the claims ran into Lakhs to cover "costly" diseases like heart attacks and bypass surgeries. These policies would be totally inappropriate for the adivasi community where anaemia, malnutrition, safe delivery and care of young children were the major problems.

So, we needed a simple package covering these illnesses. Fortunately, following a long search, we met some enterprising officers of the New India Assurance Company who were willing to design a special package for the adivasis of Gudalur. After more than two years of discussions and negotiations, we were able to design a scheme, which would address the specific health needs of our people. We finally launched the composite tribal group insurance scheme in 1992.

According to this policy, for a premium of Rs. 15 per person per year, hospitalisation expenses up to Rs.1500 would be reimbursed by the insurance company. The Adivasi Munnetra Sangam decided to insure all its members. We started by insuring 5000 adivasis in 1992 and the number has risen to 13000 by 2002, as new villages and members join the AMS.

8.0 Policy Details

To avail of the Group Discount and Long Term Discount offered by the insurance company, ASHWINI insured all the members of the AMS for five years by paying the premium en bloc. In turn, the activists of AMS, including the Health Animators of ASHWINI collect the premium from the members every year. So, in essence, ASHWINI has taken a Policy with the Insurance Company for five years, whereas the AMS takes a policy for its members with ASHWINI every year.

This arrangement made sense, considering the many restrictions imposed by the insurance company on the diseases covered under the policy, the Rs.1500 ceiling and the delay in the reimbursements. To encourage the tribal patients to seek health care at the earliest and to make the health system more effective, our health care system has to be comprehensive and should provide for all the health needs of the community.

Policy Highlights (1992-2002)
Started : in 1992
Membership : About 12000
Agency : New India Assurance Company
Annual Premium : Rs.15
Claims : Up to Rs.1500 of hospitalisation expenses

For example, pregnancy related admissions were not covered under the policy during the first seven years. But, one of our major aims was to reduce the maternal mortality and to encourage the tribal women to choose safe confinement. So, even while the insurance company was not reimbursing the expenses of pregnancy related admissions, we continued to provide free treatment to the insured tribal

women who get admitted for pregnancy related causes. However, due to our persistent efforts and representations to various authorities including the Finance Minister of Government of India, the policy was subsequently modified in 1997 to include pregnancy related admissions for the 1st and 2nd deliveries ! The table below gives the differences between the policy offered by the company and the scheme offered by ASHWINI for the comprehensive health care of the AMS members.

Details of the Health Insurance Policy

Particulars	Insurance Company*	ASHWINI
Expenses covered under the policy	Only hospitalisation expenses	Apart from hospitalisation costs, includes OP treatment in the hospital and in Sub-Centres
Ceiling on the amount reimbursable	Rs. 1500 per year	No limit on expenses.
Diseases which are not covered	Chronic illnesses like diabetes, TB, etc.	All illnesses are treated free of cost.
Time taken to reimburse claims	From 3 to 9 months from the date of sending claims.	Patients do not pay any amount on discharge, and hence claims are instantaneous.

* Details of the policy with New India Insurance Company between 1992 and March 2002.

Summary of the Financial Details of the Insurance Programme from 1992-1997

Description	1992-1997	1997-2002
Total Premium paid to the insurance company	Rs.4,35,722.25	Rs.5,94,566.00
Amount reimbursed by the company	Rs.5,94,566.00	Rs.12,68,051.00

9.0 Premium Collection

Insurance collection is a major annual event ! The collection season commences with a meeting of the tribal staff of ASHWINI and the field activists of AMS to decide the premium to be collected from the members that year. Apart from the financial status of ASHWINI, issues like the income levels of Adivasi families and the general economic situation of the Society are considered while deciding the premium.

Year	Premium per person	No. of people who paid premium
1993	Rs. 4	3726
1994	Rs. 6	2744
1995	Rs. 8	3624
1996	Rs.10	4125
1997	Rs.12	3812
1998	Rs.12	4899
1999	Rs.15	4768
2000	Rs.17	4619
2001	Rs.17	4464
2002	Rs.20	4291
2003	Rs.22	4268

We started with Rs.2 per person per year in 1992, gradually increasing it every year. We are collecting Rs. 22 per person for the year 2003. The collection period commences on December 5th, a special day celebrated as Adivasi Day by the AMS and goes on till April 14th, another special festival, "Vishu" [New Year]. Depending on the situation each year, the collection period may get extended. In the earlier years, the sangam activists used to go from house to house, from village to village explaining the insurance scheme and collecting the premium. Now, as people are aware of the scheme, they come to the sub-centres to pay the premium.

The exercise of insurance collection is an important aspect of ASHWINI's health programme, as it keeps the focus continuously on the community. Instead of interacting only with the patients in the hospital, the insurance scheme gives an

opportunity for the field workers and sangam activists to interact with all the sangam members, to explain the health programme and to get a true feedback from them.

The percentage of AMS members who pay the premium to ASHWINI has been hovering between 35% and 50%. A survey done among the AMS members revealed that one of the main reasons for non-payment of premium was the lack of ready cash during the collection period. At present, we are trying to evolve different methods to improve the premium collection from the sangam members and to increase the awareness about the scheme in the villages.

10.0 Current Status

When the policy expired in March 2002, the New India Assurance Company informed us that they were considering a steep increase in the premium from Rs.15 to about Rs.40 per person per year. ASHWINI was not prepared for this precipitous hike, as it was using all its resources to meet the operational costs of the health programme. Subsequently ***Sir Ratan Tata Trust, Mumbai*** was approached for financial assistance to pay the insurance premium and we were extremely happy to get a positive response from them in July 2002.

With the help of Tata Trust and some experts, we had undertaken a comprehensive review of our 10 year experience with the insurance scheme. The conclusions of this study have given us some direction and guidelines to take forward our health care programme. Based on these findings, Tata Trust has extended funding towards paying the premium for about 12000 adivasi members and for some administrative costs in January 2003.

Based on the findings, we approached various insurance companies to restart our insurance scheme. Our negotiations with the Royal Sundaram Insurance Company Limited were successful and we designed a new insurance policy called 'Tribal Health Shield'. This scheme came into existence from May 19, 2003 and will be in operation for a period of one year. The major highlights of this policy are given in the table below :

Tribal Health Shield

- *About 12200 members of the Adivasi Munnetra Sangam are insured under this health insurance policy.*
- *Coverage of all illnesses including common illnesses.*
- *Coverage for Pregnancy related admissions for first 3 pregnancies.*
- *Maximum coverage limit is Rs.1000 per year (Rs.500 for pregnancy related admissions).*
- *Annual Premium is Rs.20 per person.*

We are also working to create an awareness about this model of providing health care to other NGOs and disadvantaged groups also by networking with them.

11.0 Future Plans

During the next five years, our efforts will not only be to consolidate our insurance programme in the sangam villages, but also to share our experience with other charitable organisations working with underprivileged people, so that a larger insurance scheme involving them could be created. Thus our successful experiment with group insurance could spread to other people who wish to address their own health needs effectively.

NATIONAL CONFERENCE

ON

COMMUNITY HEALTH INSURANCE

At Mysore, on 30th & 31st October, 2003

Organised by

Karuna Trust, UNDP & Ministry Of Health, GOI

A REPORT

INDEX

National Conference on

Community Health Insurance

A report

Preface

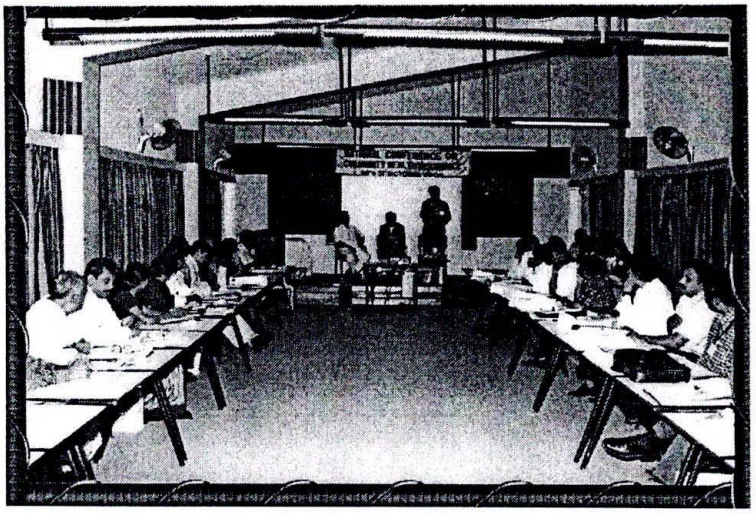
The persistent poverty and diseases have pushed the families of the unorganised sector in the process of de-capitalisation and indebtedness to meet their day-to day contingencies. Both macro and micro studies on the use of healthcare services show that the poor and other disadvantaged sections such as scheduled castes and tribes are forced to spend a higher proportion of their income on healthcare than the better off. A majority of the poor households, especially the rural ones, reside in backward, hilly and remote regions where neither government facilities nor private medical practitioners are available. They have to depend on poor quality services provided by local, often unqualified practitioners and faith healers. Further, wherever accessibility is not a problem, the primary health centres are either dysfunctional or provide low quality services.

The burden of treatment is particularly high on them when seeking inpatient care. The high incidence of morbidity cuts their household budget both ways, i.e., not only do they have to spend a large amount of money and resources on medical care but are also they are unable to earn during the period of illness. Very often they have to borrow funds at very high interest rates to meet both medical expenditure and other household consumption needs, pushing these families into a zone of permanent poverty.

The gender bias with men having better access to healthcare when compared to women due to various socio-economic and cultural reasons has also made the health care out of reach of the poor women. The poor women who are most vulnerable to diseases and ill-health due to unhygienic living conditions, heavy burden of child bearing, low emphasis on their own healthcare needs and severe constraints in seeking healthcare for themselves.

An UNDP sponsored pilot project on the development of a possible and replicable model for community health insurance has been taken up in Karnataka state. This project is being implemented in T.Narsipura taluk of Mysore district and Bailhongal taluk of Belgaum district with w.e.f. September 2002. ●

Why the National Conference?



A national conference was organised from 30th to 31st October 2003 at ANSSIRD (*Abdul Nazeeb Sab* State Institute for Rural Development) at Mysore. Around 50 representatives from Govt. of India and Karnataka, World Bank, UNDP, Insurance Companies, NGOs associated with Community Health Insurance Schemes attended the conference on 30th October 03. The next day on 31st October 03 a field visit was organised to review the project implementation and to interact with various stake holders associated with the project, viz., beneficiaries, members of the medical fraternity, officials from Government departments and National Insurance Company, social workers and rural community based organisation.

The main objectives behind organising the National Conference are to:

- Have an in-depth discussion on the UNDP sponsored pilot project being implemented in two talukas in Karnataka
- Exchange notes on the various community based insurance schemes implemented by other agencies
- Explore the possibilities of development of a possible and replicable model for Community Health Insurance Financing
- Explore the possibilities of up-scaling the scheme in other parts of Karnataka and India ●

National Conference on Community Health Insurance

30th to 31st October 2003 at Mysore

PROGRAMME

Events	Details
Date 30 Oct. 03	
Inaugural Function (1000 – 1045 hrs)	
• Lighting the lamp	Dr. Paolo Carlo Belli, Economist, World Bank, Washington
• Welcome address	Dr. H. Sudarshan, Hon. President, Karuna Trust
• Opening remarks by the Chief Guest	Dr. Paolo Carlo Belli
• Presidential address	Sri. K.H. Gopal Krishna Gowda, IAS, Chairman of the Karnataka Government Health System, who presided over the inaugural
Session II (1100 hrs – 1315 hrs)	
• Chairman	Ms. Alka Narang, In-charge, UNDP
• Co-chairman	Sri. K.H. Gopal Krishna Gowda, IAS
Presentation of Models	
	• Karuna Trust, Karnataka
	• Sri Mayapur Vikas Sangha, W. Bengal
	• Family Health Plan Ltd., Karnataka
	• SEWA, Gujarat
• Summing up	Ms. Alka Narang
	Sri. Gopal Krishna Gowda, IAS

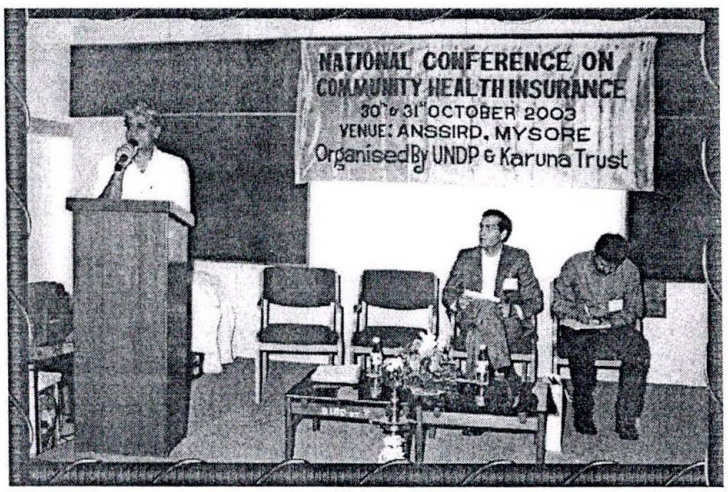
Session III (1400 hrs – 1530 Hrs)	
• Chairman	Dr. Pradeep Panda, Economist, New Delhi
• Co-chairman	Sri. Rajeev Ahuja, Fellow ICRIER, New Delhi
• Presentation of models	
•	• National Insurance, Company, Bangalore
•	• SHEPHERD, Tamil Nadu
•	• Dr. N. Devadasan, Tamil Nadu
•	• Sri. Rajeev Ahuja, New Delhi
• Summing up	Dr. Pradeep Panda Sri. Rajeev Ahuja
Plenary Session (1545 TO 1700 hrs)	
Panel Discussion: **"How Health Insurance can be spread in Karnataka and India"**	
• Chairperson	Dr. Indrani Gupta, Economist, New Delhi
• Panellists	Dr. Paolo Carlo Belli, USA
	Prof. Muraleedharan, Dept. of Humanities & Social Science, IIT, Chennai
	Sri. Rajeev Ahuja, ICRIER, New Delhi
• Vote of Thanks	Dr. H. Sudarshan
Date 31.10.2003	
• Field Visits	• General Hospital – Bannur & T. Narsipura
	• General Hospital – T. Narsipura
	• SHGs, Herbal Gardens, Kitchen Gardens, Seed banks etc.,
	• PHC – Gumballi
	• VGKK Hospital B.R. Hills.

Inaugural Session I (1000 hrs to 1045 hours)

The two-day National Conference on Community Health Insurance organised by Govt. of India, Govt of Karnataka, UNDP and Karuna Trust was inaugurated by Dr. Palo Carlo Belli, Economist from World Bank, Washington, USA by lighting the lamp on October 30, 2003. The conference started with an invocation by two local singers.

Welcome address:

In his welcome address, Dr. H. Sudarshan, Hon. President of Karuna Trust expressed immense happiness in having delegates from different voluntary organisations, National Insurance Company, representatives of Central and State Government who were actively involved with the implementation of various types of Community Health Insurance schemes in the country.

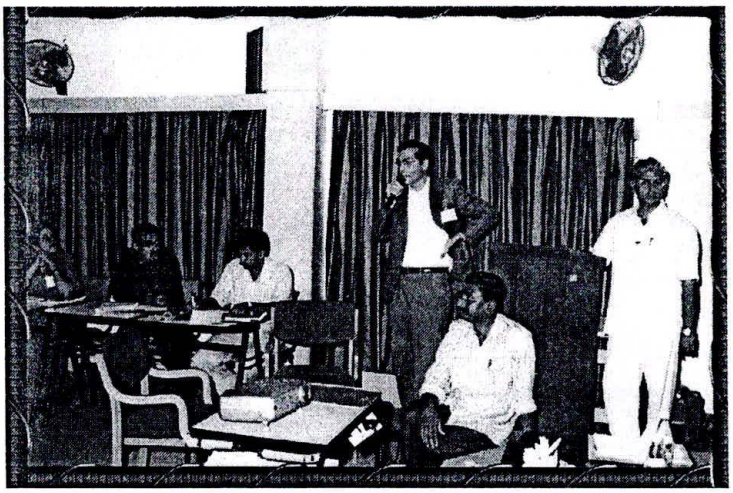


Welcoming the chief Guest, Dr. Palo Carlo Belli of World Bank, Dr. Sudarshan remarked that Dr. Palo Belli had volunteered to come from Washington at a short notice, having learnt about the conference from the media.

Talking about the pilot project, Community Health Insurance sponsored by the Government of India, Government of Karnataka and United Nation Development Programme (UNDP) being implemented at T. Narsipura taluk in Mysore district and Yelandur taluk in Chamarajanagar district since September 2002, Dr. Sudarshan said that Centre's health insurance schemes and private health insurance schemes, had not received the expected response from the people. He said that many insurance companies were making efforts to take health insurance schemes to the rural areas. Though many MNCs are also trying to foray into the villages with health insurance schemes, they are a bit hesitant. He expressed the hope that people living below the poverty line in the state would have access to medical care under community health insurance schemes in the next five years. "Successful implementation of the programme in four taluks made out a case for the scheme's extension to the entire state" said Dr. H. Sudarshan.

Address of the Chief Guest:

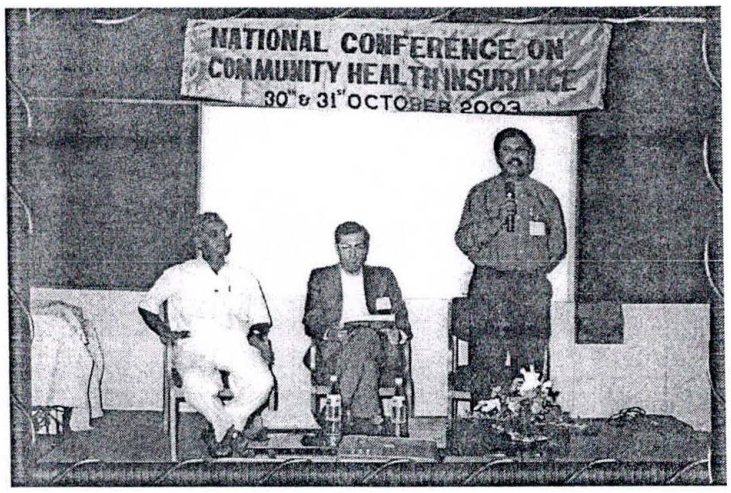
Dr. Paolo Carlo Belli, Economist from World Bank, Washington, in his inaugural address said that the benefits of health insurance schemes should reach the backward classes to ensure their health needs. Quoting a NSS survey (1995-96) he said that in rural areas of Karnataka nearly 23% have cited financial reasons for not availing treatment from Government institutions. "For the private sector the percentage is likely to be even higher", Dr. Belli remarked.



Justifying the need of health insurance for the poor, Dr. Belli said that out of pocket payments (OPP) constituted a severe barrier to access the health system. As per WHO, 2001, in India about 80% of the total financial resources for health are harnessed on OPP basis. This is made up by selling their assets to face health costs, particularly during catastrophic events like accidents, chronic conditions etc., Accordingly to data by Peters (2002) more than 20 percent of hospitalised patients in Karnataka fall into poverty due to high medical costs.

Dr. Belli who remarked that hospital care is relatively pro-rich in public sector, only 17.2 percent of inpatient bed days in the public sector (9.4 for rural populations) are by people living below the poverty line out of the 36.6 percent of the below the poverty line people in Karnataka.

Health insurance is a mechanism by which health risks are spread across a number of individuals thus protecting each of them from the loss associated with negative events, said Dr. Belli. Improved accessibility and quality of services and additional source of financing for health are the benefits brought by sound insurance schemes. Any scheme, which provides the maximum benefits at the minimal costs, must guarantee financial equilibrium, at least in long term, remarked Dr. Belli.



Presidential address:

Sri. K.H. Gopal Krishna Gowda, IAS, Chairman of the Karnataka Government Health System, who presided over the inaugural session, said that illness is a universal phenomenon. Urging that everyone should be covered under the health insurance scheme, Sri. Gowda said that it would help people falling victim to the disease. Lamenting the poor utilization of the hospital services, Sri. Gowda observed that though infrastructure is good in the government hospitals; people are still not using them. Urging the insurance companies to include private hospitals also for treatment under medical insurance cover, he said that it would alone help to popularise the scheme among all sections of the people. ●

Session II (1100 to 1315 hrs

Ms. Alka Narang, (In charge, UNDP, New Delhi) - Chairman

Sri. Gopal Krishna Gowda, IAS - Co-Chairman

Presentations of experiences:

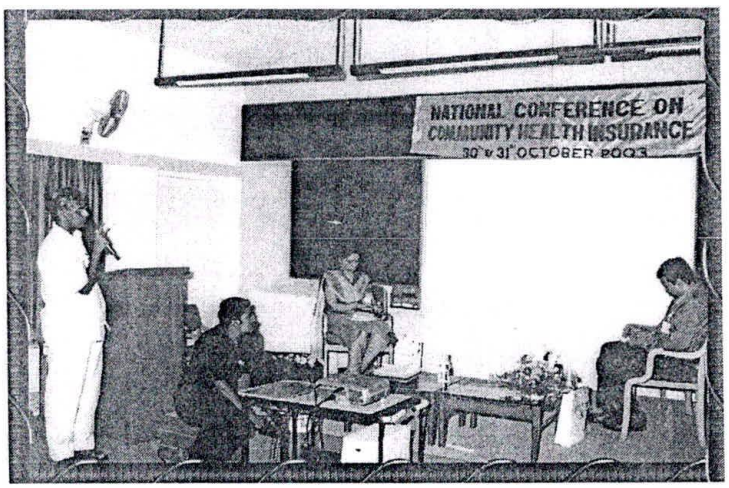
1. Karuna Trust – Karnataka
2. Sri Mayapur Vikas Sangha- West Bengal
3. Yeshasvini – Karnataka
4. SEWA - Gujarat

Synopsis of the presentations:

Karuna Trust, Karnataka

- KarunaTrust, established in 1987 as an affiliate of Vivekananda Girijana Kalyana Kendra, B.R. Hills to undertake rural health services programmes in Yelandur Taluk, has its mission the integrated development of people and improving quality of life.

Leprosy eradication was the first programme taken up due to the large



prevalence of cases at that time. In gradual stages, other neglected areas of health were taken up. Karuna Trust has got tremendous experiences in the course of implementing various programmes such as:

1	Leprosy, Epilepsy & Tuberculosis Control Programme
2	Community Mental Health
3	Community based Rehabilitation Programme
4	Community based Eye care
5	Cancer Detection Programme & Community dental health
6	Prevention and Treatment of Anaemia & Asthma Care
7	AIDS/HIV Awareness Programmes
8	Diabetes and hypertension programme
9	Tribal ANM Programme
10	Community Health Insurance Scheme
11	Empowerment of Rural Poor for better Health
12	Rajeev Gandhi National Drinking Water Mission Project
13	Home Hygiene and water Security Project
14	Total Sanitation Campaign
15	Tribal education & Integrated development

- Currently Karuna Trust is working for the development of the rural poor and needy in different parts of Chamarajanagara, Mysore, Mandya, Tumkur and Bangalore districts of Karnataka state in health, education and integrated rural development.
- The Trust is implementing a UNDP, GOI and GOK sponsored pilot project on community Health Insurance in Karnataka.
- After taking over the government run PHC at Gumballi in 1996, the trust has successfully made it a model PHC integrating conventional medical systems with Indian system of medicine.

- Pleased with the performance of the PHC run by the Trust, the Karnataka Government has handed over six more PHCs to the Trust recently.

- The Trust is running a Herbal Medicine processing Unit at Gumballi, which has been started in 1995. Funded initially by Foundation for Revitalisation of Local health Traditions (FRLHT), Bio-Conservation Network (BCN), then by Ashoka Trust for Research in Ecology and Environment (ATREE) and from internal resources.

- The Trust has been implementing an integrated literacy project in Yelandur Taluk to take care of Pre School, school education and adult literacy needs of the people.

- The UNDP sponsored pilot project on the development of a possible and replicable model for Community Health Insurance Financing, taken up in Karnataka State, is being implemented in T. Narsipura taluk of Mysore district and Bailhongal taluk of Belagaum district of Karnataka.

Partner organisations for the UNDP sponsored pilot project on Community Health Insurance Financing programme:

- United Nations Development Programme
- Ministry of Health & Family Welfare, GOI
- Directorate of Health & Family Welfare, GOK
- Karuna Trust
- National Insurance Co. Ltd.
- Centre for Population Dynamics

Objectives:

- Developing and testing a model of Community Health Financing
- Suited to the rural community
- Exposing communities to the scope of health insurance

- Developing a system for the interface with the organized Insurance sector
- Increasing access to public medical care by rural poor and lower income groups
- Ensuring equitable through prepaid insurance
- Enhancing use of primary healthcare facilities
- Enhancing awareness of the need for preventive health care
- Involving area specific community bases organizations such as SHGs, VDCs, AWWs, PRIs, Co-operative societies

MODELS

- The pilot project is organised and managed at two different places by two agencies, one by a non-governmental organisation and the other by government machinery, to study the impact of the implementation.

Model - I

In T. Narsipura, the scheme would be organized and managed by the Karuna Trust, an NGO

Model - II

In Bailhongal the official health personnel would organize and manage the scheme under the supervision of the Chief Executive Officer of the Z.P

Salient features:

- Oriented towards the poor
- Community level and family is the unit of membership

- Micro-credit financing for Out-patient care through SHGs
- The premium is Rs. 30 per person per annum for a health insurance cover of Rs. 2500/-

The insurance policy covers:

- All inpatient - hospitalisation cases.
- At public health facilities
- Rs. 50/- per Hospital for drugs
- Rs. 50/- per day - given to patient for loss of wages
- Referred cases also

The premium:

- Subsidized fully for BPL SC/ST population
- Partially subsidized for BPL non-SC/ST population
- Not subsidized for APL population
- Revolving fund at health institution –to settle claims immediately
- Active case finding by the social workers deputed at health centres and field staff.
- Referred cases to any public health institutions anywhere considered.
- Marketing the insurance and claim settlement, documentation etc. done by social workers
- No exclusion of any diseases
- No waiting period.
- Preventive & Traditional Health care: Promotion of herbal garden
- Outpatient Care and Financing: Facilitating SHGs to set aside certain fund for outpatient financing.
- Inpatient Insurance: Exposing community to health insurance

Coverage:

Details	T. Narsipura			Bailhongal		
	Rural	Urban	Total	Rural	Urban	Total
Started	1.9.02			1.10.02		
BPL-SC & ST	77223	5323	**82546**	31204	1224	**32428**
Non- SC & ST	2546	0	**2546**	20322		**20322**
TOTAL	**79769**	**5323**	**85092**	**51526**	**1224**	**52750**

	T. Narsipura	Bailhongal
Amount fully subsidized @ Rs. 30 per person	Rs. 24,76,380	Rs. 9,72,840
Amount partially subsidized	Rs. 25,460	Rs. 3,04,830
Total amount subsidized from UNDP fund	Rs. 25,01,840	Rs. 12,77,670
Amount collected from BPL Non SC& St	Rs. 50,920	Rs. 3,04,830
Total amount paid to NIC	Rs. 25,66,900	Rs. 15,82,500
Amount claimed till 30.9.03	**Rs. 4,57,400**	**Rs. 8,52,700**
Total No. of beneficiaries	**540**	**1,237**

Analysis of data:

- Max. 45% patients in the age group of 15-35 years, followed by 40% in the age group of 36-60 years age group
- Wage loss compensation helping working age group.
- Male inpatient - 54% & Female inpatient 46% in T. Narsipura
- Inpatient rate: 6.5 per 1000 per annum in T.Narsipura while in Bailhongal it is 25 per 1000 per annum
- Claim ratio: about 23% of premium paid in T.Narsipura while in Bailhongal it is 55%

Extension of the Project to other areas

In the pilot project, under both the models, the service providers are government hospitals only. In order to study the implications with private sector hospitals as service providers, operation area of the T. Narsipura Model was extended to tribal areas of Yelandur, Kollegala, Chamrajnagara and B.R. Hills w.e.f. 1.4.2003. Under the Bailhongal model, the project was extended to Belagaum Taluk from 16th June 03 to cover more beneficiaries.

The extension figures till 30 September 2003 are:

Details	Yelandur, Kollegala, Chamrajnagara and B.R. Hills			Belagaum Taluk		
	Rural	Urban	Total	Rural	Urban	Total
Started	1.4.03			16.6.03		
BPL-SC & ST	33,716	0	33,716	59,494	0	59,494
Non - SC & ST	0	0	0	0	0	0
TOTAL	**33,716**		**33,716**	**59,494**	**0**	**59,494**

Details	Yelandur, Kollegala, Chamrajnagara and B.R. Hills	Belagaum Taluk	**Total**
No. of people covered till 30 Sep.03	33,716	59,494	93,210
Amount fully subsidized @ Rs. 30 per person (Rs)	10,11,480	17,80,358	27,91,838
Total amount subsidized from UNDP fund (Rs).	10,11,480	17,80,358	27,91,838
Total amount paid to NIC	10,11,480	17,80,358	27,91,838
Amount claimed upto 30 Sep. 2003	**1, 42,700**	**81,700**	**2,24,400**
No. of beneficiaries	**297**		

Preventive health care

- As a part of the community initiatives for health care, Karuna Trust has taken up promotion of Herbal Garden concept through SHGs.
- To start with we have taken up 89 SHGs for its propagation
- The interested SHG members grow the plants in their homesteads to promote preventive and traditional herbal treatment.
- Once the group members are aware of the utility of the plants, they are exposed to the 2nd phase of the project namely HERBAL PRODUCTS FOR HEALTH PURPOSES.
- The SHG members grow the different plants for the use of their own family and community.
- Under the 2nd phase of project resource persons explain the composition of the preparation of the medicine. The idea is to prepare the medicines at the village itself.
- So far 625 people were trained under four herbal medicine preparation workshops.
- 8000 herbal saplings distributed to the interested individuals

Premium for III Phase:
National Insurance Company has agreed to bring down the premium from Rs. 30 to Rs. 20.50 per person per year.

Measures for sustaining the project

- In order to make the project sustainable, different community organisations such as SHGs, VDCs, Co-operative societies, Gram Panchayats have been involved for the awareness generation, survey of SC/ST population, identity slip distribution and premium collection.
- In Bailhongal, the patients who avail of the hospitalisation benefits are motivated to pay Rs. 50/- out of the cash benefit they receive, towards the premium charges for the next year's policy.

Strengths

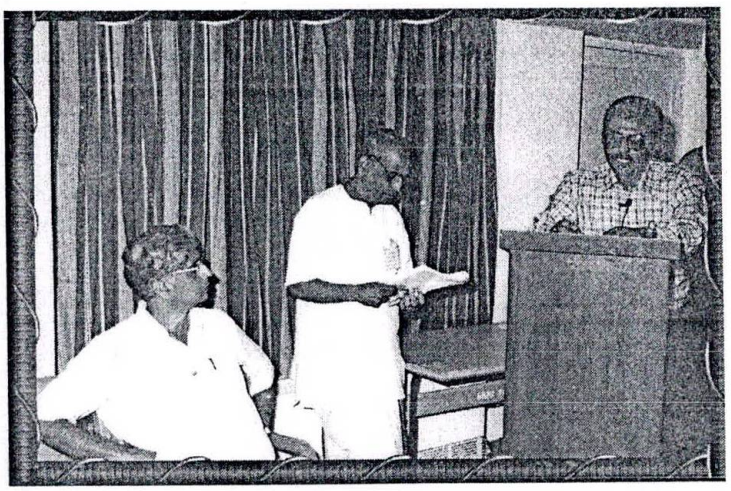
- First time wage loss compensation by an Insurance Company
- Working age group is the major beneficiary – 85%
- Utilisation of public health services has increased
- By involving the Non-Profit Organisations claim has increased
- There is no exclusions of diseases
- Fast claim settlement and re-imbursement
- Low moral hazard
- Good Community participation
- Women access to Health centre has increased
- Involvement of Health Insurance Companies
- Outpatient care thru SHGs and Traditional Medicines
- Replicability of the pilot project- Bailhongal model

Weakness:

- Fewer claims may be because of in-adequate public health services
- Service tax problem
- Service commission not enough
- I.D. slips in English
- Private (for profit) health institutions not involved
- No incentives to health staff
- Problems in sustainability

Sri Mayapur Vikas Sangha, West Bengal

Sri Mayapur Vikas Sangha, established 1998, is a secular, non-government development organisation operating in the area of Sri Mayapur, Nadia District, West Bengal, India. The objectives are for broad and holistic sustainable human resource development in the region of Sri Mayapur.



The Community Health Care Financing Project implemented since April 2001 under the UNDP, MOHFW, GOI & GOWB aims at convergence of micro-credit, micro-enterprise and local self-governance initiatives in the health sector covering 4 Grama panchayats and 6000 poor and marginalized families.

Objectives:

To empower communities to better manage their health care

Establishing partnerships with the health service providers

Reduce burden of expenses on health care.

Strategy:

- SMVS village health programme
- Micro-credit programme
- Health Services

- Capacity building of community health workers
- RCH package
- Paramedical roles
- Act as bridge between health service providers and receivers
- Curative services and community financing
- Integrating and capacity building of traditional birth attendant for safe home delivery
- Integrating and capacity building of local private health practioners on
- Rational therapeutics and diagnosis

Essential drugs

- Counselling skills for preventive and promotive health care
- Proper referral
- SHG operated Drug banks and referral transport
- Linkage with health centres, consultant doctors, hospital for referral services
- Community centred diagnostic facility

Salient features of the policy

- Reimbursement for hospitalisation due to covered diseases/surgery limited to Rs.5000
- Reimbursement for domiciliary hospitalisation expenses in lieu of hospitalisation (subject to certain condition and exclusions)
- Pre-hospitalisation expenses upto 30 days
- Post Hospitalisation expenses upto 60 days
- Age limit – 5 years to 70 years. Children between the ages of 3 months to 5 years can be covered provided one or both parents are covered concurrently.

Treatment covered:

- Expenses on hospitalisation for a minimum period of 24 hours
- In case of treatments like dialysis, chemo=therapy, lithotripsy, radio therapy, eye surgery, dental surgery, tonsillectomy, DNC taken in hospital/nursing home, the time limit of 24 hours is not applicable.

Major exclusion under the policy

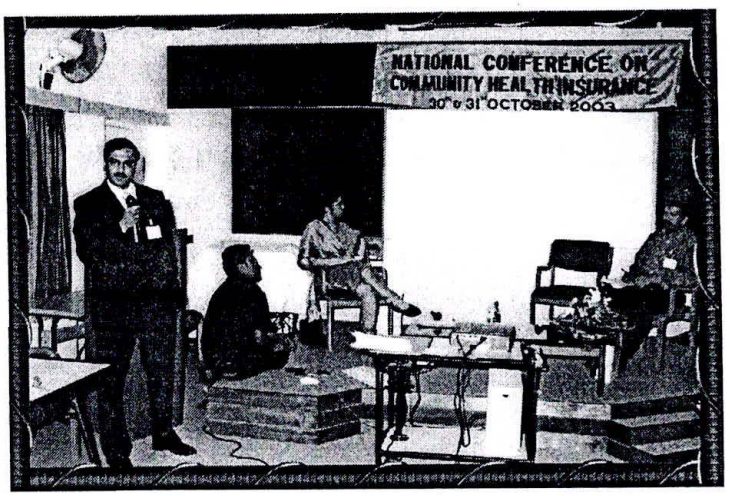
- Any pre existing disease
- Naturopathy treatment
- Routine eye examinations, cost of spectacles and contact lenses and hearing aids
- Dental treatment of surgery unless requiring hospitalisation
- Any injury or disease arising out of war invasion, act of foreign enemy
- Convalescence, general debility, congenital external disease
- Expenses on vitamins and tonics unless forming part of treatment for injury or disease
- Expenses directly or indirectly caused by or associated with HTLB-III or LAV or condition of a similar kind commonly referred to as AIDS.

Present status

- 409 members of 77 SHGs (1022 family members) i.e. 25.33% SHGs are covered under Jana Arogya Policy
- Total Rs. 61600 was paid for their annual premium
- In monthly instalment they are repaying the amount for the next year
- Rs. 10225.50 they repaid to NMCHF for their next year's premium
- Till now 2 persons (1 male and 1 female) were benefited under this scheme.

Family Health Plan Ltd., Karnataka

Yeshasvini is an innovative scheme conceptualised by Dr. Devi Shetty, Chairman, Narayana Hrudayalaya, Bangalore. Launched on 14th November 2002, the scheme is approved by the Government of Karnataka and implemented and administered by Family Health Plan Limited for the farming community. Objective of the scheme is to provide healthcare services at the doorsteps of the farming community of Karnataka and make available and accessible even to the poor, the best treatment in the best hospitals.



Salient features:

- A self funded scheme catering to the surgical need of the farmer community.
- Farmer and his family member registered with the Karnataka State Co-operative society for a period of minimum 6 months can become beneficiary under this scheme by making a payment of Rs. 60/- per annum per person.
- Corpus generated out of the member's contribution and Govt. contribution of Rs. 30/- per person per annum is placed with the Yeshasvini Trust for disbursing the payment towards entitled services as per the scheme.
- Beneficiary avails cashless treatment at 80 recognised hospitals across the State.
- Beneficiary entitled for 1600 surgical procedures with an annual coverage of Rs. 2 lakh with capping of Rs. 1 lakh per procedure.
- Beneficiary also entitled to free outpatient consultation by a physician at the identified network hospital and greatly discounted rates for out patient investigation and specialist consultations.

Detailed project map

- Only those who have been the members of co-operative society for the last 6 months are entitled to avail the benefits of the scheme

- Upper age limit to avail of the benefit of scheme is 75 years
- Over 17 lakh farmers contributed to the fund so far
- Total fund collected is over Rs.14 crores
- Scheme operated by the Yeshasvini co-operative Trust

Contributions

- Member contribution is Rs. 60 per annum (Rs. 5 per Month)
- State Government of Karnataka contribution is Rs.30 per annum (Rs. 2.50 per month) per member

Collection of fund through:

- The local District Co-operative Credit Societies
- Milk Marketing Federations
- Other recognized societies under the Ministry of Co-operatives, Govt. of Karnataka
- Collections will be deposited with DCC Banks and the same will be transferred periodically to the Karnataka State Co-operative Apex Bank Limited, Bangalore

Scope of Coverage

- Surgeries covered: Over 1600 surgical procedures have been identified and covered at a pre-negotiated tariff
- Each member can get a coverage of Rs. 1 lakh per procedure and the upper limit is Rs. 2 lakh per annum
- Free out-patient service to all farmers enrolled in the scheme at any of the hospitals

Identified Network Hospitals

- 74 hospitals across Karnataka offer service as per the pre-negotiated tariff hospitals extend services on credit and the amount is reimbursed by the Trust.
- Stringent admission protocols are followed to avoid mis-utilisation of the scheme.

Milestones

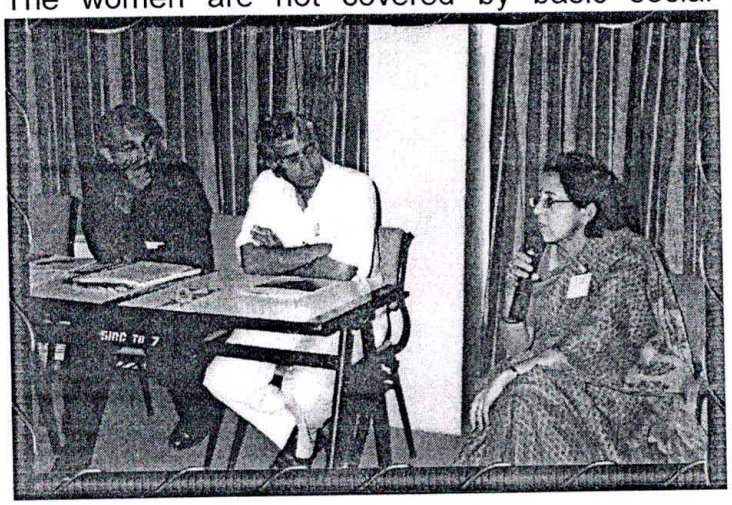
- Launched the scheme on 14th November 2002
- Till 31st May 2003-nearly 17 lakh farmers enrolled
- 1st June 2003 performed the first surgery
- 1639 surgeries performed till 30th August 2003

Forces Behind

- Government of Karnataka
- Karnataka State Co-Operative society
- Family Health Plan Limited
- Network hospitals.

SEWA, Gujarat

The women are not covered by basic social protection measures, yet sickness is a major crisis and economic leakage. Self-Employed Women's Association (SEWA) is a labour union of 7,00,000 informal women workers in Gujarat, India. In the absence of state-sponsored or other social insurance, SEWA developed its own and now reaches almost 103,000 insured persons. Operating for the last ten years, the SEWA plan is an integrated insurance package with health insurance as a major component.



Main features:

- Started in 1992 to cover Life insurance, medical insurance and asset insurance
- Targeted at SEWA Union members in 11 of Gujarat's 25 districts, and their husbands and children
- Age restriction for adults: 18 to 60 years of age for life, upto 70 for health and assets
- Minimum hospitalization for 24 hours
- First year exclusions: hysterectomy, piles, cataract, hernia etc
- Conditions for reimbursement of treatment of pre-existing diseases
- Currently three packages are offered with insurance premium varying between 85 to 400 per annum

Strengths

- Nesting within a larger, member-based organization
- Rational, data-based setting of premiums and benefits packages (due to associations with "formal" insurance companies)

- Technical and financial support from external partners/donors
- Dynamic management that has not hesitated to make changes
- Generating understanding about insurance
- Maintaining regular contact with members
- Reaching the poorest
- Targeting a widely dispersed population, thus increasing transaction costs
- Lack of knowledge about health and health care among members

Concluding remarks:

Ms. Alka Narang, summing up the pre-lunch presentations, remarked that it was a difficult job to summarise the different presentations, as each one was unique in its characteristics of health seeking behaviour and claims. Observing the statistics of SEWA where insurance claims in the first year were high and the subsequent years saw it coming down, Ms. Narang wanted to know whether it was due to steps taken for preventive care through local health traditions. Urging for sustainability of the schemes, Ms. Narang wondered whether surgeries like cataract etc, which were free under Government medical schemes, were also being brought under the health insurance cover.

Sri. Gopal Krishna Gowda IAS, in his remarks noted that focus was different in each of the presentations. He also urged for evolving a common scheme for all.

Session III (1400 hrs – 1530 hrs)

Dr. Pradeep Panda, Economist, New Delhi- **Chairman**

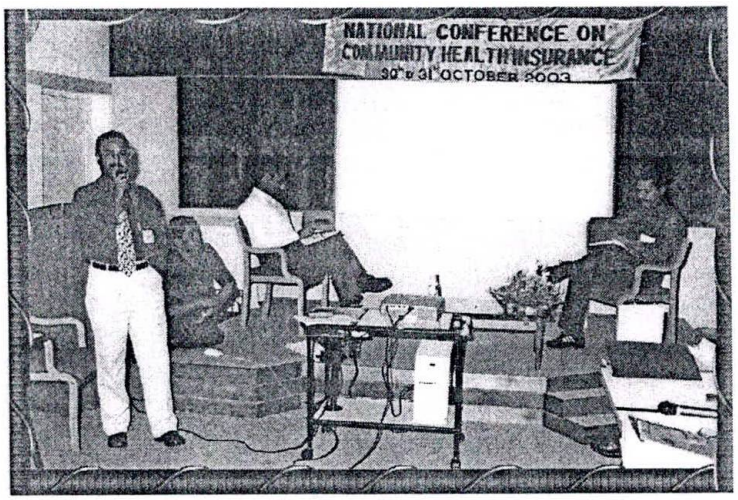
Dr. Rajeev Ahuja (Fellow at Indian Council for Research on International Economic Relations, New Delhi) – **Co- Chairman**

Presentation of Models

1. National Insurance Company, Bangalore
2. SHEPHERD, Tamil Nadu
3. Dr. N. Devadasan, Tamil Nadu
4. Sri. Rajeev Ahuja, New Delhi
5. Voluntary Health Services (presented in absentia)

Synopsis:

National Insurance Company, Bangalore



Insurance scenario

- Coverage of the population under private, social or other types of Health Insurance is limited
- ESIS : about 3.4 crores
- CGHS : about 40 lakhs
- Railways: about 12 lakhs
- Medi-claim Policy: 80 lakhs

Need for Insurance

- At any given point around 40 to 50 million people are under medical supervision for major ailments
    - Financial burden arising out of serious ailments can seriously drain the resources of any given individual
    - Health insurance for Hospitalisation is more relevant in this context

Universal Health Insurance Scheme

- Unique Health Insurance Scheme launched by the central Government aimed at providing Health Cover for all
- Particularly the poorer sections of society
- Premium Rs 1/- per day
- Premium Subsidy for Below Poverty Line Families
- Provision for loss of earning
- The Reimbursement of medical expenses upto a total of Rs.30000/- which can be utilised by one or all members of the Family

Coverage:

- The Reimbursement of medical expenses upto a total of Rs.30000/-, which can be utilised by one or all members of the Family
- Coverage for death of earning head due to accident Rs. 25,000
- Daily compensation of Rs.50/- towards loss of wages to earning Head during hospitalisation upto 15 days.

Age limits

- Between 3 months to 65 years
- Family would include head, spouse, 3 dependant children and dependant parents

Sum insured on floater basis

- The reimbursement of medical expenses will be a total of Rs.30000, which can be utilised by one or all members of the family.

Premium:

Details	Premium
For an individual	Rs.1.00 per day Rs.365/- per annum
Medi-claim premium for similar cover	Rs.637/- + tax
For a family upto 5 (including the first 3 Children)	Rs.1.50 per day Rs.548/- per annum
Medi-claim	Rs 637 x 5 = Rs.3185/-
For a family upto 7 including the first 3 Children and dependent parents	Rs. 2 per day Rs. 730/- per annum
Medi-claim	Rs. 637 x 7 = 4459/-
• For families below the poverty line the Govt. Will provide a premium subsidy of Rs.100/ per Family • Policy exempt from Service Tax	

Benefits:

- Reimbursement of Hospitalisation expenses up to Rs.30, 000/- to an individual/family subject to certain sub limits.
- Personal accident cover for death of the earning head Rs.25, 000/-
- Wage compensation @ Rs.50/- per day of hospitalisation of the earning head of the family, up to a maximum of 15 days.

- Major Healthcare needs of the most needy section of our society taken care of – Fulfilment of one of the foremost social obligations of the State.
- Optimum use of the vast healthcare infrastructure of the State, hitherto under utilised due to increased affordability by way of having insurance coverage

Exclusions:

- All pre-existing diseases
- And diseases contracted within 30 days of coverage
- Primary diagnostic expenses
- Treatment for pregnancy, childbirth etc.,
- Congenital diseases that the insurer is aware of

Administration:

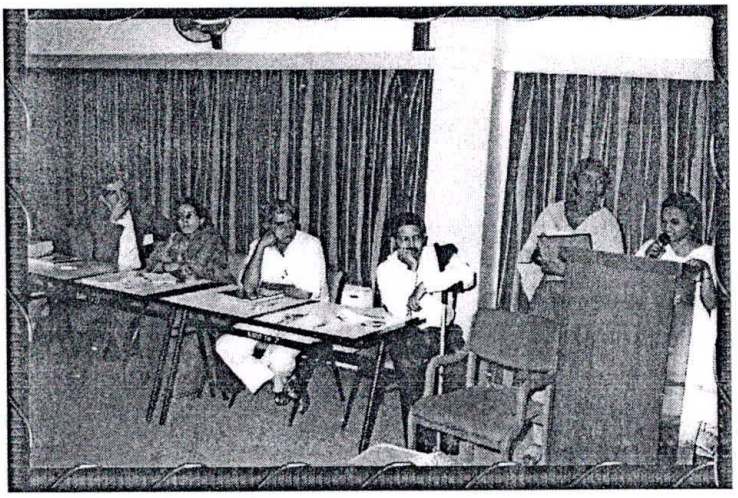
- Third party administrators are networking with low cost hospitals to provide facility of cash less access to policyholders
- Government and trust hospitals can also be used by policyholders

Constraints:

- Collection of small premiums from large interior areas
- Lack of awareness of the product
- But steps taken to overcome these constraints

SHEPHERD, Tamil Nadu

Self Help Promotion for Health and Rural Development (SHEPHERD) based at Trichy, is a professional development financial institute working with 7,500 rural families occupying the core community of central Tamil Nadu.



Started in the year 1995, under the Society's Registration Act 1995 by Mr.Peter Palaniswamy and other eminent person belonging to various fields of profession, its operations have now expanded over three districts of Tamil Nadu namely Trichy, Perambalur and Salem which are identified as backward and drought prone districts.

Processes and fruition of insurance

- Major products on insurance are FOOD security, INCOME security HEALTH security and ASSET security.

A. FOOD SECURITY

- Operational activity in which the members save fistful rice each time they gather for meeting.
- Pooled rice is donated to the needy and old aged poor

B. INCOME SECURITY

1.LIFE

i) Scheme Coverage: 2000 to 2003

- Covered 2,212 members and their spouse in the year 2000,
- Covered 8,365 members in 2003.
- The ratio of men and women were nearly 50%.

II) Life Insurance Scheme

- Three schemes with premium varying between Rs.35 to Rs.100/-
- Coverage of natural death, accidental death, hospitalisation and permanent disability.

Claims

- Total claims till 2003 are 102
- Current rate of claims per insured is 6/1000 member per year i.e. of the total of 7167 life insured during the year 2003,45 were the claimants.
- Of the total 7167 insured members, those covered under GSS are 6500, OGI-744 UNMIS-550.JBY-891.
- The cause of death is often due to liquor habits of men
- Cardio attack seems to the next common cause.
- 100% settlement was assured during last year on account of prompt submission of relevant documents.

2. NON-LIFE

SHEPHERD has entered in to partnership with UIIC for providing Health, Asset and livestock insurance.

(a) Livestock Insurance

The stress is on the three attributes viz. PREVENTION, PROTECTION and PROMOTION.

(b) Livestock Coverage

- The Livestock-diary was initiated in 2000 with coverage of 126 cattle, 350 in 2001,302 in 2002, and 85 in 2003.
- Goats are not covered due to high rate of claims.

C. HEALTH SECURITY

- This scheme aims at indemnifying the related expenses of the women if they are hospitalised for at least 24 hrs in a hospital having a minimum of six beds.
- This scheme has been from May 2003
- Covered 550 members, constituting 100% women coverage.

***Sugam* Fund:**

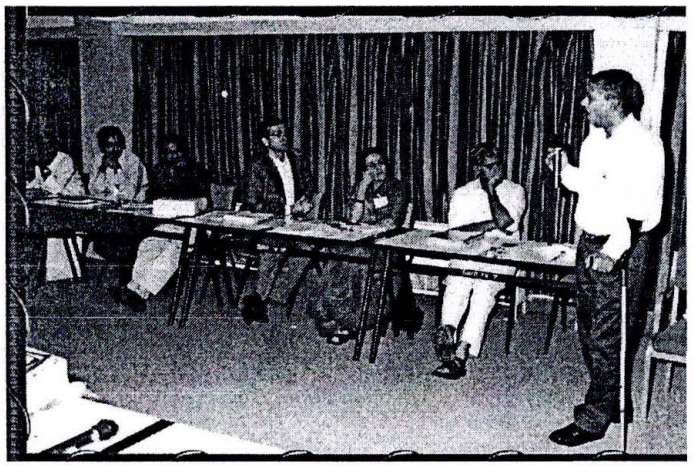
- Financial assistance to pregnant women for safe delivery
- Soft loan of Rs.2, 000 to 3,000/-
- Matching contribution from FWWB.
- Fund is kept at each Block level federation for its operation.

D. ASSET SECURITY

- Covers hut against damage by fire.
- The scheme is linked with UIIC for coverage of Rs.5000/- by paying a premium of Rs.45/-.
- 47 members enrolled

Dr. N. Devadasan, SCTIMST – Trivandrum & ITM, Antwerp.

- A review of 10 Community Based Health Insurance Programmes in India initiated by NGOs, with varying levels of community involvement.



- Only one has involved the Government.
- Six of them have used existing CBOs e.g. SHGs, Unions to develop the insurance programmes.
- All target the poor – ranging from SC / ST to poor women in SHGs
- The target population ranges from 1500 to ~ 5 million.
- Eligibility criteria = Geographic limits, member of CBO, poor, in SHGs usually adult women

Premium details:

- Mostly voluntary. Only 2 have mandatory premiums
- Unit for enrolment is the individual (7 / 10)
- Premium per individual ranges from Rs 4 per year to Rs 250 per year. 6 / 10 charge around Rs 20 to Rs 40.
- 8 / 9 has a definite collection period and 6 / 9 have a waiting period.
- Collection usually done by the CBOs, NGOs

Benefits:

- All cover hospitalisation benefits. Upper limit ranges from Rs 1250 per patient per year to no limits (Direct model).

- Some include other benefits, e.g. cover for loss of wages, ambulance fees
- Providers are either NGO or Private providers.
- Only one has Government provider.
- Co-payments in almost all the schemes
- Exclusions in many of the schemes e.g. chronic illnesses, deliveries, TB, etc.
- Almost all the NGOs also provide primary care through other resources

Output

- Subscription rates vary from 10% to 60%. Most are in the range of 20 – 40%.
- Not clear who are enrolling – the top half among the poor? Those near the health facility? Those with risk of illness?
- Hospitalisation rates – mostly (5/ 8) in the range of 1 – 10 admissions per 1000 insured.
- Again not clear who are using the benefits
- Not enough information about the impact in terms of catastrophic health expenditure.

Conclusions

- CBHIs can be effective in protecting the poor - ? The poorest?
- Can be financially sustainable.
- Scaling up
- One has to be careful about the design
- Quality of care needs to be ensured
- Management of Health Insurance is a complex task

Dr. Rajeev Ahuja, Fellow at Indian Council for Research On International Economics Relations, New Delhi.

- Health care financing in India unique in several respects
- The share of public financing in total health care financing in the country is just around 1% of GDP
- This considerably low compared to the average share of 2.8% in low and middle income countries
- The beneficiaries are not only the poor but also the well-off sections of the society.
- Over 80% of the total health financing is private financing
- Much of which takes the form of out of pocket payments and not any prepayment schemes.
- One quarter of all Indians falls into poverty as a direct result of medical expenses in the event of hospitalisation (World Bank)
- How to convert private out of pocket spending into health insurance premium and how to provide health insurance to the people who cannot afford to pay full premium-The twin challenges facing the Indian health policy experts
- Country may chose between public or private financing of health services
- But that choice is hardly available to countries like India because of its limited ability to marshal sufficient resources, nature of employment of the workers (most of them are self-employed)
- Policy of the state is to provide free universal health care to the entire population.
- Insurance through prepaid schemes has a number of advantages – more equitable, drivers of improvement in health care by encouraging investment and innovation.

- But private insurance leave out the low-income individuals who can't afford premium and limit the coverage for high-cost conditions or services.
- Private Health Insurance in India is a supplementary services – it is limited
- Most of them are mandatory, voluntary, employer based and schemes in the NGO sector.
- All these schemes together covers about 110 million or about 11 percent of the population (Garg 2000)
- This is far short of the private health insurance potential which is anywhere between 400 to 500 million people.
- Even with development of private insurance only half of the country's population will have access to health insurance.
- The low-income population (50% of the population) will be outside the ambit of private health insurance.
- After liberalisation of insurance market in 2000 no significant change in the products or volume of business.
- Medi-claim or Jan Arogya for the poor have not shown any growth
- The reasons? Lack of marketing and not coverage of primary health care costs
- Why health insurance remained under developed in India? -Govt policies, absence of data base on diseases, treatment and health profile
- Creation of standards for diseases and treatment procedures, introducing rating, credentialing of the providers to encourage standardisation of services, creation of centralised database, billing, claims and proposal forms is a must for entry into health insurance business attractive.
- Impact on the poor - they stand to benefit though private insurance company may not cover them. But the likely impact of it far from clear.

Voluntary Health Services, Tamil Nadu

- The Voluntary Health Services, a non-profit charitable society registered in 1958 is running a Medical Centre (Hospital) for catering to the medical needs of poor and middle-income group of the community in and around South Chennai. The Medical Centre consists of 405 beds with almost all the specialities. Nearly 70% of the patients admitted are given free treatment including drugs and diet.

- The Medical Aid Plan formulated by Dr.K.S.Sanjivi, founder of VHS, being implemented by VHS, for the benefit of the general public (mainly focusing on lower and middle income groups of the community) envisages covering the family as a unit of Health Care and focuses on community participation, in its Scheme.

Family membership:

- On payment of the Annual subscription, as noted below, the head of the family is enrolled as a member and his dependant members are included
- The Card is valid for one year from the date of enrolment

Income group:

Members with monthly income below Rs.750/- p.m. are given free treatment.

Subscription:

- Varies between Rs. 80 to Rs. 350/- per annum per family based on income group
- Those who do not opt for the family membership can be treated as individual members.

Higher income group:

Members get 20% concession on the charges payable

Special features:

- VHS Hospital itself is implementing the scheme and there is no third party involved.
- Beneficiaries get their benefit under a single roof.

Outreach programme:

- VHS is running 14 Mini Health Centres each covering a population of 5000, having a part time Doctor, male and a female multipurpose health worker. There is also a Lay First aider, almost a lady of the area.
- The mini Health Centres are placed in rural and semi-urban location
- Special nutritive unit where there is Nutrition Demonstration periodically.
- The Government of India have formulated the Primary Health Centre concept following this pattern.

Learning

- The Medical Aid Plan envisages coverage and participation by the general population
- In spite of our social workers addressing the patient in VHS Hospital and also Multipurpose Health Workers, in the village level in the 14 Mini Health Centres run by us, the programme has not been very successful.
- The family based programme has not become very successful on account of defaulters' rate being high and patients want to come to the hospital, only when they are sick, though the family programme provides Health Check up for all the members on getting enrolled.
- This made us go in for an individual membership scheme and any body who wants to get treated can avail the services from VHS.
- Marketing need to be done vigorously.

Summing up:

Complimenting the participants for the excellent presentations, Dr. Pradeep Panda, the chairman of the session, remarked that Community Based Insurance is an innovation and emerging field. Referring to low participation of the poor people in these schemes, he urged the service providers to extend the coverage to the poor. Dr. Panda wondered whether the deterrents were taken care while designing of the scheme.

Sri. Rajeev Ahuja, the co-chairman of the session observed that while the scheme of National Insurance Company took care of the supply side, in SHEPHERD the stress was on the demand side. Referring to the poor statistics of claims, he strongly urged for reducing the premium charged on the various Health Insurance Schemes by the service providers. "Insurance players like NIC shall strive to increase the basket of different types of policies to break-even rather than trying to achieve it on one type. Steps like this alone will enable poor people to have access to Health Insurance cover." said Sri. Ahuja.

Plenary Session IV (1545 to 1700 hrs)

Panel discussion on

"How Health Insurance Can be spread in Karnataka and India"

Chairperson Dr. Indrani Gupta, Economist, JNU, New Delhi.

Panellists

Dr. Paolo Carlo Belli, Economist, World Bank, Washington, USA

Prof. Muraleedharan, Professor, Dept. of Humanities & Social Science, IIT, Chennai

Sri. Rajeev Ahuja, Fellow, ICRIER, New Delhi.

Prof. V.R. Muraleedharan

Initiating the discussion on the topic, Prof. Muraleedharan mentioned the following as the basic issues involved.

- It shall be health care system and not health insurance system
- Revenue raising potential of the scheme is very limited
- It shall not be treated as a source of finance
- It shall be for organising health system

Dwelling on the challenges for spreading of the health insurance system, Prof. Muraleedharan remarked that the stress of the schemes should be to develop the consumer as an active purchaser of the scheme by making him well informed. Advocating for developing a strong drug policy, he urged the government to lay down clear-cut guidelines for referral cases. Pointing to the routine marketing techniques used by the players to canvass for the scheme Prof. Muraleedharan said that attempt must be to know how responsive the consumers were by initiating a consultation process prior to start of the scheme. Mutual trust between various stakeholders should be an essential part.

Dr. Indrani Gupta

Complimenting the various stakeholders for initiating the community health insurance, Dr. Indrani Gupta remarked that in India despite privatisation, people do not come forward for health insurance under the feeling that it is unlikely to happen to them. Referring to the scheme, Dr. Indrani remarked that the beneficiary is getting the benefits at a cheap rate without knowing that some body is bearing the actual costs. While trying for replicability of the scheme, this fact should be borne in mind, as public finance could not be subsidized. Asking the stakeholders for maintaining good data of the scheme, Dr. Indrani remarked that most of the schemes were for hospitalisation. "It shall be a good idea to expand the coverage beyond hospitalisation, which shall induce more people to join the scheme", said Dr. Indrani Gupta.

Referring to the target community of the scheme, she said that the scheme need not be only for the poor. "If the community scheme works why not for others?" Dr. Indrani Gupta asked.

Dr. Paolo Carlo Belli

Referring to the various sessions, Dr. Paolo Carlo Belli remarked that all of them were highly interesting. Making a strong case for targeting the poor, Dr. Belli remarked that insurance is not a panacea but had other important role to play like public care and health promotion. "But management of the scheme is one of the key limitations", said Dr. Carlo Belli.

Sri. Rajeev Ahuja

Sri. Rajeev Ahuja remarked that as a part of social security, Government policies take care of the Finance, Health and Labour. There is a genuine case of selling insurance as in house but government policy does not allow it. Urging the NGOs, researchers to influence the government policies, he said that health care system in the country is in chaos.

Talking about up-scaling the system, Sri. Ahuja remarked that the health insurance market is un-tapped in the country. But the Public insurance companies, which are becoming commercial, might not go for coverage of the poor, as they do not identify for that cause. The Private insurance should do it as their social responsibility.

Ms. Alka Narang

Ms. Alka Narang who anchored the discussion, referred to the rapid economic progress made by China. In 1947 both India and China were on equal footing but since then China's economy has made rapid stride as they focussed on poor section of the society. Since 80% of the health problem is rooted in poverty. "Why we could not turn to our panchayats to start the process in India?" she asked. Ms. Alka Narang made a strong plea for inclusion of diseases like HIV also under the schemes apart from pooling the risks.

Dr. H. Sudarshan

Referring to presentations and discussions between the representatives of World Bank, Central and State Government, UNDP, various service providers, economists and voluntary agencies, Dr. H. Sudarshan who gave vote of thanks, made a strong plea for up-scaling the community health Insurance System throughout the state of Karnataka. "With all the key players who took part in the National Conference positively inclined for it, it is for the World Bank, UNDP, Government of India and Karnataka to take a decision in this regard", said Dr. H. Sudarshan.

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ಸ್ಥಳೀಯ ಉದ್ಯೋಗಿ ವಿಮಾ ಪಾಲಿಸಿ

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ವಿಮಾಧನ ಪ್ರತಿ ವ್ಯಕ್ತಿಗೆ ರೂ. 5,000/- ವರೆಗೆ

ಪ್ರತಿ ವರ್ಷಕ್ಕೆ ರೂಗಳು

ವಿವರಗಳು	45 ವಯಸ್ಸಿನವರೆಗೆ	46-55 ವಯಸ್ಸಿನವರೆಗೆ	56-65ರ ವಯಸ್ಸಿನವರೆಗೆ	66-70ರ ವಯಸ್ಸಿನವರೆಗೆ
ಪರಿವಾರದ ಮುಖ್ಯಸ್ಥ	70	100	120	140
ಪತಿ / ಪತ್ನಿ	70	100	120	140
ಆಶ್ರಿತ ಮಗು 25 ವರ್ಷದವರೆಗೆ	50	50	50	50
ಇಬ್ಬರು ಮತ್ತು ಒಂದು ಆಶ್ರಿತ ಮಗು ಇರುವ ಪರಿವಾರ	190	250	290	330
ಇಬ್ಬರು ಮತ್ತು ಎರಡು ಆಶ್ರಿತ ಮಕ್ಕಳಿರುವ ಪರಿವಾರ	240	300	300	380

● ಸಂಪೂರ್ಣ ಮಾಹಿತಿಗೆ ಕೂಡಲೇ ನಿಮ್ಮ ಹತ್ತಿರದ ಕಛೇರಿಯನ್ನು ಸಂಪರ್ಕಿಸಿ.

ಜನ ಆರೋಗ್ಯ ವಿಮಾ ಪಾಲಿಸಿ

● ಜನ ಆರೋಗ್ಯ ವಿಮಾ ಎಂದರೇನು ?

ಜನ ಆರೋಗ್ಯ ವಿಮಾ ಪಾಲಿಸಿಯು ವಿಮಾದಾರನ ಆಸ್ಪತ್ರೆಯ ವೈದ್ಯಕೀಯ ವೆಚ್ಚವನ್ನು ವಾರ್ಷಿಕ ಮಿತಿ ರೂ. 5000/- ವರೆಗೆ ಈ ಕೆಳಕಂಡ ಚಿಕಿತ್ಸೆ ಪಡೆದಾಗ, ಭರಿಸಲು ರೂಪಿಸಿರುವ ಪಾಲಿಸಿ, 1) ಶೀಘ್ರ ಕಾಯಿಲೆಗಳಿಂದ 2) ಅಪಘಾತದ ಚಿಕಿತ್ಸೆಗಳಿಂದ 3) ವಿಮಾ ಅವಧಿಯಲ್ಲಿ ನಡೆಸಿದ ಕಾಯಿಲೆಗಳಿಗೆ ಸಂಭಂದಪಟ್ಟ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆಗಳಿಂದ.

● ಪಾಲಿಸಿಯ ಪ್ರಧಾನ ವೈಶಿಷ್ಟ್ಯಗಳು :

1. ವಿಮೆಗೆ ಒಳಪಟ್ಟ ಕಾಯಿಲೆಗಳಿಗೆ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ನಿಯಮ, ನಿಷೇಧಗಳಿಗನುಸಾರವಾಗಿ ವೈದ್ಯಕೀಯ / ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ಪಡೆದಾಗ ನಿಮಗೆ ತಗುಲಿದ ಖರ್ಚನ್ನು ರೂ. 5000/- ಗಳ ವರೆಗೆ ಹಿಂದಿರುಗಿಸಲಾಗುವುದು.
2. ಆಸ್ಪತ್ರೆ ಸೇರುವ ಮುನ್ನ 30 ದಿನಗಳ ಮತ್ತು ಆಸ್ಪತ್ರೆ ವಾಸದ ನಂತರದ 60 ದಿನಗಳಿಗೆ ಸಂಭಂದಪಟ್ಟ ಚಿಕಿತ್ಸೆಯ ವೆಚ್ಚವನ್ನು ಭರಿಸಲಾಗುತ್ತದೆ.
3. ವಯಸ್ಸಿನ ಮಿತಿ : 5 ರಿಂದ 70 ವರ್ಷ, 3 ತಿಂಗಳಿಂದ 5 ವರ್ಷದ ಮಕ್ಕಳೂ ಸಹ ತಮ್ಮ ತಂದೆ ಹಾಗೂ / ಅಥವಾ ತಾಯಿಯ ಒಟ್ಟಿಗೆ ವಿಮಾ ಪಡೆಯಬಹುದು.

● ಯಾವಾಗ ಪರಿಹಾರ ಪಡೆಯಬಹುದು :

ಆಸ್ಪತ್ರೆ ಅಥವಾ ನರ್ಸಿಂಗ್ ಹೋಂಗಳಲ್ಲಿ ನಿರ್ದಿಷ್ಟ ಕಾಯಿಲೆಗಳಿಗೆ ಚಿಕಿತ್ಸೆ ಪಡೆದಾಗ : (ಕೆಳಕಂಡ ಎರಡರಲ್ಲಿ ಒಂದು - ಅ/ಆ)

ಅ. ಆಯಾ ಪ್ರದೇಶದಲ್ಲಿ ನೊಂದಾಯಿಸಿರುವ ಆಸ್ಪತ್ರೆ ಅಥವಾ ನರ್ಸಿಂಗ್ ಹೋಂ ಆಗಿ ನೊಂದಣಿ ಪಡೆದ ಹಾಗೂ ಅರ್ಹತೆ ಹೊಂದಿರುವ ವೈದ್ಯರ ಉಸ್ತುವಾರಿಯಲ್ಲಿರಬೇಕು.

ಅಥವಾ

ಆ. ಈ ಕೆಳಕಂಡ ಕನಿಷ್ಠ ಸೌಲಭ್ಯವಿರುವ ಸಂಸ್ಥೆಯಾಗಿರಬೇಕು.

1. ಕಡೇ ಪಕ್ಷ 15 ಒಳ ರೋಗಿಗಳಿಗೆ ಹಾಸಿಗೆ ಅವಕಾಶವಿರಬೇಕು. (ಸಿ-ವರ್ಗದ ಊರುಗಳಲ್ಲಿ ಕನಿಷ್ಠ 10 ಒಳ ರೋಗಿ ಹಾಸಿಗೆ ಸೌಲಭ್ಯವಿರಬೇಕು).
2. ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ಮಾಡುವುದಾದರೆ, ಸುಸಜ್ಜಿತ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸಾಗಾರವಿರಬೇಕು.
3. 24 ಗಂಟೆಯೂ ಪೂರ್ಣ ಅರ್ಹತೆ ಇರುವ ಶುಶ್ರೂಷೆ ಮಾಡುವ ದಾದಿಯರನ್ನು ನೇಮಿಸಿರಬೇಕು.
4. 24 ಗಂಟೆಯೂ ಪೂರ್ಣ ಅರ್ಹತೆ ಇರುವ ವೈದ್ಯರು ಉಸ್ತುವಾರಿಯಲ್ಲಿರಬೇಕು.

● ಈ ಪಾಲಿಸಿಯು ಯಾವ ಚಿಕಿತ್ಸೆಗೆ ಅನ್ವಯಿಸುತ್ತದೆ.

1. ಯಾವುದೇ ನಿರ್ದಿಷ್ಟ ಕಾಯಿಲೆಗಳಿಗೆ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಕನಿಷ್ಠ 24 ಗಂಟೆ ಚಿಕಿತ್ಸೆ ಪಡೆದಾಗ ಮಾತ್ರ.
2. ಡೈಯಾಲಿಸಿಸ್, ಕೀಮೋತೆರಪಿ, ರೇಡಿಯೋ ತೆರಪಿ, ಕಣ್ಣಿನ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ, ದಂತ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ ಮೂತ್ರಾಶಯದಿಂದ ಕಲ್ಲು ತೆಗೆಯುವ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ, ಟಾನ್ಸಿಲ್ಸ್ ತೆಗೆಯುವುದು, ಡಿ ಮತ್ತು ಸಿ ಈ ಕಾಯಿಲೆಗಳಿಗೆ ಆಸ್ಪತ್ರೆಯಲ್ಲಿ ಚಿಕಿತ್ಸೆ ಪಡೆದಾಗ, 24 ಗಂಟೆಗಳ ಕನಿಷ್ಠ ಚಿಕಿತ್ಸೆ ನಿಯಮ ಅನ್ವಯಿಸುವುದಿಲ್ಲ.

● ಈ ಪಾಲಿಸಿಯಲ್ಲಿ ಕೆಳಕಂಡ ಅಂಶಗಳಿಗೆ ಪರಿಹಾರ ದೊರಕುವುದಿಲ್ಲ.

1. ವಿಮೆ ಮಾಡಿಸುವ ಪೂರ್ವದಲ್ಲಿ ಇರುವಂತಹ ಯಾವುದೇ ಕಾಯಿಲೆಗಳ ಚಿಕಿತ್ಸೆಗೆ ಮಾಡಿದ ವೆಚ್ಚ.
2. ವಿಮೆಯ ಅವಧಿಯ ಮೊದಲನೇ ವರ್ಷದಲ್ಲಿ ಕೆಳಕಂಡ ಕಾಯಿಲೆಗಳ ಚಿಕಿತ್ಸೆ ಮಾಡಿದ ವೆಚ್ಚ - ಕಣ್ಣಿನ ಪೊರೆ, ಹರ್ನಿಯಾ, ಮೂಲವ್ಯಾಧಿ, ಗರ್ಭಕೋಶದಲ್ಲಿ ಶಸ್ತ್ರ ಚಿಕಿತ್ಸೆ - ಮುಟ್ಟಿನ ಸಂಭಂದವಾದ ಹಾಗೂ ಫೈಬ್ರೊಮಯೋಮ, ಬಿನೈನ್ ಪ್ರಾಸ್ಟೇಟಿಕ್ ಹೈಪರ್ ಟ್ರೋಫಿ, ಹೈಡ್ರೋಸೀಲ್, ಆಜನ್ಮ ಒಳಗಿನ ರೋಗಗಳು, ಸೈನುಸೈಟಿಸ್ - ಮತ್ತು ಅದಕ್ಕೆ ಸಂಬಂಧವಿದ್ದ ಕಾಯಿಲೆಗಳಿಗೆ ಮೊದಲನೆ ವರ್ಷದಲ್ಲಿ, ಏನಾ ಈ ಕಾಯಿಲೆಗಳನ್ನು ವಿಮಾ ಪೂರ್ವದಲ್ಲಿ ಇತ್ತೆಂದು ನಿಷೇಧಿಸಿದ್ದಲ್ಲಿ.
3. ಪ್ರಕೃತಿ ಚಿಕಿತ್ಸಾಲಯಗಳಲ್ಲಿ ಚಿಕಿತ್ಸೆಗೆ ಮಾಡಿದ ವೆಚ್ಚ.
4. ಕಣ್ಣಿನ ಮಾಮೂಲಿನ ಪರೀಕ್ಷೆ ವೆಚ್ಚ ಹಾಗೂ ಕನ್ನಡಕಗಳ, ಶ್ರವಣ ಸಾಧನಗಳಿಗೆ ಮತ್ತು ಕಾನ್ಟ್ಯಾಕ್ಟ್‌ಲೆನ್ಸ್‌ಗಳಿಗೆ ಮಾಡಿದ ವೆಚ್ಚ.
5. ಗರ್ಭಧಾರಣೆ / ಹೆರಿಗೆಗೆ ಸಂಭಂದಿಸಿದ ಚಿಕಿತ್ಸೆಯ ಎಲ್ಲಾ ವೆಚ್ಚಗಳು.
6. ದಂತಗಳ ಶಸ್ತ್ರ/ಚಿಕಿತ್ಸೆ - ಆಸ್ಪತ್ರೆ ಸೇರುವ ಅವಶ್ಯವಿದ್ದಲ್ಲಿ ಮಾತ್ರ.
7. ಯುದ್ಧ ಅಥವಾ ವಿದೇಶಿ ಆಕ್ರಮಣದಿಂದ ಉಂಟಾದ ಕಾಯಿಲೆಗಳು/ಗಾಯಗಳು.
8. ಯಾವುದೇ ಶುಶ್ರೂಷೆ ವೆಚ್ಚ, ಸಾಮಾನ್ಯ ನಿರ್ಬಲತೆ, ಆಜನ್ಮ ಹೊರ ಕಾಣುವ ರೋಗಗಳು.
9. ಚಿಕಿತ್ಸೆಗೆ ಹೊರತಾಗಿ ವಿಟಮಿನ್ ಹಾಗೂ ಟಾನಿಕ್‌ಗಳ ಮೇಲಿನ ವೆಚ್ಚ.
10. ಏಡ್ಸ್ ತರಹದ ಕಾಯಿಲೆಯಿಂದ ನೇರವಾಗಿ ಹಾಗೂ ಪರೋಕ್ಷವಾಗಿ ಆಗುವ ವೆಚ್ಚ.

● ಪರಿಹಾರ ಪಡೆಯುವ ವಿಧಾನ

ಚಿಕಿತ್ಸೆಗಾಗಿ ಆಸ್ಪತ್ರೆ ಸೇರಿದ 7 ದಿನದೊಳಗಾಗಿ ಮೊದಲ ಸೂಚನೆಯನ್ನು ಲಿಖಿತ ಮೂಲಕ ಕಂಪನಿಗೆ ಕೊಡತಕ್ಕದ್ದು. ಆಸ್ಪತ್ರೆಯಿಂದ ಬಿಡುಗಡೆಯಾದ 30 ದಿನಗಳೊಳಗೆ ವಿಮಾ ದಾಖಲೆಯನ್ನು ಆಸ್ಪತ್ರೆಯ ವೆಚ್ಚದ ಎಲ್ಲಾ ರಶೀತಿಗಳು ಮತ್ತು ಸಂಭಂದಪಟ್ಟ ವೈದ್ಯಕೀಯ ಪತ್ರದ ಜೊತೆಗೆ ಕಂಪನಿಗೆ ನೀಡತಕ್ಕದ್ದು.

Community Health Insurance in India

An Overview

Community health insurance is an important intermediate step in the evolution of an equitable health financing mechanism such as social health insurance in Europe and Japan. Social health insurance in these countries, in fact, evolved from a conglomeration of small 'community' health insurance schemes. Historically, during the peak of the industrial revolution workers' unions developed insurance mechanisms which were eventually transformed. Community health insurance programmes in India offer valuable lessons for policy-makers. Documented here are 12 schemes where health insurance has been operationalised. The two following articles describe in some detail two successful community health projects.

N Devadasan, Kent Ranson, Wim Van Damme, Bart Criel

According to the World Health Organisation, greater than 80 per cent of total expenditure on health in India is private (figure for 1999-2001 [World Health Organisation 2004]) and most of this flows directly from households to the private-for-profit health care sector. Most studies of health care spending have found that out-of-pocket spending in India is actually progressive, or equity neutral; as a proportion of non-food expenditure, richer Indians spend marginally more than poorer Indians on health care. However, because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it. On average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill [Peters, Yazbeck et al 2002]. Aside from cases where people believed that their illness was not serious, the main reason for not seeking care was cost. The richest quintile of the population is six times more likely than the poorest quintile to have been hospitalised in either the public or private sector [Mahal, Singh et al 2000]. Peters et al (2002) estimated that at least 24 per cent of all Indians hospitalised fall below the poverty line because they are hospitalised, and that out-of-pocket spending on hospital care might have raised by 2 per cent the proportion of the population in poverty [Peters, Yazbeck et al 2001]. Given this context, health insurance appears to be an equitable alternative to out of pocket payments.

In recent years, community health insurance (CHI) has emerged as a possible means of: (1) improving access to health care among the poor; and (2) protecting the poor from indebtedness and impoverishment resulting from medical expenditures. The World Health Report 2000, for example, noted that prepayment schemes represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes (World Health Organisation 2000).

Various other terms are used in reference to community health insurance, including: 'micro health insurance' [Dror et al 1999], 'local health insurance' [Criel 2000] and 'mutuelles' [Atim C 2001]. We define CHI (along the same lines as [Atim 1998]) as "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." CHI schemes involve prepayment and the pooling of resources to cover the costs of health-related events. They are generally targeted at low-income populations, and the nature of the 'communities' around which they have evolved is quite diverse: from people living in the same town or district, to members of a work cooperative or micro-finance groups. Often, the schemes are initiated by a hospital, and targeted at residents of the surrounding area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory.

Internationally, there is a shortage of empirical evidence to assess whether or not CHI schemes have improved access and financial protection among the poor. Enthusiasm for such schemes was fuelled in part by studies showing disproportionate increases in utilisation among the poorest with the implementation of insurance [Yip and Berman 2001] or mandatory prepayment schemes [Diop, Yazbeck et al 1995] in developing countries. But studies of voluntary CHI schemes have yielded less promising results. The studies and reviews that have been undertaken suggest that many schemes are short-lived and fail even to meet the goals they set for themselves [Bennett, Creese et al 1998]. Often, the schemes enrol relatively small populations (of 1,000 people or less) thus limiting the extent to which there can be pooling and resource transfers (International Labour Office (Universitas Programme) 2002). Furthermore, CBHIs have tended to exclude the poorest among their target populations, in part because they generally charge a flat (or uniform) premium that is unaffordable to the poorest. Under the three schemes reviewed by Preker et al [Preker, Carrin et al 2001] in Rawanda, Senegal and India, even among the insured, low income remained a significant constraint to health care utilisation.

The purpose of this paper is to describe Indian CHI schemes, and where data are available, their impact – it is intended to serve as an update on earlier work by one of the authors [Ranson 2003]. In India, community health insurance has a long history. The earliest such scheme was started in Kolkata in 1952 as part of a student's movement. The Student's Health Home (SHH) caters to the students in the schools and universities of West Bengal. Currently there are more than 20 documented CHI programmes, of which five were initiated in the past three years. Based on visits to twelve of the schemes, the authors describe the context in which they are operational, their design and management, the administrative challenges faced by them, and their impact. The names and locations of the programmes included in this summary are given in the accompanying table.

Underlying Objectives

Most of the insurance programmes have been started as a reaction to the high health care costs and the failure of the government machinery to provide good quality care. The objectives range from "providing low cost health care" to "protecting the households from high hospitalisation costs." BAIF, DHAN, Navsarjan Trust and RAHA explicitly state that the health insurance scheme was developed to prevent the individual member from bearing the financial burden of hospitalisation. Health insurance was also seen by some organisations as a method of encouraging participation by the community in their own health care. And finally, especially the more activist organisations (ACCORD, RAHA) used community health insurance as a measure to increase solidarity among its members – "one for all and all for one."

Context

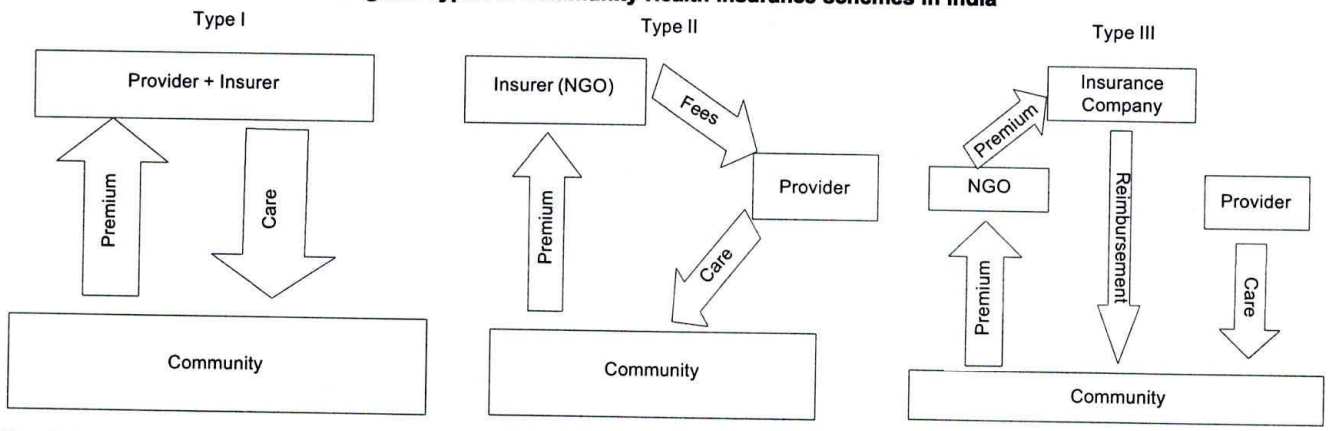
Almost all the 12 CHIs are based in rural or semi urban areas, working among the poor. This ranges from tribal populations (ACCORD, Karuna Trust, RAHA), dalits (Navsarjan Trust), farmers (MGIMS, Yeshasvini, Buldhana, VHS), women from self help groups (BAIF, DHAN) and poor self-employed women (SEWA). The size of the target population (i e, the population from which they aim to draw members) ranges from a few thousands to 25 lakh (Yeshasvini trust). Most of them (eight of the twelve) use existing community based organisations to piggyback the health insurance programme. While in some it is the existing self help groups (SHGs), e g, DHAN, BAIF; in others it is a union (SEWA, ACCORD and Navsarjan). In two others it is the cooperative movement (Yeshasvini and Buldhana). These community-based organisations have been a useful platform to explain the principles of health insurance to the community, for collecting premium and for managing claims and reimbursements. And most important, they have instilled a sense of ownership of the insurance programme among the community.

In India, there appears to be three basic designs, depending on who is the insurer (see the Figure). In Type I (or HMO design), the hospital plays the dual role of providing health care and running the insurance programme. There are five programmes under this type. In Type II (or Insurer design), the voluntary organisation is the insurer, while purchasing care from independent providers. There are two programmes under this type. And

Table 1: 12 CHI Schemes in India

Name and Location of the CHI As Well As Year of Initiation	Target Population	Type	Remarks
ACCORD Gudalur, Nilgiris, Tamil Nadu 1992	Scheduled tribes of Gudalur taluk who are members of the Adivasi Munnetra Sangam (AMS) – the tribal union. (N = 13,070 individuals)	Type I	Linked with the New India Assurance Company
BAIF Uruli Kanchan, Pune, Maharashtra 2001	Poor women members of the community banking scheme and living in the 22 villages around Uruli Kanchan town. (N= 1,500 women)	Type III	Linked with United India Insurance Company
BULDHANA Urban Cooperative and Credit society. Buldhana, Maharashtra	Farmers living in Buldhana District (N = 175,000)	Type III	Linked with United India Insurance Company
DHAN Foundation Kadamalai block, Theni district, Tamil Nadu 2000	Poor women members of the community banking scheme and living in the villages of Mayiladumparia block. Total of 4,514 members and their families. (N = 19,049 individuals).	Type II	No linkages. The women operate the scheme by themselves
Karuna Trust T Narsipur Block, Mysore District, Karnataka 2002	Total population of T Narsipur block and Bailhongal block, with a focus on scheduled tribes and scheduled caste populations. (N=634,581 individuals)	Type III	Linkage with National Insurance company
MGIMS Hospital Wardha, Maharashtra 1981	The small farmers and landless labourers living in the 40 villages around Kasturba Hospital. (N = 30,000 individuals)	Type I	No linkages. The organisation operates the scheme.
Navsarjan Trust Pathan District, Gujarat 1999 (discontinued in 2000)	Select scheduled caste individuals in two blocks of Patan district, north Gujarat (N= ?)	Type III	Linkage with New India Assurance Company
RAHA Raigarh, Ambikapur, Jashpur and Korba districts of Chhattisgarh 1980	Poor people living in the catchment area of the 92 rural health centres and hostel students. (N = 92,000 individuals).	Type I	Have their own providers
SEWA 11 districts of Gujarat 1992	534,674 SEWA Union women members (urban and rural), plus their husbands living in 11 districts (N = 1,067,348 individuals).	Type III	Linkage with National Insurance Company
Student's Health Home Kolkata, West Bengal 1952	Full-time student in West Bengal state, from Class 5 to university level. (N=5.6 million students)	Type I	Have their own health facilities
Voluntary Health Services centre. Chennai, Tamil Nadu 1972	Total population of the catchment area of 14 mini-health centres in the suburbs of Chennai. (N= 104,247 individuals in two blocks)	Type I	Have their own hospital and health
Yeshasvini Trust Bangalore, Karnataka 2003	Members of the cooperative societies in Karnataka (N = 25 lakhs)	Type II	Operate their own programme

Figure: Types of Community Health Insurance schemes in India



Type I: ACCORD, MGIMS, RAHA, SHH, VHS

Type II: DHAN, Yeshasvini

Type III: BAIF, Buldhana, Karuna Trust, Navsarjan, SEWA

finally in Type III (or Intermediate design), the voluntary organisation plays the role of an agent, purchasing care from providers and insurance from insurance companies. This seems to be a popular design, especially among the recent CHIs, with five of the 12 adopting this. The insurance companies are mostly the GIC subsidiaries, e g, National Insurance Company, the New India Assurance Company, the United India Insurance Company, etc. Of late private insurance companies like the Royal Sundaram, and ICICI Lombard have been involved with CHI programmes.

As most of these programmes serve the rural poor, the premiums also have been low; in the range of Rs 20 to Rs 60 per person per year. Only three programmes had premiums higher than Rs 100 per person. The premium is usually paid as a cash contribution once a year during a definite collection period. Two schemes (RAHA and MGIMS) allowed the community to pay equivalents in kind. The community and their representatives as well as the staff of the voluntary organisation helped with the collection of the premium, e g, at Yeshasvini, the premium collection is organised through the existing cooperative infrastructure. Enrolment to the insurance programme ranged from a thousand to seventeen lakhs (Yeshasvini).

At most of the schemes, the unit of enrolment is the individual and membership is voluntary. While some of the schemes encourage family membership by providing a family package/rate (e g, DHAN, Vimo SEWA and VHS), none requires enrolment of the whole household. However, several of the schemes do enrol groups rather than individuals – enrolment in these same schemes is to some extent 'mandatory', and they come to resemble social insurance schemes as a result. At Karuna Trust, for example, the cost of the premium is entirely subsidised for the poorest among the target population – the BPL-SC/ST – who are automatically enrolled in the scheme. Some of the self-help groups at DHAN purchase insurance for all SHG members (generally 15 to 20) out of profits earned by the SHG (i e, certain SHGs have chosen to make the scheme mandatory). At SHH, once a school or institution registers, then it becomes mandatory for all the students to pay the premium.

As stated earlier, while some of the CHI schemes limited the benefit package to only ambulatory care, the twelve studied by the authors all provided inpatient care. Some also provided out patient care as well as outreach services. It is observed that the community prefers to have both outpatient and inpatient care. Most schemes had important exclusions like pre-existing illnesses, self-inflicted injuries, chronic ailments, TB, HIV, etc. One scheme covered only surgeries, all other medical conditions being excluded. While most of the schemes reimbursed direct costs of treatment (consultation, medicines and diagnostics), one scheme (Karuna Trust) also reimbursed loss of wages for the patient. Some CHIs had also added other benefits, e g, life insurance, insurance against personal accident and/or asset insurance into the package to make it more attractive to the community.

In the Type I CHIs, there is a cashless system of reimbursement. However, in the other two types, usually it is a fixed indemnity with patients having to settle bills and then getting it reimbursed 2-6 months later from the NGO. The exception was the Yeshasvini scheme, which, though a Type III scheme, had managed to negotiate a cashless system with the private sector by using the services of a Third Party Administrator (TPA). Most of the CHIs have a fixed upper limit, ranging from Rs 1,250 to Rs 1,00,000 per patient per year.

Most of the providers are from the private sector – either for profit or not-for-profit hospitals. Only one CHI (the Karuna Trust) had a public sector provider. In the Type I schemes, where the insurer is also the provider, there is an attempt to maintain quality and keep costs down. For example at ACCORD, the hospital largely uses only essential and generic drugs. However, in the Type II and Type III schemes, where the provider is mostly the private sector, we did not find any evidence of cost containment or quality checks. Yeshasvini was the exception, where they have managed to negotiate capitation fees for each surgery. At SEWA, there is an ongoing initiative to empanel select hospitals (primarily government and trust hospitals) judged to be providing a high standard of care.

As stated earlier, most of the schemes are administered by the community, their representatives or by the voluntary organisation staff. This helps keep costs down. Usually they handle the following activities:

Creating awareness among the community; collecting premium (at ACCORD, the sangam leaders collect the premium and hand it over to the NGO); monitoring for fraud (DHAN has an insurance committee comprising of SHG members who scrutinise every single claim); submitting claims; and channelling the reimbursements (at BAIF, the reimbursements are sent to the local SHG who while handing over the amount to the patient, reinforces the benefit of insurance). All these activities help in increasing the efficiency of the scheme. Also it helps build a sense of ownership among the community and increases accountability.

One of the weaknesses of the CHIs is the lack of techno-managerial expertise. This is reflected in the fact that most of them do not have inbuilt mechanisms to prevent adverse selection or moral hazard. Due to the asymmetry of information, it is possible that only the sick enrol in these schemes (adverse selection). Simple measures like a larger enrolment unit, a mandatory enrolment, a definite collection and waiting period are measures to prevent this. While all (except VHS) have a definite collection period, other measures are usually not used. SHH to a certain extent overcomes adverse selection by using the institution as an enrolment unit.

Similarly, because of the insurance programme, the behaviour of the patient or the provider may change (moral hazard). Capitation fee structures, standard treatment guidelines and copayments are some strategies to prevent this. The only measure consistently used by most CHIs to reduce the patient induced moral hazard is co-payments and deductibles.

The absolute number of enrolees varies tremendously, from only 909 at BAIF (scheme is only in its second year) to as many as seventeen lakhs at the Yeshasvini programme. The average subscription rate varies from 10 to 50 per cent of the target population. Except at Vimo SEWA, there has been no study as to why the rest of the target population are not subscribing, but during the interviews, some of the reasons for not paying were elicited. These included:

(1) No immediate benefit; (2) premium too high; (3) "we are well, why should we pay in advance? When we fall sick, we shall pay"; (4) large families – this is specially since most of the CBHI's unit of membership is the individual; (5) "(Insurance scheme) Hospitals are far away and so we have to pay a lot to access hospitalisation. Better use the premium money to go to a nearby doctor"; and (6) "we pay every year, but do not get any benefit out of it. So we have decided not to pay anymore".

There is tremendous variation in terms of claims submitted annually for inpatient care, ranging from only 1.4/1,000 insured per annum to more than 240/1,000 insured per annum. Among schemes with the highest rates of utilisation, adverse selection appears to be responsible for the high rates.

Among schemes with low rates of utilisation, it appeared that not enough had been done to address non-financial barriers to accessing health care. The indirect costs of health care are not addressed by the schemes (Karuna Trust being an exception), and in many of the schemes, the direct costs are only covered up to a 'cap' or 'ceiling' (as at DHAN, RAHA and SEWA). Even at those schemes that do not have a cap (e g, SHH), non-financial barriers may prevent people from utilising the scheme (e g, distance, lack of knowledge about the scheme, limited awareness of health/illness, etc.)

In terms of their ability to protect individuals and households against the catastrophic costs of health care, the schemes again seem to vary considerably. Those that provide the greatest degree of protection have the following characteristics: (1) Cover 100 per cent of the direct costs; (2) cover all (or at least some) of the indirect costs; (3) cover all kinds of illness (e g, all non-elective causes of hospitalisation, including complications of delivery, chronic illnesses); and (4) provide benefit right at the source of health care, i e, with no period during which the patient has to cope with the costs of care. Thus, it was generally the Type I schemes, which provide health care directly, and usually with no upper limit to the financial benefits, that provided the greatest degree of protection.

An important question is about the financial viability of these 'small' schemes. Of the 12 studied, four (BAIF, DHAN, Buldhanha and Yeshasvini) are run purely on funds raised from the community. All the Type I schemes have supplemented the locally raised resources with external resources (either from the government or donors). These external resources range from 20-40 per cent of the total reimbursements. Only two have relied exclusively on external resources. Unfortunately, it was difficult to get accurate financial estimates of the administrative costs, especially since a lot of this is subsidised by the community.

Financing health care has always been a very difficult exercise. Even in rich countries like the US, there does not seem to be enough for all. It becomes all the more challenging in a low-income country like India. While the Constitution of India promises to provide adequate health care to the population, successive governments both at the state and the centre have failed in many ways to do so. This is probably one of the reasons why the majority of the public turns to the private sector for their health care needs.

Another equitable method of health financing is the social health insurance – seen in most European countries. Given the low percentage of workers in the formal sector, this appears to be a distant dream. However, these European (and Japanese) social health insurances have actually evolved from a conglomeration of small 'community health insurance schemes'. Historically, during the peak of the industrial revolution, worker's unions developed health insurance mechanisms to protect their members. This gradually developed into today's social health insurance [Ogawa et al 2003; Barnighausen T et al 2002]. Thus community health insurance can be seen as an important intermediate step in the evolution towards an equitable health financing mechanism.

The community health insurance programmes in India offer valuable lessons for the policy-makers and the practitioners of health care. While many state that the poor in India cannot understand the complexities of health insurance and will not accept any insurance product, we hereby document 12 schemes where health insurance has been operationalised. It is clear that what is required is a good product. Some of the conditions that have allowed these schemes to succeed are:

– An effective and credible community based organisation (or NGO). This is absolutely necessary as it is the foundation on which health insurance can be built. The CBO helps in disseminating information about health insurance and more importantly helps in implementing the programme with minimum costs.

– An affordable premium – this is very important. While most health insurance products (even for the poor) have premiums in the range of Rs 100 plus per member per year, we find that people are willing to pay only in the range of Rs 20 to 60 per person per year. This is significant, and needs to be taken into account by the insurers if they want their products to penetrate the rural market.

– A comprehensive benefit package is necessary to convince the community of the benefits of health insurance. Most of the CHIs documented, especially the Type I schemes have provided a comprehensive package and this is one of the main reasons why people have enrolled in their schemes. Unfortunately, most of the Type III schemes (except for Karuna Trust) have been forced to introduce exclusions by the insurance companies. While most insurance companies introduce exclusions, based on economic reasons, one has to look at health insurance within a public health context. Diseases like TB, HIV and mental illnesses have significant public health importance and should be covered. Similarly it is ironic that while the country has invested tremendously in safe deliveries, most health insurance products do not cover it. And finally as India enters an epidemiological transition and

will have to encounter chronic diseases like diabetes and hypertension, it becomes imperative that these diseases are included in the benefit package.

– A credible insurer is imperative for people to have faith in the product. This is where the NGOs and the CBOs score as they have a relationship with the community and so the people are willing to trust them with their money. Insurance companies need to learn from this important lesson and would need to approach the rural sector keeping this in mind.

– And last but not the least, the administration load of the scheme on the community should be minimal. Unnecessary documentation lead to frustration. In one of the schemes a community member mentioned that she had to pay more to get the certificates than she got in reimbursement. This is where the Type I and Type II schemes score over the others.

Many would dismiss community health insurance as a drop in an ocean. It may appear insignificant, given the scale of the problem in India. But, one needs to look at it in context. One of the main lessons from these case studies is the fact that a good community based organisation can help develop an effective community health insurance programme. And India is teeming with such organisations – be it the trade movement, or the cooperative movement. So upscaling should not present a problem if one uses these existing institutions. Already there are examples of community health insurance being introduced in the dairy cooperative sector (Mallur, Karnataka and Anand, Gujarat); the head loaders union (Mathadi trust in Mumbai), shop owner's union (Palakad, Kerala). The possibilities are endless, if approached properly.

However, one needs to mention a word of caution. The main pitfall in developing community health insurance is to find an appropriate provider. The Indian private health sector is unregulated and unaccountable [Bhat 1999]. In this context, introducing health insurance can lead to uncontrolled cost escalation without the promise of quality [Ranson and John 2001]. So it becomes imperative that while considering community health insurance, one should seriously consider mechanisms to introduce measures for cost containment, assuring quality and ensuring standard treatment practices. And this is where the CBO (or NGO) can play a crucial role, by countering the power of the providers. The CBO could negotiate with the providers and develop a package that is conducive for the patients and the CHI."

Yet another issue is the legality of these schemes, given the new Insurance act (IRDA Act 1999). Currently the act does not acknowledge the presence of these schemes and their role in the larger insurance market. This could also be the reason why many of the newer schemes have linked up with the formal insurance companies – to legitimise their activity. But in the process, they may have lost on the flexibility and innovations necessary for a successful CHI.

The other issue that needs to be addressed is that of financial sustainability. The very fact that many of them have been operational for more than a decade, itself is proof that it may be a sustainable form of health financing. While accurate financial data about the schemes were not available easily, rough estimates show that they are able to raise about 60 to 100 per cent of their resources. This has important policy implications, as it gives an indication towards the amount subsidy required to make these schemes viable. And given the fact that most of these schemes target the poor, it is important that the government comes forward to subsidise this equitable health financing mechanism.

In a country with one of the highest out of pocket health care expenditure in the world, it is imperative that some measures be instituted to protect the poor. We suggest that community health insurance could be an interim strategy to finance the health care of the people; till a more formal social health insurance is in place. We also suggest that this is a feasible alternative given that community based organisations and movements exist in India. What is required is to regulate the providers and to legislate so that the community health insurance programmes find a space within the Indian insurance context. EPW

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(For Private Circulation)

Health Insurance Scheme (HIS):

Chechady Valley

A Study
(11.12.03 – 30.12.03)

by
Dr. Mathew P. Abraham, C.Ss.R – MD (Community Medicine)
Sr. Prabha, HC – Director CHABI

Mahuadanr
10.01.04

CONTENTS

I INTRODUCTION

In this 3rd Millennium, with all the modern technology, knowledge and so many health professionals, why should people die prematurely of malaria, diarrhoea and other preventable diseases ? This is the reality of many of the villages in Jharkhand even today ! what is wrong with the current medical profession ? Commercialization ? profit motives ? Alma ata declaration (1978) recommended primary health care as a means to achieve health for all. All over the world, we still have health professionals committed to Primary Health Care. The health network of Chechady valley (Jharkhand) remains as a beacon of hope to this commitment.

What is impressive about the Chechady valley is the marvelous work done by the Missionaries over a century. The pioneering work of the Jesuits, the building up of tribal communities, the establishment of strong infrastructure in the form of parishes, health centres and schools covering about 120 villages in the Valley need to be definitely appreciated. Another inspiring fact of the Valley is the work of the sisters of various congregations who silently make a difference in the lives of the people. They save the lives of thousands of people who are brought to them with very little trace of life left in them. They are brought with cerebral malaria, tetanus, typhoid complicated abortions, and so on. More over they make a difference in the lives of many more through health promotion and prevention with the help of the health workers and dais.

Health Insurance Scheme (HIS) of Chechady : A matter of pride

Today there are many agencies who try to build up self financing schemes for health care. They have various intentions ; some are profit oriented and some are people oriented. About 15 years ago inspired by RAHA model, Fr. Peter Jones and Fr. Ignatius initiated the HIS of Mahuadanr. This was done in the context of many poor people dying without accessing even the available medical care facility due to poverty and ignorance. The acceptance of HIS by the people was overwhelming and it flourished with great enthusiasm. People's contribution was given in kind (rice). A year ago, the premium was changed from kind to cash. This and some other factors weakened the scheme. CHABI's interaction with the health worker's lead to the realization that a scientific study need to be undertaken about the HIS, as early as possible.

II. AIM :

- To study and Document the Health Insurance Scheme (HIS) of the Chechady Vally.

OBJECTIVES :

1. To study the History especially the background and the process of evolution of the HIS from its inception till now.

2. To critically evaluate the strengths and the weaknesses of the HIS.

3. To document the experiences and opinions of the people involved in the HIS at various levels.

III METHODOLOGY :

- In depth interviews
- Group discussions
- Studying relevant documents

Table I : In depth Interviews

Sl. No.	Date of visit	Name	Desig-nation	Congregation	Place	No. of villages covered	HIS Yes / No
01	13.12.03	Mr. Fulgence	Health worker Carmel Hospital	--	Mahuadanr	25	Yes
02	13.12.03	Sr. Philo	Nurse (ANM)	St. Joseph of Taubs	Pakripat	15	Yes
03	15.12.03	Sr. Sushma	Nurse	Srs. of Charity of Nazareth	Salae	19	Yes
04	15.12.03	Sr. Pyari Assa	Nurse (ANM)	Srs. of St.Joseph of the Aparision	Tundtoli	11	Yes
05	17.12.03	Sr.Rithamma	Nurse	St.Joseph of Taubs	Mayapur	35	Yes
06	18.12.03	Sr. Assumta Toppo	Nurse	Hand Maids of Mary	Chatma	6	No
07	19.12.03	Ms. Suchita Tigga	Nurse (ANM)	Holy Cross	Gothgav	15	Yes
08	20.12.03	Fr. Ignatius	HIS Director & Parish Priest	S.J	Mahuadanr	--	--
09	22.12.03	Sr. Prema Xalxo	Nurse	Disciples of Don Bosco	Dhawna	10	No
10	23.12.03	Sr. Rosalind	Administrat or Carmel Hospital	CMC	Mahuadanr	--	--

Table II : Group Discussion[1]

Sl. No.	Date	Name of village	Clinic Area	Participants (Number)
01	23.12.03	Rega - Tonkatoli	Carmel Hospital	Villagers (13)
02	29.12.03	Parhi - Kenatoli	Carmel Hospital	Villagers (30)
03	29.12.03	-	Carmel Hospital	Health Workers (14)

IV. Results of the Study

1. Terms & Conditions of the health insurance scheme (HIS)

1. A minimum of 20 families are required to start the scheme in any particular village.
2. Each member deposit 5 Kg. Rice or equivalent Money to the church authority.
3. One leader is chosen from each village for voluntary service, she or he gets trained and receives a medical kit with emergency medicines.
4. Each member goes to this Health Worker (H.W) at the beginning of illness for treatment. H.W keeps a register and enter the name and treatment given. Reports are submitted to the centre during monthly meetings of all the health workers in the centre.
5. When H.W. fails to manage the case, patient is referred to the dispensary or the hospital with a letter and the scheme number. Treatment given should be mentioned in the referral letter.
6. Total cost benefit for the year is Rs.750/- for each member.
7. To continue membership, each member should attend the monthly meeting held in the villages by the respective staff.
8. Pregnant women ought to go for antenatal care at least thrice during pregnancy to benefit from the scheme incase of complications.
9. Any self induced illness (such as complications of induced abortion) will not benefit from the scheme.
10. Members are taught about the mutual benefit of the scheme and the value of helping one another.
11. Members are advised to complete all vaccinations available for adults and children
12. If a pregnant woman is a member, her child at birth is also eligible for scheme benefit for that year.

Members are paying about 25% of the total cost and the Jesuit Society covers the balance amount. There are seven dispensaries in the insurance scheme area. HIS members, go to the dispensaries for the initial treatment-referred by the health workers from the villages. Carmel Hospital functions as a secondary care centre Hospital and the dispensaries send timely bills to the church authority and get it paid from them. Monitoring and evaluation is done by the community health staff.

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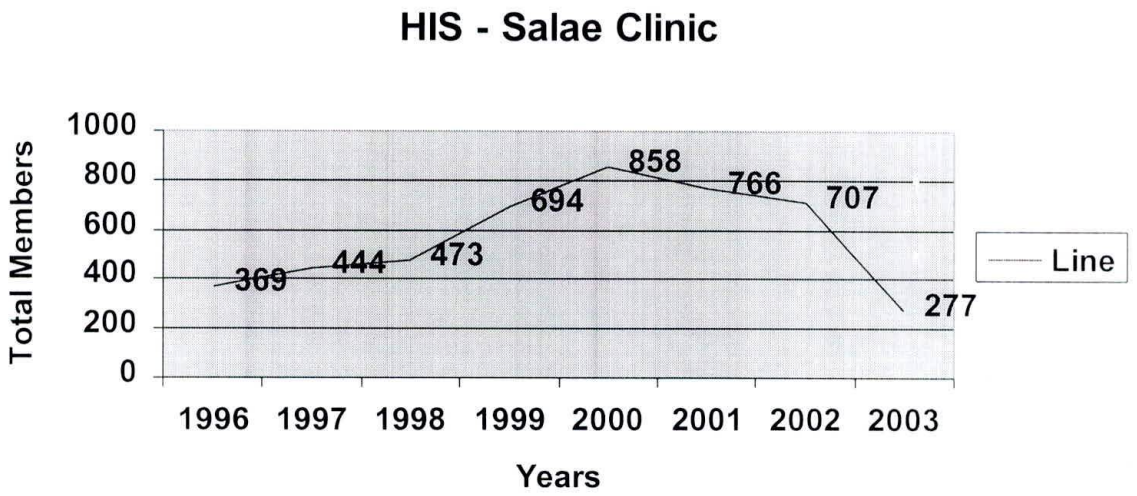
[1] - Rega – Tonkatoli was chosen because out of 30 families there, 24 were part of the HIS for the past few years.
- Parhi Kenatoli was chosen because out of 50 families none of them were part of the HIS.
- 14 health workers were those who came for the meeting in Carmel Hospital. The total no. of health workers of Carmel are 24.

Table – III

2. **Membership Pattern over the years**

Year	1996	1997	1998	1999	2000	2001	2002	2003
Total Members	369	444	473	694	858	766	707	277
Total families	76	85	106	160	184	158	166	63

Graph - I



Graph - II

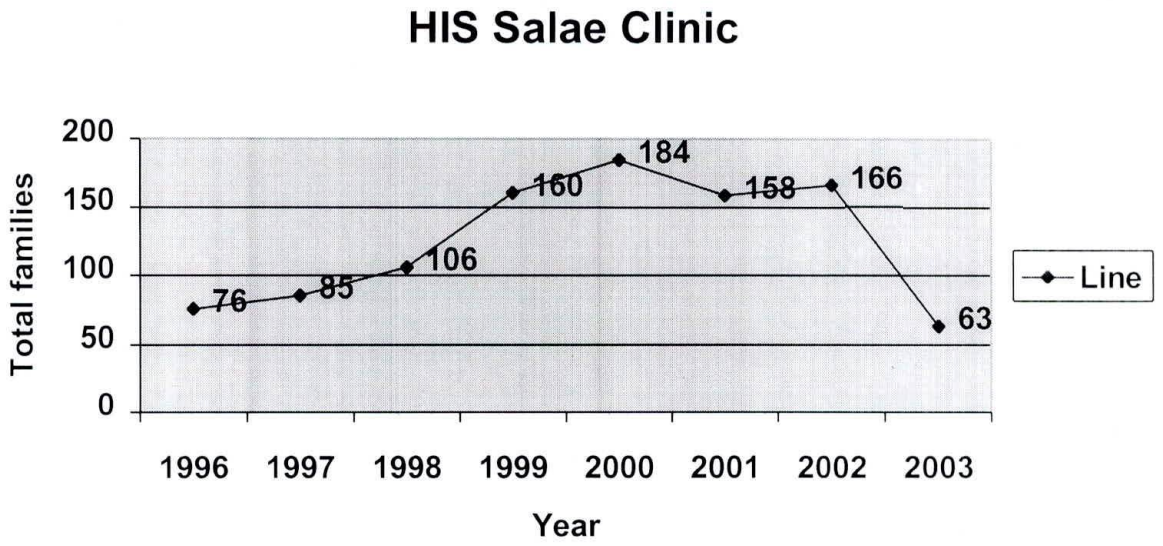
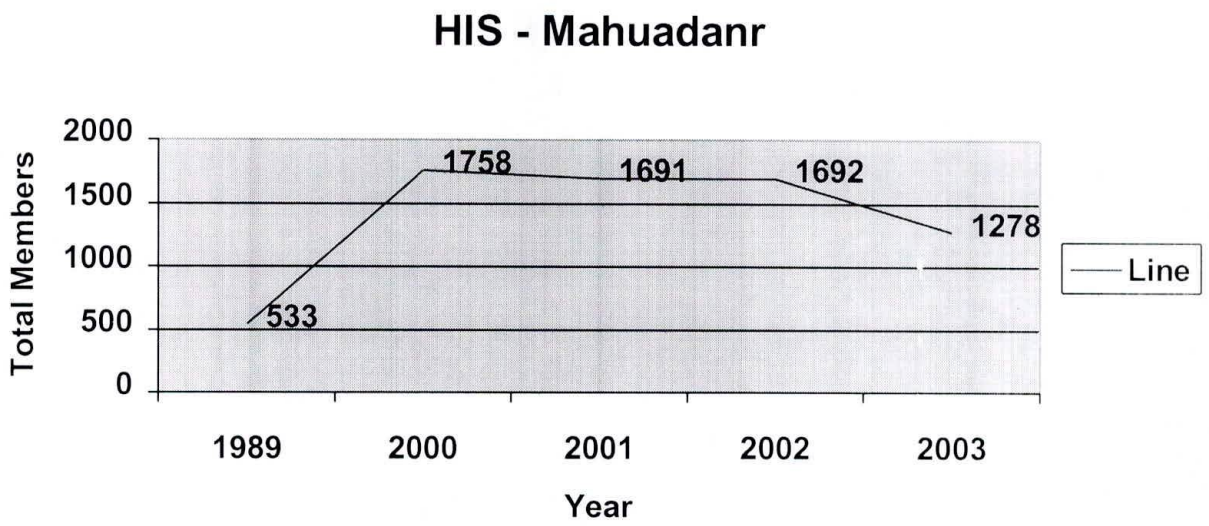


Table - IV

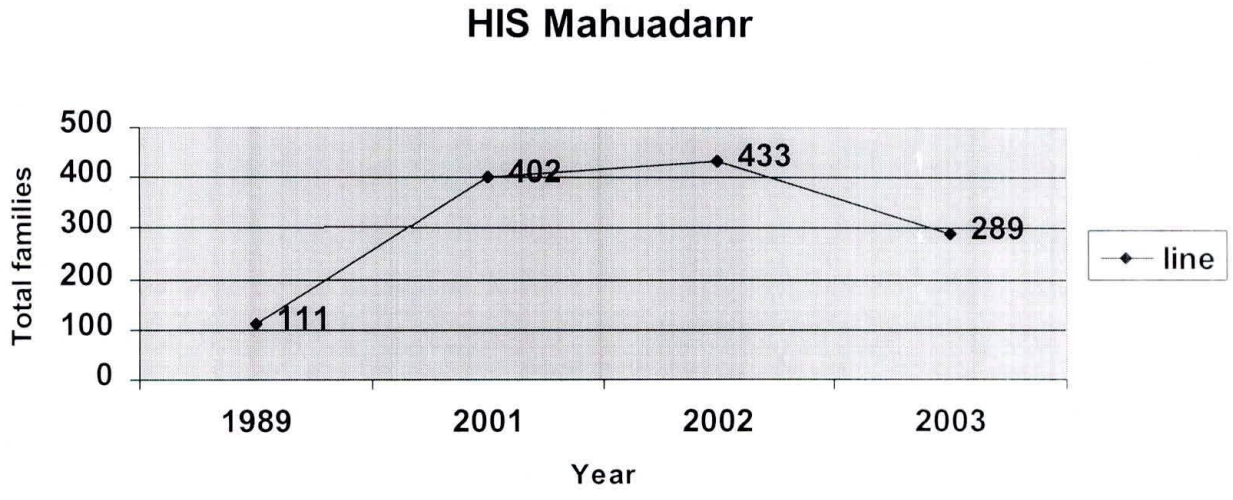
HIS Mahuadanr

Year	1989	2000	2001	2002	2003
Total Members	533	1758	1691	1692	1278
Total families	111	N.A	402	433	289

Graphs - III



Graphs - IV



3. **Issues that came up during the interviews/Discussions:-**

➢ **Director of HIS (Fr. Ignatius)**

- He feels that the scheme is in a declining phase and fears that it might die out eventually
- The expense every year is about Rs.5 lakhs and the income is very low (Rs. 2 Lakhs – 1 Lakh as interest on capital and 1 lakh as collection from people)
- According to him, reasons to change from kind (Rice) to cash were these:-
  - Rice collected were of mixed variety
  - In the previous years selling of this rice was easy. People used to buy. Now people buy from market and can afford to buy better quality rice.
  - Many people in the scheme were selling their good quality rice in the market, buying the cheapest quality from market and was giving it for the scheme.

➢ **Sr. Nurses of the peripheral clinics:**

- Of the 8 clinics in Chechadi valley, 6 of them were very much aware of the HIS. Two of them (Dhawna and Chatma) were not aware of the scheme. They too have been going regularly for the bimonthly gathering of the nurses of the Chechdi area. According to Dhawana & Chatma nurses these was no HIS for the people of those areas.

- Rest of the 6 clinics (Mahuadanar, Pakripat, Sale, Tundtoli, Gotgav and Mayapur) have HIS running quite active. All of them were of very high opinion about the scheme. All of them said that this scheme is of a great help for the people especially the poor.

- All the 5 clinics felt that in the past 2 years the scheme is loosing popularity among people and is slowly facing a decline. (some even expressed the anxiety that the scheme might die out eventually). This was evident from the statistics of the past years from what ever limited documents which were available (Ref. Table III & IV and graphs)

Some of the reasons that were mentioned for this decline were these:-

1. Lack of proper communication between the centre (Mahuadanr), the peripheral units (clinics) and people.
2. The centralized decision making without involving the peripheral units (Sr. Nurses) or the people's representatives (VHWs / Panches)
3. Lack of sense of belongingness of the peripheral units to the scheme - Almost all of them felt that the HIS was a Jesuit's scheme not the people's scheme. " Mahuadanr ka scheme he na ? ". Hence many of the sisters as well as health workers are slowly loosing their enthusiasm to work towards the progress of the scheme.
4. Shift of premium from kind (rice) to money (Rs.60/-) and again raising it to Rupees 80/- in the immediate next year.
5. Some peripheral clinics even felt that there is too much of formalities and difficulty to get the expenses reimbursed from the centre. (Availability of the Director)

6. False Propaganda against the HIS by some people with vested interests

Eg. a) The money lenders – village compounders etc.

These people propagate that :-

- Fathers are enjoying with the money collected from people.
- Those who are in the HIS are given second grade medication
- They will be converted into Christianity.
-

➢ **Health Workers meeting:-**

- HIS is a good scheme for the poor. They can access health care any time of the year even when they do not have money with them.
- For serious cases they can access to transportation (ambulance) too.
- HIS protects the poor from exploiters like – Compounders and money lenders
- If the HIS dies, diseases (esp. Malaria) still continue and poor people have to generate money by :-
  - borrowing from money lenders
  - selling animals, field or other possessions
  - getting into bonded labour for 3 – 4 yrs for just Rs.1000, where they will be given only food as wages.
- HIS Motivates people to attend monthly village meetings and thus get more informed about health and diseases.
- People want to continue in the HIS, but the increase in premium to Rs.80/- is affecting them, especially the big families. In spite of the increase in premium, even now many people are motivated to continue in HIS. " Its difficult for us, but some how we will raise Rs.80/- per head " was their response.
- Fr. Director meets health workers only once a year, (during the 3 day health convention) but has never spoken to them about the HIS.

➢ **Meeting with Beneficiaries :-**

a) Rega Tonkatoli

- All of them expressed that it is a very good scheme. It is of great help for the people.
- They found it difficult when the premium was shifted from kind (rice) to money.
- They were not even aware about the rise in premium from Rs.60/- to Rs.80/-. Not even the health workers or the panch were aware of it.
- According to them health is still a priority ; but health is the last issue discussed in the village as well as the parish meetings. Hence health issues receive only little time for discussion and also by that time half of the crowed would have dispersed. (Am Sabha)
- When asked, " if the scheme dies ? " this was their response – " Those who have money will go to the hospital. Poor will remain in the village and die "

b) Parhi Kenatoli:-

- In 1990 – 20 families were members of the HIS
  1991 – 17 families were members of the HIS
- They too feel that it's a good scheme
- During 1990, '91 some were benefited from the HIS, but not all those who were members. Those who were not benefited from HIS got discouraged and dropped out. Still some wanted to join the HIS but could not because of the '20 familes norm ' in the rule.
- When asked how many familes might join if the 20 family norms is relaxed they said that 10 – 15 families might join the HIS.

4. Suggestions that came from the stake holders:-

- Director meeting the above mentioned stake holders on a regular basis to exchange ideas and suggestions
- Collective decision making, by involving the peripheral clinics, health workers, peoples representatives and Director
- Flexibility in rules, terms and conditions according to the situation of the particular villages
- The HIS should be extended to more people
- More awareness creation about HIS should be done through
    - SHGs
    - Parish Priest's of the Chechadi Valley parishes announcing after mass
    - Gram Sabha, Catholic Sabha, Am Sabha etc.
- It is not just lack of awareness : generating so much money immediately is a problem. Hence people should be allowed to pay premium as installments.
- By reviving and propagating the founding philosophy " I am the Caretaker of my Brothers / Sisters too."
- Parish Priests of the peripheral clinic areas also assisting the Sisters in motivating people to join the HIS
- Some fund should be allowed to be handled at the peripheral clinics too.
- Poor harijans and non catholic tribals also should be included in the scheme.
- Reducing expenses by avoiding Medical representatives (Middle men). CHABI or some other common body acting as the agent to bring low cost generic drugs.
- Allow the scheme to die for 1 – 2 years, then people might realize its worth and then request to restart.

V DISCUSSION & RECOMMENDATIONS:-

On the whole stakeholders at all levels feel that the HIS is a very good scheme and it is of great help for the poor. All were worried about the declining trend of HIS especially in the past years. All of them expressed their anxiety about its too much of centralization especially in decision making, bypassing the stakeholders at the health centres and villages. However all of them feel that HIS should be continued and expanded to more people. The Director seemed to be burdened with too many responsibilities, being the Parish Priest and the rector of the S.J. Community. HIS seemed to be very low in the Director's priorities, as he seemed to be struggling for enough time. Documentation at the centre seemed to be grossly inadequate. This was true at the peripheral clinics too.

Hence we suggest the following recommendations for the revival of the HIS.

1. Since the backbone of the HIS is the health personals at the village level (VHW) and Health centre level (Nurses & Doctors), it should be built upon their strength.
2. The HIS needed to be decentralized especially regarding
    - Decision making
    - Collection of funds at the periphery (health centres)
    - In addition to the central fund, it is good to have a health centre fund to cover some of the medical expenses at the health centre and village level.

3. Directorship need to be taken up by somebody for whom HIS is a priority and have enough time to work towards its progress.
4. The communitarian bond, the strong infrastructure, the wealth & resources available in the communities of Chechady Valley has to be mobilized to its maximum potential. This includes generation of some funds for HIS at the local level too, through various income generation projects.
5. A system for documentation need to be developed and proper documents need to be maintained at all levels. These documents can be used for regular evaluation and monitoring of the HIS. This will also help others to learn from its experiences.

VI LIMITATIONS :-

1. Because it was Festival (Christmas) season. The availability of the Director was limited.

2. Since this study was done over a span of just 20 days the researcher could not organize more group meetings with the people at the village level.

3. Since there was limited knowledge of the local language, researcher could not go for ' focus group discussions ' but had to depend on ' group meetings ' with the help of a translator.

4. Lack of availability of sufficient documents, at the centre as well as in the peripheral clinics.

5. One of the peripheral Clinics, Cheropat was left out from the study due to lack of time.

VII CONCLUSION:-

The people of Chechady Valley have decided to walk on a less trodden path by accepting HIS. They are experiencing the positive effect of that decision. At this point of time dark clouds seems to be interfering the growth process of the HIS. When the present health care system prefers to walk through the path of expensive medical care for the rich minority, the great initiative taken in Chechady Valley towards a poor oriented health insurance is a matter of pride. Inorder to sustain the process of growth of HIS a timely intervention is obligatory. Let the poor and the abandoned receive our primary attention.

VIII ACKNOWLEDGEMENT

We express our heartfelt gratitude to the following people for their co-operation and support during this study.

- Fr. Ignatius – SJ, Parish Priest, Mahuadanr
- The Jesuit Community of Mahuadanr
- Dr. Romeo, CMC and the Carmel Hospital team
- The Carmel Sisters Community of Mahuadanr
- Mr. Fulgence and the other health workers of Mahuadanr
- The sisters of the health centers of Chachady Valley
- The people of Rega Tonkatoli and Parhi Kenatoli

30,000 coops – 2½ crores farmers – under cooperatives Dept.

(Health) Coop farmers health care scheme COMH-2A-1
Through all cooperatives open to coop. members + family members @ Rs 60 per head.

Yeshasvini Cooperative Farmers Health Care Scheme

COMH-2A.-

Introduction

A novel Health Care Scheme exclusive for the Cooperative farmers, first of its kind in the country is implemented by the Government of Karnataka.

The scheme was inaugurated by Honourable Chief Minister of Karnataka on 14/11/2002 and launched on 1/6/2003.

Eligibility for membership

A farmer shall be a member of any of the ~~following~~ Prescribed cooperative societies for a minimum period of six months. He/she shall contribute a sum of Rs. 60/- per annum at the rate of Rs. 5/- per month. Government of Karnataka contributes Rs. 30/- per annum towards its share to each farmer. Thus the total contribution is Rs. 90/- per member.

Benefits

Benefit is available to a member for in-patient hospitalisation including the related surgeries can be availed by the members subject to maximum upto Rs. 1 lakh in case of single surgery and upto Rs. 2 lakh in case of multiple surgery. 1600 different types of surgeries related to heart, brain, chest, ear, nose, throat and bones are identified and included in the scheme.

The benefit of the scheme is available to a member upto the age of 75 years. Apart from the member the other members of his/her family are also covered under this scheme subject to payment of Rs. 60/- per annum.

Progress

currently 16 lakhs farmers

Preliminary it was targeted to enroll 25 lakh farmers, for effective implementation of the scheme it was confined to 15 lakh members. As on 31/5/2003, 16.01 lakh farmer members are enrolled and Rs. 9.60 crores is collected towards their contribution.

Government of Karnataka have sanctioned Rs. 4.50 crores towards its share.

network
77 hospitals, – 3 have Yeshasvini counters ; 1600 diseases
Surgery 1L
med " 2L

HRM – for Health Insurance Research fellowship – 16,200 crores for 2½ crores
– Takes 1 wk for hospital to be reimbursed
CGHS delays 6-8 months / >1 yr.
Jan 13/10/03

77 Private Hospitals and Nursing Homes have been identified throughout the State in all the Districts in which the farmer member can avail the benefits under this Scheme. Photo Identity Cards have been issued to all the farmer members and the data of membership is computerised at District level. Yeshasvini counters are opened in all the identified Hospitals.

Monitoring Committees Dist com identifies hospitals, State com - meets weekly

A monitoring committee in each District is set up under the Chairmanship of the Deputy Commissioner of the Districts, with the District Surgeon, District Health Officer as its members among others. Deputy Registrar of the District is the member Secretary. This committee meets every Monday.

Yeshasvini Cell is setup at O/o Registrar of Cooperative Societies. The Additional Registrar (C&M) as its Chairman, Chief Coordinator of the scheme and representative of the implementing agency as its members.

A State Level Monitoring Committee is setup with the Principal Secretary, Department of Cooperation, Government of Karnataka as its Chairman and Registrar of Cooperative Societies, Managing Directors of the Karnataka State Cooperative Apex Bank and Karnataka Milk Federation as its members among others.

Achievement

As on 4th October 2003, 2728 surgeries are performed on the farmer members and 12,745 members are treated as out patients. In all 15,473 farmer members have availed benefit under this scheme.

The following surgeries are done under the scheme –

Gaenocology, Cardiology, Artho, E.N.T., Urology, Gastro, Enthrology, Endoconology, Vaginal Hystrectomy, Repair of Arms, Cyoscopy, CABG, AVR, MVR and General Surgery.

Trust and Third Party Authority

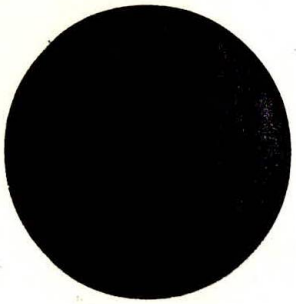
Yeshasvini Cooperative Farmers Health Care Trust is being setup which consists of the following members –

Honourable Chief Minister of Karnataka as Chief Patron.
Honourable Minister of Cooperation as Patron.
Principal Secretary, Department of Cooperation, Trustee
Registrar of Cooperative Societies, Trustee
Managing Director, Apex Bank, Trustee
Dr Devi Shetty, Chairman, Narayana Hrudalaya, Trustee
Dr Alexander Kuruvila, Medical Superintendent, Narayana Hrudalaya, Trustee
Mr A Shankar, Trustee
Dr M D Dixit, Trustee
Dr Guru Dev, Trustee
Director of Sugar, Trustee
Managing Director, KMF, Trustee

Family Health Plan Ltd., a Company incorporated under the Companies Act is being appointed as Third party Administrator licensed by Insurance Regulatory and Development Authority of India (IRDA) to implement the scheme.

Chairman
Yeshasvini Cell and
Additional Registrar of CS(C&M)

medico
278 friend
279 circle bulletin



Nov-Dec 2000

Editorial

Can Health Care Insurance Ensure Right to Health for All?

Issues for Discussion at the January 2001 Annual Meet

Barring the Annual-Meet in Mumbai (1992), the MFC has not conducted systematic discussion on the health care financing in India. The Annual-Meet in Calcutta (1993) that followed Mumbai-Meet, had potential to take up such issue, but it was poorly attended and the issue got lost in debating the stratified system (government funded system for the poor and market based for the rich) proposed by one of the background papers. Even the Mumbai-Meet which did raise some serious issues for reforms in health financing and discussed some of the international experiences, eventually focused more on the problems in private sector and means t egulate it than on the appropriate mechanism for f ncing universal access health care service system in India. This does not mean that financing issues have not been raised and debated from time to time, but they have been largely discussed within a limited framework.

In what sense, then, the next meet will recognise health financing as the central strategic issue for achieving Health For All? There are three important reasons for this optimism. First, health insurance is not new for India, though we did not consider it important enough for discussion except under a few Primary Health Care (PHC) experiments. Employees State Insurance (ESIS) has been in existence almost since independence. Public sector insurance companies have been selling few health insurance plans for some decades now. Many unions have won reimbursement packets for health care, thus making employers to partially self-insure such employees. Hopefully, this meet would force us to look at all such things and their lessons, and broaden our perspective. Second, *insurance is essentially a specific method for financing in a market system.* Permission to allow private health insurance and expectations of its wider acceptance suggest that the paying consumers are dissatisfied with fee-for-service system. The government is looking at it as a policy instrument to expand health care market and the business people see an opportunity for profit. Thus, the Meet will have to evaluate the place of market determined financing system in the strategy for achieving universal access. This has a direct relevance for much talked about public-private partnership, and the time has come to face the issue at the level of financing. And third, by linking the issue of financing with universal access, we are recognising that right to health care is not a negative demand for regulating or restraining the state from interfering with citizens' rights, but a positive demand on the state to intervene for the beneficence or welfare of citizens. In other words, grand, national plans for PHC need to be backed by a national strategy for financing them.

Insurance has an attraction not only for those who consider the health care market a panacea but also for many of those who believe in right to health care. In both cases, the strategy necessitates that people pool their resources to prevent those who happen to fall ill from suffering serious financial difficulties while availing of necessary health care. Secondly, once the group is insured for particular services, it is assumed that the individuals from the group falling sick have guaranteed access to such services. That is, insurance necessarily increases access to health care included in insurance package by the individuals subscribing to it. This commonality is at the base of interest in micro experiments in methods of financing through different types of insurance package by health activists and NGOs. The insurance principle allows pooling of resources for possible risks. This is because insurance is a technique of underwriting risks and providing protection to acceptable risks by insurer. The technique of underwriting classifies and provides rating to each risk based on the information on the occurrence of risk, attaches a specific price for providing specific protection to risk(s), and, on each risk group creates a surplus for profit. Thus, in a classical scenario, the insurer would allow only the group having similar expected and

acceptable risks to pool resources through premium. But at the same time, it ensures that those at higher risk and thus, in greater need of service are kept in separate groups from those who are less at risk and need less service. Correspondingly, the groups at greater risk pay higher premium than groups at lesser risk. Therefore, the market-place inequity existing in direct fee-for-service is brought back. If our objective is to have a system where all have universal access to a defined quantity and quality of health care without financial and social barriers, then this scenario of insurance does not bring us any closer to that objective. At best, it facilitates pooling of resources within the social and health-risk related classes and provides protection with wide variation in quantity and quality of care to each class. This would again reproduce the inequity we are trying to overcome.

There is no space here to explain how insurance actually functions and the plethora of terminologies it uses. It is sufficient to note here that in actual practice, private insurance uses numerous permutation and combinations in order to expand its market, put restrictions on claims, exclude risk-prone individuals and groups, exclude or restrict use of expensive treatment methods, co-finance the risks it insures, and so on. Here, it is sufficient to know that all such permutations and combinations are ultimately based on the above-mentioned principle of classifying, rating and underwriting risks and making profit. For, eventually the market principle asserts, that those who cannot buy health care do not get insured for the health care. Well researched material on insurance show that insurance increases use of unnecessary health care, increases cost of health care at much faster rate, promotes significant wastage of resources in promotion and advertisement of insurance plans (e.g. US health insurance companies spend one third amount of insurance claims paid on administration and promotion), and so on.

This does not mean that progressive group insurance plans are not possible within the market system. In fact, the rise of health insurance in USA was triggered off by such progressive group insurance plans won through struggles by some Trade Unions (TUs) in 1930s and 1940s. During the Depression, hospitals faced with loss of revenue due to the inability of the poor and the old to buy health care on fee-for-service basis, were more amenable to link up with employers for insurance coverage. They were progressive in the sense that those plans provided uniform coverage to employees irrespective of the wage levels and were paid for by the employers. The basic difference in this rise of initial progressive insurance in the US and the social insurance in many European countries was that the former was dispersed and market determined while the latter was universal for a set of population and was through state intervention with public funding. Thus, despite its progressiveness, the insurance won as fringe benefits by TUs in the US fuelled private insurance market while the social insurance in Europe gave impetus to universal access health care.

There are two lessons to be learnt from such history. Firstly, we must remember that all market based financing methods could be experimented in a micro situation on no-profit basis in a progressive manner. Numerous community health NGOs in India have even used the fee-for-service (the most regressive market based financing system) methods in a controlled and sensitive environment for a defined population very progressively. The experiments in insurance are no different. Secondly, the use of insurance as a strategy for market augmentation and privatisation is considered politically less controversial and consistent with the changing role of state from provider (and controller) of health services to regulator. This is to be achieved by separating provision (production) from purchasing (financing) in the government sector. This gives flexibility to the government to work on independent financing strategies in which the participation of private sector and contribution of community financing through appropriate insurance (particularly group insurance for the poor communities) could be promoted. This could "decentralise" the government health care institutions (hospitals, PHCs, etc.) by making them compete in the market for insured clients. In fact, the possibilities in such strategies for m[illegible] penetration in health care, for strengthening private providers and changing values and environment of public providers, are immense. And that is what attracts a State committed to the market values and the financial sharks towards insurance. While this may be exciting for researchers and policy makers, the end result is not difficult to envisage. For, despite excessive innovativeness, high expenditure, much higher state financial support and less proportion of indigent poor in the population than in India, the insurance based health care system of US has found it impossible to provide universal coverage. If we do not learn from that experience, then we are undoubtedly condemned to repeat all the negative consequences.

Re-emphasising the importance of health financing, the critique of insurance as a financing mechanism, in no way means that there are no progressive methods ensuring universal coverage, transcending insurance principle. In a sense, the way out is commonsensical, though it is less commonly accepted. We all know that different groups of people are at different levels of risk for illness, and [illegible]t population is stratified in different socio-economic cla[illegible]. So it is irrational and illogical to have an equal insurance premium for all, this is recognised by insurance. However, the need is to put it upside down by introducing the solidarity principle, that is, the principle of cross-subsidy. This ensures fair financing in the sense that those who earn more, pay more while those earn less, pay less. And still, this would ensure that all earning individuals are paying only a reasonable and acceptable proportion of their income. Secondly, the multiple layered financing through private insurance is both expensive and prone to wastage. The countries providing universal access have solved this problem by replacing premiums with progressive taxation systems, by public management of finances and by having single payer health financing mechanisms. Moreover, this system allow us to progress from universal coverage of the insured group to the universal coverage for all.

Thus, while there is much to learn from insurance, there is more to gain by going beyond it.

- Amar Jesani

Two Community-Based Pre-Payment Schemes in Kheda, Gujarat

M. Kent Ranson

Health insurance is the pooling of resources to cover the costs of future, unpredictable health-related events. According to the health economics and policy literature, health insurance can be used to: mobilise revenue for the health sector; protect individuals and households from the risk of medical expenses; and promote efficiency, quality and equity of health-care services. On the other hand, there is ample evidence to suggest that health insurance can worsen existing inequalities and inefficiencies.

Proponents of health insurance argue that it can be used to address specific deficiencies in *India's* health sector, in rticular: high out-of-pocket spending, inefficiency, poor ality and inequity. At present, health insurance coverage in India is extremely limited, especially outside the formal sector[1]. Non-governmental, non-profit organisations provide health-care to approximately 5% of the Indian population (Hsiao and Dave Sen 1995). Some of these NGOs have implemented prepayment health insurance schemes. There are a number of reasons as to why NGOs should make good insurers for poor populations (adapted from van Ginneken 1998):

- They know the needs of their client groups so they can develop appropriate strategies to assist them;
- They typically involve beneficiaries in the design and implementation of programs;
- Effectiveness of health insurance schemes may be enhanced by other aspects of the NGOs' work, for example, in the fields of employment and education;
- Because they are non-profit, they can provide health insurance at lower cost than for-profit insurers.

As part of my doctoral research, I conducted case-studies of the prepayment schemes run by the Tribhuvandas Foundation (TF) and the Self-Employed Women's Association (SEWA) in Kheda District, Gujarat. The primary objective of my research was to identify, and where possible quantify, the impact of these prepayment schemes on rural households, looking at a variety of outcomes. These outcomes include: medical indebtedness, access to outpatient and inpatient medical care, preference of allopathic versus traditional health care providers, and the empowerment of women to make medical decisions. Data collection for this project was recently completed, and analysis of the data is currently underway. The purpose of this paper is to provide a brief description of the two schemes and the extent to which they have been utilised. Section 1 describes Tribhuvandas Foundation's medical referral services, and Section 2 describes SEWA's Medical Insurance Fund. Section 3, the discussion, draws attention to important differences in the design and utilisation of these schemes.

Section 1

Tribhuvandas Foundation's Medical Referral Services

The Tribhuvandas Foundation was established in 1975. Seed money in the amount of 650,000 rupees was provided by Shri Tribhuvandas Patel, the founding chairman of Amul Dairy, "to initiate a project for improving the health of women and children in Kheda (and Anand) District" (TF Annual Report 1998-99). The Foundation became functional in 1980, servicing some 53 villages during its first two years. Today, the Foundation provides a broad variety of health and related services, focusing on primary and preventive care, in some 644 villages. The Foundation has its head office in Anand, with sub-centres in Kapadwanj, Balasinor, Kheda and Tarapur.

Membership & Coverage

Officially, households pay a total of 10 rupees per annum in order to become members of the Tribhuvandas Foundation (as is discussed below, many exceptions are made). Membership is most often voluntary and open to all residents of a village. The TF village health worker (VHW) normally enrols families at the office of the village dairy co-operative at the time of the annual bonus distribution. However, membership fees can be paid at any time throughout the year. In some villages, based on a decision made in the Dairy Co-operative Society general body meeting, the membership fee is automatically deducted from the bonus as it is distributed. After paying the membership fee, there is no waiting period before members may avail of TF's referral services.

Estimates of the number of TF member households are derived indirectly[2]. TF calculates its membership by assuming that half of the total fees collected are from households paying 10 rupees, and half are collected from households paying 5 rupees, as many households are allowed membership in TF at some reduced rate. Estimated current membership is 1.7 lakh households in 644 villages.

Services

The current activities of the Tribhuvandas Foundation are many and varied (see Box 1). Village-level health services are provided by female TF Village Health Workers (VHWs),

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one per village. VHWs are supervised by some 70 field-workers who visit each village once every fortnight. Generally, there is no discrimination between members and non-members in terms of the village-level services. That is to say, members and non-members alike receive free community health services and subsidised medications.

Box 1. Services Offered by the Tribhuvandas Foundation, 1997 to Present

1/ Pregnant and Nursing mothers are provided treatment.
2/ Malnourished children are provided treatment at home as well as at the Child Care Centre (Nutrition Rehabilitation Centre) run by the organisation.
3/ Children are provided vaccines (DPT, Polio, BCG, Measles, etc.)
4/ TB patients are provided treatment at home at free cost.
5/ Pregnant mothers at risk are hospitalised at the organisation and provided treatment.
6/ As part of temporary methods of Family Planning, Nirodh, Copper T and Birth Control pills are provided in the villages.
7/ Every week Family Planning Operation camps are organised at the main centre as well as the sub-centres in which laparascopic and open surgeries are done.
8/ Pregnant women who want delivery at home are provided with a safe delivery kit.
9/ Gynecologic problems are treated by Shri Krishna Hospital's Gynecologists and Obstetricians at the TF sub-centres.
10/ For advice of specialists and for further treatment, patients are either hospitalised at the Shri Krishna Hospital at Karamsad or seen by specialist in the sub-centre's out-patient department.
11/ A Nursery programme is run in the villages for children below five years of age.
12/ Women are provided training free of cost, and supplementary income in handicrafts (patchwork) so that they can generate income while sitting at home.
13/ Women who work in their free time are provided additional income for their families through the Patchwork Programme.
14/ Under the Environmental Sanitation Programme, low cost toilets and cooking stoves are constructed.
15/ The organisation prepares and shows health-related video films to bring awareness amongst rural people.
16/ With the help of the Blood bank of Shri Krishna Hospital Karamsad, blood donation camps are organised in the villages.
17/ Nutritious food is distributed in the villages at nominal cost.

Source: Derived from TF brochure, 'Health And Rural Development Programme'

TF's health care referral services are the focus of this document. Individuals who are identified as being particularly ill or malnourished are referred to Anand or one of TF's four sub-centres. TF patients who require specialised care are referred to the Shri Krishna Hospital "where specialists and modern diagnostic facilities are available" (Annual Report 1998-99). A TF worker is available full-time at the hospital to assist TF members coming from the different villages. In the most recent fiscal years, roughly 2,000 patients have been referred. Relative to TF's membership, the total number of patients admitted has changed little over the years (for example, the number admitted in 1982/83, 2,320, is almost the same as in 1997/98 at 2,360). The number of admissions per 100 TF households has dropped more than tenfold from 14.5 in 1982/83 to 1.4 in 1998/99.

Until late 1999, TF members would receive a concession for inpatient services at the Shri Krishna Hospital. TF members generally received a 50% concession on the total hospital bill, but this was to vary according to level of need (for example, very poor families would receive a 100% concession while wealthier families would receive no concession). TF members are no longer receiving special benefits at Shri Krishna Hospital.

Finances

As mentioned above, the Tribhuvandas Foundation was started with money provided by Shri Tribhuvandas Patel. As well, several domestic and international funding agencies (including UNICEF and the Overseas Development Administration, UK) contributed to the Foundation in its early years. Today, the Foundation's main sources of income include: Amul Dairy through the National Federation of Rural Development (NFRD Delhi), bank interest on funds, user-fees charged for medicines, membership fees, and Dairy Cooperative Society contributions.

Since the inception of the referral system, the concessions provided to TF patients at Shri Krishna Hospital have been offset by a donation from Kaira Can, a sister concern of Amul Dairy. The amount of the payment, however, has been fixed at 500,000 per annum. At least during the last five years, no additional payment has been made by TF to the Shri Krishna Hospital. In recent years the Shri Krishna Hospital has incurred considerable financial loss in providing reduced-cost care to TF patients (Table 1). Thus, the Shri Krishna Hospital has recently discontinued concessions to TF's members (although children under 5 continue to receive free care, there is a special scheme for women, and the poor may be provided with concession on a case-by-case basis).

Table 1. Annual debt incurred by Shri Krishna Hospital in providing concessions to TF patients, 1996/97 to 1998/99 (actual Indian rupee values)			
Fiscal Year	Shri Krishna Referral Costs (Rs)	Donation by Kaira Can (Rs)	Debt Incurred by Shri Krishna (Rs)
1996/97	1,771,707	500,000	1,271,707
1997/98	1,458,624	500,000	958,624
1998/99	1,312,886	500,000	812,886

History of the Referral Services

he system for referrals has evolved gradually since 1980. Referral services were not included in the original plan for TF. However, soon after commencement of TF's activities, it was found that there was a need for referral services among the membership. Initially, many of the cases detected by TF were taken to government or trust (charitable) hospitals in Anand.

When Shri Krishna Hospital was under construction, its director suggested that the two organisations work in co-operation. This was to be a mutually beneficial arrangement. It was agreed informally that Shri Krishna Hospital would provide care free of charge to TF members. Kaira Can committed to donating 500,000 rupees per year to cover the costs of concessions to TF members. This has continued to this day. Due to the debt it incurs in caring for TF members, Shri Krishna Hospital is no longer offering concessions to TF members.

Preliminary Analysis of Hospital Utilisation Data

his analysis is based on the bills provided to the Tribhuvandas Foundation by the Shri Krishna Hospital for the fiscal years 1996/97 to 1999/00 (each fiscal year is from 1st April through 31st March). These bills provide some basic demographic information for each patient (for example, gender, and village of residence), dates of hospital admission and discharge, total cost of the hospitalisation, the amount paid out-of-pocket by the patient, and the amount owed by the Tribhuvandas Foundation.

At present, there are 8,465 records in the database[3]. The records for fiscal year 1999/00 remain incomplete as not all of the bills have been submitted to TF. Overall, for this four-year period, the average duration of hospital stay was just over eight days, the average total costs was Rs 1,500, the average out-of-pocket payment by patients Rs 824 (55% of the average total cost), and the concession per TF patient Rs 677 (45% of the average total cost).

As shown in Table 2, the total number of TF members admitted to Shri Krishna Hospital has been decreasing over the last four fiscal years (keeping in mind that the data for 1999/2000 is incomplete). Roughly 25% of TF admissions at Shri Krishna Hospital during the last four fiscal years have been in the Nutritional Resource Centre (NRC). All children younger than 5 years of age (the threshold seems to be slightly flexible) are kept in the NRC. NRC admissions as a percentage of total are increasing, from 18% to 40% in only four years.

Table 2. Hospitalizations of TF members at Shri Krishna Hospital				
Year	Total	Adult	NRC	NRC as % of Total
96/97	2913	2391	522	18%
97/98	2225	1711	514	23%
98/99	2071	1455	616	30%
99/00	1254	749	505	40%
Total	**8,463**	**6,306**	**2,157**	
% of Total	*100%*	*75%*	*25%*	

Table 3 shows the breakup of admissions by gender for each year (and by adult versus NRC). Overall, 45% of TF admissions have been female. Very interestingly, the proportion of female admissions to the NRC (35 to 38%) is consistently lower than for adults (47 to 50%).

Table 3. Gender of TF patients hospitalised at Shri Krishna Hospital					
Year	Adult/ NRC	Total	Female	% Female	Male
96/96	Adult	2,391	1,134	47%	1,257
96/97	NRC	522	186	36%	336
97/98	Adult	1,711	807	47%	904
97/98	NRC	514	195	38%	319
98/99	Adult	1,455	729	50%	723
98/99	NRC	616	216	35%	400
99/00	Adult	749	362	48%	387
99/00	NRC	505	187	37%	317
Total		**8,463**	**3,816**		**4,643**
% Total		*100%*	*45%*		*55%*

Average duration of hospitalisation varies little from one year to the next at approximately eight days (Table 4). For each year there are hospitalisations of less than one day's duration (generally 'day surgeries' and procedures). The median duration of stay was 6 for each year, suggesting that (for all years) the distribution is skewed right by a relatively small

number of lengthy hospitalisations.

Table 4. Duration of hospitalization of TF members at Shri Krishna Hospital

Year	Total records	Duration available	Avg Duration	Median duration
96/97	2,913	2,909	8.36	6
97/98	2,225	2,222	8.27	6
98/99	2,071	2,071	7.52	6
99/00	1,254	1,252	7.66	6
Total	8,463	8,454	8.02	6

average total cost of hospitalisation varies from 1,094 rupees to 1,918 rupees over the last four years (Table 5). On average, patients paid 55% of this amount, and TF 45%. However, the average TF concession has varied considerably, from only 39% in 1997/98 to 56% in 1996/97.

Table 5. Costs of hospitalisation of TF members at Shri Krishna Hospital (actual Indian rupee values)

Year	Number	Avg total cost	Median	Avg out-of-pocket	Median	Avg TF concession	Median	% TF Concession
96/97	2,913	1,094	715	485	300	608	371	56%
97/98	2,225	1,701	1,062	1,044	500	657	389	39%
98/99	2,071	1,601	1,060	967	600	634	404	40%
99/00	1,254	1,918	1,202	983	350	935	548	49%
Total	**8,463**	**1,500**	**1,094**	**824**	**400**	**676**	**404**	**45%**

Section 2

SEWA's Medical Insurance Fund

The Self-Employed Women's Association, SEWA, is an organisation of poor, self-employed women workers. The organization's main goals are to "organise women workers for full employment and self reliance" (SEWA 1999). SEWA currently has more than 200,000 members, approximately 148,000 of whom reside in Gujarat State.

SEWA's Integrated Social Security Scheme was initiated in 1992. This Scheme provides life insurance, medical insurance and asset insurance (against the loss of house or working capital in case of flood, fire or communal riots). This document deals exclusively with the Medical Insurance Fund.

SEWA fully manages the Medical Insurance Fund (unlike the life insurance and asset insurance components, which are run in cooperation with government insurance companies). In order to join the Fund, women must be between 18 and 58 years of age. Those who pay the annual Social Security Scheme membership fee of 72.5 rupees (30 rupees of which is earmarked for medical insurance) are covered to a maximum of 1,200 rupees yearly in case of hospitalisation. Women also have the option of becoming lifetime members of the Social Security Scheme by making a fixed deposit of 700 rupees[4]. Special benefits to which only the lifetime members are entitled include: maternity benefit of 300 rupees with the birth of each child; reimbursement for cataract surgery up to 1,200 rupees; reimbursement for a hearing aid up to 1,200 rupees; and, reimbursement for dentures up to 600 rupees. Exempted from coverage are certain chronic diseases (for example, chronic tuberculosis, certain cancers, diabetes, hypertension, piles) and "disease caused by addiction" (SEWA brochures, 2000).

Annual members pay their premium in cash. Voluntary lifetime members usually pay their membership fee in cash, but they may occasionally pay by a cheque from their SEWA Bank account. Women who take a loan of more than 10,000 rupees from SEWA Bank are automatically enrolled in the Integrated Social Security Scheme as lifetime members, and the fixed deposit is deducted directly from their loan.

Annual membership fees are collected only from April 1st to June 30th, and annual members are eligible for medical insurance starting on July 1st. The lifetime fixed deposit can be paid anytime throughout the year. After paying the fixed deposit, women are eligible for benefits on whichever of the following dates comes first: July 1st, October 1st, January 1st, or April 1st. The number of members cited by SEWA refers to the number who on July 1st, the 1st day of the fiscal year, have paid their annual membership fee or lifetime fixed deposit within the preceding twelve months.

The choice of provider is left entirely to the discretion of the SEWA member. They are eligible for reimbursement whether they use private-for-profit, private-non-profit or public facilities. After discharge from hospital, the Fund member is required to submit the following documents within a three month period: a doctor's certificate stating the reason for hospitalisation and the dates of admission and discharge; doctors' prescriptions and bills for medicines purchased; and, reports of laboratory tests done during the hospital stay. After submission of these documents, the member is usually visited by a SEWA employee who verifies the authenticity of the claim. All documentation is reviewed by a consultant physician, and a final decision on the claim is then made by an insurance panel (the panel consists of eight people, a combination of SEWA Leaders and Organisers). Finally, the Fund Member is notified of the panel's decision, and when applicable, is paid by cheque.

The design and management of the Medical Insurance Fund have evolved considerably since 1992. Initially, the Fund was administered jointly by SEWA and the United India

Insurance Company (UIIC). At that time, coverage only included allopathic, inpatient care, not including gynecological illnesses. The maximum amount of reimbursement was 1,000 rupees. In 1994 SEWA assumed complete control of the medical insurance component. In 1995, coverage was expanded to include treatment from traditional bone-setters, occupational diseases, obstetric and gynecological problems, and in exceptional cases, homeopathic or traditional medical care (still to a maximum of 1,000 rupees). In 1998, the maximum coverage was increased to 1,200 rupees. In July of 1998, administration of the Medical Insurance Fund for Kheda District was decentralised, shifting from Ahmedabad to the district office in Anand.

Throughout the ten districts of Gujarat where it operates, the Medical Insurance Fund had approximately 18,700 lifetime members (63% of total) and 11,100 annual members (37% of total) in 1999-2000. In Kheda District, enrollment was 5,672, consisting of 1,548 lifetime members (27% of total) d 4,124 annual members (73% of total)[5]. State-wide, coverage by the Medical Insurance Fund is 20% (29,800 insured among 147,600 SEWA members) and 16% in Kheda District (5,672 insured among 36,500 SEWA members). Medical Insurance Fund members in Kheda represent approximately 19% of Members state-wide.

Finances

Since the Fund's inception, the premiums paid by annual members plus the interest paid from the fixed deposits of lifetime members have always exceeded medical claim payments. Table 6 shows that cost-recovery (excluding administrative costs, which are discussed in the next paragraph) has varied from 119 to 309 percent (data not available for 1992-94 and 1993-94).

It is very difficult to estimate the costs of administering the Medical Insurance Fund; many of the administrative functions are shared with the life and asset insurance mponents as well as with other activities of SEWA. A ent study by the International Labour Organization found that basic administration costs accounted for 9.3 to 19.7 percent of Integrated Social Security Scheme expenses annually (personal communication with Michaela Balke, ILO). Interest from a German Development Cooperation grant (100 million rupees given in 1993) is used to cover all administrative costs and to provide the maternity benefit of 300 rupees.

Table 6. Contributions to, and payments by, SEWA's Medical Insurance Fund (actual Indian rupee values)

Year	1994	1995	1996	1997	1998	1999
Members' Contributions	150,000	383,520	450,000	600,000	780,000	696,420
Medical Claim Payments	125,659	124,203	258,884	266,118	392,864	386,563
Operating Balance	24,341	259,317	191,116	333,882	387,136	309,857
Cost Recovery	119%	309%	174%	225%	199%	180%

Preliminary analysis of Scheme utilisation data for Kheda District

A total of 439 claims were submitted between July 1st 1994 and September, 2000 in Kheda District[6]. There was a gradual increase in the number of claims submitted to, and reviewed by, the insurance panel each year. The rate of claim submission during the two fiscal years 1997-99 was 20 per 1,000 insured women per year (in 97-98 there were 92 claims and 5,200 insured and in 98-99 there were 120 claims and 5,477 insured)[7]. Thirty-one percent of claims were submitted by women with lifetime insurance policies, and 69% by women with annual policies (N = 439). The rate of claim submission was 17 per 1,000 per year among annual Members and 30 per 1,000 per year among lifetime Members during the two years 1997-99. Ninety-six percent of claims submitted were approved for reimbursement (N = 438). Of the 16 claims that were rejected, 11 were rejected as the disease responsible for admission was judged to be "chronic" or "pre-existing" and three were rejected as documents submitted by the claimant were incomplete (data not shown).

The mean age of claimants was 39.7 years (N = 439, SD = 9.7 years, CV = 24.4%) and the median 40 years. The age distribution of claimants shows a peak between 35 and 49 years. Interestingly, three claimants received reimbursement despite age older than 58 years (theoretically, the maximum age allowed for participation in the scheme).

The mean length of admission was 6.7 days (N = 439, SE = 8.6, CV = 128%) and the median 5. The mean duration of admission was fairly consistent from one year to the next, the notable exception being 1994/95 when the mean admission was 9.2 days, but the median only 6.

The mean cost of a hospitalisation (both reimbursed and rejected claims) was 2,341 1999/2000 Rupees (N = 438, SE = 2,117, CV = 90%) or 54 USD. The median cost was 1,629 1999/2000 Rupees or 37 USD. It was difficult to break this overall value down into component costs, as many hospital receipts reported only the aggregate cost (which may include doctors fees, bed fees, medications and tests all lumped together). In the 254 records for which the costs could be disaggregated, medicine fees were the largest component of the total cost (51%), followed by bed fees (23%), doctor fees (12%), lab and x-ray fees (7%), and other fees (7%). This breakdown varied markedly according to the type of hospital. For example, medicines accounted for 48% of costs at private-for-profit hospitals, 62% at private-non-profit hospitals, and 78% at government hospitals (data not shown). Seventy-three percent of claimants used private-for-profit

hospitals, 20% private-non-profit (or charitable) hospitals, and 6% government hospitals. The duration of hospitalisation was longest for government hospitals (mean = 9.1 days, median = 7.0 days) and shortest for private-non-profit hospitals (mean = 5.8 days, median = 4.0 days). The total hospitalisation costs were much higher for a stay in a private-for-profit hospital (mean = 2,664 Rupees, median = 1,878 Rupees) than in a private-non-profit hospital (mean = 1,627 Rupees, median = 1,123 Rupees) or a government hospital (mean = 880 Rupees, median = 623 Rupees). Reimbursement on average was 75% for hospitalisation in government facilities, 61% for private-non-profit hospitals, and only 46% for private-for-profit hospitals.

The mean total cost of the 422 *reimbursed* hospitalisations was 2,332 1999/2000 Rupees (N = 422, SD = 2,091, CV = 90%) or 54 USD. The median total cost was 1,629 Rupees or 37 USD (*Table 8*). Over the six years, the standardised median total cost was between 1,466 and 1,776 Rupees, except in 1996/97 when it was 2,416 Rupees. The mean reimbursement was 1,148 1999/2000 Rupees (N = 422, SD = 307, CV = 27%) or 26 USD (Table 7). The median reimbursement was 1,211 Rupees. In general, the standardized (or real) mean and median reimbursements provided by SEWA have fallen through time. Of the 422 cases reimbursed, only 21% were reimbursed in full (90 of 422), and 28% were reimbursed to less than one-half of total costs (117 of 422, data not shown).

On average over the last six years, it took 161 days between discharge from hospital and reimbursement. This can be broken down into: 78 days from discharge to submission of the claim to SEWA, 46 days from submission of the claims to the date of the panel's decision, and 37 days between the panel's decision and receipt of payment by the claimant.

Table 7. Total hospitalisation costs expressed in 1999/2000 Indian Rupees (for reimbursed claims only, N = 422)

Year	N	Mean	SD	CV	Median	Year
94/95	39	2,532	2,562	101.2%	1,776	94/95
95/96	62	1,706	1,189	69.7%	1,574	95/96
96/97	75	3,232	2,460	76.1%	2,416	96/97
97/98	92	2,176	2,255	103.6%	1,592	97/98
98/99	117	2,173	1,777	81.8%	1,497	98/99
99/00	37	2,240	1,944	86.8%	1,466	99/00
Overall	**422**	**2,332**	**2,091**	**89.7%**	**1,629**	**Overall**

Table 8. Reimbursement paid by SEWA as expressed in 1999/2000 Indian Rupees (N = 422)

Year	N	Mean	SD	CV	Median
94/95	39	1,338	261	19.5%	1,510
95/96	62	1,179	345	29.3%	1,396
96/97	75	1,207	303	25.1%	1,307
97/98	92	1,032	302	29.3%	1,212
98/99	117	1,142	285	25.0%	1,321
99/00	37	1,087	245	22.5%	1,200
Overall	**422**	**1,148**	**307**	**26.7%**	**1,212**

Discussion

These two prepayment schemes differ tremendously in terms of design (Table 9). In both cases, the premium is paid voluntarily and is collected annually. The TF scheme covers entire households (including children) whereas the SEWA scheme covers only female members of SEWA between the ages of 18 and 58. SEWA specifically excludes certain chronic diseases from coverage, which is not the case with TF. Under the TF scheme, members receive concession only if they seek care at the Shri Krishna Hospital, while members of the SEWA may receive reimbursement for care at any public, private or trust hospital. The concession provided under the TF scheme is variable, depending on total cost of the hospitalisation and level of financial need. Under the SEWA scheme, the insured are reimbursed to the full cost of hospitalisation, up to a maximum of 1,200 rupees. The concession provided by TF is paid directly to Shri Krishna Hospital on a fee for service basis. The insured effectively receives this benefit at the time of hospitalisation when the bill is paid. Under the SEWA scheme, the insured must first pay the full cost of hospitalisation out-of-pocket, and then seek reimbursement from SEWA by submitting bills and receipts. Thus, members of TF enjoy the benefits immediately at the time of discharge, while members of SEWA receive the benefits only months later after their claims have been processed and approved.

Without assessing impact of these schemes on households, it is impossible to conclude that one design is superior to the other. Certainly the differences do highlight the conflict of freedom of choice versus ease and speed of reimbursement. Under the SEWA scheme, women may attend a health care provider of their choice, in a town or village that is close to their home. Members of TF who wish to benefit from the referral services have no choice as to where they will be treated, and the location of Shri Krishna Hospital may be inconvenient to them. However, by dealing with only a single hospital, TF has made the process of reimbursement quite short and simple. As well, it is possible that TF can monitor and influence the quality of care received by its members at Shri Krishna Hospital. It is far more difficult for SEWA to have an influence on the many hospitals that may be visited by its members.

It is difficult to estimate the level of cost-recovery for TF's referral services, as the premium paid to TF is used in providing preventive and primary care in the villages, while the inpatient care is covered (in part) by a donation from Kaira Can. Suffice it to say that TF has relied on external donors to fund the referral services, and that the prepayment scheme for hospital care has recently broken down due to financial difficulties. Premiums paid to the SEWA Medical Insurance Fund consistently cover more than 100% of the benefits paid out

to members. Administrative costs are, however, covered by an external donor.

It seems that utilisation of both schemes is quite low. A 1993 study carried out by the National Council of Applied Economic Research (Sundar 1995) found rates of hospitalisation of 85 per 1,000 people per year in rural India (6,354 households), and 56 per 1,000 people per year in rural Gujarat (only 304 households). The rate of claim submission is only 20 per 1,000 women per year in the SEWA scheme. Utilisation of Shri Krishna Hospital by TF members is in the range of 20 per 1,000 *households* per year. It is unlikely that members of SEWA and TF require fewer hospitalisations per annum than the average population. Rather, it seems likely that many SEWA members do not submit claims for their hospitalisations, and that many TF members are hospitalised in facilities other than Shri Krishna Hospital.

The absolute costs of hospitalisation under the two schemes are not directly comparable as the TF costs and reimbursements are actual, while the SEWA costs and reimbursements have been standardised to 1999/2000. On average, SEWA has reimbursed 49% of the cost of hospitalisations for which claims have been submitted, and TF has covered 45% of the costs of hospitalisations. For both schemes, members have been responsible for finding other resources to cover, on average, more than half of the cost of hospitalisation.

This brief background paper highlights some of the main differences between the SEWA and TF community-based prepayment schemes. I have touched aspects of both schemes that could be improved upon. Nonetheless, it is also important to appreciate these schemes, with all their weaknesses, as unique innovations in health-care financing. I hope that analysis of the household level data I have collected will shed some light on the extent to which these schemes have influenced households, particularly in meeting the high costs of hospital care and medical indebtedness.

Table 9. Differences in design between Tribhuvandas Foundation's medical referral services and SEWA's Medical Insurance Fund

Aspect of Scheme Design	Tribhuvandas Foundation	SEWA
Annual premium	10 Rs	72.5 Rs (lifetime membership also available)
Unit of membership	Households	Female SEWA members aged 18 to 58 years
Exclusion of pre-existing disease	No	Yes
Provider of inpatient care	Shri Krishna Hospital	Any public, private or trust hospital
Level of reimbursement	Varies depending on total cost of hospitalisation and level of financial need	Full cost of hospitalisation to maximum of 1,200 rupees
Mode of reimbursement	Directly to Shri Krishna Hospital on fee for service basis	Paid to insured after approval of certificates and receipts
Time to reimbursement of the insured	Immediate (insured pays only the difference between total cost and concession)	Average of 161 days

Notes

1. In India, the formal or organized sector "is defined to consist of all government institutions and of enterprises using power and employing ten or more persons, as well as those not using power but employing twenty or more persons" (van Ginneken 1998, p. 2). The informal or unorganised sector, by default, refers to all other forms of employment.

2. Recently, the computerization of all membership books has started, which will provide the exact number of members enrolled by TF.

3. I have included in the analysis the records for which the dates of duration and discharge are the same, i.e. duration of admission is zero days. I have confirmed these cases with TF; generally they are cases where people were admitted for short procedures, like minor surgeries or blood transfusions.

4. Interest on the 700 Rupee fixed deposit is used to pay the annual Social Security Scheme premium. When the woman reaches age 58, she is automatically withdrawn from the scheme, at which time she receives her initial deposit as well as any surplus interest that has accumulated.

5. Fund administrators explained that lifetime membership is much more popular state-wide than in Kheda District because many of the members state-wide have been required to pay the fixed deposit when they have taken a loan from SEWA Bank, whereas the majority of members in Kheda have joined the scheme voluntarily.

6. Some claims for 1996-97 and the corresponding register have been lost. It is impossible to know how many claims are missing.

7. The rate of claim submission was calculated only for 1997-98 and 98-99 as reliable information on the number of Medical Insurance Fund members in Kheda District was only available for 1997-98 onwards.

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Community Insurance - Which Way to Go? Wisdom out of the Experiential Learning from SEVAGRAM

Ulhas Jajoo

The Concept: Primary Health Care should be considered a fundamental right of the people (as it should be for primary education)

The Challenge : The poor spend considerable amount on medical care to unregulated and exploitative private sector, primarily due to low credibility of public hospitals..
The privatisation of public health services offers an opportunity to misutilise state health resources for private sector. Therefore, the private sector needs regulation

The Disease : Inspite of wide health care infrastructure in public sector medical care has not out-reached to the poor, rural people in particular, essentially because of i) paucity if funds and ii) lack of efficiency.

The maldistribution of centrally pooled resources is what primarily ails our system. The distribution of Central/State Government funds is lop-sided, favours 'haves' and neglects 'haves-not' favours urban and not rural people.

Therefore the optimal resource allocation (per capita basis) to primary care hospitals is first step towards building credible services.

The Pre-Requisite : Primary health care services must provide free curative care for its acceptability to the poorest of the poor.

The egalitarian health services can never be economically self reliant, if they have to preferentially serve the poor. Thus, no private insurance will cater to the poor. Therefore, the pro people service must be finacially shouldered by the welfare state.

The Soul : The credibility of the system revolves around:
a) Accessible hospital services of an optimum quality.
b) Accountability of health care system to the consumers.
c) Affordability of the services to the poorest.

The Fact : It is possible to offer a just primary care to all, within existing government resources, provided funds are locally available and locally governable in an efficiently decentralised set up.

The Direction : Accountability of the health-care system can not be enforced vertically downward. To inculcate responsiveness in the public health care system, a vigilant public audit system is required.

Therefore, the empowerment of the people is the key for an accountable system. The power emanates through the control of public funds and through performance evaluation of public servants. Public bodies should be entrusted with the above responsibility in a decentralised structure. The Gram Sabha in the Panchayati Raj system should be empowered with public funds (per capita basis expenditure that Central and State governments undertake.)

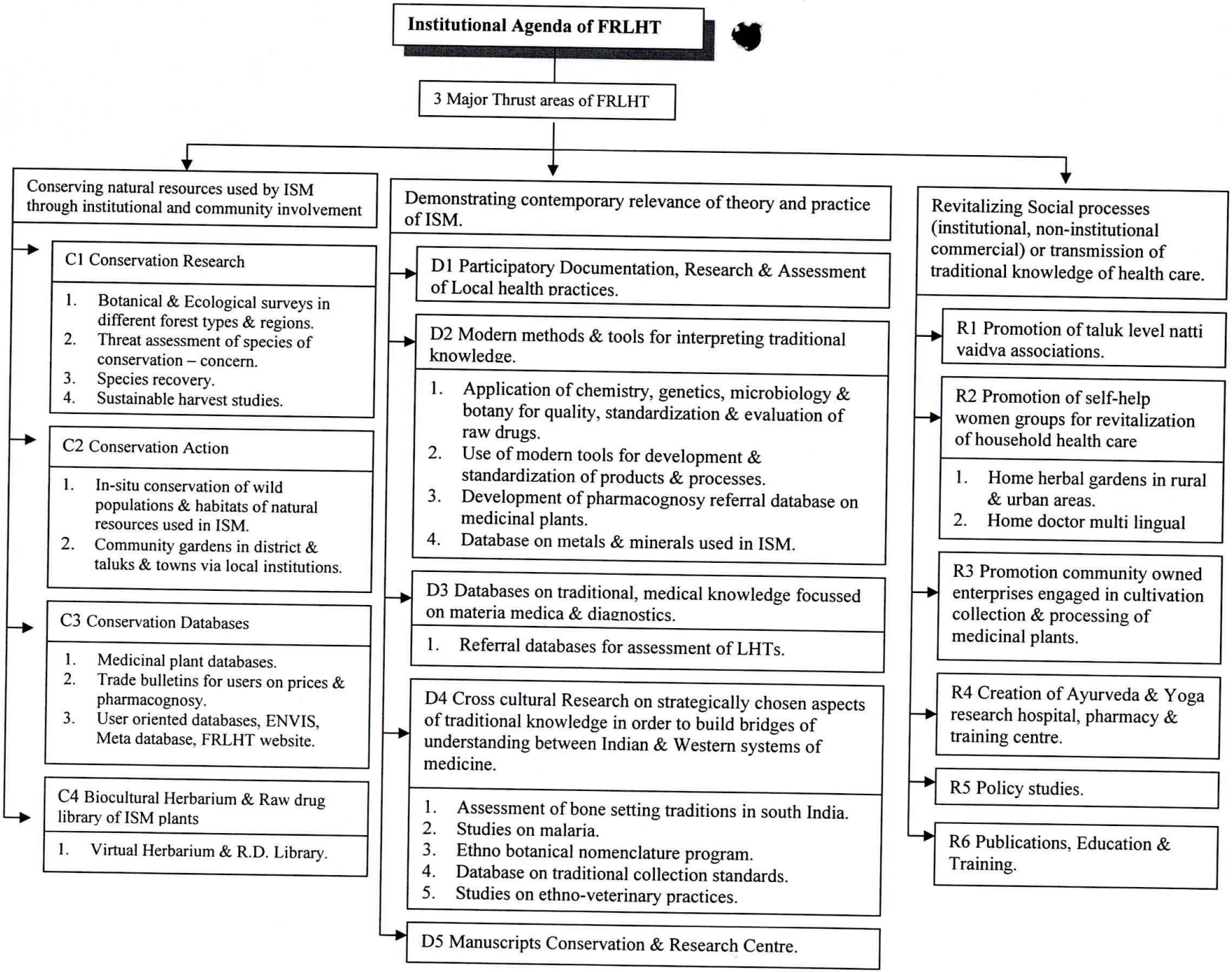
The Participatory Nature : Since charity corrupts people, the beneficiary should contribute towards health care services, albiet according to their capacity to pay and the priority need. Contribution according to capacity and service according to need must be the guiding principle, for pro-poor services. The social fnancing so raised can not meet expenses towards medical care cost, it can at best, supplement it. Apart from offereing an affordable post payment mechanism to persons who need services but are unable to pay for it, (Risk sharing) Social financing has following spin offs benefits -
i) It increases accessibility of health services
ii) It promotes operators' concern for health in the community.
iii) It generates the concept of right to demand quality health care by the beneficiary population.
iv) It responds to priorities as judged by the community.
v) It ensures the services are acceptable.
vi) It keeps service providers on their toes.
vii) It stimulates organisational self-confidence and paves way for participatory culture at the community level.

The Essence : Primary health care is a fundamental right and the welfare state has an obligation to fulfil it. The pro-poor health care services should be financed by the welfare state. Therefore, it should be obligatory for a welfare state to offer a health insurance scheme through its existing infrastructure. A decentralised Panchayati Raj set up should be entrusted financial resources allocated on per capita basis by Central and State governments. Emergency medical services should be free and accessible to the poor. Social financing raised through consumer contributions encourages demand for quality care and inclucates community participation in medical care.

The Path to Tread : As part of its constitutional obligation, the state should run the community health care scheme, through its rural hospitals (village or Mohalla of a city as a unit of community). The health care scheme should raise the finances as prepayments from Gram Sabha in the Panchayati Raj system. The health care budget alloted on per capita basis can then be routed as prepayment towards community medical care scheme. The private sector can compete with the public sector rural hospital by floating a community medical care scheme, with the choice resting with the Gram Sabha.

Annex III

Jawar Scheme	1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02	2002-03
Total Beneficiaries	7555	9349	10414	8770	14080	11812	12345	11988	11605	5892	12101	12026	9294	7759	4122	7839	6125
100% waive off																	
Total Indoor Admissions	488	604	595	365	481	533	597	574	700	304	675	552	547	499	212	462	485
Total Bill made in Rs.	39847.6	80271.6	71996.6	59729.8	80299.2	106639	114247	103894	158001	82365.8	219833	205640	219226	191673	229338	120369	344799
Total Exp	423920	538551	564791	519193	729032	954032	1228379	1079705	1477683	659089	1592457	1281619	1421336	1361392	803919	1660637	1832801
Exp. Per head under jawar scheme	56	58	54	59	52	81	100	90	127	112	132	107	153	175	195	212	299
Contributions collected from JS - Cash	17465	31952	34681	39496	51693	45093	70828	60533	58488	90695	105773	70277	148681	352928	130353	256156	105781
Billing pattern for Jawar scheme (in%)	9	15	13	12	11	11	9	10	11	12	14	16	15	14	29	7	19
Number of people against which there is 1 adm.	15	15	17	24	29	22	21	21	17	19	18	22	17	16	19	17	13
Probable Cost recovery from JS	4.1	5.9	6.1	7.6	7.1	4.7	5.8	5.6	4.0	13.8	6.6	5.5	10.5	25.9	16.2	15.4	5.8
Co-payment for foreseeable event																	
Total Indoor Admissions	217	322	286	233	337	288	354	363	636	547	591	594	676	922	203	950	1123
Total bill made	34048	42973	31541	34992	54487	47234	45985	48714	116136	79209	180636	207238	218660	245821	380891	614176	580338
Total Amount paid	9657	11752.8	10916.1	10123.1	15470.4	13136.4	12214	12653	32806.2	35371.6	46564.7	53149.2	59385.3	67212.6	96447.4	161721	349881
Total expenditure	188786	286942	271297	330731	510868	515693	728385	682810	1342580	1185926	1394285	1379133	1755570	2513613	769791	3416168	4245416
Cost recovery from copayment (This does not include the contribution amount)	5.1	4.1	4.0	3.1	3.0	2.5	1.7	1.9	2.4	3.0	3.3	3.9	3.4	2.7	12.5	4.7	8.2
Total probable cost recovery from Jawar sch (100%	4.4	5.3	5.5	5.8	5.4	4.0	4.2	4.2	3.2	6.8	5.1	4.6	6.5	10.8	14.4	8.2	7.5
Non insured																	
Total IPAdmissions	92	162	183	161	156	156	260	275	484	604	421	394	568	411	458	238	281
Total Bill made	13281	22561	34549	26959	25596	29203	48465	58391	476645	136916	151116	135752	159843	162887	323750	232876	161818
Amount paid	9248	10462	17637	11987	14858	15151	25385	27757	64872	100564	95629	94633	113796	119274	57856	152747	140553
Cost recovery from non insured pop (in%)	11.5	7.2	10.1	5.2	6.3	5.4	4.7	5.4	6.3	7.7	9.6	10.3	7.7	10.6	3.3	17.9	13.2


Institutional Agenda of FRLHT
3 Major Thrust areas of FRLHT
Conserving natural resources used by ISM through institutional and community involvement
C1 Conservation Research
1. Botanical & Ecological surveys in different forest types & regions.
2. Threat assessment of species of conservation – concern.
3. Species recovery.
4. Sustainable harvest studies.
C2 Conservation Action
1. In-situ conservation of wild populations & habitats of natural resources used in ISM.
2. Community gardens in district & taluks & towns via local institutions.
C3 Conservation Databases
1. Medicinal plant databases.
2. Trade bulletins for users on prices & pharmacognosy.
3. User oriented databases, ENVIS, Meta database, FRLHT website.
C4 Biocultural Herbarium & Raw drug library of ISM plants
1. Virtual Herbarium & R.D. Library.
Demonstrating contemporary relevance of theory and practice of ISM.
D1 Participatory Documentation, Research & Assessment of Local health practices.
D2 Modern methods & tools for interpreting traditional knowledge.
1. Application of chemistry, genetics, microbiology & botany for quality, standardization & evaluation of raw drugs.
2. Use of modern tools for development & standardization of products & processes.
3. Development of pharmacognosy referral database on medicinal plants.
4. Database on metals & minerals used in ISM.
D3 Databases on traditional, medical knowledge focussed on materia medica & diagnostics.
1. Referral databases for assessment of LHTs.
D4 Cross cultural Research on strategically chosen aspects of traditional knowledge in order to build bridges of understanding between Indian & Western systems of medicine.
1. Assessment of bone setting traditions in south India.
2. Studies on malaria.
3. Ethno botanical nomenclature program.
4. Database on traditional collection standards.
5. Studies on ethno-veterinary practices.
D5 Manuscripts Conservation & Research Centre.
Revitalizing Social processes (institutional, non-institutional commercial) or transmission of traditional knowledge of health care.
R1 Promotion of taluk level natti vaidya associations.
R2 Promotion of self-help women groups for revitalization of household health care
1. Home herbal gardens in rural & urban areas.
2. Home doctor multi lingual
R3 Promotion community owned enterprises engaged in cultivation collection & processing of medicinal plants.
R4 Creation of Ayurveda & Yoga research hospital, pharmacy & training centre.
R5 Policy studies.
R6 Publications, Education & Training.

COMH - 2A.

The Community Insurance - Which way to go.
(Wisdom out of experiential learning from SEVAGRAM)

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The Concept

* Primary health care should be considered a fundamental right of the people (as it should be for primary education)

The Challenge

* The poor spend considerable amount on medical care to unregulated and exploitive private sector , primarily due to poor credibility of public hospitals .

* The privatization of public health services offers opportunity to misutilise state – health resources for private sector .

Thus , the private sector requires regulation .

The Disease

* Inspite of wide health care infrastructure in public sector , medical care has not reached the poor , rural people in particular , essentially due to i) paucity of funds and ii)lack of efficiency .

* The misdistribution of centrally pooled resources is what primarily ails our system . The distribution of central and state government funds is lop sided , favoring "haves " and neglecting "have-nots" , favoring "urban " and neglecting "rural "masses .

Thus , the optimal resources allocation (per capita basis) to primary health care hospitals is the first step to building credible services .

The Pre-requisite

*Primary health care services must provide free curative care for its acceptability to the poorest of the poor .

* The egalitarian health service can never be economically self reliant , if they have to preferentially serve the poor .

Thus , no private insurance will cater to the poor , and

The pro-people services must be shouldered by the state .

The Soul

* The credibility of the system revolves around

a) Accessible hospital services of an optimum quality

b) Accountability of the health care system to the consumers , and

c) Affordability of the services to the poorest .

The Fact

* It is possible to offer a non-biased primary care to all , within existing government resources , provided funds are locally available and locally governable in a efficiently managed decentralized setup.

The Direction

* The accountability of health care systems cannot be enforced vertically down . to incalculate responsiveness in public health care systems , a vigilant public audit system is required .

Thus , the empowerment of the people is the key towards accountability . The power emanates through the control of public funds and performance evaluation of public servants .

The public body empowered to undertake the above is a decentralized structure .

Thus , the gram sabha in the panchayat raj system be empowered with public funds (per capita basis , expenditure that central and state governments undertake).

The Participatory Nature

* Since charity corrupts people and does so absolutely , beneficiary should contribute towards health care services , albeit , according to their capacity and the priority need .

* The contribution according to capacity and services according to the needs , must be the guiding principle , for pro-poor services .

* Though the social finance so raised cannot meet the expenses of medical care , they can at least supplement them .Apart from offering an affordable post-payment mechanism to persons who need services but who are unable to pay (Risk sharing), Social financing has some spin of benefits –

i) It increase accessibility of health services ,
ii) It promotes operator's concern for health in the community ,
iii) It generates the concept of right to demand a quality health care among the beneficiary population .
iv) It responds to priorities as judged by the community ,
v) It ensures that services are acceptable ,
vi) It keeps service providers on their toes , and
vii) It simulates organizational self-confidence and paves a way for participatory culture at community level .

The Essence

* Primary Health Care is a fundamental right and the welfare state has an obligation to fulfill it .

* No private health insurance can cater to the poor .

* The pro-people health care services must be financially shouldered by the welfare state.

Thus , it should be obligatory for a welfare state to offer a health insurance scheme through its existing infrastructure .

* It is possible to offer just primary health care to all within allotted resources by central /state governments , provide it is distributed on capita basis in a decentralized panchayat raj setup.

* The credible emergency services should be for free , for them to be accessible by the poor .

* The social finance raised through consumer-contributions according to their capacity , raises the demand for quality care and incalculates community participation in medical care .

The Path to Tread

* As a part of constitutional obligation , let the state run community health care scheme, through its rural hospitals (village or Mohalla of a city as a unit of community).

* The health care scheme should raise the finances as prepayments from gram-sabha in panchayat–raj system .

* The health care budget of central and state government can be allotted on per-capita basis to panchayat raj system . The amount can be routed as pre-payment towards community health care scheme .

*Let private sector compete with the public sector by floating a community health care scheme of their own . The choice of selection rests with the gram sabha in panchayat raj system .

* Gram Sabha should raise social finance for unforeseen emergencies which rural hospitals fail to meet .

Key Words

Structural Change - Decentralize
Empowering people - Just distribution of resources
Credible system - Affordable , accountable , egalitarian

COMH-2A.

The Jawar Rural Health Insurance (Assurance) Scheme of the MGIMS Hospital, Sevagram : A micro experiment in the spririt of Sarvodaya ideology.

By Dr. Ulhas Jajoo, Dr. Anant Bhan

The idea for the scheme started from the Medico Friends Circle (an informal group that is concerned about issues of public health importance) students group that Dr. Jajoo initiated in MGIMS, Sevagram when he joined as faculty there in the Department of Medicine after completing his masters from the Medical College, Nagpur in 1976. The group would regularly meet and discuss the various issues of relevance in medicine. Fed up of their indoor discussions and ideological debates, the group decided to move out into the community and work with them. The students divided themselves into groups, which went to four different villages, one of which was to be chosen for the proposed fieldwork. The students finally zeroed in on Nagapur village, which was around 5 kms away from the Sevagram hospital because of practical considerations, and not the other village like Pujai though needy but was quite far away and transport facilities to which were abysmal. It was the first lesson that *roads and transport are related to health care.*

The group initially talked to the villagers about their health needs. In consultation, it was decided to run a dispensary in the local school on a weekly basis. They decided against using drug samples given by medical representatives because it was unethical. A small token amount was collected towards the drug bank from the villagers and the dispensary was started. The drug selection was based on effectivity, cost and toxicity. The generic drugs were used. In the process, the group could get insight of the *exploitative drug market.*

However, pretty soon the durgs ran out and on analysis, the group realized that the rich of the village were not paying up and it was actually the poor who had paid regularly. In the next village meeting, this was brought up and addressed. The rich felt hurt for being exposed publicly but then the flow of money became more regular.

Realizing that some kind of regular follow up was needed, it was decided to have a village health worker (VHW). Initially, they thought that the traditional 'Dai' could be given this responsibility but they realized soon that the community did not give her enough credibility. It bolied down to selecting a male health worker, from the community who was not necessarily poor. Also, he needed to be respected by the community to be able to provide a leadership role.

It was also decided that only those who could pay would be allowed to access the services at the dispensary. This led to a situation where the absolutely poor were not able to access the services. To cater to this target population, which needed support, the scheme was linked to the hospital which would help in sustenance of the scheme. Dr. Sushila Nayyar, the Director and founder member of M.G.I.M.S. agreed to a policy that any person from the scheme would get free treatment from the hospital.

The next step was the establishment of a village fund. Dr. Jajoo had visited various health projects before initiating this scheme and these visits had shown him that the main reason for starting these projects was on compassionate grounds. The all-enveloping love often created dependency among beneficiaries. It breeds relationship of a doler and the begger. Moreover, these projects were so heavily financed that their replicability was not possible. (PRIA, 1986 study). Dr. Jajoo did not want donations from outside to finance the healthcare (based on the feeling of "Charity Corrupts People"). The purpose of the fund was not to raise financial support to the outreach programme , but to generate demand for qualitative service from the providers; in fact it was a tradition among villagers to collect voluntarily contribution graded according to capacity for religious village function, sport competition or for temple construction. The fund would finance the salary of the VHW and the drug requirements of the local dispensary, besides transportation cost of the mobile health team. Since Jawar (Sorghum) cultivation was quite common and it was easy to contribute in kind, it was decided to accept the contribution in the form of Jawar (Sorghum) – *the contribution would be according to capacity and the services according to need (the poor needed more support).*

The fund would act as a pre-payment scheme subscription, entitlements being free primary health care and subsidized referral care (Jajoo, 1993). A minimum amount was decided which would have to be paid by every family and also additional amount of Jawar would be charged depending on the kind of work that the family members were engaged in or on additional holdings. At present the health insurance contribution from the lowest income group (landless labourers) is 12 payali of Jawar per family per year (a payali is a measure equivalent to 1.25 kgs and a Payali of Jawar sells for around Rs. 4 at present market rates).

Since this ensured that uniform healthcare would be available to all those who paid for the village fund, some of the rich farmers felt that they were financing the healthcare of the poor and did not pay up. Thus, only 60% of the village was paying up for first year. This was brought up at the next village meet. To ensure payment, it was made clear that only those who contribute will get the benefits of the scheme. The persons from the village who had paid would get free treatment, but who did not contribute to the village fund would have to pay for the treatment. Those who had not

paid (after treatment) and absconded would he held accountable by the village and made to pay.

To prevent misutilization of services at the hospital, it was fixed that 25% of the costs of elective admissions like cataract, hernia, normal pregnancy would have to be paid by the patient, while the treatment for an emergency / unpredictable illness would be free at the hospital.

Gradually over subsequent years, as scheme gained credibility, the coverage of the scheme grew from 60% to 75% and finally 90-95%. The village fund would pay for the drugs in the local dispensary, the VHW's salary and the visit of the hospital vehicle once in three months.

The meetings in the village (Gram Sabhas) about the various aspects of the scheme would be held every year before Jawar collection and would occasionally be 'stormy' and heated discussions would ensue. This Gram Sabha would serve a dual purpose of evaluating the performance of the health structure and also enacting disciplinary action on irregularities committed by the villagers themselves. The Gram Sabha helped to facilitate communication between the health system and the beneficiary on one hand, while on the other it helped the villagers to command control on the VHW and the health team. On occasion, the Gram Sabha decided to change their VHW (Jajoo, 1993). The scheme helped the community have a right to demand good quality care from the system. It also ensured politeness and better behaviour in the hospital on the part of the providers.

On the basis of the lessions learnt from Nagapur, the team extended the health insurance scheme to other villages (presently there are 40 villages within a radius of 25 kms around the hospital, covered under the scheme).

Initially the VHW was paid a fixed amount in the form of Jawar, but later on it was decided that the honorarium would be decided in the village depending on the VHW's work performance, whether he had been helpful and accompanied the patients in the time of the need. This was to bring in accountability to his / her work.

As the scheme slowly started spreading to other villages, each village opened an account with a withdrawal by cheques facility. All the Jawar collected as premium would be sold and the money would be deposited in this account as the village fund. At the end of the year, the money remaining in the accounts would be transferred to the village fund for the next year – occasionally, a part of the fund would be transferred to the Kasturba Health Society to form a common pool of money for all the villages – a corpus, the interest of which could be used for procuring drugs (centralized distribution from the hospital). The money would also be used for organizing educative camps and

'Prabhodan Saptahs' (Educative lecture week series) where non health related topics including social / spiritual issues would be discussed.

Only 10% of the expenditure on the scheme as recovered form the contribution in the form of premium and 90% of the cost came from the hospital. Since the MGIMS hospital runs predominantly on Govt. financing, which is public money, it was felt that this would be a appropriate utilization of the same.

The structure of the scheme revolves around (Jajoo ; unpublished) :-

- Accessible hospital services of optimum quality.
- Accountability of Heath care system to the consumers.
- Affordability of the services to the poorest.

Dr. Jajoo and M.G.I.M.S. realize that the sustainability of the scheme (that it has to cater poor) without external support is not possible. It was and is their belief that the government needs to support these kind of schemes and subsidize them as a part of its social responsibilities.

Social financing has the following spin off benefits (Jajoo, unpublished) :-

- It increases the accessibility of the health services
- It promotes the operators concern of the health in the community
- It generates the concept of the right to demand a quality health care by the beneficiary population.
- It responds to priorities as judged by the community.
- It ensures that the services are acceptable.
- It keeps the service providers on their toes.
- It stimulates organizational self-confidence and paves the way for participatary culture at the community level.

At this stage, the pre-requisite for adopting the scheme was – at least 75% of village families should contribute for the village to be insured. The scheme found acceptability among villagers and once they insured, did not look back for the years to come.

It was at this time when the scheme extended focus from curative care to preventive and promotive health aspects. The strategy of cluster immunisation to achieve herd immunity was successfully implemented for vaccine preventable illnesses. The village sanitation was addressed by evolving an appropriate model of latrine. 'One house one latrine scheme' aimed at 100% coverage of village families. It was not a dole. The part contribution in cash came from beneficiary villager and the rest from Gram Panchayat and state funds. The model found acceptance of the state and central government for its replication.

Poverty being the greatest evil behind most of the health problems, as a logical corollary, the scheme extended its web to income generation programme, addressing village as a social unit for development. All familes in a village were offered membership of co-operative society for dairy development or lift irrigation scheme for agriculture where ever feasible. The later initiative could come through the bank funds. The constitution of co-operative society was framed in such a way that decisions could only occur with no less than 75% majority, thus making elections obsolete.

At this stage village health insurance scheme underwent first qualitative change. In addition to 75% participation, at least one of the following criteria was needed for elligibility.

- Participation in "one house – one latrine" scheme with near 100% coverage of village families.
- Organising lift irrigation scheme for all village families
- Organising milk co-operative for all village families
- Electing village panchayat by consensus

Organisation of people through income generation schemes became a focus issue, benefitting the whole community. The *eligibility criteria now heavily weighed in favour of community action*. The health insurance scheme had now reached a stage where it was helping and initiating action oriented culture of the village. The changed face of the insurance scheme gave impetus to 'one – house one latrine' scheme in many villages.

The various schemes available to the village are –

a) Jawar insurance scheme – under this 50% subsidy is given on outpatient care and 100% on all indoor care except for elective admissions (50% subsidy)

b) Subsidised family insurance scheme for rural area (Rs. 15 / person/year) when 75% of village families contribute. In this scheme outpatient and impatient services are provided with 50% subsidy. The village need not fulfill the above enlisted criteria for enrollment.

c) Indoor insurance scheme in which there is no insistence on 75% of village families to contribute. The contributions are at the rate of Rs. 15 / person / year. There is no outpatient subsidy offered, inpatient charges are subsidised by 50%.

d) The hospital runs a health insurance scheme for families living in semiurban pockets and in Wardha town, at the rate of Rs. 150/year for a family of five. The entitlement includes 50% subsidy in out patient and inpatient charges.

Income generation programme became quite successful and brought in visible economic upliftment, with it vices like alcohol, gambling, fierce party politics and competitiveness found inroads in the village. The police frequently found entry and visits to judicial court galloped. It was a lesson to be learnt – *cultural development must race ahead of economic upliftment for a effective change*. It was a turning point for the ethos of health insurance scheme.

If the *ultimate aim of the health insurance scheme is organising people at the lowest ebb of society*, we opted for women's self help group (SHGs), since the women in poor families are the *'prolitariat of the prolitariat'* (as quoted by Dada Dharmadhikari). The women are hard working among all classes and the ultimate sufferers. They are also culturally sane. The organisation of this culturally sane section of society found its initiative in the early 90s.

The organisation of women in to SHGs was need based, so that their dependence on money could be addressed by forming collectives that would be able to provide economic support when neded. It was noticed that the women would stand by each other and there would be transparency, leading to more accountability. The culture of decision making by consensus was thoughtfully inculcated in SHGs. As the money started coming (linkages with bank), women's status in family changed as she was now looked upon as a bread winner for the family too. The process helped empowerment of women.

By now it was realised that though *health care offers an ideal medium to get entry in village life (albeit costly), organising the entire community around it had not taken roots, simply because it was not and is not the priority need of the masses*. Illness as a calamity affects individuals and is rare to find epidemics sweeping the community around which a sustained mass action can be initiated.

The income generation programmes attract people as they serve their individual interest. Since the programmes addressing all village families were chosen (lift irrigation and milk co-operatives), every one hugged together to harvest the gains, creating a false impression of an organised community. In fact these programmes inculcated competitive life style and the greed that comes with it. The realisation dawned, that short of cultural ethos, mere economic upliftment treads the wrong path.

The health insurance scheme had now reached a stage where it was helping identify not only the action oriented culture of the village but also action oriented individuals with capacity to do good. All are not equal in a village, some are more reverable than others. The culture evolution needs active participation of these revered ones (Sajjan Samarth). With aim to organize them, the focus of health insurance scheme shifted to individuals and families than the earlier insistence on an entire village. Action

plans for individuals now emerged like – organic farming and Vastra Swavalamban (Cloth self sufficiency). These are acts in faith. For an intelligent direction of this kind, study circles (Prabodhan) became the need of the hour. It could not have been classroom learning. It had to be experiencial sharing.

The educational talks based on experiencial Wisdom were organised after the month of February, when the crop harvest was over. The usual site was temple, after "Arati" was over at 8 p.m. A discussion would be initiated on issues relating to their day to day life, linking them to social – cultural values. Organic farming was encouraged. The 'Role models' in various fields were put before the community. The educational trips to Role model's work place helped people imbibe goodness. Thus evolved programmes aiming Vastra Swavalamban and sustainable agriculture.

The focus of the scheme now shifted to organise and empower the revered ones. It aimed at breaking their *culture of silence* with a hope that reigns of power be vested in moral leadership. It is from this empowerment and leadership the anti-liquor movement has taken roots in the villages around Sevagram.

The Jawar insurance scheme underwent a major conceptual change, focusing on individuals and families than the entire village. The family had to fulfil at least one Criteria for eligibility of enrollment.

- Member of the SHG.
- Experimenting organic farming
- Taken a vow for Vastra Swavalamban
- Active member of study circle in the village.

When the scheme began in 1979, the focus was on curative care; later on it became preventable care; it then reached the stage of promotive care through income generation schemes; the focus moved on to being social and now it is to encourage moral issues in society. Those that give priority to moral issues are insured under Jawar scheme, while the rest can choose any of the other schemes listed above.

The changing focus gave impetus to SHG movement. SHGs were linked to banks, enabling them to offer crop-loans to the members. It being a unregistered body, entirely runs on faith. It selects office bearers by consensus who by rule, do not stay in office for more than two years. All codes of conduct were evolved through group discussions. The culture of decision making by consensus and transparency in all transactions buttressed the faith women enjoyed among themselves. Since it enjoyed credibility of a dependable source of financial support, hence it did not see any defaulters of loan. The forum slowly took up educational role through experiencial sharing sessions, educative trips and by attending educational camps.

It was realized that common man/woman in particular, acts in faith and that is the driving force for him/her. This faith needs to be properly directed by the wise people.

Characteristics of the Oasis :

1. Affordable and accessible:

It is due to fact that families enrolling for Health Insurance contribute according to capacity but services are provided according to need.

2. Acceptable :

The evidence - More that 95% enroll in the village. It speaks of its quality. All indoor hospitalization from adopted village occur in Kasturba Hospital, Sevagram. They do not go to the flourishing private sector in Wardha town.

3. Effective :

The Evidence – No maternal mortality in past 15 years.

- No death due to non-accessibility of medical care.
- No Tetanus, Polio, Whooping cough, Measles in last 15 years. Measles is the most sensitive indicator of herd immunity achieved.
- No misutilisation of resources.

4. Accountable :

The social finance has generated right to demand, which keeps the service providers of their toes.

5. Wholistic :

It is not an experiment planned from ivory towers with a tubular vision. The experiment has evolved with the involvement and feedback from the people and has transcended wholistically to the priority needs of the people.

6. Credible :

It is something that can not be quantitated but has be felt. It can be witnessed in –

- Late night village meetings where discussions turn in to educative sessions.
- Self-help groups not only as a transparent financing body but transforming in to a educative forum and Empowering women,

- Vastraswavalamban (Khadi for own use) and sustainable agricultural practices as a step towards freedom from exploitative market.

Self reliance in priority needs is a key to empowerment.

7. Trustworthy :

The gains of this experiment have been the relationship of a friend / partner, the free lines of communication with the beneficiary and the conversion to a big family. There is implicit trust involved and this enables the poor to share their pathos. They come to health care professional with the belief that they would do their best and leave the rest to destiny. A relationship of trust is thus established which brings people together and keep the scheme going on.

8. Replicability :

The credibility of scheme revolves around the will of the hospital management to support. Dr Jajoo is a pivot around which the scheme revolves. In his absence the need based health insurance scheme would continue, though the outreach activities and other dimensions of health would suffer.

Research :

The service to the people was main concern. Research was not really a focus because of lack of interested manpower. The focus was instead on operational research and on extending the scheme to community by emphasising other dimensions related to health ethics. Over the years, the scheme has generated a lot of data but this needs to be analysed.

The operational aspects :

The hospital has now become much more accessible to the community and this has helped bring down the incidence of deaths like that due to pneumonia and diarrhoea. Vaccine preventable illnesses (tetanus, polio, whooping cough, measles) have disappeated once herd immunity was established and maintained by cluster approach to immunisation. From the year (1995) government adopted cluster approach to immunisation, vaccination is left to government ANM. The village worker performs a watch dog function to see that all eligible receive it.

The deliveries are free in the hospital for primiparous and for complicated pregnancy. The women can choose to have delivery either in the villages assisted by traditional birth attendant (TBA) or in the hospital. The services now being accessible, women choose to have hospital delivery. ANC (Antenatal care) up to 7th month are

handled by village health worker. While around 7th month, women report to Kasturba Hospital for assessment of pelvis, toxaemia and for receiving booster of tetanus toxoid. The area catered by health insurance scheme has not witnessed maternal mortality from last 15 years and the natal / prerinatal mortality has reduced significantly.

The monthly ANC visits in the villages have been given up. ANM visits villages once in three months, checking all records maintained by village workers (ANC registration, Vaccination, Birth, Death). With appropriate strategy for vaccination and ante-natal care, which utilises village based manpower to the maximum, the need of skilled manpower is reduced to the obligatory minimum. The ANM under the scheme acts at the second tier managing the administrative work of all the villages in addition to supervision of village based activities in 40 villages. She visits all hospitalised patients, assures expeditious services, entertains their complaints, keep records and informs tricky problems to Dr. Jajoo.

The process of selection of VHW has undergone a sea change. Initially TBA was preferred with a notion that she has natural access to pregnant women and new-borns. She belongs to lowest socio-economic class, is needy, hence would be most appropriate choice. The experiences was contrary. She was called only for conducting delivery and taking care of new born for next ten days since no body else would do it. She did not and does not enjoy enough credibility in the minds of people, that advice would be heeded. She had to take permission from her husband to accompany a patient in the night to the hospital, if emergency so demands.

The option shifted for a male member. With the evolving role of VHW, a person with leadership qualities, one who is respected in the community and has aptitude to serve, happened to be the choice. Since the village fund that could be raised from prepayments did not permit lucrative honorarium (it is hardly 1000 – 1500 Rs. Per year), only a person from middle class background with aptitude to serve could be selected. Since the selection was done in consultation with wise and elderly men and women of different caste groups in the village, often in front of the temple, the person acceptable to all had to be one beyond village party – politics.

With SHG movement taking shape, it was easy to locate women with leadership potentiality and serving aptitude. Most of the villages, at present have two village workers, one male and other female, assisting each other for the comprehensive development of village.

As the vision behind the scheme was ever evolving, Dr. Jajoo, ANM (Mrs Bagade) and village workers all underwent a problem based learning. Frequent meetings (Late night) with Gram Sabha, generated directions which way to go. At no time, need for a formal training was experienced. The team learned by doing and

experiential sharing. Every thing needed had to be learned by all. The learning transcended beyond scientific to socio-economic-political-spiritual dimensions of life.

According to Dr. Jajoo, the propagated glorified role of VHW as a liberator in late 80s and early 90s had to settle down to ground realities. For a peripheral health workers to perform successfully, an effective back-up referral system needs to be in place. The credibility, ultimately in the community is for curative care and not preventive care. The experience in Sevagram has shown that the acceptability of VHW depends greatly on how much support the medical team can give him / her as a link between the community and health delivery system (PRIA study 1986).

Community involvement in health care :

Community involvement is a glibly used slogan. It has different shades –

- *Community complacence* where community is a passive receiver.
- *Community co-operation* – where manpower support is offered by community.
- *Community partnership* – demands material support from the community in addition. In all these, there is a 'big brother' that dictates.
- *Community* participation is a politicised concept. The decision making lies with the people. There is a common feeling and hence spontaneity in action.

Health being a service sector, professional relationship is vertical. Health insurance scheme, has horizontalised this relationship to the extent possible. It exemplifies health for the people. Sevagram could achieve community partnership while evolving models like 'one house one latrine scheme', milk co-operatives and lift irrigation co-operatives. The scheme did succeed in unifying village community through income generation programmes. But money brought with it liquor, gambling, party politics, police and judicial courts. *The fact brought home the painful realisation that pooling people together for material gain is not development.*

Village around Sevagram has witnessed community participation emerging during farmer's movement. It breathed its last because it aimed only for material gain.

The scheme experienced right kind of community participation emerging with Vastraswavalamban Yojana, sustainable agricultural practices and SHG movement of women in particular. It is an empowering experience, evidenced by the anti-liquor movement that is taking roots in village around Sevagram. *The right kind of community participation emerges when spiritual wisdom leads and lights.*

Experiencial Wisdom of last 20 years

For pro-people (poor) health services, self reliance is a myth. The Jawar scheme could raise around 10% of what is spent, by social finance. The private insurance which works on the principle of financial risk sharing on no loss basis, can never cater poor. Dr. Jajoo emphasizes that *pro-poor health care must be domain of state's welfare activity.*

It is possible to offer just primary health care to all within presently allotted government resources (250 Rs / Per capita year). The maldistribution of centrally pooled resources is what primarily ails our system. The percolation theory – that centrally allotted funds will reach to the periphery – fails. If the government decides to hand-over its percapita expenditure on health directly to Gram Sabha then there can be better control of the health services. Where they control health finances, they can negotiate services from the providers, it gives them a better pedestal. The community can then buy the services from the public or the Voluntary sector which is arguably propeople. Empowerment of people without ownership of resourses is not possible. The bottleneck of Sevagram experiment was the fact that people did not own resources and were on receiving end and hence the programme remained vertical and complete participation was not possible.

It requires a radical political will to truly decentralise up to Panchayat Raj system and distributing resources to it on percapita basis. The structural adjustments of this kind can see replicability of Sevagram experiment.

Short of these structural adjustments where-ever 90% of the finances can be granted to the voluntary sector (as is the case of Kasturba Health Society), mechanisms and organisational part of the scheme would be replicable. The will has to exist, it can not be replicated.

Ethos :

We live in a society where "*all men are equal, but some are more equal than others*" ! It is not an egalitarian society, social relationships are exploitative.

The fact reminds of a story form Panchatantra --

"There was a forest. Out of all the animals, a wolf and a crane together were invited for the feast KHIR. (sweet rice-milk) was served to them in a plate and both were invited to enjoy the same. Guess who must have gulped it? The wolf had its day. The host was intelligent. He invited them again for a second round, but KHIR was now served in a MATAKA (earthen vessel). It was the crane's turn, whose beak could reach the depth of the vessel, while wolf's tongue could not."

Mere availability of public facility does not make it accessible to "Have-Nots". In a democratic society, "more equal" (Haves) have to be restrained, for public benefits to percolate down. It calls for appropriate structural adjustments.

Sevagram Village Health Insurance Scheme idolizes Health Care for the people.

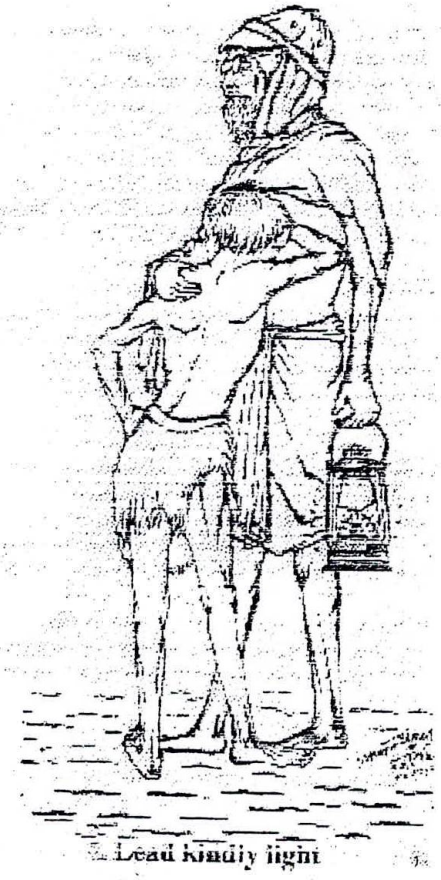
Uniqueness of the Oasis :

- The Health Insurance Scheme reaches out to the unorganized sector, poorest of poor.
- It is the lone health care experiment, which considers village as a social unit and adopts villages.
- Thereby it attempts to empower the Gram Sabha in Panchayat Raj System
- We believe that blind charity corrupts people. It is not a dole. It raises social finance.
- It evolves a relationship with the people by talking 'with them' and not talking 'at them'.
- The vision behind this experiment comes from our role model – Vinoba Bhave.

Our generation has heard about Gandhi and read of Gandhi. We have not seen Gandhi in action. We saw Vinoba in action. The line sketch of Vinoba that appeared on "First Day Cover" where his postal stamp was released, aptly depicts what Vinoba stood for.

- He has a lantern in his hand. The title reads – **Lead kindly light** or ***tamso ma Jyotirgamaya***. He leads the path.
- He has his vision on the horizon, which dreams the concept of an ideal society – a society based on principles of freedom and fraternity i.e. Gram Swarajya.
- Look at the compassion that embraces the poor. He empathizes with the poor and the dewntrodden (Antyodaya) and leads them from darkness to light.

It is this specter that haunts us.



Lead kindly light

The ethos of the whole process of the scheme's evolution has to develop a democratic society, especially revolving round the village as a unit of society. The concept of village republic (Gram – Swarajya) of Gandhi- Vinoba – Jaiprakash Narayan, is the ultimate vision of the scheme. Vinoba gave a structural form to the vision in Gramdan. The power lies with the Gram Sabha which consists of one adult male and female member of each family in the village. It is the highest decision making body. The decisions are needed to be taken by near consensus. *Election is considered a foul mean and purity of end is decided by purity of means.* The leaders are selected and not elected. It is in sharp contrast to Panchayat Raj system which has in place narrowly elected (51% against 49%) group of representatives. The representative democratic structure is not pro-people in true sense and has been replaced by participatory democratic structure of Gram Sabha.

The concept is detailed under the Gramdan act of the Indian constitution that was engineered by Vinoba. Under this act, at least 75% of the population of the village should transfer the title of their land to Gram Sabha, then only such a village be called as Gramdan village. The villagers enjoy the right to plough, cultivate and consume the produce (Crop) from the land. However the land can not be sold to any body outside the village. They decide their own land records. Under this act, the ownership is collective, but the individuals continue to enjoy consumption right over fruits of their labour for generations to come. Thus it promotes a society which survives on 'bread labour' and does not permit 'intellectual labour' to exploit. The ideal society would be one that would revolve around concept of 'bread labour'. In such society there would not be much difference between the members and interdependence be obligatory. The decision making then would be a collective exercise which would decrease the possibility of unfair or wrong decisions.

The concept of *'labour currency'* which equals physical labour to intellectual labour is considered prerequisite for the equality in socialistic philosophy. By underpaying for physical labour, exploitative society pools the *'surplus value'* in control of *'more equals'*, thus creating classes. By virtue of collective ownership of natural resources like land, water and forest, the Sarvodaya philosophy in Gramdan digs out roots of exploitative structure in present society and paves the way to nurture values of *equality and freedom.*

Empowering Gram Sabha is the key to Gram – Swarajya. Empowerment occurs when resources are owned and freedom of decision making rests with Gram Sabha, when decision making is obligatorily by consensus or overwhelming majority, no wrong decisions can occur. The opinion of the silent majority now supervenes. The *'culture of*

silence' of revered-ones is now broken. As is a saying in eastern culture – "*God speaks through them.*"

It is not a wild dream. A tribal village – Mendha (Lekha) in Gadchiroli district of Maharashtra, having population of around 400, has implemented their slogan "Delhi-Bombay exemplifies '*Our*' government, '*We*' are the government in Mendha." The poor and illiterate people of Mendha exemplify empowering of people and the culture of Gram Swarajya.

How should health system be in the context of Gram Swarajya ? It has to be health by the people, for the people and of the people. Since the resources must be owned by Gram Sabha, the Sevagram experiment proposes distribution of centrally pooled resources by the State and Central government to be distributed back to village on per capita basis. ~~Since~~ The freedom-which services to buy – should also rest with Gram Sabha so that just decisions can evolve. Short of these structural adjustments (which requires strong political will), Kasturba Hospital Sevagram holds the government grants *in trust* and distributes public money appropriately by raising a model of *health for the people*.

Jawar health insurance scheme at Sevagram is an attempt to identify revered individuals (SAJJAN SHAKTI), empower by bringing them together, inculcate a culture of decision making by consensus and initiate acts of common faith.

Looking back at the experiment that this scheme has been. Dr Jajoo feels that a model has been developed, which is ideal and is replicable in an ideal kind of society envisaged. The lamp needs to keep burning until the fire catches on. This is a 'micro' experiment for a 'macro' ideal. Multiple experiments need to be done and time would only decide when they would be replicable. The need is to act locally, while thinking globally. *One step in the right direction is enough.*

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COMH-2A.

HEALTH SECURITY FOR THE POOR : HEALTH INSURANCE THROUGH HEALTH CARE COOPERATIVE

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Fears are sometimes expressed particularly in the context of developing countries that economic reforms consisting of liberalization, privatization and globalization, primarily focus on economic objectives of efficiency of resource allocation and the social objectives of distributive equity and social development are likely to receive a back seat in the course of pursuit of economic objectives. Much is documented in the literature on the compression of the government budget in general and the overall budget of the social sector in particular, especially in developing countries during reform. This compression is more likely to affect primarily the poor and the less privileged in the society. Obviously, it is not enough if the problem is diagnosed. What is necessary is to introduce immediately the counter measures to tackle these likely developments. It should be noted that such counter measures to safeguard the interests of the poor are required under all occasions, whether there are economic reforms or no economic reforms, for, the problems of equity (inequity) lie very much in the nature of the components of social sector itself, particularly in the context of a stratified society like India. This will be brought out from Section I of the present paper. Economic reforms however are likely to aggravate the problem.

Demand for health and education, the main components of social sector, is generally highly income elastic. Similarly, access to health care and educational opportunities is also found to be highly income elastic. In a regional perspective, demand for and access to health and education seem to be elastic with respect to the level and rate of economic development of the region. It is also worth noting that health and

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education confer both private and social benefits. Opportunity costs of education and health are generally fairly high particularly for low-income households. Costs of maintaining health, costs of getting education and avoidance costs of ill health and non-education are too high to be overlooked. From all these points of view, **education and health are considered in public finance literature as *merit goods***, implying that they are so meritorious from the point of view of social welfare that issues of their provision cannot be left to the decision making of the individual or private sector alone but they need to be considered by the collectivity or public sector also. In the present paper an attempt is made to focus on issues relating to the provision of health care facilities particularly for the poor keeping in mind the characteristic features of health calling for involvement of the collectivity or public sector in its supply or making provision for it. The paper suggests a mechanism of involvement of the collectivity – community and the government, which would help better access and utilization of health care services by the poor. ***The focus of the paper is on health insurance facilitated by the health care cooperative of providers of and beneficiaries from health care services.***

The paper is divided into four sections.

In *Section I*, unique characteristic features of health relevant in the present context are briefly outlined.

Section II examines some of the resource allocation plans to the health care sector suggested in the literature, keeping in mind the requirements of the poor in general and the poor among the socially less privileged sections of population in particular. Its main focus is on the basic issues that need to be considered while implementing the plan.

Section III presents a brief review of the experiments of health care cooperatives and health insurance as in practice in selected countries with a special focus on the experiments and proposals in India.

Section IV, which is the concluding section, outlines major elements of a health security plan for the poor incorporating the insurance strategy first in general terms and then particularly for one of the villages in Karnataka, for which field data were collected for the purpose. This example attempts to indicate the order of resource requirements if such a plan needs to be implemented on a wider scale. It also examines whether there would be resource savings if such a plan with community involvement and contribution is implemented in place of the present practice of government itself taking the entire responsibility towards health security for the poor.

I. HEALTH AND HEALTH CARE SERVICES AS AN ECONOMIC GOOD IN THE INDIAN CONTEXT

Health is an economic good, the peculiarities of which need to be explicitly recognized in any health security plan. We briefly outline below some of these peculiar features particularly in the typical Indian context, with her own unique value system, traditions and socio economic conditions. In the Indian context health services would also have their own peculiarities in respect of their supply and demand, which deserve a special attention while developing a health security plan for the poor. It can be seen that inequality in access and utilization are inherent in the very nature of health and health care services as an economic good, particularly when it is left to market forces.

Is Inequality in Access and Utilization Intrinsic to Health and Health Care ?

From the following characteristic features of health and health care it would be clear that conscious efforts have to be made to safeguard the interests of the poor so far as the needs of the poor are concerned. Social and economic backwardness would further aggravate these inequities.

- There is no universally acceptable yard-stick for measuring health level of individuals. Also, there is no acceptable definition of health. As a result, there is a greater probability of episodes of general ill health (which might, at times, lead to major ill health episodes) being overlooked or treatment of which is likely to be postponed. This happens particularly in the case of poor households and in the case of those who have low social status even in the case of a well to do family. On the other hand, rich households and only socially better off members of even a better off family (such as earning members or male members or members who are accepted as heads of households, even though they are not earning members, or those who are ritually superior, such as mother in law rather than daughter in law, etc) are likely to receive more attention regarding even small health problems also, since they can afford the high costs of such medical attention and treatment or resources are made available for them rather than for others for this purpose in view of their ritual status. Thus, the *probability of medical care attention* is *a positive function of socio-economic and ritual status of the individual / household in question. In other words,* ***in the Indian context, availability of medical care attention is not just in accordance with the demand and need for it but it is most often in accordance with factors other than these.***

- In view of the low economic status of the members of poor households, who depend upon their physical capabilities and skills for meeting their daily subsistence needs, it would be imperative for them to maintain their physical and mental well-being at a fairly high level, which enables them to put in work and earn daily livelihood. Illness causes immiserization of the poor and hence it is necessary for the people to avoid illness or debilitating morbidity causing further impoverishment and immiserization.[1] This is particularly seen in the case of those members who work in the unorganized sector and who work on a daily wage basis. Thus, what one may call, the '***subsistence need for medical care attention***'

[1] Hsio and Sen reported that 40 percent of the entrants to poverty in a particular year in India attributed poverty to illness episodes in the family. Hsio, William and Priti Dave Sen (1995) 'Cooperative Financing of Health Care in Rural India' Quoted in TN Krishnan : *Economic and Political Weekly* April 13 1996

is a negative function of economic status of the individual member in question. This should not be taken to mean that better off people give less importance to health and health care. On the other hand, they pay more attention to even a small disturbance in their health, as stated earlier. What is implied here is that ***for the purpose of subsistence earning, meeting the need for health care is more mandatory for the poor than for the rich.***

- ***Some of the health care facilities are, by and large, in the nature of indivisible goods, while services from these facilities are characterized by a fair degree of divisibility and rival-ness in consumption.*** *These may be termed* ***as lumpiness in supply but a fair degree of divisibility in utilization.*** In view of this lumpiness. large investments are needed to supply these facilities. **There is a tendency of *cost recovery charges from the purchasers of services being over estimated*** in such a situation. In view of speedy technological changes in the field of medical science and public health and hence expectation of foreign initiatives in the background of globalization, uncertainties associated with the occurrence of morbidity episodes requiring the use of a particular facility, uncertainties associated with the use of the created facilities by the affected persons, etc. there seems to be ***an undue haste in cost recovery by the investors making the charges for the users unduly high.*** Added to it, the instinct of greed and a desire for more and more and more also contributes to this tendency for over -charging.

- Another factor also contributes to this tendency. which is the result of some of the **recent developments under economic reform regime.** In view of the declining interest rates on borrowings and trends of privatization. such facilities are likely to be created with the help of borrowed funds[2] by few private initiatives that can provide the necessary collateral required for loans from financial institutions. This would also give rise to a situation of ***few sellers*** **operating in the health care**

[2] CMDR proposes to study the changes in financing of activities of medical care providers before and during the period of economic reforms. For such a study micro level field data need to be collected from private sector providers. We have not come across any such longitudinal micro level study in the literature.

commodities markets. ***Such sellers can control price of services and also indirectly the clientele utilizing these services.*** This characteristic feature would have significant implications for access of the poor to health care services.

- ***Health care services consisting of both material and manpower services – are likely to get concentrated in urban areas*** **in view of their characteristic features outlined above.** Since large percent of agricultural labourers are located in rural areas, they are more likely to be deprived of the necessary benefits from health care facilities, which are not adequately available in rural areas. ***Health facility mapping*** for rural and urban areas in different states of the country would reveal how the facilities get clustered disproportionately to the population in urban areas.[3] It is useful to work out *regional inequality indices of health care facilities in rural and urban areas* of different states. District-wise facility mapping would more clearly bring out the deprivation of rural areas. Field studies show that the rural folk have to walk down / travel in bullock carts or tractors for miles together in search of medical assistance in the case of illness episodes. It is also worth noting that most of the health care centres located in many villages are mostly non-functional, ill equipped and inadequately manned. This also suggests that the ***health facility mapping needs to be done keeping in mind the functional existence of the facilities rather than merely their physical existence.*** **Intra regional facility distances are most often found to be an inverse function of the level of economic development of the region,** suggesting that ***the poor in the less developed regions are likely to be more adversely affected than the poor in the more developed regions.***

- Considering gender dimensions of commodity of health and health care would bring out many important aspects worth noting while developing a health security plan for the poor. Generally, women are considered as health care providers in the family. However, health of the health care providers in the family is generally

[3] One such attempt is in progress at CMDR in the case of Karnataka state. In view of information gaps only public medical care facilities are being mapped.

overlooked, not only by other members of the family, but also by women themselves. Traditionally, low social status of girls and women in Indian family contributes to this. As a result, female members, right from baby girls to elderly women in the family are likely to be more deprived of health care services than male members, starting from baby boys to elderly men in the family. This discrimination is more severe in poorer families, rural areas and poorer states. Health condition of female members in poorer environment- regions and households is likely to be much worse than that in more developed regions. ***Access to, utilization of and benefit from health care services are thus a function of gender with adverse effects in the case of female members.***

- ***If health and health care are under-priced in the present period even though the price payable for them by the beneficiaries in the long-run works out to be much higher, then*** **generally, there is a likelihood of the normal law of demand to operate vigorously in the short run keeping in mind the price in the present period only. Thus, in the case of demand for health care services defective telescopic faculty seems to operate.** Price elasticity of demand is generally very high for the people of all economic levels and at all price levels. But, at high income levels and at high price levels price-elasticity is likely to be higher, other things remaining the same.

- ***There is an asymmetric information flow for medical care providers and patients, with some information available more with providers and some other crucial information available more with patients.*** For example, scientific, medical information about diseases-causes and cure in general, is available with medical care persons-doctors, nurses, etc. But, information about how they feel while suffering from disease, while receiving treatment and after treatment, etc lies essentially with the patients. Information about preventive care and promotive care is available with medical and public health personnel whereas information about the effects of these measures of care is available with only the clientele-beneficiaries.

- Considering the aspects under the above two paragraphs, it follows that **there is a risk of overuse of certain types of care by the people, particularly at higher income levels,** since they can afford larger expenditures on drugs. Excessive use of drugs and medical services is termed in the health insurance literature as 'moral hazard' implying probably that people consume more of medical care than what they really require and that such over use is likely to be hazardous also. People's expenditures might be guided by what one may call, ***presumptive prescriptions by medical experts***, who in turn might act under wrong information or self-interest considerations. Provider-induced-over-use of drugs and medical services or even self-induced over use might ultimately exaggerate demand for drugs and services and distort long term planning in the case of the health care sector.

- ***Price and income elasticities of demand for health and medical care are likely to be high at high income and price levels than at low income and price levels.*** In view of this, generally, special attention seems to be paid by providers to those drugs and services, which cater to the needs of high-income groups of population. This leaves the needs of the poor unconsidered in normal circumstances, unless special initiatives are made for the purpose. This is evident from the location of medical care services in urban areas, where, generally richer sections of population live, the rate of growth of tertiary care investment is higher than that in primary care in rural areas and similar indicators. Analysis of drug prices meant for the common care and for tertiary care should also be revealing from this point of view.[4]

- Preventive health care services are characterized by special features, which deserve attention of analysts, while designing health security plan for the poor. Demand for preventive care is much less clearly articulated than demand for curative care. Also, effort for meeting this demand is also much less in this case as compared to curative care. Articulation of the need for preventive care is

[4] CMDR has commissioned a study of drug prices, the results of which would throw a light on these issues.

obviously a function of level of awareness among the people about its importance. ***Since the effect of absence of such care is felt much later after a long time lag immediate appreciation of the importance of preventive care is generally not seen both by the individual beneficiary or the collectivity as a whole.*** This is one of the reasons why the decision makers do not undertake the projects for preventive care so enthusiastically. Even at the individual level much attention is not given to measures for preventive and promotional care as in the case of curative care.

- As indicated above, preventive care can be of two types, viz. individual-specific preventive care and collectivity specific preventive care. **Demand for both types of preventive care is a positive function of level of income of the individual and the collectivity apart from the level of awareness about the importance of such care in the functional capabilities of the individuals**. Hence, preventive care becomes a predominant merit good, being so meritorious from the point of social welfare that it calls for collective intervention for provision over and above private initiative for its provision. ***Since the poor in particular, are likely to be more vulnerable if such care is not available it becomes necessary to devise ways and means for its provision to help them.***

From the above conceptual background relating to health and health care services as economic goods, it is clear that generally the poor cannot safeguard their own health care interests and that such interests can be safeguarded only if suitable mechanisms are evolved. Such mechanisms should be developed incorporating the involvement of the people, invoking the spirit of altruism and mutual sympathy among those who have higher ability to pay and better capacity to organize services with a longer out-reach both with respect to time and number of people. It is felt that the spirit of cooperation, which already prevails among the people in India, particularly in villages, needs to be aroused for invoking this spirit of altruism and mutual sympathy. Sympathy and mutual sympathy have been considered as one of the six springs of human conduct by Adam Smith. In his *Theory of Moral Sentiments* Adam Smith devotes one full chapter to

eulogize the ' Benefits from Mutual Sympathy'. Mutual Sympathy has received the highest importance in the codes of conduct sanctioned by many religions of the world also. Therefore it would be useful if this spirit of mutual sympathy is utilized for helping the poor in their health care needs. Since the poor cannot bear the high costs of health and medical care it would be necessary to ***devise a mechanism invoking the spirit of mutual sympathy and cooperation, through which it is possible to provide health care services at reasonably low current costs spreading the rest of costs in suitable installments in the future.*** The mechanism should explicitly note the seasonality (as in the case of agricultural labourers, for example, who get earning opportunities mainly during the agricultural seasons) and at times irregularity of the income flows to the poor households and adjust the payments towards health care costs to such income flows. This mechanism should also recognize the fact that occurrence of illness and its duration are uncertain. ***Any organizational mechanism that can pool the risks of illness of the poor households and that can provide for convenient cost payment arrangements should greatly help the poor.*** Health insurance is considered as such a mechanism, which can greatly help the poor. Health insurance is also a mechanism for gaining access to health care that would otherwise be unaffordable.[5] If cooperative elements were integrated with health insurance then it would have an added advantage for the poor.

II MAIN ISSUES REGARDING HEALTH INSURANCE AND HEALTH-CARE COOPERATIVES

Health insurance and health care cooperatives can be considered as the methods for pooling of risks of different types of ill health across individuals and over the period of time. A number of issues in this connection have received the attention of researchers. Some of the important ones are briefly outlined below.

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[5] John A.Nyman : 'The Value of Health Insurance : The Access Motive' *Journal of Health Economics* 18 (1999) This study shows that even in the U.S. access motive is facilitated by insurance and that the poorer of the Americans are enabled to have access to costly medical care, which they could not have afforded before

- When health sector budgets are getting compressed during the period of economic reforms can health insurance mechanism maintain the overall budgets for health care sector at high levels ? In other words, **can insurance be considered as a dependable source of financing of health ?**

- Government provision of health care services is believed to safeguard the health care needs of the poor. In this background, to what extent can health insurance mechanism be considered as responsive to the needs of the poor ?

- Does health insurance mechanism lead to what is termed in the literature as ***moral hazard***, implying more than an optimal use of medical care services ? Choice of the best health insurance plan involves a trade off between the gains from risk reduction in connection with the disease/s covered under insurance and the loss of moral hazard.[6] How far are people in a country like India in a position to make such a best choice ?

- **Does this excessive consumption of medical care have its own implications for health of the users ?** Studies have tried to show that having insurance is associated with having better health.[7] The hypothesis of effect of excessive consumption on health status, needs to be tested with micro level data.

- **Does this excessive use of medical care services by the rich result in less availability of services for the needy, who may not be in a position to bear the cost of health insurance itself?** Does this also result in inefficient allocation of scarce medical care and financial resources of the economy in the ultimate analysis ?

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[6] Willard G. Manning, M. Susan Marquis : 'Health Insurance : the trade off between risk pooling and moral hazard' *Journal of Health Economics* 15 (1996)

[7] Beth Hahn. Ann Barry Flood : 'No Insurance, Public Insurance and Private Insurance : Do these options contribute to differences in general Health ?' *Journal of Health Care for the Poor and Underserved* VI 6 1995.

- In view of its effect in terms of excessive demand for medical care services, does **health care insurance lead to further rise in price of such services and also in insurance premia in the long run, making health care more costly for the poor**, the very problem, which the insurance mechanism wanted to tackle itself ? These aspects would be very crucial in the context of developing countries where cost escalations would lead to further deprivations of the vast masses of the poor.

- **Making health insurance mandatory is likely to result in a welfare loss for those who had not purchased it earlier.** This issue needs to be examined in the specific context about which not much research seems to have been done.[8]

- **Does insurance mechanism sustain itself in the long run?** This question is relevant because the overhead costs and operating costs of such a mechanism are likely to be quite heavy and which might not be recovered from the clients through premia ?

- If the premia are hiked up significantly in order to recover the costs then in what way would this mechanism be different from the private market based supply of health care services ? **A rise in premium might discourage the less privileged people to go in for insurance cover.** One of the studies in US has estimated that a 1 percent rise in insurance cost would lead to a 1.8 percent reduction in the probability of persons seeking insurance cover.[9]

- **Should health insurance be provided by government itself or by the private sector initiatives or by both ?** If both private sector and government are operating at the same time, would there be a tendency of government being ***crowded out*** by the normally aggressive private sector initiatives ? In the context

[8] Michael Chernew *et al* : ' Worker Demand for Health Insurance in the Non Group Market: a note on the calculation of welfare loss' *Journal of Health Economics* 16 (1997)

[9] Gruber, Jonathan and James (1994), Tax Incentives and the Decision to purchase health insurance : Evidence from the self employed. *Journal of Health Economics* , 109(3).

of the U.S. however, employer delivered health benefits are reported to have been replaced by the government insurance mechanism.[10]

- Some studies have also shown that significant health status differentials among the insurers are observed in the case of public and private health insurance systems, with lower status in the case of the former.[11] Would this mean that provision of publicly managed insurance for the poor and privately managed insurance for the rich would lead to health status disparities among the poor and the rich in the society ? ***What is the optimum public private mix in the case of health insurance ?***

- Does insurance mechanism in general ensure high **quality of health care services ?** Does government operated Health Insurance ensure better quality of services or private sector operated insurance would achieve that objective ?

- **Whose out reach is better- private sector's or government's,** so as to ensure availability of health care services to the poor, to the socially less privileged, to the people in remote areas, to children and to the elderly also (as, normally private health insurance operators are found to exclude people outside a certain age)?

- Does health insurance mechanism provide for **articulation of the health care needs by the people who are in need of such services** ? Or, does this mechanism strengthen the **dominance of the providers in the health care sector** ? Would this imply the relevance of Say's Law of Markets in health care market (Supply creates its own demand) with its concomitant implications for the clientele ?

- Can health insurance mechanism be so structured as to integrate the **equity considerations** ? Thus, can there be differentiated premium system, distribution of claims in cash or kind, coverage of all types of health care needs such as

[10] A number of studies are conducted to examine the relationship between public and private health insurance systems. For a list of some of such studies please see references at the end of this paper.

preventive, promotive and curative needs, etc. ? Can a Health Insurance mechanism cover the *risks also of common ailments of masses*, which at times become economically costly for those who lose their work days on account of such weakening common ailments and which reduce their work output ? Should premia alone be graded or service charges also be so graded or both, to ensure equity in access and utilization ?

- **Are people in a country like India aware of the advantages from health insurance** so that it would have a fairly good demand just enough to sustain it in the long run ? What measures need to be taken to raise the level of their awareness about the value of health insurance ? [12]

- Can health insurance be extended to rural areas, un organized sector, all types of occupations and all income levels, all age groups, etc. for, inclusion of these under the insurance cover is feared to increase the risk of losses of insurance providers who are traditionally considered as *loss leaders* in the economy ?

- If health insurance supply is opened up to the *private sector* and also to the *international operators* then there is allegedly a risk of foul practices in health care supply. In the case of foreign companies operating in the system there is also a risk of repatriation of profits and resources from India to the other countries. Under such circumstances, what countervailing checks and **safeguards need to be introduced to regulate their activities ?**

- **How should clientele beneficiaries' involvement be ensured in the functioning of the health insurance system** so that people themselves become a watch dog for its functioning ? Can co-payment, coinsurance, group insurance, etc serve this purpose ?

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[11] Beth Hahn and Ann Barry Flood : *Op cit.*

[12] Over 92 percent of the non insured households both in rural and urban areas are not aware of the existing health insurance schemes. This is the result of a NCAER –SEWA survey (1999) as reported by Anil Gumber : 'Health Care Burden on the households in the Informal Sector' *Indian Journal of Labour Economics* Vol 45 No. 2. 2000.

These and many other issues deserve the attention of policy makers and analysts having an objective of improving the access and utilization of health care services for the poor and provide a useful health security plan for them. We believe that health insurance can be a useful health security plan for the poor if it is managed neither by the public sector nor by the private sector but by the people's sector. By people's sector we mean a cooperative of the people, which is specially created for the purpose of fulfilling the health care needs of the poor. Health insurance through health care cooperative is thus considered as a mechanism worth trying in the Indian context. Such a mechanism has been tried in some form in India and in some other countries also It would be useful to learn from these experiments and design a ***mechanism based upon the principles of mutual sympathy and pooling of risks*** for the benefit of the poor particularly in the rural areas of the country.

III A BRIEF REVIEW OF EARLIER EXPERIMENTS;

We noted above that health care cooperative and health care insurance are the two organizational initiatives that can be suitably integrated to help the cause of the poor. In what follows we briefly review the experiences of selected countries for which information is available, about the experiments of health insurance through health care cooperative. This review would help us in designing a health security plan for the poor, which we propose to develop in one of the villages of Karnataka for which data were specially collected. CMDR proposes to adopt this village or a cluster of villages in the region to implement the plan in its action research programme.

The review is presented for thirteen countries, for which the information was readily available, starting from a developing country like India to the developed country like USA. Only the salient features are outlined without going into the details. For convenience the Indian experiences are outlined at the end.

3. China[13]

The replacement of collective agricultural production by the household responsibility system as a result of economic reforms is said to have led to the decline of collectively funded Co-operative Medical Scheme (CMS) in China. The study by Yu Hao and others[11] reports that during collective farming CMS assisted farmers to meet health care costs in more than 90% villages. Considering this the government of China is encouraging the establishment of such CMS, which are said to have been set up in rural China with the help of local government.

Cooperative Medical Scheme (CMS) in Wuzhaun Township:

The plan for CMS was drawn by researchers of Shanghai Medical University. Based on household survey, the design for CMSs with varying service coverage, premium and reimbursement ratio was developed.

Features:

- Membership in 5 villages is said to be voluntary and open to all rural households.
- Premium of ¥ 5 per member, with ¥ 4 (0.5% of annual per capita) from individuals and ¥ 1 from county government. Village collective or local government though agreed to pay premiums for extremely poor households, did not pay in actual practice. Few farmers paid in terms of produce (grains). ($ 1=¥ 8.3, ¥1=Rs. 5.5)
- Services: Free registration, reimbursement for treatment and injection fees at village level, free immunization for children(up to 7), pre and postnatal maternal care and delivery service.

[13] Yu Hao et al (2000), Financing Health Care in poor rural Counties in China:Experience from a Township- Based Cooperative Medical Scheme, IDS Working Paper 66

- Management: Committee established with members from township government. Salary of Manager was paid by local govt.
- *Drugs: Village doctor is allowed to buy drugs from township health center and sell them to patients at fixed prices.
- *Village doctor has to hand over prescriptions to CMS Committee for examination and reimbursement of drugs, treatment and injection fees. 1/3 rd of the difference between wholesale and retail price of drugs was paid to the Committee which redistributed the money to village doctors at the end of the year as a performance bonus.
- *In each of the five villages one village doctor was contracted to provide health care irrespective of membership. Maternal and preventive care were organized with the help of township health center.
- Health Bureau supplied equipments and published regulations, cards and forms.

54 per cent of the households were members (984 HHs with 3355 population). HHs. which had access to health care did not *become* members. There was an average of 2.2 visits per member per year. The level of reimbursement was ¥ 2.08 per member and it varied from ¥ 3.73 to ¥ 0.8. Full time doctors were more popular. Share of drugs in total fees reduced due to CMS, which was service oriented (from 90% in 1993 to 76% in 1997). Need for continued assistance from government. encouraging poor households to become members. Increasing maternal care. which is lacking and promotion of health education are suggested measures.

2. Philippines[14]

Voluntary Health Insurance for residents of poor rural communities: In Philippines National Health Insurance Law passed in 1995 aims at universal coverage for

[14] Ron Aviva and Kupferman Avi(1996), A Community Health Insurance Scheme in the Philippines: Extension of a community based integrated project, Technical Paper – No.19,WHO, Geneva.

a range of health care benefits. In the meantime government has encouraged community health projects to develop health insurance scheme.

ORT (Org. for Education Resources and Training) Mother and Child Care Community Based Integrated Project (MCC) is run by ORT which is an International Voluntary Organisation. This project was launched in La Province of Philippines. The project provides pre- school education and basic health services. ORT Health Plus Scheme was launched in 1994.

Population: Covered the families of children attending 13 ORT centers, members of ORT co-operative and the general population of the communities where day-care centers were located. Total coverage was expected to be 2500 HHs. But, only 300 families registered in the first year. Family was the membership unit.

Services: ambulatory and in-patient care, prescribed drugs and ancillary services provided by doctors and nurses in day care centers.

Finance: considering the income flow patterns in the population contributions were collected monthly, quarterly, bi-annual and annually. Differential level of contribution for members and non-members of medi-care and family size was followed.

Contributions: P 50-single person
P 100- standard family
P130-large family (25 pesos=1 $)

These accounted for less than half the amount that the families spent on basic health care, excluding in-patient care. For those with medicare the premium for out-patient care was P 70 per month.

For the initial period ORT project continued to pay the salaries of doctors and two nurses in day care center. Non insured persons had to pay P 50 per consultation and for

drugs at cost plus 50%. For insured the cost of drugs was cost plus 20% much below the market rates.

Management: CMS is administered by ORT Multi-Purpose Cooperative which is formed by parents and staff of day care center to increase household income and sustainability of day care centers.

3. Brazil

One of the largest provider(usually owned by doctors) owned Cooperatives is said to have been established in Brazil in 1967. By 1994 its member owners were said to be 60000, with independently practicing doctors(1/3 rd of national total). Under this Unimed system an individual or 30000 enterprises which provided health insurance to their employees could get agreed services from any member doctor anywhere in Brazil.

4. Tanzania[15]

Tanzania is reported to be among the first countries in Southern Africa to introduce prepayment scheme. Tanzania has implemented Community Health Fund (CHF) based on prepayment system in rural areas. Strong community organizations existing in the country are reported to be the facilitators of growth of community dispensaries. The CHF aims to provide primary health care, maternal and child health care (including deliveries) preventive and promotive health care. The risks and benefits are shared among large pools of households and each pool is reported to be consisting of 50000 individuals. Each household will be given a health card at a cost of $ 2.57 per person per year and hospital charges add up to additional premium. There is political support, matching funds by donors and government to community fund and cooperation from health care providers(doctors). But, these CHFs are said to be facing operational problems, management and rising costs.

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[15] Beattie Allison et.al.ed.(1996), Sustainable Health Care Financing In Southern Africa-EDI Policy Seminar held in Johannesburg, South Africa, EDI-World Bank.

5. Spain

In Catalonia, a combination of user-owned and provider- owned cooperative known as Integral Health Care Cooperative system is developed by the Espriu Foundation.

Similar cooperatives operating at community level are said to exist in Italy. In Malaysia, it is reported that government and doctors are exploring the ways to set up a complementary system of provider – owned and user-owned cooperatives.

6. Ghana[16]

An evaluation study undertaken by the PHR reveals that **Nkoranza community health insurance scheme in Ghana** has proved to be successful in terms of sustainability and making quality care affordable to a high percentage of vulnerable households in the district. The study was undertaken after eight years of operation of the scheme and was funded by DIDA and WHO.

The scheme is said to be self-funded (premium income). It is said to be first of its kind in Ghana and has brought fame to the district by its mere survival. But, the PHR study pointed out that there is a lot of scope for improvement and expansion of coverage. Presently the scheme is reported to be covering only 30% of the total district population. The reasons for low coverage have been identified as inappropriate registration period, misconceptions in the community about the scheme, lack of marketing (educational) communication, lack of accounting and computing, lack of monitoring and evaluation, negative attitude of hospital staff and massive adverse selection i.e. tendency to register only the high risk groups (aged, children...). One of the encouraging factors noteworthy to be mentioned is that, though the district is reported to be having high level of poverty, poverty is not recorded as a major factor for poor coverage. There is said to be demand

[16] Atim Chris and Sock (2000). An external Evaluation of the Nicoranza Community Financing Health Insurance Scheme, Ghana. Technical Report, 50. PHR Project Publication.

for maternal and child health services including deliveries for which members were willing to pay extra amount. But, there is said to be resistance for co-payments or deductions on the existing hospitalization cover. The PHR research team has recommended incentives for registration of all members organizing Annual General meetings with the help of funding from district government, supervision from community volunteers, steps to improve relations between the hospital staff and the community and inclusion of maternity care to boost membership.

7. Italy:

In Italy, it is reported that local governments support community based health and social service cooperatives

8. Canada:

The report of the International Cooperative Alliance states that in Canada, as per the study undertaken by Federal and Provincial governments, community health centers were a cost-effective alternative to private practice as they are operated at lower cost per patient and offered more preventive and health promotion services and also accessible to disadvantaged persons.

9. USA

(i) In USA, user-controlled health cooperatives operate as HMOs. Group Health Cooperative of Puget Sound in Seattle is said to be the largest of these with 478000 members (1993). Medical care along with preventive care is provided for a fixed prepaid fee.

(ii) The United Seniors Health Cooperative provides the 9000 elderly owner – members high quality, affordable long term health care services.

(iii) User owned health cooperatives operating in partnership of government exist in USA. In 1994, there were 900 democratically governed and community owned. Community and Migrant Health Centres in rural areas and inner cities serving low-income communities. For 500 such centers funding was available from US Public Health Services.

10. Japan

(i) Members of the consumers movement have set up Health cooperatives supported by the Medical Cooperative Committee of the Consumer's Cooperative Union.

(ii) Members of multi-functional agricultural cooperatives have organized health services supported by the National Welfare Federation of Agricultural cooperatives.

11. Singapore

In Singapore Health Cooperatives have been established by The National Trade Union Congress in 1992 which represents 52 trade unions.

12. Sweden

In 1990s, the Medicop Model, a model for consumer owned cooperative medical care centers is reported to have been developed in Sweden on behalf of the housing and insurance cooperatives. It is reported to be providing cooperative partners for local government authorities interested in contracting health care services and facilities.

13. `India

The following paragraphs present a somewhat detailed account of some of the important experiments[17] in India in this connection. We also briefly evaluate a plan of medical care provision for the poor through insurance as presented by TN Krishnan. one of the pioneer thinkers in this field.

1. **SEWA:** The Self Employed Women`s Association (SEWA) provides health care to its members through two health –co-operatives viz. Mahila Sewa Lok Swasthya Co-operative and Krishna Dayan Co-operative. The services are particularly preventive health and immunization services. Rational drugs are supplied at low prices at 3 centres. Childcare is provided through 3 childcare centers and Crèches.

   Health Insurance coverage is reported to be not mandatory for SEWA households. Coverage is extended to members who make contributions. And. for members who have linked their fixed deposit savings with the insurance scheme. there is also the coverage for maternity benefit. SEWA bank runs Integrated Social Security Insurance Scheme with the help of LIC and United India Insurance Corporation. It covers events of death. accidental death. sickness. accidental widowhood and loss of household goods and work tools. On an average insured person in SEWA households is reported to be paying Rs. 70 to Rs.80 p.a. (Gumber A. and Kulkarni V., 2000). Gumber and Kulkarni`s study in Gujarat brought that. SEWA beneficiaries are interested in extending coverage to additional household members and that there is strong preference for SEWA type of health insurance scheme by the people. People in rural areas preferred public sector hospital services with some contributions from community and managed by Panchayat. Their study revealed that out-of –pocket expenses of insured (ESIS) households were lower by 30% for acute and chronic diseases and

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[17] **NIHFW (2000), Development of Health Insurance in India- Seminar Report.**
Other studies worth considering in this context , from which information is gathered for the analysis below. are listed in the References at the end of this paper.

by 60% for hospitalization cases as compared to SEWA and non-insured households.

2. **Sugar Producers' supply, processing and marketing cooperatives in Maharashtra State are reported to have set up a chain of hospitals and dispensaries for members** throughout the region of their operation. These function in the nature of cooperatives though they are not formed as health care cooperatives themselves.

3. According to a study by Dr. P.R.Sodani in Rajasthan, people preferred to pay an annual premium of Rs. 243 per capita under health insurance given a package of services and coverage of expenses excluding transport. For coverage of transport they preferred to pay Rs. 286 p.a. and Rs. 347 for coverage of transport and wage loss.

4. **A public school in Delhi has introduced Health Insurance coverage with the help of GICI**, to its students (a group) with a premium of Rs. 50 per child per year covering a risk unto Rs.100000 per year.

5. According to a study conducted by K.S.Nair in **Delhi's slums**, households in informal sector spent 8.87 % of their per capita income on health care as against 4.47% by households in formal sector. Households in formal sector were willing to pay Rs. 145 per capita per annum and households in informal sector were ready to pay Rs. 103 per capita p.a. They preferred a combination of hospitalized, non-hospitalized and chronic illness care benefit **under health insurance**.

6. VHS in Tamil Nadu has been providing health care services to rural poor for nearly 30 years. Based on the joint family income, membership fees are charged. The scheme provides members, free annual check-up and curative and diagnostic services at concessional rates. There is no waiting period between joining the scheme and the right to receive health care. Dr. N.S.Murali reported that most

members renewed or enrolled only at the time of acute illness. He has reported that ***an NGO cannot sustain Health insurance scheme from the premia received from poor members. Support by government in terms of subsidy and levying minimal user charges to users are important for the sustainability of the insurance scheme.***

7. U.N.Jajoo[18] and Co-Professors from the Dept. of Medicine, **Mahatma Gandhi Institute, Wardha set up a co-operative health service unit** in a village, in a school building with an initial contribution of Rs. 4 per family. Later a health insurance scheme was mobilized by collecting agricultural produce @ of 2.5 kgs per acre for farmers and, at a flat rate of 5 kgs for agricultural labourers. **Village dispensary is linked to Sewagram hospital.** Village dispensary is run by VHW. VHW is supported by a medical kit and monthly service of a mobile medical team. Only acute and emergency cases are treated free of charge and for normal deliveries and chronic illnesses 25% of the hospital bill is charged.

8. **In Mallur village in Karnataka, a Health Cooperative attached to a Milk Cooperative was set up long back in 1973.** Encouraged by the success of the milk cooperative the members persuaded doctors of the St.John Medical College to start a health care center which would be self sustained, financed and managed by the community. The health cooperative provides services to nearby six villages. In the first two years, members contributed one-two paise per litre of milk. Later, 5% of the profits from milk sale were given to health center. Presently there is no funding from milk cooperative. Interest earnings from the initial fund created by milk cooperative and user charges are the source of finance for health center. State government has given land, ANM service, family planning service, vaccines and nutritional supplies. St.John Medical college contributes Rs 250 p.m towards health care costs of the poor. The Health center is managed by Gramabhivruddi Sangh and a Committee of 9 members including doctors from

[18] Jajoo U.N.et.al (1985), Rural Health Services : Towards a new strategy ? Health Care Who Pays? WHO Health Forum 6:WHO.

health cooperative and St.John Medical college. There is said to be frequent absence of doctors in health center as the cooperative cannot pay the service charges of doctors at market rate.[19]

9. Insurance scheme for the Poor as proposed by TN Krishnan :

T.N.Krishnan proposes[20] hospitalization insurance plan for persons below poverty line, which he suggests, can later be extended to other sections of the society. Health insurance for the poor is justified on the ground that illness episodes take away a major portion of the income of the poor. The present **Jana Arogya Scheme** seems to be similar to the insurance scheme proposed by Krishnan.

He argues that as the proportion of falling ill requiring hospitalization is small in a large population, risk pooling can be done at a small cost with an appropriate insurance scheme.

Total cost of hospitalization is based on the NSS data (1986-87) which is adjusted to 1995. The average cost of treatment is taken to be Rs.500/- for the poor. The NSS data showed that about 4% of the bottom 40% of the population were inpatients. Taking 50% increase for 10 years the proportion of inpatient for 1995 is taken to be 6%. With this rate the total cost would be Rs.900 crores (6% of 300 million poor i.e. 18 crores x Rs.500). This works out to be an average cost of (900 crores / 30 crore population) Rs.30 /- per poor person which would cover cost of medicines, room rent, tests and consultation charges upto a limit of Rs.5000/- per family per annum. He suggests that the Govt. should provide for the total cost under anti-poverty programme or by re-allocation of expenditure.

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[19] Dave Priti Sen(1997), Community Control Of Health Financing In India: A review of Local Experiences. Tech. Report No.8, PHR, Maryland.

[20] Krishnan T.N.(1996), Hospitalization Insurance : A Proposal, EPW, April 3, Vol.XVI

To manage the health insurance implementation he suggests that the subsidiaries of GIC be converted into separate Health Insurance Corporations which work as not for profit organizations.

Panchayats will be responsible for identifying the poor and the consolidated list at the block level should be sent to Finance Ministry. Health insurance corporations should canvass and cover other population groups to meet their administrative costs and it is felt that the expansion of coverage may help to cross subsidise the poor, which will ultimately reduce the burden on government. Hospitalisation is to be referred by the PHC doctor and Corporations are required to directly settle the bills with the provider hospital. The cost of treatment should be indicated on the card issued to families. It is also proposed to set up block level Hospital Monitoring Committees to check the quality and price structure in hospitals.

He suggests that, village panchayats should levy a health cess on landholdings and businesses for universalizing the health insurance coverage. As suggested by Hsiao & Sen, he opines that a portion of this can be retained for strengthening PHC. In urban area health insurance is proposed to be implemented through trade unions, business and factory establishments and through NGO's for the urban poor. Contributions to health insurance could be made compulsory for all persons who have regular employment. These experiments he suggests should be taken up initially in two districts in each state and later can be expanded to all the districts based on experience.

OBSERVATIONS ON HEALTH INSURANCE SCHEMES IN INDIA.

- People are ignorant about health insurance. Mediclaim and, the Jan Arogya Bima policies designed to help the poor are not known to people.

- Many diseases are excluded from risk coverage (treatment for cataracts, dental care, sinusitis, tonsillitis, hernia, congenital internal diseases, fistula in anus, piles etc.) in the first year of policy unless such diseases are totally excluded as pre-existing. Expenses incurred in respect of any treatment relating to pregnancy and childbirth is also excluded.

- Jan Arogya covers only patients who are hospitalized. It is not for out- patients.

- There is lack of marketing. Villagers and the poor have to come to district places to know about the scheme and to become members. Offices of the insurance companies have not made any efforts to popularize these schemes in rural areas and even among urban poor and also middle class people.

- Officers of the insurance companies say that it is waste of time and money to go to people and market **Jan Arogya Bima Policy**. They say that it is difficult to convey common man about the policies. They agree that they have not taken up comprehensive marketing for popularizing the scheme.

- Health insurance policies for the employees of the organized sector are highly subsidized by government. Employee's contribution accounts for a small portion of total coverage (ESI and CGHS).

- Health insurance policies are introduced mainly by public sector.

- Health insurance adopted so far (except for employees) is a reimbursement policy. Individual patient has to pay to hospitals first and then claim the reimbursement and there is a long delay in getting the claim.

MAIN LESSONS FROM COUNTRY EXPERIENCES

The above thirteen country experiences seem to suggest the following conclusions that would help designing a Health Security Plan for the poor in the selected regions of Karnataka.

- To formulate a health insurance scheme for a community or a region **reliable data on health care costs and expenditure, utilization patterns and morbidity in the target population** would be useful.

- The Indian and other countries' experience in community financing of health care through pre-payment suggests that **co-operatives linked to economic activities have been the base for creating health co-operatives.** Members have contributed a part of the sale or produce or the profits to meet the health care expenses of their families and themselves.

- China's experience with CMS reveals that **it is not possible to sustain them with voluntary contributions.** Contributions need to be mandatory and members should confine to rules and regulations set in for CMS.

- The study on CMS in China emphasizes that **in addition to community contributions there is need for specific and effective mechanism to support CMS in the long run.**

- In developing countries the issue of cross subsidization for the poor to meet health care needs through health insurance needs to be worked out. In the absence of mechanism to make rich compensate for the poor, the local, State or the Central government should subsidize the provision of health insurance.

- In rural areas **people are unaware of health insurance. People are willing to provide land, building and labour for setting up health facilities. If there is**

proper guidance and education, they are even willing to contribute in terms of cash for future health risk. The Indian studies by Dr. Sodani and K. S. Nair reveal this. The currently on going study of CMDR in Karnataka also brings out the willingness of the people to contribute to the development health care cooperative.

- **People prefer health insurance schemes which are cheaper and with minimum administrative procedures for getting the claim.**

- **People prefer maternal health care, hospitalisation and outpatient curative care to be covered under health insurance.**

- People do not prefer to join health care co-operative when there are health facilities near by.

- **Co-ordination with government agencies and officials in implementation of certain health services like maternal health care is essential for a health cooperative.**

- Though members of co-operative health centers make prepayment for health care in terms of membership fees, **it is necessary to levy user charges** for two reasons. Firstly, to avoid misuse or over use of health facilities (as reported in U.N.Jajoo's Study). Secondly, it is generally opined that people do not take free services seriously.

- To control 'moral hazard' or the excess use of medical care, we can also adopt an **incentive mechanism in the insurance plan in the form of reduced membership fees for those who have not taken treatment for two or more years**. As said above, in **Sewagram hospital**, to prevent excess use nominal charges were taken from hospitalized patients for treatment of certain cases.

- **Contributions should be based on economic status of the families. But, there should be fixed minimum payment for the poor.**

- Since community programme involves creation of awareness, erosion of interest, trial and error in the application of the project and adoption of the project by the community, **it takes a long time (nearly 5 or more years) for any programme to be deep rooted in the community.**

- Treatment by VHW at the village level indicates that **a trained health worker can attend many of the diseases suffered by villagers and there is no need for expert doctor all the time.**

- Hiring the services of a medical expert daily would be costly for the villagers. Existing health insurance structure, which relies on low and differential premium system cannot meet these expenses. Therefore, as done in some experiments, monthly or fortnightly or alternate day services of expert doctors can be provided in different villages by **mobile medical unit.**

- It is not possible to treat all the cases free of charge. **A financial limit needs to be fixed based on the severity of illness, number of cases/times of treatment per patient, etc.** Based on these considerations the extent of contributions by beneficiaries can be determined. All these aspects can be incorporated in the co-operative health scheme financed by health insurance, as is done in Sewagram health care services in Maharashtra.

IV HEALTH CARE OF THE POOR THROUGH HEALTH INSURANCE AND HEALTH CARE COOPERATIVE: A CMDR PROPOSAL

In the background of the above experiences about people's involvement in health care plan for the poor, we have attempted to develop such a plan for a small region of Karnataka. **The main elements of the health care strategy for the poor** should be the following:

i. **This plan should cover all the poor**, irrespective of their social status and ability to pay.

ii. It should **provide for curative care in the case of all ailments, starting from the common cough and cold to major diseases.**

iii. The plan should **assign an added weightage to the medical care requirements of the poor and female members of the family** for the reasons mentioned earlier.

iv. The plan should make efforts to provide for **cross subsidization of costs of care**. This implies that there should be a provision for community contribution according to ability to pay rather than benefit received. This **community contribution should be mandatory** and not optional.

v. The plan should cover not simply curative care but also **promotive and preventive care services**.

vi. Health care **needs should be articulated by the people themselves** and medical services set up should only aid this process of articulation.

vii. Services should be supplied in accordance with the articulated needs.

Considering the above norms, it appears that a mechanism with cooperation between providers and beneficiaries for the purpose of supply of health care services and

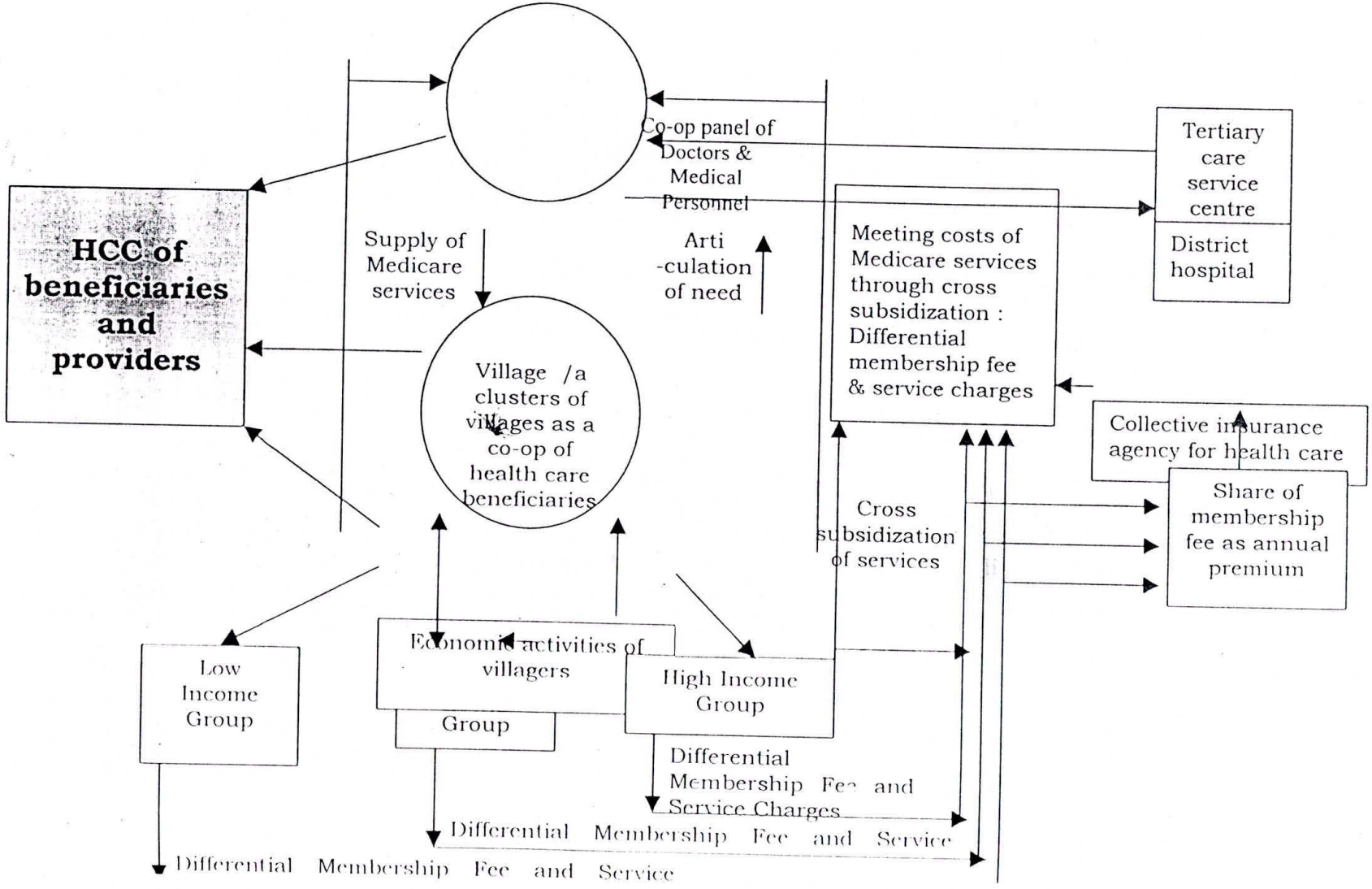
also for recovery of service costs would be helpful. As it is, in the Indian social set up, forces of mutual cooperation do exist in the institution of family, neighbourhood, village , etc.. **Family is the most effective health care cooperative with elements of cross subsidization and support.** Any health security plan for the poor should consider integrating the main elements of cooperative spirit witnessed in the case of family.

Health Security Plan should also recognize that **costs of services are found to be rising in recent years so fast that individually they cannot be met, as incomes do not rise as fast as the costs.** In such a situation cost sharing has to be visualized through a mechanism of a cooperative among beneficiaries and providers and through the principle of cross subsidization. The following **flow chart** brings out the important components of the suggested Health Security Plan for the Poor keeping in mind some of the norms laid down above.

Health Security Plan particularly for the Poor

through HCC and Health Care Insurance mechanism

CMDR as a facilitator of various links



OPERATIONAL ASPECTS OF METHODOLOGY OF HEALTH INSURANCE THROUGH HEALTH CARE COOPERATIVE:

The proposed health insurance through pre-payment and user charges is to be set up initially in one village (Chandanmatti or a manageable group of villages) and later extended to other villages each Panchayat being the unit of administration.

I. Membership: Each Household will be a membership unit. All the households in the Village will be covered under health insurance. A card will be issued to each household with details of No. of members, category of households and the details about the amount of user charges to be taken for treatment from household members. Each card should have provision to enter details of illness, treatment and cost of drugs for each member during one year.

II. Services: HCC will provide to its members curative out patient and in-patient care, child and maternal care (excluding deliveries), preventive and promotive health care services. Out patient care is provided at HCC clinic in the village. For in-patient care a link will be established between HCC and a private or district hospital which will provide referral service to members.

III. Management: The health insurance scheme will be managed by a Health Committee consisting of HCC doctor, PHC doctor, panchayat president, local doctor, mahila mandal / youth center member, school headmaster and five members from HCC.

IV. Membership fees: Considering that the burden of illness will be greater on poor households, a differential rate structure for membership may be visualized for households based on income level.

During the household survey in Chandanmatti village in Dharwad district of Karnataka, for example, respondents from the surveyed households expressed their willingness to pay an average of Rs.225 per household. Membership fee can be fixed keeping willingness to pay by the households. In view of different income levels willingness to pay by the households also would be different. Hence, differential membership fee can be determined accordingly. Membership is fixed for a family of two plus two.

Advantages from the Proposed Health Security Plan

From the proposed health security plan there are mainly four types of gains:

First, each individual becoming a member of the HCC and also linking his health care needs with insurance system through HCC, would find that he would get the health care facilities at his door step, without being required to meet various types of transaction costs. Transportation costs, cost of loss of wages for those attending upon the morbid person, additional food and other costs, etc can be avoided under this scheme. These health care services would be available at lower costs now than without HCC.

Second, provider of health care services like the providers' cooperative, would find costs of provision to be lower than before in view of the likely economies of large scale of operation. Even the insurance agency linked with providers' cooperative would find ready clientele for its insurance business ensuring better business.

Third, under the present scheme there is less chance of any resident member of HCC being deprived of health care facilities when needed, for, through the operation of the force of mutual sympathy, felt needs for health care services would be articulated, the needed services would be provided through the linkages of HCC and insurance schemes. As a result, finally, the likely direct and indirect costs of morbidity would be avoided. Cost avoidance is obviously the gain for the needy, particularly the needy poor.

Fourth, since the government had to bear the entire responsibility towards health care needs of the poor in a scenario without HCC the financial burden on the government would be higher than in the scenario with HCC, for, some of the costs of provision are now borne by the community itself through the system of cross subsidization. The spring of human conduct, viz. sympathy and mutual sympathy, which is a tremendous resource for social welfare, would be used and would stand promoted by the health security plan for the poor.

A concrete Health Security Plan for the Poor with data for one of the villages of Dharwad district of Karnataka is presented in the Appendix to this paper.

Appendix

A CONCRETE PLAN FOR HCC IN A VILLAGE IN DHARWAD DISTRICT

About the Village

Chandanmatti is a small agricultural village situated 8 Kms. from Dharwad. The village consists of 172 households with 1018 population. Fifty two percent of the population belongs to SC/ST, backward and minority communities. Fifty six percent of the population is literate. Twenty Seven percent of the households live below poverty line(<11000). But, nearly fifty eight percent of the household earn less than Rs. 20000 annually. Villagers do not have access to health facilities in the village. There is a primary school in the village. Bore well water is the main source of drinking water in the village. Villagers get this water through tap connections to individual houses.

Baseline Scenario

Analysis of out-patient situation

1. On the basis of reporting from the village during the survey, the estimated probability of incidence of sickness (outpatient type) =0.13
2. Therefore, annual prevalence of illness on average per resident person= 0.13*12=1.56
3. As per the reporting during the survey, the average cost incurred per morbid case per month =Rs.221
4. Therefore, the average annual expenditure on such sickness per resident of the village=Rs.344 (=221*1.56)

5. As against this private cost directly incurred by the residents of the village, the average indirect costs likely to be incurred (based on the FGD and survey) are also estimated:

- According to the survey, the time lost by the morbid person is four days on average per incidence. With a prevalence of 1.56, the labour time lost per average resident is 6 person days. Value of this labour time is Rs. 300.
- On average two person-day of time is lost by another member of the morbid family to attend the patient. The implied opportunity wage cost is rs. 100. Therefore, for a prevalence of 1.56 on average per resident, the value of labour time lost is Rs. 156.
- With the treatment to be availed from outside of the village, as per the survey, the cost of travel plus incidenals such as food per morbidity is Rs 20. Therefore, the incidence of this cost per average resident is Rs 31(=1.56*20)
- The total indirect cost per resident
  = 156 + 300 +31=487

Scenario with HCC

Assumptions:

1. Only 50%of medicines will be provided free of cost, the rest will be borne by the patient.
2. **Cost of pathological/radiological tests will be borne by patients.**
3. A promoting agency will provide the subsidy for the initial years(covering costs of consultation and 50% of medicine cost. There is avoidance of travel and special food cost due to HCC.)

4. The HCC's cost on each out-patient per annum then works out to Rs. 115 (rs.68 on medicines +rs. 47 doctors' fees). With the prevalence of 1.56, the average cost to be borne by HCC per resident is Rs. 179 (1.56*115).

5. The patient himself spends Rs 86 (68+16+2) per illness. Therefore, with the prevalence of 1.56, the private cost to the average resident is Rs. 134 (68+16+2*1.56).

6. The average based on a three tier differential rates, a membership plus user charges of Rs. 87 to be collected per resident.

7. The balance sheet of financial and direct costs and benefits of HCC :

(in Rs.)

	For HCC	For resident	For promoting agency	Travel and special food	For the village economy
Cost	179	134+87=221	92	0	221+92+0=313
Income or benefit	87+92=179	179+134=313	0	31	313+0+31=344

Comments:

1. The individuals have to spend only Rs.221 on average, and get benefits worth Rs. 313.

2. For HCC, there is a break even.

3. The promoting agency will bear the initial burden at the rate of rs.92 per resident as additional system cost.

4. Saving in travel cost and food costs: since the patient and the attendent do not have to travel to places outside of the village, the saving on account of

travel cost and food costs will be 31(18+2*1.56)per resident (as worked out under the baseline scenario).

5. The gains (indirectly) in the reduction of transactions costs are:

   - On average the morbid patient loses only 3 days of his/her labour time (as against 4 days in the base scenario). This amounts to a labour time loss per average resident as 5 days (=1.56*3). The value of this time is Rs 250. Therefore the net gain because of HCC in labour time is Rs.50 (= 300-250)
   - The loss of labour time of another member of the morbid family is also reduced. Assuming that only one day of labour time is lost, the value of the lost labour time is Rs. 78. The net gain in saving in labour time is Rs. 78 (as compared to the base line scenario, 156-78).
   - The total indirect benefit therefore will be rs.50+78=128 per resident of the village.

Total savings

a. Residents =Rs.92+31+128 = 251

b. Village economy = Rs.31+Rs.128 –92 = 67

The case of in-patient treatments

- As per the survey, the average cost of an in-patient per year was Rs. 3084.
- The probabiliyt fo illness leading to hospitalisation, according to the survey data is 0.035
- Therefore, the hospitalisation cost per year per average resident is Rs. 109 (=3084*0.035)

- In case, a health insurance scheme is worked out for all the residents with the jan arogya scheme of united insurance co (or any other), the insurance premium is Rs. 107 per year.

- Therefore, with proper promotional efforts and implementation, the HCC can bring in the insurance scheme to cover all the residents of the village, at no extra cost either to HCC or to the government.

- Needless to mention that the promotive and implementation efforts will be the basic catalists to be set in motion by the promoting agency.

How to manage the HCC in the long run????

1. In the long run, the HCC has to breakeven at the average cost of Rs. 179 per resident. There are several options that can be considered.

    - The memebrship fee and user charges can be gradually increased to go up to cover the cost at Rs. 179 per resident. This can be designed at a gradually increasing rate of 10% per year. Then, it will take a minimum of 7 years to be self-reliant. Till such time, the HCC will have to subsidised by one or the agency, be it the governemnt or a non-government.

    - Alternatively, since the HCC will reduce the pressure on the government outlets in health care (phc, chc and subcentres), the state governments can transfer some funds to manage the HCC under the zp or other direct allocations to the health sector.

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