Community Health Fellowship Scheme

June, 04 – Dec, 04

Report
By

Dr. Neeta S. Rao

To rest my tired wings
I perched on a shaky branch.
A hazy dream like desire appeared
To have a nest
To rest and feel secure.

Just then I saw
A flock of friends
Coming with twigs and straw
To help me create
A nest to rest
A yours and mine
To call our own.

- Jagori

Mentors:

Dr. C. M. Francis
Dr. Thelma Narayan

Field Mentors:

Dr. Ulhas Jajoo
Dr. Sundaraman
Dr. Shyla Nandakumar

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I express my indebtedness to Dr. Thelma for being a constant source of motivation and for guiding me throughout the program helping me identify my interest areas.

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Dr. Neeta S. Rao.

Preface

I wanted to avoid the highly egoistic and selfhood word 'I' in this report. But unlike other reports the objective of this is to share my experiences of the past six months of my journey through the fellowship program, my notions, beliefs, my reflections, impressions about the community and community health, the changes that induced a new school of thought and of course about the people ---- the list is exhaustive, with 'Me'/ 'I' at the center. This report might therefore seem to be too self centric!

This report is a brief account of my reflections over various issues and a compilation of various projects visited and documented during my phase of exploration. It has been written in the chronological order of my visits and hence might disrupt the sequence of cogitation.

The first chapter begins with reminiscing the past, the course of life that brought me here; followed by the beginning of a new phase marked by a period of confusion and getting prepared for a new start. The third and fourth chapters are a brief account of our first field visit to Swami Vivekanada Youth Movement at HD. Kote and a visit to the Foundation for Revitalization of local health traditions, respectively. The next chapter is a short note on the organization profile of CEHAT, which is titled, as a trip to nowhere as it wasn't fruitful in terms of any substantial learning. A Ray of Hope is an annotation on the Western Regional Public hearing, the event in itself being a ray of hope towards building a sense of awareness and collectively demanding right to health care for all. The following chapter 'In Search of direction,' is a brief account of the beginning of my search, my first field impressions and overall learning from this visit. Since there were six fellows/interns pursuing this program in two batches and we never had the opportunity to interact with the others and learn from their experience a mid term sharing was planned, which is documented in brief in the next chapter. Immediately after this break I visited ACCORD with a co-intern Ameer to know more about the tribals, their lifestyle, their health and other social and economic problems, and about the organization which has over the years organized multidimensional programs for the people addressing their needs-an endeavor beyond health for health. The state level planning and intervention through SHRC was a crucial learning experience explained in Chapter 10. The second section comprising of seven chapters is a compilation of various projects studied/documented during my visit to different project areas.

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Chapter 1

Looking Back

To everything there is a season, and a time to every purpose under the heaven.
A time to be born and a time to die -----

BOOK OF ECCLESIASTES

I can measure the passages of my life by my reflections, inhibitions and a few rich experiences. Being born in a middle class family in Mumbai, I wasn't too far located from the slums. It was a common sight on my way to school everyday----- women cooking food, men and children taking bath in the open by the side of the pathway, through all the seasons --- summer, monsoon, winter, spring! But it failed to drive my attention until one day a strange realization dawned over me. Why are they suffering? Is it the fruit of their 'purvakarmas'? What if I was born in one of those families? Its mere destiny and God's grace that I took birth in a middle class family. I stopped lamenting on the luxuries of life that I was not blessed with. With a suppressed desire of doing something substantial for them I passed by them every morning, every evening ----- doing nothing. Years glided and my ambition overtook my feelings though not completely! I knew medical profession would serve the dual purpose of serving the marginalised and achieving academic merit!

The new chapter – After completing B.A.M.S. from Mumbai, which failed to give an insight into public health, I pursued post graduation in health administration. As a MHA student of TISS I enjoyed every bit of my curriculum, I was able to relate to issues, express my ideas and engage in rounds of discussion with my classmates. Though slums were not new to me, I had never been to one and TISS gave me the opportunity to visit one of the old and dense slum pockets of Mumbai at Dahisar and the nation's oldest red light area at Kamtipura. Health status of people was appalling, people had no drinking water, squatted in the open not too far from the multiplexes blessed with 24 hr. water supply and more than 2 toilets per house. I was moved by the stories of people who immigrated to the metropolitan city in search of a job, after starving for days in their villages being hit by drought, only to be hit by the brutality of the system and the vagaries of the weather ----- their assets were washed off in the rains! My sleep was disturbed by the touching stories of women forced by circumstances into the brothel who sold themselves for a meager 50 Rs. and less per day. The one-month internship in Nainital village, Sitla opened

my eyes to the problems that people, especially the women faced on the hills. The life expectancy of women was 50 yrs. and 95% of the women were anemic. Children aspired to study but due to lack of educational facilities, were forced into the never-ending cycle of family life. The health situation in rural Karnataka were in no way better, but were of different dimension. Two years of academic and field exposure opened a new horizon to me.

There was a great amount of unrest after the completion of the course. So much could be done, but I didn't know which path to take. Every option had a disclaimer! I chose the safest option of staying in my hometown with my parents, travelling almost three hours everyday to serve for a private multinational insurance company. What drove me to this? It was not the pay package or the comfort of working in a corporate office but my inquisitiveness to know how insurance works? What is the strategy adopted to ensure financial sustainability of the scheme? What measures are taken to manage risk? How is risk defined with respect to health? and so on ---

What did I discover? Though the 11 months experience helped me gain technical knowledge, it also laid some facts bare – the schemes are so convoluted that it might not necessarily benefit the insured at the time of need, private insurance is not for charity but for profit or at least seeks financial sustainability. All my suggestions and proposals were turned off for lack of will of the company to invest in health insurance. I felt dejected and finally decided to come out of the monotonous life ----- even if it meant doing nothing.

When the search began ---- What did I want? Where did I want to go? I had no clue. Just wanted to rediscover myself, unwind my past. Manjunath, my classmate at TISS suggested me to apply for the fellowship program offered by CHC. He revered Dr. Ravi & Dr. Thelma and said that they can help me clear my doubts. I was at the crossroads of life where I was totally directionless and so I decided to apply. But the left half of my brain wasn't too pleased with this decision. And so to boost my self-esteem I appeared for the TAA post at IIM (Ahmedabad). To my amazement I got selected in both the interviews. I still remember the interview taken by Dr. Thelma in a hotel room in Mumbai. It was 18.30 pm. and being extremely busy she had only half an hour to spare. We spoke for more than an hour and discussed on various issues. She was so cordial and welcoming that I spoke without any hesitation and didn't realize that it was an interview that would have qualified or disqualified me for the program. Not thinking of the consequence I openly discussed about my weaknesses and inhibitions. When I left the room I

was glad ------ though I wasn't sure of my final decision, I knew that I met a lifetime friend/guide!

I finally put down my papers, which was outright rejected, and I was offered a better package and a new profile embellished with a new designation. Indubitably I got attracted to the offer made. Who would not want a better package, a better and challenging profile? But I was not comfortable accepting it and questioned myself ---- if I wasn't able to prove my ability and contribute substantially in 11 months, how do I envisage doing it now? If they could not provide me a favorable environment to work in 11 months, how could I be assured of the same now?

Gradually larger issues started bothering me ---

- What is the purpose of my life?
- Have I seen enough of happiness/sorrows of people to be able to decide?
- Where does my heart lie – family, friends or somewhere else; material gains or something else?

Just not being able to find answers to these questions I just decided to overlook all my temptations and take the path not tread by many. In the midst of all the confusion and constant temptation toward IIM, in a flash of a second I decided to join CHC. I walked out of my office, called up CHC to tell them that 'I am giving 6 months of my life to you, please take care of me, I am confused.'

Chapter 2

Looking Ahead ----- Together.

The interval between the decay of the old and the formation and establishment of the new constitutes a period of transition, which must always necessarily be one of uncertainty, confusion, error, wild and fierce fanaticism.

- JOHN C. CALHOUN

So was my state of utter pandemonium! With an aim to gain a deeper understanding about public/community health issues and hone my skills to enable me contribute effectively towards building a healthy society, I began my expedition! I was now a free bird all set to explore the world!

I met Jyoti at CHC and was able to relate to her feelings about health, was glad to meet someone who thought alike and was as confused as I was. We were in all four, three of us supported by SRTT. It was an altogether a different experience ---- meeting people from different backgrounds from different parts of the country. But one thing brought us together ------ a zeal to explore, a desire to delve into issues by exposing ourselves to the ground realities!

The sessions[*] – It was a feeling of getting back to the M-School ---- recalling all the discussions we had at TISS. A wide range of issues were discussed from women's health, health statistics, policy issues, health movements to social issues and social reforms all bearing its impact on health.

I was among the few fortunate one's to have had an opportunity to be mentored by Dr. C. M. Francis. I however regret for not having utilized this opportunity to the best, especially because I wasn't stationed at CHC for long.

Sessions beyond the four walls of CHC were great learning experience, meeting people working at the grassroots level and knowing their struggle and experiences. Seminars, meetings and workshops served as a pedestal to share different point of views and meet erudite, experienced and eminent health activists. It also shoved a sense of dejection due to my inability to interact with people and express my viewpoints effectively.
Some of the insights gained from these are

[*] Detailed feed back report of the orientation session has been submitted by the end of the sessions.

- Education instead of opening our minds has schooled us. To be able to think creatively we need to break the chains of formal education and look beyond.
- The determinants of health are spread through out the canvass of life and society ---- nothing can be ignored and foregone.
- Inactive cynicism of researchers and academicians and unbounded optimism of action oriented activist must work hand in hand for larger and longer impact.
- Poor people are not passive receivers of care. It is their right, which they must demand for which the concepts of health need to be demystified.
- Areas forlorn – traditional healing methods, cultural practices which are at the verge of extinction needs to be saved and revived for the benefit of the people.
- The changing economic trends with new economic policies of privatization, globalization and commercialization are a threat to the economic stability of our nation staking the lives and earnings of the poor.
- Issues on urban health are grave and of different nature as that of rural areas and to be able to comprehend them the entire process of urbanization and migration needs to be understood.

Documentary film on Periyaar river, which began with a background score from a malayali movie Bharya, counting on its cultural significance, unveiled the ugly face of privatization. The vast spread of water body which is closely interwoven with the life of the local people has its cultural value is split into bits to be packaged and sold to the highest bidders. It exemplifies on how privatization and globalization marginalizes environmental protection and human needs, just for the sake of profit.

Workshop on People's Charter on HIV/AIDS at ISI - It is a consensus/campaign document that amplifies the voices of the people affected, infected, living with and suffering from HIV/AIDS, with an objective to provide a people's perspective on HIV/AIDS and related issues like access, rights and trade issues. It is initiated and facilitated by the people's health movement. HIV/AIDS was recognized as a public health issue and not merely a medical problem and hence calls for social and political responses besides medical intervention.

CHATA (Community Health Approach for Treatment of Alcohol) – a process of enabling people to exercise collectively the responsibility to maintain their health with a focus on alcohol related problem. It includes brainstorming session with different NGOs, building people's organization, organize people in rural area, integration of health and development and utilization of local resources.

Life Skills – Life skills refers to an interactive process of teaching and learning which enables learners to acquire knowledge and to develop attitudes and skills, which support the adoption of healthy behaviors. We thoroughly enjoyed the two interactive sessions with Dr. Sheshadri. It can be effectively used as a tool for prevention of mental illnesses and there are modules designed to train adolescents in a variety of life skills. Though it is not possible to give a definitive list on life skills, interplay of variety of communication and interpersonal skills produces powerful behavioral outcomes.

The orientation session helped us achieve clarity as to what issues we need to look into, especially when we visited different project areas. The library has an excellent collection of study materials, which could not be utilized to the fullest as we were stationed at Bangalore for a short duration.

We thus set our individual learning objectives based on our areas of interest and digressed into different directions.

My learning objectives for the six months were –

1. To introspect and identify my areas of interest in Community/Public health.
2. To get a clear understanding of the conceptual and operational aspects of different health interventions.
3. To study the different methods of resource allocation and it implication on the community and the organization.

Course-

To achieve the aforementioned objectives I visited various places/projects during the six-month internship program, which are as follows –

- 28/06/04 to 30/06/04– S.V.Y.M. at H.D. Kote.
- 08/07/04 to 10/07/04- FRLHT
- 19/07/04 to 11/08/04- CEHAT Mumbai
- 28/07/04 to 30/07/04- Western Region Public Hearing at Bhopal
- 12/08/04 to 28/08/04- MGIMS, Sewagram
- 29/08/04 to 30/08/04- Southern Region Public hearing at Chennai
- 27/09/04 to 05/10/04- ACCORD, Gudalur
- 21/10/04 to 30/10/04- MGIMS, Sewagram
- 01/11/04 to 29/11/04- SHRC Raipur

Chapter 3
The Beginning

When old words die out on the tongue, new melodies break forth from the heart; and when the old tracks are lost, a new country is revealed with its wonders.

-RABINDRANATH TAGORE

From the bustling city to the serene calm and beautiful land of Kenchanahalli, my first exploration of the tribal life unleashed a New World. This chapter is a mere synopsis of my first field impression, direct from my diary.

Though primarily with an intention to get an overview of the mission and objective of the organization (Swami Vivekanada Youth Movement) being translated into action, we moved to the tribal hamlets; it was more of a guided tour for us, primarily because we did not know much about the project to be able to demand and the course of our trip was already planned! We did not confine our roles to mere visitors but also tried to critically analyze the project in the given context. Though there are active preventive and promotive interventions the approach is basically medical/curative centric. We drove around 35 kms. to reach Hosahalli to get a feel of their education program

Education – We visited the Vivekananda Tribal Centre for learning. The school provides formal education and a platform for the holistic development of young children from tribal hamlets by encouraging sports. They also provide counseling for further education through Shikshavahini. It provides every possible facility to the children like well-developed library, computer education, well-equipped laboratory and above all committed and motivated teachers and an ambience, which promotes optimum learning. We interacted with primary teacher who teaches Kannnada language and sociology. His personal experience as a teacher was extremely good and he termed it challenging as he feels that the traditional system of teaching does not function successfully in those conditions. He has to follow up with the students and get them back to school and also ensure that they regularly come to school, which is a Herculean task. Over the years the enrolment has increased while the dropouts is minimal.

The following day we visited few haadis (tribal hamlet). The first one was Jaagankote haadi – We met an old man in his 50s but he appeared to be of late 60s. He had been evicted from the forest

where he and his ancestors had been living a self-sustained life for ages. On eviction he was given some land & the government as rehabilitation for the displaced tribal got a house of cement constructed for him. The forest department now claims that a portion of his land belongs to them and hence filed a case against him. He was subsequently arrested and imprisoned for a month. Dr. Bala got him rescued and is fighting for his cause though the case still remains pending. He got himself operated for cataract and due to the harsh environment in the prison he is unable to see through one eye. The food quality was also awfully poor, which comprised of only cooked rice. He earns his livelihood through shifting cultivation, making baskets and earns around Rs. 15 per day, while by laboring on some other landlord's land he earns Rs. 30 per day. He occasionally travels to Coorg in search of work in the coffee plantation, which fetches him a better wage. Under the PDS for tribal they are entitled to buy grains at subsidy. Though the stock is generally available it is stored in poor conditions and the poor do not have enough money to buy the available grains. The government-constructed house is made of low quality cement, which leaks, and hence the old man stays in a house made of leaves, wood and grass.

We then went to ***Brahmagiri haadi*** – This is the place from where Dr. Bala began his noble initiative. He practiced in a self-sufficient small place, which is now in dilapidated condition. We met a localite who was very agitated and unhappy with the SVYM system. He complained that well educated people visit the place and when they got used to their services they (SVYM) shifted out without a minimal consideration of what people would face who were now used to their services. We spoke to few teenage pregnant women and discovered that they both were less than 15yrs. and had to perform all the household chores, carry water around three to four times a day from ½ km. distance and as they have no toilet facility they have to defecate behind the bushes in the forest before dawn. The only intervention aimed at women like them were Iron and Folic acid tablets, which they had to collect from the health centre while visiting for ANC check up. We spoke to a dai and discovered that almost 50% of the deliveries were home deliveries and yet there was no training imparted to these dais.

Gandantur – We met Jannakkamma (name changed) a 35 yr. unmarried women suffering from breast cancer from the past eight months. She did not reveal about her condition to anyone and only two months prior to our visit a health worker discovered this. The health worker spent her money and escorted her to Kenchanahalli hospital where she was admitted for two days. The

gynecologist examined her and administered some symptomatic treatment. She discharged her stating that it is in its terminal stage and is incurable. It is a pitiable sight! ------- Jannakkamma is unable to work or eat and is in agony, she does not even know what she is suffering from, thinking that it is just a wound she is hoping it to get cured. She hasn't even been taught of how to dress the wound, which is worsening day by day. As she is a non-tribal the hospital is unwilling to provide her free service.

Learning from the experience –

- There is strong gender discrimination. The wages paid to women is far lesser than that paid to men. Women are paid around Rs. 25 while men Rs. 35 to 40 for a day's labour. The clear difference in the nature of work both at home and in the field is also evidence to this. SVYM hasn't tried to tackle this issue despite of several years of active intervention.
- Equity – More facilities are provided to the tribal by the organization, which might not reach all the needy people. Thus people like Jannakkamma are denied treatment for being a non-tribal. On the other hand government hasn't been sensitive to the poor conditions of the people, the houses constructed by the government are in such a condition that the tribal don't prefer to live in them.
- Social analysis – Schools are functional but are so designed that they take the tribal children away from their own reality and leave them half way by providing education only up to higher secondary. Beyond that they are only counseled with no substantial help being extended to the poor. The bus pass to the far-located college is Rs. 500 for a year (which is almost similar to the charges in city), which the tribals are unable to bear. 80% of the population consume tobacco and alcohol to combat with their stress.

A SWOT analysis of the organization reflects the overall efforts taken by the organization and the existing lacunae.

SWOT –

Strengths –

- High level of commitment and motivation among the staff.
- The organization is flexible and sensitive to the local needs.
- Highly qualified and trained staff.

- A good support system to sustain the services.
- Innovation within the organization to provide better and effective services.
- Integration of the traditional system and the modern system to provide better health care service.
- Comprehensive services including health and non-health components. (though the reach is confined to few)
- Networking with foreign institutions and other native institutions.

Weakness –

- Unable to penetrate to the most marginalized section of the community.
- Unable to address the local needs of the people as per their requirements.
- Strategy for withdrawal is not planned and hence the question of sustainability beyond the realms of the organization.
- Segmented approach towards health, where the focus is primarily on institutionalized care (hospital centered service provision) missing out on preventive and promotive aspects of health.
- Non compliance in resource management. That is, where there is availability of infrastructure human resource is lacking thereby leading to sheer resource wastage. [e.g. labour room in Kenchanahalli hospital and no gynecologist round the clock]

Opportunity –

- As they have been providing service in the area for the past 10 yrs. They have been able to develop their foothold and hence can address other issues of relevance to the local community, by soliciting co-operation.
- As resources especially in the form of medical graduates are available better resource management can help them penetrate services to the neediest.

Threat –

- The community might not be able to take care of their health needs following the withdrawal of services, as they are not empowered.
- Failure to address other socio-economic issues might lead to ineffective service provision.

Kindly refer to Section II, Chapter 12 for the details on community based health insurance scheme designed by SVYM for its community members.

CHAPTER 4

THRIVING TOWARDS CONTEMPORARY RELEVANCE

Independent India did not see Ayurveda as a tradition to be celebrated. It was conceived only as formula to be prescribed or a drug to be swallowed not a philosophy to be lived out. Ayurveda thrives to retain its repute in the fast changing world.

Foundation for Revitalization of Local Health Tradition [FRLHT]

Located at the outskirts of the city, in the serene and green patch of land at Yelanhanka the building of FRLHT symbolizes the beginning of a new era. An era where one can hope the long lost and forgotten science of traditional medicine, the medicine of our land, the medicine linked to our people, interwoven with the life of people; to be revived!

I first heard about the institute from Dr. Thelma who suggested that I visit it to know about its initiatives. This chapter encompasses the organizational aims, objectives and activities and a brief account of my learning and observation during my two-day stay.

Vision of FRLHT –

"To revitalize Indian medicinal heritage."

The three thrust areas identified by FRLHT are[1] –

1. Conserving natural resources used by Indian Systems of Medicine [C]
2. Demonstrating contemporary relevance of theory and practice of Indian Systems of Medicine [D]
3. Revitalization of social processes (institutional, oral and commercial) for transmission of traditional knowledge of health care for its wider use and application [R]

Being aware of the magnitude of the tasks involved, FRLHT sees its role to be limited to the design and implementation of strategic projects that directly support the vision. The role of the organization is meant to be catalytic. FRLHT therefore endeavors to design primarily pilot projects on a size, scale, and in geographical locations where these demonstration programs can

[1] Refer to Annex I for the Institutional Agenda.

have large societal impact. The size and scale may not be very large in order to inspire replication and adaptation. In order to cause multiplier effect the organization collaborates with governments, non-government agencies, universities, community based organizations, research institutions, industries, cooperatives, media and international agencies.

Conservation Program –

Since 1993, a major medicinal plant conservation project in southern India has been underway with the Forest Departments of Karnataka, Kerala and Tamil Nadu, Research Institutes, local communities and leading NGOs as key players. Foundation for Revitalization of Local Health Tradition was incepted in 1995 to build a herbarium and a raw drug reference library on medicinal plants which has also been coordinating the initiative in conserving medicinal plant genetic resources the first initiative of its kind in India.

Aim –

- To facilitate sharing of resources and experiences amongst members who may be NGOs, government departments, trusts, cooperatives, companies, research institutes and others who are actively involved in conservation cultivation and sustainable utilization of medicinal plants.
- Facilitate links between medicinal plant conservation organization (it's primary members) and medicinal plant user groups (it's associate members). These links may result in mutually beneficial projects and public support for multifaceted conservation activities of the network.
- Undertake advocacy with governments and other bodies on policy matters related to medicinal plant conservation and sustainable utilization.

The 3 conservation models established to conserve the invaluable forest reserves-

1. Medicinal Plant Conservation Area **(MPCA)** Model – State forest departments have established sites of around 200 hectares in area. These represent all major forest types and geographical zones, harboring populations of most of the medicinal plant diversity of the region, including red-listed species. MPCAs act "as live field gene banks" of medicinal plants I southern India. Over 50 MPCAs have been established in the states of Karnataka, Kerala and Tamilnadu.

2. Medicinal Plant Development Areas and Non Timber Forest Produce **(MPDA & NTFP)** Model – These have been established by state forest departments in NTFP circles and on degraded forests for planting locally available medicinal plants and trees. The Forest departments and the local communities share the returns through sustainable harvest of plants from jointly managed conservation areas (under the Joint Forest Management Scheme). These sites are sources of high quality raw material, which are sustainably collected from natural habitats.
3. Medicinal Plant Conservation Parks **(MPCP)** Model – This is a network of 17 ethno botanical gardens that currently grow around 800 medicinal plant species known to local ethnic communities. They provide planting material through their nurseries to the public. Some MPCPs have herbarium, seed and raw drug museums. They also engage in training, local enterprise development and community outreach programs. MPCPs plan to develop into reliable supply centers of planting materials as well as organically grown raw material.

Some activities -

- Based on these models a botanical team conducted the survey and assisted in selection of MPCAs.
- A comprehensive computerized database on medicinal plants of India has been systematically built up at FRLHT over the last 8 years.
- Around 900 images of medicinal plants have been developed. Information is also available on primary health care for 128 species and propagation for 200 species.
- In recognition of FRLHT and its pioneering work in the area of conservation of medicinal plants and local health traditions, it has been made an ENVIS (Environment information system) node on medicinal plants of conservation concern in the country by the Ministry of Environment & Forests.
- The herbarium made by FRLHT is multi dimensional pooling plant images, including vernacular names, distribution data, plant profiles such as botanical description, threat status, efforts taken to conserve the threatened species, distribution along with the eco-distribution maps, pharmacology, pharmacognosy and cultural.
- The following issues have been identified for policy studies:
  - Implications of commercial trade in wild medicinal plants and its impact on conservation for guiding sustainable management of these wild resources.
  - Appropriate regulatory mechanisms for such trade.

- ❄ Studies relating to the implications of issues of Intellectual Property Rights for such native medicinal plant species.

Documentation/ Dissemination of information & Research

FRLHT has facilitated the building of local resource centres and has conducted exchange programs through networking and workshops to improve traditional knowledge and practice. The organization has also helped to establish kitchen herbal gardens, and income generation programs through training, sammelan and self help groups to encourage the continued use of best health traditions. Strengthening of local health traditions.

Major activities undertaken –

- A participatory methodology for documentation and rapid assessment of local health traditions was developed.
- This method has been field-tested and is being promoted through training programs.
- A training module on documentation and assessment of local health traditions has been developed and is being shared during training programs.
- A software local health tradition home remedies and food and regimen version 1.0 has been developed as a tool to documentation.
- About 22 training programs have been conducted in 4 states of southern India and three states of Northern India.

Through its laboratory, Traditional Systems of Medicine and Research groups it aims –

1. To conduct meaningful research to interpret the importance of traditional recommendations with respect to raw drugs and formulations in order to arrive at relevant quality standards using modern tools such as Chemistry, biology, genetics and botany and
2. To provide testing facility and technical support to small scale units dealing with medicinal plants and value addition.

The laboratory set up at FRLHT has the required infrastructure, facilities and expertise to certify the quality of raw drugs and finished herbal medicines as per Ayurvedic pharmacopoeial

standards. It has applied to the Dept. of Indian Systems of Medicine & Homeopathy, Govt. of India to get accredited as a Quality Testing and Certification Laboratory.

It has received a research grant from the National Geographic Society to undertake documentation of the traditional methods of collection and processing of medicinal plants from texts and living traditions.

In the last ten years, FRLHT has been documenting and developing databases on the materia medica of Indian systems of medicine. Medicinal plant databases have been already initiated on Ayurveda, Siddha, Unani system & Homeopathy.

Promotion of Taluk level Paramparika Vaidya Parishats –

In order to revitalize the diverse health traditions at both the household and the community levels, a methodology for documentation and assessment of health practices in Karnataka, Kerala, Tamil Nadu and Maharashtra at several taluk levels has been evolved. The home herbal garden program is similarly being promoted to revitalize the local health traditions at the household level in the above states. State level Paramparika Vaidya Sammelana provides an opportunity for the vaidyas to exchange their knowledge, skills and practices. It is essential to sensitise the social processes for successful promotion of these useful practices and hence local groups like women groups, self help groups are chosen as a medium for dissemination of information and to encourage sharing of local traditions in colloquial terms.

The paramparika vaidya parishats provide a forum for vaidyas and household knowledge carriers to regularly meet, interact and exchange knowledge, skills and experiences in their respective fields.

To provide guidance and training to the younger generations by establishment of centers of excellence in different areas of expertise of local health traditions through a guru-shishya method of partaking of knowledge and the skills.

In Karnataka an apex body of PVP has been constituted and registered. Taluk level parishats have been constituted and registered in Bidar, Gulbarga, Gadag, Uttar Kannada, Shimoga, Davangere, Chitradurga and Bangalore.

So far 10 taluk level PVPs have been registered and 14 taluk level PVPs have been constituted. Constitution of 25 more taluka level PVPs have been initiated.

The institute intends to establish a 100 bedded Ayurveda Wellness Center with a research oriented hospital, which will demonstrate using modern parameters the efficacy of Ayurvedic health care management for prevention, promotion and cure.

Before visiting the institute and after a brief discussion with Dr. Thelma and Mr. Abdul Kareem (from FRLHT) the following learning objectives were laid –

- To get a field experience of the interconnectivity of the traditional systems, community efforts and micro- credit.
- To examine the utility of traditional methods and its efficiency in meeting the health needs of the people.
- To understand the initiatives taken by the organization in addressing the rural health issues through indigenous system of medicine.

To achieve the first objective, a visit to 'The Covenant Centre for development,' Madurai; while to achieve the other two objectives visit to few nearby villages where MPCP (Medicinal Plant Conservation Program) project of homestead herbal gardens (HHG) is implemented to meet the primary health care needs of rural communities, was planned. However none of the plans concretized.

I had the opportunity to interact personally with Dr. Unnikrishnan[2], Dr. Gangadharan[3] and Darshan Shankar[4] to gain a broader perspective about their beliefs and prospective plans.

[2] An Ayurvedic physician qualified from Ayurveda college, Coimbatore, founder of 'Center for Ayurvedic Research & Development,' a network of clinical centers in Kerala; visiting Research fellow at Toyama Medical & Pharma unit, Toyama, Japan. He is currently co-ordinating the traditional system of medicine unit of the foundation and is involved in cross-cultural medical research, relevance of traditional medicine in public health and applied medical anthropological research.

[3] President of FRLHT.

[4] Director of FRLHT. Began his professional work in 1973 at Bombay University where he conceived, designed and coordinated a post graduate program ' Experiential learning.' Between 80-92 he lived in a tribal village in Maharashtra when he worked with an NGO, Academy of Development Sciences. It was during this period that he was exposed to tremendous social relevance of local health tradition. Since 1993 he has been the Director of FRLHT. In 98 he received the Norman Borlaug award and in 2002 the MPCP coordinated by FRLHT received United Nations Equator Initiative prize.

Discussing about the relevance of insurance to traditional system of medicine, Dr. Unnikrishanan opined that the exact definition of insurance has been forgotten over a period of time and for no substantial reason the indigenous medicine is debarred by the sector. It is perceived as a tool for minting money and hence does not operate as per conventional model. Various micro credit systems have been functioning since ages especially in agricultural practice where seeds are pooled as contribution to meet the contingency cost especially for meeting the catastrophic cost during calamities. The mahahandi parampara in Madurai is fabricated to meet the expenses during festivals. Different systems are adopted by different communities like traditional ceremonial tea party in south India where the entire community contributes for the tea party of a marriage ceremony/ funeral procession. The recipient in turn has to contribute more in the next tea party. However health though is crucial is so sensitive that people haven't yet got used to the concept of saving for health contingencies. As an initial effort a micro credit scheme has been linked with the Kitchen Herbal Garden[5] Project in Madurai where saplings are provided to the needy and the loan scheme is linked to the micro credit. Thus a blanket scheme for the entire society cannot be the ideal solution and such schemes for health needs to be linked to people's culture & tradition with due consideration of their affordability and availability of health services besides their health seeking behavior which is most crucial.

Dr. Gangadharan expressed that the only way to augment the faith of people in the system is to strengthen the educational system, work at grassroot level combining people's knowledge with the formal knowledge system and effect policy changes/initiatives by working with CCIM (Central Council of Indian Medicine)

Some serious thought –

Ayurveda in the form of folk health culture has been a part of people's lives for hundreds of years and it seems ridiculous rather ironic to plan primary health care for the rural and tribal people without taking into cognizance of this! Ayurveda is nothing but the institutionalized and formalized form of such local traditions or as anthropologists would put it Ayurveda is the synthesis of the tribal and other folk traditions. They have a symbiotic relationship. Ayurveda has long interacted with, learnt from and contributed to local folk traditions.

[5] The KHG is also linked to malaria control program – decoctions of herbal preparation are administered to the people in endemic areas as prophylactic and laboratory research is been conducted to assess its potency and mode of action.

This has undergone a phase of decay due to extrinsic and intrinsic factors[6]. The extrinsic factors relate to the monopolistic economic and political forces unleashed with the advent of colonialism and its aftermath, culminating in the current process of globalization. External domination can however gain entry only in the midst of internal infirmities and it would be unfair to attribute all internal weaknesses to external influences. The indigenous system of medicine long back reached a stage where methods, procedures, rules derived earlier by a mode of reason, analysis and logic to interpret the diversity of forms became absolutely authoritative and sacrosanct which was followed blindly by followers without questioning or rationalizing and with passage of time some of these have become obsolete.

Contemporary research in Ayurveda follows two broad approaches[7]. The first being based purely on Ayurvedic parameters, while the second is based on parameters of western science, which may also be termed cross- cultural.

Ayurveda has been developed in a culture that views the manifest nature in terms of the panch mahabhoot sidhant, which is very different from the atomic view of nature in western science. There are major differences between these knowledge systems at every level with regard to principles, categories, concepts, logical framework, philosophy and worldview. The Ayurvedic worldview is based on the shad-darshanas and Sankhya philosophy. Whereas modern science is based on empiricism, Ayurveda gives importance to apta (testimony of seers), pratyaksa (direct perception), anumana (inference) and upamana (analogy). It is thus evident that Ayurveda and modern science have completely different premises.

An important issue is the approach to validation. It is necessary to pint out that there is today in most societies a hierarchical positioning of medical systems with western biomedicine playing the dominant role. Due to this hierarchical situation validation of Ayurveda by modern science has been the tenet. Due to international dominance of western culture that exists today, even within the Ayurvedic community there is a strong belief that it needs to be validated through western science. By using a mix of Ayurveda and modern nosologies without sufficient insights into how

[6] Darshan Shankar: Cultural Cross-current: Tribal Medicine, Ayurveda and modern medicine in primary health care.
[7] PM Unnikrishnan: Challenges in current cross-cultural medical research.

to build a bridge between the two knowledge systems, leads to a stage of bricolage (i.e. a situation where non rigorous strategies are made for comprehending reality)

Ayurvedic materia medica is reduced to a treasure house for seeking herbal solutions for bioactivity relevant in modern medicine. This treasure hunt is carried out without having sufficient understanding of the way in which drugs are used in Ayurveda. In Ayurveda it is not only drug that matters but also detailed management of the condition through drugs, diet and lifestyle changes.

Another inherent problem is 'Knowledge hegemony' with severe hindrance in the free flow of knowledge from one generation to the next. In such a situation the total decay of the system is not too far!

The problem with the system is inherent and within the system and not outside it. The problems are not lack of adequate resources or gaining access; but the patriarchy, hierarchy and the stale system are destroying it. Somehow FRLHT is repeating the same mistake overlooking the lacunae within the system.

Ayurveda is the science of life and not meant only for diseases. The different aspects of individual as well as social life was well thought by ancient scholars who documented what was popular and suitable those days and hence was obviously scientific, but with passing time it lost its charm with no one updating the system. The organization has been busy testing the herbs to prove its efficacy, promoting traditional medicine and has been totally blind towards the aforementioned aspect. Though the activities carried out by FRLHT are imperative to strengthen indigenous medicine, reviving the system to be of contemporary relevance and making it scientifically more acceptable to the society is the most important aspect in its growth, which is being missed.

Yet the multi pronged effort of FRLHT is certainly one infant step ahead towards reviving the system and years of such concerted effort by committed people will indubitably make the aboriginal system of medicine contemporary relevant!

Chapter 5

A Trip to Nowhere!

"If you don't know where you are going you're never gonna get there."

- YOGI BERRA

An unanticipated circumstance changed the course of my plan and I had to plan an urgent trip to Mumbai. The time that I intended to spend in CHC library, I spent at CEHAT, Mumbai. As a part of the fellowship program another assignment of studying the organization was clubbed with it. I spent some time reading books on health finance in the library, but as far as the supplementary assignment is concerned I gained not much. This is an account of this trip to nowhere, reflected through a report, which is a mere reproduction of the organization's manual.

Experience at CEHAT

Date: 19th July to Aug 2004

Learning Objectives –

- To comprehend the vision, mission and objective with which the organization was incepted and to what extent it has been able to achieve it.
- To gain an understanding of the organization structure, culture, ethos and activities.

Introduction –

As the primary motive of visiting CEHAT was to explore the study material in the library and make the optimum utilization of it within the constrained time, a lot of time initially was spent in the library.

Initial attempts of communicating with the staff did not prove to be fruitful. However substantial information about the organization could be garnered during the course of discussion with Dr. Jesani and Dr. Amita. Informal discussion with Kamayani and Bhagyashree (from Pune) also helped in knowing more about the organization.

Vision/Mission – though they have not been spelt out clearly, they are implicit and can be stated as

Building an institution with high professional standards having commitment towards the underprivileged people and their organization.

Evolution –

CEHAT was conceived eleven years back from a negative critique of NGO based research institutions towards creating an alternative health research institution, which would be pro people and beyond academic interest.

The Anusandhan trust was formed in February and registered in August 1991. The first three years of the journey were full of dilemmas and the riot experience of Mumbai almost buried the idea. However continued voluntary work with combined efforts led to the foundation of the first institution under the Trust, called Centre for Enquiry into Health and Allied Theme on April 1 1994.

The first office of CEHAT was set up in a one room flat at Mumbai suburb. As the activities grew a larger space was needed and hence the office was shifted to another place rented by Municipal Corporation of Greater Mumbai. The office was situated above the MCGM run Maternity home, which was non-functional. As CEHAT did not want to get pressurized by the government officials they got relocated.

Though the initial years were exhilarating and gave a sense of fulfillment the organization has experienced a lot of struggles and ups and downs.

Objectives -

CEHAT is an experiment to convert the unmanageable contradiction between NGO and academia, into a permanent advantage of linking academia to people and vice-versa.

Thus it aims at achieving the **objective** of RASA viz. research, action, service and advocacy for the people and to create a space for the organization existing at the interface of activism and academics, people's organizations and institutions.

Basic principles of the organization –

These four principles applies to all themes and topics selected by CEHAT for research

Social relevance – Central to the understanding of social relevance are issues of human rights, equity and empowerment. This is irrespective of whether the organizations have raised the issues or CEHAT would need to initiate such a demand on its own for advocacy with organizations and policy makers.

Ethical concerns – It must uphold high ethical and human rights standards while undertaking research, action and advocacy. This principle complements the first.

In order to ensure social relevance, sensitivity and responsibility to participant people, the following three important ingredients are made inseparable part of all research projects – Ethics committee, informing subjects and participants, and taking the findings to subjects and participants.

Democratic functioning – institutionalization of democracy for internal functioning by using the following two mechanism-

- To emphasize the social commitment and restrict the payment disparity. The salary structure is such that nobody receives less than minimum wage and the ratio between the highest and the lowest salary scale is kept below five.
- Participation of the staff is directed through mechanism of formal democracy. Working groups are established for management functions and devolution of power.

Social Accountability – it is an integral part of sustaining democracy as well as autonomy of the research, researcher and the institution. The individuals have an access to all information on work – research, finances and functioning. A Social Accountability Group of eminent individuals is created to conduct social audit of the organization.

Areas of work –

Research –

It plans and consolidates its work into interconnected and yet well defined themes. Steady development of themes in the direction of right to health and health care is one of the ways to ensure that the project-based work is driven by the social need. Thus each theme has purpose and continuity and these themes help in systematically enriching knowledge and understanding in the relevant field.

These themes are –

- Health services and financing – The focus of this program is on determinants of health, peoples' health problems and health seeking behavior, structure and functioning of health care services, health expenditure and financing.
- Women and health - it not only undertakes research on women health but also informs all other programs with the gender dimensions.
- Health legislation, ethics and patients' rights – It endeavors to bring people and patients at the centre of health care, through policies, legislation, system of medical ethics, etc.
- Psychosocial trauma – It concentrates directly on issues related to human rights and violence, and also interrelates with programs with human rights dimensions.

Though considerable work has been done in the last two areas the strength for research by the organization, lies in the first two.

Action, Intervention and Training –

Although CEHAT was established specifically to undertake research and related activities in the fields of health and allied themes, in the course of work it also initiated field based activities to directly reach out to the underprivileged people and their organizations. These field based activities are making research and the researchers people oriented, providing opportunities to undertake demonstration, action and intervention projects and above all to link up with grassroot level organizations.

- The Arogya Sathi project stresses the importance of developing health programs and health advocacy that are in tandem with people's organizations and mass movements. It began in October 1998 in three marginalized/tribal areas of Maharashtra/ Madhya Pradesh where people's organizations are already functioning. The community based health programs have been established in Dahanu and Jawhar talukas of Thane district and Aajra taluka of Kolhapur district of Maharashtra. Since December 99 they began functioning in Badwani region in Madhya Pradesh.
- Arogyachya Margavar: Women centred community health and community based response cell for survivors of domestic violence. This project evolved while doing research on women's health in the slums of Andheri-Kurla road Mumbai. High proportion of morbidity in women, increasing reliance on self medication due to inefficient public health services and financial barriers in accessing private care led to women centered health project. Began in 98 it covers 10000 people.
- Dilaasa: Crisis Centre for women in Public hospital –After several rounds of discussion with high level officials of MCGM, it was decided to visit such crisis centres in public hospitals run by women's organizations and by the government in Philippines and Malaysia. A crisis centre has been established in collaboration with MCGM in a municipal hospital Bandra Bhabha hospital to look into the issues of domestic violence, counseling of victims, address the issues of human rights and advocacy. The project is proposed to run for three years following which MCGM is expected to handle this centre.

Services, Documentation and Publication –

As the organization was incepted at taking up socially relevant issues for research, it is imperative to develop two regular activities, viz. – the systematic development of a specialized library, documentation and a database; and advocacy, teaching and training.

Library and Documentation – The trust did not have sufficient material resources to euip its institution thus some of the trustees and staff members donated books and materials for the library and also gave lots of voluntary time to organize and run the library and documentation service. It now has around 3000 books, 2500 reports, conference seminar, workshop papers and reprints and back volumes of selected journals, which are easily available for students, journalists,

medical professionals, social workers, lawyers, trainers, activists, development workers, counselors for reference.

The library has adopted Dewey Classification (DDC) system and efforts are being made to computerize the entire library, which would make interaction with other libraries easier.

Database on health –

CEHAT undertook the task of computerizing state wise time series data on health indicators, infrastructure, human power and health financing. In 98 this database was released with its own software program and provides data (with over 500 variables) to central government, state government from 1951 to the latest available on two floppy diskettes and a manual costing Rs. 300/-

Slide shows and Films – are available on different subjects like AIDS, women's empowerment, Abortion, etc. in different languages (Marathi, English, Hindi).

Advocacy, Education and Campaigns – CEHAT has established linkages with University of Mumbai, TISS, academic teaching institutions in Pune and in other cities. On the other hand on specific issues such as abortion, accreditation of private hospitals etc. it has been able to link up with NGOs, government functionaries, professional associations and so on to build advocacy for policy change.

Various activities specific to advocacy, education and campaigns are –

Human Rights –

In 1995 some staff and trustees were actively involved in raising a public debate when hysterectomies were conducted on 17 mentally challenged girls at a state run institution at Pune. In 92-93 when Mumbai was rocked by large scale communal violence, CEHAT helped a human rights organization, solidarity for justice, prepare and publish a selected documentation of media reports on the violence in the city.

Since 1996, CEHAT has also been conducting a formal program of education on human rights and health (a regular post graduate one year diploma course) from the department of civics and

politics at Mumbai University. A 2 day training workshop was conducted in 1999 for doctors on Medical Ethics and Human rights. Dr. Amar Jesani from CEHAT is also recognized by the Mumbai University as teacher, examiner and guide for dissertation for this course.

Besides, the International conference on "Preventing Violence and caring for survivors: Role of Health Services and profession in Violence" held on November 1998 at Mumbai created space for doctors, nurses and other health workers to interact with activists from feminist, human rights, humanists and other movements.

Regulation of Private Health Sector

Minimum Quality Standards for private hospitals and accreditation system: An initiative in Mumbai – This led to the formation of a Forum for Health Care Standards, a voluntary group constituted of the various stakeholders in the health care system.

Advocacy initiatives to improve women's access to safe and legal abortion care –

The advocacy campaign has been multifaceted and designed to suit the needs of various constituencies at different levels. Its continuity in abortion research has made it possible to interact extensively and in focussed manner with the 2 important constituencies – women and abortion service providers.

Network and Collaboration –
Given that CEHAT's place is at the interface of academia and people, it has built linkages within civil society as well as with the state.

Social Accountability –

The founding principles of the institutions of Anusandhan trust demand that its institutions should not only be socially committed but should also undergo a social audit, the findings of which should be made public. Thus the Social Accountability Group was appointed in 1995, comprising of five socially committed members from various institutions. The report submitted by SAG showed that the work of CEHAT was in line of its objectives and had few recommendations. A report was subsequently written based on the actions taken viz. – staff

development process, research skill development initiatives, training of health workers, collaborating with people's movements and other NGOs.

Organizational Structure and Functioning –

The trustees of Anusandhan Trust constitute a governing board of CEHAT, who are responsible for the overall vision and mission and to provide guidance. The managing trustee devotes some time to oversee the administrative matters and the individual trustees give their advice and inputs. The entire staff meets twice a year away from the office and one of the meetings is devoted for staff development.

A Working Group was first constituted in 95 by inviting interested individuals from the staff. Further in 97 the general body of the staff formulated criteria for WG membership and framed rules for election. They elected 6 members through secret ballot. Since then one-third of the members retire every year and the ex-officio member is the co-ordinator of the WG. He/she is not elected. Within the WG all the responsibilities are distributed. The group meets once a month and reviews all projects/activities and decides on actions.

A co-ordinator of CEHAT is appointed by the trust who has full responsibility for the development of the institution, achievement of its goals and the co-ordination of work and management of CEHAT. The co-ordinator has double accountability to the trust and the working group. He/she has the decision making and implementing powers.

Further for all research projects CEHAT appoints a Consultant Committee and for research involving human participation an ethics committee. Besides it has internal scientific committee comprising senior researchers known as peer review committee, which reviews research, advocacy, etc. periodically. The performance of the staff is reviewed through a well-defined evaluation process.

Sources of Funding & Expenditure –

A large proportion of funding is from private specifically from foreign sources, share of Indian sources being very small. This is a reflection of the priority that the government and the Indian sources accord to health research in general and to social science research in health in particular.

The Trust began with lot of small voluntary initiative from its trustees and other friends. Fiscal grants gradually came from both private and public agencies. The trust's own fund is very limited and is concerned that it must increase substantially.

The expenditure has been maximum on research, minimum being on training and service. However over the years expenditure on research has been gradually decreasing.

Sustainability of the Projects –

It was not possible to examine the projects undertaken by CEHAT, in details. Hence its sustainability is not clearly understood. However, the project Dilaasa in collaboration with municipal hospital is a 3-year project and the strategy for withdrawal has been made right at the time of inception. From the second year onwards the program plans to sensitize and train the health personnel with respect to violence against women. If this would be achieved the project would become sustainable.

Critical Analysis –

The time spent with the organization was very less and it wasn't possible to interact much with the staff in order to know in details about the functions of the organization.

For this report and critical analysis there has been a high reliance on the booklet obtained from CEHAT with qualitative inputs from Dr. Jesani and few informal discussions with selected few staff of CEHAT. This would alternatively affect the quality of analysis.

Moreover the kind and the number of research activities carried out by CEHAT are numerous and diverse. This has rendered difficulty in gathering complete information about each of the project (including methodology, objectives, outcome, beneficiaries of the outcome, etc.) which is imperative for critical analysis.

It has been stated that 'A research institution like CEHAT is not a people's organization and it should never pretend to be so. Its identification with people's movements and organizations is more in terms of selecting socially relevant, pro-people themes and topics for research and

sharing the findings with such organizations to support their campaigns and advocacy for change.

The review of the topics of research and publications shows that the organization has been able to work in line with its objectives and though it is not a people's organization in due course; realizing the importance of linking up socially relevant research with advocacy it has reviewed its strategy by getting involved with people's movement and networking.

Structure –The constitution of Working Group represents a balance of autonomy and accountability. The non-hierarchical structure too contributes to the complete freedom and support given to the staff in the organization.

SWOT Analysis –

	Strengths	Weaknesses
Opportunities	➢ Importance of research in health – Research has highly remained confined to academics and seldom utilized for the benefit of the people. On the other hand there is a need for socially relevant research which can instigate ideas and strategies for implementation at grass root level. This endeavor of CEHAT to bring these two together will benefit the society at large. ➢ Sensitive to social factors – Health has largely been under the domain of medicine and remained isolated from social factors. CEHAT not only takes up socially relevant issues for research but also	➢ Implementation Strategy – Research is merely a tool (and not an end in itself) to study the intricate linkages of various factors in the society bearing its impact on health. Thus any research should lead to action-intervention or else it becomes obsolete with passing time especially in such a fast changing world. Thus the organization should design intervention programs based on the research findings and assist NGOs. and government organizations in its implementation.

	identifies issues of concern in the society and tries to study its impact on health.	
Threats	➢ <u>Multi pronged effort</u> – Past experiences have shown that mere medical intervention is in no way going to improve the health situation at large. Organizations failing to discern this cannot achieve their objectives of providing better health. CEHATs multi pronged efforts at different levels and from different angles like human rights, advocacy, etc. would aid in tackling health issues from holistic perspective.	➢ By focussing on different issues simultaneously the effort and the diligence gets diluted thus certain areas like ethics and psychological trauma have been neglected.

Chapter 6

<u>A Ray of hope.</u>

We'd never know how high we are till we are called to rise; and then, if we are true to plan, our statures touch the sky.

- EMILY DICKINSON

Western Region Public Hearing at Bhopal[8]

The health system is plagued by the problems of poor allocation and misallocation of resources, wide disparities in services and knowledge hegemony, which is further augmented by the process of globalization and privatization giving an impetus to the neo-liberal policies, withdrawal and weakening of public services. All this shows direct, immediate and severe impact on the poor, marginalized and the vulnerable, in short on the voiceless and the penniless!

Health has always been measured in terms of illness and the solutions sought have always been medical, focussing on curative aspect. We have failed to learn lessons from the developed nations where the economic growth was possible only after social welfare initiatives, thereby suggesting that economic development is closely interwoven with the general health (beyond disease) of the nation. When 75% of the total expenditure is made by the public sector in health in developed nation, India ranks the lowest with 22% public expenditure. And despite of such low expenditure on health, India vouches for privatization.

Health has social, economic, cultural and environmental dimensions besides the well-known physical, physiological, mental and spiritual aspects. Health is not dealt in this holistic perspective while designing and implementation of any program.

In this context, who are the ultimate sufferers? People obviously! Hence it is ultimately in the interest of the people that we must initiate a second freedom movement- a movement against tyranny and exploitation, a movement to demand our right; right to quality health care and just treatment to all in the society. Such a movement holds no meaning without understanding the underlying factors, causing the collapse of the system. To disseminate the information to the larger mass; health, health system and the changing face of the system, the policies adopted by its various stakeholders needs to be demystified and made comprehendible to the lay man. The cases of neglect must be identified and brought to the notice of the larger audience. Voices of the people needs to be heard, the shortcomings within the system needs to

[8] Refer to Section II, Chapter 13 for a documentation of the event with the commentary

be shown, the double standards of the policy makers needs to be understood and the sufferings of the poor needs to be felt by the concerned authorities and the world at large to create a locus of peoples power which can lay a clout over the system, awaken them to rise to the needs of the people.

The public hearing can be seen as a potential mass movement towards this development. In the darkness of despair, there seems of be a ray of hope!

I have had the opportunity to attend two public hearings, the western regional hearing at Bhopal and the Southern region hearing at Chennai. Each one had their own importance greatly influenced by the regional characteristic features. The cases presented in Bhopal reflected the dereliction of all the resources besides the infrastructural insufficiency and sheer lack of concern for the patients. The situation in south is in no way better, with numerous cases of inhuman approach towards the patients, iatrogenic diseases leading to death and total or partial incapacitation of innocent patients. Cases of environmental abuse leading to long term health hazards in larger masses were also highlighted. The responses of some of the concerned officials were encouraging while some got highly defensive.

Some agnostic individuals might just wonder what next? What has been achieved through this or what can we envisage to achieve and by when? Its true that this is just an infant step whose long-term benefits is very difficult to be envisaged! But it is indubitably a positive step ahead. If pursued with perseverance, such a collective effort is inevitably bound to bring a revolution, a revolution that will force the globe revolve faster, that will alter the centrifugal and the centripetal forces, that will change the course of life and it would no longer be a far fetched dream when India would be no less than any Scandinavian nations!

"He will win who knows when to fight and when not to fight. He will win who knows how to handle both superior and inferior forces. He will win whose army is animated by the same spirit throughout all its ranks".

Sun Tzu – The Art of War.

The article on 'Right to health care' by Dr. Abhay Shukla, the discussions with CHC fellows facilitated by Dr. Thelma and the recent article by Dr. Anant Phadke in MFC bulletin threw more light on this.

I would like to quote James Wilson "Some try to represent political economy as being a dry, cold abstract science, which has no warmth of feeling to spare on suffering humanity----- This is far from the truth; on the contrary, political economy produces feelings so intense for the removal of these evils, that it will not permit us to rest satisfied ----- but impels us to ----- discover the true causes of this wretchedness and the mode by which it may be removed -----."

Political economy as a different subject is relatively new to me and had the first exposure during MHA. I have started realizing how significant it is with concern to our present situation. How can health be segregated from the general well being of the nation?

The entire process of public hearing has evolved through infinite efforts of millions of invisible hands and minds of the past and the present. An event like public hearing may not yield substantial fruit but is certainly a contribution in the whole process. It is not meant to culminate at a huge gathering but is a continuous argument for policy measures ensuring equitable distribution of resources, attention to every individual and making health care available and accessible to all.

'Resource crunch' is the general mantra chanted by government officials as they use as a shield to protect themselves from all the legitimate attacks. We really need to question ourselves and probe into this. It is beyond doubt that resources are insufficient, but the larger problem lies in misuse and misallocation of resources.

Chapter 7

In Search of Direction

Direction is more important than speed. We are so busy looking at our speedometers that we forget the milestones.

- *ANONYMOUS*

I traversed the easiest path though my decisions were never driven by monetary or material gains. In the process of learning I discovered the fact that it is the place and the field of work which one needs to identify for a long-term objective to be achieved. The insight gained through any endeavour can be applied to the field of interest and no effort is a waste. However if one continues to force oneself in a place or working in a field of disinterest a gradual decay is inevitable.

I wasn't ever sure of my aptitude for health finance and health policy though I liked these subjects. I have always been bothered by inequitable distribution of resources and growing demand for health insurance led me towards it as it is perceived to be an effective tool to address the issue of misallocation and misappropriation of resource. It is also believed that it can systematise the whole health system as information is the key to managing any insurance scheme and this information can be used in the interest of general public. It can also be used as a magnetometer to detect the direction in which resources are spent, as a weighing scale to weigh the disease burden and the expenditure on them through different providers and different medium. CHC provided me space to explore my areas of interest. The only way to examine my interest was to get involved and discover if I fit or misfit into it. My thesis on health insurance and experience of working in an insurance company proved to be an impelling force.

With a lot of reluctance I finally decided to visit Sewagram to study the 'Jawar Scheme' on Dr. Ravi and Dr. Thelma's suggestion. After a detailed discussion and speculation finally the six-month plan was made. The study about Jawar scheme would throw light on a rural health insurance scheme which is confined to a very small population; the next visit to Gudalur will help gain insights on tribal insurance scheme; at Raipur a state level health finance could be comprehended and SEWA health insurance scheme at Ahmedabad could give a clear picture of managing a scheme for urban population. The social health insurance scheme for the rural

farmers of Karnataka, 'Yeshaswini' could then be studied against the backdrop of the all these studies.

The expedition thus began from Sewagram. Though the ultimate objective was to know more about community health finance, a broad aim of exploring all the health and the non-health programs was formed and hence a detailed report on all the interventions pertinent to the Insurance scheme was prepared. This chapter covers only my reflections and learning gained from the visit. For the detailed report kindly refer to Section II, Chapter 14. A Referral Insurance Scheme for the Hospital staff was also studied which forms chapter 15 of the same section.

Learning objectives –

- To gain a better understanding of the operational aspects of the overall health system with some focus on health finance.
- To try understanding the overall health intervention programs.

The exploration began with an initial meeting with Dr. Jajoo, when he explained the whole scheme right from the time of its inception. This was followed by few field visits and meeting some key respondents who have contributed in bringing a positive change in the society. Few field visits helped in understanding people's perspective.

My learning experience – The jawar insurance (assurance) scheme is basically a brainchild of Dr. Jajoo and its function is solely responsible on him. This implies that every person with his/her own will in whatever way possible can affect a change process. However the sustainability of such a one-man lead initiative is questionable. Most of the initiatives though are aimed at benefiting the community in the long run it seems to have been imposed on the community as they see Dr. Jajoo with reverence and hence accept his plans without actually comprehending and realizing its importance. Moreover they also face the threat of losing the membership of the insurance scheme if they do not concord to the ideas put forth by Dr. Jajoo.

The charisma that Dr. Jajoo carries is tremendous, to the extent that people worship him. This I consider as a life time achievement which is unlikely without working for the cause of people and for their benefit. Dr. Jajoo started with the people from where they were, addressing their issues of concern trying to meet their felt needs, which inevitably helped him gain the sacrosanct

image. Though Dr. Jajoo tries to give some space to the community to handle their responsibilities and tackle various issues of concern, his leadership at times was found to be overpowering! He has emerged as a lighthouse for the community guiding their path and taking care of them.

Few questions remained unanswered like why there is a huge disparity in the salary structure of the doctors vis-à-vis that of the Class IV workers who are still hired on contract for a meager salary of Rs. 30 per day, while the doctors earn above Rs. 50000 per month. This is a matter of concern especially because it is a charitable hospital based on Gandhian ideology!

The exercise on Financial Analysis of the scheme was a great learning experience, except for the fact that it is not scientifically sound and there are some inherent lacunae in the study. Whilst carrying out this study, I realized that numbers are exciting only if they convey a message, and as one proceeds with the computation the level of excitement increases as it orients towards a definitive finding, which should be necessarily illuminative. It must serve the purpose of guiding and planning the next strategy.

"I started moving in a specific direction hoping to find solace here."

Chapter 8

Midway through my journey

"We may run, walk, stumble, drive, or fly, but let us never lose sight of the reason for the journey, or miss a chance to see a rainbow on the way."

- Anonymous

To enable us reflect, share our experiences and hold our hands with other fellows, a mid term session was organized at CHC. The sessions packed in 12 days were thought provoking and edifying with each fellow sharing his/her field experiences. I can count upon this as one of a very important milestone in the learning process as in the fast paced life we are soon loosing on the very important techniques of garnering information like listening, sharing and discussing. It wouldn't be practically possible for me to visit Bissamcuttack, Javadhi hills, Sanghamitra or SPAD without discounting on my experiences in a short span of six months. It was also a period to relax and get further more equipped for the second half of the program.

Dr. Ravi's class helped me gain an insight about the health movement, which gained momentum in different directions at different period of time due to the driving force of different ideologies. Thus a movement does not only grow in length with time but also widens by coalescing different schools of thoughts. And this enriches the movement!

Learning from others learning –

Aameer – from Javadhi hills experience he realized that migration is the starting point of poverty. Poverty is not merely lack of resources but has deeper connotations attached to it. It is a consequence of structured and planned exploitation, it is a vicious cycle leading to poor health and misery. The heart-rending stories of copper sulphate added to starch to make it inedible to deter the poor from consuming it, mental stress caused due to inability to take bath, were all eye openers to the hard facts of life.

Amen – His sharing from Bissamcuttak and Omapan gave valuable insights into the problems faced by the tribal people and health hazards due to mining and its far reaching consequences.

Sandhya – Her encounter with the NGO, SVYM the differing ideologies and her endeavor in modifying her concepts and honing her skills for the benefit of the community; the perseverance in pursuing it.

Shalini – It was heartening to know about ordinary people with extra ordinary percepts who do not believe in merely preaching but steadfastly following it in their lives, like Iqbal from Bastar district, Chattisgarh. Despite being well educated he got married to a tribal woman from Bastar lived with her and without trying to change her adopted their lifestyle. He claims that he has learnt a lot from the rich tribal culture and yet a lot remains to be learnt from them.

Abraham – From Sanghmitra and over all CHC experience, that people of the villages have an identity of their own and take pride in every achievement and possession, which is seldom seen in city dwellers. The integrity and solidarity of the rural community needs to be safeguarded and the displacement of the rural poor to urban areas needs to be discouraged for which political will is indispensable. The street child who offered him food from the trash during their first meeting just shows how amicable these children are and for no fault of theirs are deprived of basic needs of life. They are paying the price for the ruthless system, which is totally indifferent to their needs!

Sunil – about the multi-pronged initiatives in addressing various issues pertinent to the grave problem of HIV/AIDS and about drop in rooms, enterprising and active workers like Christina.

This is merely a snap shot of my learning during our sharing session, while I am unable to express everything that I learnt, in words.

CHAPTER 9

A voyage beyond health for health.

"Journeys, like artists, are born and not made. A thousand differing circumstances contribute to them."

- LAWRENCE DURRELL

With an intention to study a tribal health insurance scheme, I planned to visit ACCORD located at the foothills of Ooty. Before visiting the place I met Dr. Roopa, a dynamic lady in her mid 40s, who laid the foundation for community health at ACCORD to get a broader picture of the work at ACCORD from her experience. This further intensified my desire to visit the place. Another reason for having shown keen interest in visiting this project was that the health insurance scheme instituted for the tribal population, was managed by Royal Sundaram Alliance Insurance company, the insurance company in which I worked. As I never got an opportunity to visit the place during my tenure in the company, I wanted to study it closely from the other perspective i.e. the community's perspective.

About ACCORD –

Over the last 15 years, *ACCORD*, and its associated organizations *ASHWINI* and *VIDYODAYA TRUST (the Education Program)* each committed to the reinstatement of the tribals to their rightful place in society have helped to form a strong community organization - *The Adivasi Munnetra Sangam, or AMS*. Community owned institutions were set up to deliver much needed services to the tribal community and to be a tool in facilitating them to enter mainstream society as equal partners and on their own terms.

The health status of the adivasi community was once appalling. There were countless unnecessary deaths and the quality of health care available was shocking. In 1987, a community health program was launched, through trained village health workers (VHW's), to carry out preventative health care, monitor pregnant women and children, and improve people's health awareness. In 1990, Gudalur Adivasi Hospital was started to provide the good holistic health care that the adivasi community so urgently needed. And so, ASHWINI was born.

ASHWINI's adivasi staff have been trained to undertake much of the responsibilities of the day-to-day running of the Hospital and Community Health Program and are actively involved in all the decision-making processes. This training process continues, but already enormous progress has been made.

Learning Objective - To understand the process of community mobilization, issues of sustainability, and effectiveness of the program – in a tribal hamlet- both from the health system and health finance perspective.

The organization was started to help the adivasis stand against the atrocities meted out to them. In due course of time they realized a potential threat to the community due to the declining health status of the poor and hence the team comprising of Dr. Roopa & Dr. Deva reached out to people with health education as a tool. Soon the community developed confidence in them and expressed the need to have hospital for the adivasis and at a much later stage the medical aspect of health was introduced. The strategy adopted was apt starting from where people are and this philosophy remains alive over the years.

Some of my first impressions from the field visit –

- It is heartening to see the high level of commitment of the health animators. At the same time it is also saddening to see the still prevalent poor health status of the people, especially the women and children. Despite of 15yrs. of active and multi pronged efforts by ACCORD the health status of the people though has certainly shown improvement is not a satisfactory change. The efforts taken by ACCORD are certainly commendable and the lesson learnt is that medical intervention can reduce the mortality rates but cannot affect morbidity to a great extent and despite of active interventions in different areas certain factors affecting macroeconomics severely influences the lives of people, especially the poor.

  The climb through the hills to reach the remote houses during the visit to Devasholai, helped realize the difficulties faced by the local dwellers in accessing the services, which are far located. Further, socially being from a closed community, accessibility to the services is further reduced. On interacting with the people it was realized that despite of such concerted effort by ACCORD, financial instability greatly influenced by innumerable factors like lack

of resources, ignorance of one's rights, unemployment and exploitation by upper class led to poor living condition which manifests through poor health status.

- Well planned strategy – The strategy for developing self sustained programs aiming at empowering the tribal communities has been well thought of and successfully translated into activities (though it is difficult to assess the success of the interventions). The strong value system, which is the backbone of the organization, supports the project with people from various field of expertise giving their inputs and the community members viz. the health animators/ health guides executing the plans.

- About the tribal – Though a lot has been studied about tribal culture, very less has been adopted by the so-called forward class. The values of unity and solidarity in the community, collective sharing, earning for sustenance are the prerequisites towards developing a strong community, i.e. for community organization and community development. It has been possible to initiate various development programs in the community eliciting their complete support and gradually handing over the responsibility to them only because of this inherent value system. Any such program designed for any such community driven merely by material gains could not have sustained.

  Organization and development schemes for the tribal have its own pros and cons. It is difficult to mobilize them, as they are extremely closed, coy and suppressed. This is evident from the poor response to health intervention programs in terms of health insurance coverage, hospitalization rate and number of institutional deliveries.

  A very important aspect observed in the process of exploration is the far sightedness the systematic and the diligent efforts of the health animators in their work towards the development of their community.

  It is certainly a matter of pride for the tribal to own a tea estate and is a revolutionary progressive step towards sharing a common platform with non-tribal.

- Strategy – It is most essential to offer what people need than to what the provider has to offer. The ACCORD intervention started with addressing the issue of land disputes, which was a burning issue then. It further provided services in health gauging the poor health status of people and further education to provide easy access of education to the tribal children. Income generation programs were initiated with people's cooperation. As the tribals do not accept charity the organization did not want to develop a doler beggar relation between them. Self-support schemes were started like health insurance, collection of funds for various activities.

  Decision made through consensus not only ensures agreement but also empowers people and stimulates the cognitive process of deciding for one's own welfare. The strategy of withdrawal has also been very aptly planned.

  In order to prevent power concentration and resource accumulation the organization has adopted a very good strategy of registering the different units under different societies, which are being handled by different groups comprising tribal people.

  The organization ethos believes in progressive change and hence constantly raises issues of concern and initiates dialogues with concerned people to ensure further action. This strategy of perpetual action oriented approach is commendable.

  The spirit of this movement can be kept going only by ensuring the involvement of youth in this, keeping them abreast with the activities and the historical development of these programs. This is done through youth meetings though its effectiveness is not known.

  The hospital set up is also in concordance with the health requirements of the tribal and tries to fulfil their needs at low cost. The organization has been able to channelize funds through various foreign agencies and groups.

- Some existing lacunae –

  Some bitter experiences with the government have led to distancing from the government sector. Health being a fundamental right of people and with lots of funds flowing for tribal

welfare, it must be tapped as the funds on which the different activities survive would cease someday.

Though the insurance scheme is innovative and largely benefits the poor, its sustainability on withdrawal of funds has not been thought of[9].

- Prospects for the poor –

The different projects of ACCORD are indubitably pro poor meant for the impoverished tribal population of Gudalur. These projects would empower these marginalized communities even if the organisation withdraws.

The insurance company which ends up paying more than the contribution cross subsidizes their risks with the affordable class of people. However the scheme has been able to provide services to the needy only because of the HMO kind of structure. Thus the hospital will have to continue its active role, though the other activities could be withdrawn gradually.

A short span of ten days is insufficient to assess the success of the projects which were conceived by the community members under the guidance of professionals and which assumed contour with their concerted efforts and grew to a proportion which cannot be measured on any scale, as empowerment is dimensionless. Hence the aforementioned comments are merely a first field impression which could be prejudiced!

[9] Refer to Chapter 16 for a detail note on the composite health insurance scheme.

Chapter 10

The Search Continues ----

"I believe that there is a subtle magnetism in nature, which if we unconsciously yield to, will direct us aright! It is not indifferent to us which way we walk. There is a right way but we are very liable from heedlessness and stupidity and take the wrong one. We would take that walk never taken by us through this actual world which is perfectly symbolical of the path which we love to travel in the interior and the ideal world and sometimes no doubt we find it difficult to choose our direction because it does not yet distinctly exist in our idea."

\- *HENRY DAVID THOREAU*

Only 45 days of the program were left and I was'nt still sure of my destination. Was I expected to be so definitive? I guess no, it is difficult to search outside what you want inside! And so with an open mind I proceeded with my search ---- and reached Raipur.

About State Health Resource Centre –

The government of Chattisgarh and Action Aid India initiated the State Health Resource Centre for the implementation of the Community Health Worker Program (Mitanin) and carrying forward the pro-poor reforms proposed under the Sector Investment Program. This was done under a signed memorandum of understanding. The SHRC acts as additional technical capacity to the Department of health and family welfare in designing the reform agenda under the SIP, developing operational guidelines for implementation of reform program and arranging/providing on going technical support to the district health administration and other program managers in implementing this reform program.

It has a core team of full time experts and support staff to design, build capabilities, monitor and co-ordinate the mitanin program- a program for building up community health worker in every hamlet of the state. The other work allocation as per the MOU are –

- Produce situational analysis as well as detailed studies on various aspects of the health sector.
- Prepare policy change proposals for the consideration of GoC, based on situational analysis and/or specific studies undertaken by it through individual experts /institutions including

- Conduct workshops and meetings, as may be necessary, on behalf of the GoC, for effective operationalization of the reform process
- Undertake or facilitate operational research and epidemiological enquiry into disease prevalence and determinants
- Assist in programs to build capabilities of various levels of health department cadre.

For designing and implementation of this reform process/program a number of activities are essential which are outsourced to individuals and/or institutions on a turn key basis, in which case SHRC acts as the main link between the GoC and the respective individuals and/or institutions.

Learning Objective **–**

- To be able to comprehend the various efforts taken at the state level to push health as priority and to ensure a good health system – right from the stage of conceptualization to implementation.

Knowing that the organization is involved in multi pronged self-initiated projects, it was perceived that one needs to move with the pace of work. Inhibited with this pre conceived notion and with a desire to garner a rich and diverse experience I was all set to work at SHRC to get a hand on experience! The first rendezvous with Dr. Sundaraman was encouraging as he was prepared to listen to me and wanted me to share my experiences with his staff. The second tryst with him during the three hour long journey to Kavardham district was edifying, trying to know his experience, his opinion about different issues like working with government, the cause for the success of the Mitanin program, role that health activist can play and need to play, the contribution that we need to make towards achieving the long yearned dream of all 'Health for All'

A month long sojourn included being a part of the field co-ordinators' meeting, visiting a village, staying with the field co-ordinator to get a sense of the problems faced by them, working with other office staff on various subjects like helping prepare RCH budget, assess the internal evaluation of the Mitanin program, helping in making amendments in the questionnaire to assess the household expenditure on health, food, etc. Under the guidance of Dr. Sundaraman a

proposal for supplementary social health insurance was drafted[10]. A study on financing of health care was planned and for collecting data on non-profitable private hospital, we visited Shaheed hospital and stayed for two days. To undertake an exercise on cost analysis of a User fee scheme in vogue as 'Rogi Kalyan Samiti[11]' the cost of services from two district hospitals and two CHCs were collected. Besides I also had an opportunity of getting involved in other routine tasks like writing letter to the Health Minister, helping other staff organize meetings, etc. It was an intense learning experience.

Everyday constituted new task and hence I had a dynamic experience without leaving time for documentation and reflection. Though there are some weaknesses of the organization like any other organization, it is worth mentioning the strengths of the organization.

Strengths –

- The organization exhibits a good team spirit, with all tasks being undertaken and completed through collective effort.
- Dr. Sundaraman has strong leadership qualities, serving as lighthouse guiding every sailing boat.
- Every project is meticulously planned right from conceptualization to implementation.
- Though planning is done from a macro level, in order to be sensitive to ground realities and be realistic, Dr. Sundaraman visits villages frequently without any agenda and stays over night to have a feel of their problems.

[10] Refer to Section II, chapter 17
[11] A cost analysis of Rogi Kalyan Samiti forms chapter 18 of section II.

CHAPTER 11

Conclusion

This final chapter is an epilogue of my experiences and learning from the six months expedition. It is an endeavour to encapsulate the answers to the questions raised during this period whilst exploring the field of community health. It also includes a thought process, which grew, shrunk, remained static and changed contour triggered by emotions, feelings, inhibitions and rationalisation.

Looking outward –

There has been constant changes taking place in the world around us. One not only needs to be updated about the happenings around, but to be able to work for the cause of the marginalized needs to be sensitive to the community, its needs, which is fabricated from a wide range of factors – people, their culture, their beliefs, their situation, their circumstances, which is not a static picture but a dynamic photoplay emanating from its genesis and history.

The fellowship program gave me an opportunity to visit different organizations and through them different communities and discover more about them. Besides this it also gave me an opportunity to meet like-minded people, acquaint myself about various issues of concern and understand it from different perspectives. Some of my learning and contemplation -

About the community –

We are blessed to be a part of the nation with its large varieties in landscape, climate, culture, customs, traditions, beliefs and above all people. I had been fortunate for having had an opportunity to travel to different parts of the nation. Despite of the vast differences in culture, tradition and attire; there was one striking similarity in all of them – solidarity, which the urban culture lacks.

We are all full of praises about the rural culture, people ---- but the some of the stark facts stare us at our face. IMR , MMR, infrastructure, fund allocation, Life Expectancy, etc. unveil the poor

condition. These facts are not too far from that of the urban slums. Why are these communities neglected, used merely as vote banks and deprived even of the basic necessities of life?

It is because they do not have a voice, they are not empowered by education to understand various complex issues and fight against those that are detrimental to their growth. Though there is discontent about the system, the so-called modern rulers and the total oblivion of their existence, the status quo continues. "Neglect creates mindset that accepts the current situation without protest as being normal[12]." How long can we continue ignoring this? External forces cannot work effectively unless the force develops within the community. And this is possible only through awareness, evoking the sleeping souls and arousing a mass movement.

People's Health Movement is an excellent endeavor towards such an initiative. It not only brings concerned people (both the sufferers and various organizations working for the marginalised groups) but also provides a platform to share experiences, touch upon all the spheres of life concerning health.

Change – "The only thing constant in life is change."
Change is inevitable but was rather slow in the neglected sections of the society, which is now accelerated by exploitation of the poor by the bigwigs of the society. Change can be termed progressive or positive in the middle and the upper middle class section of the society, while it is regressive for the poor.

A NCAER study states 24,000 Indian households have an annual income of more than Rs. 50 lakh and another study by Cap Gemnini Ernst and Young found that 60,000 Indians have an asset worth more than Rs. 4.5 crore. This potential market crowded in urban India, is being targeted by various MNCs. These MNCs in turn are flexing their muscles to further exploit the already distressed poor.

The immediate impact of crashing tea prices on the health status of the Gudalur tribals, the deteriorating status of people from Raigarh (Chattisgarh) with the expanding empire of Jindal,

[12] Dr. Dilip Mavlankar.

the displacement of the tribals in HD Kote due to the forest conservation act are all an evidence to the ugly face of globalization, privatization and liberalization.

By providing assistance to such communities we are initiating a change. We need to bring a change in ourselves first, as they are already accustomed to their state and in fact far better strugglers to have survived such vagaries of the society. It is therefore essential to research if the interventions are actually in the benefit of the community, such that we do not add to their burgeoning problems.

The tribal and rural culture is deemed to be very rich and there has been an ongoing debate of the long-term impact of extrinsic interventions, which are believed to erode their conventional beliefs and practices. By introducing modern education and modern practices there is a fear of wiping the rich customs and knowledge system. To what extent can external aid be provided? Till when will such support systems exist? And if they are withdrawn isn't it being unfair by luring them with bright prospects and then leaving them half way? It is known that all conventional practices are not healthy and hence some of them need to be changed. Most of the practices related to obstetrics are unhealthy which endangers the lives of both the mother and child. But the whole process of change is a complex process, which carries along both positive and negative influences. Where do we draw the line? How do we determine to what extent is change required in different communities? How do we ensure that the community will remain untouched by the negative influences of the interventions?

Continuous and Collective effort –

I cannot resist quoting the Hundredth Monkey Phenomenon, which I learned about in talks with Dr. Sundaraman. This phenomenon shows that when enough of us are aware of something, all of us become aware of it.

That concept confirmed my own intuitive trust in the basic tenet of my work — that the appreciation and love we have for ourselves and others creates an expanding energy field that becomes a growing power in the world.

There is no need to feel helpless or get paralyzed by hopelessness. We know we have the power to make changes if we can join together and raise our voices in unison. There is more power in numbers that we ever hoped to dream about!

The story of the Hundredth Monkey:

The Japanese monkey, Macaca fuscata, has been observed in the wild for a period of over 30 years. In 1952, on the island of Koshima scientists were providing monkeys with sweet potatoes dropped in the sand. The monkeys liked the taste of the raw sweet potatoes, but they found the dirt unpleasant. An 18-month-old female named Imo found she could solve the problem in a nearby stream. She taught this trick to her mother. Her playmates also learned this new way and they taught their mothers, too.

This cultural innovation was gradually picked up by various monkeys before the eyes of the scientists. Between 1952 and 1958, all the young monkeys learned to wash the sandy sweet potatoes to make them more palatable. Only the adults who imitated their children learned this social improvement. Other adults kept eating the dirty sweet potatoes.

Then something startling took place. In the autumn of 1958, a certain number of Koshima monkeys were washing sweet potatoes — the exact number is not known. Let us suppose that when the sun rose one morning there were 99 monkeys on Koshima Island who had learned to wash their sweet potatoes. Let's further suppose that later that morning, the hundredth monkey learned to wash potatoes.

THEN IT HAPPENED! By that evening almost everyone in the tribe was washing sweet potatoes before eating them. The added energy of this hundredth monkey somehow created an ideological breakthrough!

A most surprising thing observed by these scientists was that the habit of washing sweet potatoes then jumped over the sea —
Colonies of monkeys on other islands and the mainland troop of monkeys at Takasakiyama began washing their sweet potatoes![13]

[13] Lifetide by Lyall Watson, pp. 147-148. Bantam Books 1980.

Thus, when a certain critical number achieves awareness, this new awareness may be communicated from mind to mind. Although the exact number may very, the Hundredth Monkey Phenomenon means that when only a limited number of people know of a new way, it may remain the consciousness property of these people. But there is a point at which if only one more person tunes-in to a new awareness, a field is strengthened so that this awareness is picked up by almost everyone!

One of us might be the "Hundredth Monkey" and what if we are not-----, we certainly have certainly added to the reserve of the consciousness property!

Though the impact on the health status of the tribals in Gudalur was not too heartening the last 15 yrs. of concerted effort by committed medical professionals (community health specialist, surgeon, gynecologist, pediatrician) advocate, social worker, architects, accountant and many others have certainly changed the face of the society. They are empowered to fight for their rights.

Having recognized that health cannot be improved by merely providing medical service, most of the organizations I visited are working in different directions to improve the living conditions of the people. The tribal welfare initiatives began with mobilizing people to fight for their land rights at Gudalur, the SHRC's Mitanin program endeavors to bring health to the people's hands and link it up with panchayat and government health system. The Jawar scheme implemented in rural Sewagram underwent incessant alterations to motivate people to thrive for a better quality of life and to ensure community organization and participation.

Every inspired soul can make a difference –

The 'Jawar scheme' conceived and implemented by Dr. Jajoo and the multidimensional efforts made by SHRC under Dr. Sundaraman's guidance both are great examples of strong leadership qualities. It is also apparent that though it is lead effectively it cannot be executed single handedly and hence calls for mass mobilization by igniting minds. It is evidence to the fact that every soul has the potential to bring a positive change in whatever way possible.

"There is more hunger for love and appreciation in this world than for bread."

- MOTHER TERESA

About community health –

Community Health – "A process of enabling people to exercise collectively their responsibilities to their own health and to demand health as their right."

Some observations -

- The impact of iniquitous globalization is directly seen on the health status of poor and margnialized.
- We need to take the first step ahead though the final objective may seem to be difficult. Everyone needs to play their role irrespective of when the fruits would be borne.
- Mere medical intervention can never address overall health issue though curative service is an indispensable for maintaining overall health.

What is community health?

Any endeavor that is –

- Committed towards continuous improvement of health.
- Focused on tracking area health indicators and eliminating identified disparities.
- Community and resident based.
- Inclusive of key stakeholders in health improvement: residents, consumers, coalitions, communities of faith, local and state governments, businesses, and providers of community-based health, education, and human services.
- Reflective of the age, racial, ethnic, gender, sexual orientation, and linguistic diversity of the area

We are coming to understand health not as the absence of disease, but rather as the process by which individuals maintain their sense of coherence (i.e. sense that life is comprehensible, manageable, and meaningful) and ability to function in the face of changes in themselves and their relationships with their environment.

The link between community health and public health –

It is essential to develop an understanding of public health among the social workers and community and develop capacity to solve ordinary health problems at local levels for which training of the voluntary workers is imperative. This however needs to be linked up with government efforts and the community by empowering them to identify their problems offering alternative solutions and tackle them. This is true essence of community health.

What is not community health –

- Demand generated by the community for services from the government.
- Mere participation in service delivery by the community.
- Mere acceptance of government programs.

It is empowering the community to shape their own destiny.

About health finance –

Access to health care depends on how the provisions for healthcare is financed. In most of the developed nations the health care for all its pupils is ensured by the government where a single pool of resources is created to meet the health finance needs. In most of these countries 85% of finance comes from the public resources like taxes, social or national insurance which caters to health needs of over 90% of its population. Canada gives health care access to 100% population.

In India though a large proportion of household income is lost in taxes, a minimum proportion of less than 1% is allocated to meet the health needs of the people. Moreover it addresses the health needs of only a fragment of the population not necessarily of the unaffordable. Thus the intelligentsia forming the upper starta of the society often get the services (of superior quality) free of cost, while those who barely manage to earn enough for sustenance end up paying more thereby being heavily indebted and further get pushed to lower socio economic strata.

Thus those who can afford to pay get free services and also evade taxes, while the poor not only pay their taxes but are also deprived of quality health care services. This gap is further broadened by privatization and commercialization of medical care, with pharmaceutical companies, corporate groups and medical entrepreneurs offering hi-tech care at subsidized cost to the middle and the upper middle class population. They not only evade tax payments under the

banner of 'charitable hospital' but also get huge subsidies from the government which is withdrawing its services for the poor!

There are various means of generating resources for health like charging cess earmarked for health on the sale of high demand low need products like cigarettes, alcohol, vehicles, gold, diamond, etc. however the problem does not terminate at this end, further a matter of concern is appropriate resource allocation. In the public health care system there has been a mismatch of resources. Existing resources if utilized effectively and efficiently can meet the basic needs of all the people. There is no dearth of management professionals to correct this ailing system. What is indispensable is political will and people's commitment without which it is not possible to cure this ailing system.

Role of information and insurance –

Apollos, Wockhardts have been able to expand their business in the so-called health industry due to strong market research. Information is the most powerful tool for the successful planning and implementation.

To ensure a system that meets the health needs of the people, that utilizes the resources to its optimum, that provides the best quality services to its people, that addresses all the issues of local pertinence- unmasked, infallible information is essential. However information has no role to play if it remains sealed in the lockers the authorities, it must be transparent and available to the public at large.

As per my experience most of the places do maintain some amount of basic data, however its relevance an importance is not known and hence it is in unusable form. Thus the health information scenario at the field level is disappointing with few exceptions like at ACCORD a detailed record of all the relevant data is maintained for the past 10 yrs. Similarly all the information was available for Jawar scheme though it was a time consuming exercise.

There is a very close and intricate relation between health information and health insurance. The nature of risk, the value of the risk, the probability of occurrence of the event insured, the time value of money, etc. which are valuable for the designing a scheme can only be ensured by a

good HIS. Just as we blindly accepted the foreign model of health care, so did we adopt a health insurance scheme that does not befit the requirements of the poor and deprived!

Looking inward –

It is difficult to look within and be true to oneself, as we are in a habit of 'self deception' and most of us inherently suffer from 'escapism'. These questions helped me realize my potentials and focus my energies towards building the community with these reserved potentials. It helped me understand a very important thing that we all are blessed with different talents and abilities. We cannot perform all the acts that we desire and cannot alone bring a change. We all need to play our role as a part of the team and create a conducive atmosphere for others to work and success will indubitably embrace us.

These six months have taught me a lot and brought a change in my life. Few aspects of change that I picked up -

- Change happens
- Anticipate change
- Monitor change
- Adapt to change quickly
- Enjoy change.

The continuing dilemma –

We are always convinced by our brain of how essential it is to pursue the route commonly chosen by everyone which takes one up on the ladder of success, the success of having made materialistic gains. What do we mean by materialistic gain? Is it 'mundane' or 'practical'? With changing times and changing scenario luxury items have assumed the form of basic necessities. So it is practical at least in the former years, while after a certain point of time it becomes mundane. But when and how this line is to be drawn, materials draw upon themselves the human urges which soon becomes habit and exponentially grows which is too difficult to be arrested!

On looking back I believe that it provided a fertile ground for learning, from different perspective and from different levels. It helped me get a macro as well as a micro view of

community health. The work culture promotes innovation and allows everyone to express, the problems faced by one is discussed with everyone so that the team spirit is alive.

Every journey comes to an end! ------ only to convey that a new journey is awaiting to take you through another fascinating phase of life. So is my expedition coming to an end through Community Health Cell, a genial place where I met like-minded people, where I got an opportunity to unleash into the field of community health, a place where I could introspect and be myself!

"As I travel along, with the years gliding by
Adding to the richness of my experiences
Making me realize how less I know
With more and more that I discover about this wonderful world."

CHAPTER 12

Community based Health Insurance –

SWAMI VIVEKANANDA YOUTH MOVEMENT

The scheme was conceptualized on 1st June 2004 and was yet to be implemented, when we visited SVYM. A pilot project to assess the success of the scheme and investigate the prospective problems in implementation and administration of the scheme was planned aiming to cover only a handful of non-tribal people, who were to be identified by various groups like SHGs and health workers. The modules for training the trainers (the organization employees) to identify and train the SHG members on various aspects of the health insurance scheme was being contrived.

Benefits available - The insured will be eligible for all types (Inpatient care, Out patient care, Preventive and Promotive) of health intervention either free of cost or for subsidized charges.

The free and discounted services are made available only at SVYM hospital and the listed referral centers.

Services available for free –

1. Eye Care
2. Health Promotion
3. Health Education

Services available at discounted price –

1. 10% discount on Laboratory charges.
2. 30% discount on surgical procedures.
3. 20% discount on delivery charges.
4. 50% on emergency care.

Listed Referral Centres –

Type of service	Names of hospitals
Cardiac	Narayan Hrudyalaya, Bangalore.
Cancer	Bharat Cancer Institute, Mysore.
Ophthalmic care	Minto Eye Hospital, Bangalore.
	L.V. Prasad Eye Hospital, Hyderabad.

Training would be provided by Orbis, technical inputs from LV. Prasad, while the scheme is proposed to be managed by SVYM.

Eligibility – In the pilot phase only the members of specific groups or members of the community identified by specific groups were eligible in order to ensure full contribution and follow up and facilitate monitoring of the scheme.

Contribution from the insured – The insured is eligible for an annual cover under the scheme on payment of Rs. 5 per month per head, on the pre-condition that the entire family will be enrolled.

Basis of the scheme – A HIS (Hospital Information System) at SVYM hospital ensures the availability of all the requisite information for designing an insurance package. This information (occupancy rate, length of stay, disease trend, utility rate) was said to have been used to determine the premium per head. Besides some other social insurance schemes were also studied and few insurance companies were also consulted to give their valuable inputs for the scheme. The involvement of specific groups like SHGs would ensure continuous monitoring of the scheme. Besides this the tie up with specific health care providers like Narayan Hrudyalaya would in turn ensure monitoring and prevent misuse of the scheme. As the premium amount will be managed by the hospital itself, the chances of moral hazard are further reduced.

The hospital authorities are open to change in the scheme and want to scrutinize all the possible effects of the scheme on the community and the organization and hence, wants to try the scheme on a selective population from whom contribution is assured, i.e. the non-tribal population. If the scheme is found to be successful by the end of a year, it will be expanded to cover the entire population, the premium for the tribal segment being borne by the organization. If the premium amount collected is high an insurance company is proposed to be roped in to manage the finance and administer the scheme.

Comments – The scheme is in infant stage and hence too early to be commented upon. Moreover in the limited time a detailed study of the proposed scheme could not be undertaken. Though we could not have a preliminary look at HIS it is rather difficult to believe that a

premium of Rs. 60 per annum could be reached based on scientific calculation. This comment cannot be rationalized and is based purely on impression. From the community's point of view it in fact does not seem to be too attractive a proposition due to the following reasons –

- The services are made available only in selected few Centres, most of them being in cities much beyond the reach of the local poor.
- The indirect cost including transport charges, food charges, loss of wages are not being taken into consideration. This needs to be taken in special consideration because the services are available only in restricted few hospitals, which are geographically far located.
- Despite of 15 yrs. of diligent effort by the organization, it is yet difficult to persuade the tribal people to seek timely treatment from the hospital. In such a scenario the benefit of the scheme cannot be expected to be utilized to the fullest.

Financial stability and sustainability can be assessed only on the availability of detailed information on - the number of beneficiaries, the morbidity rate and pattern in the community, the health seeking behavior, the cost of care, the hospitalization rate for different ailments, the average length of stay and the expected utilization rate.

Chapter 13
Western Regional Public Hearing

Pre-event Day

Date: 28th July 2004

In order to project the cases with maximum impact within the restricted time provided, a day before the actual hearing, all the concerned people with the patients and/or their relatives having faced denial to health care, assembled at Gandhi Bhavan, Bhopal for a pre-event preparation.

28th morning started with arrival of people from the four states namely, Madhya Pradesh, Rajasthan, Maharashtra & Gujarat to be a part of this historic event, which is first of it's kind in the nation. Around noon with all preparedness the program co-ordinator addressed the group, elucidating the program objective and hence the need to be brief and lucid. The case presentations were required to reflect two issues primarily – the issue of denial of service (including the lackadaisical attitude of the health professionals) and the consequence or loss due to denial (where the loss could be physical, mental, psychological or financial)

Two parallel sessions were conducted – one of Madhya Pradesh & Rajasthan while the other of Maharashtra & Gujarat cases, facilitated primarily by the CEHAT team and with inputs from the health activists and health workers from different organizations.

It was decided that each case would be presented by either the patient (sufferer) or his/her relative in his/her local language in 2.5 mins, which would then be translated by the health worker in hindi in 2 mins. focussing on the aforementioned two issues. If the cases were presented in hindi by the patient or kin, he/she could consume 4 mins. allowing the health worker to expound upon the main issues of concern in 1 min.

As I had decided to attend Maharashtra and Gujarat session on the final public hearing, I decided to voluntarily attend the rehearsal of the other session, i.e. from Madhya Pradesh & Rajasthan.

Though the presenters were asked to present in a standing position, which was found essential to develop confidence of facing the crowd and speaking through the mike, it was not made mandatory (its significance was not explained to them). Many spoke from the place where they were seated and in low voice using colloquial terms, which made it difficult for people like me to

comprehend. Some inter linkages in few cases were also missing like the date of event/ the kind of hospital from where the treatment was sought, the chief complaints/the final diagnosis, etc.

In each case Dr. Abhay Shukla, Dr. Ajay Khare and few others pointed out the issues to be stressed upon or to be highlighted. It was further realized that the time taken was more, the presenter was unable to comprehend in the time slot, crucial aspects of the cases were not being adequately highlighted and hence a change was suggested –

Those unable to explain in Hindi would just accompany the health worker or would narrate in brief while the health worker would be responsible to present the main issues.

By the end of the rehearsal for the states of MP & Rajasthan the following aspects were realized–

- Cases from these two states were more fluid, where the denial was more indirect than direct.
- As the case presentation was not well formulated it was found necessary to plan and rehearse again.
- Cases from MP reflected the shunting of patients with poor referral mechanism where the kind and level of health care was extremely important to be known. However this was being missed out.
- Cases from Rajasthan reflected on the mismatch of resources at different levels of health care and the indifferent attitude of health personal, which was also not duly reflected through the case.

The following corrective measures were identified –

- More emphasis to be laid on the two critical areas.
- Level of health service and the kind of service must be specified in each case.
- Health co-ordinator and personnel from different organization to assist the team in their rehearsals.

Lacunae identified in the session –

- The significance of the medical documents was overlooked.
- The cases were not documented with all specifications and minute details.

- The cases seemed to be the only one's selected rather than a sample of the cases, as they were not too diverse.
- In some cases the issue of denial was not clearly understood or reflected.
- The issue of violation of human rights was not well thought of in any case and not clear in some cases.
- There was a lot of ambiguity about the criterion of selecting the cases if they were denial or violation.

Learning from the session –

The objective of public hearing as I perceive, is to reflect the lacunae in the system, wherein the case hearing would just specify about the existence of such an incompetent system and the impact of such a system on the lives of people i.e. the official is expected to understand that these are not isolated cases but an end product of the failing system.

It is just a tip of iceberg and there is a huge chunk of such cases – some which are visible but not brought to anyone's notice or known only to grassroots level workers and not known to the concerned officials or known to those concerned with the system but the top level officials are still unaware of it.

Thus it is apparent that such a session and case hearings would be highly sensitive – where on one hand there is a possibility of officials wanting to take corrective actions against the health personnel responsible for the loss caused to the individual, which may in turn also bear undesirable consequences on the victims like a backlash on them; while on the other hand the patient might expect a positive outcome from the same.

It is therefore essential to convey the correct intentions and objective of the program to–

- The officials that it is aimed to cure the ailing system and not to punish individuals responsible for the cases presented.
- The patients and their relatives that they would benefit only in the long run and no immediate relief should be expected.

Besides these the following measures needs to be taken into consideration to achieve the objective of the program to the optimum –

Sampling –

Cases must be representative i.e if there has been a death due to a snake bite and unavailability of ASV vaccine, the presented case must be one amongst many (with specified numbers) such that the presentation shows the following statistics

------- Number of deaths in Maharashtra due to snake bites (from secondary source)

------- Number of deaths in Buldana district due to snake bites (from secondary source)

------- Number of deaths in ------- villages, as per the survey (in the specified geographical area) due to snake bites, due to lack of availability of ASV vaccines (primary source)

And this case represents such cases

This kind of an approach will reflect both the magnitude of the problem and the severity (loss of human life)

This could be further enhanced with the aid of information (recommendation) like

- lack of ASVs in ------ number of PHCs ------ number of CHCs, etc.
- Number of lives that could be saved if the vaccine was available.
- Need of a primer in local language which includes the identification of bite marks of poisonous snakes, administration of ASV – test dose, dosage quantity, duration of action, side effects, other drugs to be administered, etc.
- Need of a training of health personnel for the same.

Case Documentation –

Each case must be documented with all its trivialities including some of the following details –

- The date when the case was first reported or brought to the notice of the health worker.
- Date of occurrence of event.
- Flow of the event like referral, experience at each health care facility with the details of how the health professionals handled the case.
- Name of the health service, like rural hospital, CHC, etc.

- Name of the concerned people (which might be kept confidential)

These details might be required at any stage to resolve the problem faced by the patient, to lessen the impact or provide compensation. It should therefore be available with the concerned NGO but must be revealed only on getting an assurance that it will not lead to backlashing of the sufferers.

Lack of these details poses problems like the Ngo is blamed for not having done their work, the officials might express their inability to either take corrective measures or even verify the genuineness of the case.

Importance of Medical Reports –

The patient/relative/ health worker must posses a copy of all the medical reports as it is a substantial evidence and would aid in figuring out the exact case and how the denial lead to such a severe loss. It would also aid in assessing the time lag.

It is desirable to seek a medical opinion based on the patients' experience and the case paper by a professional who is sensitive and aware of human rights issue. This will strengthen the case presentation.

Presentation Technique –

The presentation could include NFHS figures or from any other authentic source. However instead of presenting all the 10 cases first and then presenting the statistics; they could be clubbed like that mentioned with the snake bite example. Or any other technique of presentation could be adopted to enhance the impact such that the objective of the public hearing is etched upon the minds of the government officials and the NHRC who tend to get carried away either by figures or by individual cases.

Western Regional Public Hearing

Date: 29th July 2004

Panelist –

Mr. Murthy, Dep. Secretary NHRC
Justice Bhaskar Rao, Member NHRC
Dr Antia, Member Health Committee, NHRC (FRCH)
Dr. Iqbal,
Dr. Subhash Salunke, Director Health Service, Maharshtra. (for cases from Maharshtra)

Objective (as mentioned by Mr. Murthy) – To work in close partnership with the state governments, state human rights commission to improve health care.

The inaugural session started at 10.30am. though it was scheduled to get started by 9.30 am. with a formal introduction of the panelist viz. Dr. Antia from FRCH (also represents the Health Committee of NHRC), Justice V. Bhaskar Rao (Member, NHRC), Mr. Murthy (Dep. Sec. NHRC) and Dr. Abhay Shukla from CEHAT by Dr. Ajay Khare.

Excerpts –

Dr. Abhay Shukla stated that it has taken almost six months of collective effort of different organizations to conduct the survey, identify cases of denial, conduct local hearings and collect a sample of 10 from the universe of more than 60 cases and document them and lay out the entire program structure. The objective of this hearing is not to antagonize the public health system but to enable it strengthen itself with a joint effort of NGOs. Though private sector forms a major part of health care provider; there is a predisposition of denial cases from public sector for the case presentation as there are hopes of improving the public health system especially considering the fact that the lower strata of the society are not being catered to by the private sector. However in each of these cases the drawbacks in the private health care situation is also duly portrayed.

Justice Bhaskar Rao in his discourse on public health listed all the public health issues and legislative provisions concerned with it. He gave a number of suggestions like requirement of

strengthening health system, drug price control policy, availability of all essential drugs, mobile services to remote areas, ascertaining accountability, provision of specialized care for the vulnerable section of the society, etc.

Ten cases from Maharashtra were then presented by the patient or his/her relative in around 3 mins. and were accompanied by the health worker. These cases were then translated in hindi and crucial issues were highlighted. Dr. Salunke interrupted the first presenter during his case presentation and interrogated him about the specifics like the name of the PHC, the name of the doctor, etc. He also stated that there was a discrepancy in the information provided to him and in the case presentation. He informed the audience that all the case histories were mailed to him and just in 48 hrs. he collected all the information about the case from the providers.

By the end of the session Dr. Salunke got very defensive and stated that the state public health department is too large and manned by lakhs of employees. So loopholes in the system are apparent. He assured stringent actions against the one's responsible for these cases of denial but also stated that the same system provides health care to many people, it also has committed people working in remote areas with no facilities. He expressed his inability to execute certain decisions in the interest of the public due to red tapisim and pressure from ministers. He lamented that there are innumerable vacancies however the qualified doctors just refuse to serve for the rural segment. He vehemently stated that instead of blaming the public health system, the NGOs should pressurize the government and the ministry to increase budgetary allocation for health and to change policy guidelines.

Justice Bhaskar Rao complemented the NGOs for their efforts and acknowledged the difficulties in correcting the system and stated that it cannot negate human rights and hence the collective efforts by different groups is indispensable.

Dr Iqbal said that the cases and the survey findings should be read together to be able to visualize the entire scenario which is very grave. The session was concluded in the evening after the case hearing from all the four states organized in two different sessions by Dr. Antia who stated that health has been always dealt in segmentation. If health is merely curative it means 'failure of health' however it is a social problem and hence it is essential to impart knowledge to the people so that they can take care of their own health. When we talk of health from a

sociological or a technical point of view we tend to overlook the entire socio-economic dimension. Role of NGOs is supportive and not a substitute to the public system. He also mentioned of Human Happiness Index on which we need to focus rather than always looking at GDP.

Post Event – Meeting

Date: 30th July 2004

Agenda of the Meeting –

- Review of Bhopal Regional Public Hearing

Logistics & Budget: -funds for public hearing has been provided by NHRC and a detailed planning is required for logistical arrangement to be made for the pre-event and the post event day, which can be easily managed within the budget allocated. However it will have to be reallocated with a 15-day prior intimation.

Case Presentations: - Overall the session was successful and the variety of testimonies selected and presented were good. But this primarily holds true for the state of Maharashtra. Documentation was also very weak in the remaining states. Importance of sampling and adept presentation techniques were discussed.

It was felt that more number of cases was of personal denial (denial of care by health personnel) whereas the focus needs to be more on cases representing weaknesses in the health system. It was also suggested that we need to give a patient hearing to the other party (the government officials) and then strategically present our points. Presentation skills needs to be enhanced to allude that these cases are merely a tip of iceberg. The issues of violation of human rights also needs to be made very clear.

Recommendations: - It was also realized that whilst giving recommendations to the government officials it is essential to be sensitive to their problems too like procurement of

ventilator in a public hospital, which requires a lot of time and effort, posting of a medical officer to a PHC, while a mini PHC might not necessarily be manned by a MO. There is a requirement for an Institutional/Administrative reform and the colonial administrative system needs to be broken off.

Inclusion of cases of denial from Private Sector: - some cases must be presented. People do have control over the private sector but do not know how to exercise their control over it.

- Documentation of the proceedings of this hearing –

After every regional hearing a report with recommendations is expected from NHRC. However, JSA is expected to assist them in this, rather prepare the document and give it to NHRC for approval.

The process decided upon for this documentation is –

State wise report will be prepared with a common list of suggestion (besides suggestion from different states). Investigation of the testimonies will be done by NHRC with the help of JSA and appropriate measures will be suggested.

Dr. Antia suggested that for the report to be useful, it must be clear of what does it aim to achieve and who would finally benefit from it. Hence the cognitive process should begin now and the recommendations must be feasible, comprehensive and selective. It must also include suggestions for participation (including regulation) from the private sector. The report must be published in local languages besides English and the national language and must be easily available to all.

- Dissemination of information and Media coverage –

The pre-event preparation needs to be more proficient in order to have a wide and extensive media coverage ensuring that it is known to people even from remote segments of the society. The experience from the first regional hearing shows that the information has got disseminated to only urban areas through well known English newspapers like Times and Indian Express. These were not covered by local newspapers.

The testimonies must be documented and printed in local languages and must be distributed to as many JSA members as possible. Sharing of information will thereby aid in learning for other's experience and will also help in proper documentation.

- Other crucial issues –

The importance of informed consent and safeguarding them against backlash was discussed. It was also realized that though it is not a grievance redressal forum, the aggrieved would expect some substantial restitution from the whole process.

It was also felt that the case details must be submitted to the officials at least a week in advance, except for those that are included at the last moment. The public health professionals and those from ministry need to be treated with dignity in order to avoid friction and to ensure that this endeavor (of public hearing) would complement the public health system and aid in improving their efficiency.

- Preparation of Other Regional Hearings –

The preparation for other regional hearings was reviewed and various suggestions were made. Kerala is expected to present cases on environmental health and 10th of August was fixed for screening the cases, while 19th was fixed for screening the cases from Karnataka.

The logistical problems for the case collection, intimation, co-ordination and arrangements for the north-eastern regional hearing were discussed and it was decided that each of the issue of concern would be discussed in a regional meeting at either Bihar or West Bengal.

- Preparation for National Hearing –

  - The dates for National hearing were tentatively fixed from 13th to 18th, such that it gets accomplished before Christmas.
  - As it would be a two-day event issues like women's health, mental health, HIV/AIDS etc. will also be covered.
  - There would be no individual case presentations and each state will be allotted specific time to present on the survey findings; the number of cases collected, filtered and presented at the regional hearing; and recommendations.
  - The state level report and the presentations must comprise recommendations which are clear and with clear roles for different bodies must be specified.
  - All the reports and work must be directed towards – 'Health as a human and fundamental right.' The operating mechanisms must be clarified.

Groups were created and assigned with specific responsibilities –

- Analysis group – Responsible for making recommendations and report writing
- Program group – Responsible for co-ordination and program arrangement
- For follow up with NHRC
- To pressurize/ influence Union Health Ministry for budgetary allocation and policy issues.

CHAPTER 14

Jawar Health Assurance: Beyond the realms of health.

Introduction –

Inhabited by the great souls – Mahatma Gandhi and Vinoba Bhave, the sacred land of Sewagram is distinctly seen on the map of India, connecting it to different parts of the country through the various roads of development. Serenity however still prevails in the air!

Gandhiji first came here in the year 1936 to serve the poor and an ashram was set up in the land donated by Shri Jamnalal Bajaj. Dr. Sushila Nayar, then a medical student and a disciple of Gandhiji started a small dispensary in the premises of the ashram. However since the patients created chaos and disturbed the discipline of the ashram, the dispensary was shifted to Birla House, which was later developed into a hospital – Kasturba Hospital. The hospital caters to the health needs of the vast rural populace spread around in wardha district.

Agriculture is the main occupation of the villagers, while other means of livelihood are diary farming, welding, carpentry, small establishments like grocery and some also have salaried jobs in sugar mills, steel factories, etc. Besides anganwadis and balwadis, only primary schools and secondary schools in some villages are the means of formal education. Children traverse on foot or cycle through the villages to reach the educational institutions. Colleges are concentrated at Wardha and sewagram. Caste system is not too visible and health care needs are catered by Sewagram hospital, civil hospital and few private hospitals at Wardha, while outreach services are provided through Sewagram hospital and PHCs and sub centers.

An initial quest into the well known Jawar scheme brought me here only to explore the role of health in the larger socio-economic-politico- culture-spiritual milieu.

According to the Hindu teachings, life is a pilgrimage that leads through many lives to God. This is the story of such a pilgrimage---

"Service to mankind is the true service to God."

Evolution: From then to Now -----

Endurance unfolds facts! The lessons learnt in the course of an action prove to be milestone for the next endeavor. Evolution of an organization or scheme reflects on the self organization of the system and the people – their far sightedness, their commitment and values.

The Sewagram experience is thus a great learning experience as it has emanated from the people, their commitment and is not an off spring of a vague model created within the four walls of an institution.

The birth of an institution -

The history takes us back to 1945 when Gandhiji incepted Kasturba Hospital in the memory of his wife Kasturba. The 15 bed hospital meant for women and children expanded to a 50 bed hospital catering to the needs of all, including men. Following Gandhiji's assassination in 1948, the management of the hospital was taken over by 'Gandhi Smarak Nidhi', which in due course of time could not manage the hospital finance and wanted the government to take over the hospital administration.

Genesis of Insurance –

The workers being unhappy with this consultated the village leaders who offered their contributions, thus Dr. Ranade and Smt. Manimala went around collecting Jowar at the harvest time – this constituted the genesis of health insurance. It assumed the form of a scheme in the following years, requiring a contribution of Re. 1 per member of a family.

The Kasturba Health Society was keen to extend comprehensive health care to the villagers through their own contribution which gave rise to the need of insuring the entire village. Thus all the services – preventive, promotive and curative were extended to the villages on the pre-condition that 75% of the villagers contributed a meager amount of Rs. 1 per head per year. With inflation the contribution was revised to Rs.3, Rs.7 and subsequently to Rs.30. As 25% of the bill was to be borne by the patients, the poor did not avail the scheme and utilized hospital only when emergency situation compelled them.

Attempt towards self reliance that failed–

As the hospital was running in deficit of one lakh per year, the hospital management was handed over to the Kasturba Health Society registered in 1964, with an endowment of Rs 10 lakhs.

In 1969 when the hospital became a teaching hospital and the bed strength was increased the students, nurses, staff members and their families were also insured.

Though the hospital provided services to those who contributed, it was imperative to know if the services were reaching the needy ones.

The Path Ahead –

In 1977, Dr. Ulhas Jajoo joined as faculty in the Department of Medicine, MGIMS, who brought a new dimension into the community health care. Imbued by Sarvodaya ideology, he founded a study circle, 'Medico Friends Circle' of students who were concerned about the public health issues afflicting the country. The enthusiastic souls very often had discussions on health issues especially those concerning the marginalized. Having had enough of such ideological debates within the four walls, they decided to step outside and work with and for the community.
To make preliminary enquiries about health and social issues of the villages, to provide them medical aid and then graduate to deeper issues, the group strategized on selecting a village that is accessible, small in size and cohesive to enable closer and frequent contacts with the community. With little or relatively no direct exposure to community health, but highly charged by values and allegiance to improve the situation of the rural poor, the group got divided and set out to explore different villages. Though villages like Pujai were in dire need of medical services, a village 'Nagapur,' which was only 5 kms. away from the hospital and could be transversed on foot, was selected. This was the first lesson learnt by the group of how developmental factors like road and transport are interlinked to health.

After an initial assessment of the health needs of the people and in consultation with them, it was decided to start a weekly clinic, the drugs for which would be provided from the drug bank. Villagers agreed to contribute Rs. 4 towards the drug bank and offered the school building for the clinic. Management of the drug bank gave the group an insight into the exploitative drug market. However, very soon the drug bank went bankrupt and an analysis showed that the rich

were evading the contribution. It was thus decided to deny drug facility to defaulters and to impose penalty for delay. Though this problem was solved, it was soon realized that a poor mother could not take her ailing child to the clinic because she did not have ready money to pay!

Realizing the problem of the services not penetrating to the poorest section of the community, the group held a meeting with the villagers to find a way out. It was found that though 95% of the illness were self limiting and treatable in the village, it was the treatment of the remaining 5% who require hospitalization that earns credibility. The poor had to sell off their assets to meet the catastrophic cost of hospitalization. As the cost of these 5% illnesses were beyond the reach of the poor they evaded hospitalization till it attained the end stage. Even the cost of antibiotics prescribed in the village dispensary was beyond their reach. The lesson learnt was that for serious illness treatment must be free.

The scheme was thus linked up to the hospital in 1980, with the approval of the Director Dr. Sushila Nayyar, the founder member of MGIMS.

Risk Sharing –

Dr. Jajoo resolutely believes that charity corrupts people and people must pay to demand quality service from the providers. He had visited various voluntary health projects of repute in India. From his observation emanated a belief that mere benevolent service will breed a relationship of doler and beggar between the provider and the beneficiary. Moreover the schemes were heavily financed thereby posing a threat to its long term sustainability. The tradition of contributing as per one's capacity already prevailed in the villages especially for ceremonial purposes and for construction of temples. The same strategy was agreed upon by the villagers and it was therefore decided in consensus with the villagers to create a pool of contribution to meet their health needs.

The objective of this fund was to ensure –

- Right to quality health care for health contingency to the rural sector.
- Making health care services not merely available but accessible to the poorest of the poor.

- Considering village as a social unit, an integral part of the larger society, making health care services available to more than 75% of the village population with their active participation.
- A system to deliver appropriate and prompt health care services to the needy, irrespective of the amount of contribution.

The collective pool of contribution was expected to finance the salary of VHW, drug requirement for the local dispensary and transportation cost of mobile health team.

As the contributions were made in kind for other purposes and jawar was locally cultivated the villagers unanimously agreed to contribute 2 payali (2.5 kgs.) of Jawar per acre of landholding. Landless labourers offered to contribute a flat rate of 4 payali in a village meeting. Those having additional sources of income would contribute 4 payali more. If family members exceeded five, 2 payali per additional member was fixed. For the salaried class, contribution was decided in proportion to the SALDAR's (landless labourer on yearly contract) income. The collected jawar was sold to the market and converted into cash for utilization.

Since universal health care was available to all those who paid, some of the rich farmers felt that they were financing for the poor and hence refused to contribute. By the end of the first year it was seen that only 60% of the villagers contributed. To ensure wider contribution a village meeting was called and it was made clear that only those who pay will get free treatment and of those who do not pay or abscond without paying will be held accountable in the village meeting.

Health in the hands of people –

As the work progressed, to facilitate an efficient referral mechanism and to provide health care at the doorstep it was essential to have a village representative who could serve as a lynchpin between the providers and the beneficiaries. Selection of a VHW was an educative process in itself. Over the years of experimentation it was learnt that a VHW must be committed, responsible, possess leadership qualities and above all must be beyond party politics.

Reorientation (1980) –

More lessons had to be learnt! A pregnant woman was admitted a month prior to delivery because she complained of recurrent abdominal pains. The husband expected free food and treatment till she delivered. Others used admission as a convenient alibi for avoiding court summons. And few others got a paraplegic admitted and took a pair of clean heels! Such bitter experiences, led to a revision in the criteria for charging indoor patients. Though hospital services were free for most of the illnesses, 25% of the hospital bill was charged for foreseeable hospitalization like normal delivery and chronic illnesses like cataract, hernia, psychosis, etc.

The VHW was trained and handed over a drug kit with a descriptive manual in local language using colloquial terms, for diagnosis and treatment of minor ailments and to enable diagnose ailments that need referral (such that there is not delay in seeking medical attention).

It was critical to decide on the remuneration of the VHWs as their work being more preventive, promotive and educative, it was too naïve to imagine people paying for such services. In 1983-84, the Gram Sabha was empowered to adjudge their performance and thereby decide on their remuneration. It was decided to set aside 35% of the collection (Jowar), of which 20% to be given to them, in the beginning of the year and 15% towards the end of the year, based on the performance. 65% of collection was deposited with Kasturba Hospital to meet the cost of drug kit, and fuel charges of the vehicle that attended village every month. Periodic meetings were organized at the village to bridge gaps of communication and to appraise the performance of the VHW. Though the insurance contribution subsidized hospital expenditure by mere 10%, it was an appropriate strategy to ensure optimum utilization of resources.

The Gram sabha thus helped to facilitate communication between the health system and the beneficiaries on one hand, while on the other it helped the villagers have their say regarding the VHW and the health team, and could also decide to change the VHW (Jajoo, 1993). Through Dr. Jajoo's efforts, courteous behavior on the part of doctors and prompt services in the hospital was ensured.

Thus the scheme gradually started gaining credibility and the enrollment increased to around 90% and villagers from adjoining villages approached Dr. Jajoo demanding that the Jawar Scheme be extended to them. The team held a meeting during late evenings in these villages and assessed their needs, their extent of co-operation and feasibility of administering the scheme.

Thus after examining the practicalities new villages were adopted under the scheme. Since the aim cherished at that time was organizing village community (the unit of the society), the pre-condition for adopting village was voluntary participation of at least 75% of population.

With the commitment of more and more health care in the hands of the people a Gram kosh (a village fund) was raised with the entire contribution. A village fund (a bank account for each village in 1985-86) was created with three signatories- the Medical Superintendent, the Health insurance in charge (Dr. Jajoo) and the VHW, and was chiefly controlled by the hospital authorities to avoid misuse. The utilization of the fund was decided in the village meetings and it was open for public audit. The Jawar (Sorghum) collected was sold in the market after handing over the VHW his/ her share and the remaining amount was deposited in the account, which was utilized for village drug kit, fuel charges of the van and educational activities. With soyabean replacing jawar sowing, from 1998 onwards, the contribution was converted into cash collection i.e the villagers had to pay the market price of the stipulated jawar contribution. However those who wish to pay in kind are still welcomed.

From 1999 onwards the balance amount from each village fund was transferred to Kasturba Health Society to form a corpus, the interest of which would be utilized for procuring drugs, educative lecture week series (Prabhodan Saptahs), educational camps and providing Ambar Charkhas (Spinning Machine) for Vastra Swavlamban program.

Towards Integrated development –

By now close ties were developed with the villagers and parallel to it, some developmental activities were also being run under the initiation of Dr. Jajoo. The scheme had found its roots in the community and Dr. Jajoo gained credibility. In the process of addressing health issues, it was realized that social and economic issues need to be tackled. To address the sanitation problem government and state funds were channelized to subsidize the cost of latrine and with affordable contribution, people very soon had latrines under 'One house one latrine scheme' which was aimed at 100% coverage. This model was adopted by the government for replication in other states. The diary in a village (Nagapur) which was at the verge of shutting down, with community initiative under Dr. jajoo's guidance, Diary Co-operatives was rejuvenated. With the aim of equitable water distribution, lift irrigation cooperative society for the entire village land was

initiated. The funds came in form of bank loan to be paid back in ten installments. The creation of the constitution of the village co-operative society was such that, decision could not be taken with less than 75% majority, making elections obsolete.

Each of these schemes emanated from the needs of people, their participation and cooperation. No task was undertaken without the initiative from the people. Community involvement has different shades – community compliance – where community is a passive receiver, community cooperation – 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. And community participation is a politicized concept. The decision making lies with the people. There is a common feeling and hence a spontaneity of action. (Dr. Jajoo, Anantbhan)

The Jowar scheme could now magnetize people and villagers were ready to agree on any terms or conditions to get enrolled. Taking a cognizance of this, Dr. jajoo with his group excogitated a new pre-condition for the Jawar Scheme to be offered to the village–

- Should have initiated the lift irrigation scheme for the entire village.
- Should have availed to the 'One house one latrine' scheme with 100% participation.
- Each family in the village be a member of the diary co-operative.
- Elect village panchayat by consensus.

In the whole process of upliftment the most vital, sane and organized but the highly neglected section of the society- the women group could not be overlooked. In order to initiate a process of empowering them, Self Help groups were constituted. They were brought under one roof to imbibe a sense of oneness as they were all sufferers – 'the proletariat of the proletariat.' A collective movement was envisaged to provide mutual support – both morally and economically. A common pool from individual contributions was made to meet contingency requirements and meet expenditure on educational activities. Besides transparency, accountability, a culture of decision making by consensus was ingrained in them. They were trained to handle their accounts and sent for excursions, to learn from others' experiences. This gave an impetus to the group to take bold action against liquor producer.

It was thus realized that credibility earned through health care initiative is a very effective vehicle to induce change, but being the lowest priority among people cannot sustain the organized and

collective movement for long. Income generation programs served as an alternative to maintain cohesiveness. The community compliance was visible in health, community cooperation and partnership with income generation and development activities, but community participation was still invisible!

A wind of change –

With all these efforts the per capita income increased thereby bringing about a wave of change in the lifestyle of villagers. Health indicators showed awesome improvement- infant mortality shrunk and maternal mortality dropped to zero. However roses are always accompanied by thorns. Socio-economic improvement gave way to alcoholism, gambling, conflicts, groupism, and party politics inflating vices like jealousy, greed and competitiveness.

They again reached at the cross roads with questions – What did the village benefit? Is this what we had aimed at? It was soon realized that economic development must be preceded by socio-cultural upliftment. The seed cannot germinate into a plant unless it has adequate supply of water and the land and ambience are conducive for growth.

The need of the hour was to revolutionize and awaken the sleeping souls which required active participation of the devout men (sajjan Samarth). The health insurance scheme had now reached a stage where it was helping to identify not only the action oriented culture of the village but also action oriented individuals with capacity to do good. The strategy adopted was to exert thrust on constructive programs in the present context viz. ANNA SWAVLAMBAN through organic farming, VASTRA SWAVLAMBAN by making use of ambar charkha (spinning machine) and VITTA SWAVLAMBAN through self help groups. These venerated activities were believed to aid in cleansing the soul, take one close to nature.

It is believed that these are not merely physical activities but rouses conscious and is an engine to internalization. They are the acts of faith. To induce faith in people, take this message to people educative lecture series were started (Prabhodan). These were started as hymns at the temple where people usually assembled with devotion. However they were unable to perceive it. It was therefore felt essential not to have such sermons but discussions on issues pertaining to day to day life, issues concerning them and link it to socio cultural values through experiential learning.

While organic farming ensured sustainable yield from agriculture without causing any harm to mother earth, it required a lot of hard work and dedication. Vastra swavlamban aims at achieving self reliance in clothing. These messages were disseminated in the villages and to ensure its assimilation, role models were introduced to them.

The kaleidoscope was now focused on identifying the devout and support and empower them to serve as role models for others to follow. A moral leadership is required to ensure sustained development which encompasses all – the voiceless, the poor, the marginalized. It aimed at breaking the 'culture of silence.' People were required to be alert to their needs and be pro-active.

The focus now shifted from a progressive village to the individual families who participate in creativity. As jawar health insurance has the bargaining power those actively involved in any of the following are now entitled to the scheme –

- Member of Self Help group.
- Having assumed organic farming.
- Organizer or participant in Prabhodan
- Having taken a vow for Vastra Swavlamban.

These activities are believed to morally uplift individuals. Some get involved in any of these merely to avail to the benefits of the scheme. It is believed that by subjecting to such a process, change is inevitable! Though the time taken is not predictable! For those who are not interested in moral issues, alternative schemes are available.

The whole process began with a dream of Gram Swarajya where health was chosen as a medium of entry into the rural life. Though health is vital to be able to enjoy other benefits in life, it does not enjoy priority. Issue of income generation larger to it was chosen as a pedestal. However activities revolving around materialistic gains are driven by individual interests engendering an illusion of community organization. The focus thus had to be risen to address moral and ethical issues.

There has been a paradigm shift in the scheme from an initial focus on curative care to preventive and further to promotive care. It didn't stop there and with perpetual experience and learnings shifted the focus on social aspects, which now rests on moral issues.

As I walk along, I see things gliding away---
I halt and ponder to realize that they have been passing through me,
Reforming me! Recharging me! Revitalizing me!

Ethos –

Every society is constituted of 'Haves' and 'Have-nots.' Inequality is ingrained in nature with multiple classes and categories of flora and fauna one mightier than the other, topped by human beings. Human beings are not the superior most merely because of their intellectual capacity, but because they are blessed with 'brain power to serve humanity'. Proximity to nature breeds humanity as nature takes care to suffice the needs of every human but not the greed of any. Nature ensures adequate resources provided individuals makes the best use of their mental pursuits and toil to obtain their share.

However our society is not egalitarian with power concentration being highly skewed towards the intellectual class. Power leads to corruption, contempt and exploitation of the lower class for accumulation of wealth and personal gains. In order to ensure a fair share to everyone, the ownership needs to be collective such that individuals enjoy the fruits of nobody else but their own labor for generations to come.

Thus the ethos of the scheme revolves around the ideologies of Gandhi-Vinobha-Jaiprakash Narayan, soliciting the concept of village republic (Gram Swarjya). This vision assumed contour of Gramdaan proposed by Vinoba. As per the Gramdaan Act, the 75% population are required to transfer their land to the Gram Sabha, the highest decision making body in the village, which is then no mans land and has a collective ownership. They preserve their right to toil on the land and enjoy fruits of labour. The leader is selected not elected, as elections are a foul play. 'Purity of end can only be possible through purity of means.'

Decentralization of the power to the Panchayat is by no means an answer to this as the panchayat constitutes of narrowly elected group of representative which reflexly becomes a locus of power. True democracy cannot be manifest by representative democratic structure but can only be attained by collective decision making process. Such an ideal society needs an apt structure to imbibe the correct values. These two complement each other and the absence of even one would wreck the society. This structure is reflected in 'oceanic circles' and not in pyramid. Years of experience have shown that the trickle down theory never works in the larger interest of the poor. For the benefits to seep through the people the structure must be horizontalized complemented with collective action driven by motives that benefit the larger masses overriding individual interest. What Gandhi Vinoba propose is participatory democracy, where in the most decentralized social units (village) decision making body will not be less than Gram sabha.

Its relevance to health –

Health must be in the hands of people – for the people, by the people and of the people. Health cannot be dealt in isolation of other social, cultural, economic and political issues which are all closely interwoven. Trying to view from the ivory tower with the aid of a binocular will not help the community need to be examined under a microscope and so the soul of this experiment lies in -

"Go to the people,
Live with them,
Learn from them,
Love them,
Live like them,
Build upon what they have"

Health being a nodal point of entry it now tries to achieve the **mission** of 'identifying revered individuals in the society, honing their leadership skills to evoke community action for the benefit of the society'.

Dr Jajoo believes that conscentization of individuals is the stepping stone to create a morally upright society which is self reliant and self sufficient.

Objective –

The objective of the entire process is to continually educate people and motivate them through role models and convert them to change agents for the benefit of the community. This would ensure a sustained progress.

The model seeks to enhance individual capabilities and sense of awareness by aligning individuals of high moral values with revered men through various venerated activities. Its primary focus revolves around igniting minds to progress into better individuals thereby laying the foundation towards creation of sane society.

Strategy – Perpetual Revision

Every incident served as a learning opportunity thereby necessitating restructuring of the strategy. Each endeavor was strategically planned and had to be maneuvered from time to time. The entry point strategy was to take into account the health needs of the people by focusing on curative care – a strategy which reaches to the poor, involves people, does not make them dependent and attempts to raise resources locally. The inception of Jawar scheme with all the changes that it underwent is evidence to this.

Various experiences in the field are a witness to this –

Health Education –

Influenced by the conventional preventive medicine style – talks on various issues like malnutrition, leprosy, tuberculosis, venereal diseases, diarrhea, family planning, immunization, etc. were held which fell on deaf ears. The bookish information were neither feasible nor appropriate to their lifestyle. In a family where two full meals could not be guaranteed, what kind of nutritional food could be advised to the pregnant mother and the children in the family? A lot could be learnt from the mothers when they said, "We do not have cattle, milk sold in the village is diluted and sold at exorbitant cost. We cannot afford, eggs, oil, sugar, vegetables, fruits."

The admonitions on the repercussions of large family size to promote family planning methods were retorted back by responses like, "Will you support us when we get old?" One old woman asked "Doctor have you seen a bullock cart with only one bullock? You need at least a pair; if one succumbs at least the other will drag the cart on." In a patriarchal society, it was natural that family waited till they have two male kids. Thus it struck that unless under 5 mortality is reduced, unless security for old age is provided and unless agriculture becomes profitable any incentive will not convince them of the benefits of small family. Health education is often glibly used slogan. People are wise and adapt to situations. It is not they but we who need to be educated!

MCH care –

The door step maternal service was the top most priority – enlisting expectant mothers, detecting early pregnancy, identifying local dais, supporting her for home deliveries, utilizing her as link worker during antenatal visits, identifying at risk mothers and supervising their hospitalization was the popular strategy. However two cases of casualty – (1981) the death of a second gravida due to post partum bleeding whose delivery was conducted at home by dai; and (1983) a primi gravida whose fetus died in utero compelled to rethink on the strategy -------

Road and transport facilities were the key factors determining accessibility to the hospital was the lesson learnt. It was now dawned that none should be denied hospitalization under the pretext of providing health care services at the village. A villager does not demand hospitalization for no reason. It costs him heavily – apart from hospital bill, lost wages, lost wages of attendant, transportation, food, drug, etc. everyone has a right to just health care service whether primary, secondary or tertiary.

The highlights of the learning were –

- Emergency services must be free to enable accessibility to the poor.
- The public facility when made available to all, are gulped by the rich powerful and few. For making the facility available to the poor, the elite few must be restrained by the system.
- A trained dai working in isolation can do little. All loud talks of empowering her in the absence of a well knit referral system only glorify her role. Its purpose is to camouflage the double standards employed towards villagers and urban elite.

Strategy revised on the basis of the learning –

- The monthly visits by ANM serve no purpose in complicated pregnancy like excessive bleeding per vaginum. In such cases the patient takes charge of herself and tries to access the hospital services. She should not be denied care.
- Fetal growth retardation is not remedial and regular iron, folic acid, and calcium supplements need to be assured which can be entrusted to the dai.
- 7th and 8th month of gestation being crucial a thorough examination is imperative and requires a hospital setting. Newly married women being immunized against tetanus through annual cluster immunization while booster dose for the pregnant woman could be administered during her ANC visit to the hospital.

Wasteful expenditure on monthly visits were thereby trimmed off and these services were replaced by that of the dai who is trained well to tale care of minor needs, ensures visits of the pregnant women to the hospital in the 7th and 8th month of gestation and refers complicated cases.

Thus the ANM visits the village once in 4 months and is linked with dai who is empowered by assistance of an alert medical service, centered in the referral hospital.

This effectively brought down maternal mortality to zero and drastically reduced natal/perinatal mortality in the last 15 years.

Vaccination –

Low priority for preventive health needs coupled with unawareness of its benefits, misconceptions about it and inaccessibility to vaccination facility kept the villagers away from its benefit. As it was not feasible to carry out a door step immunization visiting house to house, the concept of immunization of entire village by an appropriate strategy of cluster immunization was therefore conducted to check effectively the transmission of infection by removal of host susceptibility. An appropriate time was chosen to achieve wider coverage and people were educated about vaccine preventable diseases through CINEMA. The cluster immunization approach of getting all eligible at one place could achieve herd immunity to be followed by vaccination of new comers (new borns or newly wed) every year. Since new comers in a village

are few the strategy could trim off human power requirement (and therefore the cost) and yet maintain the herd immunity.

Thus a strategy of health education contributed with pulse immunization was found successful which drastically brought down the vaccine preventable illnesses.

In search of VHW-

The drive began with selecting a young educated representative of the people, elected by the people. The lean amount of Rs. 25 per month could not hold him for long and being discontented with the profile of work he soon set up his paan shop at Wardha and hence had hardly anytime for the village activities. It was therefore decided to select a lesser educated or uneducated person who is unlikely to settle outside the village.

By this time women and children warranted a lot of attention, it was an appropriate time to select the village dai as VHW. However illiteracy barred her from taking over the responsibility of purchase of drugs and maintaining records, gender became a barrier in accompanying patients at night hours to the hospital and in communicating freely with men on health issues. Her role remained confined to conducting deliveries and post partum care which was considered filthy and hence did not command respect in the society. Meanwhile the jawar scheme was started and the VHW besides all the other health work was now required to collect jawar, store them, maintain records, etc. She could no longer handle the responsibility and gave up.

Back to square one, a male health worker was needed, however if he would be from low economic status he is not likely to devote much of his time for social purpose. A people's representative would represent only the vocal affluent. A VHW selected by the doctor would be accountable to the medical fraternity and not to the villagers.

It was realized that only a person with strong leadership qualities befitted this work. Such dynamic individuals were identified from the farmer's movement. But they had to be selected by the people, especially the voiceless. Hence a system was excogitated for the selection process –

- The reigns of the village fund and the developmental activities were to be handed over to the villagers for which a public body was to be identified. This task became relatively easier due to the credibility earned through health care delivery in the villages and due to constant liaison with them. Such a body of village erudite was formed known as "Karbhari mandals."
- The gram sabha meet was held at the village temple, where the names of the preferred candidates were called out
- The villagers were asked to select one male and one female candidate for the work and the opinion of the erudite were sought, which was kept confidential.
- The most accepted candidate was declared the co-ordiantor of Karbahri Mandal who was most suited for the village health work.

A responsible, committed person beyond party politics but who possessed leadership qualities was needed for this kind of a job. Such a person whose potentialities were identified by Dr. Jajoo in consultation from wise people from all caste groups in the village was selected. In the initial years most of the VHWs were men. With the movement of the Self help groups gaining momentum the lady with leadership qualities proved to be a better option.

Thus the VHW was selected by the people with an expert opinion of the erudite villagers and facilitated by Dr. Jajoo (Health Insurance Incharge)

Adoption of villages for Jawar Scheme –

Starting off with one village in 1978, the number increased to 15 in 1985, and currently covers 40 villages under the scheme. On requisition from any village a preliminary visit was made to the village at late evening to have a discussion with the villagers. The decision of extending the cover was made after an initial assessment of their needs, accessibility, morality of the villagers and extent of co-operation.

The criteria have again been revamped to suit the changing time.

Thus a multi pronged strategy was adopted which was subject to change. The scheme has been open to change, realizing the 'only thing constant is change.' Revision of strategy is seen as a rider to adapt to the changing needs and demands of the community.

"Adaptation is not imitation. It is a process of reorientation and assimilation."

The Formula for Success -------- duplication or adaptation?

Every newly identified problem sows the seed of the formation of a new institution as the only solution to tackle it effectively. Every newly formed institution breeds its own set of organizational problems. This has led to proliferation of institutions and organizations which work in isolation, thereby hindering not only each others growth but also that of the society at large!

With scarce resources it is at the same time difficult to meet the needs of the people. Though monetary incentives act as motivating factors it cannot be the sole driving force! People from different fields of expertise can contribute through their skills, experiences, instincts, insights and recommendations.

The success of jawar scheme is ingrained in this formula of voluntarism and non hierarchical, non institutional, non structural, collective endeavor of the committed people. The volunteers represent different fields like medicine, polytechnic, education, funding organization, and from the community itself. Some have formed facilitators group rendering technical know how, while some have taken over the role of animators motivating people and still others live their life as role models to be followed!

The entry strategy for addressing issues of concern in these villages was to tackle their needs. Gradually funds were channelized, development schemes were started, group initiatives gained momentum, equipment and means of daily use were designed to befit the local needs ------ all voluntarily with no direct involvement of the parent organizations. These initiatives are supported by the organizations but could not have been possible without the will and selfless and unwavering efforts of the members.

It is in the light of this that one needs to understand to what extent is the project replicable. The concept based on voluntarism and non institutional function is replicable, but the vision and the intervention strategy cannot be replicated. It is unique for every society! Every community is governed by its own principles and its ethos, culture, creativity, sense of urgency and extent of assimilation of any new concept varies greatly. Having realized this, a combined strategy of replicability and adaptability was adopted.

The concept of a program is replicable but needs to be guided by a vision (which is not duplicable) and fine tuned to befit the culture, ethos and need of the society. The basic concept around which the lift irrigation scheme, diary cooperative, self help groups are governed is the same –

- Every initiative should be need based.
- It should emanate from people.
- People must participate in it.
- Purity of means is imperative for purity of goal and hence the revered path must be opted.

The lack of power and authority and right to income led to the formation of a women's group aiming at empowering them, while the dire need of water for agriculture led to the collective action towards lift irrigation. The search for an alternative source of income, already existing link with 'Goras Bhandar" initiated by Gandhiji – led to the constitution and successful management of Diary cooperative in Nagapur, which could not be duplicated anywhere else. Jawar scheme too emanated from people's need and willingness to contribute in kind.

Thus the aforementioned concept can be replicated but it is virtually impossible to duplicate the same scheme design. For instance SHGs are functioning smoothly in Nagapur village but number of groups has fallen apart in another village 'Takli-kite'

Thus with a vision proposed by a visionary, learning from experience and other successful models, based on the needs of people, their level of commitment, their ability to organize and discipline themselves their ethos and culture a scheme can be designed that would be nurtured and further built upon based on local experiences.

Health: A Social, Economic, Cultural, Political and Spiritual Perspective

Multiple schemes are running in the villages. All are not equally successful everywhere. Every village has its own culture according to which it adopts and then adapts itself. Thus a need was felt to visit some villages and explore the facts. To gain an insight into these activities the Centre of Community Polytechnic was also visited.

This section comprises a detailed account on various developmental activities carried out in the villages.

Sanitation –

It was a usual scene in the village – the roads were lined by people squatting engaged in the early morning ritual. The villagers were explained about its harmful effects; medicines would be of no use if sanitary conditions were not maintained. It fell on the deaf ears, the medical team hence decided to take up the issue.

A previous effort of constructing a public utility had proven to be futile. No one shouldered the responsibility of cleaning it. It was an externality on which free riders would ride, till they could! And finally it became defunct when people stopped utilizing it due to its unhygienic condition.

A scheme was conceptualized to build a latrine for every house. Though it was welcomed no one took the initiative and tried finding excuses when the time for action came. It was thought that financial constraints could be one of the reasons for eluding. A model latrine constructed totally free for some poor villagers, was thought would inspire others after its benefits were actually seen and felt by people. A latrine was built within three months and to the disappointment of the team it served as a store room or converted into a bathroom!
Though the reason behind such behaviour could not gauzed; to probe into the matter Dr. jajoo tried speaking to a village woman. She informed that "the latrine needs water to be kept clean and water needs to be fetched from far flung wells. This will unnecessarily increase our burden." When he enquired if they did not feel ashamed to defecate in the public, she backfired the question to him "Where would you go if you were to stay in the village – to the fields located miles away which is infested with snakes and other creature, lacks proper illumination and is extremely dirty during the rains or on the pavement of the village which is not plagued by all these problems."

The answer was sought – a latrine needing minimal water to maintain hygiene is the solution and until a strategy to achieve this was discovered, not a finger could be raised against them.

With the technical inputs from the Center of Science for villages a low cost latrine attached to soak pit with a flap to ensure hygiene with minimal water was designed. It facilitated the conversion of feces into manure which could be used for agriculture. Walls were to be constructed of cement and tin were to be used for door. This odorless dry decomposition and cost effective model of latrine was easily accepted by people.

As the principle behind any community program was to initiate community participation and discourage charity, a nominal contribution as per the landholdings was decided by the Gram sabha – Rs.300 for a landowner, Rs. 500 for the one who owns irrigated land and Rs. 200 for a labourer. Villagers were encouraged to help construct the latrines themselves (Shramdaan) and supervise the quality of work in the process.

Meanwhile the Gram Sabha that resolved to divert their funds of Jawahar Rozgar Yojna with the help of state subsidy and beneficiary contribution could achieve commendable target of 100% sanitation in their village. This was achieved in Karanji Bhoge within a year's time and spread to 12 more villages. It gained the acceptance from the government as a role model for replication in other states. The scheme could address the issue of hygiene through community participation and self discipline.

The characteristic features of the scheme are –

- It is not merely a relief work; it commands action, community organization governed by people's need. It symbolizes the collective decision making process and conferring of the power in the reign of people.
- Just as the five fingers of the hand are different the situations of people are different and hence the contribution was graded as per affordability and the sources of income.
- It succeeded in reaching to the poorest of the poor.

<u>Diary Co-operative –</u>

The only means of livelihood was agriculture in the villages which was highly dependant on nature's grace. The lives of villagers were so intricately interwoven with nature that its vagaries shattered them completely. An alternative means of livelihood was imperative for sustenance. However it was indispensable to take into consideration the market situation to avoid exploitation.

Except in Nagapur and few more villages most of the villages were linked to the government diaries. Nagapur had an old dairy that was at the verge of shut down due to loss instigated by corruption and its mismanagement. However some families (5 to 10) continued selling their diary yield to a dairy in an adjacent village karanji Bhoge.

The diary cooperative of Nagapur was revived with people's participation in 1983 and health insurance again became a medium of change. The diary cooperative of Nagapur was linked up with 'Gosavardhan Goras bhandar,' a trust formed in Gnadhi's time to promote exclusive cow's milk. The scheme survived due to transparency of management and combined efforts of the villagers. The credibility enjoyed by this milk federation (which supplies milk at door step in Wardha town) is such that consumer purchases cow's milk priced always higher by around 10% than the market prices. The issue of concern now was how to manage the fund and who would manage it? How to ensure democratic participation and quality control? The secretary was chosen and handled the responsibility of managing the account. Monthly meetings of all the members of the co-operative served as a pedestal to decide on terms and conditions. Dr. jajoo's role was confined to a facilitator's and advisor, while decision were taken by the members of the co-operative. In one of the meetings it was revealed that the secretary has been attempting some foul play. Dr Jajoo in the capacity of President of the society, himself could not appoint anyone as he wasn't sure that the newly appointed secretary would not repeat such a deed. He however was aware of the fact that he enjoys credibility and if he quit from the cooperative as president, it would collapse. He therefore proposed – The amount siphoned to be returned back to the organization, the account to be handed over to the representative selected by consensus and all work would be voluntary to discourage misdeeds encouraged by monetary incentive. The system would continue as it is for a month following which a meeting would be called and each member will be asked two questions – If the same person should continue as the secretary and if the reply be No who would befit the role? Dr. jajoo admonished that if this strategy was not agreed to by the members he would resign from the president ship. The bullet hit the target!

The strategy was executed and the villagers chose to allow the same secretary to continue, though he would no more enjoy monetary incentive. This created accountability.

Some standard operative procedures were decided

- The milk would be collected in a separate clean utensil and would be tested for fat content and S.N.F. if the content was found less it would fetch lesser value and if foul play was detected no money would be paid to the producer.
- The milk producer gets 90% of the selling price which no milk federation in India has ever practiced. Thus the members themselves did not want to sell it anywhere else. However the rules also spelt out clearly that milk produced by the members must be sold in the market only through the cooperative.

For administrative purpose a Secretary and a Chairman had to be elected as per the norms of the federation. In order to avoid representative election; a strategy was adopted—by a secret ballot each member would suggest a name for the post. One who gets maximum recommendation is then selected by consensus for the respective post.

The cooperative had no accumulated fund for administrative purpose. Loans were available from the Goras Bhandar (federation). This amount was deposited in the cooperative fund and then disbursed to the farm producers.

Bitter experiences of people not repaying the loan, eloping with money, selling off the cattle taught few lessons. They were given a notice period of one month to repay the loan with interest accrued; failing which their membership would be cancelled. In the light of this experience a new stringent rule was constituted. If the loan would be repaid within a year 2/3rd of the interest was returned back to the farmers, failing which they were required to pay the full interest. People obviously yearned to repay the loan as soon as possible!

While applying for the loan the members would require two signatories as guarantee giving consenting to monthly deduction from their earnings, if the proposer did not repay the loan in the stipulated time. Gradually the needs started increasing with increase in the cost and requirement of fodder, cattle and medical attention to them. The fund in the co-operative were falling short of the needs and so 5 paisa from the amount earned on every litre of milk was

retained in the account to form a corpus to meet contingency needs of the farmers. Two third of the interest was returned back if the loan was repaid within a year. When the fund grew to a larger size it was disbursed to avoid accumulation of money thereby breeding greed and conflicts.

The practice of utilizing the loans for alternative purposes engendered the concept of loan being made available for other purposes too, but with a ceiling of Rs. 10000 which has now been increased to Rs. 15000. A farmer was unable to repay the loan due to the sudden death of the cow and so a new strategy was devised of retaining 50 paisa as deposit from the amount earned on every liter of milk till the loan is repaid. This enlarged the corpus and was known as 'Suraksha Nidhi.' The benefits of creating such a revolving fund are –

- A petty contribution from every member resulted into pooling of money that could be put to alternative use and meet contingency needs.
- If due to some unavoidable natural disaster or event the farmer is unable to repay the loan, the loan amount could be met from this fund.
- Every penny earned is spent instantaneously by the farmer, this fund would ensure availability of money at the time of need.

In order to undertake developmental activities 10 paise on the amount earned over every litre of milk was collected by the federation at the source and was decided that if this amount remained unutilized for 3 years, it would be transferred to the federation, thereby compelling proper utilization of this fund. Various developmental activities besides educational tours were undertaken like making vermin compost, gobar gas, providing Veterinary services, reconstructing the cow shed, etc.

The crucial learning from the experience were, when people come together for a common purpose there is bound to be conflict of interest, but decision by consensus and disciplining the entire community through certain spelt code of conduct which is free of politics and does not favour anyone, can resolve such issues under a staunch leadership. People have to rise above the level of self interest to reach for a common goal.

Self help Groups –

Women represent the lower most strata of the society. Though they toil harder than men, they do not enjoy any right and comfort. They lack economic power and hence are never involved in decision making. However it is observed and accepted that they are more sensitive to the needs of the people and have better organization capacity. As women represent the weaker section of the society they will not assume power unless they rise to the level of men. Collective decisions avoid power concentration and reduce dependency on male folks. The goal was to empower the women folk, 'the proletariat of the proletariat,' to unite to fight against injustice.

Self-Help Groups [SHG] were formed to bring them together towards achieving common goal and becoming self reliant. Though most of the SHGs are created for economic gains and financial freedom, it was realized that such an association for mere monetary gains would soon get entangled into politics and will get corrupt. The objective of constitution of such groups were to bring the women together so that they could discuss individual problems and the problems plaguing the society, to pool money which would serve as contingency fund and to instigate collective action against the societal perils.

Strategy adopted –

- As there cannot be a national or uniform model to form such groups, each group evolved from its own functional system based on its requirements and goal with the aid of a facilitator, i.e. Dr. Jajoo and his group. New groups learnt from sharing and experiential learning from successful ones.
- To increase the capacity of the members and of groups, emphasis was on fabricating new relationships in the village, enhancing skills and knowledge, and building local leadership.

Activities –

- To save small amounts regularly
- To mutually agree to contribute to a common fund
- To meet their emergency needs
- To have collective decision making
- To solve conflicts through collective leadership and mutual discussion

- To provide collateral free loans with terms decided by the group at specified rates.

Such groups were only confined to women and started in 1990. With Dr. Jajoo as the facilitator, the women of the villages were called for a meeting, where its importance and its operational aspects were elucidated. Initially women got enrolled to break the vicious cycle of taking loan from the landlords at high interest rates. They were glad to have an account of their own. A nominal amount was decided in the village meeting of women which varied from Rs. 10 to Rs. 25 per month. As a non formal group was envisaged the group size is kept to minimum not exceeding 20 beyond which it would need registration and involve unnecessary procedures. Monthly meetings are held to discuss on the financial aspects, resolve individual problems and to assess the authenticity of the cases when loan is demanded. This process ensures collective decision making and transparency. There are no elected office bearers. Responsibilities are distributed and rotated with the aim to involve all the members in the educative process. A coordinator (Sangthika) holds regular monthly meeting, another member keeps records and accounts.

A saving account for each group is maintained which requires assent of other three signatories for withdrawal, thereby avoiding pilferage. The interest rate were discussed and fixed in the meetings. Since the landlords granted loan at a rate of interest of 10% per month, it had to be lesser than that. However a very low rate of interest would encourage women to take loan form the group and grant it to others at a marginally higher rate of interest. It was thus fixed as 5%. However after linking it with NABARD the rate of interest has fallen to 3%. Compound interest of 12% per year is added to everybody's investment while the remaining amount gets converted into a common fund (samuhik kosh) to be utililzed for contingency, educational tours, educative material purchase and as seed money to purchase appliance, equipments of use like grinding mill. Loans are granted to the needy at a nominal rate of interest of 3% of which 2% is paid back to the bank.

The scheme is run in around 40 villages and there are 90 women SHGs and 25 men SHGs. Of these 40 are linked to NABARD which grants cash credits double the amount of savings. 90% of this loan has already been repaid. These groups are very often taken for field visits to show them role models i.e. successfully running SHGs in different parts of the country. Training, discussions and ability to take responsibility have honed their skills, which is reflected through

effective and smooth management of the group and through increased self confidence. They have not only become active in thrift and credit management but have also undertaken other activities like anti-liquor movement, managing grinding mills, etc. to serve local needs and are equally capable of exerting a clout on the gram panchayat for developmental activities. Moreover as men folk are already seen defaulting, the loans are more easily available to the family through SHG.

However such a collection of people striving for individual interest and material gain is bound to fall apart. Some groups have collapsed when individual gains have overpowered collective gains. However on a large scale this process has empowered them and empowerment transforms them into powerful change agents. They command more respect as they are also seen as the bread winner of the house and it is through them that the entire family enjoys the benefit of the jawar scheme.

Right to income, awareness and education of women ensures better nutrition, education and living condition to the entire family and hence aids in building towards a better society.

Community Polytechnic –

Community polytechnic is a government of India project under the ministry of human resources development. Through this project various rural developmental and income generation activities are undertaken with the cooperation and participation of the community. To attain this purpose the project embodies flexibility to accommodate with various organization or individuals to reach to the villages. The project activities are as follows –

1. *Transfer of technical knowledge* –

   Various technical know how which aid in reducing unnecessary hard work and wastage of resources and energy, to improve the efficiency and which are chiefly environment friendly are shared with people. Example –vermicompost, gobar gas, techniques that aid in agricultural activities to improve efficiency and yield with reduced efforts, preparation of pesticides using locally available resources, etc.

2. *Vocational training* –

To enhance the talents of the youth vocational training are imparted to them. These are targeted especially towards the school drop outs. An entrance exam is used as a tool to assess their aptitude. Vocational training in various fields is designed for a 3 month to 6 month duration. Example – plumbing, screen printing, photography, motor rewinding, welding, turner, water cooler and fridge repair, TV repairing, garment making and designing, computer maintenance, bamboo craft, carpentry, etc. they are also encouraged to innovate. The marking system is linked to their selling capacity in order to enhance marketing skills.

3. *Technical Services* –

Expert advices of the teachers and students from the polytechnic are made easily and readily available to the villagers. To reach out to the rural population and provide them with technical services various strategies are adopted. Service center at the village level, training cum production center, rainwater harvesting, construction of bamboo houses are demonstrated to the villagers. Advice and guidance is also provided to initiate village based activities as a source of income. Besides all these rural camps to mend and repair devices are also arranged.

4. *Community Services* –

To facilitate rural development, it is imperative to create awareness among people and educate them on various issues, provide facts and remedial measures available. Various activities are organized aiming at different set of rural population. An orientation course for school going children, science exhibition, mobile library, male and female self help groups, educational tours, camps, film shows, etc. are organized.

Thus it tries to make all the services available to the rural population which urban population already enjoys.

<u>Organic farming</u> –

Organic farming is a pattern of farming in which the ecosystem is preserved by abstaining from the use of harmful chemicals and fertilizers. Culturing symbiotic life forms ensures weed and pest control and optimal soil biological activity is undertaken to maintain fertility.

Pesticides and chemical fertilizers known to increase the yield in the long run pollute the environment; reduce the fertility of the soil besides poisoning the crop. The farmers have to spend huge sums to buy them and then to sustain the harvest.

Thus organic farming is promoted to create a pure, poison-free, sustainable environment. This transformation must start from within — raising the individual and society to live in accord with Natural Law so that they no longer pollute or destroy life. Only this will bring true balance in Nature.

Close to the Nature –

This is the story of a couple 'Vasant and Karuna Futane' from a village 'Rawala' in Amravati district. They have pledged to live a self sustained life by employing only organic techniques in farming and would not be depend on the market except for the minimal needs like salt, oil and jaggery. This has been driven by a principle of accepting the nature's rule, by offering human labour and being content with whatever mother soil offers. This is faith! They have experimented on 2.5 acres of land on which they produce for personal consumption and dwell in mud house which protects them from the vagaries of nature in all the season.

The drive began by deciding to be least dependant on the market. All the materials required for agricultural purposes to be cultivated and utilized locally. They decided to never use chemical fertilizers and pesticides. They use homegrown bio-pesticides and manure from the cow shed and utilize a number of well known traditional methods which are safe and affordable alternatives. They would never produce sugarcane or soyabean for the market. They cultivate cereals, pulses, grains, vegetables, fruits that suffice their needs.

The second pledge that they took was of self reliance. Everyman tries to satisfy his personal and his family's needs and desires. So does the farmer satisfy the needs of his larger family – his cattle, birds, cat, dog, etc. Sufficient amount of yield hence needs to be ensured, thereby satisfying everyone's requirements. This requires planning! Nature takes care of not only their needs but also that of their cattle. Wood is utilized for cow shed and house, besides for fuel; gobar gas provides fuel for cooking and also serves as a source of energy for illumination. They do not possess any electronic gadgets and have electric connection only for lifting water from well for irrigation.

They use Ambar charkha to attain self sufficiency for clothing and have never been to flour mill. The flour is ground at home with the aid of modified traditional grinding machine which requires manual labour. However money is essential in today's life to meet some indispensable needs. Money is obtained by selling the diary products, seeds and saplings. In case of illness natural cure through ayurveda and naturopathy is opted. They have attempted to teach their kids at home and send for formal education only from 7th standard onwards. They believe in imbibing right values in their children which cannot be achieved through formal education.

However such a life though simple is not free of hurdles and problems. They have however discovered that god always comes to their rescue. It is this faith that takes them along on a path untread! Such a life can only be experienced!

They live a life by example and hence serve as a role model to prove how by hard work, dedication and faith one can live a simple life but the one which nourishes their soul. They prefer to adhere to their principles than get swayed off by the glitter of modernism and technology.

All this is rooted in developing individual life to higher states of consciousness — so that individual actions nourish the environment — and in creating coherent collective consciousness in society.

Rendezvous with the villagers –

The exploration would have been left incomplete without a dialogue with the villagers – the beneficiaries, the providers and the managers of the scheme. The expedition began one afternoon by traveling in a milk van to the model village 'Nagapur.' the meeting of diary co-operative was enlightening and helped me draw a fine sketch of the evolution and the management of the scheme. Practical issues were dealt with and solutions were sought in consensus. An interaction with the VHWs and the Dai revealed the problems that they faced as VHW, besides all the benefits that they have reaped over the years. They face difficulty in making the ends meet – manage the daily household chores, organizing meetings, entertaining visitors, managing the SHG activities, etc. however they could not disvow the efforts taken by Dr. Jajoo and his team in rehabilitating them. They agreed to the fact that there has been tremendous changes in the lifestyle and values of people and everyone feels empowered. It was heartening to know that no one fears institutional care and no one needs to be educated about

the significance of nutritional food, small family size, hygiene and ill effects of addiction. The villagers with collective efforts of SHG members and staunch support of male members were able to wipe off the nuisance of alcoholism. Though a more robust effort was made at Karanji Kaji, without male support the anti-liquor movement succumbed. The VHW being pro-active and brave continues to inform the police about such miscreants discreetly. The following day I visited Nandora- another village where 100% target for sanitation and successfully administered dairy co-operative were achieved. The balwadi teacher who is also an active member of the SHG, shared her experience of the group. It was a difficult task for her to walk the tight rope as whenever she refused to grant loan without the consent of the group, she would be accused. The villagers at times distrust her. She yet feels a deep sense of satisfaction.

An early morning drive through the villages to reach Khadka was pleasant until it we approached the village as the road was lined by people defecating. On enquiry we were informed that the 'One house one latrine' scheme could not be extended to all due to shortage of funds. Ramu Nagtode who currently works as an insurance agent, serves the community as VHW, furnished all the technical and operational details on lift irrigation and also escorted us to the pump house through the fields of cotton, soyabean and pumpkin. We were shown gobar gas and kandi kolsa- an equipment devised to cook food for a family of five using coal without creating pollution. Pimpalgaon tops in the participation where 'prabhodan' (educative lecture series) are consistently conducted in the month of Feb.

Takali kite symbolized a village full of conflicts and party politics. Around 15 years ago the villagers had got together to construct a community well and link it to tap supply for drinking purpose. With acute shortage of water the villagers got together and approached the gram panchayat to help them out. The building cost of the well was assured but labor had to be provided by the people. Each villager labored in shifts. The prevailing factions in the village and the party politics led to wreckage of some female SHGs. A SHG coordinator eloped with Rs. 20000 deposited by the group. Sanitation was not available and people had to walk miles on bad roads to defecate. The ideal place were pavements approaching main roads as they were illuminated.

In the whole process, a reverence for Dr. Jajoo and his team could be felt and people seemed willing to undertake that he proposed. Except for Takali Kite the rest of the villages exhibited a sense of fulfillment cherished their achievements though they were facing numerous problems

administering them. They had gained self confidence which they considered their greatest asset. One woman said "Farmers lives are difficult. They possess lakhs of rupees but only for a day – at the harvest time. Though they know they cannot hold on this money it gladdens them as they are now assured that they will not be indebted. All these schemes are good and boosts our confidence, but we are blessed only by Mother Nature. They day she destroys our crops we will be wiped off."

Salient features of the scheme –

1. Available – primary care is available to the people in the villages itself and they can avail to secondary and tertiary care at the medical college hospital. Thus all the services are available round the clock to the villagers.
2. Accessible to the poor – Mere availability does not make services accessible. The system where payment is as per capacity and services according to the needs, makes it accessible. The culture of hospital is not alien to villagers. They can catch hold of the people responsible for the management of the scheme (Dr. Jajoo & Sister Bagade), at any time. Moreover, the villages are well connected to the hospital and transport facilities are conveniently available, such that some VHWs accompany almost every referred patient.
3. Acceptable – The bargaining power of the jowar scheme shows acceptability of the services. No more do villagers need to be coaxed about sterilization or vaccination.
4. Affordable – contribution is essential but is limited to one's paying capacity. However services are not determined by one's contribution.
5. Appropriate – innovations in sanitation, immunization strategy and introduction of numerous developmental activities have all risen from the needs of people.
6. Adaptable – The scheme does not aim at replicability but is based on the fundamental principles aiming to achieve its objective through adaptation. The emphasis on varied activities like Prabhodan, male self help groups, well construction for drinking water is evidence to this.
7. Accountable – Social financing, democratic decision making and appropriate training makes all those responsible for the service delivery, accountable.
8. Credible – Credibility is an intangible asset which is visible in the villages. The respect commanded by the team, the readiness of people to co-operate is evidence to this.

9. Effectivity – Improved health status apparent through improved health indicators, vanishing apprehensions amongst the villagers to cater health services shows the effectivity of the health program. Community organization, improved level of organization reflects the effectivity of other programs.
10. Holistic – The scheme has evolved from people's health needs with their efforts gradually seeping to social, developmental and spiritual activities being sensitive to the changing milieu.

From an Insurance perspective –

A community based health insurance scheme is any not for profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of collective pooling of health risks and in which members participate in its management.

- Chris Atim.

The Jawar Scheme satisfies all the above (underlined) criteria. However the definition embodies the concept of self reliance which in turn implies financial sustainability. If health services have to cater preferentially to the poor, it cannot be economically self reliant. The scheme does not aim at financial self reliance and hence cannot fit into any structured definition of insurance. It can be rather termed as 'health assurance to the poor'.

Health Assurance – The Concept –

The essence of assurance is 'an affirmation of just health care service', in contrary to insurance which ensures 'financial aid' only for health contingency. Hence jawar scheme can be termed as an assurance scheme rather than an insurance scheme.

Primary health care is the fundamental right of the people and hence should be available, acceptable, accessible and affordable to them. The poor however spend considerable amount on medical care to unregulated and exploitative private sector, primarily due to low credibility of public hospitals. The maldistribution of centrally pooled resources is what primarily ails our system. The distribution of government funds is lop-sided favors "Haves" and neglects "Have Nots."

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.

It is possible to offer a just primary care to all, within existing government resources provided funds are locally governable in effectively managed decentralized set up. It cannot sustain on a vertical model and empowerment of the poor is the key towards an accountable system. Power emanates through the control of public funds and its management. And conferring such a power to the people would mean empowering Gram sabha. This requires a strong political will.

Charity corrupts people and so beneficiaries should essentially contribute towards health care services as per their capacity though enjoy services as per needs. However social financing of such a kind can never meet the expenses towards medical cost and hence such a financial mechanism must be utilized to generate demand for quality care.
The spin off benefits of social financing are –

- It increases accessibility of health services.
- It promotes operators concern for health in the community.
- It generates the concept of right to demand a quality health care by the beneficiary population.
- It responds to priorities as judged by the community.
- It ensures that services are acceptable.
- It keeps service providers on toes.
- It stimulates organizational self confidence and paves way for participatory culture at community level.

It is obligatory for the welfare state to offer health care services to all. This can be achieved by appropriate resource allocation. The vertical approach towards medical care needs to be horizontalized to penetrate the proletariat of the proletariat. Social health insurance is an effective means of percolation to the marginalized which can never be served by the profit yearning private companies!

Health insurance in Sewagram evolved to develop an egalitarian and just health care delivery system which must be acceptable, affordable, available and accessible to all. Scrutinizing the scheme –

Issues	Conventional Insurance Schemes	Jawar Assurance Scheme
Size and diversity of membership	Larger and diverse the group lesser is the risk of loss. As it aims at financial security the limited geographical coverage could rather be perceived as a financial threat, especially in cases of epidemics.	Though it covers diverse population in terms of age and area, the geographical spread is limited to ensure access to services. The assurance of services can only be given to accessible areas.
Financial protection to the beneficiary	Insurance ensures financial protection against the paying capacity.	However this scheme ensures financial protection irrespective of the paying capacity.
Cost recovery from the scheme	It is indispensable for the sustainability of the scheme.	It is just used as information to assess the level of contribution through public funds and other private bodies.
Rates of utilization	An increase in this indicates moral hazard, morale hazard or adverse selection.	As health care is guaranteed irrespective of the ability to pay an increase indicates change in the trend.
Lack of awareness of the scheme in the beneficiaries	The bureaucratic structure and low penetration leads to this problem.	A strong tie with the community by constant interface with them over the past few years overcomes this problem. Infact, the hospital is more known to the people because of the scheme.
Moral hazard [The tendency to superfluously utilize the services; both by the providers of	It is a threat and tried to be controlled by employing terms and conditions.	As the scheme is managed through the hospital moral hazard is avoided. The other measure adopted to avoid moral hazard is a system of co-payment, wherein the patient has to bear some proportion of the payment.

health care by over prescribing or overcharging and by the beneficiaries by over utilizing the services.]		
Morale hazard [Fraudulent act to reap benefit from the scheme]	Though close scrutiny of cases do reveal it, a well knit plan generally evades.	Every insured is required to produce a receipt signed by the VHW and at times the VHW accompanies the patient thereby ruling out morale hazard.
Adverse Selection [Inclusion of high risk group]	Various conditionality are laid to avoid this.	The scheme does face a problem of adverse selection as all pre-existing conditions* are covered and there is no waiting period. (* all the ailments extant before the inception of the coverage)
It requires a support system	A lot of resources are drained in manpower and infrastructure to support the scheme as it does not involve the community in management.	Appropriate and optimum resource allocation coupled with affordability of the scheme has offered revenue stability and community co-operation.
Benefit package not compromised	Schemes offer very limited flexibility with numerous limitations like upper limit on services.	The scheme has evolved through and for the need of the people and hence has undergone numerous changes to befit the changing needs with changing time. All the services are provided except that for un forseeable events a co-payment is initiated.
Financial stability	It is a priority	It is not a priority.
Salability of the	It is not easy to sell	Since the scheme evolved from the

product		people it does not have to be sold.
Coverage	Covers only a proportion of payment.	There are no sub limits to care except for foreseeable hospitalization.
More oriented towards community than individuals	Benefits the community more than individuals, there may be reluctance to participate	Scheme having evolved from people managed by people there is no reluctance among people to participate.

SWOT Analysis – from an Insurance perspective.

	Strengths	Weaknesses
Opportunities	• Health care services are largely inaccessible to the poor. A unique scheme like this can penetrate to such masses and cater their needs. • Segmented approach to health leads to disease control and not promotion of health. Need based diversified effort employed through this scheme can aid in achieving health in its true perspective.	• Though such schemes can aid in providing need based and effective services to the marginalized, it being operationalized through the hospital cannot extend the services to geographically far placed regions.
Threats	• None of the schemes whether health or others can be replicated. All initiatives in all the villages convey this and serve as a model of adaptability rather than duplicity.	• The health insurance scheme sustains on government and private aid. If this oxygen supply is cut the scheme would succumb.

Financial Analysis[14] –

Number of schemes are being managed by employing innovative means which are run through MGIMS. In order to understand its implications and learn from its experience, an exercise has been carried out to analyze the financing and cost of care.

The broad aim of this study is to decipher the complex picture of financing and cost of care provided through the hospital.

The analysis has been broadly classified into two sections, viz. the hospital data analysis which includes the income and expenditure details besides the changing trends; the analysis of jawar insurance scheme.

Background –

Kasturba Hospital is a medical college hospital and is utilized for training undergraduate and post graduate students, nurses and paramedics; besides rendering medical services to the patients. It therefore has to satisfy the norms with regard to staff pattern and facilities laid down by the MCI for a teaching medical college and for research activities. Thus the cost incurred is apparently more than that in a pure service providing hospital. Moreover, it serves as a referral hospital catering to the needs of patients from all over the state and from other states too.

The different health insurance schemes run through the hospital are as follows –

- Jawar Insurance Scheme
    - Pre payment according to capacity but services according to the needs.
    - 50% subsidy is given for OPD, while the total bill is waived off for unexpected/unforeseen IP admissions, except for few planned hospitalization.
- Subsidized family insurance scheme

[14] Refer to Annex II for the statistics.

- Rs. 15 to be paid per person per year, provided 75% of the villagers contribute.
- Both IPD and OPD services are subsidized by 50%

- Indoor Insurance scheme

  - Rs. 15 per person per yer.
  - Only IPD services are subsidized by 50%.
  - 75% coverage of the village population is not obligatory.

- Hospital run family insurance scheme for semi urban/urban population.

  - Rs. 150 per family of five persons per year.
  - 50% subsidy in IPD & OPD services.

- Staff insurance scheme

  - This is benefit provided to all the staff and their family members.
  - The premium is deducted at source, which is 0.5% of the basic pay and DA per month.
  - All hospital services are available free of cost, except food and appliances.
  - If the patient is referred to any other hospital, the additional cost of treatment is reimbursed up to a limit of Rs. 5000/-

- Referral insurance scheme for the staff offered by the credit cooperative society of the employees.

  This scheme is deposit linked scheme provided only to the staff and their family members on payment of a stipulated deposit as premium which is refundable. It will be dealt in details later.

The objective of this exercise is to estimate how much does the hospital spend in provision of services vis-a vis the contribution made under insurance scheme, to assess to what extent a community based health assurance/insurance scheme can meet the hospital expenditure.

Sources of Information–

1. Income/Expenditure –Annual Budget.
2. Hospital Statistics, Data on Insurance Scheme – Annual Report.
3. Statistics pertaining to Jawar Scheme and the non insured from the villages eligible for the scheme – Hospital Register.

Methodology –

A systematic method has been adopted to present the income and expenditure obtained from the Annual Budgets following which the cost recovery through different financial mechanisms is estimated.

1. To compute the income of the hospital, the contributions made by the patients and the premium paid for various insurance schemes are taken, which includes recovery both for indoor and outdoor services. However, computerized data for only indoor bills has been maintained since the year 2000, which has been utilized to assess the income under both the categories, viz. indoor & outdoor services.
2. To compute recurring expenditure, expenses only under some major heads are analyzed, it being a medical college hospital number of activities pertaining to training and research are not directly related to delivery of medical services. The major heads under which the expenses are taken for computation of hospital annual recurring expenditure are –
    - Salary of the staff; including doctors, nurses, interns and other non clinical hospital staff and wages paid to class IV workers.
    - Expenditure on food, materials and equipment.
    - Expenditure on repair and maintenance.

    Note – The expenditure under the following head is excluded

    Pay allowances for the nursing school staff, for Provident fund and Gratuity, traveling expenses, office expenses, nursing training expenses, and under materials and supplies required for rural centers and other additional activities.

3. The jawar scheme was evolving from 1979 to 1985. Hence data from 1986 to 1994 was considered in the first phase. The scheme further evolved from 1995 to 1999, wherein multiple schemes were offered to the same villages, till in the year 2000 a uniform pattern was implemented. Hence in the second phase scheme has been analyzed from 2000 onwards.

Average Expenditure/Capita (Jawar Scheme) =

$$\frac{\text{Total hospital expenditure on jawar scheme}}{\text{Total beneficiaries covered under Jawar scheme.}}$$

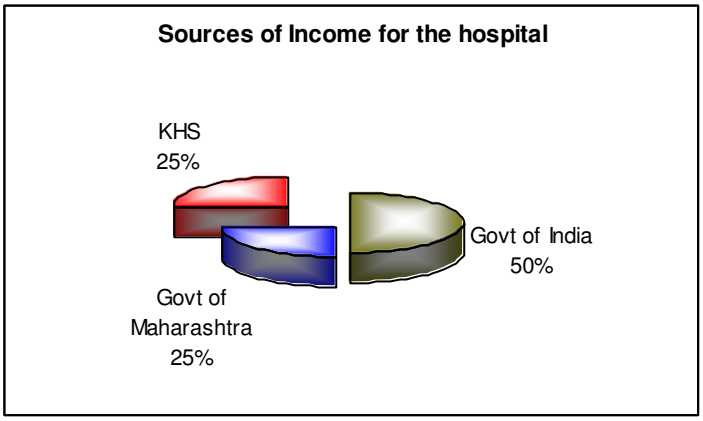
Cost recovery = $\frac{\text{Total in hospital collection/ insurance contribution}}{\text{Total expenditure}} \times 100$

Section I – Hospital data analysis

Revenue Structure –

The various sources of income for the hospital are as follows –

Graph 1: Pie chart showing the sources of income for the hospital.



1. 50% of the total expenditure is received from the Govt. of India, Ministry of health and family welfare, Department of health as grants-in-aid.
2. 25% of the total expenditure is obtained from Govt. of Maharashtra, medical Education and drugs department as grants-in-aid.
3. 25% of the remaining expense is met by Kasturba Health Society.
    a. Receipts from college.
    b. Receipts from hospital*.

* This study examines only this aspect of income generation, as the income generated through other sources are either received as grants from the government or are met from the medical college.

i. Patient payment – These are payments made by the patients at the time of seeking service, including co payments[15] of the insured population. This comprises payments made for both indoor and outdoor services.

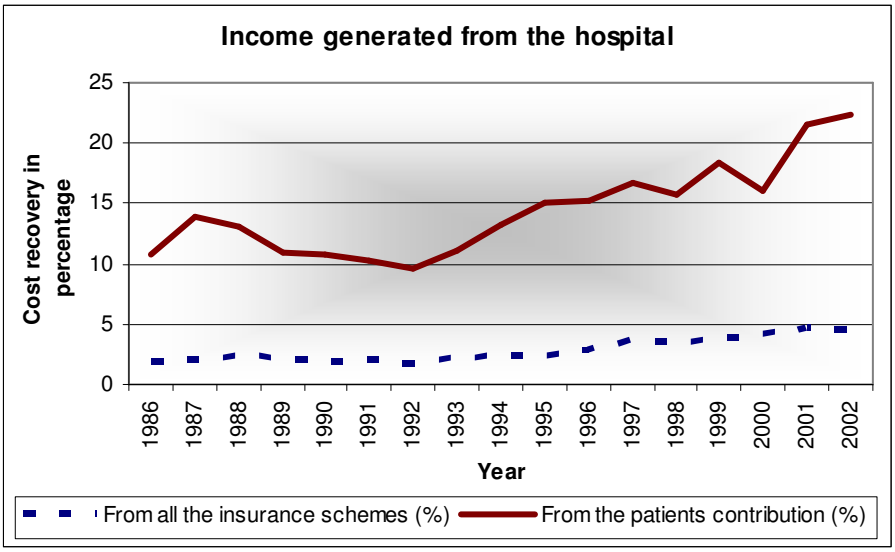
ii. Income from health insurance – These include the premium collected through various insurance schemes, both from the hospital and the college, as all the staff & students avail to the services rendered by the hospital, besides the other insured population.

(a) The graph clearly shows that the recovery of the cost is more from the patients, while it is negligible from the insurance schemes. This can be attributed to the huge expenditure incurred by a medical college and referral hospital, in contrary to the minimal premium collected through

[15] 25%(up to 2001) or 50% of the bill is paid by the insured person at the time of seeking services.

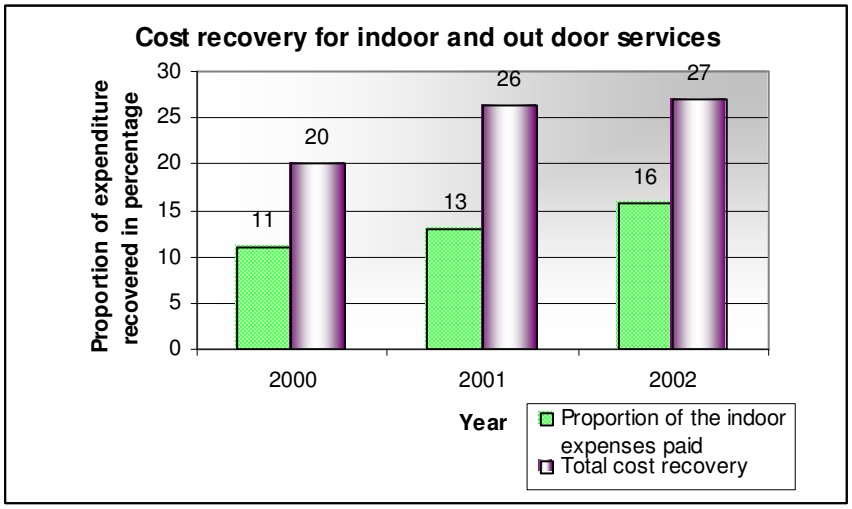
various insurance schemes. The cost recovery through jawar insurance scheme will be discussed later, which will throw more light on this.

Graph 2: Line diagram showing the income generated from the hospital.



(b) Of the total expenditure, 10.7% (1986) (Graph 2) is met with, from the hospital receipts, which has shown an increase to 22.4% in 2002. This includes the recovery from the out patient fees also besides that from in patient care. Though this is nearly close to 25%, which the Trust is expected to generate every year, the above analysis does not include the other costs incurred by the hospital like administration, expenses on training, etc. Hence the actual cost recovery is expected to be lesser than aforementioned value.

Graph 3: Composite Bar diagram showing the cost recovery from the indoor and outdoor services



(c) From the indoor bills record, it is seen that the cost recovery from indoor charges is 11% (2000) which has risen to 16% (2003). The corresponding figures for the cost recovery from both indoor and outdoor charges are 20% and 27%, respectively. Thus the cost recovery from only outdoor charges is estimated to be 9% and 11% respectively for the two years. Thus, a little than 50% of the total cost recovery is from outdoor charges (Graph 3).

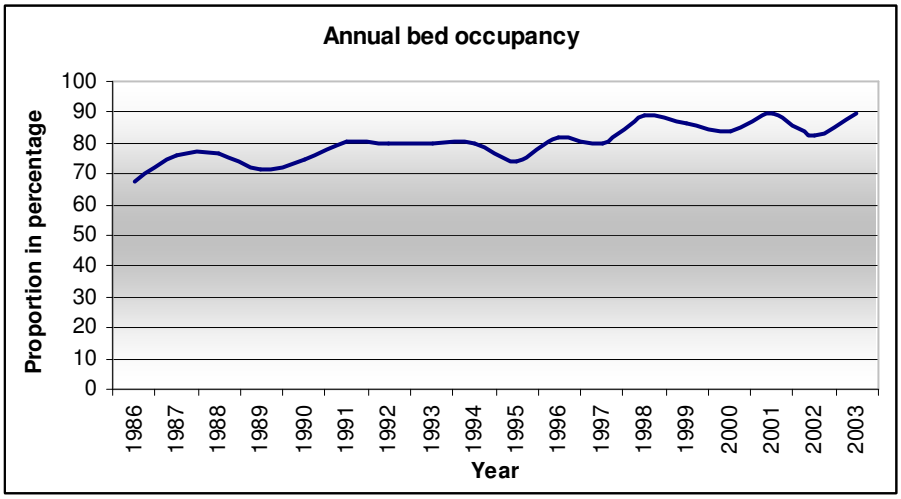
Fee Structure –

The pricing is ad hoc with no reference to the actual cost. The charges are determined from the market prices and based on annual expenditure, they are increased at random based on the decision taken by the Medical Superintendent. Due to increasing cost of materials and drugs the hospital is unable to provide it at free of cost and hence most of the drugs and accessories are now prescribed to the patients thereby adding to his/her out of pocket expenditure. Even the insured patients have to buy medicines from outside!

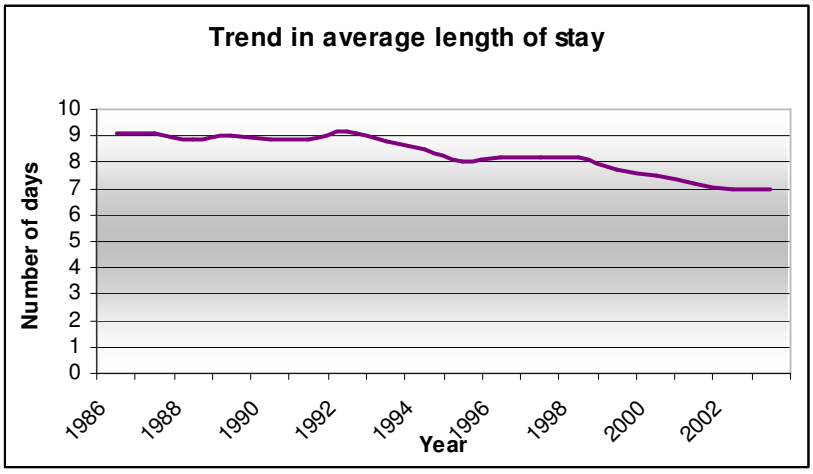
Changing trends –

Over the years the number of admissions has shown a considerable increase which is consistent with the increase in the bed occupancy. This reflects in decline in the average length of hospital stay.

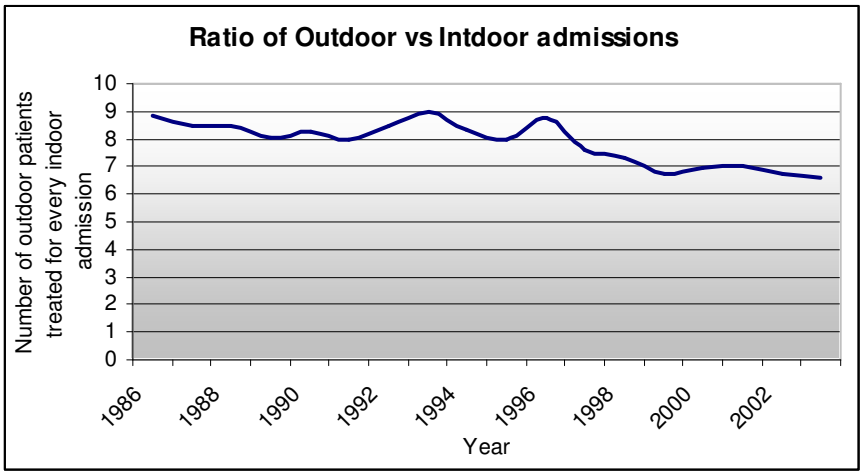
Graph 4: Line graph showing annual bed occupancy ratio



Graph 5: Line diagram showing trend in average length of stay.



Graph 6: Line diagram showing the ratio of outdoor vs indoor admissions



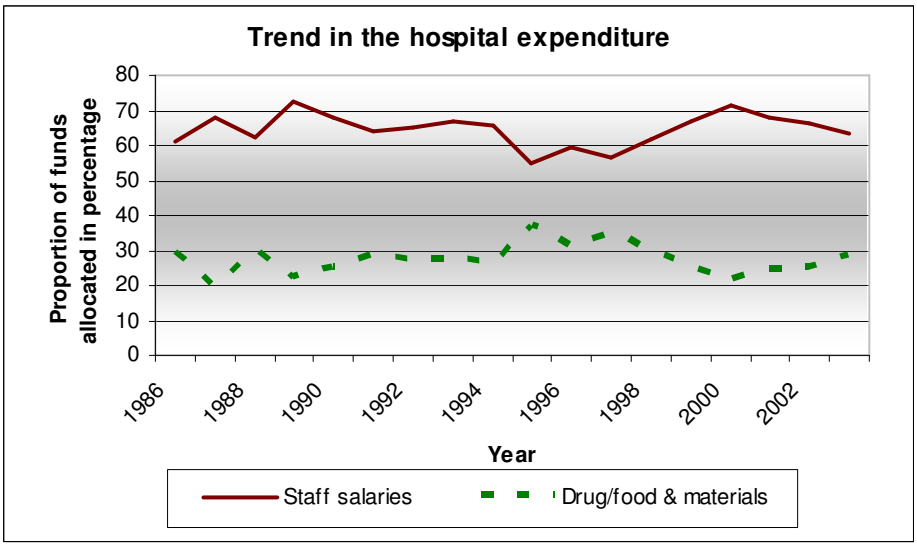
The ratio of the number of out patient services sought vis a vis the indoor admissions has shown a decline from 9:1 in 1986 to 7:1 in 2004. This implies that the rate of increase in indoor admissions is more than that of out door patients. This could be considered as an evidence of the increasing popularity of health services provided at MGIMS.

Expenditure –

The focus of the study being on rural community based health insurance scheme, an attempt was made to calculate all the costs pertinent to provision of essential care. As the provider hospital is a medical college hospital with large capital expenditure, which is less likely in service oriented hospital the capital costs were not taken into consideration for computation of the hospital expenditure.

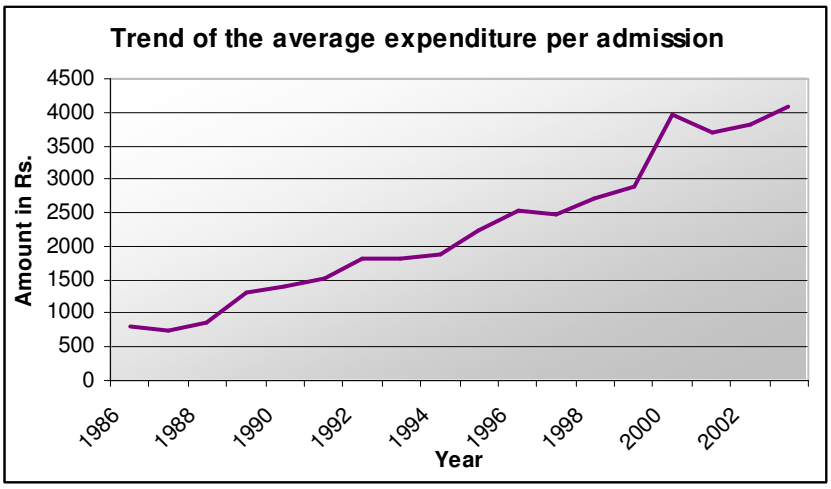
1. The major chunk of expenditure is on salaries engulfing around 62% (in 1986) to 64% (in 2003) maximum being 73% in the year 1989. The allocation of fund on drug food and other materials has shown a decline from 30% (1986) to 28% (2003) with the mode being around 28% over the years. Thus a very large amount is spent on salaries while the fund allocated for the essential products viz. medicines and equipment indispensable for the treatment, has shown a rise in late 90s which has again declined after 2000.

Graph 7: Line diagram showing the trend in the hospital expenditure



2. The hospital data on expenditure includes the expenses made on both indoor and outdoor services. Thus the average expenditure per admission includes expenditure on n number of outdoor patients also. The number of outdoor patients for every indoor admission is shown in the graph above (Graph 5). The average number of outdoor patients treated for every one indoor patient over the years is 8.

Graph 8: Line diagram showing the trend of average expenditure per indoor admission.



The average expenditure per admission (which also includes approximately 8 outdoor patients) has increased from Rs. 803 (1986-87) to Rs. 4078 (2003-04). As already mentioned the hospital being a referral and medical college hospital, the expenses are too high which is reflected

through the aforementioned figures. This is also attributable to inflationary changes and technological advance.

Section 2: Analysis of the Jawar scheme

The members covered under the Jawar scheme (100% subsidized) are covered for all hospital services including both inpatient and out patient care with no conditionality. However the insured is required to bear 50% of the hospital expenses arising due to any foreseeable event, which was 25% of the total bill till 2001.

The insurance scheme was conceived in 1979, which went through a phase of evolution till 1985. From 1986 to 1994 the entire village was offered the scheme i.e. all the villagers from the selected villages, were eligible for the scheme. From 1995 onwards more than one scheme was offered to the villagers and from 2000 onwards the scheme was open to selected families satisfying the eligibility criteria. As the scheme was in evolutionary phase till 1986, and as it was difficult to separate the data of Jawar scheme from the pooled data from 1995 to 1999, the data from 1986 to 1994 has been analyzed. Further the data from 2000 to 2002 has been analyzed to estimate the difference in the billing pattern of the indoor admissions from the insured villages with those from the general hospital admissions.

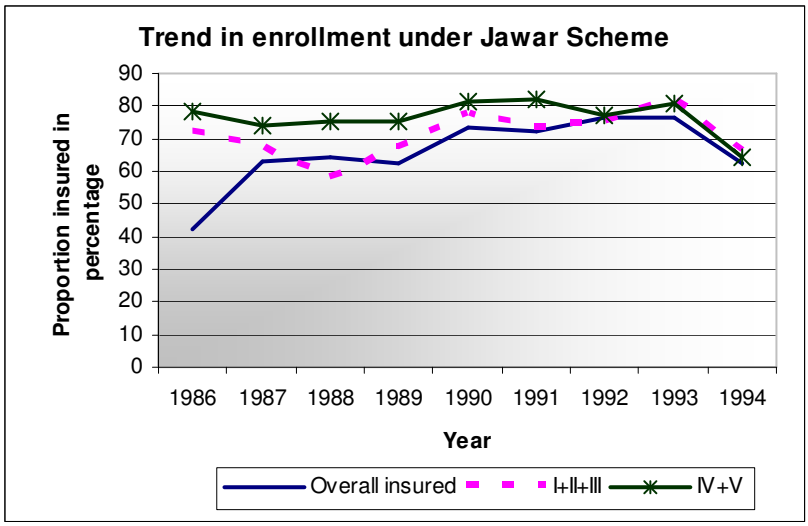
Acceptability -

The scheme gradually evolved out of the needs of the people and expanded from handful of villages to nearly 40 villages. The below graph shows the trend in enrollment over the years, under different categories based on the socio economic status.

Category I – Families who employ labourer on yearly contract (Saldar) for agricultural work.
Category II – Families who own irrigated land and a pair of bullocks, but do not employ saldar.
Category III – Family who own unirrigated land and a pair of bullocks but do not employ saldars.
Category IV – Families who own dry land but neither employ Saldar nor have bullocks.
Category V – Landless labourer.
Any other additional occupation raises the economic grade by one.

Thus the villagers from category I, II & III can be considered from comparatively higher socio economic status as compared to those from category IV & V.

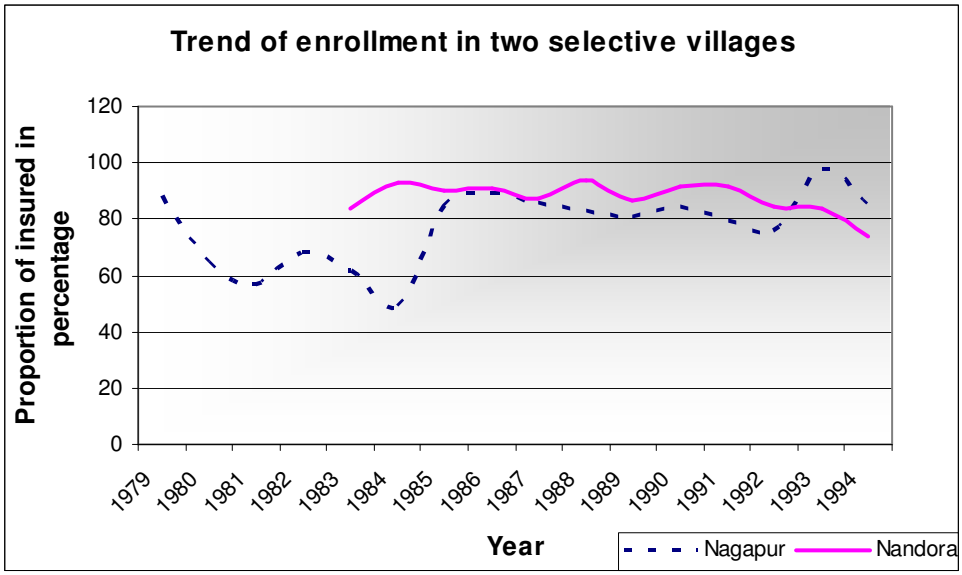
Graph 9: Line diagram showing the trend in enrollment under the jawar scheme.



The increase in overall enrollment shows increased acceptance of the scheme. However few villages were dropped out intermittently due to non adherence to the conditions laid. The level of enrollment from the lower economic strata has always remained more than that from the upper strata, till the year 1992, after which both categories equal.

Nagapur was first adopted in 1979 as a role model and continued to receive the service and hence the acceptability of the jawar scheme in this village is examined. Villagers from another village Nandora, having learnt from Nagapur's experience also got enrolled subsequently. As this village has remained insured for a number of years uninterrupted, it has also been taken into consideration for analysis on acceptability.

Graph 10: Line diagram showing the trend of enrollment in two selective villages



The scheme was incepted in Nagapur and as mentioned in the evolution of the scheme, the villagers readily agreed to contribute as seen in the graph showing 88% enrollment. However in subsequent years as the villagers, especially the rich did not benefit as much as the poor did, some stopped contributing. This is seen through the falling curve of the graph. Around 1982 the enrollment again showed an upsurge, which increased further in 1986 after a drastic fall in 1984. Thus after an initial fall in enrollment, the rate of enrollment has remained consistent around 75 to 85%. It took five years for the scheme to earn credibility in the role model village!

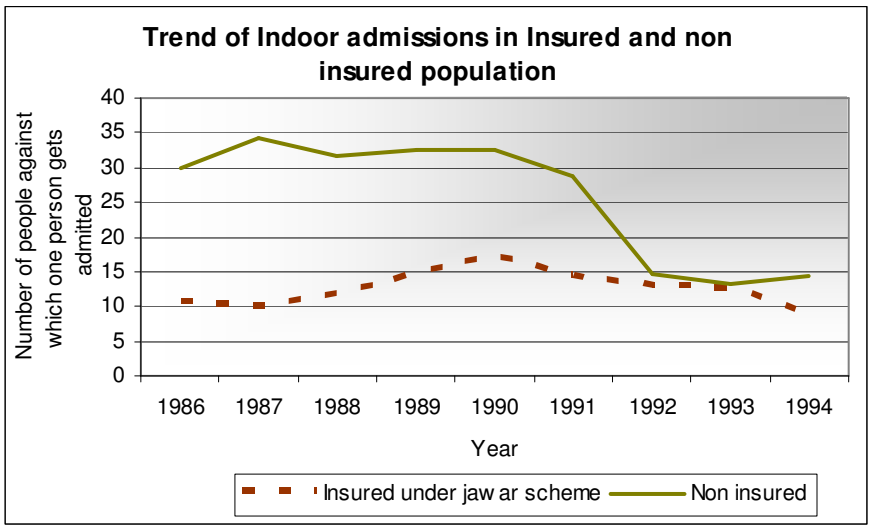
Nandora was included in the scheme in 1983 and the enrollment is high from the first year after which it has remained almost consistent. The villagers from Nandora had observed benefits that Nagapur had reaped; hence it did not take time to gain acceptability.

Changing trends –

The number of persons against which there is one indoor admission amongst the beneficiaries of Jawar scheme has remained almost consistent around 11 in 1986 to 9 in 1994.

However, only one patient got admitted for every 30 non insured members from the same village in 1986, this figure reducing to 13 in 1994 (Graph 10). This shows that even from the non insured population more and more people are now getting hospitalized. It reflects the increasing credibility that hospital services enjoy even in non insured population.

Graph 11: Line graph showing the trend in the indoor admissions in insured and non insured population.



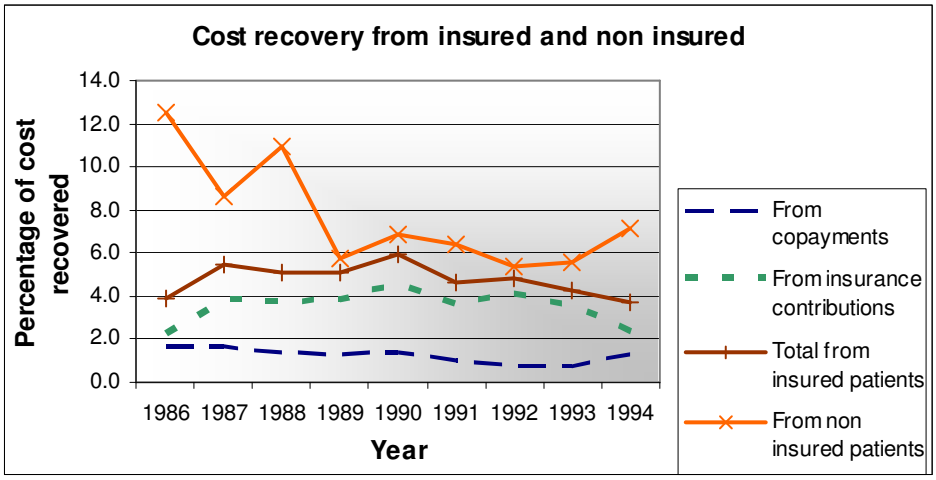
With increased enrollment the number of admissions have also increased over the years.

Cost Recovery –

Cost recovery can be expressed as the proportion of the amount recovered in percentage, of the expenditure made. For this study to determine the cost only recurring expenditures from the hospital have been taken into consideration and on the income side the premium paid under insurance and the payment made by the patients at the time of seeking care has been taken into account.

As already mentioned, the cost recovery from Jawar scheme is assessed to elucidate as to what extent the cost of health care can be met by such insurance schemes.

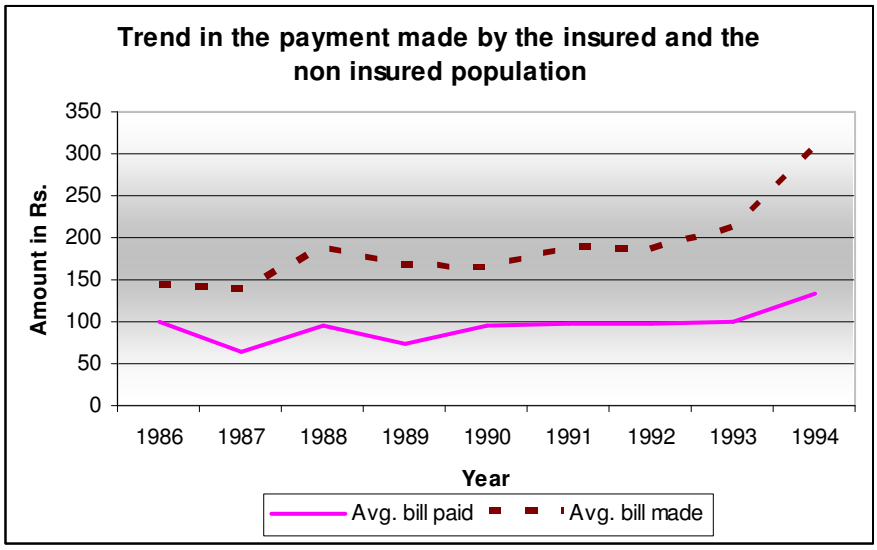
Graph 12: Line graph showing the cost recovery from the insured and non insured.



1. The premium collected from the beneficiaries under the scheme is deposited in the village fund which is utilized for providing only outreach services. This amount is not pumped back to the hospital and hence cannot be considered as a source of income to the hospital. However, if this amount was to be used for provision of hospital services, the probable cost recovery would have been 2.2% in 1986 of the total hospital recurring expenditure, which has remained constant to 2.4% in 1994.
2. However, the amount collected from co-payment system for foreseeable hospitalization under jawar scheme is utilized by the hospital. The cost recovery from only the co-payment allowed under jawar scheme has remained below 2% in the overall years. Thus copayment system can be seen only as an effective tool to avoid moral hazard[16] and not as a source of income.
3. The cost recovered from the non insured patients' contribution from the villages covered by jawar scheme has fallen from 13% in 1986 to 7% in 1994, thereby implying that as they could not pay the hospital bills, some portion of it had to be waived off.

[16] The tendency to superfluously utilize the services.

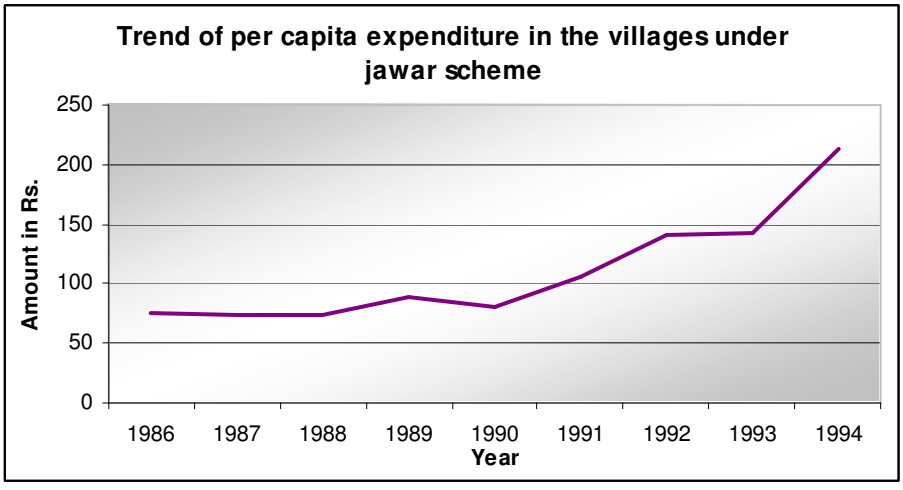
Graph 13: Line graph showing the trend in the payment made by the insured and the non insured population.



The above graph shows that irrespective of the bill amount, the amount paid by the non insured has remained almost consistent i.e. they cannot pay beyond a certain paying capacity and hence the bill amount has to be waived off. As patient exhausts his pocket money in getting drugs and material by the time he/she gets discharged he/she does not have enough money to pay the hospital bill.

Per capita average expenditure –

Graph 14: Line diagram showing the trend of per capita expenditure in the villages under jawar scheme.



The average expenditure per person under jawar scheme has shown an increase from Rs. 75 (1986) to Rs. 213 (1994). This amount is expected to be more due to the following reasons –

- The hospital is a medical college hospital and has to satisfy certain norms laid by MCI in terms of facilities available and in terms of manpower. As seen from Graph 4, the expenditure on the staff salaries contributes to more than 60% of the fund allocation. Thus the overall expenditure is expected to be high.
- It also serves as a referral hospital with complicated cases being referred here from other hospitals. In order to meet the increasing demand of patients and to enable deal with complicated cases the expenses are further bound to be more.

  From the data available it is seen that the average length of hospital stay is comparatively more in the overall admissions than those of the insured population. This could be because the hospital caters to referrals and complicated patients. Hence, the expenditure on these patients is expected to be higher than the admissions under jawar scheme.

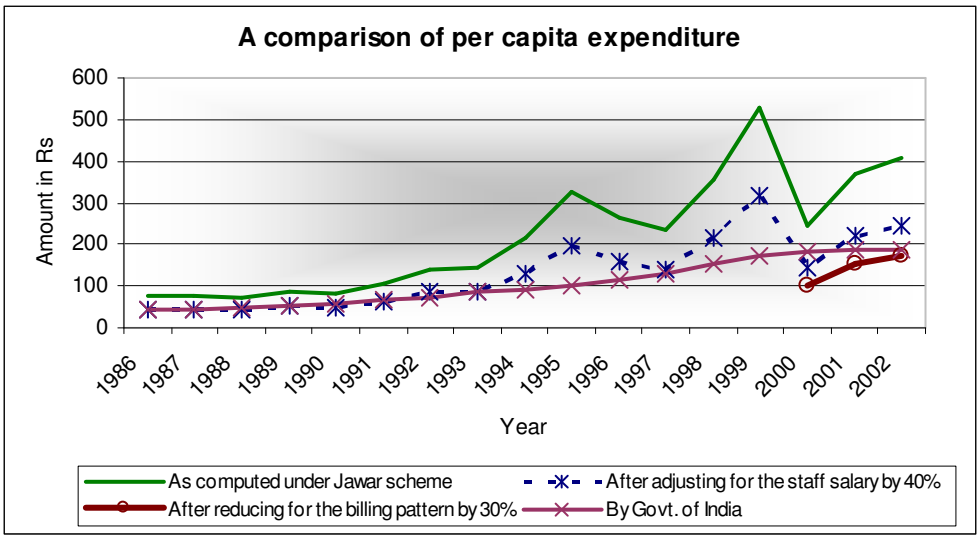
  Above facts have reflected in the billing pattern – From the data available from 2000 to 2002 and the hospital computerized data, it is seen that the average bill per indoor admission is Rs. 700 against Rs. 484 for the patient from the insured village in 2000, thereby amounting to 69%, which has remained constant for three years. This implies that the average per capita expenditure would be necessarily lesser than the computed figure by around 30%.

  Though billing is uniform for all the hospital patients, it is seen that it is lesser for those from the insured villages. This could be because the later group represents the general population while the former group comprises of more of referred (complicated) patients thereby requiring more expensive intervention and longer hospital stay. This apparently leads to more average expenditure per admission and hence amounting to higher bill.
- With increased utilization of beds the cost of care is bound to fall.

Observations & Suggestions -

In a service providing hospital the budgetary allocation on salaries are not expected to exceed 40% of the total fund allotted. Thus considering a hypothetical situation where, if the allocation of funds on salaries were reduced to 40% keeping every other variable constant, the average per capita expenditure comes to Rs. 59 (1986) to Rs. 104 (1994) and to R 146 (2000) and Rs. 244 (2002) .

Graph 15: A hypotheses giving the adjusted per capita expenditure against the computed value.



Though there are various factors affecting the billing pattern, from the above analysis it is clear that on an average the bill made for the indoor patients from the insured village is around 30% less. If this were to be considered in computing the average per capita expenditure it is bound to reduce to Rs.100, Rs. 152 and Rs. 171, in the year 2000, 2001 and 2002 respectively.

Further considering all the aforementioned factors influencing the cost the actual per capita expenditure would further be reduced. The average per capita expenditure by government being Rs. 41, Rs.91, Rs. for the years 1986 & 1994, respectively. *Considering this it would be possible to provide quality service to the patients with the current budgetary allocation if the resources are managed efficiently.*

Conclusion –

In India with huge misallocation of resources, community based initiatives which aid in channelizing the resources, addressing larger issues behind health and relentless pursuit in achieving the goal towards holistic development and sustenance is required. Most of the activities in Sewagram are undertaken with this enlarged perspective and have shown relative success.

Inspired by Gandhian ideologies most of the initiatives started by Dr. Jajoo are aimed at strengthening community, creating interdependence and taking them closer to nature. The threat

of environmental degradation was poignantly highlighted by Gandhi in his response to a question on Indian economic development. "It took Britain half the resources of the planet to achieve prosperity. How many planets will a country like India require?" Thus technology has been used to revolutionize – use for locally relevant, feasible and affordable techniques. Various such schemes were initiated to promote self sufficiency. To sustain programs people were inspired to a higher level of commitment ignited by sincerity of expectations.

From Sewagram experience one gains a wisdom that the poor are willing to contribute for health needs but only to the extent that they can afford. As justified by Dr. Jajoo that when the government allocation on health is less than 1%, why do we expect the poor to pay more?"

Primary health care is a fundamental right of people and hence they should have easy access to health care at any point of time. This can be achieved by a well managed pre payment system with risk pooling. However to achieve this, the CBHI scheme should be sensitive to the needs of people and accordingly assume different forms depending on their health profile and health risk. 95% of all useful remedies that science and human experience has discovered whether in curing or prevention can be provided at a cost that even the poorest countries can afford for their population. The remaining 5% is also crucial as it is this cost that the poor has to meet at the time of emergency.

The findings of this study support this statement. Primary health care services to all, is an achievable goal with the existing resources. This however calls for a strong political will to decentralize to the level of Gram sabha.

Private companies aiming to target rural segment must be prepared to invest in their health, bearing in mind that almost 87% of external aid is required. Health activities served as a nodal point of entry into the villages and gain their confidence. Deprofessionalization of medical practice and active involvement in community activities enhanced their credibility. Their sincere efforts nurtured deep linkages with people to bring a remarkable and holistic change over the years by 'walking an extra mile'

Sewagram experience depicts a true picture of the initiatives that makes a difference to the society at the national level by catering to the needs of people – beyond the realms of health!

CHAPTER 15

An Insurance Scheme for Referral Services provided by the Mahatma Gandhi Institute of Medical Sciences Employees' Credit Cooperative Society.

Objective

To examine the referral scheme managed by the Credit cooperative society, in order to assess its viability and feasibility.

The Premises -

All the staff of MGIMS except the contract labourers are covered under the hospital insurance scheme, which is extended to their family members also. The premium is deducted at source, which is 0.5% of the basic pay and DA per month. All hospital services are available free of cost, except food and appliances and if the patient is referred to any other hospital, the additional cost of treatment is reimbursed up to a limit of Rs. 5000/-

Thus most of the health problems were being addressed through different insurance schemes at MGIMS hospital. The only health contingency which escaped the bracket was of super specialty services which could not be handled at the hospital and required referral to major hospitals in major cities! Though the hospital insurance scheme covered up to Rs. 5000, this amount was found to be insufficient. This not only increased the unnecessary trepidation of referral but also of making financial arrangements to meet the cost.

In the year 1997, the MGIMS Emp. Credit Cooperative Society having had already covered some members of the society under Group Personal Accident policy, thought of extending the medical insurance exclusively for referral care. The premium quoted by the insurance companies was however, exorbitant with limited services, disclaimer and above all a non refundable annual premium. Who would agree to shell out around Rs. 2250 to Rs. 2500 every year for no guaranteed benefit?

The Cooperative Credit Society being principally involved in financial business is concerned with granting loans to the members and taking loan on credit from the bank. The Credit Society

received loans from bank @ 18% and granted loans @ 20% (1999-2000). It was thought therefore, by some members that if the amount is collected at the interest rate offered by the bank i.e. 12% and a margin of 8% is maintained, instead of transferring the risk to the insurance company, they could not only manage the scheme with lower contribution but could also ensure guaranteed benefits, besides a good referral check. This would serve everyone's purpose, as the Credit Society could now look upon the hospital staff as lenders under the scheme who in turn would get the entire amount reimbursed with an interest of 12% (interest rate which concords with that given by bank) on cancellation of the membership and would also be eligible for reimbursement up to Rs. 1 lakh for any referral care.

Following a brainstorming session, a scheme was conceptualized which would benefit everyone and befit everyone's needs. Based on some preliminary assumptions and forecasting, an amount of Rs. 50 was arrived as a monthly deposit per member the scheme being open to the staff of the hospital and their family members. This amount would be refundable with a stipulated interest on the cancellation of the membership caused due to the termination of the service.

The scheme is a credit linked scheme which is linked to loan benefit scheme, providing complete exemption from any loan taken from the society in case of death of the member. It is also linked to Personal Accident policy the premium for which is paid by the society.

The conditions of the scheme are as follows –

- It is a voluntary scheme and for permanent staff.
- Benefit is available to all the family members, irrespective of their age and pre-existing conditions.
- Any member wishing to continue after retirement is required to make an annual payment of the premium at the beginning of each year.
- Any member withdrawing from the scheme receives 50% of the stipulated interest on the deposited amount and shall loose his/her right to become member of the scheme in future.
- Any member who has claimed the benefit provided by the scheme and institution within five years of membership the entire sum (premium and interest) will be forfeited. He however continues to be a member and builds up the deposit afresh.

- The referral service entitled for the reimbursement must be necessarily for an intervention which cannot be done at MGIMS*.

(* All the staff covered under this scheme are insured with the hospital under hospital staff insurance scheme and are also entitled to a reimbursement up to Rs. 5000 from the hospital for referral care. The referral scheme reimburses only above Rs. 5000)

Benefits under the scheme –

- The insured is eligible to treatment in any referred hospital upto a maximum of Rs. 1 lakh.
- There is no limit to the number of claims that can be made by any insured.
- If no claims are made, the entire amount deposited is refundable with the stipulated interest.

Operational Aspects –

- The member can choose amongst the following options for payment of premium –
    1. Monthly deduction from salary
    2. Annual payment
    3. Deduction from annual MGIMS workers co-options society dividend.
- Depending on the changes in the rate of interest on the amount granted by banks, the interest rate earned over the premium is also revised.
- On availing the benefit of the scheme the refundable amount is reduced based on the amount claimed.
- The society preserves the right to investigate the referral claim from a medical board appointed for the purpose.
- On producing all the requisite documents, payment is directly made to the hospital by the society or the amount is directly paid to the claimant if the bills are submitted.
- In case of a pre-existing condition proven thereof, 50% of the claim amount not exceeding Rs. 50000 will be paid by the cooperative society, while the remaining 50% is required to be paid to the cooperative society by the insured such that the entire amount is directly paid to the hospital by the society.

Some Facts –

- There are around 900 staff members of which only 448 are enrolled. As enrollment was not too encouraging in the initial two years and some employees started enrolling only on the prospect of claiming, a new condition was introduced. All those getting enrolled after 2003 will have a waiting period of 3 years. This will however not be applicable to new entrants (employees).

- The simple interest of 12% (1999-2000) compounded yearly fell to 10% (2000-2001, 2001-2002) and at present is 6% (2002-2003). The interest offered by banks has also shown a dip to 15%, the margin now being 9%.

Analysis –

The objective of the financial analysis of this scheme is to assess its viability and utility so as to propose a scheme that can be managed by such cooperative society for their members.

Methodology –

The data obtained from the past five years i.e. from the inception of the scheme are analyzed. In order to simplify the analysis and to achieve the objective of proposing a referral insurance scheme linked to credit society, the study focuses only on the amount deposited for the purpose of referral insurance and the claims made; excluding all the interlinked benefits like personal accident and loan benefit.

- Firstly only the deposits made by the members is taken into consideration to compute the interest accrued on it.
- Income is computed taking the interest earned by the society on the deposit, the forfeited amount of the claimant and the interest earned on it.
- Assuming no money would be withdrawn claims are taken as expenditure thereby shown as liability for the society
- This claim amount has then been adjusted against the deposited amount.

Findings & Observations[17] -

The total amount in the deposit by the end of the second year is Rs. 334824. After adjusting the claims against the income earned the society still has a liability of Rs. 40349. On paying this claim the balance remaining with the society is Rs. 294475. Thus over the years, the experience shows that each year the claim has been met with from the corpus.

From the 4 years experience, the net claim expenditure is Rs. 432561 with an average of Rs. 108140. Though the claim each year could vary, for simplicity taking 1.08 lakhs as an annual estimated claim, assuming the claim pattern would continue, the fund is required to have minimum of Rs. 1.10 lakhs with some amount for the management of the scheme. From the four years experience, it is seen that the balance amount remaining by the end of the year 2003 is Rs. 1226522. Deducting the liability, Rs. 110387 is obtained @ 9%. Thus by the end of the fourth year the scheme has reached a state of breakeven. However considering that the fund would receive an additional deposit the scheme can be termed as self sufficient. However it must maintain either the margin of interest a 9% or must increase the enrollment to achieve this. Each year with the present number of members remaining same, the deposit will be built by around Rs. 4 lakhs. Interest earned on it will fill up the existing gap in the corpus and meet bigger claims in the coming years.

On the other hand the deposit that can be withdrawn from the members is considered to be a liability for the society. However there are no chances of withdrawal in the initial few years as the amount deposited is less and would reap no benefit to the member. Increasing risk of health hazards with age will be covered by the insurance up to Rs. 1 lakh, which if the deposit amount is expected to meet will take numerous years. Moreover he/she is not allowed to take the membership again which is another disincentive for withdrawal. The benefit is available to even the retired staff provided he/she makes an annual payment of the premium. This further acts as an additional incentive to increase enrollment and reduce drop outs. Even if there are withdrawals made it would be spread over time and of negligible amount. The society is expected to meet this expense over a period of time.

[17] Refer to Table I, II & III in the Annex for the data and calculations.

At the same time the margin of interest serving as income to the society needs to be maintained. However over a period of time with fluctuation in the economy and the overall interest rates offered by the banks the margin might have to be altered. Envisaging this possibility, in order to sustain the fund the number of enrollment must be increased. The current number of members covered is 633 (including family members) of around 900 staff (families with approximate family size of 2.5). This amounts to around 2250. Thus the estimated current enrollment is only 28% of the total potential members. Even if those individuals covered under the scheme are convinced to get their family members included the total membership would increase to 943 (Table IV), thereby providing a greater pool of fund to manage big claims, if any arise! It is seen that the enrollment for the family members from Class III & IV is relatively less. In order to encourage more individuals for extension of the cover to a wider group, the premium could be reduced with corresponding reduction in the limit of benefit.

Table IV: Members enrolled under the scheme

Category	Families	Individual members	Total members	Family size	Expected total members
I, II	21	10	73	3.00	136
III	83	142	342	2.41	542
IV	11	169	193	2.18	217
Credit Soc Staff	10	2	25	2.30	48
			633		**943**

Claim analysis –

Table V – Claim details

Year	Nature of illness	Amount claimed in Rs.	Total amount in Rs.
1999-2000			
2000-2001	Cardiac ailment	50075	50075
2001-2002	Orthopedic case	500	
	Cardiac ailment	100000	

	Brain Hemorrhage	57781	158281
2002-2003	Investigation	7400	
	Brain Hemorrhage	9750	
	Spinal injury	4122	
	Ophthalmic	7000	27200
2003-2004	Orthopedic case	1307	
	Ophthalmic	1125	
	Cardiac ailment	50000	197005
		432561	

As seen from the above table the expenditure is more for cardiac ailments, while the expenditure on the other ailments is negligible. It is seen that in few claims the claim amount was lesser than the current deposit amount of the member. This being a welfare scheme, as the deposit gets forfeited on the payment of any claim the claimant must be informed about the current status of his account. To facilitate this, a pass book could be maintained for each member for periodic updating, which will also gain credibility to the society besides aiding in proper account keeping.

Chapter 16

Composite Package Insurance for tribals of Gudalur taluk

Introduction –

It is a tripartite venture between the insurance company the NGO i.e. ACCORD and the tribals of the Gudalur taluk, represented by the Adivasi Munnetra Sangam (AMS). After negotiations with the three partners the 'Composite Package Insurance for tribals' was started on 26th Feb 1992. The New India Assurance Company (NIAC) offered a package whereby the tribals were required to pay a premium of Rs. 15 per individual per year for a period of five years. This made them eligible for hospitalization benefits up to Rs. 1500/- per individual per year. However the organization (ACCORD) reimburses the total hospitalization expenditure.

Besides each family was also expected to pay an additional premium of Rs. 7/- per family per year for the following benefit-

1. Coverage against any damage to their huts and contents (including cattle) up to Rs. 1500/-
2. Coverage against any personal accident to the head of the family up to Rs. 2500/-

Thus a family of four had to pay Rs. 67/- as annual premium.

However even this was a burden for the tribal community especially when they had to pay five years premium in one installment. Thus ACCORD offered to pay the premium on behalf of the tribal community. The community through the AMS repaid a part of this premium to ACCORD in installments. Similarly ACCORD offered to process the claims and receive the reimbursements on behalf of the community provided they were admitted to ACCORD's hospital – the Gudalur Adivasi hospital (GAH)

Objective of the scheme – The objective of the scheme forms a part of the objective of ASHWINI the health program.

To establish a health system which is accessible and acceptable to the tribals and effective. It should be managed by the tribals themselves and should be sustainable.

Exclusions under the scheme (provided by the insurance company)–

1. Pregnancy and pregnancy related illness.

2. Domiciliary treatment, i.e. Out patient charges which did not require hospitalization.
3. Any expenditure above Rs. 1500/-

Review of the scheme –

At the time of renewal i.e. by the end of 1995, the scheme was reviewed by ACCORD to make it more expedient for all the concerned partners.

Number of patients admitted, claims made and reimbursed. (April 1992 – Feb 1996)

Year	Total number of tribal patients[18]	Total number of insured patients[19]	Total number of claims	Total number of claims reimbursed	Proportion insured	Proportion reimbursed
1992	516	302	264	264	59	100
1993	870	556	459	458	64	100
1994	685	422	331	300	62	91
1995	689	417	282	261	61	93

Though around 96% of the claims are reimbursed, of the total tribal admissions only 46.5% are reimbursed. The low reimbursement rate could be attributed to the following reasons –

1. 40% of the patients are not insured due to various reasons especially the red tapism involved in insuring them.
2. More than 20% of the insured patients' claims are not made because they are pregnancy related.
3. About 4% of claims are not reimbursed because they are 'common diseases' or chronic diseases.

Amount of claims made and reimbursed (April 1992 – Feb 1996)

Year	Premium paid	Total claim amount in Rs.	Total reimbursements in Rs.	Percentage reimbursed
1992	386318	82674	81556	98.6
1993	44296	149400	136077	91.1
1994	20372	119478	106384	89
1995	10513	128946	105060	81.5
1996	3905	NA	NA	-

[18] This includes insured as well as non-insured tribals. All tribals are not insured by ACCORD.
[19] These are the AMS members on whose behalf ACCORD makes the payment. They in turn pay the organization.

Though 96% of the number of claims were reimbursed only 89% of the amount was reimbursed by the NIAC. This could be because of the maximum limit of Rs. 1500/- per claim. About 4% of the total claims exceeded the Rs. 1500 limit.

Strengths of the scheme as stated by ACCORD

- It was seen more as a social obligation providing service to the downtrodden community of the tribals and not as a profit making venture.
- It was not seen as 'free treatment' by the tribal community and they actively contributed towards the repayment of the insurance premium.
- ACCORD manages the scheme and hence spares the tribals from this major headache. Besides the problems of moral hazard is also avoided as the premium is first paid by the organization, which also covers all the conditions, excluded under the formal scheme.
- By removing the financial burden for the tribal this scheme has ensured that they can avail to good quality medical care.

Some **weaknesses** of the scheme as stated by ACCORD –

- Though pregnancy related maternal deaths are unacceptably high in many of the villages, the scheme did not address this problem as such conditions were excluded.
- Around 4 to 5% of all the admissions need referral to a higher medical centre, requiring specialized health care. As the cost of referral care ranges from Rs. 5000/- to Rs. 10000/- and the reimbursement is only up to Rs. 1500/- by the insurance company the remaining amount is borne by ACCORD.
- The cost of domiciliary treatment is not covered.
- Though an additional amount of Rs. 7/- was collected per family for insurance against accident and huts, no family could avail to this coverage. It was therefore decided to discontinue this cover.

Thus the scheme was renewed for another five years i.e. from 1997 to 2002 from which the home and accident insurance were excluded. The premium was increased to Rs. 20 per head. No other changes were made in the coverage though maternity cover was desired.

The total premium paid from 1992 to 2002 is Rs. 594566/-

Total claims sent by ASHWINI to NIAC is Rs. 1363371/-

Total reimbursements made by NIAC is Rs. 1268051/- i.e. 93% of the total claims.

The claims ratio is 213% i.e. more than twice the premium is reimbursed by the insurance company.

Current scheme –

As the claim ratio was high NIAC refused to renew the policy. An analysis was done to assess if the fund could be managed by the organization without transferring the risk to any insurance company. As it was found unfeasible to self manage the fund, the state government was approached to bear some proportion of the premium. As any such provision could not be extended to one NGO run hospital, the proposal was turned off. It was realized that as the insurance company had been reimbursing more than the premium collected, the best option would be to get the scheme managed by some insurance company. Various insurance companies were approached and finally RSA agreed to the deal.

From May 2003 the tribals are covered by Royal Sundaram Alliance Insurance Company ltd. and they offered to cover first three pregnancies in a family. The premium was increased to Rs. 30 per head with sum insured increased to Rs. 2000 per hospitalization. Maternity claims are confined to maximum of Rs. 500/- per case.

Sir Ratan Tata Trust has supported the scheme by paying the premium on behalf of the organization. The premium amount collected by the tribals is pooled into a saving account, which can be used after the cessation of any grants.

Particulars	**19.5.03 - 18.5.04**	
	Claimed amt. In Rs.	Nos. Claimed
Premium Paid	244520	0
Insured Bill Amount	522314	107446
Amount Claimed	333268	0
Amount Reimbursed	309379	0

Around 93% of the total amount claimed is paid and the claim ratio is 127%. The scheme is proposed to be renewed under the same conditions with no limits on maternity claims per family.

Operationalisation of the scheme –

The amount collected by the insured in the form of premium and from the patients (non tribals & non insured tribals, i.e. non sangha patients) in the form of fees are pooled into a corpus. The donations granted by different donor agencies and recently the SRTT funds are used to pay the premium for the insured population. The amount reimbursed by the company are collected by the hospital and pumped into the corpus. The money from this corpus and all the other donations are collectively utilized for running of the hospital.

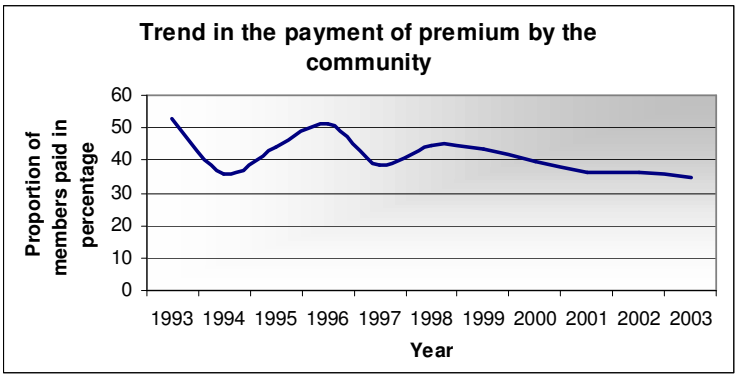
However as the SRTT fund to support the premium is soon expected to cease a separate corpus of Rs. 200 crore is proposed to be formed @ 5% and all the patients' contributions will be pooled into this.

Analysis of the Scheme –

The premium amount is paid by ACCORD on behalf of the community, which is subsequently collected from the community. The organization pays the premium from the corpus for which it gets contribution from different donor agencies. Since the past two years this premium amount is met from SRTT donation.

Affordability –

Given the living conditions though the premium of Rs. 15 now increased to Rs. 30 per person per annum, seems to be nominal it is imperative to know if it is actually affordable to the triabls who cannot afford two meals per day. One of the indicators to assess affordability is to examine the proportion of tribals paying the premium and the trend in payment of the premium by the community.

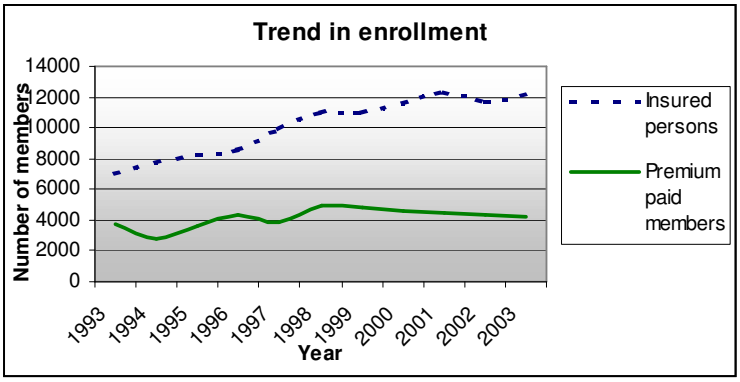


From the graph it can be seen that the contribution from the community has remained almost constant ranging from 55 % to 35% of the total members. From 2000 it has shown continuous decline. This implies that the affordability of the tribals to pay the premium is low and is on decline.

A new mechanism has been adopted on a pilot basis. In the year 2004, a premium of Rs.22 was collected in five out of the eight Areas (clusters). In one area it was Rs.10 per person + Rs. 10 per family. In another, it was different premium for different villages, i.e., Rs.10, 15, 20 and 22 per person. In the third, it was a fixed amount per family. It was seen that more number of people were willing to pay the premium.

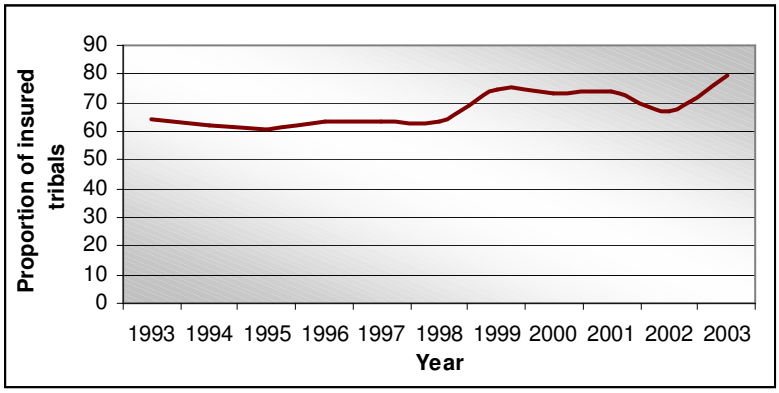
Enrollment pattern –

The tribals have to pay an annual membership fee of Rs. 15 (1993), Rs. 30 (2003) for the sangha (Adivasi munnetra Sangha). All the members are eligible for the insurance cover and ACCORD pays the premium on their behalf. Depending on their affordability the members pay the premium anytime during the year. However irrespective of this payment they remain eligible to claim under the scheme.



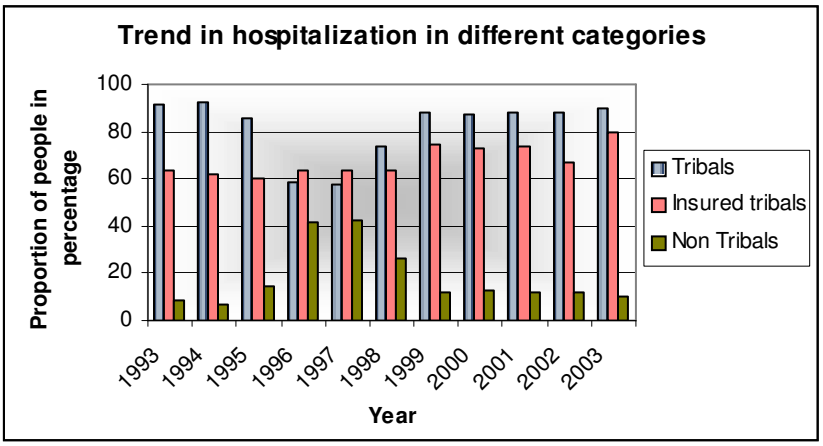
The number of AMS members have increased over the years, but the number of members paying the premium have remained almost constant. This implies that the number of members affording the premium is almost the same over the years.

Utility of the scheme –



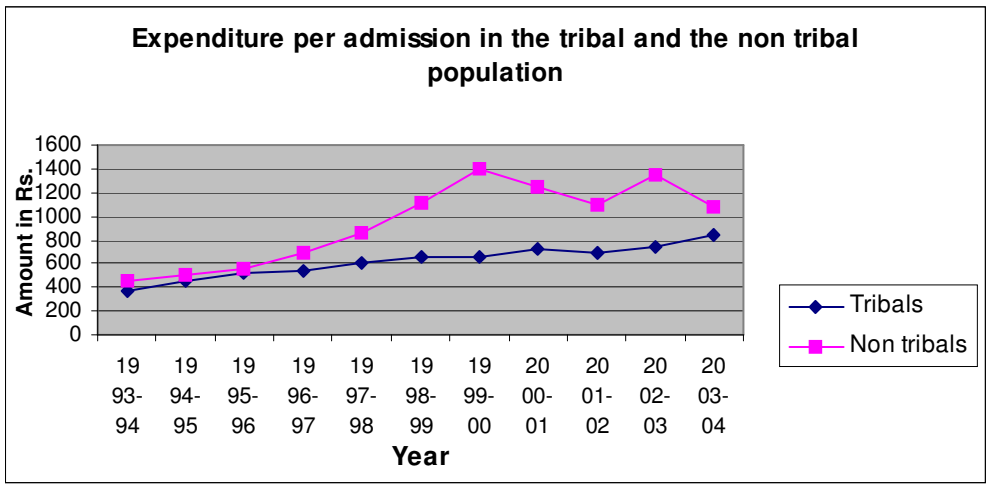
Of the total tribal patients having sought treatment from the adivasi hospital most of the tribal patients are those covered under the scheme. This shows that the proportion of tribal population not covered under the scheme who have to pay the expenses from their pocket, seeking service is less.

Utilization of services by the tribal and non-tribal population –



The number of non-tribal people getting treated in the hospital is relatively less. It however does not mean that the non-tribals do not prefer this hospital. Preference is given to tribals for admission. It is evident from the graph the proportion of non-tribals' admission is more in the years 1996 and 1997, when correspondingly the proportion of tribals' admission has shown a dip. As stated by Dr. Shyla the non-tribal patients being more outward than the tribals, they use unfair means to get preference in the treatment and in getting admitted to the hospital. As a result of this non-tribal patients are seen in the OPD only once a week. Moreover, the number of beds is restricted and as no other hospital is inviting to the tribals the tribal patients are given preference. It also needs to be remembered that it is adivasi hospital owned and managed by them.

The expenditure per admission in the non-tribal population is seen to be consistently more than the per admission expenditure in the tribal population. This implies that the non-tribals are admitted for relatively more complicated cases thereby leading to higher expenditure and longer length of stay in the hospital. As mentioned before it being an adivasi hospital preference is given to tribals. However non-tribals are not denied treatment or admission, though they have to pay for the services. The cost of the treatment for the non-tribals is just the same as that charged in any private hospital.



Health insurance is seen as a mechanism to generate demand in the tribal community for health care. The hospital authorities have stated that despite of insurance coverage to all the sanga members only those who have paid the premium seek services more often. This can be

quantified only by comparing the hospitalization rate of the people who have paid against those who haven't paid their premium. However such a data was not available.

Financial viability of the scheme –

The adivasi hospital is managed with the aid of the following sources–

- Grant from Paul Hamlyn foundation.
- Grant from Skillshares International.
- Grant from Tata trust.
- Other donations and grants.
- Fees charged from non insured patients.
- Premium collection

Other indirect sources for various resources are –

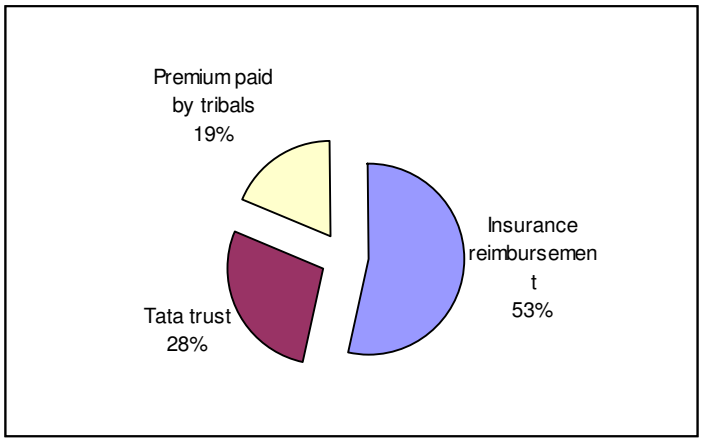
- Diabetic medicine reimbursement from a German based NGO.
- Government sickle cell program.
- Receipts from ambulance and balwadis.
- Government family planning program.

Besides a corpus fund is managed and interest is earned on it.

The premium collection from the insured tribals comprises of around 2% of the total income (with an exception of 8% in 2000-01). It thus forms a negligible component in terms of income generation.

The expenditure on only insured patients is estimated to be almost 5 to 11 times more than the premium collection. Thus the scheme is not viable in terms of financial sustainability. On having a closer look at the scheme, the funds are merely processed through a cycle called insurance but the cost of care is met directly through funds. The Tata trust donation is made available to pay the premium, which is paid to the insurance company. The insurance company in turn reimburses the claim amount, which is almost 200%, more than the premium paid. Thus in short almost 50% of the cost is provided by the insurance company and remaining 50% is provided by the grant from Tata trust of which the actual contribution from the community forms a very negligible part.

From 2003-2004 data –



The contribution from the tribals in the form of premium constitutes 40% of the total premium paid. Out of the actual expenditure on the insured only 64% is claimed from the insurance company, of which 92% is reimbursed. Thus of the total expenditure on insured patients 19% is met by premium contribution from the community members, another 28% is met from the balance insurance premium (i.e from Tata trust). The remaining 53% of the expenditure is paid by the insurance company.

Conclusion –

The scheme is unquestionably not a viable scheme where most of the cost is met by the insurance company and other donor agencies. However, it serves the following purposes – it makes a private insurance company pay for the medical care of the tribals, it provides a learning experience to the tribals to finance and manage a scheme on their own and necessitates the maintenance of a good information system.

To make the scheme more acceptable and affordable for the community some innovative measures need to be adopted like the flexible premium structure as seen in the pilot project.

Chapter 17

Supplementary Social Health Insurance Approach

Part I - For Chattisgarh

Need for the Scheme – Though the infrastructure for referral and secondary health care is provided by the state, the recurring costs are to be generated internally. In the process of ensuring cost recovery the basic health care services have become inaccessible to the most vulnerable section. However it is not possible for lowering operational costs further. Even as of now the fact that the doctors have to forgo fees for seeing beneficiaries leads to low returns for medical personnel and distortions in utilization. However, it is imperative to make the health care facilities available and accessible to the poor. The proposed scheme is an approach to achieving this.

The scheme will be initially tried on pilot basis in 8 to 10 selective towns for a year. If the programme runs successfully, Phase I as proposed in Annexure II could be implemented in the subsequent year or else by the end of the second year, the scheme could be phased out of the pilot project towns.

The three major variables affecting the scheme are –

1. The range of benefit, i.e. the package offered.
2. The premium charged to the patient and
3. The extend of coverage i.e. for whom will it be mandatory and for whom it will remain voluntary.

The Beneficiaries –

The entire population may be classified into three groups as follows –

Class I – General – those with an annual salary of 1 lakh or more.

Class II – Poor – Beneficiary.

Class III – Vulnerable – as identified by the ULBs. (This category would include migrants, rag pickers, street children, CSWs, slum dwellers, etc.)

The scheme will be mandatory for Class II & III and the government will partly pay the premium for Class II & will pay the entire premium for the beneficiaries under Class III. The

scheme will however be discretionary to Class I as they are required to pay for their premium themselves.

The target for the first Phase I (first one year) would be as shown in the table below (Refer to Table 1). Based on the experience gained from the fist year the scheme may then be extended to the other population.

Definition of family – A family covers four members viz. the proposer, his/her spouse and three unmarried children. To extend the benefits of the scheme to other members a premium of Rs. 150 (for all the Categories) needs to be paid by the proposer for an annual cover.

The average family size is 5.

	Class	Total beneficiaries to be covered in Phase I	Number of households that could be covered in Phase I
Category A	I	600000	120000
	II	300000	60000
	III	100000	20000
Total		1000000	200000
Category B	I	240000	48000
	II	120000	24000
	III	40000	8000
Total		400000	80000
Category C	I	120000	24000
	II	60000	12000
	III	20000	4000
Total		200000	40000
Category D	I	60000	12000
	II	30000	6000
	III	10000	2000
Total		100000	20000
Grand Total		1700000	340000

Benefits –

The insured is eligible only for certain categories of hospitalization expenses where treatment can be provided by the Secondary Centers including the township hospitals and the Mitanin kendras, 'designated accredited rate fixed clinics' under the following two categories

Category	Benefits covered	Approximate cost for procedure in Rs.
Major procedures/surgeries	• Shall include Caesarean Sections, Hysterectomies and other gynaecological and obstetric procedures. • Common surgical procedures like that for hernia repair, appendicitis, etc.	5000/-
Minor procedures	Shall include Normal deliveries, Day care procedures, short duration hospitalizations and minor surgical procedures like I & D, haemorrhoids, hydrocele, circumcision, RTI/STI, Family planning services, etc.	1000/-

Contribution-

For Class III the total premium shall be paid by the government, while it will bear only 50% of the premium for Class II. The scheme is thus mandatory for these two classes while it is voluntary for Class I who are required to pay their premium.

Category A:

Class	Contribution in Rs.			Total in Rs.
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	72000000	0	72000000
II	Per family	300	300	
	Total	18000000	18000000	36000000
III	Per family	0	600	
	Total	0	12000000	12000000

Total		90000000	30000000	**120000000**

Category B:

Class	Contribution in Rs.			Total in Rs
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	28800000	0	28800000
II	Per family	300	300	
	Total	7200000	7200000	14400000
III	Per family	0	600	
	Total	0	4800000	4800000
Total		36000000	12000000	**48000000**

Category C:

Class	Contribution in Rs.			Total in Rs.
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	14400000	0	14400000
II	Per family	300	300	
	Total	7200000	7200000	14400000
III	Per family	0	600	
	Total	0	2400000	2400000
Total		21600000	9600000	**31200000**

Category D:

Class	Contribution in Rs.			Total in Rs.
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	7200000	0	7200000
II	Per family	300	300	
	Total	1800000	1800000	3600000
III	Per family	0	600	
	Total	0	1200000	1200000
Total		9000000	3000000	**12000000**

Grand Total –

Category	Contribution in Rs.		Total in Rs.
	from the beneficiaries	from the government	
A	90000000	30000000	120000000
B	36000000	12000000	48000000
C	21600000	9600000	31200000
D	9000000	3000000	12000000
Total	156600000	54600000	211200000

The contributions to be collected from Class I & Class II can be deducted at source i.e. in the form of health tax of Rs. 600 and Rs. 300 per family, respectively; thereby ensuring the collection of the premium from every household.

The government contribution accounts for only 26% of the total contribution and the total contribution expected is Rs. 211.2 million. The government contribution for Class II & Class III is Rs.34.2 million & Rs. 20.4 million, respectively.

However as the scheme is optional for Class I the actual number of beneficiaries might be less than the expected numbers. Thus if we consider only 60% of the target figures from Class I assuming that they would willing to subscribe for the policy, the premium collection will be as follows –

Category	Contribution in Rs.		Total in Rs.
	from the beneficiaries	from the government	
A	61200000	30000000	91200000
B	24480000	12000000	36480000
C	15840000	9600000	25440000
D	6120000	3000000	9120000
Total	107640000	54600000	162240000

Thus the premium collection would come down to Rs. 162.2 million. In this case the government contribution would be 34% of the total amount collected.

Viability of the scheme

(A.) CBR being 25/1000, we can expect 42,500 lakh births in a population of 17 lakhs. Only 10% of these are expected to undergo Caesarean Section.

Therefore, total expenditure on

1. Normal deliveries = (Expected births – Expected Caesarean Section) X Reimbursement per normal delivery.

= (42,500–4250) X 1000

= 38,250 X 1000

= **Rs. 38.25 million**

2. Caesarean Section = Expected Caesarean Section X Reimbursement per section

= 4250 X 5000

= **Rs. 21.25 million**

(B.) Of the total population 1% require any surgical intervention out of which only 15% would require any major surgical intervention.

Therefore the expenditure on

1. Minor Surgical interventions = (Expected total minor surgeries – Expected total major surgeries) X Reimbursement per case.

= (17000 – 2550) X 1000

= 14450 X 1000

= **Rs. 14.4 million**

2. Major Surgical interventions = Expected total major surgeries X Reimbursement per case.

= 2550 X 5000

= Rs**. 12.75 million**

Thus the total claims expected in one year is Rs. **86.7** million.

Administrative costs @ 20% - Rs. 17.34 million

Total Expenditure = Rs. 104.04 million

Profit = **Rs. 107.1 million**

Govt. contribution = Rs. 54.6 million

Net profit = **Rs. 52.56 million**

In effect therefore the program can expand to the whole state area with no burden on state system but a transfer of resources to the poor.

If to this we add that the poor (beneficiaries and the vulnerable beneficiaries) will get first contact curative care at the door step through HHWs, the profit projections appear adequate to cover their remuneration and services also.

However as the scheme is optional to Class I the actual enrolment might be lesser than this. The scheme is believed to breakeven at a point where the enrolment from the non-poor class i.e. Class I is 60% of the total. This implies that for the scheme to be self sustaining the enrolment from the non poor should be around 60% and if this falls down the scheme needs to be subsidized.

Conditions –

1. A prerequisite for the implementation of the scheme is that the PPP policy and the Mitanin Kendra must be already in place.

The payment made under this scheme is a third party payment which is directly paid to the health care providers and no beneficiary is entitled to cash reimbursements. The third party payments are made to Rogi Kalyna Samiti in case of hospitalization to CHC or district hospital or to the Mitanin Kendra, Mitr Chikitsalaya for private providers.

2. For the Class III beneficiaries a prerequisite is to enrol in a SHG.

Complementary Scheme: The Role of the SHGs.

Complementing this scheme to meet the indirect costs which are also estimated to be high a deposit linked scheme functional through SHGs could be devised.

A monthly contribution of Rs. 10 per family is paid into an SHG from which loans can be prioritised for the purpose of meeting the indirect costs, viz. the transport charges, food charges, wages lost by the patient and the relative accompanying the patient to the hospital, etc. this is mandatory for Category III but optional for Category II. The banks would be called in to give matching grants to the SHGs, so that they have an adequate corpus for the purpose. Their membership in an SHG makes the family eligible for the social insurance.

The scheme could be possibly handled by an insurance company for efficient risk management, to ensure continual monitoring and for effective settlement of the claims with no loss of time.

Part II - PILOT PROJECT

The project will be first tested in few towns especially the company towns. Depending on the success of the scheme it would be extended to other areas in Phase I i.e. covering 17 lakhs population in the first year.

Assuming the around 8 to 10 towns would be selected for the pilot project, the distribution of the beneficiaries from different Categories and Classes would be as follows –

The Beneficiaries –

The entire population may be classified into three groups as follows –
Class I – General – those with an annual salary of 1 lakh or more.
Class II – Poor – Beneficiary.
Class III – Vulnerable – as identified by the ULBs. (This category would include migrants, ragpickers, street children, CSWs, slum dwellers, etc.)

Definition of family – A family covers four members viz. the proposer, his/her spouse and three unmarried children. To extend the benefits of the scheme to other members a premium of Rs. 150 (for all the Categories) needs to be paid by the proposer for an annual cover.
The average family size is 5.

	Class	Total beneficiaries to be covered in Phase I	Number of households that could be covered in Phase I

Category A	I	100000	20000
	II	50000	10000
	III	16667	3333
Total		166667	33333
Category B	I	40000	8000
	II	20000	4000
	III	6667	1333
Total		66667	13333
Category C	I	20000	4000
	II	10000	4000
	III	3333	667
Total		33333	6667
Category D	I	10000	2000
	II	5000	1000
	III	1667	333
Total		16667	3333
Grand Total		283333	56667

Contributions for the scheme –

Category A:

Class	Contribution in Rs.			Total in Rs.
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	12000000	0	12000000
II	Per family	300	300	
	Total	3000000	3000000	6000000
III	Per family	0	600	
	Total	0	2000000	2000000
Total		15000000	5000000	**20000000**

Category B:

Class	Contribution in Rs.			Total in Rs
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	4800000	0	4800000
II	Per family	300	300	
	Total	1200000	1200000	2400000
III	Per family	0	600	
	Total	0	800000	800000
Total		6000000	2000000	**8000000**

Category C:

Class	Contribution in Rs.			Total in Rs.
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	2400000	0	2400000
II	Per family	300	300	
	Total	1200000	1200000	2400000
III	Per family	0	600	
	Total	0	400000	400000
Total		3600000	1600000	**5200000**

Category D:

Class	Contribution in Rs.			Total in Rs.
		from the beneficiaries	from the government	
I	Per family	600	0	
	Total	1200000	0	1200000
II	Per family	300	300	
	Total	300000	300000	600000
III	Per family	0	600	
	Total	0	200000	200000
Total		1500000	500000	**2000000**

Grand Total –

Category	Contribution in Rs.		Total in Rs.
	from the beneficiaries	from the government	
A	15000000	5000000	20000000
B	6000000	2000000	8000000
C	3600000	1600000	5200000
D	1500000	500000	2000000
Total	26100000	9100000	35200000

Thus the total income is **Rs.35.2 million** and the government contribution accounts for only 26% of the total contribution. The government contribution for Class II & Class III is Rs. 57 lakhs & 34 lakhs, respectively.

The contributions to be collected from Class I & Class II can be deducted at source i.e. in the form of health tax of Rs. 600 and Rs. 300 per family, respectively; thereby ensuring the collection of the premium from every household.

Benefits –

The insured is eligible only for certain categories of hospitalization expenses where treatment can be provided by the Secondary Centers including the township hospitals and the Mitanin kendras, 'designated accredited rate fixed clinics' under the following two categories

Category	Benefits covered	Approximate cost for procedure in Rs.
Major procedures/ surgeries	• Shall include Caesarean Sections, Hysterectomies and other gynaecological and obstetric procedures. • Common surgical procedures like that for haemorrhoids, hydrocele, hernia repair, appendicitis, etc.	5000/-
Minor procedures	Shall include Normal deliveries, Day care procedures, short duration hospitalizations and minor surgical procedures like I & D circumcision, RTI/STI, Family planning services, etc.	1000/-

Viability of the scheme

(A.) CBR being 25/1000, we can expect 7000 births in a population of 2.8 lakhs. Only 10% of these are expected to undergo Caesarean Section.

Therefore, total expenditure on

1. Normal deliveries = (Expected births – Expected Caesarean Section) X Reimbursement per normal delivery.

= (7000-700) X 1000

= 6300 X 1000

= Rs. 6300000/-

2. Caesarean Section = Expected Caesarean Section X Reimbursement per section

= 708 X 5000

= Rs. 3541667/-

(B.) Of the total population 1% require any surgical intervention out of which only 15% would require any major surgical intervention.

Therefore the expenditure on

1. Minor Surgical interventions = (Expected total minor surgeries – Expected total major surgeries) X Reimbursement per case.

= (2833-425) X 1000

= 2408 X 1000

= Rs. 2408000/-

2. Major Surgical interventions = Expected total major surgeries X Reimbursement per case.

= 425 X 5000

= Rs. 2125000/-

Thus the total claims expected in one year is Rs. 14.37 million.

Administrative costs @ 20% - Rs. 2874933/-

Total Expenditure = Rs. 17.25 million

Profit = **Rs. 17.95 million**

Govt. contribution = Rs. 9100000/-

Net profit = **Rs. 8850400/-**

In effect therefore the program can expand to the whole state area with no burden on state system but a transfer of resources to the poor.

If to this we add that the poor (beneficiaries and the vulnerable beneficiaries) will get first contact curative care at the door step through HHWs, the profit projections appear adequate to cover their remuneration and services also.

For Class III however a prerequisite to be covered under the scheme is membership in a Self Help Group, by contributing Rs. 10 per month. This amount would be utilized in meeting the indirect costs borne by the beneficiary at the time of seeking health care.

The scheme therefore benefits all the stakeholders – the vulnerable gets the health services free of cost while his contribution takes care of the indirect cost; the poor get quality service for a nominal premium with equal contribution from the government, the middle class can seek service without having to pay at the time of seeking the service for a nominal premium and the providers get volume of patients. This mechanism ensures cross subsidization so as to meet the cost of health contingencies of the poor and the vulnerable.

Chapter 18
Cost Analysis of Rogi Kalyan Samiti in Chattisgarh.

Introduction –

The private sector in health primarily caters to the needs of the affordable class making the services inaccessible to the poor. While public health service is the only facility available to them, the decades old decaying public hospital and health care centres are unable to serve their needs.

As an alternative to provide quality health care services to the needy, the concept of 'Rogi kalyan Samiti' evolved during the catastrophic plague event of Surat in 1994. People's contribution was utilized for providing services that were initially unavailable to them. Following the success of the Maharaja Yeshwantrao hospital, it was replicated to other hospitals gradually. The scheme spread to more than 1000 hospitals in 61 districts with an objective of providing different health care system (public) resources and autonomy to function at their best.

The scheme is operational in MP, Chattisgarh since mid-nineties. It assumed the form of Medical Relief Societies in Rajasthan in 1995 which was followed by 68 more societies. In March 2003, Chikitsa Prabhodan Samiti (formerly known as 'Chikitsa Sudhar Samiti) covering district and combined and base hospitals was formed in Uttaranchal.

The basic objective of all these initiatives is to improve and strengthen the Public System through people's participation. It thus requires a nominal contribution from the people in the form of user fees at the time of seeking health care services from the government hospitals. The fund collected is used for improving the hospital infrastructure and provision of other related services. In such a scenario it is found imperative to know how the fund is utilized, if it actually meets the needs of the people. For effective implementation it is important to know the cost of the services, the cost to the government and by the people. This would also aid in assessing the efficacy of such a scheme and in examining different alternatives.

What is Rogi Kalyan Samiti?

Rogi Kalyan Samiti are the registered societies constituted in the hospitals as an innovative mechanism to involve the peoples representatives in the management of the hospital with a view to improve its functioning through levying user charges[3].

Instead of assuming a zero-sum relationship between Government involvement and private co-operative efforts, some social capital theorists argue about the possibility of state –society synergy. They hold the view that an active government and mobilised communities can enhance each other's developmental efforts. In the construction of synergy, micro level social capital has an important place. The Rogi Kalyan Samiti scheme in the health department is an example of how this synergy can be harnessed at the micro level.

Inception –

Maharaja Yeshwantrao hospital a 750 bedded hospital, established in 1955, known to be a premier institute was gradually deteriorating ----- it had become a home for the rodents! The plague scare of Surat in 1994 raised an alarm and soon attention was driven towards the appalling condition of hygiene in the hospital. The then collector S. R. Mohanty with the district administrator took up the task of revamping the system to change the condition of the hospital. An appeal was made to the people for their cooperation and in turn would also ensure transparency and accountability. Donations started pouring in, patients were shifted to the neighbouring government and private hospitals, the complex was cleaned, tons of rubbish, truckloads (around 150) of junk, furniture were removed and deweeding, external and internal baiting, sealing of the sewerage system were undertaken to trap the rodents. Finally the rodents were killed by using poisonous gas and disposed off in electronic crematorium. The general public was involved at every stage of planning. Though the physical facilities were restored there was still a general apprehension that the system might again collapse unless an administrative structure is inbuilt within the system to ensure its permanency. It was thus decided to adopt the following strategy

- Undertake a scientific reallocation of available space to improve efficiency.
- Redefine administrative responsibilities.
- Introduce user charges to strengthen resource base.
- Establish a management structure to ensure smooth running of the hospital.

This was named as 'Rogi Kalyan Samiti.'

In the first year, a handful of districts, especially those close to medical colleges adopted the scheme. In 97-98 almost all the district in the state adopted it, while in most districts the initial work was done in the district level hospitals, there were several smaller hospitals where local

officials started the scheme. After a review in 1999, the government issued instructions that gave sweeping powers to the Samitis and the objectives and the duties were expanded[1].

Highly impressed with this novel programme, Chief Minister Digvijay Singh issued directive for the implementation of this program in all the district level public hospitals in the state. The RKS was reportedly formed in "more than half of the nearly 1,200 public hospitals in the state" and "an estimated Rs. 37 – 40 crore" was raised across undivided Madhya Pradesh in the five years and spent on the improvement of the hospital (India Today, January 8, 2001)

> "We see decentralisation as the strategic architecture for democracy to become articulate in our country. It is essential architecture to make democracy full-blooded and full-throated. Decentralisation has intrinsic merit as an enabler of democracy by maximising participation.'
>
> - Digvijay Singh.

The poor patients who could not afford to pay for the services were exempted from paying the user fees and treated free of cost. They were not required to bring any testimony to prove their poor state of being.

'Rogi Kalyan Samiti.'- Structure[1]–

The basic structure of the Rogi Kalyan Samitis is as follows –

- RKS would be a registered society and be set up in all medical colleges, district hospitals and community health centres.
- It would have people's representative, health officials, local district officials, leading members of the community, representatives of the IMA, members of the urban local bodies and Panchayat Raj representatives as well as leading donors as their members.
- For its functioning it shall be deemed not as a government agency, but almost as an NGO.
- It could utilize all the government assets and services to impose user charges. It would be free to determine the quantum of charges on the basis of the local circumstances.

- It could raise funds additionally through donations, loans from financial institutions, grants from government as well as other donor agencies.
- It could utilise surplus land available in the hospital for commercial purposes or to construct shops and lease them out.
- It could take over and manage canteens, rest houses, stands, ambulance services and other facilities within the hospital complex owned or managed by the government.
- Private organizations offering high tech services like Pathology, MRI, CAT Scan, Sonography etc. could be permitted to set up their units within the hospital premises in return for providing their services at a rate fixed by the RKS.
- The funds received by the RKS will not be deposited in the state exchequer but will be available by the executive committee constituted by the RKS.
- As a result of the RKS system coming into effect, the government would not reduce its budgetary allocation traditionally received by the hospital.

Objectives of RKS[2] –

1. Improve the management of the hospitals with community participation.
2. Up gradation of health institution, modernisation of health facilities and purchase of equipment for institutions. Effect a continual up gradation of facilities.
3. To ensure discipline and monitor accountability.
4. Provide assured ambulance services for emergencies and during accidents.
5. To establish public private partnership for betterment of the institution.
6. Maintenance & expansion of hospital building.
7. To develop the unused extra land of the hospital for commercial purposes as per the guidelines of the state government for strengthening the financial condition of RKS.
8. Increase community participation.
9. Organise training & workshops for staff members.
10. Ensure adequate and safe disposal of hospital wastes.
11. Arrange for good quality diet and drugs and stay arrangements for the relatives of the patients. Ensure equity through provision of free treatment to patients below poverty line.
12. Ensure proper maintenance of hospital, wards, beds, equipment, cleanliness of premises.
13. Monitoring & supervision of National Health Programs.

14. To obtain loans from banks & financial institutions for development & up gradation of medical facilities in hospitals.

Constitution of RKS[2]*–*

Rogi Kalyan Samiti have been set up at various level of hospital

1. District hospital.
2. Civil hospital.
3. Community Health Centre.
4. Primary Health Centre.

Rogi Kalyan Samiti at each level has two bodies for its effective functioning, General body and Executive body.

District hospital

General body –

I/C Minister of the district	Chairman
President Jila Panchayat	Member
Mayor of Municipal Corporation	Member
Collector	Member
Superintendent Police	Member
Chief Medical Officer	Member
MLAs of district	Member
President of Health Committee	Member
Municipal Corporation/Municipality	
Senior MO of hospital	Member
Municipal Commissioner	Member
CEO Zila Panchayat	Member
Ex. Eng. PWD & PHED	Member
Secretary Red Cross	Member
President IMA	Member
Two Donors (donated Rs. 50,000)	Member
Nominated by Chairman	

Two social workers nominated by the chairman	Member
Civil Surgeon cum Hospital Superintendent.	Member

Executive body –

For managing day to day functioning of the Rogi Kalyan Samiti Executive Committee have been given certain powers. The composition of executive body is as follows –

Collector	Chairman
Municipal Commissioner	Member
CEO Zila Panchayat	Member
Chief Medical Officer	Member
Senior MO of hospital	Member
Ex. Eng. PWD	Member
One Donor (donated Rs. 50,000)	Member
Nominated by Chairman	
Civil Surgeon cum Hospital Superintendent	Member

Tehsil & Block Level Hospital Rogi Kalyan Samiti

The Community health centres, Civil hospitals and other hospitals at the tehsil & Block level come under this category. The composition is as follows –

MLA of the area	Chairman
S.D.M.	Member
President Janpad Panchayat	Member
President of Municipality	Member
President of Health Committee of Municipality	Member
CEO Janpad Panchayat	Member
One parshad of area	Member
S.D.O., PWD, PHED	Member
Two Donors (donated Rs. 80,000)	
Nominated by Chairman	Member
Senior MO nominated by CMHO	Member
Block MO I/C MO Hospital	Member Secretary

Executive body –

SDM	Chairman
President Janpad	Member
CEO Janpad Panchayat	Member
S.D.O., PWD	Member
Senior MO nominated by CMHO	Member
Block MO I/C MO Hospital	Member Secretary

Other Health Institutions/Dispensary/PHC

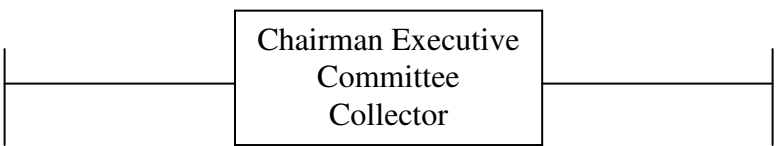
General Body –

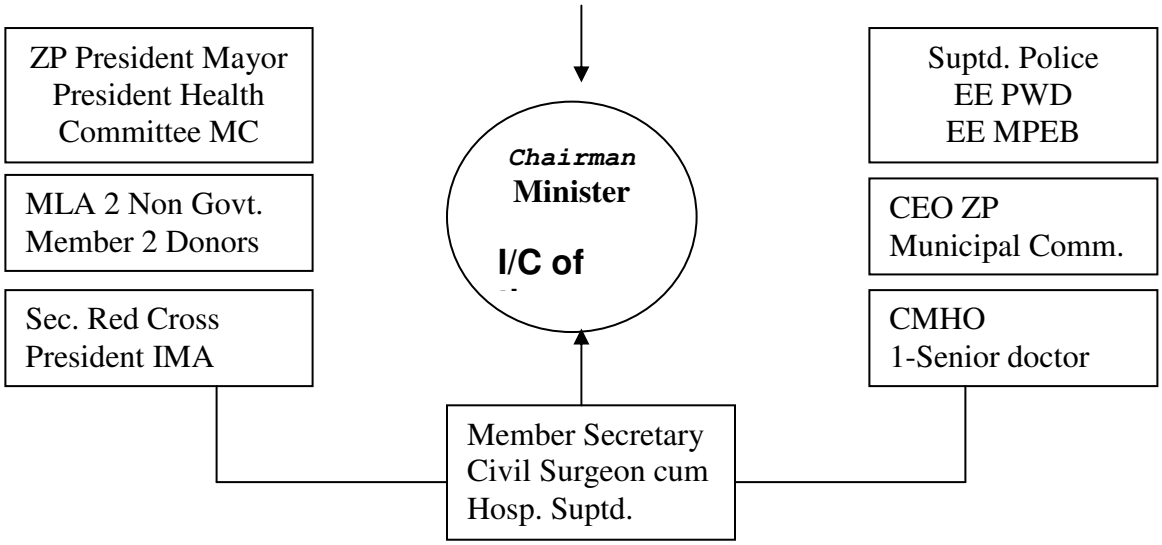
Janpad Panchayat member of area	Chairman
President Nagar/ Gram Panchayat	Member
President of Municipality	Member
President of Health Committee of Nagar/ Gram Panchayat	Member
Nagar/ Gram Panchayat female member	Member
Sub Eng. PWD & MPEB	Member
Two Donors (donated Rs. 10,000)	Member
Nominated by Chairman	
Tehsildar/Nayab Tehsildar	Member
I/C MO Hospital	Member Secretary

Executive body –

Tehsildar/Nayab Tehsildar	Chairman
President of Health Committee of Nagar/ Gram Panchayat	Member
Sub Eng. PWD & MPEB	Member
I/C MO Hospital	Member Secretary

District Level Rogi Kalyan Samiti[2]





Powers and responsibilities of General body of RKS–

1. The general body shall meet at least twice in a year. However the Executive Committee or 1/3rd members on request can call meetings of RKS.

2. The newly constituted RKS shall hold its meeting within 3 months and shall elect its office bearers.
3. The Executive committee can call the special meeting of the old RKS General body and this body can amend objectives, membership, change in rules and regulations or it can approve the removal of the left out members from the list.
4. The chorum of the General body shall be 1/3rd of the members.
5. The General body shall take the policy decisions and it will be implemented by Executive Committee under rule 10 of the constitution of RKS.
6. General body can authorise the Executive Committee for implementation of functions, it can delegate financial powers to members of Executive Committee and also approve financial proposals that are that are beyond the powers of the Executive Committee.
7. The General body shall review the financial account at least once in a financial year, review the income & expenditure statements and shall approve the budget for the next year.
8. General body shall have powers to appoint chartered accountant and can constitute sub committees for specific purposes such as new construction and commercial use of land.

Powers and Responsibilities of Executive Committee –

1. The Executive Committee will meet at least once in two months. The chorum will be of 50% members. The presence of the Chairman will be essential.
2. Executive Committee will perform its day to day functions with existing manpower.
3. Executive Committee will implement the decisions taken by GB and will function within its powers invested by GB.
4. Executive Committee can delegate its financial powers to the member secretary.
5. Executive Committee shall have authority of raising the funds for the activities approved by GB e.g. new construction, equipment purchase, and modern investigative facilities. It shall have the authority to take loan from banks.
6. The Executive Committee can appoint cleanliness staff, para medical staff, and security guard and part time employees on contract.
7. Executive Committee will levy user charges from the patients and facilities given for their relatives.
8. Executive Committee can purchase equipment, drugs, furniture, pathological reagents, X-Ray films in consultation with the Sr. MO for quality purchase.

Devolution of powers –

The government authorised the RKS to manage the existing facilities and assets of the concerned hospital. RKS has been given the freedom for operations, management and investment to meet service requirements. The RKS is empowered to mobilise resources through levy of user charges.

It allows commercial use of assets like land of the institution, donations in cash or kind from the public at large and allotments/Grants from the government or non-government bodies & loans from financial institutions.

Levy of user charges –

User fees are considered not only a tool for ensuring efficient use and equitable financing of public services, but also as an investment, guide, because consumers' willingness to pay for services in many instances is considered to be the only way in which the benefits of a service can be ascertained and compared with the cost of providing the service.

The guidelines for user charges are as follows –

Charges must be levied for all facilities provided in the hospital including the outdoor patient ticket, pathological tests, indoor beds, specialised treatment, operation, etc.

The economically weaker sections of the society and other groups as determined by the government (for e.g. persons below the poverty line, freedom fighters, etc.) would be exempt from the levy. Identification would be based on self-certification. The charges for general ward would be nominal while those for private wards would be higher. Funds so received would be deposited with the RKS and not in the government exchequer.

Implementation –

The Executive Committee acts as a watchdog to oversee the day to day functioning. People's representatives on the RKS facilitate social audit. The activities of RKS are monitored by the members of the district government and the Minister In-charge of a district is also the President of district level RKS which ensures effective supervision.

Other studies on Rogi Kalyan Samiti –

A study conducted by Girish Kumar[3], for the 18th European Conference on Modern South Asian Studies, is based on data collected from 9 hospitals in selected five districts of Madhya Pradesh which is primarily a documentation of the innovative reform scheme critically examining the decision making process and sharing of responsibilities by the different stakeholders. It also aims at assessing the strength of institutional arrangements, transparency and accountability of the new management structure. The study shows that the scheme has heralded a major initiative to reform the near defunct government hospitals in Madhya Pradesh by enforcing accountability of the staff, transparency in the use of available resources, and above all providing more facilities to the patients without putting financial burden on the state exchequer. However the patients interviewed in few hospitals were not content, monitoring is limited as it is more attuned to observing procedures than an exercise in ushering dynamism in the functioning of the RKS. The main actors of the scheme seem to be complacent, even saturated with their performance as if they have reached the end of the journey. There is hardly any organised effort to bring about a change in the behavioural pattern, work ethics, inject the sense of duty and mould the traditional mindset of the health functionaries in order to make them de facto agents of change. However it has been able to demonstrate that the huge infrastructure created in 1970s and 1980s could be saved from going waste in the face of ever – shrinking budgetary allocation if reforms in these lines are introduced with little innovation.

An article on Rogi Kalyan Samiti[1] states that a total of Rs. 350-400 million have been collected by the various districts through donations and user charges, MPs and MLAs have earmarked funds out of their discretionary local area development funds for improvement of the health institutions. The district Red Cross Societies have been functioning in tandem with RKS and in fact been more active of late with the expenditure jumping to Rs. 70-80million in 94-99 from 4 million in 1990-1994. Daily collection in each of the hospital depending on the location is around Rs. 500 to 25000 and a conservative estimate of monthly collection of Rs. 25 to 30 million which is still on increase. It states that the social benefits due to the implementation of RKS is both direct and indirect, improving both the quality of service the acceptance and the willingness to pay. However there is no evidence of any study showing the willingness to pay or for the acceptance of service and satisfaction. It has been assumed that it is acceptable, as there have been no protests in the entire state over the introduction of user fees. The study states that

there has been improvement in the efficiency of the doctors, arresting the deterioration in the hospitals and increase in the number of patients coming to the government hospitals after the introduction of user charges reflecting their willingness to pay.

Similarly some hospitals have been adopted by Rajasthan State to provide better services in medical field which has been documented by Dr. A.S. Bapna in a Handbook for General guidelines for Rajasthan Medicare Relief Societies[4]. It states that to improve resources to primary health care it is necessary to evolve a process by which state resources can be conserved at secondary and tertiary level of health care and hence RMRS was constituted. However the irony is that to improve primary health care, resources are being generated and utilised at secondary and tertiary level. It aims to provide autonomy and convenience in utilisation of resources. However all the requirements to utilise the resources is reserved with the community composed of technocrats thereby breeding hierarchy and systemic approach.

An exhaustive study[2] on the RKS in Madhya Pradesh since the time of inception to 2001, suggests that once the management of the hospitals improved, the MPs and the MLAs too came forward in earmarking funds out of their discretionary local area development funds for improvements of health institutions. District Red Cross Societies too started functioning in tandem; and around Rs. 40 lacs were spent on the hospitals. Various ancillary services like Pathology, Sanitation, MIS, Security and Canteen services have been introduced in phased manner. The net gainer being the consumer as the rates are almost 30% lower than elsewhere. On an average Rs. 10 lakhs have been generated per district per year. The pattern of resource mobilisation does not indicate sustainability as the major amount of funds were generated from non medical sources like donation. The resource mobilisation is only up to 50% from medical resources. It is stated that there is a need to augment the resource mobilisation from medical sources like special investigations, surgical procedures, ambulance services & pathological investigations. There is a mis match in income generation and expenditure pattern. The study shows an improvement in the utilisation as the number of patients from middle class have increased, though there is no direct evidence of increase in below poverty line patients. As the below poverty line patients are exempted from user charges, the number of BPL patients is believed to not have reduced.

Analysis of the report shows the positive evidence of increase in the specialised investigations like ECG, X-Ray, number of blood transfusions but there is a decline in the routine blood test in many districts.

Aim of the study –

To estimate the cost effectiveness of the Scheme.

Objective of the study –

- To analyse the costing pattern of the government health care providers (district hospitals/CHCs) vis-à-vis the collections made under the Rogi Kalyan Samiti.
- To study the utilization of the funds from Rogi Kalyan Samiti.

Sampling –

For the purpose of the study three CHCs from three different districts- Raigarh (Pusaur), Jhanjgir (Baloda) and Kanker (Charama) were selected and district hospital of Raigarh and Jhanjgir were selected. This is a purposive sampling based on the criterion of availability of information and accessibility.

The CHC is conceived as a 30-bed secondary referral centre, the most important component of secondary referral along with the district hospital. though the norm expects a CHC to cover one lakh population, on an average 1.5 lakh population are covered per CHC in Chattisgarh. There are 121 CHCs in 16 districts of the state.

Methodology –

The following information was obtained from the health centres –

1. The salary of the overall hospital staff and those specially appointed by RKS.
2. The staff pattern and the different units in the hospital and the number of hours spent by the staff especially the doctors in different activities.
3. The tariff rate for the different services provided under RKS.
4. A statement of the income earned and the expenditure made under RKS.

5. The number of OPD patients, IPD patients, Operations conducted (both major and minor)
6. The number of deliveries conducted and number of L.S.CS.
7. The total number of injections administered to the Out patients and the number of X-Rays, USGs and CT Scans conducted.
8. The details from the stock register as to the number of equipments purchased, the medicines purchased and dispensed, etc.

With the aid of the aforementioned data, and making the following assumptions the cost for the different services were computed–

1. The annual capital expenditure by the hospital in the form of depreciation for its assets is assumed to be 10% of the total, while that for the staff salary is assumed to be 60% and the expenses on water/electricity/maintenance/repair and consumables is estimated as 5 and 25% respectively. Though this is not expected to be same for all the institutions especially the district hospitals and the CHCs, the assumption has been kept uniform.

Based on the aforementioned assumptions, the total expenditure made by the hospital has been estimated.

2. The total number of patients having sought services from different units is multiplied with the rate of service to obtain the total income in the respective units. This figure has been further discounted by around 60% (43% for BPL and remaining for other waive off) to estimate the net income under Rogi Kalyan Samiti. This figure is very close to the income mentioned in the statement of income and expenditure of RKS, though not the same.

The computation of the income unit wise was essential to estimate the cost recovery per unit and to compare with the actual allocation of the fund to the respective units.

3. The data was available for different periods and hence has been adjusted to obtain the annual figure to allow comparison.

4. The expenditure has been apportioned for different units as follows –

OPD	IPD	OT	LAB	PHR	INJ	X-RAY	ADMIN	Total
25%	22%	16%	6%	6%	10%	7%	8%	100%

1. Jhanjgir -

Premises -

As mentioned before based the Jhanjgir district hospital was selected on the geographical accessibility and availability of information. The district Jhanjgir-Champa is situated in the center of Chattisgarh and so it is considered as heart of Chattisgarh and the district hospital is situated at the heart of the district around 2 kms. from Naila station which is around 175 kms from the state capital Raipur. The district covers 13,16,140 population in 9 blocks, of which 43% are below poverty line (Article by Myra MacDonald – New Indian State Pioneers free market reforms – Internet). The health care facilities available to the people are around 10 PHCs, 6 CHCs, 211 SCs and one district hospital besides other private services.

District Hospital-

The building was constructed in 1956 to serve the primary health care needs of the people. It was converted to district hospital in 1998 and is manned by 45 employees. The remuneration for 3 staff viz – 1 radiographer and 2 sweepers is met through Rogi Kalyan Samiti and hence they are called contractual employees under Rogi Kalyan Samiti. The staff pattern has been given in the Annexure I. As per the existing staff both the manpower and the infrastructure are far below the requirements of the hospital.

It is a 28 bedded hospital with the following units under the control of the Civil Surgeon. The different departments in the hospital –
Outdoor services, Indoor facilities, Laboratory services, Operation Theatre, Labour room, Pharmacy, X-Ray Centre, Dressing room, Injection room, Ophthalmic centre, Administration.
As mentioned before in the general description of RKS, the charges for different services are fixed by the Committees.
The tariff for different services in Jhanjgir district hospital is as follows –

Sr. No.	Unit/Service	Current rates in Rs.	Revised rates in Rs

1	Haemoglobin	5	5
2	Total & Differential counts	5	10
3	ESR	10	10
4	Urine-Sugar/Albumin	5	5
5	Urine-Routine/Microscopic	10	10
6	Blood Grouping	10	20
7	UPT	30	40
8	Urine Bile salt pigments	10	10
9	Blood- B.T.C.T.	10	10
10	Blood sugar – Calorimeter	10	20
11	Blood sugar – Glucometer	30	30
12	Serum bilirubin	15	20
13	Blood urea	10	20
14	Widal	10	20
15	V.D.R.L.	10	20
16	Australian Antigen 'B'	45	60
17	Hepatitis 'C'		140
	X-Ray charges		
1	12X15	45	35
2	10X12	45	35
3	8X10	25	20
4	6X8	25	20

Unit wise Cost analysis –

OPD Clinic –

The OPD services are provided in two rooms, one in which the Civil surgeon sees his patient and the other larger one in which 4 Medical Officers examine their patients. None of the rooms have an examination table and there is a lack of privacy for the patients. However, while the larger room is well illuminated and ventilated the smaller room lacks appropriate light supply. There is only 1 small 4 feet long bench for the patients to be seated, while waiting to be seen by the doctors.

The OPD timings are 8.00 am. to 14.00 pm. and from 16.00 pm. to 18.00 pm. thereby amounting to 8 hours. However the clinic starts not before 10.00 am and closes around 17.30 pm.

The total number of patients seen in nine months (April to Dec, 03) is 37523. The average number of patients seen in a month is around 4169. Thus the average number of patients examined/treated in a day is around 175.

Assuming that of the total expenditure 25% is spent on OPD services the annual expenditure on OPD is Rs. 1743049. Thus expenditure per patient comes to Rs. 35. This however excludes the cost for pathology and X-Ray. The cost of these services would be taken separately. As the data for Indoor and Outdoor patients getting services in the aforementioned units is not separately available, it is not possible to estimate the separate cost for these services (X-Ray, pathology, etc.) for Out door patients. Rs. 35 per patient is inclusive of the staff salary, maintenance & repair, cost of consumables and the capital cost.

The registration charge per patient is Rs. 2 for out patient service. This amounts to around Rs. 1,00,061 in a year. If 60% of the total patients were given free treatment (BPL, pensioners, etc.) the income through OPD would be Rs. 40024. Thus of the total expenditure on Out patient services around 2.3% is recovered from the patients.

Indoor Services –

It has two wards one for the male patients and the other of the female patients. In all there are 28 beds, the average bed occupancy being ----- The average length of stay is around 3 to 4 days. The total number of patients admitted in 9 months (April to Dec, 03) is 154. The average number of admission per day is either one or nil while the monthly admission is around 17.

Assuming that of the total expenditure, 22% is spent on IPD services the annual expenditure on Indoor patients is Rs. 1533883. Thus expenditure per patient comes to Rs. 1643. This is inclusive of only the staff salary, building cost, maintenance & repair cost and cost of consumables. The recovery from the patient's contribution is 0.21%. This excludes the cost of X-Ray, lab investigations, surgical procedures & delivery (including L.S.C.S).

Laboratory –

The laboratory is located in a small room close to the entrance and is congested. The laboratory can conduct normal tests like blood, sputum, urine, malaria, etc. but microbiological cultures and

histopathology are not available. The total number of investigations done in seven months (Jan, 04 to July, 04) is 12651, the details being available in the Annexure. The total income generated through the laboratory could be around Rs. 96119. If 60% of the patients being either pensioners or BPL were waived off the fees, the income from pathological tests would amount to Rs. 98865.

Assuming 6% of the total expenditure would be on laboratory the net expenditure comes to Rs. 418332. Thus the cost recovery from the patients contribution amounts to 15.76%.

[As the detailed profile of the Pathological tests is not available, to estimate the collections from the lab facility the following assumptions have been made.

1. If around 350 ANC cases are seen, and assuming that at least 80% of them would have done UPT, the actual number of UPT done in a year would be around 280.

Assuming that the remaining 60% would be for Routine/Microscopic Urine. 20% for bile salt and remaining 13% for blood sugar the total collection from Urine examination sums to Rs. 38744

2. For blood investigations assuming that the cost of each test could have been Rs. 10, the total income from blood investigations could be taken as Rs. 44600.
3. From other blood investigations considering that only around 5% would have undergone Australia Antigen test for Hepatitis 'B', and around 20% for Serum bilirubin, the income under this head amounts to Rs. 11615.]

X-Ray –
The X-Ray department is manned by a radiographer appointed under Rogi Kalyan Samiti on contractual basis. He therefore does not enjoy other benefits like pension, provident fund, etc. Moreover his salary is lower than the other technicians.
The total number of X-Rays done in a year is 2320. The detailed classification of X-Rays done in the month of Oct, 2004 is available in the Annexure. The estimated income from X-Rays for a year after discounting for the free patients is Rs. 41520. The total expenditure on the patients for X-Ray being Rs. 488054, the cost recovery is 8.51%.

Operation Theatre –

There is only one OT in which both minor and major surgeries are conducted. The total number of Major surgeries conducted in 2003- 2004 is 30, while only 28 minor surgeries have been conducted. The total number of Caesarean Sections done is 3.

The minor surgeries are not charged and for major surgeries Rs. 25 is charged. For 30 major surgeries this sums to Rs. 750 which on discounting for waive off comes to Rs. 300.

Allocation of funds for different units from RKS –

Unit	Fund Allocation in Rs.	Estimated fund generation in Rs.
Medicines	51716 (30%)	-
X-Ray	33001 (19%)	41520 (27.49%)
Lab	2467 (1%)	65910 (43.64%)
Labour	32884 (19%)	-
	2837 (22%)	-
Advertisement/Publication	38057 (1%)	NA
Hospital Exp and Meetings	1720 (2%)	NA
BPL	3784 (2%)	NA
Other Exp	3477 (4%)	NA

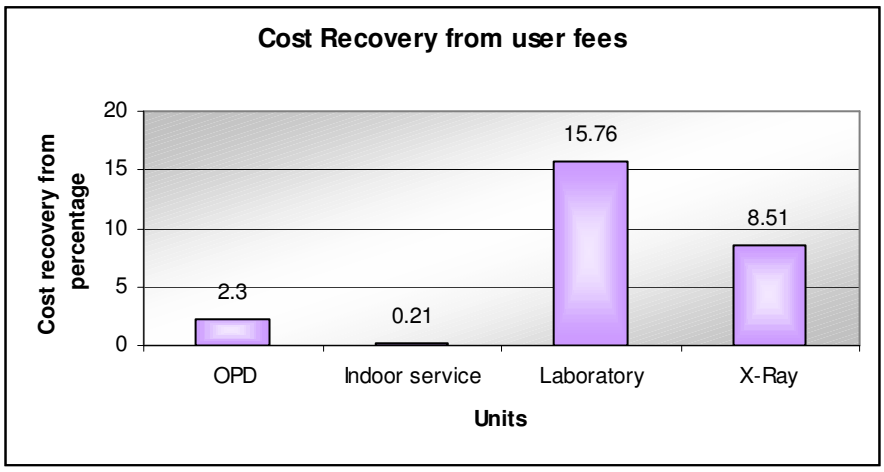
The fund allocation is independent of the fund generated by each of the units. The hospital was converted from a community health centre to a district hospital around 5 yrs. ago and the requisite number of manpower and infrastructure are yet to be increased. Provision of medicines, which is primarily government's responsibility, is met by the fund collected from RKS.

With the expansion of services more facilities are required to handle the additional caseload, especially in the provision of Lab services. However over the past five years no attempt has been made either to provide more technicians or to improve the infrastructure.

Total income generated under the scheme is Rs. 172867 while the amount spent from this fund is Rs. 169943, which is 98% of the total. The estimated overall hospital expenditure is Rs.

6972196 and hence the cost recovery is estimated to be 2.5%, i.e. of the total expenditure only 2.5% is met through the RKS fund.

The cost recovery from different units is as follows –



The estimated cost recovery is more from Laboratory services and X-ray. This implies that the number of investigations suggested to the patients is more. These are supportive services and though aid in diagnosis and hence in treatment, they do not directly benefit the patients in terms of relief from diseases. These departments can also be seen as revenue generating units!

Community Health Centre-

On an average 1.18 lakh population are covered per CHC in Jhanjgir. ***Baloda CHC*** is located around 50 kms. from Naila station. The RKS was constituted here in 1996.

It is a -- bedded hospital with the following units - Outdoor services, Indoor facilities, Laboratory services, Operation Theatre, Labour room, Pharmacy, X-Ray Centre, Dressing room, Injection room, Administration.

Note- As the number of indoor patients is par less than the out door patients and the number of minor surgeries conducted are also less, the expenditure apportioned for different units in a CHC are as follows –

OPD	IPD	OT	LAB	PHR	INJ	X-RAY	ADMIN	Total
40%	5%	5%	10%	10%	10%	10%	10%	100%

OPD Clinic –

The total number of patients seen in a year (April 03 to March 04) is 33172. The average number of patients seen in a month is around 2764. Thus the average number of patients examined/treated in a day is around 92.

Assuming that of the total expenditure 40% is spent on OPD services the annual expenditure on OPD is Rs. 3947625. Thus expenditure per patient comes to Rs. 119. This however excludes the cost for pathology and X-Ray. The cost of these services would be taken separately. Rs. 119 per patient is inclusive of the staff salary, maintenance & repair, cost of consumables and the capital cost.

The registration charges per patient is Rs. 2 for out patient service. This amounts to around Rs. 66344 in a year. 14% of the total patients were given free treatment (8% BPL, pensioners and others 6%) the income through OPD would be Rs. 57056. Thus of the total expenditure on Out patient services around 1.4 % is recovered from the patients.

Indoor Services –

The total number of patients admitted in a year (April 03 to March 04) is 76. Assuming that of the total expenditure 5% is spent on IPD services the annual expenditure on Indoor patients is Rs. 493453. Thus expenditure per patient comes to Rs. 6493. This is inclusive of only the staff salary, building cost, maintenance & repair cost and cost of consumables. The recovery from the patient's contribution is 0.21%. This excludes the cost of X-Ray, lab investigations, and surgical procedures.

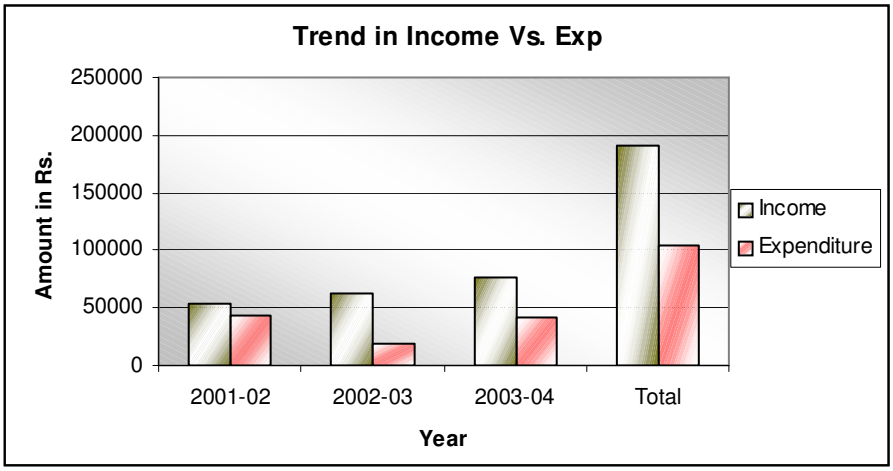
The details on income expenditure are as follows –

RKS - Expenditure	2001-02	2002-03	2003-04	Total	Percentage
Ambulance-Maintenance			14813	14813	14.29
Equipment-Repair & Maintenance	1315	2340		3655	3.53
Medicines		380	1415	1795	1.73
Hospital Maintenance					
Eye Camp	37358	9589	2100	49047	47.30
Staff salary	200	2400	17800	20400	19.68

Other expenses	4778	4063	5133	13974	13.48
Total	43651	18772	41261	103684	100

RKS-Income	2001-02	2002-03	2003-04	Total	Percentage
Donation	16556		2220	18776	9.83
OPD Registration	23836	42148	45768	111752	58.51
IPD Registration		450	500	950	0.50
Delivery charge	150	750	1300	2200	1.15
Other income		20	850	870	0.46
X-Ray	1170	2780	340	4290	2.25
Blood Investigation	175	640	440	1255	0.66
Urine	65	510	350	925	0.48
Other Investigation	300	2285	3650	6235	3.26
Eye Exam	860	1420	1540	3820	2.00
Eye camp	10000	10650	4725	25375	13.29
Ambulance charge			11050	11050	5.79
Others		408	3096	3504	1.83
Total	53112	62061	75829	**191002**	100

The maximum income is from OPD patients while the maximum expenditure is on eye camp. A generator has been purchased from the contribution of patients. However during power cut it could not be used as it was out of order. The accountant was very displeased with the system and stated that though a scheme like this is operational for patient's welfare, even despite of frequent power cut the officials do not grant permission to buy even inexpensive candles.



The income through RKS has shown consistent increase over the years, which is not congruous with the expenditure pattern. A huge amount is left unspent.

Raigarh -

Premises –

Situated on the eastern border of Chattisgarh, Raigarh district covers an area of around 6,836 sq km. It covers a population of 12,65,084 and is around ---- kms. from the state capital Raipur. There are 7 CHCs covering on an average 1.8 lakh population per CHC.

District Hospital –

It was started as a 117 bedded hospital, which was further, expanded to 190 beds in 1995. Facilities of delivery, eye, child, surgical, medical, T.B. and burn unit are available here. Dental treatment facilities are also available in this Hospital along with those of X-Ray, Blood Bank, Pathology and I.C.U. Ward. District Rogi Kalyan Samiti at district hospital, Raigarh for the welfare of the patients was established during the month of October, 1995 with public contribution. The Samiti with the help of public collected Rs. 42,92,969.00 for different facilities. In 1998-99, the District Rogi Kalyan Samiti made available an amount of Rs. 2,45,392.00 for construction of two I.C.U. Rooms.

Indian Red Cross Society, Raigarh branch was established during the year 1991-92 and with the help of public Rs. 1,27,53,952.00 was collected till 2002 of which Rs. 91,14,869.00 was expended. During the year 1997-98 an amount of Rs. 12,09,023.00 and during the year 1998-99 an amount of Rs. 11,43,337.00 has been expended for different types of works.

Unit wise costing

OPD Clinic –

The OPD timings are 8.00 am. to 14.00 pm. and from 16.00 pm. to 18.00 pm. thereby amounting to 8 hours. However the clinic starts not before 9.30 am and closes around 17.30 pm. The total number of patients seen in a year (Jan to Dec, 03) is 136555. The average number of patients seen in a month is around 11380. Thus the average number of patients examined/treated in a day is around 438 in different departments.

Assuming that of the total expenditure 25% is spent on OPD services the annual expenditure on OPD is Rs. 6730984. Thus expenditure per patient comes to Rs. 49. This however excludes the

cost for pathology and X-Ray. The cost of these services would be taken separately. As the data for Indoor and Outdoor patients getting services in the aforementioned units is not separately available, it is not possible to estimate the separate cost for these services for Out door patients. Rs. 49 per patient is inclusive of the staff salary, maintenance & repair, cost of consumables and the capital cost.

The registration charges per patient is Rs. 2 for out patient service. This amounts to around Rs. 2,73,110 in a year. Around 53% of the total patients were given free treatment (BPL, pensioners, etc.) thus the net income from out patients is Rs. 129440. Thus of the total expenditure on Out patient services around 1.9% is recovered from the patients.

Indoor Services –

Assuming that of the total expenditure 22% is spent on IPD services the annual expenditure on Indoor patients is Rs. 5923266. Thus expenditure per patient comes to Rs. 365. This is inclusive of only the staff salary, building cost, maintenance & repair cost and cost of consumables. The recovery from the patient's contribution is 5.41%. This excludes the cost of X-Ray, lab investigations, surgical procedures & delivery (including L.S.C.S).

Laboratory –

The total number of investigations done in a year (Jan, 03 to Dec, 03) is 15581, the details being available in the Annexure. The total income generated through the laboratory is Rs. 67790.

Assuming 6% of the total expenditure would be on laboratory the net expenditure comes to Rs. 1615436. Thus the cost recovery from the patients contribution amounts to 4.19%.

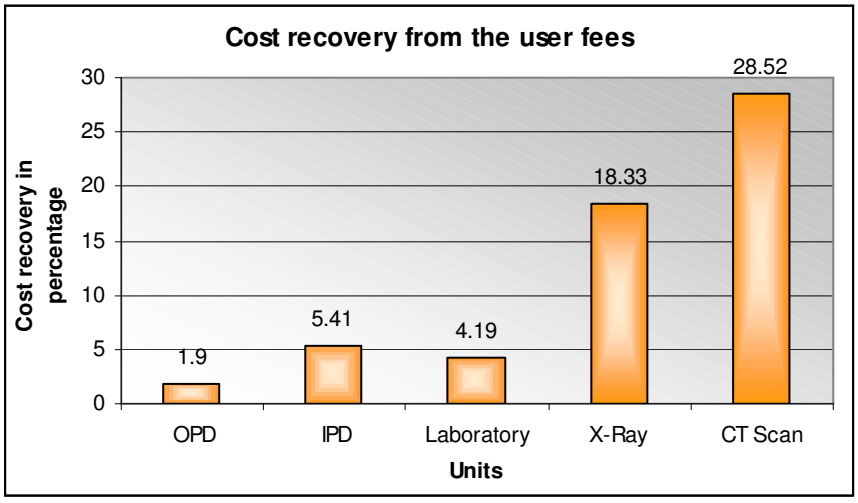
X-Ray –

The total number of X-Rays done in a year is 9492. The detailed classification of X-Rays done in the month of Oct 2004 is available in the Annexure. The estimated income from X-Rays is Rs. 345475. The total expenditure on the patients for X-Ray being Rs. 1884676, the cost recovery is 18.33%.

CT Scan –

This service is charged even for the BPL population and the pensioners. The charges are Rs. 800 for general category with an additional Rs. 200 for the plate and computerised report, while for BPL population Rs. 400 plus Rs. 200 is charged. For contrast media another Rs. 400 is charged. Around 852 patients underwent CAT scan and the total revenue generated through this is Rs. 767800. Assuming that of the total hospital expenditure if 10% were utilised for providing this service, the estimated expenditure is Rs. 2692394. Thus the cost recovery for the hospital from the patients contribution is 28.51%.

The cost recovery from different departments are as follows –

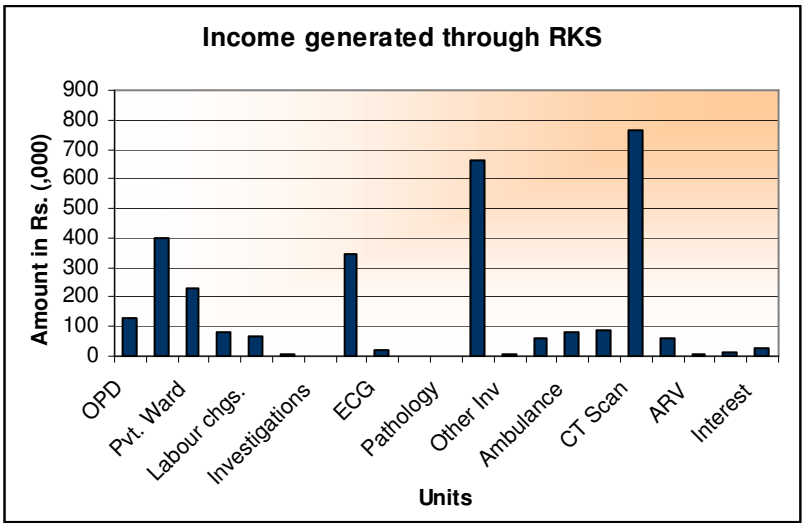


The cost recovery is more from CT Scan & X-Ray department while that from Indoor patients is also considerable. This implies that a lot of patients are suggested investigations like X-ray & scan.

The statement of income from Rogi Kalyan Samiti for the year 2003 (Jan, 2003 – Dec, 2003) is as follows –

Unit Head	**Amount collected in Rs.**	**Proportion in percentage**
OPD	129440	4.24
IPD	400510	13.13
Pvt. Ward	229220	7.51
ICU	79365	2.60
Labour chg.	67790	2.22
Plaster chg.	3825	0.13
Investigations		
X-Ray	345475	11.32
ECG	18320	0.60
Pathology		
Blood Inv.	665349	21.80

Other Inv	10050	0.33
Cycle stand	59666	1.96
Ambulance	83108	2.72
Attendant Entry	88868	2.91
CT Scan	767800	25.16
Rent-Shop	58747	1.93
ARV	7195	0.24
Others	11652	0.38
Interest	24999	0.82
	3051379	100.00

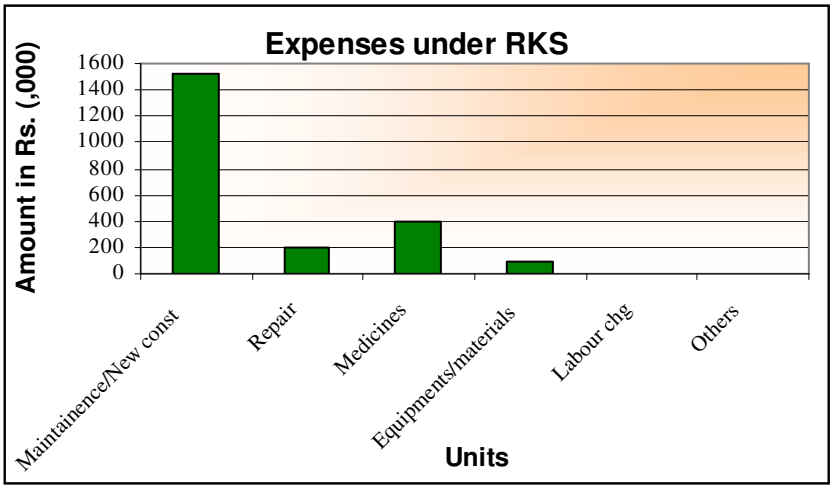


The maximum income is made through CT Scan, following which is blood investigation and X-Ray. Thus it is seen that maximum income is through investigative procedures, which aid in diagnosing and not in treating the patients. (Though it indirectly aids in treatment.) However the irony is that in many cases even after the ailment is diagnosed the hospital is not equipped enough to handle the case and provide appropriate treatment. For instance though the Raigarh district hospital has high tech diagnostics like CT Scan it is not equipped to handle L.S.C.S.

The fund collected through RKS is utilised for various purposes like new construction, maintenance and repair and purchase of medicines, which is as follows –

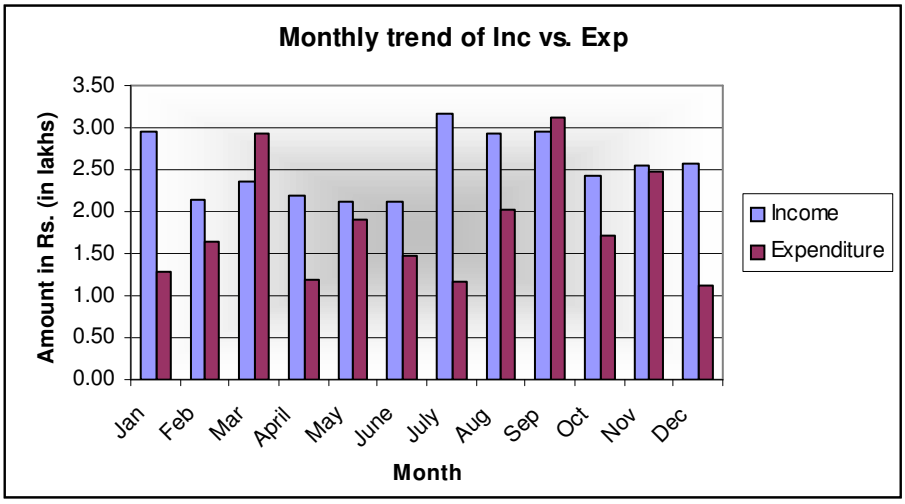
Unit Head	**Amount in Rs.**	**Proportion in percentage**
Maintenance/New construction	1516374	68.73
Repair	195867	8.88
Medicines	393762	17.85
Equipments/materials	97220	4.41

Labour chg		
Others	3053	0.14
Total	**2206276**	100.00



A huge proportion of the amount collected through RKS is spent on New construction and maintenance of the building and major equipment.

The sanitation and hygiene conditions of the hospital is appalling with the infective and the non infective wastes being dumped in the open space at the centre of the hospital building which is flanked by wards on all its sides. On enquiring the justification given for the poor sanitary condition was that the Class IV staff were on strike for a hike in the salary. Though the hospital is able to collect a considerable amount through user fees a huge chunk of around Rs. 10 lakh is earmarked for the maintenance of CT scan machine. It is well known that not many patients need to undergo this investigation and while the general state of the hospital in terms of manpower and basic sanitation is so poor, it seems ridiculous to hold back such a big amount of people's contribution which is meant to serve people's needs. Moreover the charges for CT Scan though is less than market price is not subsidised to a great extent.



72% of the total contribution is utilised though the utility of the services for which the amount is spent could not be assessed. The income generated from the patients has never been less than Rs. 2 lakhs while in almost 4 months the expenditure has been maintained less than Rs. 1.5 lakhs. The expenditure surpassed the income in the month of Sep & March. However the gap between income and expenditure has been consistently maintained, despite of the fact that the staff is discontent with the pay package, the hospital is unkempt.

In some hospitals every unit enjoys the autonomy with respect to utilisation of resources generated by it. However in Raigarh hospital the resource generated through different units are pooled and utilised for different purposes based on the decision of the committee. It was therefore not possible to compare the unit wise resource utilisation.

Community Health Centre –

Pusaur CHC is located around 35 kms. from Raigarh station. The RKS was constituted here in 1997.

The tariff chart for the user fees as decided by the committee –

Sr. No.	Unit/Service	Current rates in Rs.
1	Haemoglobin	5
2	Total & Differential counts	5
3	ESR	5

4	Urine-Sugar/Albumin	5
5	Urine Bile salt pigments	5
6	Serum bilirubin	20
7	Widal	30
8	V.D.R.L.	15
9	Major surgery	50
10	Minor surgery	25
11	OPD	2
12	IPD	10/day
13	X-Ray	40/50/60
14	Sickle cell	15
15	RA	15
16	Serum Cholesterol	20

OPD Clinic –

The increase in the number of out patients has been consistent from the time of inception of RKS in 97, which is around 20% increase every year. However in 2001-2002 the number of patients fell by 11% in comparison to the preceding year and in 2002-2003 the number of out patients increased by 47% which showed a mere increase of 8% in the subsequent year.

Currently on an average around 60 patients are treated each day. Assuming that of the total expenditure 25% is spent on OPD services the annual expenditure on OPD is Rs. 813810. Thus expenditure per patient comes to Rs. 49. This however excludes the cost for pathology and X-Ray. The cost of these services would be taken separately. Rs. 49 per patient is inclusive of the staff salary, maintenance & repair, cost of consumables and the capital cost.

The registration charge per patient is Rs. 2 for out patient service. The total number of patients seen in a year (April 03 to March 04) is 16776. 59% of the total patients i.e. 9904 patients were given free treatment. The revenue generated through OPD in 2003-2004 is Rs. 12182. Thus of the total expenditure on Out patient services around 1.5% is recovered from the patients.

Indoor Services –

The total number of patients admitted in a year (Jan 03 to Dec 03) is 801. Assuming that of the total expenditure 22% is spent on IPD services the annual expenditure on Indoor patients is Rs. 716152. Thus expenditure per patient comes to Rs. 894. This is inclusive of only the staff salary, building cost, maintenance & repair cost and cost of consumables. The recovery from the

patient's contribution is 2.17%. This excludes the cost of X-Ray, lab investigations, and surgical procedures.

The income from 801 indoor patients being Rs. 15520 the average fees per patient can be estimated to be Rs. 19, which means that the average length of stay could be 2 days (Indoor fees per patient per day is Rs. 10).

Laboratory –

The total income generated through the pathological investigations in 2003-2004 is Rs. 2455. Assuming 6% of the total expenditure would be on laboratory the net expenditure comes to Rs. 195314. Thus the cost recovery from the patients contribution amounts to 1.26%.

X-Ray –

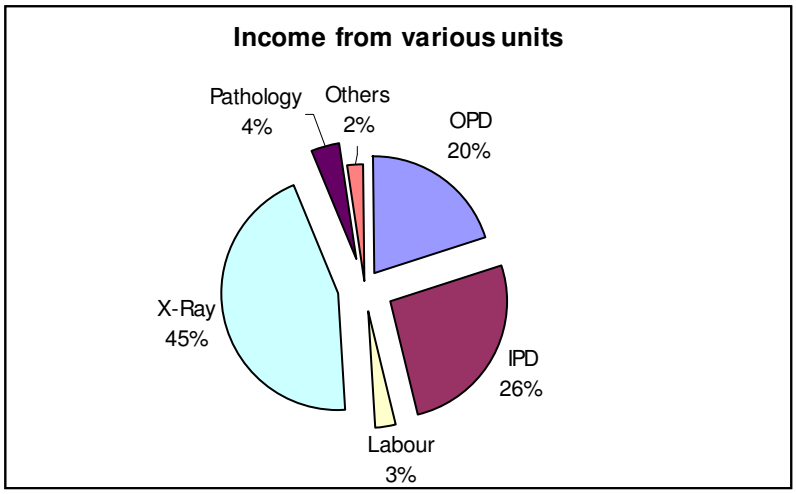
The revenue generated from X-Rays in 2003-2004 is Rs. 26890. As per the assumption the total expenditure on the patients for X-Ray is estimated to be Rs. 227867, and hence the cost recovery is 11.8 %.

The details on income expenditure are as follows –

Income	97-98	98-99	99-00	00-01	2001-2002	2002-2003	2003-2004	Total
OPD	1460			2888	2438	6380	12182	25348
IPD	1180		1970	3070	2680	5140	15520	29560
Labour	500		565	870	1190	1180	1660	5965
Investigation								
X-Ray						20280	26890	47170
Pathological								
Blood	15		335	980	535	1395	1180	4440
Others			500	345	810	875	1275	3805
From other sources				212	238	1061	999	2510
Total	3155		3370	8365	7891	36311	59706	118798

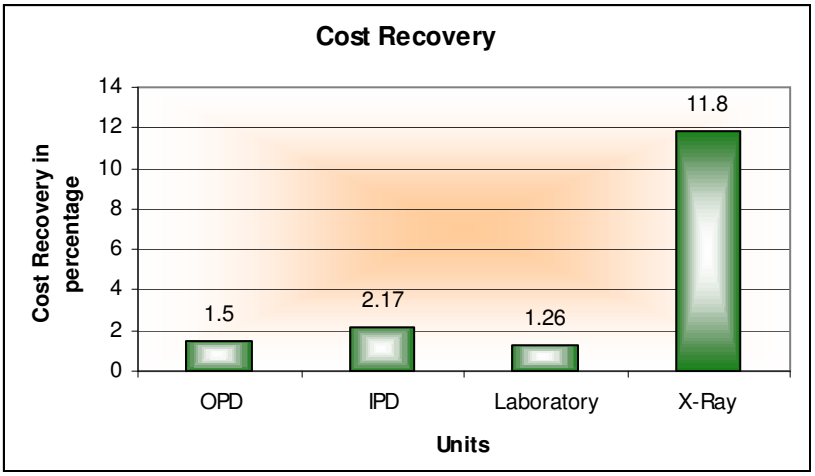
Expenditure	97-98	98-99	99-00	00-01	2001-2002	2002-2003	2003-2004	Total
Medicine	475				560			1035

Consumables	1145			3046	3682	11026	44614	63513
Total	1620			3046	4242	11026	44614	64548
Balance	1535		3370	5319	3649	25285	15092	54250

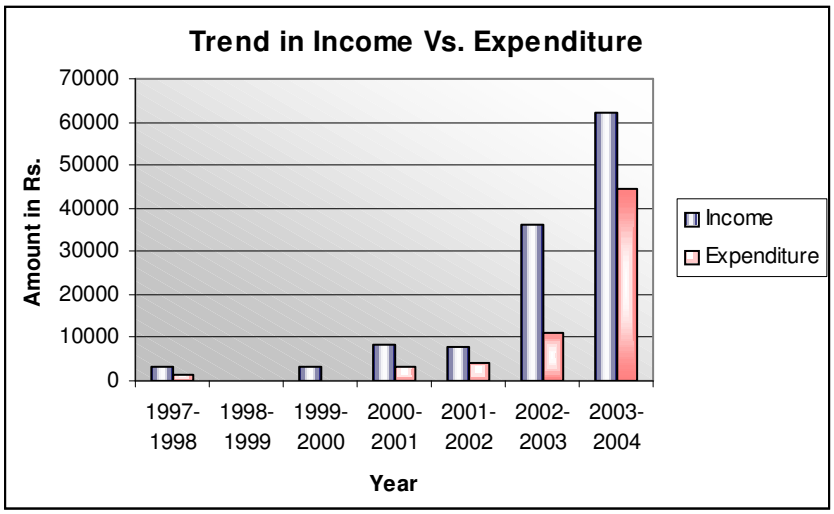


The maximum income is from X-Ray while the contributions from Indoor patients is the next higher revenue generating unit.

Cost recovery from different units –



The cost recovery through X-Ray department is maximum as implied even from the previous graph showing maximum income from the same department. However though the income generated from Indoor wards is more the expenses are also more on the indoor patients and hence the cost recovery is substantially reduced to 2%.



No income & expenditure is shown in 1998-1999, the reason is not known. In 97 though some amount has been spent it is negligible, while in 1999-2000 no money has been spent despite of contribution from the patients. The gap between income & expenditure is considerable in all the years, i.e. a huge amount is left unspent though the patients are in dire need of services.

No one is exempted from fees as it is felt that everyone should pay for health care services*. This decision is reached at unanimously by the committee as it is felt that if the BPL population is exempt from the levy everyone will try evading payment on the same pretext and there will be no source of income. It is also felt that by paying the people will be able to demand for services. Though patients are compelled to pay for the service around Rs. 62495 from their contribution is left unutilised.

The doctors are indulged in private practices and pick up medicines from sample packets as is known to many. Though the CHC is spacious there is no separate room allotted for injection administration and a corridor outside the female ward is utilised for the same. A table which is loaded with register, syringes, needles and swabs and a bench adjacent to it to make the patient lie down while administering the injection are allotted for the purpose. This is not only unhygienic but also does not allow privacy to the patients both indoor and outdoor.

Charama – Community Health Centre –

* Some patients are treated free on a special consideration from the Medical Officer.

Kanker has a population of 651333 in 7 blocks. It has 6 CHCs with each CHC covering on an average a population of 1 lakh.

OPD Clinic –

Assuming that of the total expenditure 25% is spent on OPD services the annual expenditure on OPD is Rs. 743800. The number of patients seen in 6 days (a week) is 446. If this is extrapolated the total number of out patients examined in a year can be estimated to be around 21408. Thus the expenditure per patient will be Rs. 35.

The registration charge per patient is Rs. 2 for out patient service. The revenue generated through OPD after discounting for the free patients can be estimated to be Rs. 36672. Thus of the total expenditure on Out patient services around 4.9% is recovered from the patients.

Indoor Services –

Assuming that of the total expenditure 22% is spent on IPD services the annual expenditure on Indoor patients is Rs. 654544. Thus expenditure per patient comes to Rs. 2081. This excludes the cost of X-Ray, lab investigations, and surgical procedures.

Laboratory –

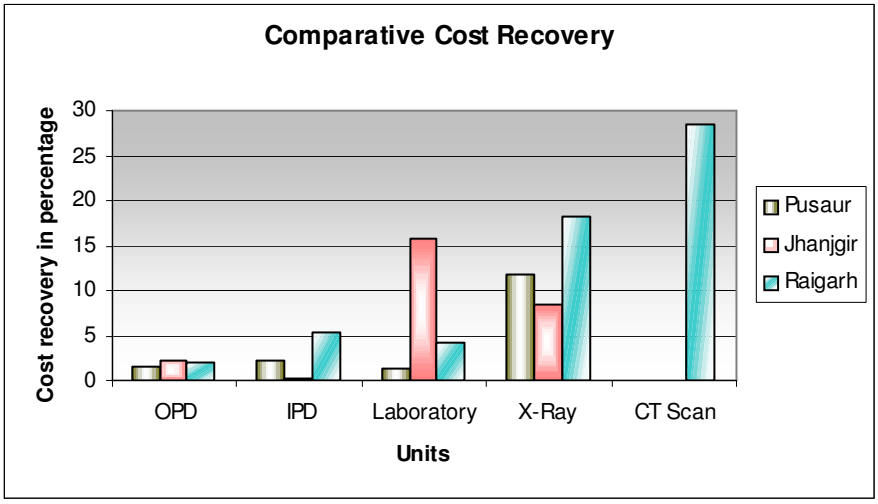
Assuming 6% of the total expenditure would be on laboratory the net expenditure comes to Rs. 178512.

As some important information was not available like the charges for various services, this section is left incomplete.

A Comparative Analysis –

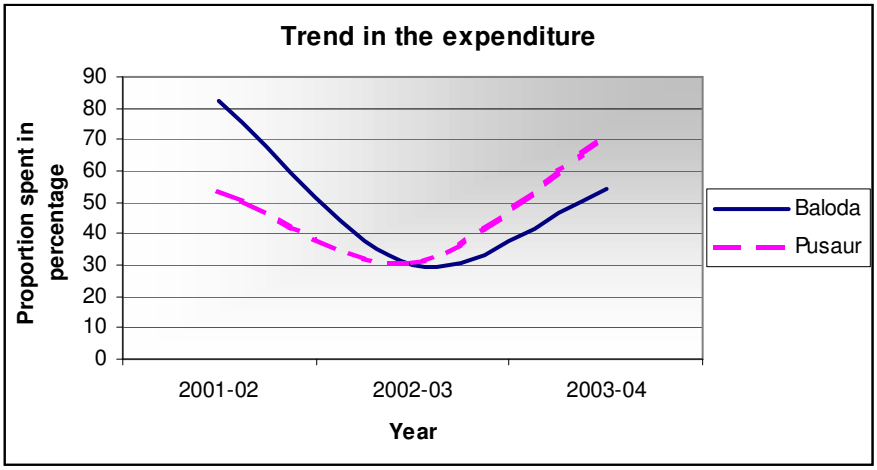
The CHCs and the district hospitals selected for the study being highly varied in terms of infrastructure, evolution, facilities, etc. serving populations of varied background in terms of

socio-economic conditions and demography they are not comparable. However a general impression gathered about the functionality of the scheme shows that the scheme has its pros and cons.



1. The cost recovery for the hospital is more from the investigative procedures like pathological tests X-Ray and Scan. This is suggestive of more patients being sent for diagnosis. Thus it can be considered as a good revenue-generating unit.

2. Not more than 72% of the contribution has been utilised in any of the hospitals, though the hospital does not seem to be self-sufficient. In the year 2003-2004, in Raigarh, Baloda and Pusaur 72%, 54% and 72% of the total contribution from the patients have been utilised. Moreover the income in all these centres are generated from patient contribution, as there is no record of any donation being received.



In the two CHCs the amount spent from the total collection dropped to mere 30% in 2002-03, which again increased in the following year.

Conclusion

The user fees are fixed on ad hoc basis by the committee/trust without considering affordability, accessibility to the service and the indirect cost incurred by the people. Some studies[3] also show that decentralization is in turn centralized at the hands of few like the dean of the hospital or the CMO and thereby leading to improvement in selective services confined to few departments which in true terms might not benefit the patient, like provision of CT Scan in a place where there is no facility for provision of basic services. A large amount of the fund collected is earmarked for maintenance of some major equipment or service, which in turn is blocking the money for some definite purpose not actually taking into consideration the immediate and the urgent needs of the poor patients.

The cost recovery from each the unit is minimal and the chief stated objective of introducing user fees is to encourage people's participation in the management of the hospital and to create a demand for fair services from the hospital. However since the power of allocation rests with few it still manifests the problems of implementation.

As there is a shortage of staff some are appointed as RKS staff but are employed on contractual basis and are paid less than others and also are devoid of other additional benefits. This has led to dissatisfaction among the staff appointed under RKS.

A list of activities[2] undertaken in a handful hospitals are commendable, but these are in few hospitals as compared to the total number of hospitals and more amount is seen to have been spent on infrastructure development, and investigative procedures which do not address the immediate needs of the patients.

As stated in one of the studies[1] the increase in the number of middle income class patients and lack of protest is seen as an evidence for acceptability & willingness to pay. This could also be attributed to the fact that people have no other option and in the time of crises they are

compelled to pay. It is also to be noted that the study shows increased utilisation by middle income patients and not by poor patients which implies that either even the poor are charged or the quality of treatment given to the poor is unaffordable. One must also be cognisant of the indirect cost to the patient, which could be another cause of not seeking service, which the scheme fails to reckon.

Some studies[2] suggest augmentation of revenue from ambulance, pathological and Investigative services. Most of the hospitals are seen doing the same, without strategizing on how these resources could be effectively spent for the benefit of the patient. It seems to be more of a revenue generation mechanism.

One of the main objectives of establishing RKS was to provide autonomy to the hospital so as to increase the efficiency. However the constitution of the committee is a clear evidence of hierarchical structure. The Executive Committee meets quarterly and the decisions have to be stalled until then. The CMO has limited power, which he/she utilises for vested interest, like lakhs of rupees are earmarked for the maintenance of CT scan in a hospital where basic sanitation is absent, and there is virtually no waste management.

Due to lack of strong civil society presence, there is no pressure for the funds to be spent for the benefit of the poorer patients or even the hospital development. A sizeable collection of user fees is used even for petty things like paying of electricity, water and telephone bills. In most of the hospitals the collected amount has been spent in buying cooler and generator which might not benefit the patients directly.

Though it was not possible to elicit minute details about the implementation of the scheme, the findings of similar schemes[5] in other states suggest–

- It increases the accountability of the hospital staff but in the absence of 'real powers'; it unnecessarily increases the burden of the staff.
- Though the resources generated are supposed to be utilised for hospital development, in bigger hospitals they are used for paying electricity bills and in smaller hospitals to buy medicines.

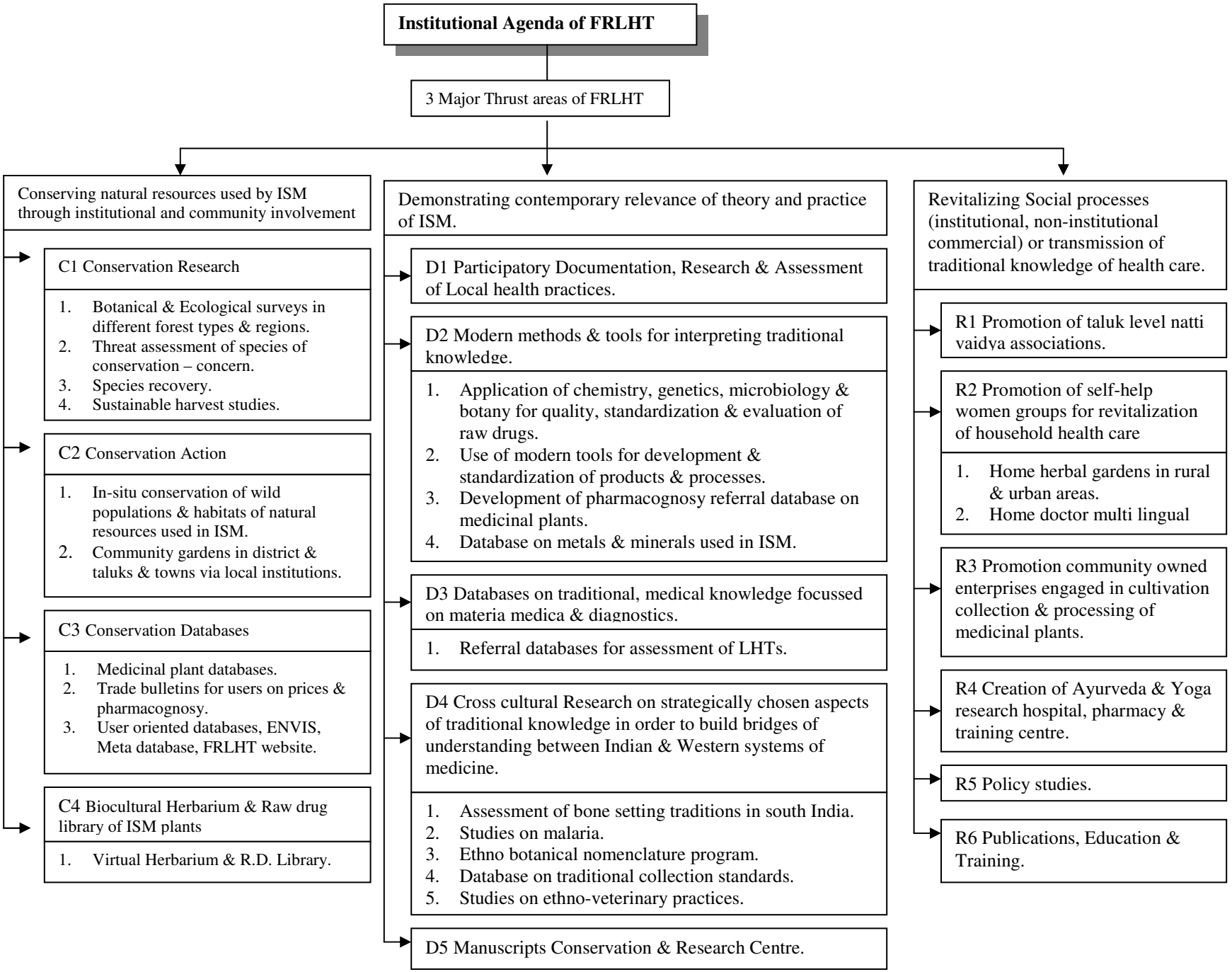
- There is very little public awareness of the functioning of the scheme and politicisation of the scheme.

Suggestions for further study –

- To analyse the utility of the services from the time of inception of the scheme.
- Detailed analysis of trends of expenditure.
- Detailed analysis of trends of user fee collection.
- Client satisfaction studies.

References –

1. RKS
2. Rogi Kalyan Samiti – A detailed report on RKS in Madhya Pradesh
3. Girish Kumar: Public Hospital Reforms in Madhya Pradesh (India)- Perceptions and trends. Paper prepared for the 18th European Conference on Modern South Asian Studies Lund University, Sweden.
4. Dr. A.S. Bapna: A Handbook for General guidelines for Rajasthan Medicare Relief Societies.
5. Initial assessment of Chikitsa Prabhadhan Samiti (CSS) in Uttaranchal.
6. Ramesh Bhat, Harshit Sinha, Dileep Mavalankar: Cost Analysis of government hospital services at block level. Case study of Community Health Centre at Sanand Taluka in Ahmedabad district, Gujarat.
7. Edited by Andrew Creese & David Parker: Cost Analysis in Primary Health Care- A training manual for program managers.


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.

Annex II

Hospital Statistics	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	2003-04
Total Hospital (Recurring) Expenditure (in Rs.)	11778979	13659395	15657684	20174342						43357817	47096029	53099414	61429549	76421671	110833821	100626988	111089631	133603411
Exp on salaries	6486499	8667032	9587067	14853003						25564619	31007992	34444903	40900626	54732951	85399007	71434584	75568503	85494653
Exp on non clinical staff										2548513	2879981	6689497	3524319	3456816	10302186	4306445	5536311	6764121
Net exp on salaries of the hospital staff	7543157	8793409	9648328	15211598	16378641	17641191	20446289	21998447	23470086	23016106	28128011	27755406	37376307	51276135	75096821	67128139	70032192	78730532
Exp on drug/food & Materials	3255719	2331837	4226261	4185029	5355059	7197537	7941211	8288331	8812656	14501202	15002319	17193001	18470793	19268099	22812049	24423177	26398518	35295908
%age exp on salaries	64	65	64	74	70	60	63	70	64	56	64	60	65	70	75	70	66	62
%age exp on drug/food & materials	28	17	28	20	23	24	24	27	24	36	34	37	32	26	23	25	25	28
Net recurring exp on the hospital	11775857	13627943	15000075	20513312	23407192	29621902	32511917	31221150	36756301	40809304	44216048	46409917	57905230	72964855	100531635	96320543	105553320	126839290
Total Indoor Adm.	13542	15274	15813	14433	15450	16543	15801	16598	17412	18823	18742	19989	22297	26755	26511	26797	27926	30476
Average length of stay	9.1	9.1	8.9	9	8.9	8.9	9.2	8.8	8.5	8	8.2	8.2	8.2	7.7	7.5	7.2	7	7
Total OP	119674	129784	133789	116329	127760	131333	133417	149647	145238	149518	164528	152556	163466	181112	185135	187624	187330	199866
Annual bed occupancy (in %)	67.4	75.7	76.4	71.3	75	80.4	79.9	80.1	80	74	82	80	89.2	86.1	84	89.3	82.5	89.6
Avg. Exp/Admission (in a ratio of 1 IP:nOP)	870	892	949	1421	1515	1791	2058	1881	2111	2168	2359	2322	2597	2727	3792	3594	3780	4162
Avg. Exp/Admission/day	96	98	107	158	170	201	224	214	248	271	288	283	317	354	506	499	540	595
Number of OP cases every Inpatient case (n)	9	8	8	8	8	8	8	9	8	8	9	8	7	7	7	7	7	7
Total bill made in Rs.															18015953	20397458	24825885	27751398
Total bill paid in Rs.															10986153	12568791	16533323	18320963
Billing pattern for the hospital (in %)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	17.9	21.2	23.5	21.9
Proportion paid															61.0	61.6	66.6	66.0

Hospital Income from the patients and insurance	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	2003-04
Health insurance - only from hospital	167619	184656	281354	352439	311864	413557	417331	576460	686445	908197	1201421	1657903	1958657	2590920	4064610	4420356	4241535	
From patients	1167355	1601414	1807101	2051512	2308700	2590183	2748525	3360841	4355619	6342060	7227403	8241586	9521835	14223825	16903960	21409144	23781868	
Total income	1365645	1822722	2129825	2456612	2682776	3074022	3245443	4024740	5137252	7350969	8539303	10025576	11626270	17036106	21187296	26059793	28532167	0
Total cost recovery from all the hospital patients	11.6	13.4	14.2	12.0	11.5	10.4	10.0	12.9	14.0	18.0	19.3	21.6	20.1	23.3	21.1	27.1	27.0	0.0
Health insurance - hospital + college	198290	221308	322724	405100	374076	483839	496918	663899	781633	1008909	1311900	1783990	2104435	2812281	4283336	4650649	4750299	
Cost recovery from all the insurance schemes	1.7	1.6	2.2	2.0	1.6	1.6	1.5	2.1	2.1	2.5	3.0	3.8	3.6	3.9	4.3	4.8	4.5	0.0

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

Annex IV

Table I

Year	Number of members		Total number of members	Amount Deposited	Total amt. c.f. from the preceeding yr	Amt. forfeited	Bal remaining	Interest accrued on the bal amt. i.e G	Rate of interest	Total deposit amt. with interest	Liability- From Table III	Deposit bal after paying the claim
	Class I,II,III	Class IV										
	A	**B**	**C=A+B**	**D**	**E**	**F**	**G=E-F**	**H=G*I**	**I**	**J=D+E+F**	**I**	**J=H-I**
1999-2000	184	118	302	102500								
2000-2001	277	163	440	213350	102500	1272	101228	20246	20%	334824	40349	294475
2001-2002	401	188	589	242807	294475	4345	290130	52223	18%	585160	136086	449075
2002-2003	461	193	654	362244	449075	8179	440896	70543	16%	873683	3144	870539
2003-2004	447	191	638	389805	870539	9063	861476	129221	15%	1380502	153981	**1226522**

Table II - Exp/Liability

Year	Premium Deposited	Rate of interest	Total Liability
1999-2000	102500		
2000-2001	213350	12%	12300
2001-2002	242807	10%	31585
2002-2003	362244	10%	55866
2003-2004	389805	6%	**55254**

Table III - Income

Year	Deposit Amt.	Interest margin	Income earned on the deposit	Deposit forfeited	Interest accrued on the forfeited amt.	Rate of interest	Total income earned	Claims	Liability
1999-2000	102500								
2000-2001	213350	8%	8200	1272	254	20%	9726	50075	40349
2001-2002	242807	8%	17068	4345	782	18%	22195	158281	136086
2002-2003	362244	6%	14568	8179	1309	16%	24056	27200	3144
2003-2004	389805	9%	32602	9063	1359	15%	43024	197005	153981
								432561	333559