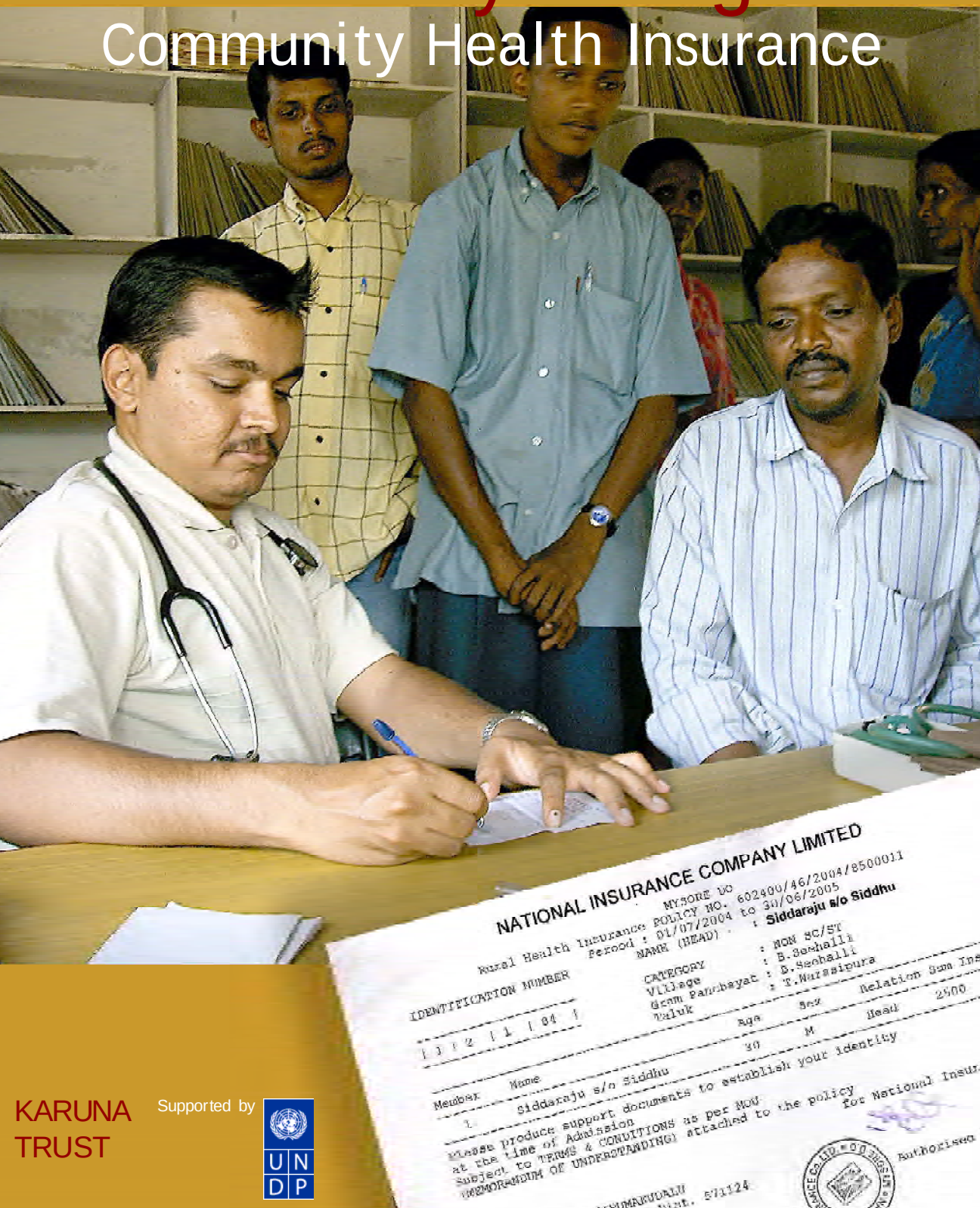
A Healthy Change

Community Health Insurance



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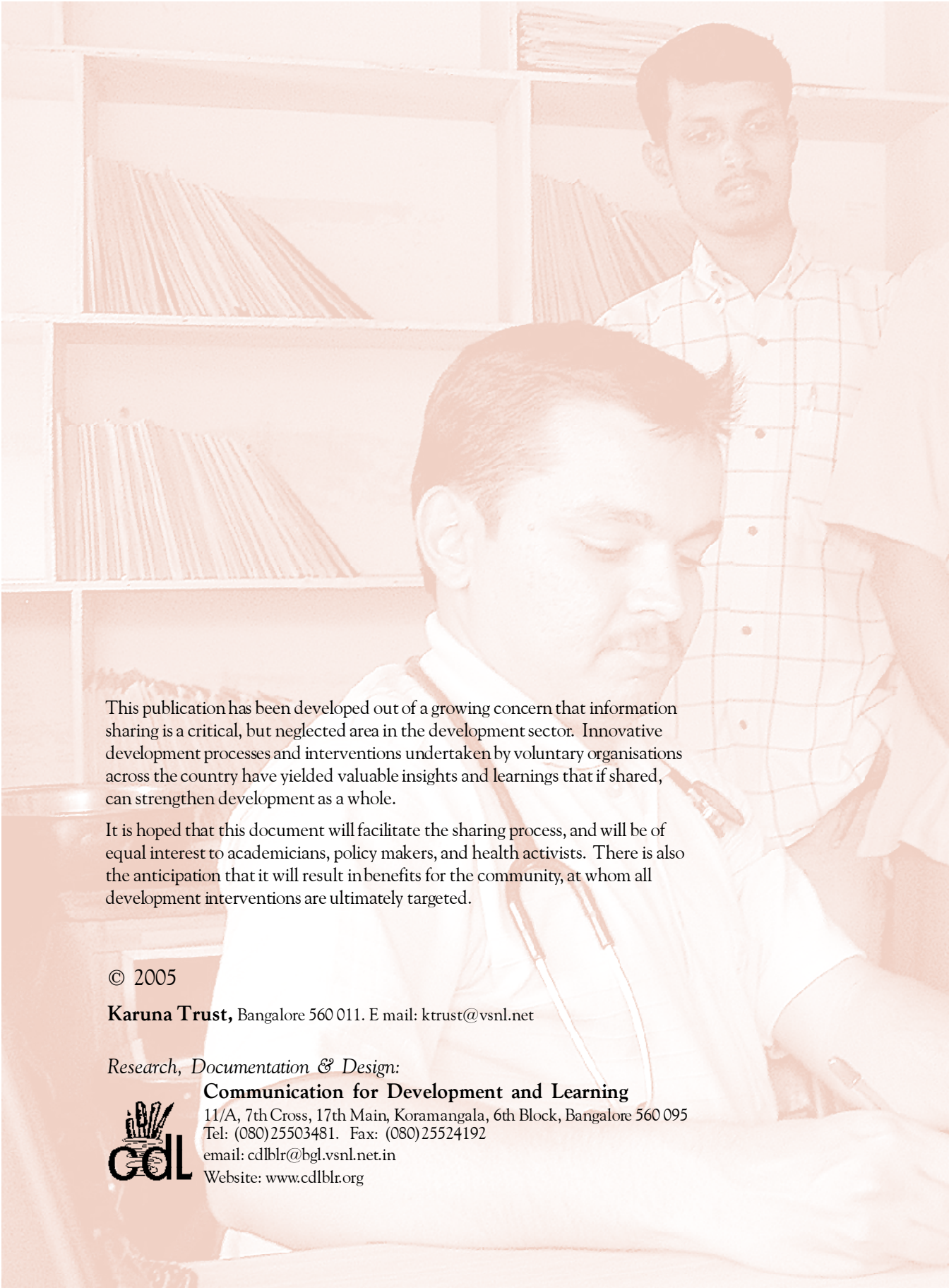

This publication has been developed out of a growing concern that information sharing is a critical, but neglected area in the development sector. Innovative development processes and interventions undertaken by voluntary organisations across the country have yielded valuable insights and learnings that if shared, can strengthen development as a whole.

It is hoped that this document will facilitate the sharing process, and will be of equal interest to academicians, policy makers, and health activists. There is also the anticipation that it will result in benefits for the community, at whom all development interventions are ultimately targeted.

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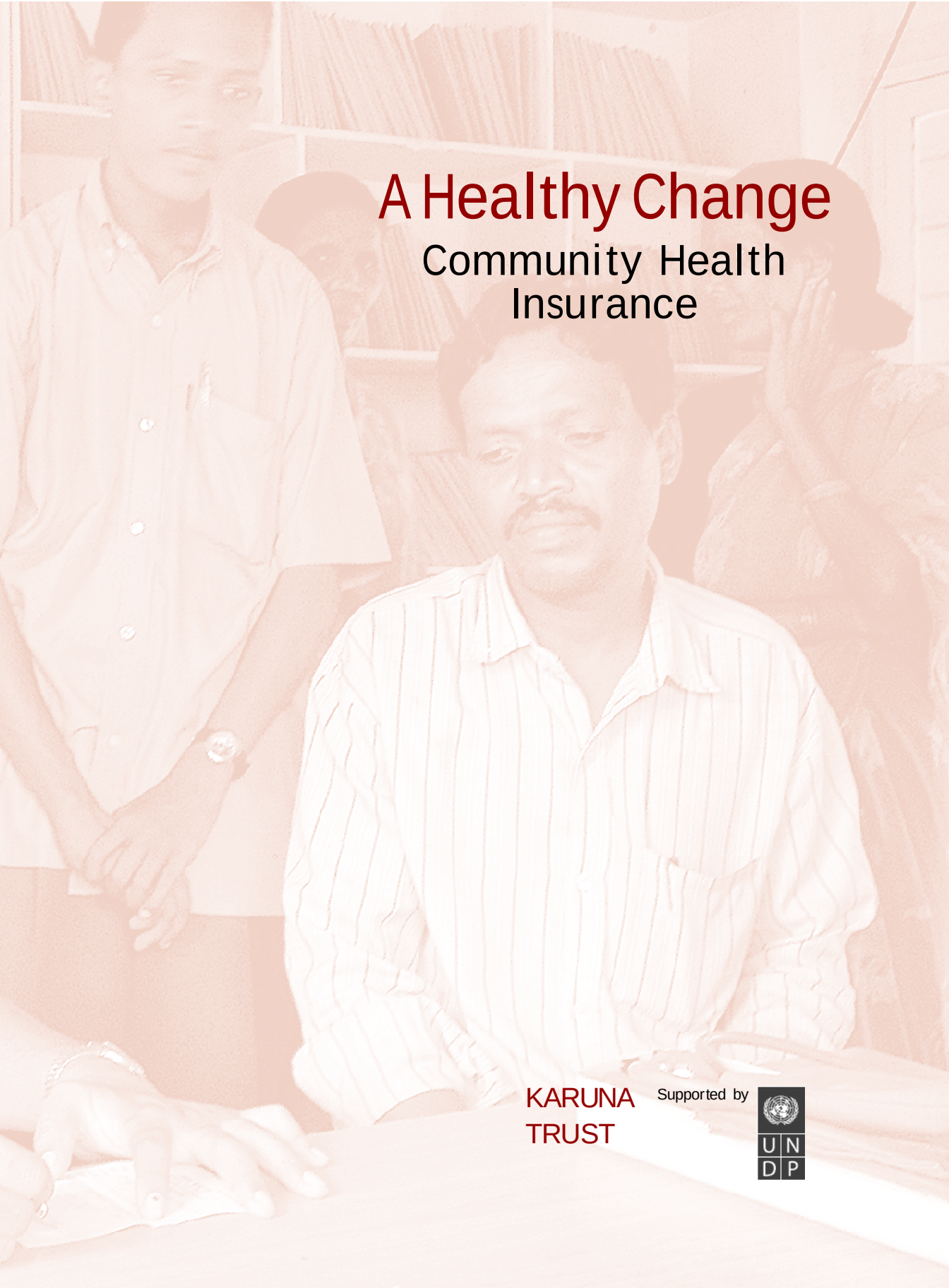

A Healthy Change

Community Health Insurance

KARUNA TRUST

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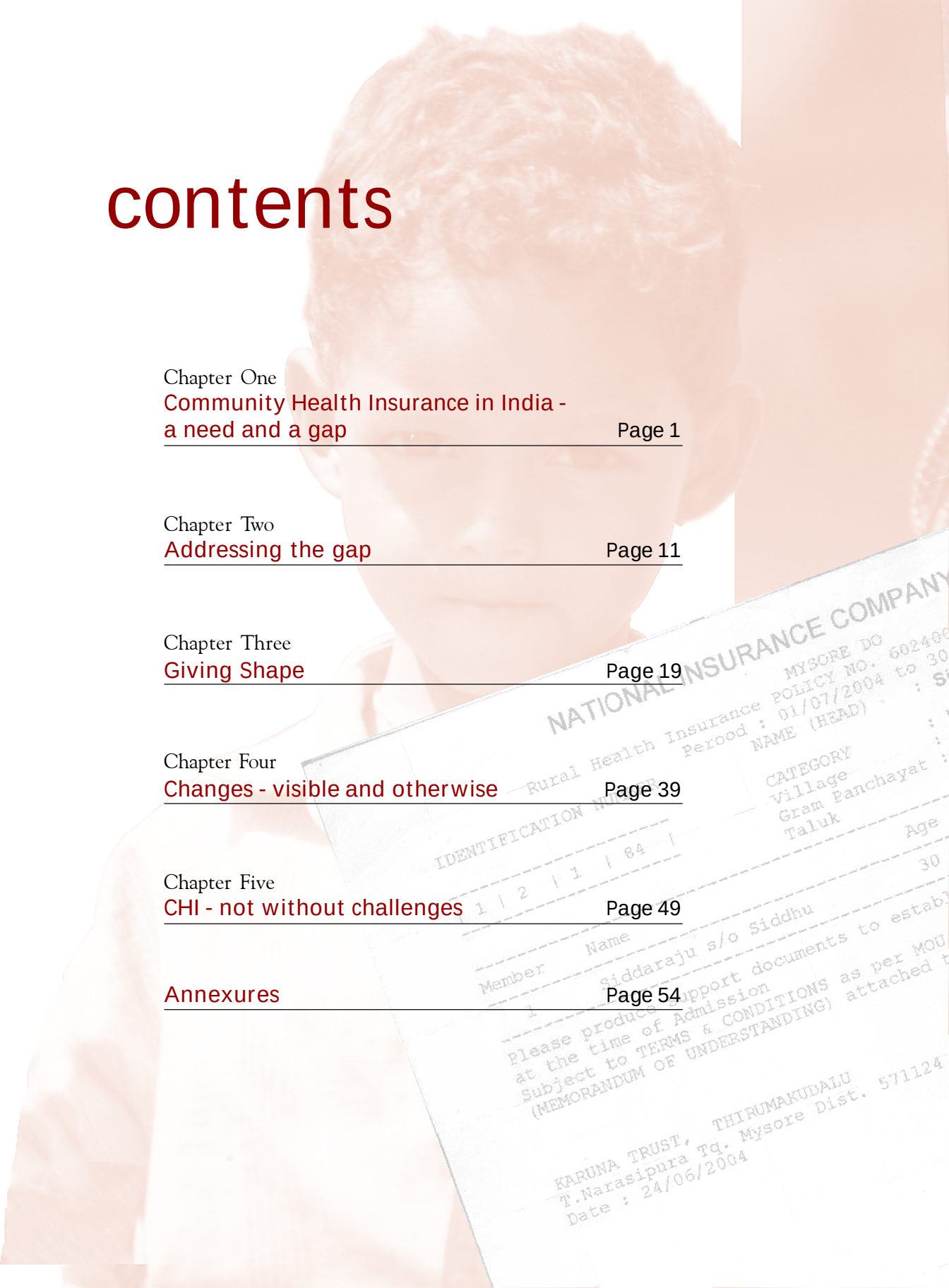
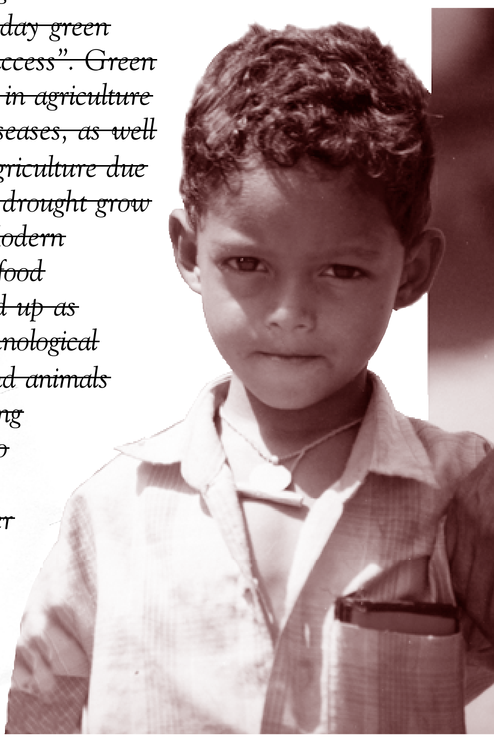
contents



letter from undp

The highly productive industrial methods of farming and food processing prevalent in the developed world that have had an overarching influence on the developing world are being questioned. Issues have been raised about overuse of chemicals and hormones, animal welfare and possible effect on human health and the environment. World food production is wedged between dichotomies of the pressure to feed the population and yet contain the erosion and exploitation of nature's capital. The loss of genetic diversity in food and agriculture, in other words referred to, as the biological meltdown is a cause for concern. It is a well-established fact that the plant and animal genetic diversity is the foundation of sustainable agricultural practices and global food security irrespective of the fact that they are used in traditional farming systems, conventional breeding or new technologies.

Genetic diversity in agriculture enables crops and animals to adapt to new pests and diseases, as well as to changing environment and climates. Diversity in agriculture due to naturally occurring genes has the ability to withstand drought grow in poor soils, resist pests and provide better nutrition. Modern agriculture is a classic example of the destabilization of food production and today green revolution has been summed up as "nothing fails like success". Green revolution was a technological solution Genetic diversity in agriculture enables crops and animals to adapt to new pests and diseases, as well as to changing environment and climates. Diversity in agriculture due to naturally occurring genes has the ability to withstand drought grow in poor soils, resist pests and provide better nutrition. Modern agriculture is a classic example of the destabilization of food production and today green revolution has been summed up as "nothing fails like success". Green revolution was a technological solution Genetic diversity in agriculture enables crops and animals to adapt to new pests and diseases, as well as to changing environment and climates. Diversity in agriculture due to naturally occurring genes has the ability to withstand drought grow in poor soils, resist pests and provide better nutrition. Modern agriculture is a classic example of the destabilization of food production and today green revolution has been summed up as "nothing fails like success". Green revolution was a technological solution



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DEPARTMENT

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DR. B.R. AMBEDKAR VEEDHI
BANGALORE-560 001

Dated 4-7-2005

MESSAGE

A UNDP sponsored pilot project on the development of a replicable model for Community Health Insurance has been in place in Karnataka since September, 2002 at T.Narasipur Taluk and in Bailahongal Taluk and later extended to Yelandur and Belgaum Taluks. The project is a unique example of public-private partnership, with the Zilla Panchayat being the implementing agency in Bailahongal and Karuna Trust being the Implementing Agency in T.Narsipur and Yelandur Taluks. The programme is an unique experience with an in-built sustainability component with the premium collection being handled by self-help groups.

I congratulate the supporting agency and the partners (UNDP, Karuna Trust, National Insurance Company and Zilla Panchayat, Belgaum) who brought these unique programmes to this State and wish them all the success in using their experience to increase the coverage of the Community Health Insurance Programme, all over the State.

The complete report of the programme with the methodology and the relevant statistics will help establish Community Health Insurance as a key to health security for the rural poor.

I once again congratulate the partners in the initiative.

(D. THANGARAJ)
Principal Secretary to Government
Health & Family Welfare Department

preface

Poverty and disease have pushed the families of the unorganized sector into indebtedness. Both macro and micro studies on the use of health care services show that the poor especially the scheduled castes and tribes are forced to spend a significantly higher proportion of their income on health care than the better off. The burden of treatment is particularly high on them when seeking in-patient care. Even when they access Public Hospitals the 'out-of-pocket' expenditure is significant. Health security for the poor has not been given enough importance and hence ill health poses a significant lifetime risk for the rural poor. Ill health and poverty thus form a vicious cycle with deleterious effects on both the health of the community and the economy of the state. The gender bias with men having better access to healthcare when compared to women due to various socio-economic and cultural reasons has also made healthcare inaccessible to rural women. The poor women, who are most vulnerable to diseases and exploitation in addition to the heavy burden of childbearing, are unable to access both the public and private hospitals.

Ms Sujatha Rao, the then Joint Secretary, Ministry of Health, and Ms. Alka Narang, UNDP approached me with the basic idea of this scheme, and I was immediately convinced that a replicable model for community health insurance was indeed possible. Centre for Population Dynamics and National Insurance Company joined the team and jointly we evolved the concept of Community Health Insurance for the poor. It is indeed unique in being implemented with the active support of the National Insurance Company, a Public Sector unit which went out of the way to include in the scheme – a wage loss compensation (first time in the country), no-exclusion (any illness) policy, immediate claim settlement and low premium rates. We wanted the public hospitals and the private – not for profit hospitals to be the service providers instead of the private sector – for profit hospitals. The project was implemented with the active assistance of an NGO in T N Pura and by the Government of Karnataka (Zilla Panchayat) in Bailhongal, Belgaum, thus demonstrating that the project is workable within the government setup also. This is even more relevant with the recent investment in upgrading secondary care public hospitals in Karnataka with World Bank assistance. It was also necessary that the huge government health care system be better utilized. The results shown are indeed encouraging. The scheme brought about a significant increase in utilization of government hospitals. Wage loss and 'out of pocket' expenditure was compensated, and access to Public Health services by women increased.

The first step was a significant step; it was a challenge. Health security to the rural masses does not involve any prohibitive costs and this has been successfully demonstrated in the TN Pura and the Bailhongal models. The next step of involving women self-help groups addresses the sustainability issue. The project has successfully shown that health security to the poor is a possibility. In its next phase, the experience gained in the implementation of the project will be extended to the whole network of 20 PHCs run by Karuna Trust and include in the policy coverage for HIV/AIDS patients also. Karuna Trust is also playing an important role formulating the Health insurance policy for the entire Karnataka state through the World Bank Aided Karnataka Health System Development and Reform Project.

Dr. H Sudarshan
President, Karuna Trust

chapter one

Community Health Insurance in India – a need and a gap

He, who has health, has hope.
And he who has hope, has everything

- Arabian Proverb

- *Mahadevi is a young woman of about 25 years. She has been admitted to the Naganur Primary Health Centre (PHC) of Bailhongal taluk, Belgaum district, Karnataka, for treatment of 20 per cent burns from a stove burst. She is likely to stay in hospital for a fairly prolonged period. While her treatment at the hospital will be free, Mahadevi will suffer from loss of wages for the days she does not go to work. She will also have to pay for any medicines that are required to be bought from outside. All of this will cost her dearly, and probably push her and her family into a vicious debt trap.*
- *Kethe Gowda, 26 is a tribal from Devarahalli near BR Hills. He is the only earning member of his family. When he developed gangrene in his left foot, it required amputation and he had to be shifted to the KR Hospital at Mysore, about 100 km away. Wage loss and out-of-pocket expenditure would normally have made it impossible for him to avail treatment. This could have had grave implications for his family.*
- *Basavaraj of Nilasoge village in T. Narasipura taluk, Mysore district, Karnataka, has a little daughter Chandusoge, aged three years, who had to be treated at K.R. Hospital in Mysore for a serious throat injury. He depends on his daily wages as an agricultural labourer to earn a living. When he accompanied his daughter to Mysore, Basavaraj was deprived of work, and his wages. He also had to spend money to buy extra medicines for her.*

Mahadevi, Rudrappa and Basavaraj hail from different geographical areas, yet they share a lot in common. They all belong to Scheduled Castes (SCs) or Scheduled Tribes (STs) and live below the poverty line (BPL)[1]. Dependent on daily wages for their most basic needs like food, a single episode of illness has the capacity to wipe out any savings or assets they might have, and push them into a perpetual cycle of debt. Incurring additional costs of purchasing medicines means sinking further below the poverty line – a situation that might be impossible to retrieve from.

However, there is a glimmer of hope in each of their lives. They are members of a unique community health insurance (CHI) programme initiated by UNDP and Karuna Trust, a local NGO, through the National Insurance Company (NIC). As members of the scheme, they will be compensated for wage loss at Rs 50 per day up to a maximum of 25 days of hospitalisation in a government Primary Health Centre (PHC) or hospital. An additional amount of Rs 50 per day will be available to them for medicines not stocked by the hospital and required to be purchased from outside.

As Basavaraj's little daughter is also insured under the scheme, he will be eligible for the cash compensation - including his wage loss while he stays in the hospital with her. This will not affect him, as it would have otherwise done. Reimbursement is immediate, thereby giving them the additional advantage of having enough money to tide over their convalescence period.

[1] As per order of the Karnataka Food and Civil Supplies Department, the BPL indicator is based on the annual income of the individual and fixed as: Rural – Rs 12,000 p.a., Urban – Rs 17,000 p.a.

Community Health Insurance (CHI) in India – a vital need

The need for effective community health insurance schemes for people living in economically challenged circumstances emerged out of several micro and macro studies conducted in recent years. These studies have shown that 30 per cent of India's population lives below the poverty line and a further 20 per cent lives marginally above it.

Poverty combined with poor nutrition and harsh living conditions makes this section of society extremely vulnerable to ill health and diseases. They traditionally live in backward, hilly or remote areas and have poor access to medical facilities, either government or private. Additionally, where government facilities are available, they are either of poor quality or not functional. This leads them to resort to expensive private medical treatment, which they can ill afford and results in indebtedness[2]. The studies clearly demonstrate that a majority of these people have been pushed further below the poverty line as a direct result of bearing the burden of medical expenses.

For instance, a survey was conducted by Centre for Population Dynamics[3] (CDP) in 2002 in Bailhongal and T. Narasipura taluks in Karnataka state among 4000 BPL households per taluk. The study reveals that in times of sickness most people from this segment resort to loans as the single largest source for meeting costs of illness and hospitalisation, followed by sale of

[2] Reliance on out-of-pocket payments is not only inefficient and less accountable than other methods of financing, it is also iniquitous to the poor on whom the disease burden falls disproportionately more, who are more susceptible to disease and who are much likely to be pushed into poverty trap (Gumber 1997, Visaria & Gumber 1994).

[3] A Bangalore based NGO

livestock or other assets. It also revealed that while the concept of insurance for other purposes e.g. vehicle insurance was familiar to them the practice, or even the awareness of insuring against illness was non-existent.

Sources for meeting health related expenditure
(T Narasipura taluk*)*

	Illness		*Hospi-talisation*		*Maternity expenses*		*Family planning*		*Death*	
	Rs	*Per cent*	*Rs*	*Per cent*	*Rs*	*Per cent*	*Rs*	*Per cent*	*Rs*	*Per cent*
Own money	*129*	*14.86*	*16*	*10.19*	*23*	*25.56*	*7*	*22.58*	*4*	*14.29*
Property sold	*33*	*3.80*	*8*	*5.10*	*3*	*3.33*	*0*	*0.00*	*1*	*3.57*
Livestock	*46*	*5.3*	*28*	*17.83*	*4*	*4.44*	*0*	*0.00*	*3*	*10.71*
From relatives	*38*	*4.37*	*23*	*14.65*	*1*	*1.11*	*2*	*6.45*	*2*	*7.14*
Any scheme	*6*	*0.69*	*3*	*1.91*	*2*	*2.22*	*1*	*3.23*	*0*	*0.00*
Loan	*616*	*70.97*	*79*	*50.31*	*57*	*63.33*	*21*	*67.74*	*18*	*64.29*
Total	*868*	*100.00*	*157*	*100.00*	*90*	*100.00*	*31*	*100.00*	*28*	*100.00*

The reality

Despite the critical need for community health insurance, evidence actually points to the fact that there are very few options available. As per a report in Economic and Political Weekly[4],

"…According to the World Health Organisation, greater than 80 per cent of total expenditure on health in India is private (figure for 1999-2001 [World Health Organisation 2004]) and most of this flows directly from households to the private-for-profit health care sector.

Most studies of health care spending have found that out-of-pocket spending in India is actually progressive, or equity neutral; as a proportion of non-food expenditure, richer Indians spend marginally more than poorer Indians on health care. However, because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it.

On an average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill [Peters, Yazbeck et al 2002]. Aside from cases where people believed that their illness was not serious, the main reason for not

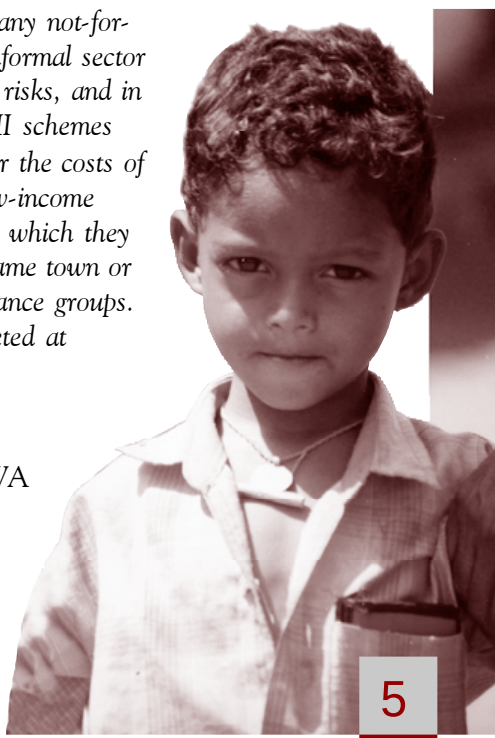
[4] Excerpt from 'Community Health Insurance in India – An Overview', by N Devadasan, Kent Ranson, Wim Van Damme, Bart Criel - Economic and Political Weekly, July 10, 2004.

seeking care was cost. The richest quintile of the population is six times more likely than the poorest quintile to have been hospitalised in either the public or private sector [Mahal,Singh et al 2000]. Peters et al (2002) estimated that at least 24 per cent of all Indians hospitalised fall below the poverty line because they are hospitalised, and that out-of-pocket spending on hospital care might have raised by 2 per cent the proportion of the population in poverty [Peters, Yazbeck et al 2001] …"

A gradual shift

The situation however, is gradually changing. The EPW report continues

"… Given this context, health insurance appears to be an equitable alternative to out of pocket payments. In recent years, community health insurance (CHI) has emerged as a possible means of: (1) improving access to health care among the poor; and (2) protecting the poor from indebtedness and impoverishment resulting from medical expenditures. The World Health Report 2000, for example, noted that prepayment schemes represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes (World Health Organisation 2000). Various other terms are used in reference to community health insurance, including: 'micro health insurance' [Dror et al 1999], 'local health insurance' [Criel 2000] and 'mutuelles' [Atim C 2001]. We define CHI (along the same lines as [Atim 1998]) as "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." CHI schemes involve prepayment and the pooling of resources to cover the costs of health-related events. They are generally targeted at low-income populations, and the nature of the 'communities' around which they have evolved is quite diverse: from people living in the same town or district, to members of a work cooperative or micro-finance groups. Often, the schemes are initiated by a hospital, and targeted at residents of the surrounding area…"



Some CHI schemes currently in operation include efforts initiated by Karuna Trust in Karnataka, SEWA in Gujarat, Narayana Hrudayalaya and the Government of Karnataka in Karnataka, and the Universal Health Insurance Scheme of the Central Government. Targeted at the rural as well as urban poor, predominantly BPL population, each of the schemes is designed differently and includes various needs, such as hospitalisation, surgery, medication etc.

Health Insurance Models at work

SEWA

Self Employed Women's Association (SEWA), based in Ahmedabad offers an integrated insurance package with health insurance as a major component to its members. 1,03,000 members are covered under this plan. Begun in 1992, the insurance scheme covers life, health and asset insurance.

The main features:

- Age restriction – 18 to 60 years of age for life insurance, up to 70 years for health and asset insurance
- Minimum hospitalisation – 24 hours
- First year exclusions – hysterectomy, piles, cataract, hernia etc
- Pre-conditions for reimbursement of treatment of pre-existing diseases
- Premiums vary between Rs 85 and Rs 400 per annum

Yashasvini Health Scheme

Yashasvini is an insurance scheme launched by Narayana Hrudayalaya, Bangalore. Approved by the Government of Karnataka and implemented and administered by Family Health Plan Limited, the objective of Yashasvini is to provide healthcare services to the farming community of Karnataka and make quality treatment available and accessible to the poor.

The main features:

- Self funded scheme catering to the surgical needs of the farmer community
- Farmers and their families registered with any co-operative society, *grameen* bank etc eligible to become members by paying Rs 60 per annum per person as premium
- Corpus generated out of member's contribution and government contribution of Rs 30 per annum placed with the Yeshasvini Trust for disbursing payment towards entitled services as per the scheme
- Cashless treatment for beneficiaries at 80 recognised hospitals across the state
- Beneficiaries entitled to1600 surgical procedures with an annual coverage of Rs 2 lakhs, and a cap of Rs 1 lakh per procedure
- Free outpatient consultation by a physician at the identified network hospital and discounted rates for outpatient investigation and specialist consultations

Universal Health Insurance Scheme

Launched by the Central Government, the Universal Health Insurance Scheme aims to provide health cover for all, particularly the poorer sections of society.

The main features:

- Age limit – 3 months to 65 years
- Premium – Re 1 per day
- Premium subsidy for BPL families
- Wage loss compensation of Rs 50 per day during hospitalisation up to 15 days
- Reimbursement of medical expenses up to a total of Rs 30,000, which can be utilised by one or all members of the family
- Coverage of Rs 25,000 for accidental death of earning head
- Treatment can be availed at low cost hospitals, government and trust hospitals

Exclusions

- All pre-existing diseases
- Diseases contracted within 30 days of coverage
- Primary diagnostic expenses
- Pregnancy, childbirth etc
- Congenital diseases that the insurer is aware of

Arogya Raksha Yojana

Biocon and Narayana Hrudayalaya in association with Karuna Trust and ICICI Bank have initiated Arogya Raksha Yojana (ARY), a CHI scheme in Anekal taluk. The scheme presently covering six lakh people is limited to Anekal. There are plans to extend the scheme across the state. The ARY centre at Huskur village in Anekal has a clinic, herbal pharmacy and an office attached to it.

Salient features:

- Multi-layered premium structure depending on the number of family members enrolling e.g. Rs.120/person/year for a family of six members, Rs150/person/year for a family of three, and Rs 180/person/year for a family of two
- Ward charges, consultation and testing free for three days for a patient who gets admitted under the scheme
- Network of hospitals at the service of registered members
- Free hospitalization of a maximum of three days per year for a person for medical assistance and surgery. Life saving medicines at subsidized rates
- Free registration and counselling
- Diagnostic facilities at subsidized rates
- Eligibility criteria for registering under this scheme – restricted to residents of Anekal below 70 years of age.

"The need for CHI in India is beginning to be felt, and some efforts have been made towards providing health security to the disadvantaged sections of society. But it is a complex situation and before attempting to initiate CHI in T Narasipura and Bailhongal, we had to first address other issues such as poor awareness on health in general, and health insurance in particular," says Dr H Sudarshan, President, Karuna Trust.

Karuna Trust had learnt down the years that health in general took low priority among the underprivileged, particularly women, as they had other, more severe and pressing concerns like livelihood to address. Finding the money for medical treatment was a daunting task for them, and often led to indebtedness. Added to this was the fear they had of losing their wages when they were sick and had to seek treatment. This often caused them to ignore their illness and continue working, sometimes till it was too late.

Therefore parallel to introducing and establishing the importance of timely medical care, Karuna Trust had to generate awareness among the community that insurance could address and solve these problems. The other important factor that had to be considered was their inability, or reluctance to pay for CHI.

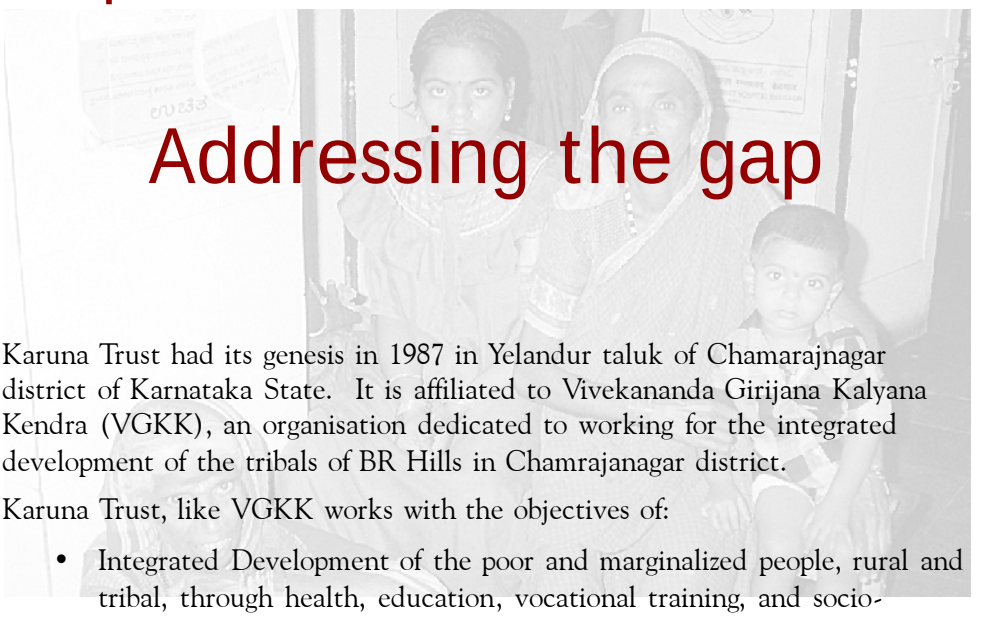
As Honappa of Kuragund village in Bailhongal taluk recalls, "I am a coolie, barely able to fulfil the bare subsistence needs of my family. When my son fell sick, I tried getting him treatment locally and spent whatever money I had. Treatment at a private hospital was not possible, as it would cost a lot of money, which I did not have. Taking him to the PHC, which was far from my house, meant loss of work and wages for me, and starvation for the whole family. We also felt that treatment at a government hospital was not satisfactory. I saw

him suffering, and wondered what hope there was for people like us……"

With the aim to provide a comprehensive CHI service towards developing a replicable model, a pilot project was initiated in two taluks in the state. Implemented by Karuna Trust with support from UNDP, the project was undertaken in partnership with National Insurance Corporation and the Government of Karnataka (Directorate of Health and Family Welfare).

The pilot CHI project was implemented in T Narasipura and Bailhongal taluks of Mysore and Belgaum districts in September and October 2002 respectively. In the second phase, the operational areas were extended to cover Belgaum taluk and Yelandur taluk in BR Hills in Belgaum district and Chamrajanagar district respectively. The project closed in 2005.

chapter two



Addressing the gap

Karuna Trust had its genesis in 1987 in Yelandur taluk of Chamarajnagar district of Karnataka State. It is affiliated to Vivekananda Girijana Kalyana Kendra (VGKK), an organisation dedicated to working for the integrated development of the tribals of BR Hills in Chamrajanagar district.

Karuna Trust, like VGKK works with the objectives of:

- Integrated Development of the poor and marginalized people, rural and tribal, through health, education, vocational training, and socio-economic programmes
- Empowering rural poor to organise themselves and work towards achievement of a self-reliant community

Karuna Trust was established primarily to address leprosy eradication in the area, as Yelandur taluk was hyperendemic in leprosy, with a prevalence of 21.4 per cent[5] in 1987. It has over the years expanded both, its geographical spread as well as areas of activities. Its activities now span health, education, and integrated rural development. In 2005, Karuna Trust has a strong presence in the state with one PHC adopted in every district, impacting over 4,00,000 people. Karuna Trust initiated the CHI project as an extension of its health-related activities.

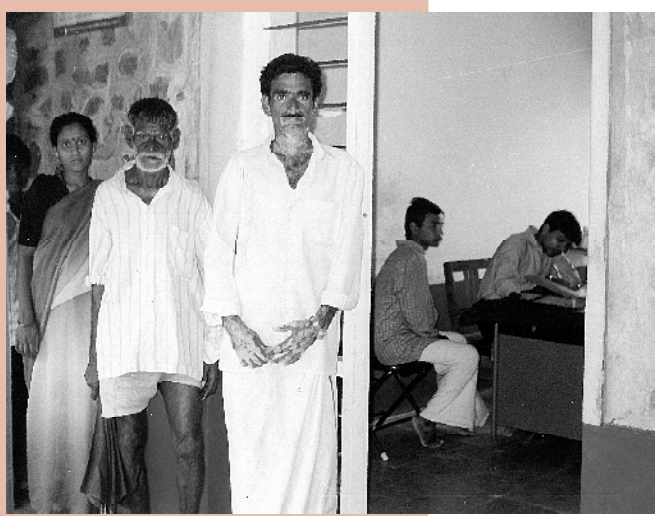
Dr Sudarshan contextualises Karuna Trust's foray into CHI, "Through Karuna Trust we had made considerable inroads in the health sector in the area. We were aware of the health problems that the local population was facing as well as their inability to pay for curative services. We had also learnt in the course of working with them that the government health infrastructure was largely unutilised due to negative perceptions about its quality. On the one hand, we saw a demand for low-cost health services, on the other an infrastructure that

[5] Anubhav – Experiences in Health and Community Development. A VHAI publication on Vivekananda Girijana Kalyana Kendra.

Karuna Trust

Areas of activities

1	Leprosy, Epilepsy and Tuberculosis Control Programme
2	Community Mental Health
3	Community based Rehabilitation Programme
4	Community based eye care
5	Cancer Detection Programme and Community dental health
6	Prevention and treatment of Anaemia and Asthma care
7	HIV/AIDS awareness programmes
8	Diabetes and hypertension programme
9	Tribal ANM programme
10	Tribal education and Integrated development
11	Empowerment of Rural Poor for better health
12	Rajiv Gandhi National Drinking Water Mission Project
13	Home hygiene and water security project
14	Total sanitation campaign
15	Total Management of 20 PHCs
16	Community Health Insurance scheme



was equipped to, but for various reasons, was not able to satisfy the demand. In order to ensure that the infrastructure was used and to avoid duplication of facilities, it was evident that it could, and in fact, should be integrated into the implementation of a successful CHI programme. In view of the fact that we had established a rapport with the local people, we were confident about initiating the programme in our areas."

Community Health Insurance Financing – the programme, its components

The CHI pilot project was initiated as a partnership between UNDP, Karuna Trust, National Insurance Corporation and the Government of Karnataka (Directorate of Health and Family Welfare). Started in September 2002, its operational areas were extended in 2003 and 2004. The project ended in 2005.

The stated objectives of the project were to:

- Improve access to medical care among the rural poor through prepaid health insurance
- Enhance awareness of the need for primary health care
- Increase use of primary health care facilities
- Develop and test a model of Community Health Financing, suited to the rural community
- Sensitise communities to the scope of health insurance
- Develop a system for interface with the organised insurance sector
- Involve community based organisations (CBOs) such as Self Help Groups (SHGs), Village Development Committees (VDCs), Panchayati Raj Institutions (PRIs), Co-operative societies etc in CHI schemes

The scheme itself was simple. Beneficiaries would be given health insurance cover for a premium of Rs 30 per person, per annum. The most important component of the CHI scheme was the wage loss component. It provided for the compensation of wages to the beneficiaries at Rs 50 per day for every day of hospitalisation up to 25 days as also Rs 50 per day for medicines not provided by the hospital. The funding from UNDP covered the cost of

the premiums while wage loss compensation and cost of medicines came from the insurance cover itself.

The phases, the people

The project was conducted in a phased manner. The initial phase was implemented in 210 villages of T Narasipura taluk, Mysore district and 112 villages of Bailhongal taluk, Belgaum district. The second i.e. extension phase consisted of 40 villages of Yelandur taluk, 57 *podus* of B R Hills, Chamarajanagar district, and — villages of Belgaum taluk, Belgaum district.

Among the SC/ST population, several criteria were further defined to ensure maximum benefits for those who needed this most. The categories of people that emerged are:

- Landless labourers
- Rural self-employed population
- Small and marginal farmers

Pilot Project Phase 1

Name of area	Period
T Narasipura	1 September 2002 to 31 August 2003
Phase I Extended	
Bailhongal	1 October 2002 to 31 September 2003
Chamarajnagar	1 April 2003 to 31 March 2004
Belgaum	16 June 2003 to 15 June 2004
Phase II	
T Narasipura	1 June 2004 to 30 May 2005
Chamarajanagar	1 January 2005 to 31 December 2005
Bailhongal	1 January 2005 to 31 December 2005
Belgaum Taluk	1 January 2005 to 31 December 2005

The partners – their roles

UNDP	Funding agency
Karuna Trust, Yelandur	* Implementing agency – T Narasipura, Yelandur and B R Hills
	* Monitoring agency – Bailhongal and Belgaum taluks
Zilla Panchayat, Belgaum	Implementing agency – Bailhongal and Belgaum taluks
	Government of Karnataka (Directorate of Health and Family Welfare)
	Healthcare service providers through PHCs and government hospitals
National Insurance Company	Insurance provider
Centre for Population Dynamics	Baseline survey

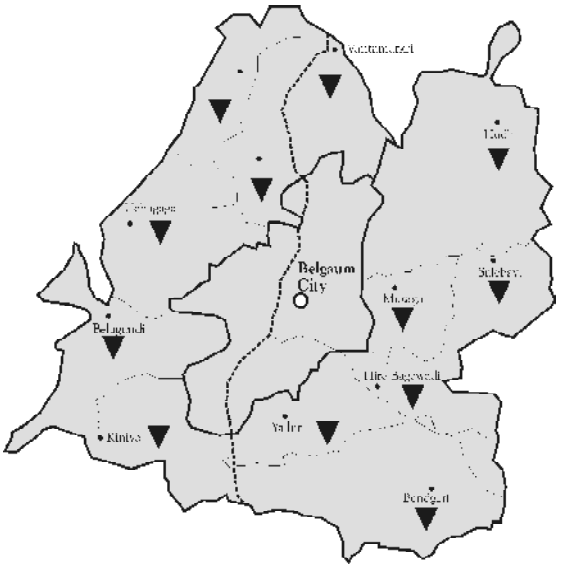
- Unorganised agricultural labour class with seasonal employment
- Labourers engaged in building construction
- Forest dwelling tribes

Two models at work – a strategic requirement

An important feature of the CHI project was the clause that stipulated compulsory use of government healthcare facilities. In order to ensure complete government participation, as well as demonstrate the benefits of public/private partnership, the programmes designed two models from inception of the project.

- In T Narasipura, Karuna Trust was the implementing agency.
- In Bailhongal, the zilla panchayat took on the role of the implementing agency, while Karuna Trust restricted itself to monitoring the programme and ensuring smooth flow of funds for the activities.

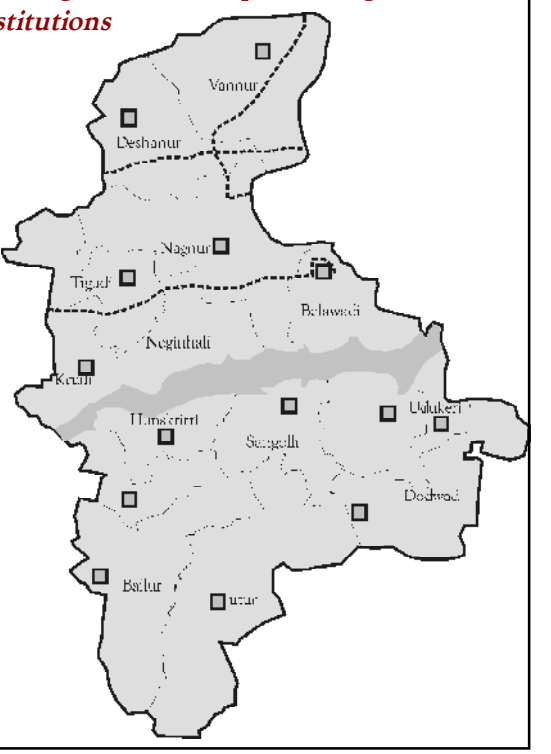
Map showing Belgaum Taluka Location



• The model at Bailhongal was also to be tested for possible replication in areas where NGOs with established credibility were not present.

The strength of the Bailhongal model lay in the fact that the implementing agency, the zilla panchayat was a part of the system. The CHI scheme needed to be integrated into existing health programmes. As the monitoring agency, Karuna Trust was responsible for providing funds to the zilla panchayat to settle the claims of beneficiaries before they could be discharged from hospital. This entailed a strong working relationship between the two.

Bailhongal Taluka Map Showing Health Institutions



"Each partner had its own strengths and applied them in its respective areas," says Dr S.C. Dharwad, District Health and Family Welfare Officer, Belgaum. "The government is always a willing partner in schemes that look at the larger good. As the implementing agency, we had entered into a unique partnership with

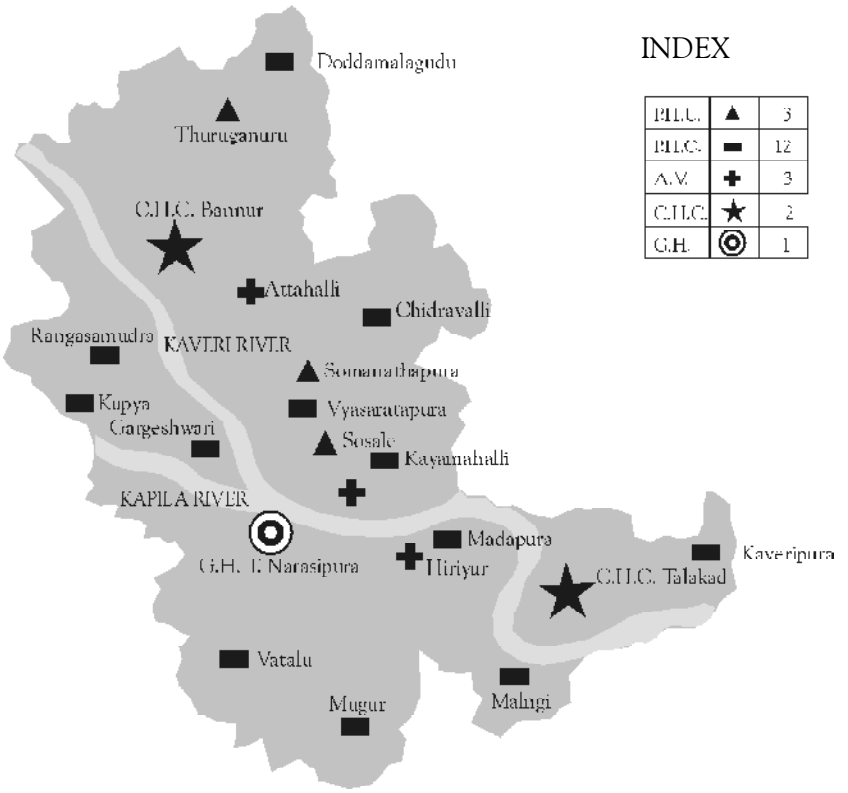
Karuna Trust, which was a private entity, and despite procedural and other limitations, we were determined to make the partnership work."

In T Narasipura however, Karuna Trust was the external implementing agency. It therefore had to work intensively to establish a rapport with the PHCs and government hospitals. This was essential in order to ensure smooth service delivery for the beneficiaries.

Special attention was given to community involvement. Both models worked with Gram Panchayat functionaries to spread awareness and influence the community on the benefits of CHI. Additionally Karuna Trust used community platforms like Self-help Groups (SHGs), Village Development Committees (VDCs) and Village Health Committees (VHCs) to spread awareness about CHI.

Different approaches and strengths notwithstanding, the two models have attempted to establish a working model of CHI, which is driven and can be sustained by the community. To understand the working of the model…

T. Narasipur taluk of Mysore district



chapter three

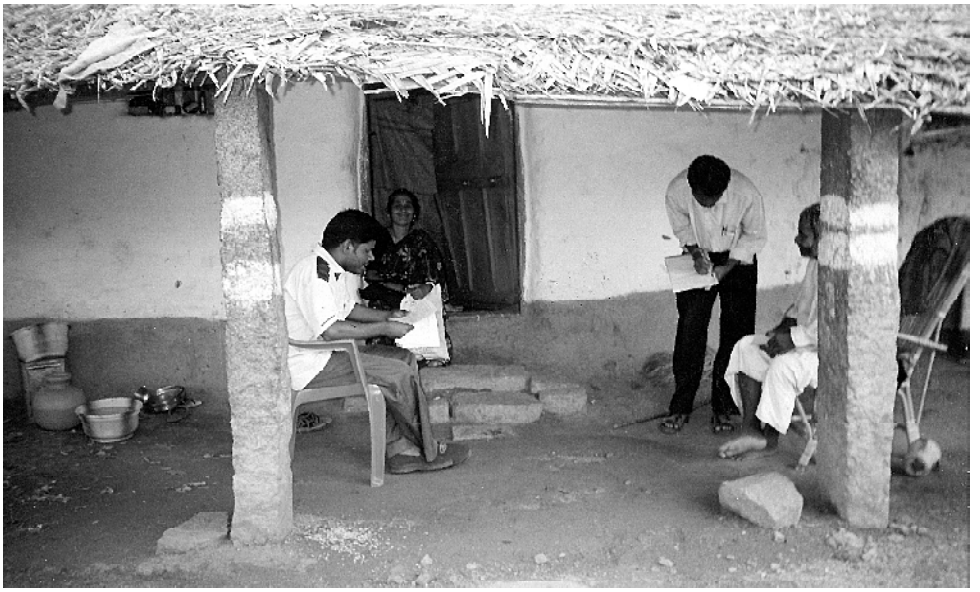
Giving Shape

The CHI project in T Narasipura and Bailhongal were started with the long-term objective of establishing two replicable, working models that could be sustained and managed by the community with the insurance company as the major partner.

The activities of the programme started with a baseline survey and were common to both models and geographical areas. These included activities related to:

Implementation

- Baseline survey
- Design of the CHI scheme
- Awareness generation
- Enrolment and facilitation of claims
- Extension of operational area



Consolidation

- Building sustainability
- Herbal gardens to promote preventive care

To facilitate effective implementation, Project Implementation Committees were set up in both areas at the taluk and district levels. They consisted of members drawn from the zilla panchayat, the implementing agency, and the taluk health office. The committees were responsible for monitoring and implementing the scheme.

District level committee

Chairman – Chief Executive Officer, zilla panchayat

Members

- Deputy Secretary (Administration) zilla panchayat
- District Surgeon
- Deputy Director, Child Development Project
- Executive Officer, Taluk Panchayat
- NIC representative
- Karuna Trust representative
- Member Secretary, District Health and Family Welfare Office

Taluk level committee

Chairman – Executive Officer, Taluk Panchayat

Members

- Administrative Medical Officer, General Hospital
- Administrative Medical Officers of designated CHCs
- Medical Officers of the designated PHCs
- Child Development Project Officer
- NIC representative
- Project officer, Karuna Trust
- Member Secretary, Taluk Health and Family Welfare officer

They were also responsible for overall monitoring of the programme. This included the number of beneficiaries enrolled, issue of identity cards, settlement of claims, accounting of sums allocated to the hospitals as part of insurance payments, overseeing the operation of the revolving fund allocated to the designated public health institutions etc.

"By involving the health department officials, representatives from NIC and the implementing agencies in the committee, we ensured that at all times there would be interaction and cooperation among all the stakeholders. This would enable better implementation," says Dr Sudarshan. "This was also an

opportunity for us to increase interaction between the general population and the government healthcare functionaries, an important factor while seeking to change the negative perceptions people had about PHCs and government hospitals."

Baseline survey

The survey, designed and facilitated by CPD, covered a sample population of about 4,000 households per taluk to determine health status and other elements relevant to the objectives of the project. With particular reference to the health delivery system and insurance, it sought to explore use of health care facilities, health insurance awareness, reasons for non-enrolment, problems encountered in using a health insurance scheme, willingness to enrol in existing plans, perceptions about new health insurance schemes etc.

The staff of Karuna Trust conducted the survey in T Narasipura taluk, while ANMs and *aanganwadi* workers (AWWs) took this responsibility in Bailhongal taluk. PHCs and hospitals were also included in the survey to determine the availability of drugs and other facilities. CPD additionally held the role of overall supervision of both areas while the survey was underway.

Intensive training was given to the staff on how to conduct the survey. Senior personnel from CPD and officials of the Department of Health and Family Welfare office served as resource persons for the training programmes. This was followed by a day's field orientation to minimize errors. Interview techniques, establishing rapport with respondents and eliciting unbiased information were the main aspects of the training.

Training helped in other ways as well. Pauline Mascarenhas, ANM, Uchgaon PHC, Bailhongal taluk says, "In the course of my work as an ANM, I used to

Health seeking patterns in T Narasipura and Bailhongal

	T Narasipura	Bailhongal
Treatment	Per cent	Per cent
Self treatment	32.0	8.2
Home remedies	34.2	14.1
Private homeopathic doctor	16.3	18.9
Govt homeopathic doctor	12.7	8.4
Private ayurvedic doctor	14.8	10.9
Govt ayurvedic doctor	88.3	58.5
Private allopathic doctor	89.2	58.1
Govt. allopathic doctor	2.1	5.8
Quacks	43.8	34.3
Folk medicine	68.5	19.3
Chemist shop	13.9	13.2
Rural health paramedics	8	3.7

Comparison between the expenditure incurred at a private hospital and a government hospital in T Narasipura and Bailhongal

Heads of expenditure	T Narasipura		Bailhongal	
	Private 14.5 days	Government 11 days	Private 15 days	Government 12 days
Consultation expenses and drugs supplied	338	193	342	192
Drugs purchased outside	313	180	263	218
Diagnostic charges	227	135	262	158
Cost of travel for patient	149	132	142	119
Cost of travel for escort	158	143	192	145
Cost of additional items prescribed	192	130	184	152
Wage loss of escorts of patient	302	182	325	196
Wage loss of escorts of escort	375	290	375	272
Speed money	75	114	84	112
Other expenses	275	118	280	146
Total cost	2404	1617	2449	1710
Average cost per day	165.79	147	163.3	142.5

Knowledge and perception of health insurance in T. Narasipura and Bailhongal

Kind of insurance	T Narasipura Percentage of Awareness	Bailhongal Percentage of Awareness
Life insurance	29.5	28.8
Vehicle insurance	4.1	11.6
Property insurance	2.3	6.9
Fire/theft insurance	1.7	4.7
Health insurance	7	49.2

Reasons for not availing insurance in T Narasipura and Bailhongal

Reasons	T Narasipura In percent	Bailhongal In percent
Too expensive	9.09	19.66
High premium	11.36	8.64
Why pay before falling sick	15.91	8.28
Low coverage for health services	9.09	7.32
Complicated schemes	11.36	9.01
Prefer paying for consultation	4.55	9.10
No trust in insurance	11.36	10.1
Hassles of claiming	2.27	4.57
Others	2.27	13.58
Cannot say	22.74	9.83

meet the very people I later interviewed for the survey. It was only after being trained in survey formats that we were able to look in depth into their problems. We learnt so much more about them this way. In the course of the survey, I was often able to identify people who needed urgent medical attention and had not sought it for various reasons."

"We knew that people were suffering due to ill health and the inability to pay for quality treatment. It was only through the survey however, that we understood the depth and scale of the problem," says Mr Shashikanth, Programme Coordinator - Health, Karuna Trust. "On the other hand, when we surveyed PHCs and hospitals, we understood that government doctors

sometimes worked under severe limitations and it was not always the lack of will that prevented them from providing service. They were often faced with paucity of drugs, lack of qualified staff and other facilities. This affected the quality of service that they were able to offer. For instance, in the course of the survey, we learnt that against a requirement of about 60,000 paracetamol tablets per year, government regulations allowed for a supply of only 10,000 to each PHC."

"We also used the period of survey to spread awareness about the insurance scheme and get a grip on the other problems that the people were facing. We almost always came up against disbelief when we introduced the scheme," adds Mr Pandu Kumar, Social Worker, Health Insurance, Karuna Trust. "People initially refused to believe that some scheme would actually pay them compensation for wages lost during hospitalisation."

Malligamma, resident of Vyasarajapura village in T Narasipur taluk and SHG member says, "When the Karuna Trust staff came to our house asking us what we knew of insurance, we were completely unaware that such schemes existed. Even though facilities at PHCs were free, we were always asked to buy our own medicines. When my son was admitted to a PHC recently for fever, we not only had to spend money on medicines, he could not go to work and lost a week's wages. Initially I found it hard to believe that insurance could give us so many benefits."

Design of the CHI scheme

National Insurance Company (NIC), a leading government owned insurance company was the insurance provider to the CHI scheme. As the scheme was meant to be beneficial to lower income groups, the design had to encompass several factors.

"While designing the scheme, the survey findings gave us new insights. It revealed that affordability of premiums would be a crucial, limiting factor. Poor usage of government health facilities was another factor that had to be addressed. As PHCs and government hospitals were free of user charges for our target population, it stood to reason that we attempt to increase use of those facilities. The survey also revealed that children's health was often neglected due to unaffordability. This indicated a need for insurance among them," recollects Dr Sudarshan. "We had several rounds of discussion with senior officials from NIC before reaching a consensus on a scheme that would translate into all-round benefits for our target audience, as well as be profitable to NIC."

Mr Aswathnarayana, Regional Manager, NIC, adds, "Insurance by its very

nature, looks at covering various risks. Therefore it is very important to structure premiums accordingly. In the CHI scheme however, our social commitment, and not profitability per se was the overriding factor. We have tried to design a socially responsible scheme, without completely compromising on the company's profitability. The large numbers of beneficiaries insured under the scheme have also made this scheme possible."

"We were clear that our beneficiaries had to be the poorest and the most marginalized, as these are the people who suffer the severest forms of deprivation at all times, and especially during times of illness," says Dr Sudarshan. To achieve this, the project was targeted at the rural BPL/SC/ST, and BPL/non SC/ST communities.

In order to formulate the premium structure, the community was categorised as:

1. BPL/SC/ST population
2. BPL/non SC/SC
3. Other categories.

Features and special elements of the scheme:

- Insurance cover available only for medical attention with hospitalisation for 24 hours i.e. inpatient care. Outpatient care not covered by insurance.
- Beneficiaries entitled to a maximum of 25 days of hospitalisation in one year of insurance
- Benefits of insurance available only at government designated public health institutions, including referral cases. Exemptions where government facilities are not available e.g. B R Hills
- No exclusions of any ailments or diseases, including deliveries and tubectomies
- No exclusion of any age group including infants, children and the elderly
- Wage loss compensation of Rs 50 (in the case of nonworking members such

Premium subsidy was determined as follows:

Category	Premium structure
BPL/SCs/STs	Premium of Rs 30 per person per annum fully subsidized
Persons below the poverty line but not SCs or STs i.e. BPL/non SCs/STs	Premium partially subsidized - Rs 20 per person per annum - beneficiary contribution - Rs 10 per person per annum – subsidy - Karuna Trust
The rest of the community i.e. persons who include those SCs and STs and others who are above the poverty line (APL)	Entire premium of Rs 30 per person per annum to be paid by the beneficiary

as the elderly and very young children) useful for working members who lose wages while accompanying the patient for out-of-pocket expenses.

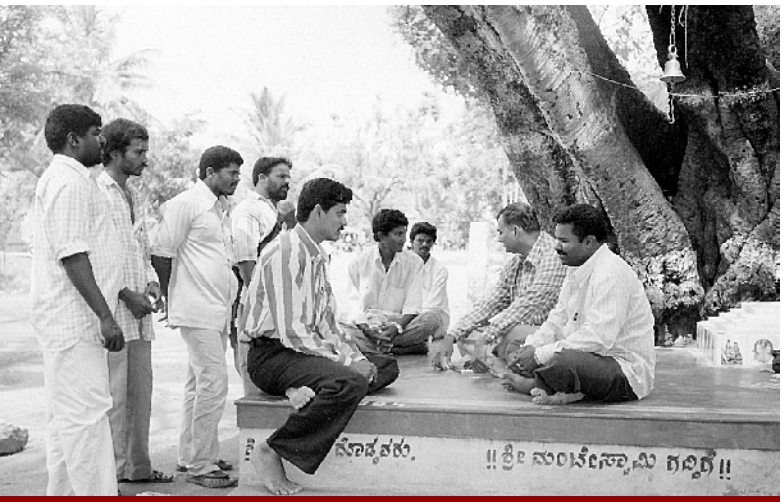
- Charges for special drugs at the rate of Rs 50 per day paid from the insurance entitlement. Unused funds, if any, from this amount used to build up a fund for unforeseen expenses like ambulance charges etc.
- Revolving fund established in each designated public health institution to settle claims immediately. Amount claimed later from the insurance company.

Generating awareness

At the end of the three-month survey, the actual task of enrolling members into the scheme began. Parallel to the survey however, awareness generation activities were being conducted in both areas. These included:

- Street plays
- Video shows
- Public announcements
- One-to-ones
- Posters and hoardings
- Community level meetings through SHGs, VDCs and VHCs

While some activities like street plays, video shows, and community level meetings were used intensively in T Narasipura; the Bailhongal model used other forms of communication. Dr V.D. Dange, District TB Officer, and Nodal Officer, UNDP and AIDS programme explains, "As a government implementing agency, it was more practical for us to conduct IEC activities through the



hospitals and PHCs. We also used our own ANMs and AWWs to personally interact with the community as they were already making daily visits to villages for other activities like RCH, immunization etc. We used hospitals and PHCs to generate awareness by painting the walls and displaying posters with messages on insurance. The response was encouraging."

Karuna Trust used their street play team to write and enact plays dedicated to the message of CHI in the villages of T Narasipura taluk. "Street plays are popular among the community and large numbers gather to watch them. After the performance we would distribute pamphlets on insurance," says Mr Pandu.

Community spaces like SHGs and VDCs were used extensively to generate awareness. Mr Mahadev, VDC President, SKP Agrahara, says, "Our village has 350 households. We are all from the ST community and most of us are classified as BPL. When the scheme was explained to our committee by the Karuna Trust staff, we realised immediately that our community needed it acutely. The entire committee consisting of 15 people including three women came forward to spread the message. Initially it was easy convincing people about insurance, as the premium was fully subsidised."

Malligamma, SHG member, Vyasarajapura, says, "Members of our sangha (SHG) were very happy when they heard about the insurance scheme. They all came forward to enrol and spread the message to their friends and relatives."

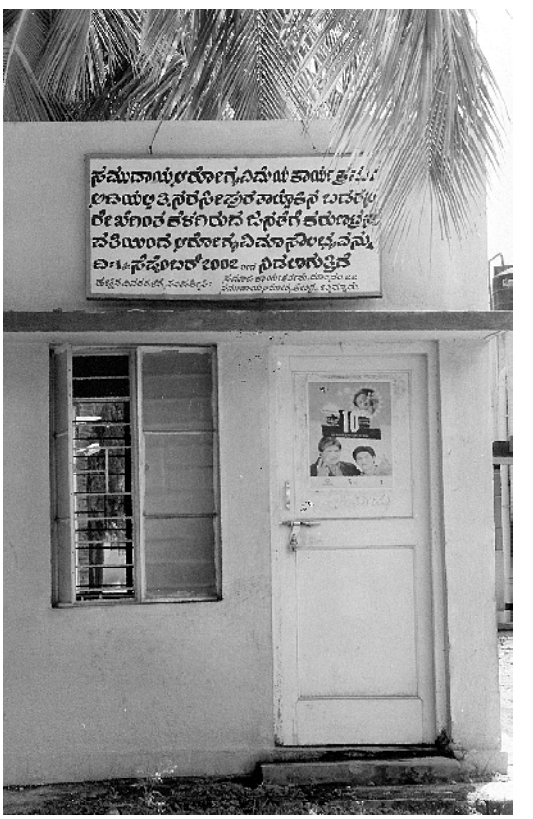
Magdalena Pinto, ANM, Community Health Centre (CHC), Bannur village, T

Narasipura taluk says, "I visit about 60 households per day in the course of my work. While telling the people about insurance, I stress on the fact that now they will not have to lose their wages while seeking in-patient treatment. This makes them seek treatment on time rather than when it is too late and complications develop. When they come to the PHCs for treatment, it also gives us an opportunity to talk to patients and their relatives, particularly women on many other health issues, including preventive health care."

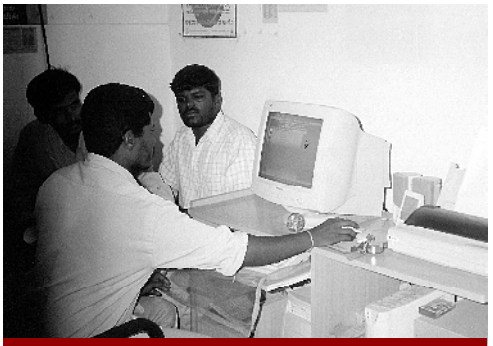
Public announcements and video shows are also other popular forms of IEC used in both the areas.

Enrolment and facilitation of claims

Several methods were adopted to enrol beneficiaries depending on their category. BPL/SC/ST beneficiaries were identified and enrolled from official lists, while SHG, VDC, and VHC members motivated non-BPL/SC/ST beneficiaries in T Narasipura taluk.



"As the premium for the BPL/SC/ST category was entirely subsidized, Karuna Trust, or the CEO, zilla panchayat, Belgaum paid the premium directly to NIC, based on the official list," says Mr Achutha Rao, Project Coordinator, Karuna Trust. "For the other categories, the ANMs and AWWs in Bailhongal, and CBOs in T Narasipura handled the task of approaching people, collecting the beneficiary contribution, and



sending it to Karuna Trust or the taluk Health Office. The subsidy element was then added and sent to NIC."

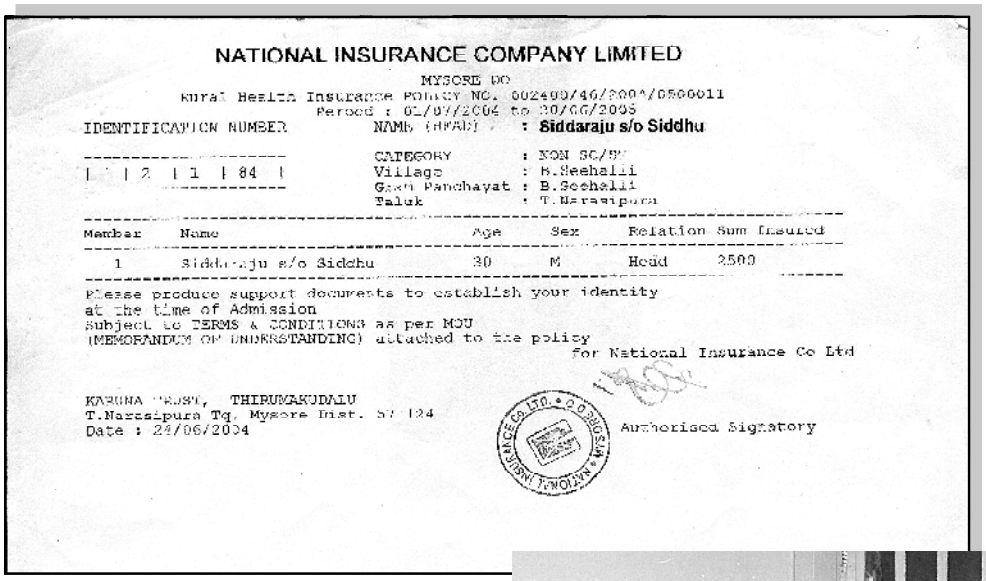
"Considering the large numbers of beneficiaries that were enrolled under the scheme, we had to set systems in place that would not only enable easy identification, but also help claims to be settled speedily. Therefore we designed special software that assigned easily decipherable identification numbers for each beneficiary. Identification cards were issued to each beneficiary. The card, at a glance gave details of the taluk, village and household that the beneficiary belonged to," says Dr N. L. Manjunath, Senior Divisional Manager, National Insurance Co. Ltd, Belgaum.

Mr Shashikant says, "The procedure for admissions and claims has been kept very simple. We have set up computers in each designated PHC and hospital. When a patient seeks treatment s/he approaches us with the ID card. We feed their details into the computer, and it gives us comprehensive information about the patient, including the number of days s/he has availed benefits, and the number of days available. Thereafter, we approach the hospital authorities and facilitate their treatment."

Dr Dange says, "Most of our beneficiaries are illiterate, but know the value of the card they possess. Even though they do not know while seeking treatment, whether their illness will require admission, they come equipped with the card.

In the instance that they have forgotten or neglected to bring their cards, our ANMs and health workers, having been involved in the enrolment process, know what to do and ensure that the patient is helped. Chances of moral hazards in a scheme of this kind are high. Therefore we have motivated our staff to take special care to prevent it."

In the initial phase, three healthcare centres in T. Narasipura, and four in Bailhongal were identified for induction into the pilot project. "We had administrative constraints while processing and settling claims and therefore had to limit ourselves to a smaller number of centres," says Dr Dange. "We were careful however, to include CHCs and General Hospitals, in order to give the people access to better medical facilities."



NATIONAL INSURANCE COMPANY LIMITED

MYSORE DO

Rural Health Insurance Policy No. 002400/48/2004/0500011

Period : 01/07/2004 to 30/06/2005

IDENTIFICATION NUMBER | | 2 | 1 | 84 |

NAME (HEAD) : Siddaraju s/o Siddhu

CATEGORY : NON SC/ST

Village : B.Seehalli

Gram Panchayat : B.Seehalli

Taluk : T.Narasipura

Member	Name	Age	Sex	Relation	Sum Insured
1	Siddaraju s/o Siddhu	30	M	Head	2500

Please produce support documents to establish your identity at the time of Admission

Subject to TERMS & CONDITIONS as per MOU (MEMORANDUM OF UNDERSTANDING) attached to the policy

for National Insurance Co Ltd

KARUNA TRUST, THIRUMAKUDALU

T.Narasipura Tq. Mysore Dist. ST 124

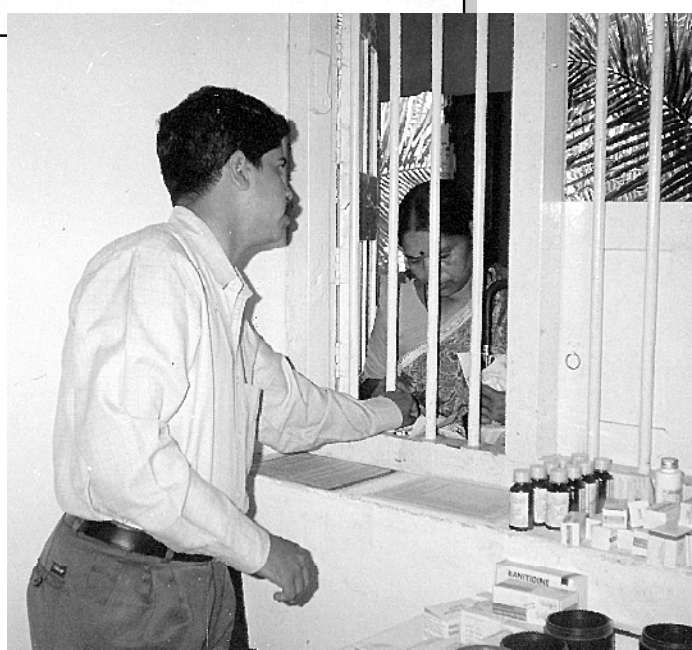
Date : 24/06/2004

Authorised Signatory

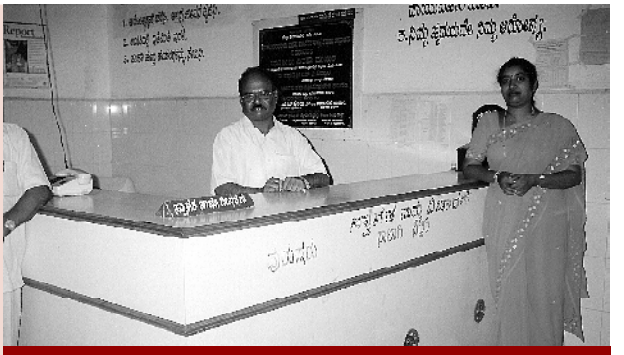
Extension of operational area

The initial phase had yielded valuable insights that could strengthen the concept of CHI. The first and probably the most significant one was the value of immediate reimbursement of claims. Karuna Trust had facilitated the creation of a revolving fund at each designated healthcare facility to settle claims before the beneficiary could leave hospital.

This ensured that the time lapse



Bailhongal General Hospital – profile of a government hospital



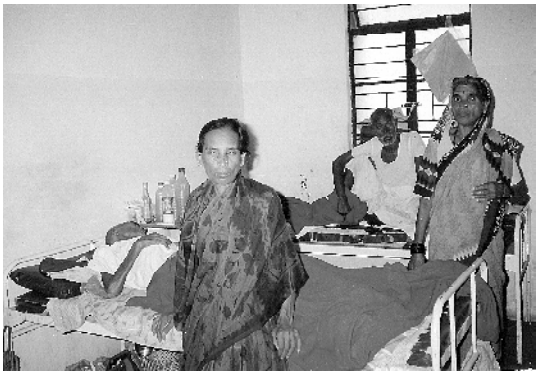
The entrance to the Bailhongal General Hospital is like entering an urban private hospital. The reception desk is fully operational and the person sitting behind it is briskly registering outpatients and admitting inpatients. His attitude is warm and friendly. The walls of the reception hall are a study in creativity. IEC messages are splashed across them.

The hospital corridors sport messages about hygiene and sanitation and caution visitors about carelessly throwing garbage. The wards are clean, despite being full to capacity. A well-stocked pharmacy ensures that patients or their attendants almost never have to leave the hospital in search of medicines.

The operation theatre, the diagnostic laboratory, the x-ray room, and the labour ward are equipped and fully functional. Colour coded bins are strategically placed around the hospital to collect and dispose segregated waste. Doctors are at hand to deal with emergencies as well as routine admissions.

Bailhongal General Hospital is evidence of a system that works.

between the claim and settlement when NIC had to fulfil procedural requirements did not affect the beneficiaries. This went a long way in establishing the credibility for insurance schemes in general. The second important innovaton was that PHCs and hospitals, despite best efforts, had to prescribe for medicines to be bought from outside. Karuna Trust attempted to overcome this by providing generic low-cost medicines procured from unused money that had accrued in the Drug Fund. This fund was also used to cover costs like ambulance charges where the situation demanded.



The community was appreciative of these special efforts and they could clearly perceive the benefits and financial security

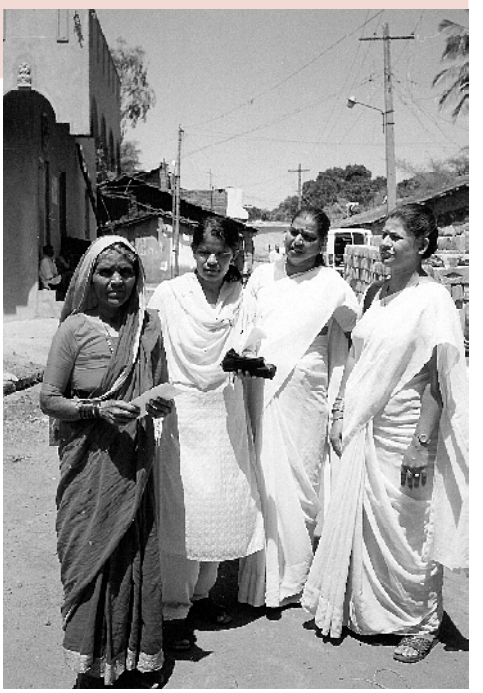
A unique partnership - Gumballi PHC, Yelandur taluk

Amidst a large expanse of vacant land outside Yelandur town, stands a stone and tile building. It has corridors lined with ornamental pillars. A central courtyard open to the skies looks green and fresh from the grass growing in it. Looking rather like a heritage home, it bears testimony to a vibrant public–private partnership. Innovative design apart, immaculately clean corridors, well-equipped wards, and courteous staff are features of the Gumballi PHC that set it apart from many other government PHCs.

The Gumballi PHC with five sub-centres was handed over to Karuna Trust in 1995 by the government with a view to improve the quality of service delivery by encouraging private partnership in the healthcare system. The PHC takes care of the primary health needs of 21,500 people in 14 villages of Yelandur taluk. While it provides the entire preventive, curative and rehabilitation services that are required of a government PHC, it also has some special elements built in such as advanced diagnostic equipments, eye care facilities, clean drinking water for the patients and hygienic toilets.

The staff at the PHC and the sub-centres has been appointed by Karuna Trust. The committed group pride themselves on the care they are able to give to patients who come from far-off villages in search of relief from pain and disease.

The Gumballi PHC along with the sub centres it serves amply demonstrates all the benefits that such a partnership can have. Quality service, and timely and efficient care are only two.



that the insurance could provide in times of illness. It was also evident in this phase that given the opportunity, people were willing, and in fact wanted to seek healthcare on time. It was reassuring to them that they would not have to lose their wages either in case of hospitalisation. Therefore any future efforts at CHI would need to include these elements.

In order to facilitate insurance benefits for a greater number of people, the CHI scheme was extended to Chamarajnagar, Kollegal and Yelandur taluks and rural areas of Belgaum taluk in 2003.

While the activities were consistent with the initial phase, the difference lay in the beneficiary groups.

- Enrolment in Chamarajnagar and Kollegal was restricted to BPL/STs as these areas were predominantly tribal areas.
- In Yelandur and Belgaum, BPL/SC/ST population was included.

There were some unique elements to the extension phase. "Accessibility of PHCs from BR Hills in Chamarajnagar is poor. The area is home to a large tribal population that uses the healthcare facilities at the Vivekananda Girijana Kalyana Kendra (VGKK) Tribal Hospital. What was unique in this area was that NIC recognized claims made through this hospital," says Dr Sudarshan.

The tribals of BR Hills were all paying members of CHI scheme. "CBOs like SHGs and VDCs had been functioning for long in the area and had matured to a point of being able to discuss the benefits among themselves and reach decisions about enrolling for the CHI scheme," says Mr Ramachar, Project Manager, VGKK.

Consolidation efforts

Building sustainability

Sustainability of the CHI scheme in T Narasipura, Bailhongal and the extension areas was a serious concern. Insurance schemes as a rule are limited to 12-month blocks and prone to people dropping out of the scheme after a year. The CHI scheme was no different, and a large number of dropouts would have rendered the scheme unviable.

Name of taluk	Number of designated centres	Category of centre
Bailhongal	16	1 General hospital I CHC 14 PHCs
T Narasipura and Yelandur	5	2 PHCs 2 CHCs 2 General Hospital
BR Hills	1	VGKK Tribal Hospital (Jayavijayam Hospital)

List of commonly treated ailments

T. Narasipura	Bailhongal
Gastroenteritis	Typhoid and Para Typhoid
COPD* and Asthma	Gastroenteritis
PUO (fever for evaluation)	Respiratory infections
Malaria	Puerperal sepsis
Intranatal Care	COPD and Asthma
Heart diseases	Fever
Surgeries, excisions, amputations	Heart diseases

* COPD – Chronic Obstructive Pulmonary Disease

The concern in the consolidation phase was also that funding for the premiums would no longer be available and the community would have to assume responsibility for paying their own premiums. Therefore several measures were initiated to ensure sustained enrolment of members.

- NIC reduced the rate of the premium from Rs 30 in Phase I period to Rs 20.52 in Phase II
- ANMs and AWWs were actively involved in motivating the community to become paying members in Bailhongal area
- Efforts were intensified to motivate people through CBOs in other areas as well
- High levels of motivation among the tribals of BR Hills had already demonstrated that a self-paying CHI scheme could work.

Herbal gardens

In what is not directly related to the CHI scheme, and yet contributes to the overall health status of the community, Karuna Trust promoted the concept of herbal gardens for preventive health. SHGs were given training on the benefits of using roots and herbs for simple ailments like cough, fevers, poor digestion, etc. Saplings of medicinal plants were given to SHG members for planting in their backyards.

Mr K Vijayan Vaitheyer, a traditional medicine practitioner from Tamil Nadu was invited to give a series of trainings to Karuna Trust staff on different aspects of herbal medicine. He says, "Herbal medicines can make a big difference to the general health of people. We have simple tonics that build up resistance to disease among children and adults. The Karuna Trust staff has been trained to make these medicines. People must be motivated to use these medicines regularly. This will have a positive impact on overall health and lead to a healthier population."

The CHI programme as originally envisaged ended in June 2005. And yet, it can only be considered a beginning, as it has resulted in several changes, attitudinal and others among the community. To understand the changes…

Phase I
1st September 2002 to 31st August 2003

Coverage	T Narsipura					
Premium	Rs. 30.00/person/year					
Name of the Taluk	BPL SC/ST			Non SC/ST BPL		
T N Pura	Rural	Urban	Total	Rural	Urban	Total
	77,223	5323	82,546 (fully subsidized)	2546	-	2546 (Partial subsidy)
			Claims			
	Number of beneficiaries	No. of bed days		Claims in rupees (Wage loss + Drugs)		Percentage claims
	655	5490		2,74,500 + 2,74,500	21.4 %	

Terms
- Rs. 50 per day towards wage loss for in-patients
- Rs. 50 per day for drugs (out-of-pocket expenditure)
- No exclusion of any disease

Phase I Extended
1st October, 2002 to 31st September, 2003 at Bailhongal Taluk
1st April, 2003 to 31st March, 2004 at Chamarajanagar District
16th June, 2003 to 15th June 2004 at Belgaum Taluk

Coverage	**Chamarajanagar district, Belagaum and Bailhongal taluks**					
Premium	**Rs. 30.00/person/year**					
Name of the Taluk	BPL SC/ST			Non SC/ST BPL		
Bailhongal	Rural	Urban	Total	Rural	Urban	Total
	31,204	1224	32428	20,322	-	20,322
Chamarajanagar	33,716	-	33,716	-	-	-
Belgaum	59,496	-	59,496	-	-	-
Total	1,24,416	1224	1,25,640	20.322	-	20,322

Claims

Name of the Taluk	Number of beneficiaries	No.of bed days (Wage loss + Drugs)	Claims in rupees	Percentage claims
Bailhongal	1719	12,241	6,12,050 + 6,12,050	77.3 %
Chamarajanagar	402	3187	1,59,350 + 1,59,350	31.5 %
Belgaum	339	1245	62,250 + 62,250	6.9 %
Total	2460	16,673	16,67,300	38.1 %

Terms
- Rs. 50 per day towards wage loss for in-patients
- Rs. 50 per day for drugs (out-of-pocket expenditure)
- No exclusion of any disease

Phase II

1st June 2004 to 30th May, 2005

1st January 2005 to December 31st, 2005

Coverage	**T Narsipura Taluk, Chamarajanagar District, Bailhongal Taluk and Belgaum Taluk**
Premium	**Rs. 20.52/person/year**

Location	SC/ST	Others	Total
T N Pura Taluk	61,779	3,990	65,769
Chamarajanagar Dt.	-	4698	4,698
Belgaum Taluk	60,955	-	60,955
Total	1,12,734	8688	1,21,422

Claims

Taluk	Number of beneficiaries	No. of bed days (Wage loss + Drugs)	Claims in rupees (Wage loss + Drugs)	Surgery claims	Claim %
T N Pura	1233	11,781	5,89,050 + 5,89,050	2,31,000 + 2,31,000	122 %
Yelandur	582	1442	72100 + 72100	25000 + 25000	201 %
Belgaum					

Terms
- In addition to wage loss compensation, additional compensation for surgery patients of Rs. 500 towards surgery, and Rs. 500 towards drugs
- Tubectomy included under the scheme
- Rs. 50 per day towards wage loss for in-patients
- Rs. 50 per day for drugs (out-of-pocket expenditure)
- No exclusion of any disease

BR Hills is a stretch of hills in southern Karnataka. The hills, which are endowed with rich biodiversity, have for generations, been home to the semi-nomadic Soliga tribe. As VGKK, the mother organisation of Karuna Trust had been providing healthcare, education, and other developmental support to the tribals since 1980; CHI was a natural extension of this support.

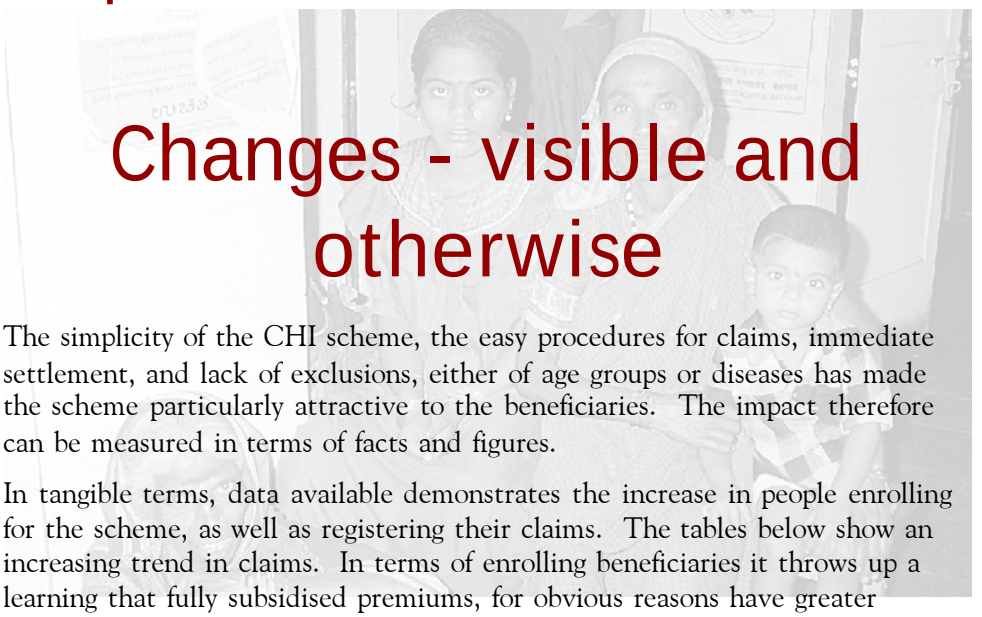
The difference however, was in the way it was introduced. The concept of CHI was introduced through SHGs which were already functioning in the area. The savings collected by the SHG members were used by them to pay the premiums. In these cases, from inception itself, the tribals assumed the responsibility of paying the premiums.

Bedamma of Sri Sharada Mate Swasahaya Sangha says, "When we heard of the insurance scheme, there was no doubt in our minds about its advantages. All our members immediately agreed to pay. Those who cannot pay immediately are given loans to pay the premium. The amount is not too much when we consider the benefits we are getting out of it."

"We have enrolled close to 3,000 tribals into the CHI scheme and most of them have paid their own premiums. Even those who were unable to pay, have been helped by the SHG they belonged to," says Mr Ramachar.

Bedamma and others of her ilk have certainly demonstrated that health insurance is not only viable, it is essential.

chapter four



Changes - visible and otherwise

The simplicity of the CHI scheme, the easy procedures for claims, immediate settlement, and lack of exclusions, either of age groups or diseases has made the scheme particularly attractive to the beneficiaries. The impact therefore can be measured in terms of facts and figures.

In tangible terms, data available demonstrates the increase in people enrolling for the scheme, as well as registering their claims. The tables below show an increasing trend in claims. In terms of enrolling beneficiaries it throws up a learning that fully subsidised premiums, for obvious reasons have greater acceptance among the population. It also points to a greater need to generate motivation among the people to pay and insure.

Impact data tables

Category	T Narasipura 1 September 2002 to 31 August 2003			Bailhongal 1 October to 30 September 2003		
	Rural	Urban	Total	Rural	Urban	Total
BPL SC/ST	77223	5323	82546	31204	1224	32428
BPL non SC/ST	2546	-	2546	20322	-	20332
Grand total			85092			52750

More important however, is the impact that cannot be supported by data and yet, is truly at the core of what the project set out to achieve.

- ***Awareness***

The project was initiated to demonstrate the benefits of health insurance to an audience that was largely unaware, and unwilling in the beginning to accept the concept. Intensive community level interaction has impacted awareness and motivation levels. The situation currently shows a vast difference in both,

Month wise claims made in T Narasipura and Bailhongal

T Narasipura September 2002 to August 2003		Bailhongal October 2002 to September 2003	
Month	Amount in Rs	Month	Amount in Rs
September	12500	November	5600
October	31000	December	18100
November	20400	January	39800
December	22800	February	65300
January	25200	March	70800
February	27700	April	65300
March	38000	May	76300
April	24400	June	81100
May	31500	July	121000
June	55400	August	154500
July	53500	September	154200
August	74200	October	149200

attitudes and awareness. Awareness about the benefits of insurance is strongly evident among the community, as also the need to set aside a small sum of money every year to insure against sickness.

Shanti, who is admitted in the General Hospital, T Narasipura for appendicitis, says, "I always felt money should be spent on health only when one fell sick. The concept of insurance was so alien to us. Now I know that but for insurance, all the days I am going to spend in hospital would have cost me dearly in terms of wages lost, as well as for medicines etc. I am going to ensure that all the members of my family pay money and insure in future."

In both models, the community has realised the benefits of the scheme and is expressing willingness to participate by paying for insurance. The concern however, is of garnering the numbers required. Gram panchayat members, SHGs, VHCs and VDCs have been involved in this process. As Renuka Rama Kamble, Chairperson, Uchgaon Gram Panchayat, Bailhongal taluk says, "I will personally motivate as many members as I can, to pay and enrol for insurance. The long-term benefits and sense of security that a family gets out of insurance are undoubtedly useful."

- ***Increased use of PHCs and other government healthcare facilities***

An important feature of the CHI project was the clause that stipulated compulsory use of government healthcare facilities. This has led to increased use of PHCs and government hospitals. "The clause has led to dual benefits," says Dr Dange. "It has at one level changed the negative perception that people had about the quality of care available at government healthcare facilities. People who previously avoided visiting government healthcare centres and opted for expensive private healthcare, even at the risk of having to raise loans are now seeking medical help at PHCs willingly.

At another level, increased attendance at these facilities has motivated doctors and support staff to deliver better service. Additionally it has facilitated deeper interaction with the community, thereby leading to a better understanding of their problems.

Increased attendance at T Narasipura General Hospital

Year	No of patients
2001	66,000
2002	72,420
2003	90,060
2004	1,01,640

Patterns of utilisation of health services indicate that there is a steady increase in the number of patients seeking treatment before complications set in. These are mostly patients who would have postponed visiting the hospital for fear of losing their daily wages. The health functionaries have more opportunities to spread awareness about general and primary health, hygiene, sanitation, and other aspects in the course of their increased interaction with patients. Very often, a patient who has come for treatment for a simple fever might go away with increased knowledge on family planning or HIV/AIDS. Anita smiles shyly and says, "A smaller family means less pressure on my health. It also means better use of whatever little we earn. My children can get better education and will have a good future."

- ***Easy procedures***

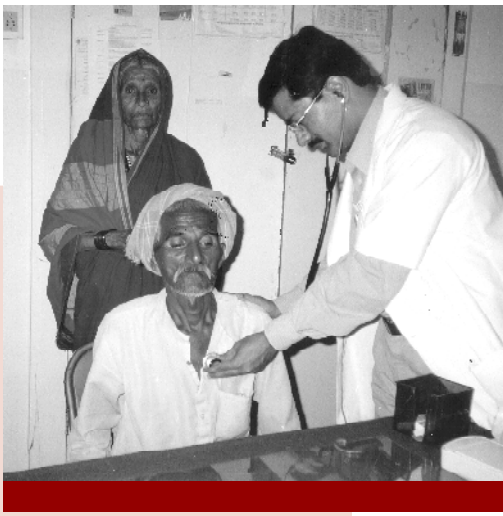
The simplicity with which the scheme was designed enabled a largely illiterate population to enjoy its benefits. Being devoid of exclusions, either on the basis of age or ailment, every age group could be enrolled, thereby ensuring the critical mass a scheme of this nature required. The claim process was speedy, there were no administrative delays, and compensation was given to the beneficiaries even before they left the hospital. This went a long way in instilling confidence in the people and motivating them to continue the insurance.

"We are illiterate people and when Karuna Trust approached us to become members of the insurance scheme, I was worried how I would use the card as I do not read or write. But the procedure was so simple. We just had to go to the hospital and show our card. The staff did the rest of the work. We were given our money even before they claimed it from the insurance company," says a relieved Bhimavva Salhalli.

- ***Viability of the scheme***

The project has proved that CHI is certainly a viable proposition for the disadvantaged classes in India. Since CHI has been linked to government healthcare facilities, this has resulted in a synergy that can prove beneficial to both, the system as well as the people. The large infrastructure that the government has created can be used more effectively to benefit the poor.

Dr. S. C. Dharwad reiterates, "Health is the only asset that poor people possess. The CHI scheme has proved that insurance is a vital need for them. It can make the difference between living a life of insecurity and ill-health, and one that assures help for them when they are sick. The USP of this programme is that it has not involved creating a new infrastructure. It has instead focussed on using the existing one to better advantage."



Voices of satisfaction – the beneficiaries speak

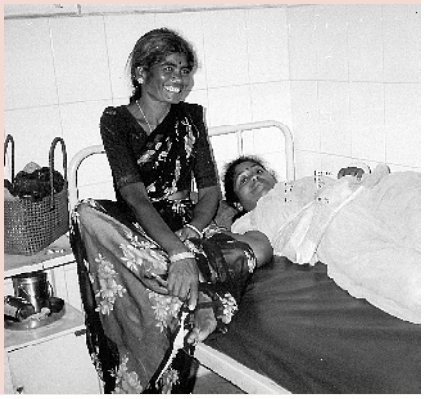
- "I am not scared of illness anymore. Suffering aside, whenever I, or anyone from my family fell ill, we were worried about how to afford treatment. We do not worry anymore. We get good treatment, money for medicines and money if we cannot work!" – *Savithri Sainappa Birje*

- "I have been staying with my little daughter in the hospital. She has fever and the doctor says we cannot go home till her fever subsides. How would I have managed without going to work for so many days? Now I am not worried. With the money that is given to her through the insurance, we will manage." – *Satyavva Yellappa*

- "I already have four children and have given birth to the fifth. The doctors have now operated on me. The insurance money I get will help me to recover faster because I can buy tonics and good food for myself." – *Chinnamma*

- "My sister was disabled and she died a few weeks ago in hospital. We got her insurance money, even though she had died." – *Basavaraj*

- "We were not very happy to pay for insurance as we are poor and every rupee is important to us. Later, when I was admitted in hospital for chest pain, I was very happy, as I got a good sum of money as compensation when I was discharged. This money more than compensated for what I had spent initially on the insurance." – *Siddamma, Soliga tribal from BR Hills.*



- ***Increased productivity through improved general health***

The general health of the population, particularly women, in the project area is improving gradually owing to the increased attention they are giving to their health. "Timely treatment for ailments, combined with the security of not having to lose wages will definitely contribute to a healthier population. If we value our human assets, we have to look at CHI as a priority and do everything we can to popularise it," says Dr Dange.

Indirect impact

Spin off impact is evident in the form of increased commitment on the part of government health functionaries. In the course of the survey, they interacted closely with the community and this resulted in increased rapport between them. On the other hand, use of government facilities has also given the community an opportunity to understand the system better and demand facilities where they were lacking.

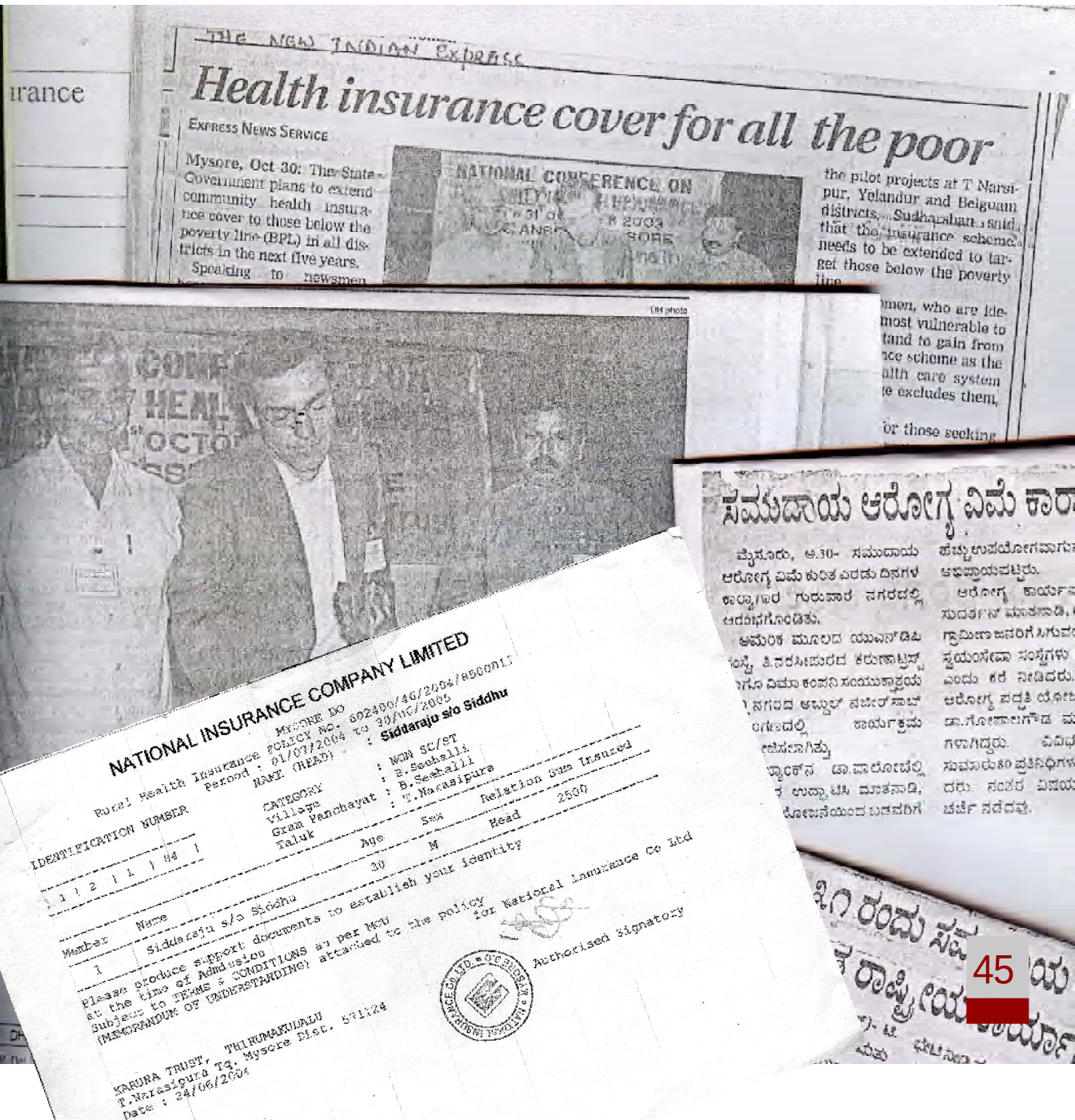
Dr V.B. Kulkarni, Taluk Health Officer, Belgaum says, "This is the first time that we have collaborated with a NGO to deliver healthcare, particularly insurance. We have got an opportunity to observe and learn from their approach, which focuses more deeply on long-term change, rather than merely meeting targets."

NIC has demonstrated continued commitment to the CHI project and in fact have brought down the rate of the premium from Rs 30 in the first 12-month period to Rs 20 in the second12-month period. "Our experience with this scheme has been good. The implementing agencies have been alert to the possibility of moral hazards and exercised caution to avoid their occurrence. Even while displaying social commitment, we had to make this a paying proposition. We are not only looking to continuing the CHI scheme in the same areas, but we will happily welcome other, similar group insurance schemes," says Mr Aswathnarayana.

"The CHI scheme in T Narasipura and Bailhongal has demonstrated the need as well as the benefits (especially the wage loss component) of insurance for the poor and needy of this country. The experience in the state has shown that it is possible to replicate CHI in other parts of the country, provided we have the numbers, and the commitment on the part of the implementing agency, whether it is an NGO, or the government itself," says Mr W.K. Vijayaraghavan, Senior Divisional Manager, NIC, Mysore.

The impact of the CHI project demonstrates that the concept has found acceptance with the community. While it is premature to assess the members who choose to will stay with the programme in the absence of subsidies for

premiums, it is evident that the benefits have proved invaluable to the community. Reaching this stage of acceptance however, has not been free of challenges. To enumerate them…



Q & A with Dr H Sudarshan

A critical mass is essential for any Community Health Insurance scheme to be effective. What are the challenges that come in the way of achieving this critical mass?

Yes. The scheme would not have been viable without the critical mass. Karuna Trust was already doing a lot of work in TN Pura. There was already an established network of Self-help Groups. Also, I insisted on implementing the project in the whole taluk, and not only in TN Pura or at BR Hills. People were also reluctant to opt for the scheme as the paying capacity of the people was low and the awareness regarding health insurance was practically non-existent. This is now no more a problem with people availing of the benefits of the scheme.

What are the salient features of the scheme?

The scheme has the following innovative features

- Low premium rate
- No exclusion policy
- Wage loss compensation
- Immediate claim settlement
- Involvement of public sectors
- Very low moral hazard

How can CHI be made possible in the absence of subsidised premiums?

This is in fact, the next phase of the program. A system of 'revolving funds' with the SHGs will be used. Community participation through SHGs will be a key factor to the success of the program. We have thus evolved a sustainable model without subsidies for the next phase of the program. I would like similar CHI schemes to be operational all over the state. Our scheme in the next phase incidentally includes treatment for HIV/AIDS.

How can CHI include the urban poor who have an equally critical need?

The urban poor are a neglected lot, with similar needs as the rural poor. However, as the public health infrastructure in urban areas (PHCs) is quite poor, it will be difficult to implement a CHI scheme. The primary need is to strengthen the public health infrastructure in urban areas, and then concentrate on CHI

Why did you involve public hospitals and public sector insurance company rather than the private sector?

The Community Health Insurance scheme would not have been possible with profit-making institutions. It was high on 'social dividends'. It would not have been possible with the private sector. NIC has been very flexible, and community-oriented with their approach. After a session of negotiations over the policy and its terms, they agreed to keep the premium low, for No exclusions and compensation of wage loss. These were key elements of the scheme. They even developed a simple mechanism of disbursement of bonds, user-friendly software for documentation and a system of immediate claim settlement. I am happy about this public sector involvement.

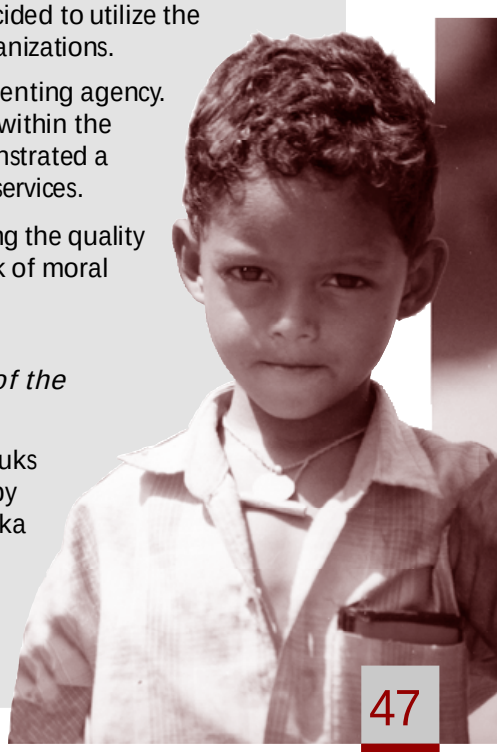
The rural poor have very poor access to primary and secondary care. This is mainly because the poorest of the poor cannot afford to lose wages. Hence the utilization of the government hospitals was poor in spite of the huge investment in upscaling these facilities through World Bank assistance. Hence, we decided to utilize the government health facilities and some not-for-profit organizations.

Also, in Bailhongal taluk, the government is the implementing agency. This was done to show that the CHI model is workable within the government framework too. The project has also demonstrated a significant increase in utilization of government health services.

Moreover, there is no accreditation system for monitoring the quality of services in the private sector. Also, there is higher risk of moral hazards in the private sector

What are your future plans for upscaling the CHI? What is its impact on the health insurance policy of the government?

The rich experience gained in TN Pura and Yelandur taluks will be extended to the population in the 20 PHCs run by Karuna Trust. We are already working with the Karnataka health department for evolving a CHI scheme that covers the rural poor all over the state in a phased manner with World Bank assistance.



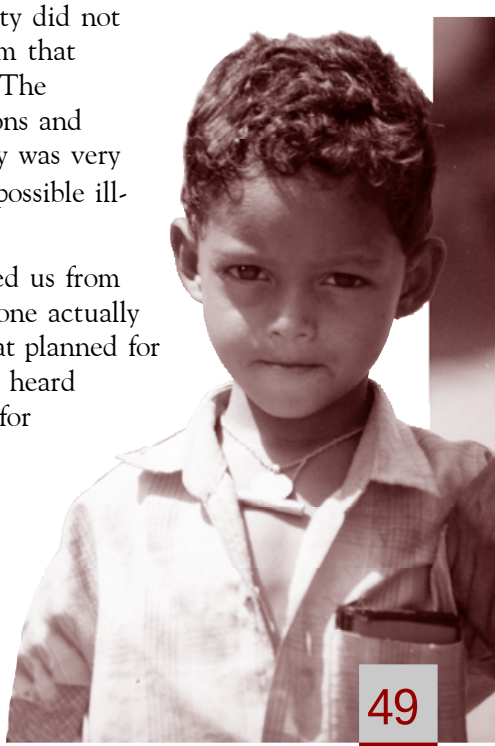
chapter five

CHI – not without challenges

The implementing staff encountered several challenges in the course of the CHI project. The primary challenge lay in introducing the concept of CHI, and this was probably the most difficult. There were several reasons for this. The survey had shown that the population was largely unaware about options that existed for insuring health, and healthcare itself was seen as a low priority area.

- ***Changing existing perceptions and practices***

There were reservations from the community about the value of health insurance. The concept was new and the community did not appreciate it easily. It was difficult to convince them that financial planning was actually possible for illness. The implementing team had to also deal with superstitions and beliefs that impeded quick progress. The community was very superstitious about discussing and planning for the possible ill-health of themselves and their children.

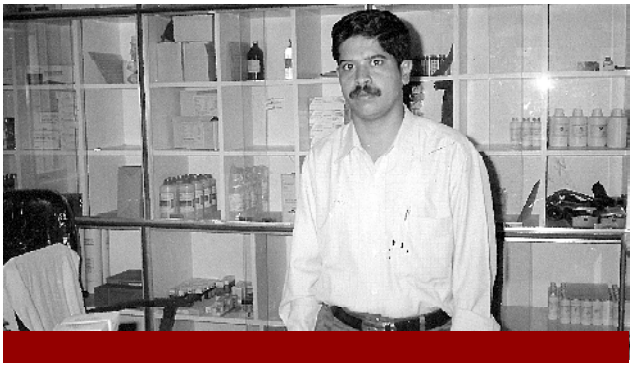


Savitri Bai recalls, "In the past superstition prevented us from thinking about expense and other matters till someone actually fell ill. We also did not know about any scheme that planned for expenditure incurred during illness. When we first heard about a scheme that would actually compensate us for wages lost we found it hard to believe. It was only when some of us availed the benefits that we were convinced."

- ***Reducing dependence on private healthcare facilities***

An additional challenge was that of tracking the health-seeking patterns of the community, and thereafter motivating them to access services at

PHCs and government hospitals. "The general trend in the community was to seek treatment at private facilities. They viewed government facilities with a negative attitude vis a vis quality of service, availability of drugs and other facilities and attitude of the staff. Changing those perceptions took time and effort," says Pandu Kumar.



"When we heard about this scheme, the only worry we had was that we would have to go to government hospitals where we were not treated well," remarks Seethamma.

Dr Dange says, "There might be occasional lapses while delivering health services, but the state has a health infrastructure that by and large functions satisfactorily. Through this scheme, we have got an opportunity to demonstrate this to the community. It has also been an opportunity for us to look at ourselves closely and correct gaps."

- ***Motivating government functionaries***

Government healthcare functionaries had to handle the functions of the CHI scheme in addition to the other work they were already handling. In the absence of incentives, it required high levels of motivation. Magdalena Pinto says, "Initially we had reservations about how we would handle this extra work, as we were already doing so much. But when we started telling people about the scheme and enrolling them, it became clear that all the extra work would be worthwhile. The relief we see on their faces now, when they get their wage loss compensation is incentive enough for us. We want to enrol more members into the scheme."

- ***Working in partnership with the public system***

In T Narasipura area, Karuna Trust had to work with the PHCs and hospitals. Even though its staff was present at the centres to disburse the compensation, the treatment component was the responsibility of the hospital. "We had to work with patience and perseverance to build up rapport with the staff so that our beneficiaries would not have problems. Initially we did have problems but after the staff at the centres saw the value of what we were doing, they came forward to cooperate with us," says Pandu Kumar.

Learnings

Challenges notwithstanding, the pilot phase of the CHI scheme is invaluable for the learnings it has thrown up. The most important ones are the need to:

- Motivate women to pay more attention to their health
- Intensify efforts through CBOs to sustain the programme
- Strengthen partnerships with the government healthcare facilities

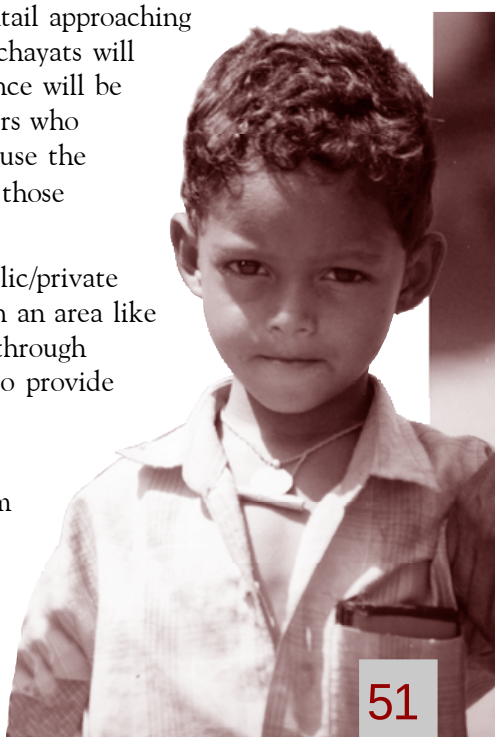
Efforts are on to address all these needs and will be intensified in the future. Particular attention will be paid to women's health through PHCs as also CBOs. ANMs will be alert to health issues among women in their areas and track problem pregnancies to ensure timely intervention. Spreading awareness on the importance of primary health care for women will be given special attention.

"Women need to be convinced that they are an important part of society and therefore their health is as important as that of their husbands or families. This is an important message that we will be giving out in future," says Mr Shashikant.

The future of the CHI programme rests on how the community can be motivated to continue enrolling for it. This will entail approaching them through SHGs, VDCs and VHCs. Gram Panchayats will also be playing an important role. Financial assistance will be given for paying premiums through SHGs to members who require it. Gram Panchayats will be approached to use the funds they have available to subsidise premiums for those members of the community who cannot pay.

The CHI scheme has successfully shown that a public/private partnership is not only possible; it is also desirable in an area like healthcare. This partnership will be strengthened through increased interaction and sustained mutual efforts to provide value to the facilities available.

The viability of the CHI scheme in both models has been established. In order to sustain the momentum as well as to scale up the activities so that a greater number of people can be covered for health risks, Karuna Trust has formulated several plans. "Quality of service is very important to the success of a programme of this nature. If they have to remain with the programme, we will have to



Health seeking patterns in T Narasipura and Bailhongal

Sl.No	Name	PHC/PHU	Taluk	District
1	Gumballi	PHC	Yelandur	Chamarajanagar
2	Sugganahalli	PHC	Magadi	Bangalore Rural
3	Kammasandra	PHU	Doddaballapura	Bangalore Rural
4	Shimsha	PHU	Malavalli	Mandya
5	Shivanasamudra	PHU	Malavalli	Mandya
6	Yemalur	PHU	Bangalore Urban	Bangalore Urban
7	Pattanayakanahalli	PHC	Sira	Tumkur
8	Idaguru	PHC	Gowribidanoor	Kolar
9	Ashoka Nagara	PHC	Khanapura	Belgaum
10	Aralugodu	PHU	Sagara	Shimoga
11	Castle Rock	PHC	Joyida	Karwar
12	Sriramarangapura	PHC	Hospet	Ballery
13	Dindavara	PHC	Hiriyur	Chitradurga
14	Hudem	PHC	Koodlagi	Bellary
15	Anegundi	PHC	Gangawati	Koppal
16	Kannur	PHC	Bijapur	Bijapur
17	Mallapura	PHC	Jagaluur	Davanagere
18	Galigi Hulakoppa	PHC	Kalaghattagi	Dharwad
19	Tithimathi	PHC	Virajpet	Kodagu
20	Kallusadarahalli	PHC	Arsikere	Hassan

ensure that they get the same, if not improved levels of service. We will also extend the CHI facility to all the 18 PHCs that we have adopted in Karnataka state. The future will also see Anti Retro Viral (ARV) drugs for HIV/AIDS being eligible for claims under the insurance scheme," says Dr Sudarshan.

Networking and efforts to initiate policy level changes

Karuna Trust has networked with organisations engaged in similar initiatives across the country. At the National Conference on Community Health Insurance,[6] held on 30-31 October 2003 in Mysore, efforts initiated by SEWA in Gujarat, Narayana Hrudayalaya and the Government of Karnataka in

[6] Organised by Karuna Trust, UNDP and Ministry of Health, GOI

Karnataka, and the Universal Health Insurance Scheme of the Central Government were shared.

"Through the conference, we presented our model of CHI and exchanged information on the work other organisations were doing. We also explored the possibilities of upscaling the scope of CHI in Karnataka as well as in other parts of the country. It gave us a good opportunity to study the strengths of other models and integrate them into ours, wherever possible," says Dr Sudarshan.

There are efforts to lobby with the government to effect policy level changes that will view health insurance as an integral part of health initiatives across the state. In view of the tangible results that the UNDP/Karuna Trust CHI scheme and other similar efforts in Karnataka have achieved, the government has plans to include health insurance as an important component in the future health plans for the state.

In its quest to provide health security to the disadvantaged rural people, Karuna Trust in T Narasipura, and the zilla panchayat in Bailhongal, has set a process in motion. Both models have proved that CHI can provide the much-needed security that the poor require when they fall sick. It also impacted on society in many ways. Timely medical attention, which CHI can facilitate, results in improved general health, and increased productivity among the people.

A healthy society can ultimately translate into a progressive nation. Unmistakable evidence that micro-level interventions can lead to macro-level changes.

Annexure 1

Karuna Trust

Karuna Trust is a voluntary organisation established in 1987 with the objective of facilitating integrated development among the poor and marginalized people, both rural and tribal, through health, education, vocational training and socio-economic programmes. It also looked at empowering the rural poor to organise themselves and work towards achieving self-reliance. Its operational areas span 40 villages in Yelandur taluk of Chamarajanagar district, and 207 villages of T Narasipura taluk of Mysore district.

In Yelandur, Karuna Trust has several ongoing programmes related to health, education, sanitation, and other areas. These are:

- Health - Leprosy, epilepsy, and tuberculosis control, Community Mental Health, Community based eye care, Community dental health, Community Based Rehabilitation (CBR)
- Drinking water and sanitation
- School adoption – adoption of government schools to improve the quality of teaching, facilitate community participation and provide safe drinking water
- Economic programmes - promotion of Self Help Groups and micro financing, vocational training, income generation programmes
- Human resource development – centre to motivate and train social workers with emphasis on development of physical, mental and spiritual potential
- Community Health Insurance
- Model PHC – adoption of government PHC to facilitate improved quality of service

T Narasipura has been functioning since 1996 and works in the areas of:

Health

- Community development - promotion of Self Help Groups and micro financing, vocational training, income generation programmes
- Community Convergent Action (CCA) – Formation of Village Development Committees (VDCs) and convergence of all services at the village
- Education - adoption of government schools to improve the quality of teaching, facilitate community participation and provide safe drinking water
- Community Health Insurance

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Annexure 2

National Insurance Company

National Insurance Company Limited was incorporated in 1906 with its registered office in Kolkata. Consequent to passing of the General Insurance Business Nationalisation Act in 1972, 21 Foreign and 11 Indian Companies were amalgamated with it and NIC became a subsidiary of General Insurance Corporation of India (GIC), which is fully owned by the Government of India. After the notification of the General Insurance Business (Nationalisation) Amendment Act, on 7th August 2002, NIC became a Government of India undertaking.

The Company has earned international recognition as one of the top 5 General Insurance Companies in the Asia Pacific, at the Asia Insurance Industry Awards held by Asia Insurance Review, at Singapore in October 2003.

National Insurance Company Ltd (NIC) is one of the leading public sector insurance companies of India in non life insurance business. Innovative and customized policies ensure that even specialized insurance requirements are taken care of. The Company offers protection against a wide range of risks to its customers. The Company offers insurance to almost every sector or industry in India:

- Banking
- Telecom
- Aviation
- Shipping
- Information Technology
- Power, Oil & Energy
- Agronomy
- Plantations
- Foreign Trade
- Healthcare, including community health insurance
- Tea
- Automobile
- Education
- Environment
- Space Research

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Annexure 3

Centre for Population Dynamics

Centre for Population Dynamics (CPD) is a not-for-profit NGO established under the Karnataka Societies Registration Act 1960, to address issues that are of current importance in the area of health, child survival and related sectors. The focus areas include general population issues and those related to health, women's reproductive rights, mother and childcare, nutrition etc. Prevention of AIDS and STDs and other health related activities, including information, education, and communication (IEC), and training are other important activities.

A major thrust area of CPD relates to issues of quality determination and maintenance in the health and related services. The improvement of the management systems and associated reporting and monitoring systems of these services is also an important area of interest.

CPD undertakes innovative projects that address vital issues in the area of reproductive health and child survival, and include elements that impact social attitudes. Interventions that enhance both knowledge and practice of measures for improvement of family and individual health are built into these activities. CPD directs focus within projects to develop innovative approaches that could be adopted or adapted across the country.

CPD has strong links with professional organisations and experts in the country and abroad with whom it works in close collaboration. It liases with reputed professionals and experts in the conceptualisation, planning, execution, monitoring, and evaluation of projects. Institute for Social and Economic Change, Population Centre of the Government of Karnataka, Family Planning Association, State Resource Centre, Mysore, are some organisations CPD has worked with, besides prominent women's NGOs, and health administrators.

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