2006 | ASIAN DECENT
2015 | WORK DECADE

International Labour Organization

SERIES:

SOCIAL SECURITY EXTENSION INITIATIVES IN SOUTH ASIA

INDIA: PREM RURAL HEALTH SCHEME

(ORISSA)

"DEVELOPING A HOLISTIC HEALTH PROTECTION APPROACH"

ILO Subregional Office for South Asia

INTRODUCTION

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1st) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role has to rely on practical evidence, ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. The holistic approach to health care adopted by PREM while designing its health insurance intervention provides such an example.

BACKGROUND

Since 1980, People' Rural Education Movement (PREM), an NGO based in Bherampur District of Orissa is involved in many local development support activities for the benefit of Adivasis, Scheduled Castes and small and marginal farmers.The direct interventions among these communities needed to rely on Community-based Organizations (CBOs) and a strong network for advocacy and lobbying.

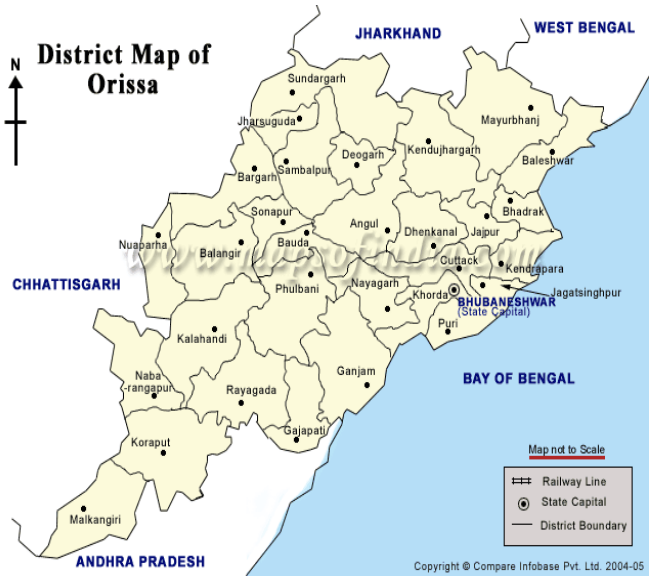
This was done by organizing CBOs into federations at apex levels. Embedded in a wider health promotion programme, PREM initiated in 2002 an innovative health insurance targeting the poor tribal population spread over two districts. It is a comprehensive programme which covers preventive and promotive health care along with curative treatment while ensuring a deep sense of ownership among its members.

This in-house scheme is one of the few using public health facilities to deliver health care service covered under the insurance plan. With support of PLAN-International, the scheme also innovated in

setting up some 500 Village Medicine Depots run by trained volunteers aiming at ensuring doorsteps availability of essential medicines at affordable prices. This still unique experience in India is seen as a major factor explaining the scheme's success in enrolling the local population with high renewal rates observed over the years. According to a study recently released by WHO, medicine costs amount to some 45% of the entire health care expenditures borne by poor households in India. The availability of essential medicines through a network of village depots may thus be seen as an essential component of any community-based health insurance scheme to be promoted among the poor

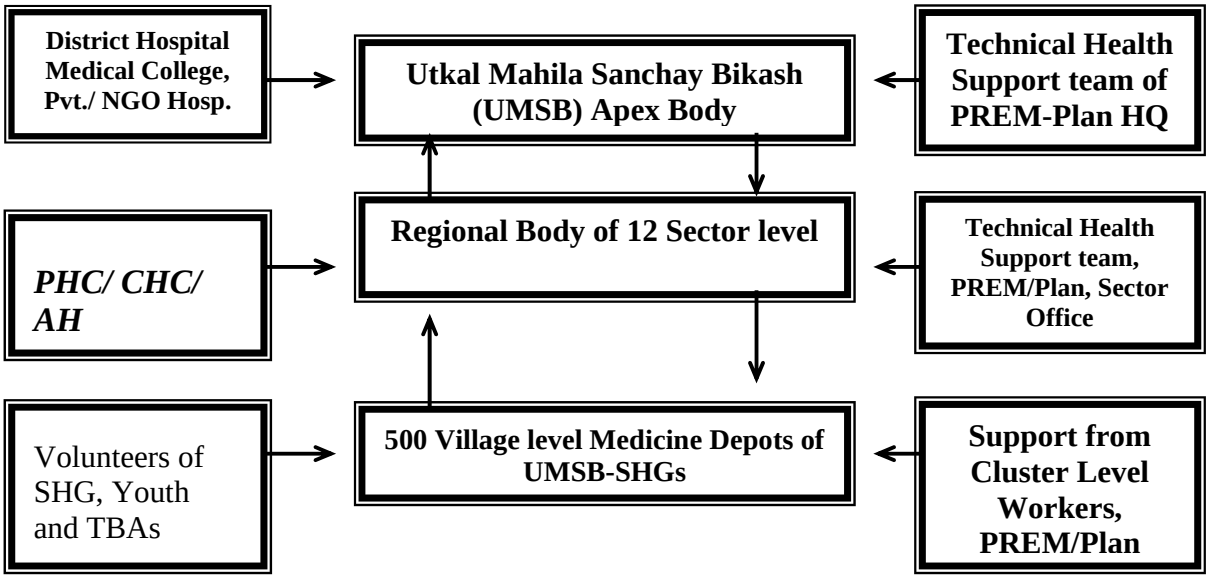
TARGET POPULATION

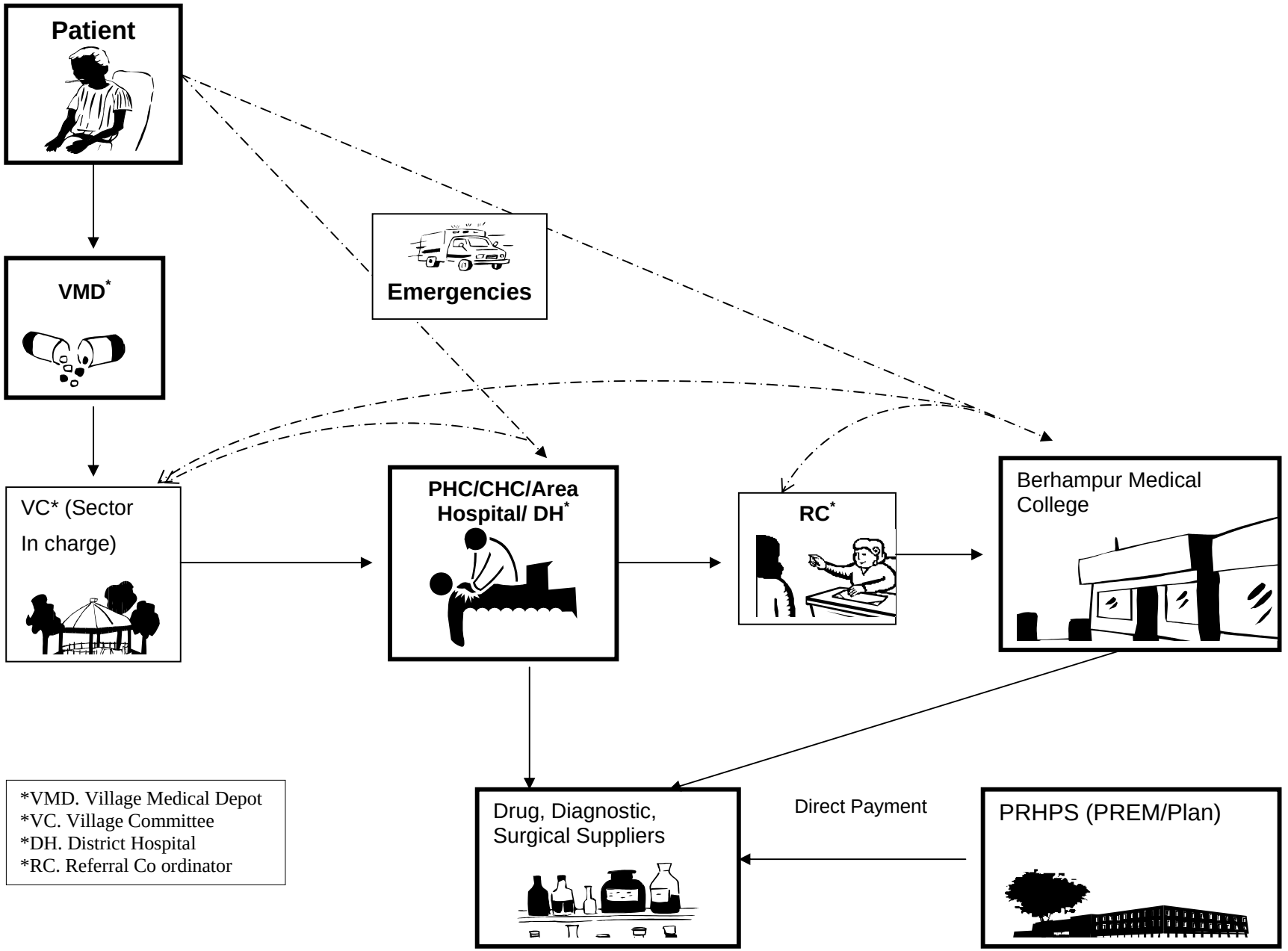
PREM and its partner organizations have already developed a long experience working with indigenous groups living in remote forest and hilly areas in the most backward districts of India. The tribals and dalits are not only the poorest people in the country, but they are also socially excluded and face a heavy burden of stigma and discrimination because of their low caste status. There is much evidence to show that the bulk of disease burden is concentrated in this population segment, disproportionate to the percentage of indigenous population. PREM and its partner organizations have been involved over the last few years in similar experiences in testing community based health micro-insurance mechanisms targeting these vulnerable groups. Some of the lessons learnt include the following:



- There is a need to answer to the comprehensive health care needs of the target groups, covering both primary and secondary health care services
- Relying on existing solidarity groups makes a big difference to the success of any insurance scheme.
- The new demand for services created by the members of these schemes put pressure on public hospitals to become more functional and improve the quality of services
- When paying even a small contribution, the members play a more active part in demanding quality of care and pushing for more efficient health care delivery mechanisms

ORGANIZATION




Patient
VMD*
Emergencies
VC* (Sector In charge)
PHC/CHC/Area Hospital/ DH*
RC*
Berhampur Medical College
Drug, Diagnostic, Surgical Suppliers
Direct Payment
PRHPS (PREM/Plan)
*VMD. Village Medical Depot
*VC. Village Committee
*DH. District Hospital
*RC. Referral Co ordinator

THE INSURANCE PLAN

Eligibility

The scheme is open to all families already covered by the other PREM health interventions in the two districts of Gajapathi and Puri. It is a mandatory scheme: all families in a village must enrol in the scheme and there is no age bar.

Exclusions

No real exclusion clause, but benefits may be limited to those available at the secondary level hospitals. Hence, specialities may not be covered everywhere under the scheme. Some excluded diseases such as tuberculosis are not covered under the insurance scheme since full treatment, even for non-members, is already provided by the Government. HIV/AIDS and conditions related to the syndrome are not intentionally excluded by the scheme due to lack of testing.

Plan Benefits

The plan covers the following services:

Level	HC Facility	Services	Coverage
First	Village medicines depots	Diagnosis, treatment, medicines,safe delivery	Free OPD 50 % discount on medic.
Secd.	PHCs, CHCs, area hospitals	Any disease	Up to Rs 3,600
Third	Private hospit.	Any disease	Up to Rs 3,600

Premium Rate

Premium to be paid for each member of the family was set as follows:

- Rs 20 per family member in Years I, II and III
- Rs 30 per family member in Year IV

Plan Distribution

Village committees with the assistance of PREM staff take charge of the responsibility of distributing the plan and of collecting the premium. The strong solidarity traditions existing in tribal villages and the slogan “one for all and all for one” instil a sense of ownership and thus ensure a large membership basis, prompt premium collection and prevention of moral hazard;

General Overview

Starting date	2002
Ownership profile	NGO/CBO
Target group	Dalits, tribals
Outreach	2 districts
Intervention area	Rural
Risks covered	Single risk: Health
Premium Insured/Y.	Rs 30
Co-contribution	-
Total premium	Rs 30
No of insured	150,000
Percentage of women	50%

Operational Mechanisms

Type of scheme	In-house
Insurance company	No
Insurance year	Fixed (Jan. to Dec.)
Insured unit	Family
Type of enrolment	Mandatory
One-time enrolm. fee	None
Premium payment	Yearly – upfront
Easy payment mechanisms	Soft loans, access to local health funds

Scope of Health Benefits

Tertiary health care	
Hospitalization	
Deliveries	
Access to medicines	
Primary health care	

Level of Health benefits

Hospitalization	Up to Rs 3,600
Medicines	50%
OPD services	Free

Service Delivery

Health prev/educ. programmes	Health camps, wider health education progr.
Prior health check-up	No
Tie-up with H.P.	Yes
Type of H.P.	Public & private
Type of agreement	Informal agreement
N°of associated HP	8
TPA intervention	No
Access to health care services	Pre-authorization required
Co-payment	None
HC payment modality	Cashless/reimburse.

Service Delivery

- First level: The patient is first treated at the Village Medicine Depot by the volunteer who has been trained by PREM. He/she is treated with the basic drugs available at the VMD which the volunteer was trained to use. The treatment cannot exceed three days at this level;

- Second level: If the patient is still sick after three days, he/she has to be transferred to the nearest public or private health facility (Public Health Centre, dispensary, private hospital…). If some costs are incurred at this level, these are covered up to Rs 3,600 by the scheme;

- Third level: The patient has to be transferred to the District Hospital or the Medical College. In this case, all costs incurred such as diagnostic fees, laboratory tests, surgical procedures and medicines are covered up to the same benefit amount. In exceptional cases where surgeries have to be performed for a higher cost, PREM may decide to extend the cover up to this new level.

Administration

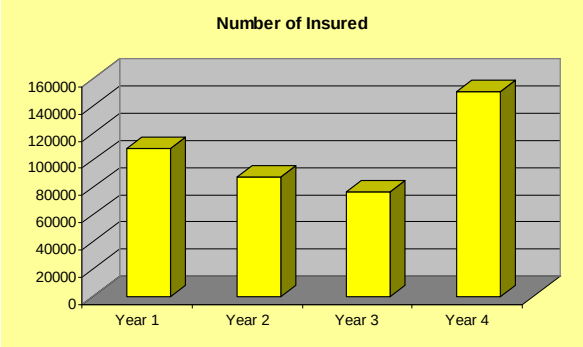
The scheme is fully administered by PREM staff in collaboration with the partner organizations operating at the local level (federations of Self-Help Groups and co-operatives).

MAIN ACHIEVEMENTS

Coverage

More than 15,000 families enrolled in the scheme in Year I with a very high level of penetration (80%) and renewal (94%). The number of members decreased over the last two years due to some fishermen communities dropping out of the scheme. With a new focus set on tribal groups, the scheme is now extending its coverage, planning to reach 500,000 people over the next two years.

	Year 1	Year 2	Year 3	Year 4
N° Insured	108,529	87,280	76,652	150,000

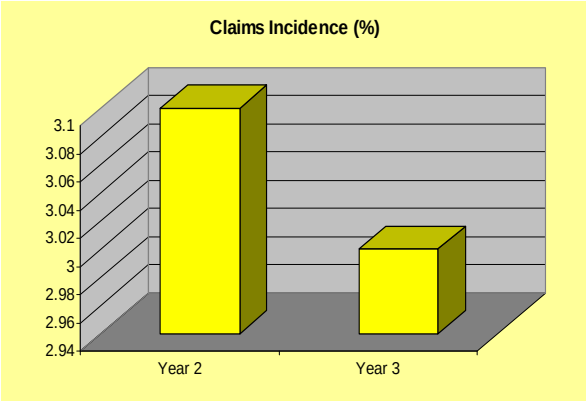


Services Provided

Over time, a significant reduction in the number of referrals due to services provided at the primary level could be observed (downwards profile of claims incidence and claims cost).

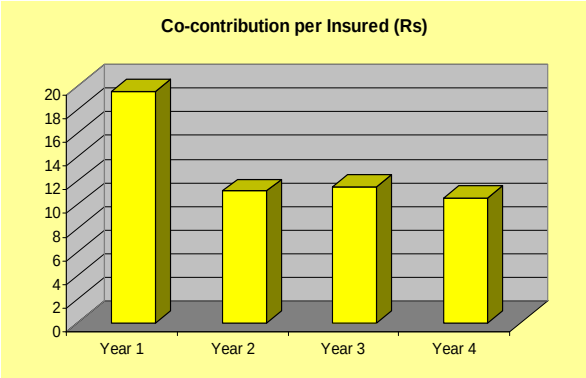
Claim incidence has also slightly decreased from 3.1 per cent to 3 per cent over the last two years.

	Y 2	Y 3
Claim Incid.	3.1 %	3.0 %



Co-contribution

The scheme benefits from a progressively declining lump sum grant provided over its first six years by PLAN International. In its fourth year of operation, this grant represented a co-contribution of Rs 10.5 per insured.



	Y 1	Y 2	Y 3	Y 4
		X 1000		
Co-contribution	1,500	1,200	1,000	800
N° of Insured	77	108	87	76
Co-contr/Insured	19.5	11.1	11.5	10.5

Administration Costs

Although kept at a low level, administrative costs are not yet fully recovered with the resources generated by the scheme. It still relies today on an indirect subsidy provided by PLAN International. The scheme plans to reach its operational sustainability level through a state-wide expansion effort allowing it to increase its coverage while taking the best advantages of a wider network of health providers.

CHALLENGES

The insurance plan has still to address the following key challenges:

- Increase plan benefits;
- Achieve full operational sustainability;
- Develop a partnership arrangement with Government of Orissa with a co-contribution mechanisms allowing for an increase of plan benefits;
- Improve management information system (PREM and its partner organizations will use the software developed by Uplfit with ITB for all its micro-insurance activities: SYLIFT – MFMS (Mutual Fund Management System). It is meant for community-based organizations sharing with UpLift the same vision and engaged in the progressive development of a common health insurance database;
- Organize the full transfer of management responsibilities to CBO apex organization.

THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme. Evidence also suggests that building efficient linkages between community-based initiatives and government programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages

Financing:	☺
Operations:	No
Service Delivery:	☺
Governance:	No
Policy Planning:	☺
Legal framework:	No

PREM health insurance scheme was one of the first to be designed as a component of a wider health intervention which included prevention, promotion and curative activities. It also showed a new avenue in partnering with public health providers and in ensuring the availability of essential medicines at the village level. This holistic approach, together with a strong involvement of each community proved to be highly successful in providing efficient and comprehensive health care services to disadvantaged groups.

1. Financing

To support and stabilize the scheme, PLAN International (India) has been paying seed money for six years on a progressively declining basis. The scheme presently uses this annual grant for the payment of all health services while investing the premium collected in mutual funds with a small amount in shares and loans. Investments in mutual funds are in both low return – highly secured schemes based on Debts, Government Securities and Debentures as well as in high return but relatively less secure equities. By the sixth year, using the returns yielded by these investments, the scheme is expected to become self reliant.

2. Operations

There is no direct role for the State Government in the present scheme. However, PREM actively collaborates with various Government programmes such as Malaria Control and TB Eradication and Immunisation programmes which have a bearing on both the health status and health behaviour of the target group.

3. Service Delivery

This in-house scheme is one of the few using public health facilities to deliver health care service covered under the insurance plan. With PLAN support, the scheme also innovated in setting up some 500 Village Medicine Depots run by trained volunteers aiming at ensuring doorsteps availability of essential medicines at affordable prices. This still unique experience in India is seen as a major factor explaining the scheme's success in enrolling the local population with high renewal rates observed over the years.

According to a study recently released by WHO, medicine costs amount to some 45% of the entire health care expenditures borne by poor households in India. The availability of essential medicines through a network of village depots may thus be seen as an essential component of any community-based health insurance scheme to be promoted for the poor.

4. Governance

The scheme still has to evolve into a closer partnership with the Ministry of Health and Family Welfare in order to plan, organize and develop together a far wider intervention.

5. Policy Planning

Having demonstrated noteworthy progress in all its endeavours, the scheme also showed a strong potential for growth and expansion within the state. As a result, PREM has recently been approached by the state government to look at the possibility to expand its activities to a larger BPL (Below Poverty Line) population. Discussions are currently under way with both the State Government and the Central Government.

6. Legal Framework

Being a self-funded scheme, without any tie-up with an insurance company, PREM rural health scheme remains out of the purview of the micro-insurance regulations issued in November 2005 by the Insurance Regulatory and Development Agency (IRDA) of India.

CONCLUSION

PREM's work in the health sector provides a good background for developing health insurance as part of an overall programme of health promotion including activities in preventive health. Preventive health care programmes and peripheral care offered through the Village Medicine Depots help to reduce referral morbidity and thereby reduce the expenditure load on the insurance scheme. As the scheme is mainly using public health facilities for referrals, it is to some extent also insulated from excessive cost increases observed in the private sector. Firmly rooted in the community, and preparing a progressive transfer of responsibilities to a federation of women's SHGs, the health insurance scheme already provides one of the best examples of community solidarity and ownership.

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