Composite Tribal Health Insurance Programme

ASHWINI - Sir Ratan Tata Trust Project

Narrative Progress Report for the year 2005

INTRODUCTION

ASHWINI, a registered charitable society, has been running a comprehensive health program for tribals in the Gudalur and Pandalur Taluks of the Nilgiri District in Tamil Nadu. Together with sister organisations, ACCORD and Vishwa Bharathi Vidyodaya Trust, a program for the holistic development of the tribal community is implemented through the peoples' organisation, AMS (Adivasi Munnetra Sangam).

In keeping with this philosophy, a health insurance scheme was started in 1992 to encourage participation of the community in accessing health care with dignity. Health insurance was provided through a mutual insurance scheme where all members of AMS contributed money to ASHWINI. Reinsurance for inpatient care was done with The New India Assurance Company.

At the end of a ten-year period, a critical analysis of the Insurance program was done at a review workshop organised with the help of Sir Ratan Tata Trust. Recommendations from the expert committee were incorporated in the formulation of a Composite Health Insurance Program for the tribals of Gudalur. With support from SRTT the program was launched in January 2003. The Royal Sundaram Insurance Company provides reinsurance for inpatient care. Each year ASHWINI negotiates with Royal Sundaram for the premium amount and claim ceilings.

The program is in its fourth year now. There has been tremendous progress in the capacity of the tribal team to administer the program. The community has been actively participating in discussions about insurance. We have been part of studies on community-based insurance and extensive networking has been done. Policy makers and academicians see this program as a successful model of community based insurance.

It is important to consider the insurance program in the context of the other interventions in health and economic development.

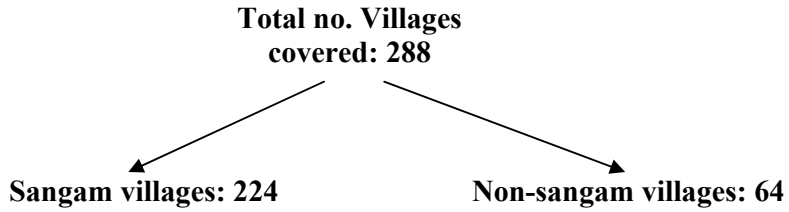
HEALTH SCENARIO IN THE YEAR 2005:

Nilgiris is going through a phase of economic depression. In the last 4-5 years there has been a crash in the prices of tea, coffee and pepper, the main cash crops in the area, on which the entire economy depends. Plantations are unable to sustain themselves and have stopped employing labour. Tribals who are dependent on manual labour are unable to find work. Income levels have dropped. This is very visible in the health parameters in the last few years, there being a steady downward trend in these.

Many a time, the reason given by the family for not assessing heath care on time has been the fact that they have not paid the insurance premium. The tribals are a timid community with much self-respect; begging is unheard of. Not having paid the premium amounts to not being a part of the process and they are diffident to come to the hospital. This is one of the main reasons why we are working out various ways to make the insurance program all-inclusive.

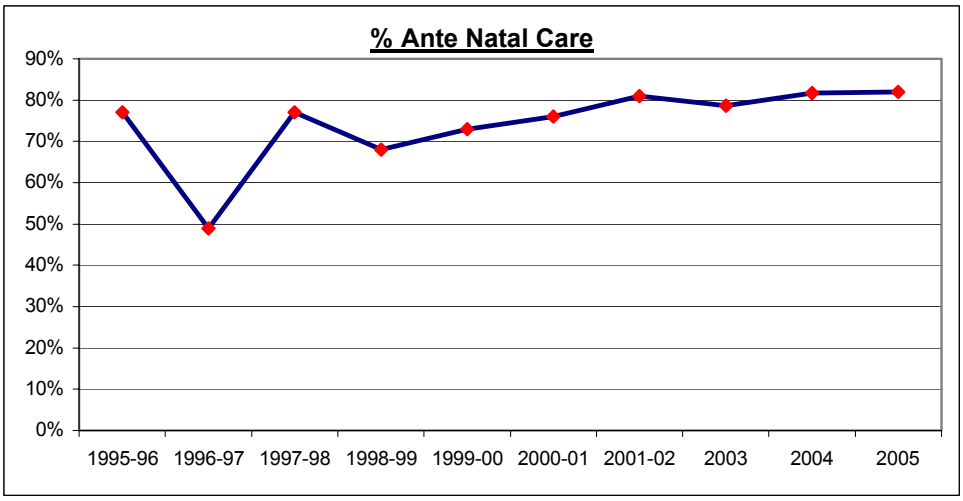
The community health program has been strengthened by the participation of village health volunteers, whose support to the health animators functioning out of the eight area centres is invaluable. Health volunteers from over half of the total if 210 villages have been regularly attending training sessions and taking responsibility for the health of their villages. Preventive care, health education and primary curative care is being provided at the area centres. Detecting illnesses early has helped us to keep costs of curative care and hence insurance premiums down.

Some of the statistics of the health program for the year 2005 is given below:



Antenatal Care

In the 224 sangam villages, more than 80% of the women receive antenatal care. Maternal mortality had come down to zero for a period of 3 years but is showing an upward trend again.



Total number of deliveries: **258**

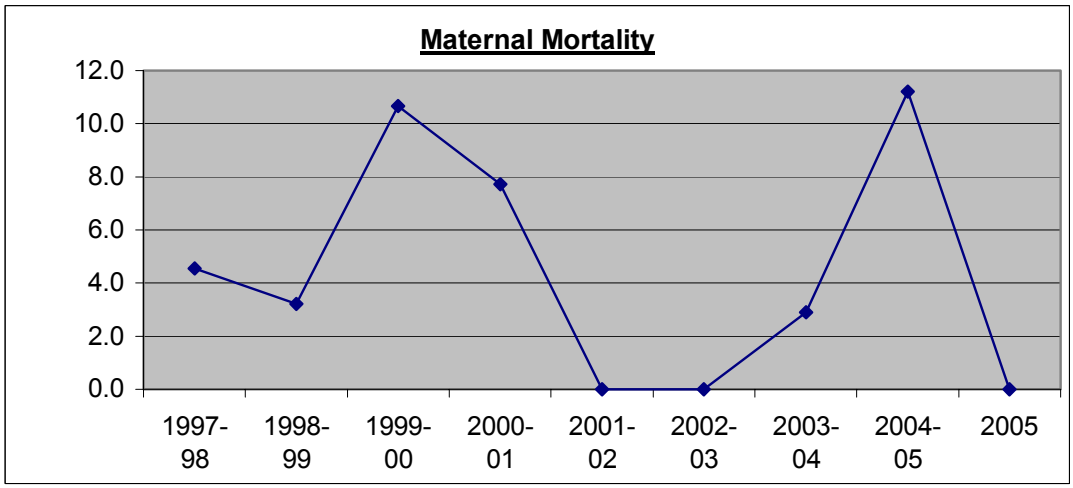
Antenatal check-ups:

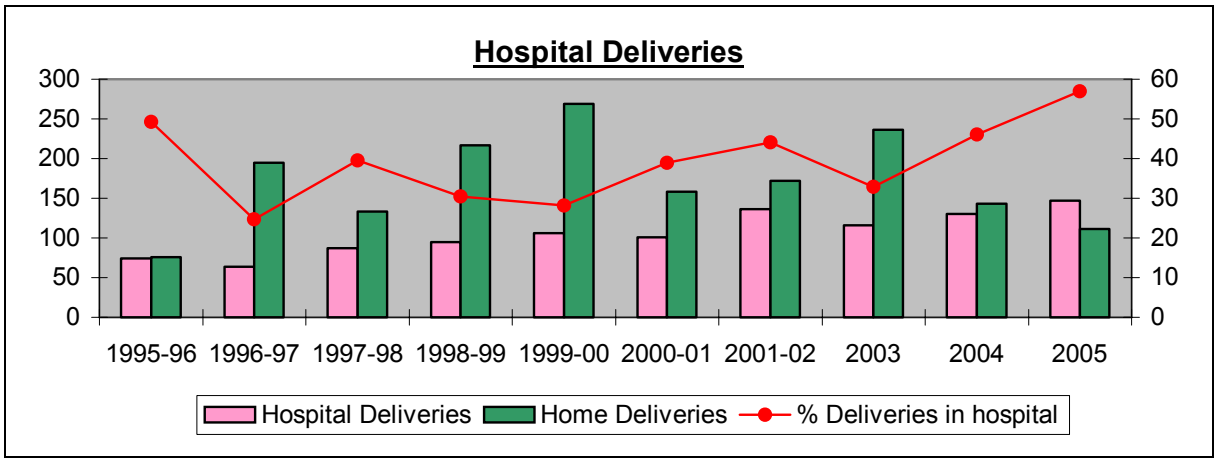
3 or more check-ups: **211 (82%)**

Pregnancy outcome:

Hospital delivery:	147 (57%)
LSCS	**9** (6% of hospital deliveries)
Abortion:	8
IUD:	7
Stillbirth:	3
Maternal mortality:	0
Eclampsia:	3

There was one maternal death and 2 eclampsias reported from non sangam villages. There has been a very high incidence of eclampsia this year.





Under 5's Monitoring

1. Immunisation

Children 1-2 years of age: **274** Children 2-4 years of age: **585**

Received all 10 doses immunisation (i.e. fully immunized): **88%**

Although in the initial years, our team did almost all immunisation, we have succeeded in handing over this responsibility to the government. We continue to monitor and intervene where necessary.

2. Growth monitoring

Number of children 4 years and under: 1206
Their Nutritional Status:
Normal weight: 229
Grade 1 malnutrition : 269
Grade 2 malnutrition : 235
Grade 3 malnutrition : 27

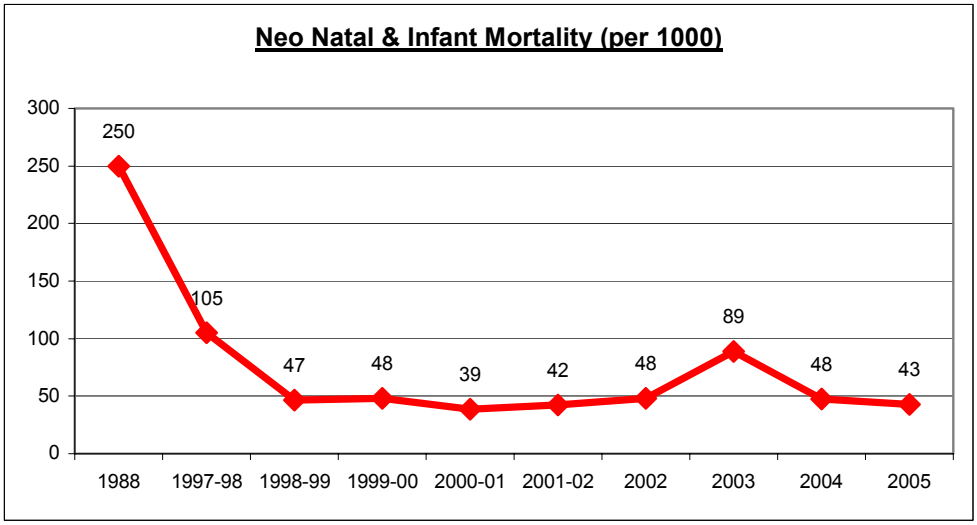
Combating malnutrition is an uphill task, especially with the income levels of families having gone down. We provide supplemental nutrition and education. Many economic activities have been started like rice trading, chicken bank, and tealeaf marketing society etc to address these issues.

3. Child mortality

- Neonatal mortality – (1-28 days): 8 deaths
- Infant mortality – (28 days to 1 year): 3 deaths
- Child mortality – (1 year to 5 years): 4 deaths

Many of these were preventable deaths. In most cases the families had not accessed health care in time. This emphasizes to us the importance of the village health volunteer that can

act as a resource at the village level, to detect illnesses early and ensure that these children receive prompt treatment. The insurance program also should be such that no one feels excluded.



Family planning

Couples accepting Copper T - 28
Tubectomy - 35

Within the tribal community, the birth rate is falling, with people voluntarily opting to have fewer, healthier children. There is better spacing of pregnancies, which has undoubtedly been one of the factors in the improvement in the nutritional status of young children.

Curative care

Basic curative care is given during village visits, in addition to outpatients seen in the area centres. Anyone requiring more specialized care is referred to the Gudalur Adivasi Hospital.

Number of patients seen in the area centres: 5327

The commonest problems are acute respiratory illness, fever, anaemia and gastritis. Due to early treatment at the area center or the village, most people need not go to hospital. Scabies, impetigo and diarrhoea have all reduced, but the Health Animators are seeing more tribal people with chronic non-communicable diseases, such as hypertension, heart disease, diabetes and mental illness. Their treatment and compliance is monitored regularly, but it is a difficult task. We feel that, by having trained village health volunteers, we can address this difficulty.

Curative care at The Gudalur Adivasi Hospital continues effectively. The trainees are more confident now and help in the nursing care. They also do health education sessions in the evenings for patients and bystanders. Dr Ashwin, a young medical graduate joined us in April. Dr Shalini, also a fresh graduate works part time with us. Nursing staff is stretched

with Indira, one of the senior nurses having joined a 2-year diploma in pharmacy course. Sudha, one of the staff nurses is also on study leave.

Out-patients:	**12263**	**Surgeries:**	**218**
Tribal:	7239	Tribal:	154
Non-tribal:	5024	Non-tribal:	64
In-patients:	**1083**	**Deliveries:**	**161**
Tribal:	992	Tribal:	140
Non- tribal:	91	Non-tribal:	21

Referrals

Referral to major centers of patients that cannot be treated here poses a major problem. Apart from the fact that many are still too scared and would rather not go anywhere, financing the patients who are ready to go is an issue. Suresh and Vijayan two young paraplegics were referred to CMC, Vellore for rehabilitation. Thanks to Henry, one of our alumni, the treatment costs were written off. Nevertheless, transport and food were big expenses that were covered by individual donations. They are back after two months, walking with calipers.

During the policy period, many other patients were referred to various hospitals. This was taken up with RSI for discussion.

Mortality (above age 5)

Total deaths over 5 years:	**91**
Suicides:	4
Cancer:	11
Strokes/Cardiovascular diseases	19
Others	59

Suicide and Mental Health

If one were to extrapolate the number of suicides in our tribal population to a population of 1 lakh, we would arrive at a suicide rate of well over 100 per 100,000 people. This is an extraordinarily high figure, around 4 or 5 times the national average, more than triple the figure in the neighbouring Kerala districts. It is an indicator of the severe socio-economic stress faced by the tribal community and of the increasing prevalence of mental illness. In the past few months we have started a Community Mental health program with the support of The Sir Ratan Tata Trust.

Awareness Creation

Many health education sessions and discussions on insurance are held for health volunteers, sangam thalaivers and youth groups. There is active participation in these meetings. We are confident that, by targeting the younger adivasi generation, and creating better awareness of the factors affecting health and disease, our Health Programme will have a more powerful and sustained impact on the tribal community as a whole.

Training

8 new health animators are undergoing training in health and other socio-economic issues. They stay in the hospital or are posted with the different health animators in area centres. They have regular classes and learn many things on the job. The staff has ongoing training in planning, evaluation as well as clinical skills.

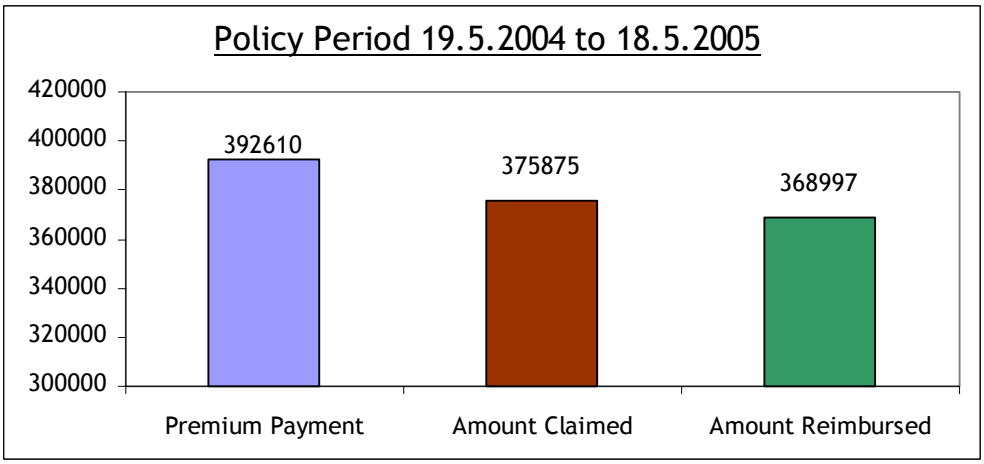
The other major training activity is of the health volunteers. They attend training at the area centres and come to Gudalur for 2-day camps. At these camps insurance and health financing is discussed at great length.

INSURANCE PROGRAM

Reinsurance with Royal Sundaram Insurance Company:

The second year of the insurance package came to an end in May 2005. The following is the analysis of the second year's reinsurance:

Claims and reimbursements between May 19 2004 and May 18 2005.

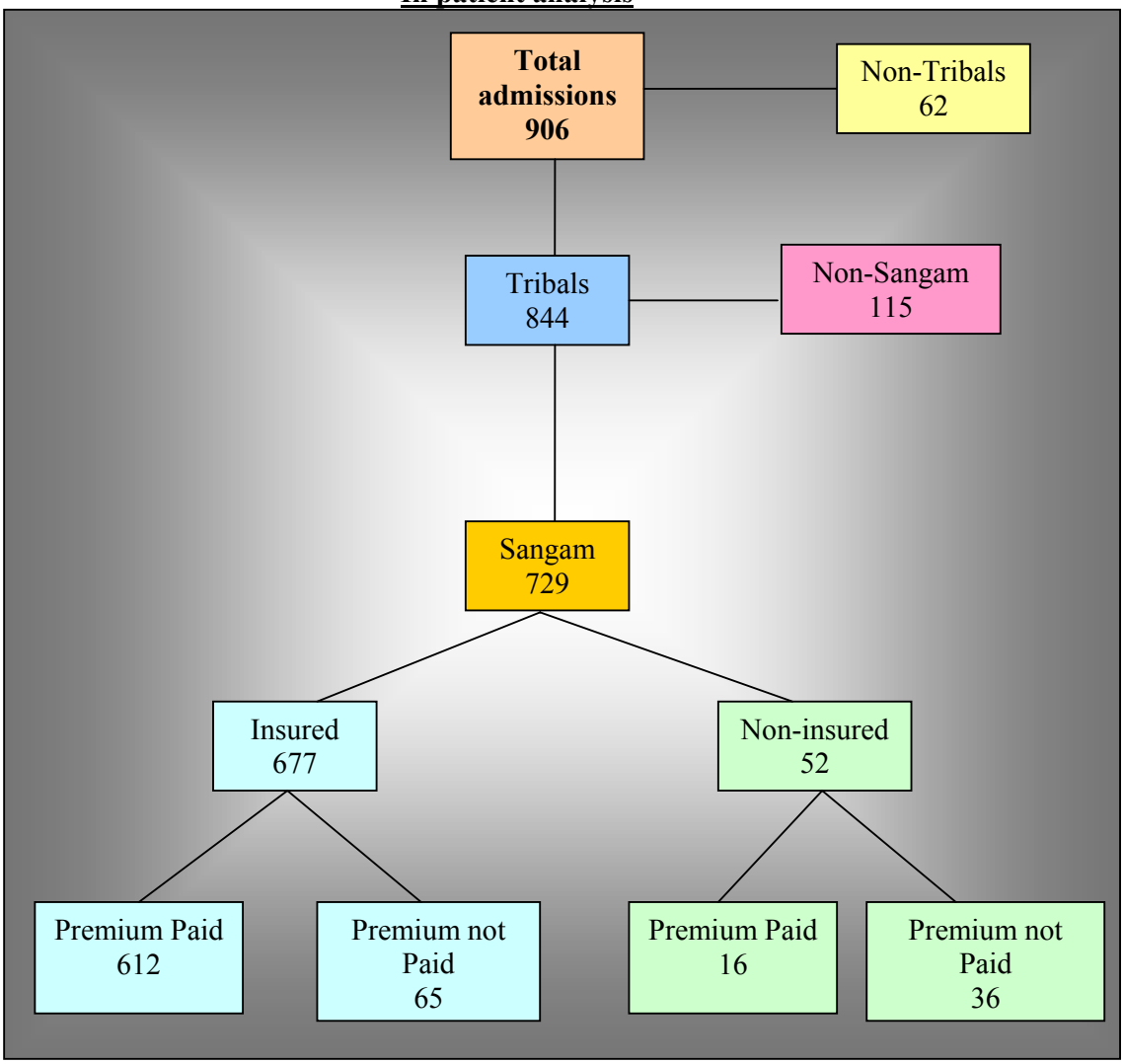


For the first time, the premium paid has been more than the amount claimed. RSI supported ASHWINI with a sum of Rs 50000 for a Royal Sundaram ward that will help cover costs for non-claimable ailments.

Income and expense analysis

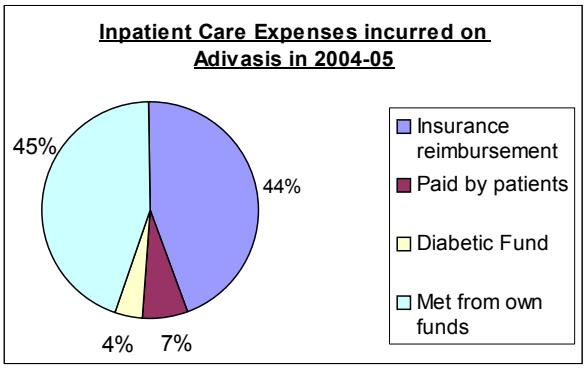
Category of Patients	Total Bill Amount	Paid by patients	Reimbur-sements	Met from own funds	No. of Patients
Insured, Premium Paid	541487	11368	311174	218945	612
Insured, Premium not paid	53758	8875	35263	9620	65
Non-Insured, Premium Paid	8253	6316	0	1937	16
Non-Insured, Premium not Paid	140130	26510	0	113620	151
Total Tribals	**743628**	**53069**	**346437**	**344122**	**844**
Non-Tribals	91338	85537	0	5801	62
Total Patients	**834966**	**138606**	**346437**	**349923**	**906**

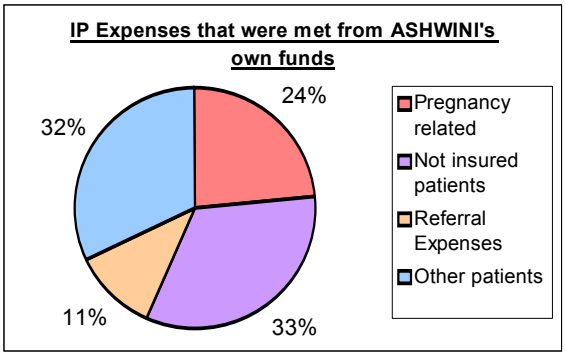
In patient analysis



	2003-04 *	2004-05
Total Bill Amount	761505	743628
Referral Expenses	21833	40293
Total IP Expenses	783338	783921
Insurance reimbursement	309414	346437
Paid by patients	41467	53069
Diabetic Fund	29606	31498
Met from own funds	402851	352917
Met from own funds	**2003-04 ***	**2004-05**
Pregnancy related	89402	82990
Not insured patients	107128	115557
Referral Expenses	21833	40293
Other patients	184488	114077
Total	**402851**	**352917**

* The Insurance Policy related details are for the period from 19.5.2003 to 31.3.2004





It is clear that with the claim limit at 1500, only 44% the in-patient costs are being met by the policy. The main non-claimable amounts are the delivery expenses and above claim limit expenses. About Rs.40000 was spent on referral expenses.

Dr Shylaja visited Chennai and had discussions with the concerned officers regarding possible changes in the new policy.

Representatives of The RSI Company visited Gudalur and expressed greater confidence in this policy. After analysing the data for the year, RSI agreed to the following :

- Claim limit was increased from Rs 1500 to Rs 2500 per year.
- Claim limit for delivery was increased from Rs 500 to 1000.
- An additional claim for referral expenses of Rs 2000 per claim to a maximum of Rs 30000 a year was added.
- The premium was raised from Rs 30 to Rs 40 per person per year.

We hope that this will be an ideal premium, which will cover the bulk of in patient costs. Referral expenses remain a problem that we will need to address in the coming years.

Premium Collection from the community:

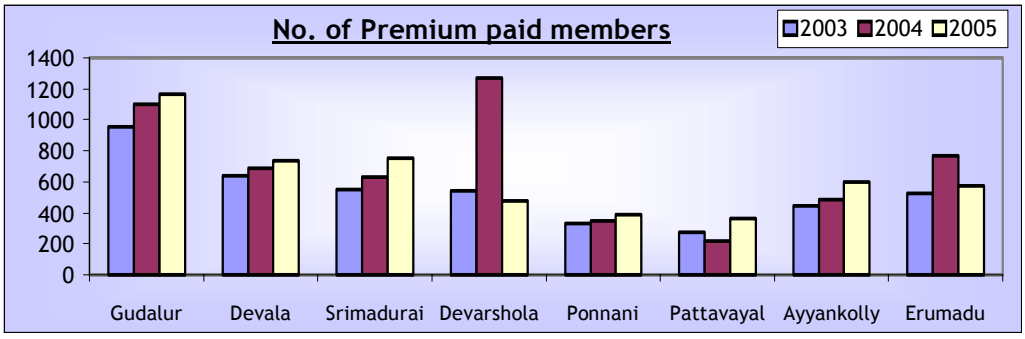
After many discussions, different area developed different strategies for collecting premium.

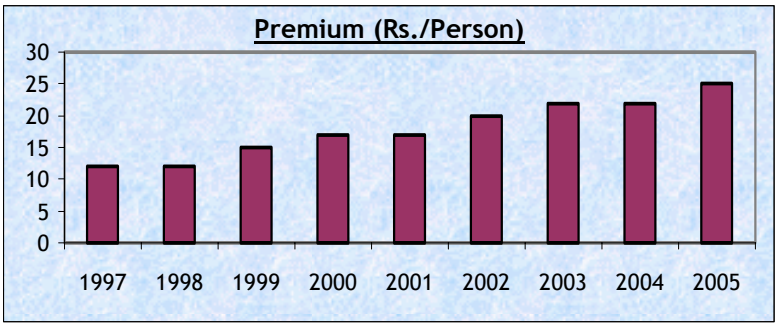
Year	1997	1998	1999	2000	2001	2002	2003	2004	2005
Premium/Person	12	12	15	17	17	20	22	22	25
Gudalur	554	938	1059	1254	863	943	956	1097	1162
Devala	561	583	656	627	676	720	643	689	736
Srimadurai	401	475	572	792	586	564	550	628	752
Devarshola	543	674	659	525	717	569	546	1274	480
Ponnani	363	430	398	385	409	299	330	351	391
Pattavayal	380	577	391	281	302	280	272	220	361
Ayyankolly	424	539	407	355	402	430	447	484	599
Erumadu	586	683	625	399	510	486	525	766	577
TOTAL	**3812**	**4899**	**4768**	**4619**	**4464**	**4291**	**4268**	**5509**	**5058**
Premium collected	45739	58784	71515	78518	75895	85820	93896	102325	119870

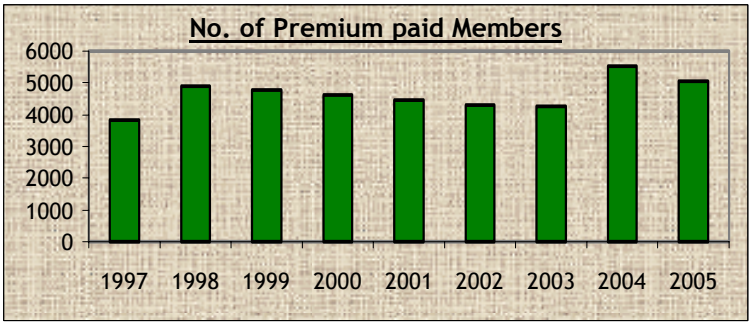
The Kattunaikkans who collect forest produce for a living have most access to cash during the honey collection time. Srimadurai area encouraged people to save 10 Rs per Kg of honey in the savings account. Unfortunately when festival season came, the people used up these savings and were, as usual, in a difficult position to pay the insurance premium! This year the team is planning a wiser strategy of getting them to pay the premium with honey instead of keeping it as savings.

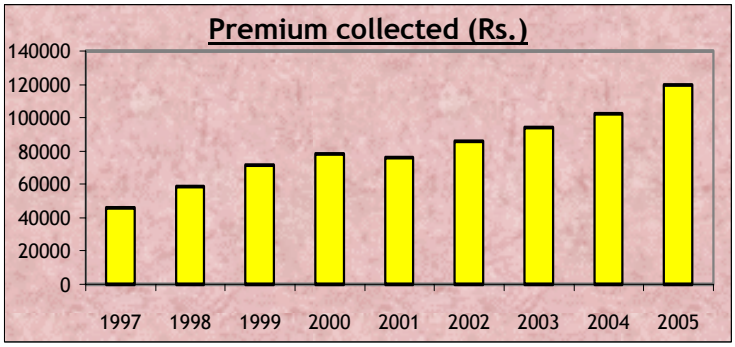
Devarshola had experimented with a lower premium with 100% participation. Although premium was reduced to Rs 10, they collected more money than ever and obviously the participation was much more. This year they tried the same strategy but with Rs 20 premium and discovered that it was a big mistake. Much less money, fewer people participating. It is highly probable that people are not participating because of lack of availability of cash.
Erumad and Ayyankolly collected family premiums. The amounts collected have not changed much.

Gudalur area as always paid the most. This is obviously because they use the services of the hospital much more because of proximity.









The high point has been the amount of discussions taking place in the villages and the increasing awareness about insurance. The overall premium collection has been more than in the former years but has not reached the target that was set.

Future Plans for premium collection

It is obvious to the team that a discussion with the community alone is not sufficient to increase people's contributions. It will have to be linked to an economic activity, which will ensure that people have access to money.

Work has started in setting up community funds in the areas with income generated from economic activities.

"Just Change" has started trading activities in some villages. Presently rice, coconut oil and umbrellas are being traded. Profit from this goes into the community fund.

A "chicken bank" concept has been set in motion. With the help of "good gifts" from the Charities Advisory Trust, UK, 5 chickens are being gifted to over 1000 families. The returns from these chickens will be used to meet health care costs of the families.

Here again the stress is on routing the insurance premium through a village collection rather than an individual collection. This will attempt to include all sangam members in the insurance program

The Adivasi tealeaf marketing society is functioning well. Most members pay for their insurance. We have until now encouraged people to pay voluntarily for insurance so that they understand the importance of such planning ahead. Automatic deductions may take away this very important component of the insurance program.

Training

Malathi, a tribal girl has been receiving training in insurance related administrative work. She is now fully capable of corresponding with the company on claims related matters. She is also able to retrieve some information necessary for various analyses. She makes a presentation every month to the health team about the various income and expenses as well as an analysis of the in patient profile. She also informs the entire team an analysis of the insurance collection from the people

Networking and Research

We attended many meetings at the national level organised by the Government, SEWA, FWWB, The Tamil Nadu health systems development project etc. Presentations of insurance scheme were made and many important aspects of insurance from a poor man's perspective were brought out. We stressed the need for doing away with exclusions in the policy, having no age bars, covering common as well as pre existing diseases, cover for maternity etc.

The Tamil Nadu Government has invited us to be on 3-member expert committee to formulate a health insurance scheme for the state.

Dr Devadasan completed an exhaustive research on various aspects of the insurance program as part of his doctorate thesis. Publication is awaited.

Conclusion

The entire insurance program has become much more streamlined, discussions with the community have been extensive and there is a lot of analysis being done at different levels about the various aspects of health insurance.

Although it is clear that insurance has helped people to access health care, there have been a number of instances where catastrophies have taken place when people who had not paid the premium have been diffident to access timely health care. An important consideration in the years to come is to find ways of making all people participate in the program.

The last few years have also seen much more networking with various organisations and the Government. We thank The Sir Ratan Tata Trust for making this possible. We hope the entire exercise will build in the community a habit of insuring themselves against unexpected health care expenses.