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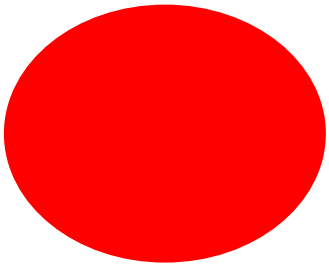

Editorial

Can Health Care Insurance Ensure Right to Health for All?

Issues for Discussion at the January 2001 Annual Meet

Barring the Annual-Meet in Mumbai (1992), the MFC has not conducted systematic discussion on the health care financing in India. The Annual-Meet in Calcutta (1993) that followed Mumbai-Meet, had potential to take up such issue, but it was poorly attended and the issue got lost in debating the stratified system (government funded system for the poor and market based for the rich) proposed by one of the background papers. Even the Mumbai-Meet which did raise some serious issues for reforms in health financing and discussed some of the international experiences, eventually focused more on the problems in private sector and means to regulate it than on the appropriate mechanism for financing universal access health care service system in India. This does not mean that financing issues have not been raised and debated from time to time, but they have been largely discussed within a limited framework.

In what sense, then, the next meet will recognise health financing as the central strategic issue for achieving Health For All? There are three important reasons for this optimism. First, health insurance is not new for India, though we did not consider it important enough for discussion except under a few Primary Health Care (PHC) experiments. Employees State Insurance (ESIS) has been in existence almost since independence. Public sector insurance companies have been selling few health insurance plans for some decades now. Many unions have won reimbursement packets for health care, thus making employers to partially self-insure such employees. Hopefully, this meet would force us to look at all such things and their lessons, and broaden our perspective. Second, *insurance is essentially a specific method for financing in a market system.*

Permission to allow private health insurance and expectations of its wider acceptance suggest that the paying consumers are dissatisfied with fee-for-service system. The government is looking at it as a policy instrument to expand health care market and the business people see an opportunity for profit. Thus, the Meet will have to evaluate the place of market determined financing system in the strategy for achieving universal access. This has a direct relevance for much talked about public-private partnership, and the time has come to face the issue at the level of financing. And third, by linking the issue of financing with universal access, we are recognising that right to health care is not a negative demand for regulating or restraining the state from interfering with citizens rights, but a positive demand on the state to intervene for the beneficence or welfare of citizens. In other words, grand, national plans for PHC need to be backed by a national strategy for financing them.

Insurance has an attraction not only for those who consider the health care market a panacea but also for many of those who believe in right to health care. In both cases, the strategy necessitates that people pool their resources to prevent those who happen to fall ill from suffering serious financial difficulties while availing of necessary health care. Secondly, once the group is insured for particular services, it is assumed that the individuals from the group falling sick have guaranteed access to such services. That is, insurance necessarily increases access to health care included in insurance package by the individuals subscribing to it. This commonality is at the base of interest in micro experiments in methods of financing through different types of insurance package by health activists and NGOs. The insurance principle allows pooling of resources for possible risks. This is because insurance is a technique of underwriting risks and providing protection to acceptable risks by insurer. The technique of underwriting classifies and provides rating to each risk based on the information on the occurrence of risk, attaches a specific price for providing specific protection to risk(s), and, on each risk group creates a surplus for profit. Thus, in a classical scenario, the insurer would allow only the group having similar expected and

acceptable risks to pool resources through premium. But at the same time, it ensures that those at higher risk and thus, in greater need of service are kept in separate groups from those who are less at risk and need less service. Correspondingly, the groups at greater risk pay higher premium than groups at lesser risk. Therefore, the marketplace inequity existing in direct fee-for-service is brought back. If our objective is to have a system where all have universal access to a defined quantity and quality of health care without financial and social barriers, then this scenario of insurance does not bring us any closer to that objective. At best, it facilitates pooling of resources within the social and health-risk related classes and provides protection with wide variation in quantity and quality of care to each class. This would again reproduce the inequity we are trying to overcome.

There is no space here to explain how insurance actually functions and the plethora of terminologies it uses. It is sufficient to note here that in actual practice, private insurance uses numerous permutation and combinations in order to expand its market, put restrictions on claims, exclude risk-prone individuals and groups, exclude or restrict use of expensive treatment methods, co-finance the risks it insures, and so on. Here, it is sufficient to know that all such permutations and combinations are ultimately based on the above-mentioned principle of classifying, rating and underwriting risks and making profit. For, eventually the market principle asserts that those who cannot buy health care do not get insured for the health care. Well researched material on insurance show that insurance increases use of unnecessary health care, increases cost of health care at much faster rate, promotes significant wastage of resources in promotion and advertisement of insurance plans (e.g. US health insurance companies spend one third amount of insurance claims paid on administration and promotion), and so on.

This does not mean that progressive group insurance plans are not possible within the market system. In fact, the rise of health insurance in USA was triggered off by such progressive group insurance plans won through struggles by some Trade Unions (TUs) in 1930s and 1940s. During the Depression, hospitals faced with loss of revenue due to the inability of the poor and the old to buy health care on fee-for-service basis, were more amenable to link up with employers for insurance coverage. They were progressive in the sense that those plans provided uniform coverage to employees irrespective of the wage levels and were paid for by the employers. The basic difference in this rise of initial progressive insurance in the US and the social insurance in many European countries was that the former was dispersed and market determined 'while the latter was universal for a set of population and was through state intervention with public funding. Thus, despite its progressiveness, the insurance won as fringe benefits by TUs in the US fuelled private insurance market while the social insurance in Europe gave impetus to universal access health care.

There are two lessons to be learnt from such history. Firstly, we must remember that all market based financing methods could be experimented in a micro situation on no- profit basis in a progressive manner. Numerous community health NGOs in India have even used the fee-for-service (the most regressive market based financing system) methods in a controlled and sensitive environment for a defined population very progressively. The experiments in insurance are no different. Secondly, the use of insurance as a strategy for market augmentation and privatisation is considered politically less controversial and consistent with the changing role of state from provider (and controller) of health services to regulator. This is to be achieved by separating provision (production) from purchasing (financing) in the government sector. This gives flexibility to the government to work on independent financing strategies in which the participation of private sector and contribution of community financing through appropriate insurance (particularly group insurance for the poor communities) could be promoted. This could "decentralise" the government health care institutions (hospitals, PHCs, etc.) by making them compete in the market for insured clients. In fact, the possibilities in such strategies for market penetration in health care, for strengthening private providers and changing values and environment of public providers, are immense. And that is what attracts a State committed to the market values and the financial sharks towards insurance: While this may be exciting for researchers and policy makers, the end result is not difficult to envisage. For, despite excessive innovativeness, high expenditure, much higher state financial support and less proportion of indigent poor in the population than in India, the insurance based health care system of US has found it impossible to provide universal coverage. If we do not learn from that experience, then we are undoubtedly condemned to repeat all the negative consequences.

Re-emphasising the importance of health financing, the critique of insurance as a financing mechanism, in no way means that there are no progressive methods ensuring universal coverage, transcending insurance principle. In a sense, the way out is commonsensical, though it is less commonly accepted. We all know that different groups of people are at different levels of risk for illness, and that population is stratified in different socio-economic classes. So it is irrational and illogical to have an equal insurance premium for all, this is recognised by insurance. However, the need is to put it upside down by introducing the solidarity principle, that is, the principle of cross-subsidy. This ensures fair financing in the sense that those who earn more pay more while those earn less pay less. And still, this would ensure that all earning individuals are paying only a reasonable and acceptable proportion of their income. Secondly, the multiple layered financing through private insurance is both expensive and prone to wastage. The countries providing universal access have solved this problem by replacing premiums with progressive taxation systems, by public management of finances and by having single payer health financing mechanisms. Moreover, this system allows us to progress from universal coverage of the insured group to the universal coverage for all.

Thus, while there is much to learn from insurance, there is more to gain by going beyond it.

- Amar Jesani

Two Community-Based Pre-Payment Schemes in Kheda, Gujarat

M. Kent Ranson

Health insurance is the pooling of resources to cover the costs of future, unpredictable health-related events. According to the health economics and policy literature, health insurance can be used to: mobilise revenue for the health sector; protect individuals and households from the risk of medical expenses; and promote efficiency, quality and equity of health-care services. On the other hand, there is ample evidence to suggest that health insurance can worsen existing inequalities and inefficiencies.

Proponents of health insurance argue that it can be used to address specific deficiencies in *India's* health sector, in particular: high out-of-pocket spending, inefficiency, poor quality and inequity. At present, health insurance coverage in India is extremely limited, especially outside the formal sector". Non-governmental, non-profit organisations provide health-care to approximately 5% of the Indian population (Hsiao and Dave Sen 1995). Some of these NGOs have implemented prepayment health insurance schemes. There are a number of reasons as to why NGOs should make good insurers for poor populations (adapted from van Ginneken 1998):

> They know the needs of their client groups so they can develop appropriate strategies to assist them;
>
> They typically involve beneficiaries in the design and implementation of programs;
>
> Effectiveness of health insurance schemes may be enhanced by other aspects of the NGOs' work, for example, in the fields of employment and education;
>
> Because they are non-profit, they can provide health insurance at lower cost than for-profit insurers.

As part of my doctoral research, I conducted case-studies of the prepayment schemes run by the Tribhuvandas Foundation (TF) and the Self-Employed Women's Association (SEWA) in Kheda District, Gujarat. The primary objective of my research was to identify, and where possible quantify, the impact of these prepayment schemes on rural households, looking at a variety of outcomes. These outcomes include: medical indebtedness, access to outpatient and inpatient medical care, preference of allopathic versus traditional health care providers, and the empowerment of women to make medical decisions. Data collection for this project was recently completed, and analysis of the data is currently underway. The purpose of this paper is to provide a brief description of the two schemes and the extent to which they have been utilised. Section 1 describes Tribhuvandas Foundation's medical referral services, and Section 2 describes SEWA's Medical Insurance Fund. Section 3, the discussion, draws attention to important differences in the design and utilisation of these schemes.

Section 1

Tribhuvandas Foundation's Medical Referral Services

The Tribhuvandas Foundation was established in 1975. Seed money in the amount of 650,000 rupees was provided by Shri Tribhuvandas Patel, the founding chairman of Amul Dairy, "to initiate a project for improving the health of women and children in Kheda (and Anand) District" (TF Annual Report 1998-99). The Foundation became functional in 1980, servicing some 53 villages during its first two years. Today, the Foundation provides a broad variety of health and related services, focusing on primary and preventive care, in some 644 villages. The Foundation has its head office in Anand, with sub-centres in Kapadwanj, Balasinor, Kheda and Tarapur.

Membership & Coverage

Officially, households pay a total of 10 rupees per annum in order to become members of the Tribhuvandas Foundation (as is discussed below, many exceptions are made). Membership is most often voluntary and open to all residents of a village. The TF village health worker (VHW) normally enrolls families at the office of the village dairy co-operative at the time of the annual bonus distribution. However, membership fees can be paid at any time throughout the year. In some villages, based on a decision made in the Dairy Co-operative Society general body meeting, the membership fee is automatically deducted from the bonus as it is distributed. After paying the membership fee, there is no waiting period before members may avail of TF's referral services.

Estimates of the number of TF member households are derived indirectly". TF calculates its membership by assuming that half of the total fees collected are from households paying 10 rupees, and half are collected from households paying 5 rupees, as many households are allowed membership in TF at some reduced rate. Estimated current membership is 1. 7 lakh households in 644 villages.

Services

The current activities of the Tribhuvandas Foundation are many and varied (see Box 1). Village-level health services are provided by female TF Village Health Workers (VHWs),

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1 per village. VHWs are supervised by some 70 field-workers who visit each village once every fortnight. Generally, there is no discrimination between members and non-members in terms of the village-level services. That is to say, members and non-members alike receive free community health services and subsidised medications.

Box 1. Services Offered by the Tribhuvandas Foundation, 1997 to Present

1. Pregnant and Nursing mothers are provided treatment.
2. Malnourished children are provided treatment at home as well as at the Child Care Centre (Nutrition Rehabilitation Centre) run by the organisation.
3. Children are provided vaccines (DPT, Polio, BCG, Measles, etc.)
4. TB patients are provided treatment at home at free cost.
5. Pregnant mothers at risk are hospitalised at the organisation and provided treatment.
6. As part of temporary methods of Family Planning, Nirodh, Copper T and Birth Control pills are provided in the villages.
7. Every week Family Planning Operation camps are organised at the main centre as well as the sub-centres in which laparoscopic and open surgeries are done.
8. Pregnant women who want delivery at home are provided with a safe delivery kit.
9. Gynecologic problems are treated by Shri Krishna Hospital's Gynecologists and Obstetricians at the TF sub-centres.
10. For advice of specialists and for further treatment, patients are either hospitalised at the Shri Krishna Hospital at Karamsad or seen by specialist in the Sub-Centre's out-patient department.
11. A Nursery programme is run in the villages for children below five years of age.
12. Women are provided training free of cost, and supplementary income in handicrafts (patchwork) so that they can generate income while sitting at home.
13. Women who work in their free time are provided additional income for their families through the Patchwork Programme.
14. Under the Environmental Sanitation Programme, low cost toilets and cooking stoves are constructed.
15. The organisation prepares and shows health-related video films to bring awareness amongst rural people.
16. With the help of the Blood bank of Shri Krishna Hospital Karamsad, blood donation camps are organised in the villages.
17. Nutritious food is distributed in the villages at nominal cost.

Source: Derived from TF brochure, 'Health And Rural Development Programme'

TF's health care referral services are the focus of this document. Individuals who are identified as being particularly ill or malnourished are referred to Anand or one of TF's four sub-centres. TF patients who require specialised care are referred to the Shri Krishna Hospital "where specialists and modern diagnostic facilities are available" (Annual Report 1998-99). A TF worker is available full-time at the hospital to assist TF members coming from the different villages. In the most recent fiscal years, roughly 2,000 patients have been referred. Relative to TF's membership, the total number of patients admitted has changed little over the years (for example, the number admitted in 1982/83, 2, 320, is almost the same as in 19971/98 at 2,360). The number of admissions per 100 TF households has dropped more than tenfold from 14.5 in 1982/83 to 1.4 in 1998/99.

Until late 1999, TF members would receive a concession for inpatient services at the Shri Krishna Hospital. TF members generally received a 50% concession on the total hospital bill, but this was to vary according to level of need (for example, very poor families would receive a 100% concession while wealthier families would receive no concession). TF members are no longer receiving special benefits at Shri Krishna Hospital.

Finances

As mentioned above, the Tribhuvandas Foundation was started with money provided by Shri Tribhuvandas Patel. As well, several domestic and international funding agencies (including UNICEF and the Overseas Development Administration, UK) contributed to the Foundation in its early years. Today, the Foundation's main sources of income include: Amul Dairy through the National Federation of Rural Development (NFRD, Delhi), bank interest on funds, user-fees charged for medicines, membership fees, and Dairy Cooperative Society contributions.

Since the inception of the referral system, the concessions provided to TF patients at Shri Krishna Hospital have been offset by a donation from Kaira Can, a sister concern of Amul Dairy. The amount of the payment, however, has been fixed at 500,000 per annum. At least during the last five years, no additional payment has been made by TF to the Shri Krishna Hospital. In recent years the Shri Krishna Hospital has incurred considerable financial loss in providing reduced-cost care to TF patients (Table 1). Thus, the Shri Krishna Hospital has recently discontinued concessions to TF's members (although children under 5 continue to receive free care, there is a special scheme for women, and the poor may be provided. with concession on a case-by-case basis).

Table 1. Annual debt incurred by Shri Krishna Hospital in providing concessions to TF patients, *1996/97* to *1998199* (actual Indian rupee values)			
Fiscal Year	**Shri Krishna Referral Costs** (Rs)	**Donation by Kaira Can** (Rs)	**Debt Incurred** by **Shri** Krishna (Rs)
1996/97	1,771,707	500,000	1,271,707
1997/98	1,458,624	500,000	958,624
1998/99	1,312,886	500,000	812,886

History of the Referral Services

The system for referrals has evolved gradually since 1980. Referral services were not included in the original plan for TF. However, soon after commencement of TF's activities, it was found that there was a need for referral services among the membership. Initially, many of the cases detected by TF were taken to government or trust (charitable) hospitals in Anand.

When Shri Krishna Hospital was under construction, its director suggested that the two organisations work in co-operation. This was to be a mutually beneficial arrangement, it was agreed informally that Shri Krishna Hospital would provide care free of charge to TF members. Kaira Can committed to donating 500,000 rupees per year to cover the costs of concessions to TF members. This has continued to this day. Due to the debt it incurs in caring for TF members, Shri Krishna Hospital is no longer offering concessions to TF members.

Preliminary Analysis of Hospital Utilisation Data

This analysis is based on the bills provided to the Tribhuvandas Foundation by the Shri Krishna Hospital for the fiscal years *1996/97* to *1999100* (each fiscal year is from 1st April through 31st March). These bills provide some basic demographic information for each patient (for example, gender, and village of residence), dates of hospital admission and discharge, total cost of the hospitalisation, the amount paid out-of-pocket by the patient, and the amount owed by the Tribhuvandas Foundation.

At present, there are 8,465 records in the database". The records for fiscal year 1999 / 00 remain incomplete as not all of the bills have been submitted to TF. Overall, for this four-year period, the average duration of hospital stay was just over eight days, the average total costs was Rsl,500, the average out-of-pocket payment by patients Rs 824 (55% of the average total cost), and the concession per TF patient Rs 677 (45% of the average total cost).

As shown in Table 2, the total number of TF members admitted to Shri Krishna Hospital has been decreasing over the last four fiscal years (keeping in mind that the data for *1999/2000* is incomplete). Roughly 25% of TF admissions at Shri Krishna Hospital during the last four fiscal years have been in the Nutritional Resource Centre (NRC). All children younger than 5 years of age (the threshold seems to be slightly flexible) are kept in the NRC. NRC admissions as a percentage of total are increasing, from 18% to 40% in only four years.

Table 2. Hospitalizations of TF members at Shri Krishna Hospital				
Year	Total	Adult	NRC	NRC as% of Total
96/97	2913	2391	522	18%
97/98	2225	1711	514	23%
98/99	2071	1455	616	30%
99/00	1254	749	505	40%
Total	8,463	6,306	2,157	
% of Total	100%	75%	25%	

Table 3 shows the breakup of admissions by gender for each year (and by adult versus NRC). Overall, 45% of TF admissions have been female. Very interestingly, the proportion of female admissions to the NRC (35 to 38%) is consistently lower than for adults (47 to 50%).

Table 3. Gender of TF patients hospitalised at Shri Krishna Hospital					
Year	Adult/ NRC	Total	Female	% Femal	Male
96/96	Adult	2,391	1,134	47%	1,257
96/97	NRC	522	186	36%	336
97/98	Adult	1,711	807	47%	904
97/98	NRC	514	195	38%	319
98/99	Adult	1,455	729	50%	723
98/99	NRC	616	216	35%	400
99/00	Adult	749	362	48%	387
99/00	NRC	505	187	37%	317
Total		8,463	3,816		4,643
% Total		*100%*	45%		55%

Average duration of hospitalisation varies little from one year to the next at approximately eight days (Table 4). For each year there are hospitalisations of less than one day's duration (generally 'day surgeries' and procedures). The median duration of stay was 6 for each year, suggesting that (for all years) the distribution is skewed right by a relatively small number of lengthy hospitalisations.

Table 4. Duration of hospitalization of 1F members at Krishna Hospital				
Year	Total	Duration available	Avg. Duration	Median duration
96/97	2,913	2,909	8.36	6
97/98	2,225	2,222	8.27	6
98/99	2,071	2,071	7.52	6
99/00	1,254	1,252	7.66	6
Total	8,463	8,454	8.02	6

average total cost of hospitalisation varies from 1,094 rupees to 1,918 rupees over the last four years (Table 5). On average, patients paid 55% of this amount, and TF 45%. However, the average TF concession has varied considerably, from only 39% in 1997/98 to 56% in 1996/97.

Table 5. Costs of hospitalisation of TF members at Shri Krishna Hospital (actual Indian rupee values)								
Year	Number	Avg. total cost	Median	Avg. out-of-pocket	Median	Avg. TF concession	Median	%TF Concession
96/97	2,913	1,094	715	485	300	608	371	56%
97/98	2,225	1,701	1,062	1,044	500	657	389	39%
98/99	2,071	1,601	1,060	967	600	634	404	40%
99/00	1,254	1,918	1,202	983	350	935	548	49%
Total	8,463	1,500	1,094	824	400	676	404	45%

Section 2

SEWA's Medical Insurance Fund

The Self-Employed Women's Association, SEWA, is an organisation of poor, self-employed women workers. The organization's main goals are to "organise women workers for full employment and self reliance" (SEWA 1999). SEWA currently has more than 200,000 members, approximately 148,000 of whom reside in Gujarat State.

SEWA's Integrated Social Security Scheme was initiated in 1992. This Scheme provides life insurance, medical insurance and asset insurance (against the loss of house or working capital in case of flood, fire or communal riots). This document deals exclusively with the Medical Insurance Fund.

SEWA fully manages the Medical Insurance Fund (unlike the life insurance and asset insurance components, which are run in cooperation with government insurance companies). In order to join the Fund, women must be between 18 and 58 years of age. Those who pay the annual Social Security Scheme membership fee of 72.5 rupees (30 rupees of which is earmarked for medical insurance) are covered to a maximum of 1,200 rupees yearly in case of hospitalisation. Women also have the option of becoming lifetime members of the Social Security Scheme by making a fixed deposit of 700 rupees", Special benefits to which only the lifetime members are entitled include: maternity benefit of 300 rupees with the birth of each child; reimbursement for cataract surgery up to 1,200 rupees; reimbursement for a hearing aid up to 1,200 rupees; and, reimbursement for dentures up to 600 rupees. Exempted from coverage are certain chronic diseases (for example, chronic tuberculosis, certain cancers, diabetes, hypertension, piles) and "disease caused by addiction" (SEWA brochures, 2000).

Annual members pay their premium in cash. Voluntary lifetime members usually pay their membership fee in cash, but they may occasionally pay by a cheque from their SEWA Bank account. Women who take a loan of more than 10,000 rupees from SEWA Bank are automatically enrolled in the Integrated Social Security Scheme as lifetime members, and the fixed deposit is deducted directly from their loan.

Annual membership fees are collected only from April l "to June 30th, and annual members are eligible for medical insurance starting on July 1st. The lifetime fixed deposit can be paid anytime throughout the year. After paying the fixed deposit, women are eligible for benefits on whichever of the following dates comes first: July 1st, October 1st, January I", or April 1st. The number of members cited by SEWA refers to the number who on July 15" the 1st day of the fiscal year, have paid their annual membership fee or lifetime fixed deposit within the preceding twelve months.

The choice of provider is left entirely to the discretion of the SEWA member. They are eligible for reimbursement whether they use private-for-profit, private-non-profit or public facilities. After discharge from hospital, the Fund member is required to submit the following documents within a three month period: a doctor's certificate stating the reason for hospitalisation and the dates of admission and discharge; doctors' prescriptions and bills for medicines purchased; and, reports of laboratory tests done during the hospital stay. After submission of these documents, the member is usually visited by a SEWA employee who verifies the authenticity of the claim. All documentation is reviewed by a consultant physician, and a final decision on the claim is then made by an insurance panel (the panel consists of eight people, a combination of SEWA Leaders and Organisers). Finally, the Fund Member is notified of the panel's decision, and when applicable, is paid by cheque.

The design and management of the Medical Insurance Fund have evolved considerably since· 1992. Initially, the Fund was administered jointly by SEWA and the United India

Insurance Company (UIIC). At that time, coverage only included allopathic, inpatient care, not including gynecological illnesses. The maximum amount of reimbursement was 1,000 rupees. In 1994 SEWA assumed complete control of the medical insurance component. In 1995, coverage was expanded to include treatment from traditional bone-setters, occupational diseases, obstetric and gynecological problems, and in exceptional cases, homeopathic or traditional medical care (still to a maximum of 1,000 rupees). In 1998, the maximum coverage was increased to 1,200 rupees. In July of 1998, administration of the Medical Insurance Fund for Kheda District was decentralised, shifting from Ahmedabad to the district office in Anand.

Throughout the ten districts of Gujarat where it operates, the Medical Insurance Fund had approximately 18,700 lifetime members (63% of total) and 11,100 annual members (37% of total) in 1999-2000. In Kheda District, enrollment was 5,672, consisting of 1,548 lifetime members (27% of total) and 4,124 annual members (73% of total)", State-wide, coverage by the Medical Insurance Fund is 20% (29,800 insured among 147,600 SEWA members) and 16% in Kheda District (5,672 insured among 36,500 SEWA members). Medical Insurance Fund members in Kheda represent approximately 19% of Members state-wide.

Finances

Since the Fund's inception, the premiums paid by annual members plus the interest paid from the fixed deposits of lifetime members have always exceeded medical claim payments. Table 6 shows that cost-recovery (excluding administrative costs, which are discussed in the next paragraph) has varied from 119 to 309 percent (data not available for 1992-94 and 1993-94).

It is very difficult to estimate the costs of administering the Medical Insurance Fund; many of the administrative functions are shared with the life and asset insurance components as well as with other activities of SEWA. A recent study by the International Labour Organization found that basic administration costs accounted for/9.3 to 19.7 percent of Integrated Social Security Scheme expenses annually (personal communication with Michaela Balke, ILO). Interest from a German Development Cooperation grant (100 million rupees given in 1993) is used to cover all administrative costs and to provide the maternity benefit of 300 rupees.

Preliminary analysis of Scheme utilisation data for Kheda District

A total of 439 claims were submitted between July l" 1994 and September, 2000 in Kheda District". There was a gradual increase in the number of claims submitted to, and reviewed by, the insurance panel each year. The rate of claim submission during the two fiscal years 1997-99 was 20 per 1,000 insured women per year (in 97-98 there were 92 claims and 5,200 insured and in 98-99 there were 120 claims and 5,477 insured)? Thirty-one percent of claims were submitted by women with lifetime insurance policies, and 69% by women with annual policies (N = 439). The rate of claim submission was 17 per 1,000 per year among annual Members and 30 per 1,000 per year among lifetime Members during the two years 1997-99. Ninety-six percent of claims submitted were approved for reimbursement (N = 438). Of the 16 claims that were rejected, 11 were rejected as the disease responsible for admission was judged to be "chronic" or "pre-existing" and three were rejected as documents submitted by the claimant were incomplete (data not shown).

The mean age of claimants was 39.7 years (N = 439, SD = 9.7 years, CV = 24.4%) and the median 40 years. The age distribution of claimants shows a peak between 35 and 49 years. Interestingly, three claimants received reimbursement despite age older than 58 years (theoretically, the maximum age allowed for participation in the scheme).

The mean length of admission was 6.7 days (N = 439, SE = 8.6, CV = 128%) and the median 5. The mean duration of admission was fairly consistent from one year to the next, the notable exception being 1994/95 when the mean admission was 9.2 days, but the median only 6.

The mean cost of a hospitalisation (both reimbursed and rejected claims) was 2, 3411999/2000 Rupees (N = 438, SE =2,117, CV =90%) or 54 USD. The median cost was 1,629 *199912000* Rupees or 37 USD. It was difficult to break this overall value down into component costs, as many hospital receipts reported only the aggregate cost (which may include doctors fees, bed fees, medications and tests all lumped together). In the 254 records for which the costs could be disaggregated, medicine fees were the largest component of the total cost (51 %), followed by bed fees (23%), doctor fees (12%), lab and x-ray fees (7%), and other fees (7%). This breakdown varied markedly according to the type of hospital. For example, medicines accounted for 48% of costs at private for-profit hospitals, 62% at private-nonprofit hospitals, and 78% at government hospitals (data not shown). Seventy-three percent of claimants used private-for-profit hospitals, 20% private-non-profit (or charitable) hospitals, and 6% government hospitals.

Table 6. Contributions to, and payments by, SEW A's Medical Insurance Fund (actual Indian rupee values)

Year	1994	1995	1996	1997	1998	1999
Members' Contributions	150,000	383,520	450,000	600,000	780,000	696,420
Medical Claim Payments	125,659	124,203	258,884	266,118	392,864	386,563
Operating Balance	24,341	259,317	191,116	333,882	387,136	309,857
Cost Recovery	119%	309%	174%	225%	199%	180%

The duration of hospitalisation was longest for government hospitals (mean = 9.1 days, median = 7.0 days) and shortest for private-nonprofit hospitals (mean = 5.8 days, median = 4.0 days). The total hospitalisation costs were much higher for a stay in a private- for-profit hospital (mean = 2,664 Rupees, median = 1,878 Rupees) than in a private-non-profit hospital (mean = 1,627 Rupees, median = 1,123 Rupees) or a government hospital (mean = 880 Rupees, median = 623 Rupees). Reimbursement on average was 75% for hospitalisation in government facilities, 61 % for private-non-profit hospitals, and only 46% for private-for-profit hospitals.

The mean total cost of the 422 *reimbursed* hospitalisations was *2,*3321999/2000 Rupees (N = 422, SD = 2,091, CV = 90%) or 54 USD. The median total cost was 1,629 Rupees or 37 USD *(Table* 8). Over the six years, the standardised median total cost was between 1,466 and 1,776 Rupees, except in 1996/97 when it was 2,416 Rupees. The mean reimbursement was 1,148 *199912000* Rupees (N = 422, SD = 307, CV = 27%) or 26 USD (Table 7). The median reimbursement was 1,211 Rupees. In general, the standardized (or real) mean and median reimbursements provided by SEWA have fallen through time. Of the 422 cases reimbursed, only 21 % were reimbursed in full (90 of 422), and 28% were reimbursed to less than one-half of total costs (117 of 422, data not shown).

On average over the last six years, it took 161 days between discharge from hospital and reimbursement.

Table 7. Total hospitalisation costs expressed in 1999/2000 Indian Rupees for reimbursed claims only. N - 422)

Year	N	Mean	SD	CV	Median	Year
94/95	39	2,532	2,562	101.2%	1,776	94/95
95/96	62	1,706	1,189	69.7%	1,574	95/96
96-97	75	3,232	2,460	76.1%	2,416	96/97
97/98	92	2,176	2,255	103.6%	1,592	97/98
98/99	117	2,173	1,777	81.8%	1,497	98/99
99/00	37	2,240	1,944	86.8%	1,466	99/00
Overall	422	2,332	2,091	89.7%	1,629	Overall

Table 8. Reimbursement paid by SEW A as expressed in 1999/2000 Indian Rupees (N - 422)

Year	N	Mean	SD	CV	Median
94/95	39	1,338	261	19.5%	1,510
95/96	62	1,179	345	29.3%	1,396
96/97	75	1,207	303	25.1%	1,307
97/98	92	1,032	302	29.3%	1,212
98/99	117	1,142	285	25.0%	1,321
99/00	37	1,087	245	22.5%	1,200
Overall	422	1,148	307	26.7%	1,212

This can be broken down into: 78 days from discharge to submission of the claim to SEWA, 46 days from submission of the claims to the date of the panel's decision, and 37 days between the panel's decision and receipt of payment by the claimant.

Discussion

These two prepayment schemes differ tremendously in terms of design (Table 9). In both cases, the premium is paid voluntarily and is collected annually. The TF scheme covers entire households (including children) whereas the SEWA scheme covers only female members of SEWA between the ages of 18 and 58. SEWA specifically excludes certain chronic diseases from coverage, which is not the case with TF. Under the TF scheme, members receive concession only if they seek care at the Shri Krishna Hospital, while members of the SEWA may receive reimbursement for care at any public, private or trust hospital. The concession provided under the TF scheme is variable, depending on total cost of the hospitalisation and level of financial need. Under the SEWA scheme, the insured are reimbursed to the full cost of hospitalisation, up to a maximum of 1,200 rupees. The concession provided by TF is paid directly to Shri Krishna Hospital on a fee for service basis. The insured effectively receives this benefit at the time of hospitalisation when the bill is paid. Under the SEWA scheme, the insured must first pay the full cost of hospitalisation out-of-pocket, and then seek reimbursement from SEWA by submitting bills and receipts. Thus, members of TF enjoy the benefits immediately at the time of discharge, while members of SEWA receive the benefits only months later after their claims have been processed and approved.

Without assessing impact of these schemes on households, it is impossible to conclude that one design is superior to the other. Certainly the differences do highlight the conflict of freedom of choice versus ease and speed of reimbursement. Under the SEWA scheme, women may attend a health care provider of their choice, in a town or village that is close to their home. Members of TF who wish to benefit from the referral services have no choice as to where they will be treated, and the location of Shri Krishna Hospital may be inconvenient to them. However, by dealing with only a single hospital, TF has made the process of reimbursement quite short and simple. As well, it is possible that TF can monitor and influence the quality of care received by its members at Shri Krishna Hospital. It is far more difficult for SEWA to have an influence on the many hospitals that may be visited by its members.

It is difficult to estimate the level of cost-recovery for TF's referral services, as the premium paid to TF is used in providing preventive and primary care in the villages, while the inpatient care is covered (in part) by a donation from Kaira Can. Suffice it to say that TF has relied on external donors to fund the referral services, and that the prepayment scheme for hospital care has recently broken down due to financial difficulties. Premiums paid to the SEWA Medical Insurance Fund consistently cover more than 100% of the benefits paid out to members.

Administrative costs are, however, covered by an external donor.

It seems that utilisation of both schemes is quite low. A 1993 study carried out by the National Council of Applied Economic Research (Sundar 1995) found rates of hospitalisation of 85 per 1,000 people per year in rural India (6,354 households), and 56 per 1,000 people per year in rural Gujarat (only 304 households). The rate of claim submission is only 20 per 1,000 women per year in the SEWA scheme. Utilisation of Shri Krishna Hospital by TF members is in the range of 20 per 1,000 *households* per year. It is unlikely that members of SEWA and TF require fewer hospitalisations per annum than the average population. Rather, it seems likely that many SEWA members do not submit claims for their hospitalisations, and that many TF members are hospitalised in facilities other than Shri Krishna Hospital.

The absolute costs of hospitalisation under the two schemes are not directly comparable as the TF costs and reimbursements are actual, while the SEWA costs and reimbursements have been standardised to 1999/2000. On average, SEWA has reimbursed 49% of the cost of hospitalisations for which claims have been submitted, and TF has covered 45% of the costs of hospitalisations. For both schemes, members have been responsible for finding other resources to cover, on average, more than half of the cost of hospitalisation.

This brief background paper highlights some of the main differences between the SEWA and TF community-based prepayment schemes. I have touched aspects of both schemes that could be improved upon. Nonetheless, it is also important to appreciate these schemes, with all their weaknesses, as unique innovations in health-care financing. I hope that analysis of the household level data I have collected will shed some light on the extent to which these schemes have influenced households, particularly in meeting the high costs of hospital care and medical indebtedness.

Notes

1. In India, the formal or organized sector "is defined to consist of all government institutions and of enterprises using power and employing ten or more persons, as well as those not using power but employing twenty or more persons" (van Ginneken 1998, p. 2). The informal or unorganised sector, by default, refers to all other forms of employment.

2. Recently, the computerization of all membership books has started, which will provide the exact number of members enrolled by TF.

3. I have included in the analysis the records for which the dates of duration and discharge are the same, i.e. duration of admission is zero days. I have confirmed these cases with TF; generally they are cases where people were admitted for short procedures, like minor surgeries or blood transfusions.

4. Interest on the 700 Rupee fixed deposit is used to pay the annual Social Security Scheme premium. When the woman reaches age 58, she is automatically withdrawn from the scheme, at which time she receives her initial deposit as well as any surplus interest that has accumulated.

5. Fund administrators explained that lifetime membership is much more popular state-wide than in Kheda District because many of the members state-wide have been required to pay the fixed deposit when they have taken a loan from SEWA Bank, whereas the majority of members in Kheda have joined the scheme voluntarily.

6. Some claims for 1996-97 and the corresponding register have been lost. It is impossible to know how many claims are missing.

7. The rate of claim submission was calculated only for 1997-98 and 98-99 as reliable information on the number of Medical Insurance Fund members in Kheda District was only available for 1997-98 onwards.

Table 9. Differences in design between Tribhuvandas Foundation's medical referral services and SEW A's Medical Insurance Fund

Aspect of Scheme Design	Tribhuvandas Foundation	SEWA
Annual premium	10 Rs	72.5 Rs (lifetime membership also available)
Unit of membership	Households	Female SEW A members aged 18 to 58 years
Exclusion of pre-e existing disease	No	Yes
Provider of care	Shri Krishna Hospital	Any public, private or trust hospital
Level of reimbursement	Varies depending on-total cost of hospitalisation and level of financial need	Full cost of hospitalisation to maxim urn of 1,200 rupees
M ode of reimbursement	Directly to Shri Krishna Hospital on fee for service basis	Paid to insured after approval of certificates receipts
Time to reimbursement of the insured	Immediate (insured pays only the difference between total cost and concession)	Average of 161 davs

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Reforming Health Policy For Universal Health Care

Ravi Duggal

"Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health to all, free of charge; medicine like education is then no longer a trade - it becomes a public function of the State." Since Henry Sigerist said this long ago, most of Europe and many other countries have made this a reality. And today when such demands are raised in third world countries, India being one of them, it is claimed that this is no longer possible - the welfare state must wither away and make way for global capital! Europe is also facing pressures to retract the socialist measures which working class struggles had gained since 19th century. However, while this is an era of global capital in endless search of profit, it is also the era when social and economic rights, apart from the political rights, are increasingly on the international agenda and an important cause for advocacy. The Peoples' Health Assembly is one such example of an initiative on this front and this is perhaps for the first time that health care has come up as a common concern for peoples' organisations, NGOs and others from all over the country.

Thus health and health care is now being viewed within the rights perspective and this is reflected in Article 12 "**The right to the highest attainable standard of health**" of the International Covenant on Economic, Social and Cultural Rights. This requires *availability, accessibility, affordability,* and *quality* with regard to both health care and underlying preconditions of health.

"Availability refers to the existence of health facilities, goods and services to meet the basic health needs of the people, including, *inter alia,* hospitals and clinics, trained medical personnel, essential drugs and so forth. *Accessibility* means that the above must be within physical reach for all parts of the population *(without any discrimination or conditionality). Affordability* requires that the above be affordable for all. *(That is there should be no constraints in the form of payments for seeking health care.) Quality* means that they must be scientifically and culturally appropriate. This requires, *inter alia,* skilled medical personnel, scientifically approved drugs and hospital equipment, clean water and adequate sanitation, sufficient information on environmental hazards and health risks. Cultural appropriateness signifies that health policies must be at once respectful of the people's culture and aimed at improving people's health status." (Committee on Economic, Social and Cultural Rights Twenty-second session 25 April-12 May 2000; *italicised text in parentheses added by author)*

Review of the 1983 National Health Policy

As a consequence of the global debate on alternative strategies during the seventies, the signing of the Alma Ata Declaration on primary health care and the recommendations of the ICMR-ICSSR Joint Panel, the government felt that a new approach was required. This was the background of the 1983 National Health Policy (NHP) was drafted.
The salient features of the 1983 health policy were:

(a) It was critical of the curative-oriented western model of health care,
(b) It emphasised a preventive, promotive and rehabilitative primary health care approach,
(c) It recommended a decentralised system of health care, the key features of which were low cost, deprofessionalisation (use of volunteers and paramedics), and community participation,
(d) It called for an expansion of the private curative sector which would help reduce the government's burden,
(e) It recommended the .establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions, and
(f) It set up targets for achievement that were primarily demographic in nature.

There are three questions that must now be answered. Firstly, have the tasks enlisted in the 1983 NHP been fulfilled as desired? Secondly, were these tasks and the actions that ensued adequate enough to meet the basic goal of the 1983 NHP of providing "**universal, comprehensive primary health care services, relevant to actual needs and priorities of the community**"? (MoHFW, 1983, P 3-4) And thirdly, did the 1983 NHP sufficiently reflect the ground realities in health care provision?

During the decade following the 1983 NHP rural health care received special attention and a massive program of expansion of primary health care facilities was undertaken in the 6th and *T"* Five Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5000 population. This target has more or less been achieved, though few states still lag behind. However, various studies looking into rural primary health care have observed that, though the infrastructure is in place in most areas, they are grossly underutilized because of poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms. Further, the system being based on the health team concept failed to work because of the mismatch of training and the work allocated to health

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workers, inadequate transport facilities, non-availability of appropriate accommodation for the health team and an unbalanced distribution of work-time for various activities. In fact, all studies have observed that family planning, and more recently immunisation, get a disproportionately large share of the health workers' effective work-time. (NSS,1987, IIM(A),1985, NCAER,1991, NIRD,1989, Ghosh,1991, ICMR,1989, Gupta&Gupta,1986, Duggal & Amin,1989, Jesani et.al,1992, NTI,1988, ICMR,1990)

Among the other tasks listed by the 1983 health policy, decentralisation and deprofessionalisation have taken place in a limited context but there has been no community participation. This is because the model of primary health care being implemented in the rural areas has not been acceptable to the people as evidenced by their health care seeking behaviour. The rural population continues to use private care and whenever they use public facilities for primary care it is the urban hospital they prefer (NSS-1987, Duggal & Amin, 1989, Kannan et.al., 1991, NCAER, 1991, NCAER, 1992, George et.al., 1992). Let alone provision of primary medical care, the rural health care system has not been able to provide for even the epidemiological base that the NHP of 1983 had recommended. Hence, the various national health programs continue in their earlier disparate forms, as was observed in the NHP (MoHFW, 1983, p 6).

As regards the demographic and other targets set in the NHP, only crude death rate and life expectancy have been on schedule. The others, especially fertility and immunisation related targets are much below expectation (despite special initiatives and resources for these programs over the last two decades), and those related to national disease programs are also much below the expected level of achievement. In fact, we are seeing a resurgence of communicable diseases.

However, where the expansion of the private health sector is concerned, the growth has been phenomenal thanks to state subsidies in the form of medical education, soft loans to set up medical practice etc ... The private health sector's mainstay is curative care and this is growing over the years (especially during the eighties and nineties) at a rapid pace largely due to a lack of interest of the state sector in non-hospital medical care services, especially in rural areas (Jesani & Ananthram, 1993). Various studies show that the private health sector accounts for over 70% of all primary care treatment sought and over 40% of all hospital care (NSS-1987, Duggal & Amin, 1989, Kannan et.al., 1991, NCAER, 1991, George eLal., 1992). This is not a very healthy sign for a country where over three-fourths of the population lives at or below subsistence levels.

The above analysis clearly indicates that the 1983 NHP did not reflect the ground realities adequately. The tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially those residing in rural areas. The present paradigm of health care development has in fact raised inequities, and in the current scenario of structural adjustment the present strategy is only making things worse. The current policy of selective health care and a selected target population has got even more focused since the 1993 World Development Report: *Investing in Health.*

In this report the World Bank has not only argued in favour of selective primary health care but has also introduced the concept of DALY s (Disability Adjusted Life Year's) and recommends that investments should be made in directions where the resources can maximise gains in DALY s. That is, committing increasing resources in favour of health priorities where gains in terms of efficiency override the severity of the health care problems and questions of equity and social justice. So powerful has been the World Bank's influence, that the WHO too has taken an about turn on its Alma Ata Declaration. WHO in its "Health for All in the 21't Century" agenda too is talking about selective health care, by supporting selected disease control programs and pushing under the carpet commitments to equity and social justice. India's health policy too has been moving increasingly in the direction of selective health care - from a commitment of comprehensive health care on the eve of Independence, and its reiteration in the 1983 health policy, to a narrowing down of concern only for family planning, immunisation and control of selected diseases. Hence, one has to view with seriousness the continuance of the current paradigm and make policy changes which would make primary health care as per the needs of the population a reality and accessible to all without any social, geographical and financial inequities.

Section I

Rationale For A New Health Policy

Universal coverage and equity for primary health care are accepted and oft repeated goals. The experience of all countries having near-universal health care systems is that with increased coverage of health care services, inequities in health status decline rapidly.

To assure equity and universal coverage the present health care system needs modifications. The health sector in India is a mix of public and private health care services. To compound this duality there are multiple systems - allopathy, ayurveda, homoeopathy, Unani, Siddha etc ... Studies have shown that the multiplicity of systems is confined to training alone because in actual practice an overwhelming number of practitioners of all systems practice modern medicine (NSS-1987, Duggal & Amin, 1989, Kannan et.al., 1991, NCAER, 1991, NCAER, 1992, George et al., 1992, FRCH, 1993, Nandraj & Duggal, 1996).

The general practitioners together handle over three- fourths of all outpatient cases in both rural and urban areas. These practitioners qualified in various systems of medicine, practice modern medicine - a whopping 96% of them according to the 1987 National Sample Survey on morbidity and utilisation of health services. Thus, private medical practitioners operate under conditions of complete absence of any control, monitoring and regulation by either the government or professional bodies. In fact, there are a large, unknown number of unqualified practitioners, especially in areas where qualified doctors are difficult to find. The role of the private sector in hospital care is comparatively limited

but expanding at a fast rate. The private sector, though owning 68% of the hospitals accounts for only 36% of the hospital beds and 54% of all hospital cases (NSS-1997). However, with the availability of a new generation of health care technologies and the consequent entry of the corporate sector in a large way, the private hospital sector is all set for an unprecedented growth (Jesani, 1993).

In contrast, the public health sector presents a vastly different picture. In urban areas the public health sector has hospitals and dispensaries which provide both outpatient and inpatient care. These hospitals are generally overcrowded; firstly, because their number is inadequate and they are insufficiently staffed, and secondly, populations from peripheral rural areas also utilise urban hospitals for both outpatient and inpatient care because rural areas lack these services. Further, increased migration and expansion of the urban population adds to the pressure on the urban system. In the 1983 NHP it was recommended that hospitals should become only referral centres but no effort is in evidence for evolving such a system. In the rural areas the state has set up a network of primary health centres through which various national health programs are integrated. We have discussed in a preceding section the observations of various studies on the performance and utilisation of PHCs. The weakest component of PHC services is curative care and this is the main reason why PHCs are so grossly underutilized -less than 8% of all illness care (NSS-1987, NCAER, 1991, Jesani,1992) - and have so little credibility. The PHCs and sub centres, in public opinion, are basically family planning centres. The effort at setting up rural hospitals to fill this demand gap for curative care is woefully slow, and is further made more difficult with the no availability of medical personnel. Observations show that where rural hospitals are well staffed and equipped they are as crowded as the district hospitals. Thus, in comparative terms the public sector serves the urban areas better than it does the rural areas but in absolute terms even the urban population is under-served as far as public health services are concerned.

Apart from the above noted scenario of health care services in the country a further rationale for change in the health policy is provided by global experience in evolving universal health care systems. There is a general tendency to move towards more organised national health systems and an increased share of public finance for health care (Roemer, 1985, oECD, 1990). Almost all developed capitalist (exception USA) and socialist countries have universal health care systems where the share of the fiscal burden by the public sector is between 60% and 100% (ibid.). This trend is the consequence of the pursuit for equity and universal coverage. Countries that have not set up universal systems for health care continue to experience high inequities. In spite of being economically most developed, the USA is an outstanding example where still over 30 million persons don't have access to a reasonable level of health care (President Clinton in his campaigns had promised to wipe out this lack of health care through Federal intervention). The fate of most Asian and African countries is miserable - low public sector investment, large private sector, and wide-ranging inequities in access to basic health care. In the case of most Latin American countries a significantly large proportion of population is covered for primary health care, though coverage is still not universal. A large country like India cannot wait for economic development as a precondition for health care development. Intervention in social sectors like health, education and housing can be independent of economic development as demonstrated by most socialist countries. These in turn create social conditions for a more rapid economic development.

Framework for a New Health Policy

Before we set out to outline the framework for a new health policy and identify the main issues to be tackled, it is important to define the frame of reference of the health sector. As pointed out earlier, for all practical purposes the health sector may be divided into the private sector and public sector, each with its specific features. To re-emphasise, we had identified two set of dichotomies in the health sector, the curative (private sector) - preventive (public sector) dichotomy, and the rural (preventive) - urban (curative) dichotomy. It is extremely important to remove these dichotomies for universal coverage and equity considerations. Therefore the first step is to recognise the health sector as a single sector of a public - private mix with a social goal, and the second step is to consider health care as comprehensive without any social and geographical discrimination. Hence there is a need for organising the existing health care system under a universal umbrella for the delivery of primary care as per the rational needs of the people. Further it is important in this context to define the minimum which should be included under primary care.

Primary care services should include at least the following:

(a) General practitioner/family physician services for personal health care.
(b) First level referral hospital care and basic speciality (general medicine, general surgery, obstetrics and gynaecology, paediatrics and orthopaedic) services, including dental and ophthalmic services.
(c) Immunisation services against vaccine preventable diseases.
(d) Maternity services for safe pregnancy (or safe abortion), delivery and postnatal care.
(e) Pharmaceutical services - supply of only rational and essential drugs as per accepted standards.
(f) Epidemiological services including laboratory services, surveillance and control of major diseases with the aid of continuous surveys, information management and public health measures.
(g) Ambulance services.
(h) Contraceptive services.
(i) Health education.

The above listed components of primary care are the minimum that must be assured, if a universal health care system has to be effective and acceptable. The key to equity is the existence of a minimum decent level of provision, a floor that has to be firmly established. However, if this floor has to be stable certain ceilings will have to be maintained

toughly, especially on urban health care budgets and hospital use (Abel-Smith, 1977). Those wanting services beyond the established floor levels will have to seek it outside the system and/or at their own cost.

There has been some amount of debate on standards of personnel requirements [doctor: population ratio, doctor: nurse ratio] and of facility levels [bed: population ratio, PHC: population ratio] but no global standards have as yet been formulated though some ratios are popularly used, like one bed per 500 population, one doctor per 1000 persons, 3 nurses per doctor, health expenditure of approx 5% of GNP etc. Another way of viewing standards is to look at the levels of countries that already have universal systems in place. In such countries one finds that on an average per 1000 population there are 2 doctors, 5 nurses and as many as 10 hospital beds (OECD,1990, WHO,1961) The moot point here is that these ratios have remained more or less constant over the last 30 years indicating that some sort of an optimum level has been reached. In India with regard to hospital care the Bureau of Indian Standards (BIS) has worked out minimum requirements for personnel, equipment, space, amenities etc. For doctors they have recommended a ratio of one per 3.3 beds and for nurses one per 2.7 beds for three shifts. (BIS 1989, and 1992). Again way back in 1946 the Bhore Committee had recommended reasonable levels (which at that time were about half that of the levels in developed countries) to be achieved for a national health service which are as follows:

- one doctor per 1600 persons
- one nurse per 600 persons
- one health visitor per 5000 persons
- one midwife per 100 births
- one pharmacist per 3 doctors
- one dentist per 4000 persons
- one hospital bed per 175 persons
- one PHC per 10 to 20 thousand populations depending on population density and geographical area covered
- 15% of total government expenditure to be committed to health care, which at that time was less than 2% of GNP

The above requirements were worked out, after a thorough study of the health situation in the country, by the Committee members. This exercise is lost to history because of inadequate efforts on part of the planners and policy makers to implement fully the recommendations of the Bhore Committee. The first response from the government and policy makers is that they are excessive for a poor country and we do not have the resources to create such a level of health care provision. Such a reaction is invariably not a studied one and needs to be corrected. We have obtained the following profile after reviewing available information:

(i) Daily morbidity = 1 % to 2% of population, that is about 10 - 20 million patients to be handled everyday (4 - 7 billion per year)

(ii) Hospitalisation Rate = 20 per 1000 population per year with 12 days average stay per case, that is a requirement of228 million bed-days (that is 20 million hospitalisations as per NSS - 1987 survey, an underestimate because smaller studies give estimates of 50/1000/year or 50 million hospitalisations)

(iii) Prevalence of Tuberculosis = 11.4 per 1000 population or a caseload of over 11 million patients

(iv) Prevalence of Leprosy = 4.5 per 1000 population or a caseload of over 4 million patients

(v) Incidence of Malaria = 2.6 per 1000 population yearly or 2.6 million new cases each year

(vi) Diarrhoeal diseases = (under 5) = 7.5% (2-week incidence) or 1.8 episodes/child/year or about 250nlillion cases annually

(vii) Acute Respiratory Infections (under 5) = 18.4% (2-week incidence) or 3.5 episodes per child per year or nearly 500 million cases per year

(viii) Cancers = 1.5 per 1000 population per year (incidence) or 1.5 million new cases every year

(ix) Blindness = 1.4% of population or 14 million blind persons

(x) Pregnancies = 21.4% of childbearing age-group women at any point of time or over 40 million pregnant women

(xi) Deliveries/Births = 25 per 1000 population per year or about 68,500 births every day

(Estimated from CBHI, WHO, 1988, ICMR, 1990<a>, NlCD, 1988, Gupta et.al.,1992, NSS,1987)

The above is a very select profile which reflects what is expected out of a health care delivery system. Let us take handling of daily morbidity alone, that is, outpatient care. There are between 10- 20 million cases to be tackled every day. Assuming that all will seek care (this usually happens when health care is universally available) and that each GP can handle about 60 patients in a days work, we would need about 350,000 GPs equitably distributed across the country. The actual requirement will depend on spatial factors (density and distance). This means one GP per about 500 families, this ratio being three times less favourable than what prevails presently in the developed capitalist and the socialist countries: Today we already have over 1,300,000 doctors of all systems (550,000 allopathic) and we can integrate all the systems through a continuing medical education (CME) program and redistribute doctors as per standard requirements.

Section II

Making Structural Changes - A New Approach

The conversion of the existing system into an organised system to meet the requirements of universality and equity

will require certain hard decisions by policy-makers and planners. Before we discuss the issues involved for a new health policy we first need to spell out the structural requirements or the outline of the model which will need the support of a policy. More than the model suggested hereunder it is the expose of the idea that is important and needs to be debated for evolving a definitive model. The most important lesson to learn from the existing model is how not to provide curative services. Curative care is provided mostly by the private sector, uncontrolled and unregulated. The system operates more on the principles of irrationality than medical science. The pharmaceutical industry is in a large measure responsible for this irrationality in medical care. Twenty thousand drug companies and over 60,000 formulations characterise the over Rs. 160 billion drug industry in India. (In addition to this there is a fairly large and expanding ayurvedic and homoeopathy drug industry estimated to be atleast one-third of mainstream pharmaceuticals) The WHO recommends 306 drugs as essential for provision of any decent level of health care. If good health care at a reasonable cost has to be provided then a mechanism of assuring rationality must be built into the system. Family medical practice that is adequately regulated is the best and the most economic means for providing good primary health care.

Family Practice

Each family medical practitioner (FMP) will on an average enroll 400 to 500 families; in highly dense areas this number may go upto 800 to 1000 families and in very sparse areas it may be as less as 100 to 200 families. For each family/ person enrolled the FMP will get a fixed amount from the local health authority, irrespective of whether care was sought or no (of course, those in remote and sparsely populated areas will get a higher per family compensation because their client strength would be lower). He/she will examine patients, make diagnosis, give advice, prescribe drugs, provide contraceptive services, make referrals, make home-visits when necessary and give specific services within his/her framework of skills. Apart from the capitation amount, he/she will be paid separately for specific services (like minor surgeries, deliveries, home-visits, pathology tests etc.) he /she renders, and also for administrative costs and overheads. The FMP can have the choice of either being a salaried employee of the health services (in which case he/ she gets a salary and other benefits) or an independent practitioner receiving a capitation fee and other service charges.

Epidemiological Services

The FMP will receive support and work in close collaboration with the epidemiological station (ES) of his/her area. The present PHC setup will be converted into an epidemiological station. This ES will have one doctor who has some training in public health (one FMP, preferably salaried, of the ES area can occupy this post) and he/she will be assisted by a health team comprising of a public health nurse and health workers and supervisors. Each ES would cover a population between 10,000 to 50,000 in rural areas depending on density and distance factors and even upto 100,000 population in urban areas. On an average for every 2000 population there will be a health worker and for every four health workers there will be a supervisor.' Epidemiological surveillance, monitoring, taking public health measures, laboratory services, and information management will be the main tasks of the ES. The health workers will form the survey team and also carry out tasks related to all the preventive and promotive programs (disease programs, MCH, immunisation etc…) They will work in close collaboration with the FMP and each health worker's family list will coincide with the concerned FMPs list. The health team, including FMPs, will also be responsible for maintaining a minimum information system, which will be necessary for planning, research, monitoring, and auditing. They will also facilitate health education. Of course, there will be other supportive staff to facilitate the work of the health team.

First Level Referral

The FMP and ES will be backed by referral support from a basic hospital at the 50,000 population level. This hospital will provide basic specialist consultation' and inpatient care purely on referral from the FMP or ES, except of course in case of emergencies. General medicine, general surgery, paediatrics, obstetrics and gynaecology, orthopaedics, ophthalmology, dental services, radiological and other basic diagnostic services and ambulance services should be available at this basic hospital. This hospital will have 50 beds, the above mentioned specialists, 6 general duty doctors and 18 nurses (for 3 shifts) and other requisite technical (pharmacists, radiographers, laboratory technicians etc ..) and support (administrative, statistical etc ..) staff, equipment, supplies etc. as per recommended standards. There should be two ambulances available at each such hospital. The hospital too will maintain a minimum information system and a standard set of records.

Pharmaceutical Services

Under the recommended health care system only the essential drugs required for basic care as mentioned in standard textbooks and/or the WHO essential drug list should be made available through pharmacies contracted by the local health authority. Where pharmacy stores are not available within a 2 km. radial distance from the health facility the FMP should have the assistance of a pharmacist with stocks of all required medicines. Drugs should be dispensed strictly against prescriptions only.

Organising the Health Care System

For every 3 to 5 units of 50,000 populations, that is 150,000 to 250,000 populations, a health district will be constituted (Taluka or Block level). This will be under a local health authority that will comprise of a committee including political leaders, health bureaucracy, and representatives of

consumer/social action groups, ordinary citizens and providers. The health authority will have its secretariat whose job will be to administer the health care system of its area under the supervision of the committee. It will monitor the general working of the system, disburse funds, generate local fund commitments, attend to grievances, provide licensing and registration services to doctors and other health workers, implement CME programs in collaboration with professional associations, assure that minimum standards of medical practice and hospital services are maintained, facilitate regulation and social audit etc... The health authority will be an autonomous body under the control of an autonomous State Health Authority. The FMP appointments and their family lists will be the responsibility of the local health authority. The FMPs may either be employed on a salary or be contracted on a capitation fee basis to provide specified services to the persons on their list. Similarly, the first level hospitals, either state owned or contracted private hospitals, will function under the supervision of the local health authority with global-budgets. The overall coordination, monitoring and canalisation of funds will be vested in a National Health Authority. The NHA will function in effect as a monopoly buyer of health services and a national regulation coordination agency. It will negotiate fee schedules with doctors' associations, determine standards and norms for medical practice and hospital care, and maintain and supervise an audit and monitoring system.

Licensing, Registration and CME

The local health authority will have the power to issue licenses to open a medical practice or a hospital. Any doctor wanting to set up a medical practice or anybody wishing to set up a hospital, whether within the universal health care system or outside it will have to seek the permission of the health authority. The licenses will be issued as per norms that will be laid down for geographical distribution of doctors. The local health authority will also register the doctors on behalf of the medical council. Renewal of registration will be linked with continuing medical education (CME) programs which doctors will have to undertake periodically in order to update their medical knowledge and skills. It will be the responsibility of the local health authority to assure that nobody without a license and a valid registration practices medicine and that minimum standards laid down are strictly maintained.

Financing the Health Care System

We again reemphasise that if a universal health care system has to assure equity in access and quality then there should be no direct payment by the patient to the provider for services availed. This means that the provider must be paid for by an indirect method so that he/she cannot take undue advantage of the vulnerability of the patient. An indirect monopoly payment mechanism has numerous advantages, the main being keeping costs down and facilitating regulation, control and audit of services.

Tax revenues will continue to remain a major source of finance for the universal health care system. In fact, efforts will be needed to push for a larger share of funds for health care from the state exchequer. However, in addition alternative sources will have to be tapped to generate more resources. Employers and employees of the organised sector will be another major source (ESIS, CGHS and other such health schemes should be merged with general health services). The agricultural sector is the largest sector in terms of employment and population and at least one-fourth to one-third of this population has the means to contribute to a health scheme. Some mechanism, either linked to land revenue or land ownership, will have to be evolved to facilitate receiving their contributions. Similarly self-employed persons like professionals, traders, shopkeepers, etc. who can afford to contribute can payout in a similar manner to the payment of profession tax in some states. Further, resources could be generated through other innovative methods - health cess collected by local governments as part of the municipal/house taxes, taxes on ownership of various assets like property, vehicles etc., proportion of sales turnover and/or excise duties of health degrading products like alcohol, cigarettes, paan-masalas, guthkas etc... should be earmarked for the health sector, voluntary collection through collection boxes at hospitals or health centres or through community collections by Panchayats, municipalities etc ... All these methods are used in different countries to enhance health sector finances. Many more methods appropriate to the local situation can be evolved for raising resources. The effort should be directed at assuring that at least 50% of the families are covered under some statutory contribution scheme.

Section III

Projection of Resource Requirements

The projections we are making is for the fiscal year 2000 - 2001. The population base is one billion. There are over 1.3 million doctors (of which allopathic are 550,000, including over 200,000 specialists), 600,000 nurses, 950,000 hospital beds, 400,000 health workers and 25,000 PHCs with government and municipal health care spending at about Rs.250 billion (excluding water supply).

An Estimate of Providers and Facilities

What will be the requirements as per the suggested framework for a universal health care system?

- Family medical practitioners = 400,000
- Epidemiological stations = 35,000
- Health workers = 500,000
- Health supervisors = 125,000
- Public health nurses = 35,000
- Basic hospitals = 20,000
- Basic hospital beds = 1 million

Basic hospital staff:

- General duty doctor = 120,000
- Specialists = 120,000
- Dentists = 20,000

- Nurses = 360,000

Other technical and non-technical support staff as per requirements (Please note that the basic hospital would address to about 75% of the inpatient and specialist care needs, the remaining will be catered to at the secondary/district level and teaching/tertiary hospitals)

Except for the hospitals and hospital beds the other requirements are not very difficult to achieve. Training of nurses, dentists, and public health nurses would need additional investments. We have more than an adequate number of doctors, even after assuming that 80% of the registered doctors are active (as per census estimates). Crash CME programs to facilitate integration of systems to produce a single cadre of doctors. The PRC health workers will have to be reoriented to fit into the epidemiological framework. And construction of hospitals in under-served areas either by the government or by the private sector (but only under the universal system) will have to be undertaken on a rapid scale to meet the requirements of such an organised system.

An Estimate of the Cost

The costing worked out hereunder is based on known costs of public sector and NGO facilities. The FMP costs are projected on the basis of employed professional incomes. The actual figures are on the higher side to make the acceptance of the universal system attractive. Please note that the costs and payments are averages, the actuals will vary a lot depending on numerous factors.

Table 1. Projected Universal Health Care Costs (2000-2001)

Type of Costs	Rs. in millions
Capitation/salaries to FMPs (@ Rs.300 per family p.a. x 200 mi fam.)50% of FMP	60,000
services Overheads 30% of FMP services	36,000
Fees for specific services 20% of FMP services	24,000
Total FMP Services	120,000
Pharmaceutical Services (20% of FMP services)	24,000
Total FMP Costs	144,000
Epidemiological Stations (@ Rs.3 mi per ES x 35,000)	105,000
Basic Hospitals (@ Rs.6 mi per hospital x 20,000, including drugs, i.e.Rs.120, 000 per bed) Total Primary Care Cost	120.000 369,000
Per capita = Rs, 369; 1.84 % of GDP	
Secondary and Teaching Hospitals, IncI. med. edu. and trng of doctors/ nurses/ paramed. (@ Rs.2.5lakh per bed x 3 lakh beds)	75.000
Total health services costs	444,000
Medical Research (2 %)	8,880
Audit/Info. Mgt/Social Res. (2%)	8,880
Administrative costs (2 %)	8.880
TOTAL RECURRING COST	470,640
Add capital Costs (10% of recurring)	47,064
ALL HEALTH CARE COSTS	517,704

Per Capita = Rs. 517.70; 2.59% of GDP

(Estimates done on population base of 1 *billion and GDP of Rs. 20,000 billion)*

Distribution of Costs

The above costs from the point of view of the public exchequer might seem excessive to commit to the health sector. But this is only 2.6% of GDP or Rs.518 per capita annually, including capital costs. The public exchequer's share, that is from tax revenues, would be about Rs.350 billion or two-thirds of the cost. This is well within the current resources of the governments and local governments put together. The remaining would come from the other sources discussed earlier, mostly from employers and employees in the organised sector, and other innovative mechanisms of financing. As things progress the share of the state should stabilise at 50% and the balance half coming from other sources. Given below is a rough projection of the share of burden by different sources:

Table 2: Projected Sharing of Health Care Costs (2000·2001 Rs, in millions)

	Type of Source			
	Central Govt.	State/ Muncp.	Orgns'd. Sector	Other Sources
Enidem. Ser vices	70,000	25,000	7,000	3,000
FMP Services	5,000	65,000	45,000	5,000
Drugs (FMP)	--	11,000	11,000	2,000
Bask Hospitals	--	65,000	45,000	10,000
Secondary/Teach Hospitals	20,000	30,000	20,000	5,000
Medical Research	7,000	1,000	880	--
Audit/ Info. Mgt./ Social Research	4,000	4,000	880	--
Admin. Costs	2,000	6,000	880	--
Capital Costs	20,000	20,000	5.000	2,064
ALL COSTS	128 000	227000	135.640	27 064
	Rs.517.704 million			
Percentages	24.7	43.8 |	26.2 |	5.3

Section IV

Making the System Work - Policy Issues

To make the above recommended system work a. number of policy initiatives and decisions need to be taken. We will not discuss the question of feasibility here because it is a political matter. We will only say this that provision of basic health care will have to be made statutory if the goal is health for all with equity. Thus, the first task on the part of the government would be the proclamation of an organised health care service under which every citizen would be enrolled irrespective of his/her social, geographical or financial status. The structure, the terms and conditions,

administrative measures etc., will have to be spelt out by an Act of Parliament. The Act must take cognisance of existing ground realities and assure that the implementation process addresses these ground realities. For instance, the elimination of rural-urban disparities in health care provision must be the primary task to begin with if such a policy has to be successful.

Another priority policy initiative needed for implementing a universal health care system would be related to tackling the medical profession. A small, established section of the medical profession would oppose any organised system of health care because it would threaten their position in the health care market. In sharp contrast, the younger professionals (the majority) would welcome such a step because it would not only give them an assured market/ clientele but it also would provide for relative equality within the profession. This is precisely what happened when Britain introduced the NHS system or Canada implemented its health sector reforms. Thus one of the prime foci of such a policy should be regulating provider behaviour. This would include issues of licensing, registration, CME, compulsory public service, especially in rural areas, strict controls over out migration of doctors, integration of various systems of medicine, standards of medical practice and hospital care etc...

Hitherto the health sector has operated without any restrictions and regulations. This has to be changed to assure better distribution of health human power. Thus licensing in setting up medical practice will have to be resorted to. Strong restrictions and disincentives in over served areas and incentives in underserved areas will be necessary to ensure equitable access to all. This would mean setting up of norms for access and availability, for instance, minimum and maximum number of doctors in a given radial distance or population in dense and sparse areas. Under the FMP system discussed above the remuneration or capitation amounts should be significantly higher in underserved or remote areas, both because of fewer families as well as to encourage the setting up of medical practice in these areas. Further to enhance the number of doctors under the public health sector compulsory public health service must be legislated. No medical graduate must be given a registration until he/she has served a minimum of 5 years in public health services, of which at least 3 years should be in rural areas. Similarly, until the 3 years of rural service is completed postgraduate course registration too should not be allowed. This is the minimum return that must accrue to society for its contribution to the social production of doctors. Also doctors working in the health bureaucracy (directorates, district administration etc...) must by rotation do clinical work so that their skills are not wasted. Further, doctors trained in the country should not be allowed to migrate abroad. In specialties where training is not available within the country only government service doctors should be allowed to go abroad for obtaining those skills and must return and develop that speciality with public sector support.

A major policy issue would be with regard to medical education. In practice the multiple-system doesn't work because people overwhelmingly demand modem medicine, and non-allopathic doctors too practice modern medicine. Hence there is a need to bring drastic changes in medical education. Whether MCI or the other Councils like it or not, the only solution is to have a single cadre of basic doctors. Those who want to study alternative systems can do it as a basic specialisation. This restructuring is a must to prevent the gross medical cross-practice and malpractice, which at times is dangerous. Thus there is an urgent need to restructure medical education to produce a cadre of basic doctors who would provide compulsory service in the public health sector for a specified period. The integration of existing doctors of different systems of medicine can be done through a crash CME program so that their knowledge and skills are rationalised and updated. Further, doctors should not get permanent registration but periodic with renewal being linked to completion of relevant CME programs as is done in many countries.

Another area of policy action would be setting up standard norms for medical practice and hospital care. The Bureau of Indian Standards has begun this process but more concerted efforts are needed to finalise norms and assure their implementation. This is very important for the universal health care system because the entire monitoring and auditing of the system will depend on having such norms. Social audit and information management can only be facilitated if standards of practice and care are well established.

Issues related to pharmaceutical production and pricing should be a major concern of a national health policy. Unfortunately as of now the health ministry's role is limited to monitoring drug quality standards. The health ministry is presently in no position to assure the production of essential drugs or even drugs required for the various national programs. The health ministry must make efforts at vesting control of the pharmaceutical industry in order to assure the production of rational and essential drugs. For a universal health care system to function unimpaired essential drugs must be available in the required quantities whenever and wherever needed. This will be possible only if the health ministry has complete control of the pharmaceutical industry under its wings.

Finally, the most important area for policy initiative would be the efforts needed to generate resources through various alternative modes of financing. The thumb-rule for a policy on health financing should be that no direct payments are made by patients to providers because a direct payment system increases both costs and inequalities, as well as leaves ample room for irrational medical practice. The health ministry has to pressurise the government to commit a much larger quantum of funds to the health sector. This need not be only through the 'existing mechanism of financing (tax revenues) but also through other public and private sources as discussed in a preceding section. The universal health care system will mean the existence of monopoly buyer/s of health care services. This will necessitate the creation of a National Health Authority that will receive contributions from all specified sources and will disburse funds to all agencies under the organised health care system.

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Community Insurance - Which Way to Go? Wisdom out of the Experiential Learning from SEVAGRAM

Ulhas Jajoo

The Concept: Primary Health Care should be considered a fundamental right of the people (as it should be for primary education)

The Challenge: The poor spend considerable amount on medical care to unregulated and exploitative private sector, primarily due to low credibility of public hospitals...

The privatisation of public health services offers an opportunity to misutilise state health resources for private sector. Therefore, the private sector needs regulation

The Disease: Inspite of wide health care infrastructure in public sector medical care has not out-reached to the poor, rural people in particular, essentially because of. i) paucity if funds and ii) lack of efficiency.

The maldistribution of centrally pooled resources is what primarily ails our system. The distribution of Central/State Government funds is lop-sided, favours 'haves' and neglects 'haves-not' favours urban and not rural people.

Therefore the optimal resource allocation (per capita basis) to primary care hospitals is first step towards building credible services.

The Pre-Requisite: Primary health care services must provide free curative care for its acceptability to the poorest of the poor.

The egalitarian health services can never be economically self reliant, if they have to preferentially serve the poor. Thus, no private insurance will cater to the poor. Therefore, the pro people service must be financially shouldered by the welfare state.

The Soul: The credibility of the system revolves around:

a) Accessible hospital services of an optimum quality.
b)Accountability of health care system to the consumers.
c) Affordability of the services to the poorest.

The Fact: It is possible to offer a just primary care to all, within existing government resources, provided funds are locally available and locally governable in an efficiently decentralised set up.

The Direction: Accountability of the health-care system can not be enforced vertically downward. To inculcate responsiveness in the public health care system, a vigilant public audit system is required.

Therefore, the empowerment of the people is the key for an accountable system. The power emanates through the control of public funds and through performance evaluation of public servants. Public bodies should be entrusted with the above responsibility in a decentralised structure. The Gram Sabha in the Panchayati Raj system should be empowered with public funds (per capita basis expenditure that Central and State governments undertake.)

The Participatory Nature: Since charity corrupts people, the beneficiary should contribute towards health care services, albiet according to their capacity to pay and the priority need. Contribution according to capacity and service according to need must be the guiding principle, for pro-poor services. The social financing so raised can not meet expenses towards medical care cost, it can at best, supplement it. Apart from offering an affordable post payment mechanism to persons who need services but are unable to pay for it, (Risk sharing) Social financing has following spin offs benefits -

i) It increases accessibility of health services
ii) It promotes operators' concern for health in the community.
iii) It generates the concept of right to demand quality health care by the beneficiary population.
iv) It responds to priorities as judged by the community.
v) It ensures the services are acceptable.
vi) It keeps service providers on their toes.
vii) It stimulates organisational self-confidence and paves way for participatory culture at the community level.

The Essence: Primary health care is a fundamental right and the welfare state has an obligation to fulfil it. The pro-poor health care services should be financed by the welfare state. Therefore, it should be obligatory for a welfare state to offer a health insurance scheme through its existing infrastructure. A decentralised Panchayati Raj set up should be entrusted financial resources allocated on per capita basis by Central and State governments. Emergency medical services should be free and accessible to the poor. Social financing raised through consumer contributions encourages demand for quality care and inculcates community participation in medical care.

The Path to Tread: As part of its constitutional obligation, the state should run the community health care scheme, through its rural hospitals (village or Mohalla of a city as a unit of community). The health care scheme should raise the finances as prepayments from Gram Sabha in the Panchayati Raj system. The health care budget allotted on per capita basis can then be routed as prepayment towards community medical care scheme. The private sector can compete with the public sector rural hospital by floating a community medical care scheme, with the choice resting with the Gram Sabha.

List of background papers for Annual Meet 2001, published in the MFC bulletins.

Issue No. 276-277

Towards Universal Health Insurance: A Rural Perspective - Shyam Ashtekar

Extending Health Insurance to the Poor: Some Experiences from the SEW A scheme - Anil Gumber

Issue No. 278-279

Two Community-Based Pre-Payment Schemes in Kheda, Gujarat - M. Kent Ranson

Reforming Health Policy For Universal Health Care - Ravi Duggal

Community Insurance - Which Way to Go? Wisdom out of the experiential learning from SEVAGRAM - Ulhas Jajoo

The Medico Friend Circle (MFC) is an all India group of socially conscious individuals from diverse backgrounds, who come together because of a common concern about the health problems in the country. MFC is *trying to critically analyse the existing health care system while searching for a system of health care which is humane and which can meet the needs of the vast majority of the population in our country. About half of the MFC members are doctors and medical students, the rest include researchers, health and gender activists, community health experts, public health professionals, academicians and students from different disciplines. A loosely knit and informal national organisation, the group has been meeting annually for more than twenty five years.*

Thank You

A publication such as the MFC bulletin can hardly be sustained without the voluntary effort of many individuals. The Mumbai based MFC members have been especially supportive, providing time, labour and advice. However, there are several others, outside this circle, who have come forward to help. We would not like their contribution to go unrecognised. We would like to convey our thanks to all those helped us establish the editorial office in Mumbai and set the bulletin on firm ground. Satish Kulkarni and Sanjay Kulkarni at Parkar Arts for teaching us the basics of page making, giving us continued guidance and support. Prabhakar and Suvrata Chirmuley at Pradish Mudran, who have always given the printing of the bulletin prioirity over their other jobs and helped us meet nearly impossible deadlines. Friends at CEHAT, Saramma Mathew, Vikas Gamre and Devidas Jadhav, who have independently and enthusiastically managed the mailing of the bulletin, Margaret Rodrigues at CEHAT, who helped with the computerization of the mailing list. Maya Nadar at MASUM, for systematically handling subscriptions and renewals and all the other administrative work related to the bulletin.

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- Editorial Committee

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