INNOVATIONS IN MICROHEALTH INSURANCE SCHEMES IN TRIBAL CONTEXT

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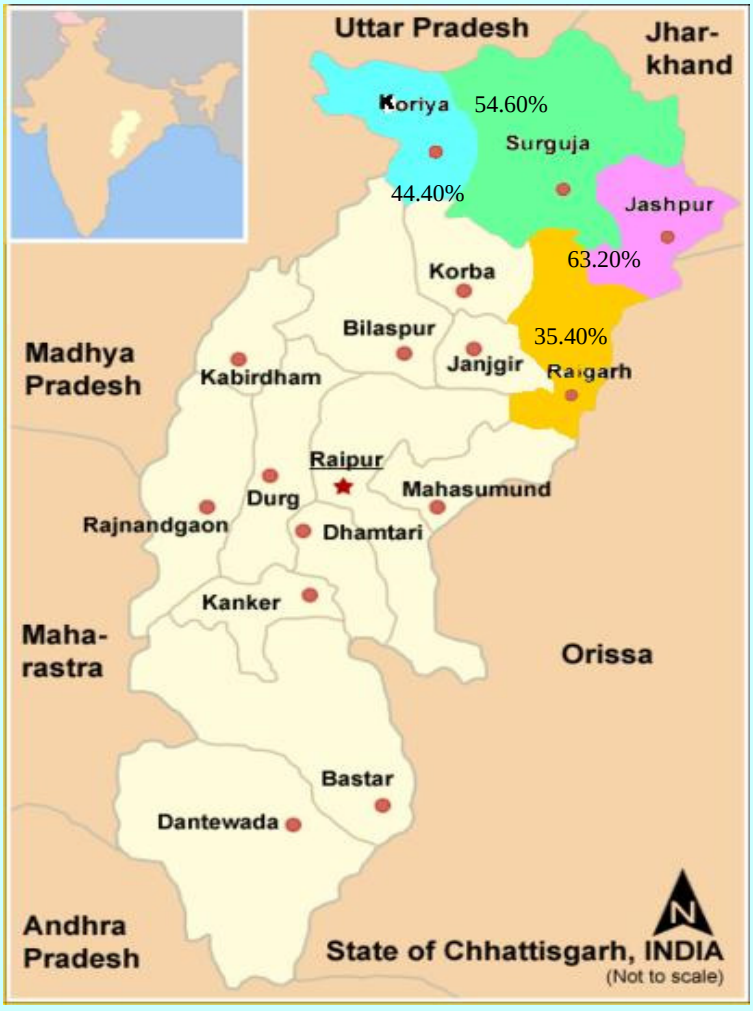
RAHA



Scenario

- Tribal Population 31.80%
- Literacy 64.66%
- Sex Ratio
  - Chhattisgarh 989
  - India 931
- Infant Mortality 63 (58 India)
- Life Expectancy at Birth 61.4years
- Proportion below poverty line
  - Chattisgarh 37%
  - India 26%

	Chattisgarh	Jashpur	Surguja	Raigarh	Koriya
3 ANC*	48.7	51.3	48.2	51.2	20.4
Delivery by skilled person	29.1	30	27.6	27.3	16.9
Full Immunization	60.9	62.7	54.8	66.9	61.9
Adequately staffed PHC	26.3	13	21.9	36.7	10

* Ante Natal Care

** Primary Health Center

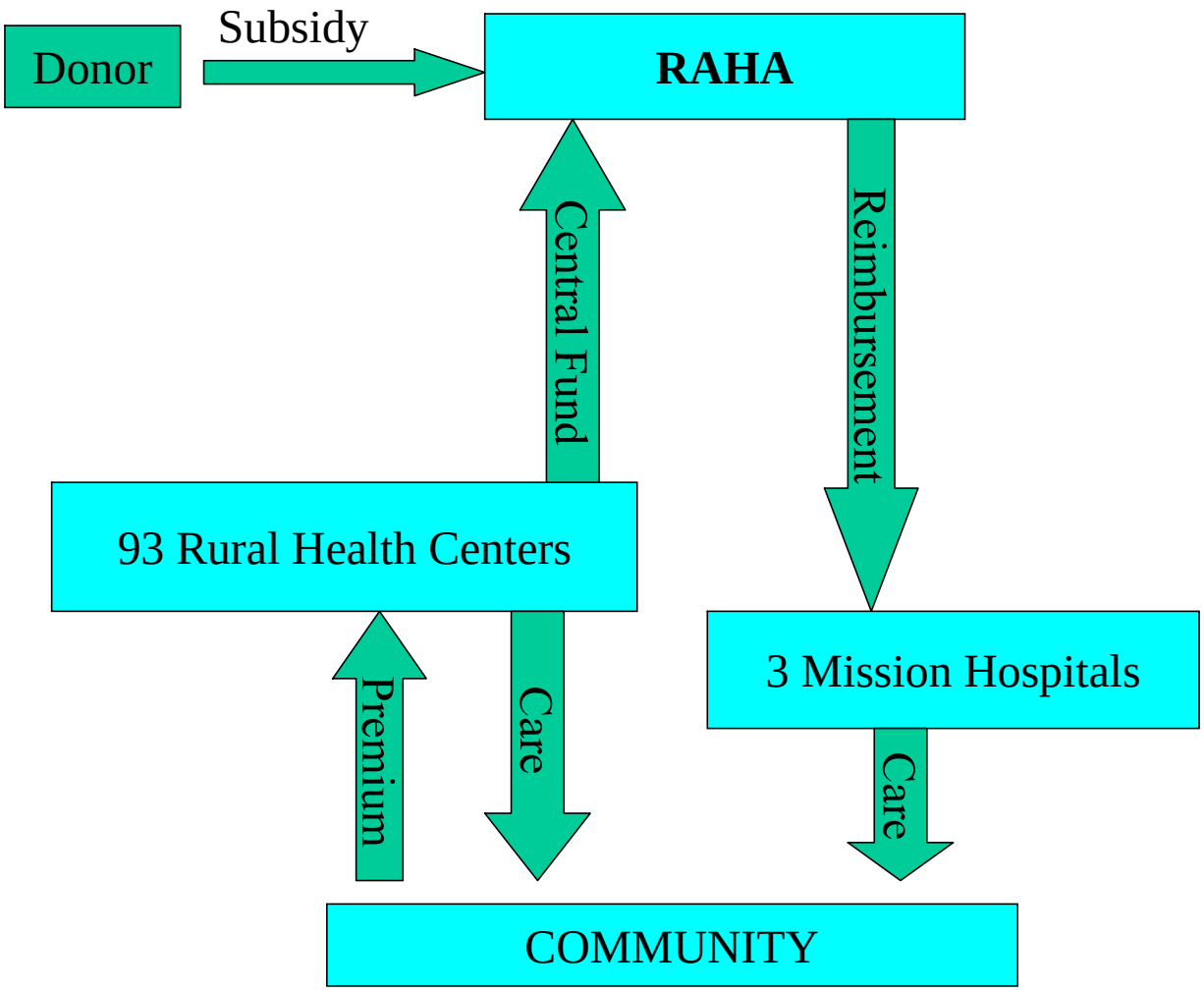
- Doctors shortage in PHC
  - Out of sanctioned1034 post, 406 is remaining vacant.
- Government expenditure on medical, public health and family welfare as ratio to aggregate disbursement is1.40 %
- Diarrhoeal disease, malaria and tuberculosis are major public health problems.
- Sickle cell disease has high prevalence.

Raigarh Ambikapur Health Association (RAHA)

- Works towards Health and Development since 1969
- **Vision**
  - Envisions a wholesome, sustainable, caring and transformed community of people
- **Mission**
  - To build up local leadership through value based training
  - To work in partnership with people through an integrated and holistic approach
  - To facilitate promotive, preventive, curative and rehabilitative health care services
  - To promote Alternative System of Medicine
  - To Collaborate with like minded individuals and organizations and government.

RAHA'S MICROHEALTH INSURANCE

- Microhealth Insurance was initiated in 1980 with the following objectives
  - To subsidize the cost of medical care of the members
  - To encourage people's participation in health services
  - To strengthen existing solidarity among tribals
  - To reduce exploitation from Moneylenders
- Insurer Model
- Premium Rs.20/person/year



- Three levels of care
  - Village Health Promoters
  - 93 empanelled Rural Health Centers
  - 3 empanelled Hospitals
- Benefits
  - Free medicines from Village Health Promoters
  - Rs.100 worth free medicines at Rural Health Centers
  - Rs. 1250 free treatment at the hospitals and a small amount of co payment

Good Practices

- Health Insurance is embedded in the larger development programmes.This lends credibility and people trust the scheme.
- Capitalizes on existing tribal solidarity
- Premium collection coincides with the time the tribal people have disposable cash.
- Defined collection period and waiting period
- Compulsory enrollment of school children in most mission schools
  - Relatively healthier population
- Comprehensive benefit package
  - Promotive, preventive and curative
  - Some tangible benefits for the members as Hospitalization is not very exciting (Just about 1 or 2 hospitalization in a year in one village)

- Improved quality of care and equipment available at the Rural health Centers which reduces referral to hospitals and need of the patient to travel long distances. This also facilitates comfort to the tribal people as the Rural Health Nurse is in constant contact with them and living in their area.
- Through its network of committed staff and well wishers Health Insurance is promoted which reduces marketing cost.
- Total members enrolled in 2007 – 89477

Challenges

- Poor geographical accessibility of rural health centers and referral hospitals
  - Problems of terrain and absence of adequate spread of roads and transport facilities. Only 15% of villages are connected with pucca road.
  - Seasonally cut off
  - Indirect cost such as transportation, accomodation etc
- Poor socio economic conditions
- Jhola Doctors/ Unqualified Medical Practitioners

- Educating the community on the concept of insurance
  - "We are not getting sick so it is not required for us"
  - "We are not getting any benefit by becoming a member when we don't get sick"
- Still requires substantial donor support (MISEREOR)
- MIS perceived as an instrument of conversion

New changes to address the challenges

- Hospitalization benefits increased to Rs.2500
  - 75% of patients can walk off without out of pocket payment
- Travel benefits
- Destitute arbitrarily estimated at 5% of the population will not have to pay the premiums
- Whole village enrollment in the selected model villages in each RHC
  - Negotiation with the community
  - Increase membership
  - Avoid adverse selection
  - No exclusion

- IEC activities focuses on Illness to Security
- Increase community participation in the microhealth insurance
  - Village and Rural Health Center level assemblies
  - Regular feedback to the community

Thank You