The Jawar Health Assurance Scheme

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Introduction

The Jawar health assurance scheme is a unique scheme managed by Dr. Ulhas Jajoo, Prof. Of Medicine, Mahatma Gandhi Institute of Medical Sciences, Wardha and his team. It is one of the earliest scheme in which the contribution was collected in kind (Jawar/ Sorghum) to ensure access to timely health care service. The basic principle on which the scheme is based is that everyone must have access to quality health care, irrespective of their ability to pay, but everyone must contribute to it as per their ability. Hence it is known as an assurance scheme. Though Dr. Jajoo initiated the scheme in 1979. However, the genesis of the scheme runs back to early 50s. Following Gandhiji's assassination in 1948, the management of the hospital was taken over by 'Gandhi Smarak Nidhi', which in due course of time could not manage the hospital finance and wanted the government to take over the hospital administration. The workers were unhappy with this. They consulted the village leaders, who offered their contributions in the form of Jawar.

Dr. Jajoo resolutely believes that charity corrupts people and people must pay to demand quality service from the providers. He has visited various voluntary health projects of repute in India. From his observations emanated a belief that mere benevolent service will breed a relationship of doler and beggar between the provider and the beneficiary. Moreover the schemes were heavily subsidised thereby posing a threat to its long term sustainability. The tradition of contributing as per one's capacity already prevailed in the villages especially for ceremonial purposes and for construction of temples. The villagers agreed upon the same strategy and it was therefore decided in consensus with the villagers to create a pool of contribution to meet their health needs.

Objectives of the scheme

- To generate demand for quality health care to meet health contingencies.
- To make health care services not merely available but accessible to the poorest of the poor.
- Considering village as a social unit, an integral part of the larger society, to make health care services available to more than 75% of the village population with their active participation.
- To create a system to deliver appropriate and prompt health care services to the needy, irrespective of the amount of contribution.

The whole process began with a dream of Gram Swarajya where health was chosen as a medium of entry into the rural life. There has been a paradigm shift in the scheme from an initial focus on curative care to preventive and further to promotive care. It didn't stop there and with perpetual experience and learning shifted the focus on social aspects, which now rests on moral issues.

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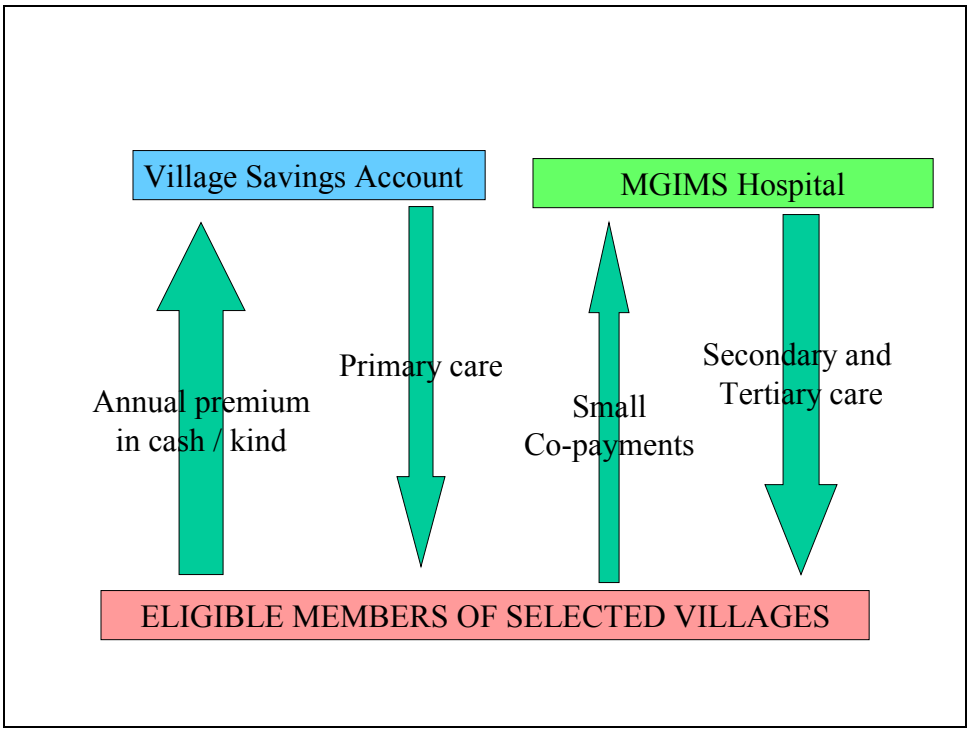
Design

The contribution from the people is collected by the VHW (village health worker) which is either in cash or in kind. This amount is deposited in the village fund, which is used only to pay the remuneration of the VHW, manage the drug kit, meet the fuel expenses of the vehicle for the village visit and to arrange village level meetings. The MGIMS supplements the benefit package by providing secondary and tertiary care.

Figure 1: The design of the Jawar Rural Health insurance scheme



The Community

The scheme covers all the villages within a radius of 25 kms from the hospital. The inhabitants of these villages are either farmers or landless labourers. The process of enrolling a village to the scheme is as follows:

- On requisition from any village, a preliminary visit is made to the village to have a discussion with the villagers.
- The decision of extending the cover is made after an initial assessment of their needs, accessibility, morality of the villagers and extent of co-operation. No more villages are included now as almost all the nearby (accessible) villages are covered and further inclusion will not ensure physical accessibility to the hospital.

Till 1994 all the villagers were eligible to join the scheme; from then on the members were required to satisfy one of the following criteria to be eligible to join the scheme-

- He/She should have initiated the lift irrigation scheme for the entire village.

- He/She should have availed to the 'One house one latrine' scheme with 100% participation.
- Member of the family must be a member of the diary co-operative.
- He/She should have elected village panchayat by consensus.

These conditions were further amended as follows from 2002 onwards. The eligible candidate should:

- Be a member of Self Help group.
- Have assumed organic farming.
- Be an organizer or participant in Prabhodan (educative lecture series)
- Have taken a vow for Vastra Swavlamban. (spinning charkha)

Contributions

The contributions to the scheme are income rated. The villagers are expected to contribute as per their ability. Dr. Jajoo decided a tariff in consultation with the villagers depending on their income and assets. The villagers unanimously agreed to contribute 2 payali (2.5 kgs) of Jawar per acre of landholding[3]. Landless labourers contribute a flat rate of 4 payali per family of five. Families with more than five members contributed 2 payalis per additional member. Those having additional sources of income would contribute 4 payali more. For the salaried class, contribution was decided in proportion to the SALDAR's (landless labourer on yearly contract) income. The collected jawar was sold to the market and converted into cash for utilization. Members may also contribute the equivalent in cash.
The contribution is deposited in the village account. This amount is then transferred to the 'Kasturba Health Society' corpus and utilized for various village level activities. It does not reimburse the hospitalisation expenses of the beneficiaries.

Provider

Mahatma Gandhi Institute of Medical Sciences is the provider of medical care. It is a 648 bedded tertiary hospital with 23 teaching and research departments. The hospital being a medical college hospital and a research institute, provides all the diagnostic and curative facilities. The preventive and promotive care is provided to the select villages through other community development projects. It is an autonomous institute but receives grants from the Government of India.

Benefit package

The insured members are eligible to receive free primary health care from the VHWs with the aid of the village drug kit. This is funded from the Village Savings Account. The latter also reimburses the expenses for the doctor's visit.

Other than this, the members receive secondary and tertiary care at the MGIMS hospital. This includes OP and IP services. There are no upper limits for the services and no exclusions.

[3] One kilo of Jawar costs Rs 4 (2004).

However the insured is required to bear 50% of the hospital expenses for elective admissions. Also the insured patient is required to meet the cost of referral services as well as purchase medicines that are not available in the hospital pharmacy.
Preventive and promotive care is provided through various developmental initiatives.

Payment of provider

The cost of the drug kit for the villages and the VHW's remuneration are met with from the insurance contributions. Besides this, the expenses of arranging the village level meetings and the fuel charges of the vehicle for village meetings are also reimbursed from the contributions. The hospital expenses on insured patients are usually met by the hospital funds. Moreover, the doctors in the hospital are paid fixed salaries, and so there is no incentive to over treat the insured patients.

Administration

Collection of premium:

The VHW and community representatives manage the collection of the premium. They collect the cash or the jawar and handle the accounts. These accounts are presented to the community at village meetings, so there is transparency at all levels.

Claims and reimbursements:

Each beneficiary is given a card at the time of enrolment. When the patient seeks treatment in the OPD (Out patient department) he/she has to just show the card, while in case of admission he/she has to produce a note in the prescribed format from the village health worker. A staff appointed for management of the scheme enters the details in a register and endorses the note following which the patient is admitted in the ward. At the time of discharge, the patient may have to pay the co-payment (in the event of elective conditions) or the cost of medicines purchased outside the hospital pharmacy. No other costs are charged to the patient.

Risk Management

Measures to control adverse selection:

The family is the enrolment unit. Also there are very stringent conditions for enrolment. Thus there are very little chances of adverse selection at the time of enrolment. However there are no waiting periods, upper age limit or exclusions in the scheme.

Measures to control moral hazard:

The providers have no incentive in treating the patients as the scheme does not reimburse the cost of the treatment. Hence provider induced moral hazard is negligible.
The patients have to incur all the additional charges like that of medicines prescribed from outside, besides indirect cost like transportation, food, loss of wages, and cost of accompanying relatives. Thus patient induced moral hazard is also minimised. Also there is a referral system and without the VHWs' note, the patient cannot get admitted to the hospital.

Achievements

Coverage

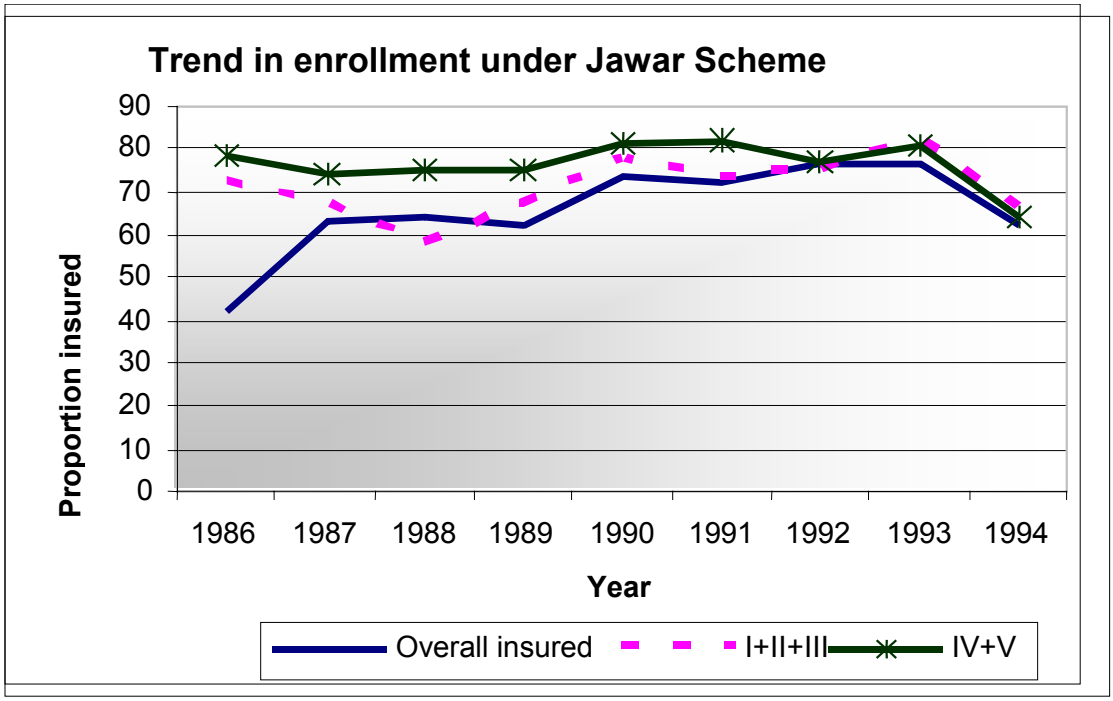
From one village in 1979, the numbers of villages increased to 15 in 1986 and currently 40 villages are covered under the scheme. Around 9628 villagers were covered under the scheme in 2003.

The insurance scheme was conceived in 1979, which went through a phase of evolution till 1985. From 1986 to 1994 the entire village was offered the scheme i.e. all the villagers from the selected villages, were eligible for the scheme. From 1995 onwards more than one scheme was offered to the villagers and from 2000 onwards the scheme was open to selected families satisfying the eligibility criteria. As the scheme was in evolutionary phase till 1986, and as it is difficult to separate the data of Jawar scheme from the pooled data from 1995 to 1999, the data from 1986 to 1994 is analyzed.

From Fig. 2, the overall coverage shows an initial increase till 1992, which then falls. Though there was a high demand for the scheme from the people, their inability to satisfy the stipulated conditions made them ineligible for the scheme.

It is interesting to study the coverage in different classes of people, which also reflects on their acceptance for the scheme. The graph below shows the trend in enrolment over the years, under different categories based on the socio economic status.

Fig 2: Line diagram showing the trend in enrolment under the jawar scheme.



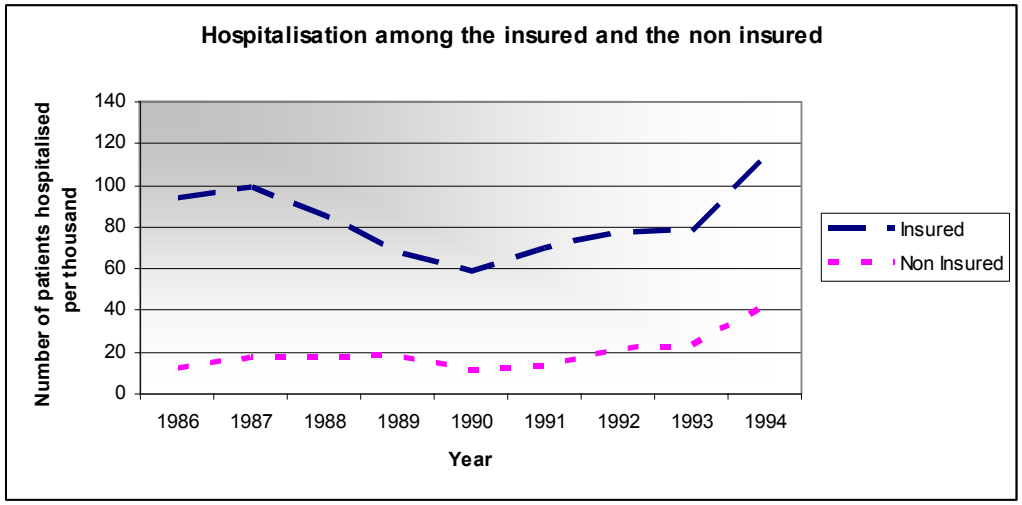
Category I – Families who employ labourer on yearly contract (Saldar) for agricultural work.
Category II – Families who own irrigated land and a pair of bullocks, but do not employ saldar.

Category III – Family who own unirrigated land and a pair of bullocks but do not employ saldars.
Category IV – Families who own dry land but neither employ Saldar nor have bullocks.
Category V – Landless labourer.
Any other additional occupation raises the economic grade by one.
Thus the villagers from category I, II & III can be considered from comparatively higher socio economic status as compared to those from category IV & V.
The increase in overall enrolment shows increased acceptance of the scheme. However few villages were dropped out intermittently due to non adherence to the conditions laid. The level of enrolment from the lower economic strata has always remained more than that from the upper strata, till the year 1992, after which both categories equal.

Utilisation

Though the insured members are eligible for both out patient and inpatient care, as no separate register is maintained of insured and non insured patients in the OPD, the utility of the out patient service cannot be assessed.
The utilization of indoor services has been high from 93 to 115 per thousand insured members (Figure 3)

Figure 3: Hospitalisation rates among insured patients over time.



Cost recovery

The objective of this scheme is to generate demand for health services by the poor and make these services available to them at the time of need irrespective of their affordability to pay. Hence it does not aim at meeting the cost of care from the contributions.
The collected amount is not pumped back to the hospital and is utilized to cover the cost of providing outreach services. However, if this amount was to be used for the provision of hospital services, the probable cost recovery would be 2.2% in 1986 of the total hospital recurring expenditure, which has remained constant to 2.4% in 1994. The scheme therefore reimburses only the cost of the outreach services while creating a demand for even out patient and inpatient services in the medical college hospital.

Conclusions

Some of the unique features of the scheme are it has been able to generate demand for the services and has created a sense of ownership. Tertiary care services are available to the poor at minimal expense. As only two staff at the hospital manage the scheme, the administrative cost is also kept minimal and above all it has served as a nodal point of entry for other developmental programs in the village.