# Community-Based Schemes

## Ashwini Case Study

Working Paper no. 3

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## Ashwini Case Study

**Saliya Kanathigoda**

Working Paper no. 3

International Labour Office
Geneva

**Strategies and Tools against social Exclusion and Poverty (STEP)**

The Strategies and Tools against social Exclusion and Poverty global programme (STEP) of the International Labour Organization (ILO) is active in two interdependent thematic areas: the extension of social protection to the excluded and integrated approaches to social inclusion.

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## Foreword

Although the informal economy workers in India contribute to some 63 % of the GNP, fair redistribution mechanisms of the generated wealth are not yet in place. At the present day, it is considered that more than 90 % of the whole population still do not benefit from any kind of social protection. Being not protected against the various risks they face on a daily basis, the broaden segments of the population remain caught in a continuing cycle of vulnerability and poverty. At the same time, the most disadvantaged groups are facing increasing difficulties in accessing essential social services such as health care.

In the recent years however, it has been observed in India a growing perception of the necessity to extend social protection to all excluded groups and a wider commitment to actively contribute to this extension through various strategies including the promotion on new micro-insurance schemes. As a direct result, numerous actors of the civil society (community-based organisations, women's groups, trade informal economy trade unions, NGOs, micro-finance institutions…) have already taken numerous initiatives designing and setting-up micro-insurance schemes that were tailor-made to answer the priority needs and contributory capacity of their target groups.

As an integral part of ILO's Social Protection sector, the ILO/STEP programme has been actively engaged since 1998, in the identification, promotion and support of various innovative interventions that could efficiently address the social protection needs of the poor and excluded groups. At present, the programme operates in some 40 countries spreading over four continents. Since 2002, it has started to increase its activities in Asia through a regional coordination based in New Delhi. Recognising the particular situation, challenges and opportunities existing in India, the STEP programme recently intensified its interventions in India.

Recognising knowledge building as a first key issue, the STEP programme initiated in India a series of case studies aiming at documenting the various health micro-insurance experiments conducted at the local level, highlighting their operational mechanisms and assessing their present and potential impact in order to facilitate their possible development or replication. The present study on the Ashwini health insurance scheme, developed in Tamil Nadu Gudalur district, is part of this series and has been established with the cooperation of the GTZ

## Acknowledgements

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## Abbreviations

| | |
|---|---|
| **ACCORD** | Action for Community Organization, Rehabilitation and Development |
| **AMS** | Adivasi Munnetra Sangam |
| **ASHWINI** | Association for Health Welfare in the Nilgiris |
| **CBO** | Community Based Organisation |
| **CHP** | Community Health Programme |
| **GAH** | Gudalur Adivasi Hospital |
| **GOI** | Government of India |
| **GTZ** | German Technical Cooperation |
| **HA** | Health Animator |
| **HG** | Health Guide |
| **HMIS** | Health Microinsurance Scheme |
| **HSC** | Health Subcentre |
| **IC** | Insurance Company |
| **ILO** | International Labour Organization |
| **IS** | Insurance Scheme |
| **NIAC** | New India Assurance Company Ltd |
| **NGO** | Non Governmental Organisation |
| **OP** | Outpatient services |
| **PHC** | Primary Health Centre |
| **RSA** | Royal Sundaram Alliance Private Insurance Company Ltd |
| **SRTT** | Sir Ratan Tata Trust |
| **STEP** | Strategies and Tools against social exclusion and Poverty |
| **TB** | Tuberculosis |
| **VBVT** | Vishwa Bharathi Vidyodaya Trust |

# Introduction

This case study describes the operations of ASHWINI, an NGO based in Gudalur, which provides health services to the adivasi tribal people based in the Gudalur taluk. ASHWINI provides universal health coverage for its target group, through a three-tier system which has trained tribal health workers at the village level, nursing assistants at the regional health sub-centres (HSC), and a central integrated hospital at Gudalur which is also the main administration centre of ASHWINI. ASHWINI has developed from ACCORD, another NGO, which was founded in 1986 with the mission of improving the lives of the adivasi people, and from the Adivasi Munnetra Sangam (AMS), a CBO, which is a membership organisation of 1.300+ tribals living in Gudalur taluk.

The case study begins by presenting the organisation (section 1) and explaining the context in which the health scheme operates (section 2). It was found necessary to present the many activities that are facilitated by ACCORD and ASHWINI. To be able to give an adequate description of the integrated HMIS run by ASHWINI, it was also important to provide some background of how the health scheme developed and ACCORD's long grassroots involvement with the local tribal community which enabled such a project to evolve. The same section also gives some demographic, social and economic background on the local tribal community.

Section 3 describes the phases of implementation of the health scheme, focussing on the development from a decentralised community health programme to the founding of an integrated hospital and finally to the establishment of health subcentres at regional level.

Section 4 describes the major characteristics of the health scheme which include details of the target group and the beneficiaries. Section 5 details the benefits and services offered by the scheme. The following sections deal with the financial aspects of its operations, its relationship with formal insurance companies and some brief information on its management structure, the assistance it receives from external sources and the actors' viewpoints.

# 1. The Organisation

ASHWINI developed from a community health programme (CHP) run by an NGO - ACCORD. It was founded in 1986 by a husband and wife couple who, upon seeing the conditions in which the adivasi people lived, had decided to try to improve these conditions. ACCORD's mission is to *"fight against the unjust alienation of the adivasi lands and other human rights violations by organising them as a strong group."*[1] A major aim of its operations has been to *empower the adivasi to achieve self-reliance through their own endeavour and develop dignity and self-respect as an ethnic group*.[2] This is fundamentally embedded in all areas of ACCORD's activities. A further point is that its areas of intervention were designed with the clear purpose of responsibility for their operations eventually being entirely transferred to the adivasi community. This was the reason why the AMS was created and works closely with ACCORD and ASHWINI. In fact, most of the members of the ASHWINI governing body are representatives of the AMS. These characteristics are strongly reflected in the design and structure of its health activities.

The health scheme initiated by ACCORD is one programme within a portfolio of development activities serving to support and strengthen the adivasi community. The focus is the same: to facilitate the adivasi community becoming *"self-reliant in getting access to various essential services"* based on solidarity principles - encouraging *"systems where such services can be accessed not as individuals, but as an organised group"*.

## *1.1 The Development of ACCORD's Activities*

ACCORD's first concrete area of interventions was to promote solidarity within the adivasi community. The first step was to facilitate the formation of recognised village level sangams through 'Animators' at village level. At these sangams, with participation from men, women and children, the adivasis were encouraged to stand up for their rights. The immediate motive for this was to mobilise demonstrations against the increasing confiscation of traditional lands by non-tribal interest groups and government planners.

In 1988, a federation of village sangams was formed – the "Adivasi Munnetra Sangam" (AMS) - to represent the over 200 sangams which had been formed during the first two years' of ACCORD's operations. AMS' first public act was to hold a massive demonstration (of some 10.000 people) in Gudalur asserting adivasi land rights. The demonstration was successful in its goal, which strengthened the burgeoning community spirit and sealed AMS' position as the representative body of the adivasis. Since its establishment, AMS has concerned itself with defending the rights of adivasis and to

[1] ASHWINI Webpage

[2] *Historically the adivasi consist of five different tribes (Paniyas, Bettakurumbas, Mullukurumbas, Kattunaickens and Irulas) settled around the Gudalur Valley area. The social status of the adivasi is below that of the dalits (the "untouchables"). The Government of India has classified the Paniyas, the Bettakurumbas and the Kattuanaickens as "primitive tribal groups", indicating that their social status is even lower then the average scheduled tribes.*

promoting socio-economic development.[3] AMS has developed into a strong representative association, run *for* the adivasi people *by* the adivasi people and is involved in virtually every aspect of tribal life. Having consolidated its structures over the past decade, it is currently focussing on mobilising youth from the tribal villages to be actively involved in the various development programmes in order to secure the future of adivasi community activities.

ACCORD's many areas of intervention are developed and managed with the full participation of AMS. Indeed nearly all staff in the various programmes have been selected from the adivasi community. In addition to the health scheme, current activities are in the following areas:

### *1.2 Education Programme – The Vidyodaya School*

Initially set up with the objective of increasing adivasi attendance at Government schools, the Programme began by addressing the issue of incorporating tribal culture and language into the state education system. This was done through the provision of scholarships for pupils for uniforms, materials etc. and the training of tribal volunteers to work within these schools. As it was clear that this would not succeed in improving the quality of education received by the adivasi children, ACCORD established an independent school (from an existing one) to be operated by tribal youths and managed by AMS. This has been complemented by the creation of an informal education centre, tuition centres for school drop-outs, mobile library services for adivasi children attending other schools and "camps" to teach adivasi children about their own culture. Significantly, this Vidyodaya School functions as a Resource Centre and Training Centre for the adivasi youth involved in education activities at the villages.

### *1.3 Economic Development Societies*

Since its inception ACCORD has aimed to improve the economic situation of the adivasis with several activities in the field of economic development. A tea planting programme also addressed the issue of land rights for the adivasis, who had had land taken away from them in previous years and thus been transformed from cultivators to wage labourers. The tea planting programme reversed this trend and again made the adivasi settled agriculturists – this time growers of a mainstream cash crop, tea.

Gradually the economic development scheme developed to cover a wider range of products and auxiliary services. Currently, tea and pepper nurseries have been established to provide the adivasis with farming inputs, while cooperatives have been created for honey, pepper, tea leaves and coffee for marketing and sales activities and for securing stable prices throughout the year. Other factor and technical inputs are also provided, as is credit – both for production and consumption needs. The most significant of these initiatives, the "Adivasi Teal Leaf Marketing Society" is currently searching for opportunities to market adivasi produce on a national and international scale.

[3] *including addressing legal issues and representing the adivasi community in discussions with GoI*

### 1.4 Cultural Programme

An important part of ACCORD'S work with AMS is "preserving and promoting" the culture of the adivasis around Gudalur. Part of this involves the documentation of cultural aspects such as history, music and story-telling. An Adivasi Cultural Festival was introduced. This has become an annual event at which traditional sports and singing and dancing are celebrated within the entire community.

### 1.5 Collective Wealth Programme

Initiated by the tribal community in 1995, the idea of an adivasi-owned section of land was realised in 1998 through the purchase of the Madhuvana Estate. The 176-acre estate was bought by ACCORD with funding from the Charities Advisory Trust in the UK. The rationale behind the purchase was to provide a source from which to generate wealth to help cover the costs of the other programmes operated by ACCORD and AMS. The estate is managed by adivasi youth and is primarily used for the adivasi's main economic activity – tea cultivation. The long-term strategy is to further develop the land and to use the estate as a base for other tribal programmes and activities.[4]

### 1.6 Housing Programme

As traditional housing material became scarce, the adivasis were dependent on government housing programmes. These were relatively undesirable and were abandoned by the tribals soon after construction. To overcome this, the ACCORD instituted a housing programme in 1993, wherein local adivasi youth were trained to use low cost but appropriate material to construct houses. This team has subsequently been instrumental in advocating for better government houses.

The considerable range of ACCORD's activities together with AMS gives an idea as to how strongly embedded in the adivasi community it is. This is of great significance to the form its HMIS has taken. Further details about AMS, ACCORD and ASHWINI are available at http://www.adivasi.net/

## 2. The Context in which the Scheme Operates

### 2.1 Demographic Aspects

The IS' zone of intervention is in the hilly and forested Gudalur taluk, in the Nilgiri district in the tri-junction of Tamil Nadu, Kerala and Karnataka in South India.[5] The population figures for 1991 and 2001 are given in table 2. The tribal population for 2001 is from the AMS records.

[4] *Currently only some 60 acres are in a suitable condition for cultivation and resources are being invested in improving the quality of the remaining land.*

[5] The author was not able to collect any statistics on the Gudalur Valley area. Information may be available through the GoI census.

**Table 1 : Demographic Aspects – Nilgiri District**

| | Census 1991 | Census 2001 | Decadal Growth Rate |
|---|---|---|---|
| Total population in Nilgiris district | 710.214 | 764.826 | 7,7 % |
| Tribal population in Nilgiris district | 25.048 | 28.373 | 13,3 % |
| Tribal population in Gudalur taluk | 11.694 | 13.246 | - |
| Paniyas | 7.460 | - | - |
| Kurumbas (Betta + Moola) | 3.180 | - | - |
| Irulas | 610 | - | - |
| Kattu Naickens | 410 | - | - |
| Kothas | 34 | - | - |

## *2.2 Economic Aspects*

Before the support from ACCORD, the adivasis were almost entirely living on a subsistence basis with little interaction with the money economy. Although increased economic activity has reduced this somewhat, many adivasis still have limited access to cash funds. This is, above all, a barrier to being able to collect premium payments from a wider range of people. The percentage of AMS members paying the premium for health insurance coverage has fluctuated in recent years between 35-40% (see section on premium payments)

## *2.3 Social Aspects*

Before ACCORD's intervention, there were minimal social protection and group solidarity arrangements within the adivasi community, but they had no prior experience with formal insurance services. Some traditional group risk-sharing arrangements had existed for long time, but were limited to informal collections (e.g. of rice) for events such as weddings and bereavements. There was also a system of "piruvu" wherein the villagers collected money from neighbours (both adivasis and non-adivasis) whenever an adivasi required hospitalisation.

The adivasi people were almost completely excluded from Indian society, with no social activities or structure and negligible access to Government health services due primarily to lack of knowledge and a fear of formal health systems, and to the insensitive approach of the mainstream development agencies to the distinct culture of the adivasis.

Some social indicators are as follows:

**Table 2: Social Indicators – Nilgiri District**

| Indicators | Adivasis in Gudalur | Adivasis in Tamil Nadu | Adivasis in India | Tribals in India |
|---|---|---|---|---|
| Literacy rate | - | 73,5 % | 64,8 % | - |
| No of doctors per 1.000 | 1:3.250 | - | 1:3.600 | - |
| Total immunisation rate | 86 % | 88,8 % | 42 % | 26,4 % |
| Antenatal coverage rate | 80,5 % | 98,5 % | 66 % | 57 % |
| Institutional deliveries | 45 % | 79 % | 34 % | 17 % |
| Infant mortality rate | 29,0 | 40,0 | 67,60 | 84,2 |
| Maternal mortality rate/1.000 | 0 | | 4,24 | - |
| Crude birth rate/1.000 | 21,0 | 19,9 | 24,80 | - |
| Crude death rate/1.000 | 9,5 | 7,6 | 9,70 | - |

Source: NFHS – 2 1998/1999 and the TN health services website http://www.tnhealth.org/

## 3. The Implementation of the Insurance System

The health insurance system started in 1992, at which time, health insurance for the poor was a relatively new concept. During those times, health insurance was limited to civil servants, the employees of the formal sector (mandatory social health insurance) and to the richer sections of Indian society (private voluntary health insurance). However, today, the Government of India has specific plans of introducing health insurance for the poor. The latest National Health Policy (2002) talks about covering the population under a health insurance programme. In keeping with this policy, the Government of India has made budgetary allocations for a subsidised health insurance product for the poor.

### *3.1 Identifying Needs and Defining Objectives*

From the work of ACCORD's founders with the community, it was evident that the adivasis previously had practically no access to health care services. The impetus for the CHP came from the adivasis themselves through AMS, which had provided a platform for the individual sangams to voice their main areas of concern to ACCORD. A key concern was on improving the health of the community, particularly focussing on the high death rate of mothers during childbirth and diseases amongst children.[6]

The two founders of ACCORD, themselves having no medical experience, began to search for doctors. In 1987 another husband and wife couple, both doctors, joined ACCORD and launched the Community Health Programme (CHP) for the adivasis within the Gudalur area.

It is important to mention that in the design and evolution of ACCORD's health scheme strong recognition has always been given to the social and cultural norms of the adivasi people. This was seen by the staff as crucial for gaining acceptance and mobilising active participation while introducing modern medicines and practices to a traditional community.

The health insurance programme arose from the need to start a hospital. The AMS had requested ACCORD to start a hospital to complement the CHP. However, during various discussions with the community, it was clear that financing the hospital would be a difficult proposition. While the community was willing to contribute towards hospital expenses, ACCORD realised that the traditional "fee for services" was an inequitable form of payment and would create a lot of financial barriers for the adivasis. It was during this search for an alternate system of financing the health programme that the ACCORD staff came across a "Tribal health insurance policy" managed by the national insurance companies. Given the equitable mode of funding and the emphasis on solidarity, ACCORD (after clearance from the AMS) negotiated with the New India Assurance Company (NIAC) for an affordable package in 1992.

The basic objectives of the insurance programme were as follows:

1) To access health care with dignity by not depending on charity or handouts;
2) To encourage health seeking behaviour by offering comprehensive health care with minimal payment at the time of use of the services

[6] No documentation is available regarding the objectives stated at the outset of the health insurance scheme.

3) To enhance the feeling of solidarity among the members of the AMS
4) To protect the AMS members from catastrophic health expenditure
5) To enhance the feeling of ownership of the health programme among the members of the AMS by contributing towards their own health care
6) To provide a stable income for the Adivasi hospital

### *3.2 Context and Financial Feasibility Studies*

No formal context or feasibility studies were carried out – ACCORD was aware that a health scheme offering universal coverage for adivasis would not be self-sustainable in terms of generating the necessary revenue from the adivasi community. The decision to start operations was a social commitment to provide health care and to then try to collect revenue to recover *some* of their costs with the aim of eventually developing a sustainable system owned and run by the tribal people themselves.

While no formal studies were carried out, there were a lot of discussions at various levels to assess the feasibility of the health insurance scheme. The ACCORD team discussed with the intricacies of insurance with the community over a period of nine months. This was not only to create awareness, but also to arrive at an affordable premium. It was also during theses meetings that a strategy of phased premiums was developed. The AMS leaders felt that the premium needs to be subsidised initially, and once the benefits of health insurance are recognised by the community, then the subsidy can be removed.

The ACCORD team also conducted negotiations with the NIAC to develop an affordable and appropriate product. And finally the ACCORD team approached donors to provide funds for the initial subsidy.

### *3.3 Information on the Target Group*

As by 1991, the ACCORD team had a baseline census on all the AMS members (about 8.000 people) including demographic, social and economic data. Also because of the health programme, there was preliminary information of the morbidity pattern and the approximate cost of health care. These last two information were used to arrive at an affordable premium. The definition and prioritisation of the adivasis' needs was conducted - and is constantly evolving - through ACCORD's interaction and fundamental anchoring of their activities with the community, starting with the initial solidarity-based activities and developing through AMS and its linked programmes.

### *3.4 The Evolution of Health Activities*

Gudalur has a network of government primary health centres (PHC) and a 100 bedded Taluk hospital. However, in most of these institutions, both manpower and medicines are found to be wanting, resulting in poor quality care.

The private sector in Gudalur is limited to Gudalur town, and consists mainly of individual private practitioners. There is a Christian NGO hospital but its prices are similar to any private sector hospital. Other than this, there are a few Estate hospitals that cater to the plantation workers. The workers are provided free care. Outsiders are not allowed to use these facilities.

The multi-tier ASHWINI health system which is currently in operation has been developing since 1987. There was no specific event undertaken to announce the launch of activities. The health scheme was started at the sangam level as a community health programme, in conjunction with ACCORD's other activities.

### Community Health Programme (from 1987)

For the first years after its inception in 1987, the CHP was the sole element of ACCORD's health scheme. The programme was designed to have a strong participative orientation, operating entirely in the field and focussing on training adivasis selected by the tribal communities to intervene as health workers at village level. Staff consisted of two doctors.

The main tasks of these village health workers were as follows:

- To provide preventative health care
- To provide basic curative care, including first aid and treatment of minor ailments
- To provide antenatal checkups and give nutritional advice to pregnant women and motivate them for immunisation
- To monitor the growth of children and to motivate young children to accept immunisation
- To improve the general awareness of health issues within the adivasi community
- To refer serious patients to the nearest hospital

After a few years' of operation, this had brought about significant improvements in the health of the adivasi community, notably:

- Drastic reduction in preventable deaths among the adivasis (e.g. through diarrhoea or during childbirth)
- Strong improvement in immunisation status of children and pregnant mothers
- Increased awareness of growth monitoring and nutrition

In extreme cases where hospitalisation was necessary, patients would be referred to the local Government hospital or to the private clinics. This arrangement, however, proved to be unsatisfactory, with inadequate treatment at Government hospitals, high costs incurred at private hospitals which had to be subsidised by ACCORD and time constraints brought about by the doctors having to follow up on hospitalised cases.

### Gudalur Adivasi Hospital (from 1990)[7]

As a result of bad experience with Government and private hospitals, high demand developed from the adivasi community for ACCORD to establish its own hospital. This was resisted at first by the doctors running the CHP, with whose original vision this conflicted against. They had previously regarded the programme as a capacity and

[7] *ASHWINI is an NGO that runs the health programme now. One of the components of the health programme is a 30 bedded hospital called the Gudalur Adivasi Hospital (GAH). ASHWINI and GAH are integrated together and operate from the same building, partly with the same staf.*

awareness-building initiative tackling preventative and primary health care issues, which was eventually to be transferred entirely over to the adivasi community. They were unsure of the ability of the programme to be able to sustainably operate such an institution on a long-term basis. The key issue was staff-related: how to find qualified doctors and how to train the number of nurses necessary to make it a viable proposition.

The decision to found the Gudalur Adivasi Hospital in 1990 was very strongly linked to the fact that the CHP were able to find two doctors (another husband and wife couple – this time a surgeon and a gynaecologist) prepared to join the programme. Within the sangams, young adivasi girls were selected to train as nurses. As a hospital requires a different legal framework to manage it, the AMS decided to gradually handover the ACCORD health programme to ASHWINI. This had the dual effect of meeting the statutory requirements and forcing the AMS to take over the health programme. So while initially there was much duplication, with ASHWINI using the ACCORD staff and the infrastructure, by 1997, the entire programme was managed by ASHWININ.[8]

Operations were initially divided into two areas: the two original doctors continued with the CHP, while the new doctors began training the girls selected to become nurses. Given the cultural difficulties in adapting from life in a tribal village to working in a hospital, training needed to be more broadly based than purely medical training, for example including basic Maths and English.

### Health SubCentres (from 1994)

In 1994, it was decided – at the request of the adivasi community – to establish Health SubCentres (HSCs) at the intermediate level. This was based on the eight regional “areas” created by AMS around Gudalur. AMS had had already founded “Area Centres” at regional level to coordinate sangam activities within the villages.

The function of these HSCs (manned by two health animators –HA) is to “coordinate the community health programme in the villages of that Area, provide first aid and primary level curative care by dispensing medicines, screen patients regularly, refer those needing doctor's intervention to Gudalur Adivasi Hospital, follow-up chronic patients regularly, liase with the Governement health services and follow up the patients discharged from the Hospital.”[9]

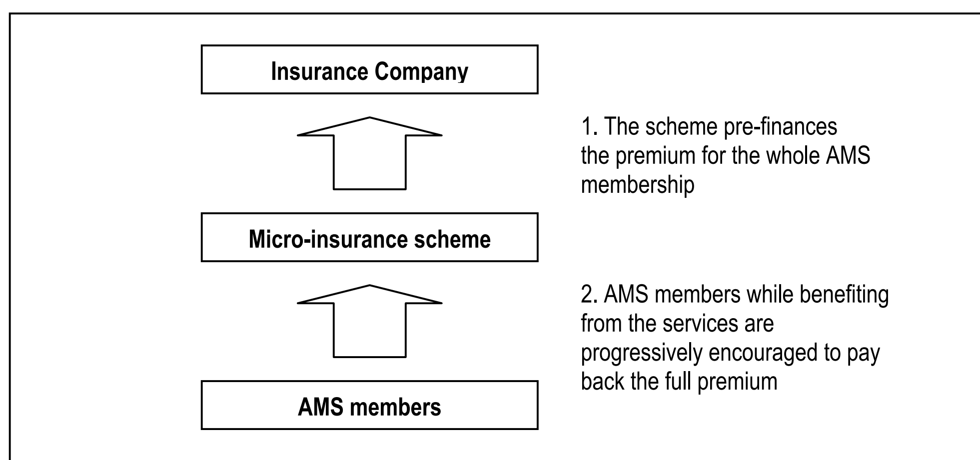
The activities of the Has are to conduct village visits, train village workers, to provide basic curative care and to promote health through health education, The HA also monitors the community health programme – especially MCH and chronic diseases. Each HSC has adequate medicines and also registers to monitor the programme.

## 4. The Insurance System’s Characteristics

The ASHWINI health insurance scheme should be seen at two levels – one provided by the insurance company to ASHWINI and the other by ASHWINI to the adivasi community.

*8 The two organisations remain very closely linked to one another*

[9] *ASHWINI Info.*




### *4.1 The Target Group*

The target group are the adivasi communities living in the Gudalur taluk. Families from the community have to be members of the people's organisation (AMS) to be able to join the health insurance scheme.[10] Once tribals have joined AMS (where membership is voluntary) they are *automatically* insured with the insurance company. However, those who pay an annual premium of Rs. 20 per person are entitled to universal health care. Those who do not pay this amount, can avail of health care from ASHWINI, but by paying a small user fee. However, joining AMS does necessitate participating in all the community-based activities of AMS - this bond of solidarity has to be demonstrable and reduces the likelihood of moral hazard. The risk of adverse selection is also countered by the system of automatic membership for all AMS members.

Thus free health care is provided to all AMS members but those who have not paid the premium that year, must pay nominal amount for outpatient and inpatient services.

### *4.2 Categories of Beneficiaries*

There are three sub-categories of beneficiaries - members of AMS who have paid their premium are entitled to free universal health coverage from the scheme. Members of the AMS who have not paid the annual premium can avail of the health benefits but have to pay a small co-payment. And finally those who are not members of the AMS have to meet the cost of the medicines. The difference between these groups is that tribals who have paid their premium have to pay less of the costs of their treatment. Investigations by ASHWINI show that there is considerable difference in utilisation between those who have paid the premium and those who have not paid. In the case of the former, the utilisation rate is about 10 admissions per 100 insured while in the case of the latter it is about 4 for 100 non-insured.

Non-tribals from the surrounding area can also access the services at GAH for a higher fee. Such fees are used to cross-subsidise treatment for adivasis. Non-tribals - as a part of ACCORD's explicit aim of empowering the adivasi community with regard to non-tribals - are treated with lower priority than adivasi patients. In GAH, OP services are limited to

[10] *There is a nominal annual fee for AMS membership of Rs. 10 per family.*

2 days per week, IP admissions are limited to about 4 of the 20 beds; Community Health Services are available exclusively for adivasis, including the OP services at the HSC.

### *4.3 Evolution of the Number of Beneficiaries*

The number of beneficiaries of the health scheme has grown along with the growth of AMS. During the first full year of the insurance policy with NIAC 7.050 adivasis were covered. This has increased to a current level of over 12.000 members. The breakdown of members can be seen in table 3 below.

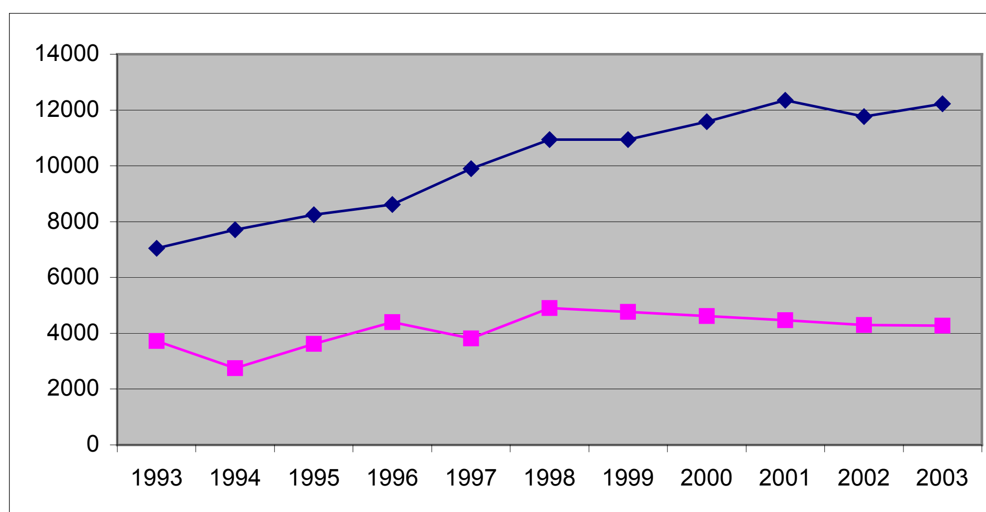



**Table 3: Evolution of Beneficiaries**

| Year | Total Members Ins. Co. Scheme | Total Members Ashwini Ins. Scheme | Percentage |
|---|---|---|---|
| 1993 | 7.050 | 3.726 | 53 % |
| 1994 | 7.710 | 2.744 | 35 % |
| 1995 | 8.247 | 3.624 | 44 % |
| 1996 | 8.621 | 4.395 | 51 % |
| 1997 | 9.900 | 3.812 | 38 % |
| 1998 | 10.942 | 4.899 | 45 % |
| 1999 | 10.942 | 4.768 | 43 % |
| 2000 | 11.585 | 4.619 | 40 % |
| 2001 | 12.347 | 4.464 | 36 % |
| 2002 | 11.765 | 4.291 | 36 % |
| 2003 | 12.226 | 4.268 | 35 % |

Based on the latest figure available, age-group distribution and sex-disaggregated data are as follows

**Table 4: Breakdown of Beneficiaries – By Age Group and Gender**

| Age Group | *Male* | *Female* | *Total* |
|---|---|---|---|
| 0 – 5 years | 989 | 1.113 | 2.102 |
| 6 - 18 years | 1.617 | 1.551 | 3.168 |
| 19 – 65 years | 3.267 | 3.672 | 6.939 |
| 65+ years | 13 | 16 | 29 |
| Total | 5.886 | 6.352 | 12.238 |
| % | % | % | |

During the first years of operation, encouraged by ACCORD, entire communities and villages joined the scheme simultaneously. This was in order to promote solidarity within each community and had the further benefits of diminishing the risk of adverse selection and reducing transaction costs for both parties. At present, families may join AMS individually.

### *4.4 Reasons for Losing Membership Status*

As a socially-oriented scheme which aims to provide the entire community with health services, there have not yet been any circumstances under which individual membership would have been revoked. However, if a person does not pay the annual premium, then the benefits are not provided for that year.

### *4.5 Target Group's Penetration*

The IS covers approximately 200 adivasi villages, with a total population of 15.000 people.[11] Of this figure, some 12,200 are covered through their membership of AMS. The main reason for the exclusion of the remaining adivasis is their geographical distance. Decentralising some activities to village level has significantly improved outreach, but further expansion is not deemed feasible.

There are no geographical restriction on membership, however services are much more heavily used by adivasis living nearer to the health centre - beyond a certain distance it would not be viable for ASHWINI to provide services and too expensive for the adivasis to travel to the hospital in Gudalur or the regional centres.

## 5. Benefits and Other Services Offered by the IS

### *5.1 Health Services Covered by the Insurance System*

ACCORD's rationale was that all AMS members should have access to universal health coverage. Thus, an identical package of benefits is available to all adivasis, which essentially covers them against all illnesses. Its *"Composite Tribal Insurance Scheme"* is based on group solidarity principles. There were two main reasons for using this form of insurance scheme:

1) The fundamental goal of ACCORD was to establish solidarity within the adivasi community
2) The adivasis already had historical experience with traditional insurance systems.

The focus of its activities is on health issues predominant within the tribal communities, particularly ante- and post-natal care and health and nutrition issues for babies and young children. These activities can be broken down onto two levels: the regional and village-based CHP and the central GAH.

[11] Based on an internal calculation from ACCORD.

Community Health Programme

The CHP is operated by the two doctors financed by Skillshare International, together with the HAs, village health workers and volunteers and encompasses both the workers at sangam level and the HSCs. Its focus is on establishing a system of *preventative and primary health care* which can be entirely run from and by the adivasi community itself *without external assistance*.

The HSCs play a coordinating role for the CHP at a regional level. They also provide medical advice, dispense medicines and act as referral units. Patients are referred up to a higher level of care according to their needs. Health workers at sangam level may, for example, recognise a problem during pre-natal care and refer the patient to the HA at HSC level. The HA may then refer the patient to the doctors at GAH if this is deemed necessary.

The CHP provides a range of services:

- *Antenatal Care*. All pregnant women from the adivasi community receive antenatal care where necessary, regardless of whether they have paid a premium.
- *Immunisation of children under 5 years old*. All children under 5 within adivasi villages around the Gudalur Valley area are covered by the CHP.
- *Growth monitoring of children*. This involves both the monitoring and advice on which cheap locally available foods can alleviate malnourishment. An added facet of the growth monitoring initiative is the provision of ragi for malnourished children and the planting of ragi seeds for families who cannot afford to nourish their children.
- *Health education*. In 2002, ASHWINI conducted over 1200 health education sessions at village level, including sessions for large groups (50-60 people) and for schoolchildren. The focus is on basic prevention, for example creating awareness of hygiene issues, diarrhoeal illnesses, scabies and TB.
- *Village visits/work at SHC level*. Health animators are responsible for visiting the villages within their region. In 2002, 210 villages were visited at a frequency of every one or two months. Use of HSCs has grown significantly in recent years. In total some 8.000 patients were seen in 2002 (5.635 at HSC level, 2.289 in villages). Of these 166 (2%) were referred on to GAH.
- *Family planning*. ASHWINI have estimated that some 20% of eligible couples at village level are using family planning methods.[12]
- *Chronic diseases*. Tribals are also monitored for chronic illnesses (e.g. diabetes, hypertension, heart diseases and mental illness). For patients who have suffered chronic illnesses, individual “chronic cards” are produced so that health animators monitor them regularly. Currently ASHWINI is in the process of decentralising the responsibility of this monitoring to the health worker(s) at village level.

This on-site care is provided automatically at all member villages, and is not limited to members who have paid the health insurance premium. This is particularly the case for pregnant women and children under 5. In general, the

[12] ASHWINI Annual Report 2002.

HAs do not visit non-member villages, although exceptions are made if there is a pressing need.

### Gudalur Adivasi Hospital

GAH is the “first referral unit” for ASHWINI and also serves as a Resource and Training Centre for health staff at all levels. The hospital has 20 beds, with an operation theatre, a labour room and a laboratory.

Both doctors from within India and from other countries have worked at the hospital for short- to medium-term periods. Trained non-tribal nurses are also taken for short periods, if found necessary and if suitable persons are available. A significant responsibility of such professionals is to pass on their theoretical knowledge to the adivasi staff through classes and workshops.

GAH offers adivasis secondary care for whichever illnesses occur within the local community. The most common treatments given during the 12 months from April 1st 2002 to 31st March 2003 were deliveries (61), with other pregnancy-related services also highly represented. Tuberculosis, typhoid, acute gastro enteritis, bacillary dysentery, TAO and PPS was also ailments regularly referred to GAH. A detailed list of illnesses treated in this period is available in Annex 1.

Annual admissions rose to a peak of 1233 in 1996-7, but have since fallen to 883 in 2002-3. The higher admission was due to the fact that at that time ASHWINI experimented with opening the OP services to non-tribals on all days, encouraging more admissions. Subsequently, this was reverted back.

A detailed table of admissions, with costs and a breakdown of insured tribals, non-insured tribals and non-tribals is available in Annex 2.

Based on last year admission list (April 1, 2002 – March 31. 2003: out of a total of 518 admissions) more frequent illnesses treated were as follows:

**Table 5: Most Frequent Admissions - GAH**

| N0 | Diagnosis | No. Admissions | Average Cost |
|---|---|---|---|
| 1 | Normal Delivery | 22 | 1.574 |
| 2 | Typhoid | 21 | 660 |
| 3 | Delivery G2 | 17 | 1.229 |
| 4 | Acute Gastro Enteritis | 13 | 629 |
| 5 | TAO | 13 | 1.974 |
| 6 | Delivery Primi | 11 | 1.408 |
| 7 | Bacillary Dysentery | 10 | 331 |
| 8 | PPS | 10 | 902 |
| 9 | False Labour | 9 | 256 |
| 10 | Pulmonary Tuberculosis | 9 | 699 |
| 11 | Tuberculosis | 9 | 365 |
| 12 | Acid peptic Disease | 8 | 467 |

Based on the same, most costly interventions were as follows:

**Table 6: Most Expensive Admissions - GAH**

| N0 | Diagnosis | Average Cost | No. Admissions |
|---|---|---|---|
| 1 | Gastric Outlet Obstruction | 6.182 | 1 |
| 2 | Oesophagitis | 5.884 | 1 |
| 3 | LSCS with Sterilisation | 4.266 | 1 |
| 4 | LSCS | 3.549 | 2 |
| 5 | Pyomyositis | 3.327 | 1 |
| 6 | Twins Delivery | 3.185 | 1 |
| 7 | PIH | 3.064 | 1 |
| 8 | Hydramnious | 2.777 | 1 |
| 9 | Lumbar Sympathactomy | 2.720 | 1 |
| 10 | Tendon Injury | 2.512 | 1 |
| 11 | Cut Injury Knee | 2.020 | 1 |
| 12 | TAO | 1.974 | 13 |

### Supplementary services provided by GAH

Several supplementary services are also available at GAH:

- ASHWINI has established a "Patient's Mess" within GAH in order to address one of the barriers facing potential adivasi patients requiring hospitalisation. Food is provided at a sustainable but low cost to the majority of patients. For those who cannot afford to pay these fees, this service is subsidized.
- Transport to or from GAH is not covered by the scheme. There is one ambulance available that charges at cost.
- In 2002, a crèche was provided for children of nurses and other staff.

### Linkages to other health providers

ASHWINI is linked to both the district Hospital and Calicut Medical College, from whom treatment is available at no charge and only costs of transport must be met.[13] These tertiary institutions are able to cover most additional procedures.

Radiology cases are referred to a private hospital in town with ASHWINI paying for the fees incurred.

GAH has built up linkages with a number of institutions and individuals which provide it with subsidised or free access to medical experts and treatment from a wide range of fields:

- *Dental clinics* through weekly visits from a dental surgeon.
- *ENT clinics* through voluntary monthly visits of a doctor from Bangalore. These dates are fixed and announced to the community well in advance in order to maximise utilisation of this service.

[13] *In these rare cases, transport costs are in fact covered by ASHWINI.*

- *Mental health activities* were supported and further developed by visits to tribal villages by a qualified psychiatrist from Bangalore over a seven-month period.
- *AIDs awareness* was increased through an anti-AIDS programme conducted with support from two external doctors, one involved in an anti-AIDS campaign in Kerala and the other formerly a health trainer at ASHWINI. This took the form of workshops at SHC level for groups of adivasi youth congregated by the health animators.[14]
- *Tuberculosis control programme* conducted with support from the State Government of Tamil Nadu. This programme was facilitated by a Rs. 50,000 grant from the State Government, used to finance the purchase of medicines and laboratory materials and subsidise hospital treatment for afflicted tribals.
- *Diabetes control programme* providing free treatment to diabetics. This has been facilitated through a "Diabetic Fund" financed by the Charities Advisory Trust, a U.K. charity.
- *Exposure programmes* facilitating the exchange of experience between ASHWINI staff and other organisations involved in similar activities. Such exposure programmes have partly been funded by Skillshare International.
- *Family Planning Procedures* are performed in the hospital (Tubectomy, Vasectomy and Copper-T insertion) under the Government' family planning programme. The patients are provided with the financial assistance sanctioned by the Government.

Where possible, training is also provided to tribal staff in the above areas (see below for further details on training).

## 5.2 Training of Tribal Staff

The focus of ASHWINI is very much on *creating health expertise within the adivasi community*, particularly at the most decentralised level – the sangam. A key feature of ASHWINI's staff members is that there are very few non-tribals involved in the system. At HSC and village level all staff are adivasis and live within the local community. It is also important to note that staff are predominantly female.

For example, at GAH – the level at which the highest medical and technical expertise is required - the only non-tribals are the doctors, a lab technician, a staff nurse and two administrators.

**Table 7: Breakdown of Staff Origin**

| | Male | Female | Total |
|---|---|---|---|
| *Adivasis* | 5 | 21 | 26 |
| *Non-Adivasis* | 3 | 4 | 7 |
| *Total* | 8 | 25 | 33 |

Source: Accord Report- December 2003

[14] *There has yet to be a diagnosed case of AIDS within the adivasi community. Rather the programme is increasing preventative awareness in light of flows of migrant labour which increase the likelihood of the issues of AIDS arising.*

A significant element of ASHWINI's operations thus involves *training of tribal health workers and volunteers* from the local community. This is in accordance with ACCORD's objective that all institutions are eventually managed and operated by tribals and indeed have their roots within the adivasi villages.

Training is a continual process. The selection of villagers for training is conducted by an adivasi committee which identifies those in the villages who are committed enough to do this for the community. Initially, training was provided solely by doctors. Training of trainers – supported by SKILLSHARE – has been conducted for health animators and nurses which has resulted in training capacity now being available at tribal level. The content of the training has evolved with the increasing knowledge and experience of the staff to cover illnesses within the adivasi community as they arise. Training is also given, formally or informally, when other institutions, clinics and experts visit ASHWINI to provide certain services

The CHP was initially run by the two doctors, who gradually built up the capacity of the local tribals to assist in the implementation of the scheme. GAH had a combination of professional staff and members of the local community. When the HSCs were established, they were staffed by health animators. As health awareness grew, it was no longer deemed necessary to have village health workers as the permanent paid staff of ASHWINI. They were gradually substituted by tribal girls (health guides) who volunteered their time for health work.

For these HGs, training includes a full-day workshop on "drama skills" so that they will be able to effectively communicate the CHP to the adivasi community, as well as reporting systems and monitoring & evaluation.

Training is also given on an *ad hoc* basis when the need arises. This is typically based around demand from the adivasi community for services in areas which are outside of the sphere of ASHWINI's operations.[15]

Through this continual training, staff have - according to their responsibilities - built up capacity in many different areas, primarily medical (e.g. midwifery, assistance in surgery), but also administrative (general admin, drug stock control, performance monitoring, IT). By 2002 there were *13 trained health animators, 148 health guides and 250 youth volunteers*.[16] Almost 100 adivasi villages currently have at least one health worker. In the long-term, ASHWINI have targeted having a trained voluntary health worker in every adivasi village to support the health animators at regional level. The health guides and youth workers (in total almost 400 people) responsible for the health scheme at village and (partly) at HSC level are *unpaid volunteers*.

[15] *This has been the case, for example, for a remote adivasi area without feasible access to health care services due to its geographic location, where members of the local community requested to be taught basic medical skills in order to be able to serve their own area. The husband-and-wife couple were brought to GAH where they received basic training in primary health care. Another example is where a group of 13 villages a long distance from the medicinal access point collectively gathered a small parcel of land to serve as an area centres. The centre is used twice weekly to provide medicines and as a meeting point for youth community groups.*

[16] *ASHWINI Annual Report*

There is also strong overlapping of responsibility between tribals working for the health scheme and those involved in ACCORD's other activities. The staff and volunteers working primarily for ASHWINI are heavily involved in ACCORD's other development programmes. Similarly, some 50 tribal staff working within the non-health programmes have active involvement in ASHWINI's operations. The most relevant are listed below:

*Sangam Animators:* These are paid by ACCORD and are essentially the activist for AMS. They "conduct the village level meetings and train the youth volunteers/sangam leaders, discuss about the health programme with the sangam members and encourage their active participation in the management of the programme".

*Professional Staff:* ASHWINI take advantage of the expertise of professionals already working for ACCORD. This is particularly used for the financial side of operations, management aspects and monitoring & control. Advertising for professional staff, particularly doctors, is also conducted over the internet.[17]

*Coordination Team*: A team of senior adivasi staff from the different programmes, institutions and villages within ACCORD/AMS constitute a formal body to "provide feedback and guidance to the health staff and ASHWINI". They review all adivasi activities (including all non-health activities run by ACCORD and AMS) on a weekly basis.

### 5.3 Benefit Payments

If an AMS member who is ensured with the insurance company is admitted, then the claims are sent to the company. Claim sheets are sent to the insurance company on a monthly basis. It takes between 15 and 20 days to process these claims. This is significantly faster than under the earlier arrangement with NIAC, where claims were also sent monthly, but processing could take anywhere between 3-9 months.

## 6. Financial Aspects of the Insurance Scheme

### 6.1 IS's Financial Sources

ASHWINI have created an "Adivasi Health Insurance Fund" from its income. This derives partly from premium payments and medical fees paid by the adivasi community. However*, a significant proportion of funds comes from external sources* such as donations from individuals and organisations, Government sources and charities.

Initially, ASHWINI was entirely funded through donors and from friends and relatives of its founders, and this trend has continued throughout its existence. It has been supported by several formal donors. The start of the CHP in 1987 was funded by Action Aid, a British charity. From 1993, GAH received funding from the Dutch agency, BILANCE.[18] In 1997 this funding arrangement was handed over to MEMISA. During this period, insurance reimbursements and hospital income covered some 40% of the total costs of the

[17] *Although also other medical and administrative staff are also sought after.*

[18] *Formerly CEBEMO*

HMIS (accounting for cross-subsidisation from health payments of non-tribals) with the remaining 60% covered by MEMISA.

After MEMISA's funding expired in 1999, ASHWINI experienced severe financial difficulties until the Paul Hamlyn Foundation stepped in January 2002 with an offer of financial support for three years.

In 2002, the Mumbai-based Sir Ratan Tata Trust provided a grant of Rs.1.500.000 to cover the payment for the external insurance policy for five years. Two charitable organisations based in the USA, *Indians for Collective Action* and *India Abroad Foundation*, also mobilise funds from Indian ex-pats living in America.

It is clear that the major source of income is from donation and grants. Payments from patients constitute a relatively small source of income, compared to the level of income from grants, although the figure has remained relatively constant.[19]

The costs of treatment to patients are thus significantly subsidised by ASHWINI. However, beyond the premium payments, there are certain co-payments which patients are obliged to make. Fees can be broken down into three components – an administration fee, an overnight hospitalisation fee and a fee for medicines received/procedures performed. At GAH, all in-patients have to pay the standard administration fee of Rs. 10. The standard "bed charge" is Rs. 100 for tribals and Rs. 150 for non-tribals, which includes the nursing fees, doctor fees and other materials. Non-paying tribals also have to pay the cost of their medicines and other materials. Non-tribals have to pay for the complete cost of their treatment. Those who have paid the premium do not have to pay anything other than the administration fee. Those who are AMS members but have not paid the annual premium pay a small co-payment, which is at the discretion of the adivasi nurse. On the other hand, the adivasi who is not an AMS member, has to pay the cost of medicines.

The payment of medical fees is made in cash when the patient leaves the hospital. If the patient is not able to meet the bill, nurses can charge a subjective discretionary amount, depending on how much they can afford. Nurses may also defer payment which will then be chased up by the health animators, village workers or at tribal meetings and paid at HSC level. Non-payments are written off after one year, although non-payment has not proved to be a common occurrence.

### Premium Payments

The introduction of a premium was not done with the sole purpose of generating resources to partly cover the costs of the health scheme, but also to create a sense of ownership and responsibility within the community. Furthermore, insurance collection has provided a valuable opportunity to explain the scheme to the adivasi villagers and to get their feedback as to its performance and monitor problems.[20]

[19] *Although it must be taken into account that the Rs. 15 lakhs from SRRT in 2002 has further increased this difference.*

[20] *Due to the fact that they are paying for a service, the members feel more ownership in the service and tend to be more vocal when they are dissatisfied.*

ASHWINI has set a collection period which has a strong resonance with the adivasi culture. Premiums must be paid annually in cash between 5th December – celebrated by AMS as "Adivasi Day" and 14th April which coincides with the Festival of Vishu. The beginning of the period is marked with a meeting of all ASHWINI's tribal staff and AMS activitists. After this period, non-members have to wait until the next year to join, although in its first few years of existence, these dates were not rigorously adhered to.[21]

In its first years of operation, staff went from village to village individually visiting houses to explain the HMIS and to collect premiums. Once awareness had reached a certain level this "door-to-door" method was no longer practical and premiums are generally collected through the HSCs. During the collection period, all of ACCORD's various programmes work to encourage premium payment from the community.

The premium payment is set by the tribals themselves with participation of ASHWINI staff – the village leaders have an annual meeting at which they review the premium and set a new one if deemed necessary. The level of the premium takes into account general economic conditions and levels of income within the adivasi community, but involves no specific calculations – being based, rather, on group consensus amongst the tribal leaders.

In Year 1 of ASHWINI's operations, the premium was set at Rs. 2 and by 2003 had reached a level of Rs. 22. The cost of the entire health scheme, including the preventative care, out-patient services and other decentralised activites would be some Rs. 130 per person.

In this sense, Rs. 22 is a negligible contribution. Added to this is the fact that in 2003 only 35% of members paid contributions. It was important for the scheme that the tribals pay a fee for the services they received, irrespective of how nominal it might be. As mentioned above, the aim was to *create a mentality within the adivasi community that they are paying for a service and thus increase the sense of ownership of and responsibility towards the scheme.*

**Table 8: Premium Revenue under the Ashwini Scheme**

| Year | Paying Members | Premium (Rs.) | Premium Revenue |
|---|---|---|---|
| 1993 | 3.726 | 4 | 14.904 |
| 1994 | 2.744 | 6 | 16.464 |
| 1995 | 3.624 | 8 | 28.992 |
| 1996 | 4.395 | 10 | 43.950 |
| 1997 | 3.812 | 12 | 45.744 |
| 1998 | 4.899 | 12 | 58.788 |
| 1999 | 4.768 | 15 | 71.520 |
| 2000 | 4.619 | 17 | 78.523 |
| 2001 | 4.464 | 17 | 75.888 |
| 2002 | 4.291 | 20 | 85.820 |
| 2003 | 4.268 | 22 | 93.896 |

It must be noted that, as ASHWINI was launched, it was never held as realistic that the CHP would become financially self-sustainable. In fact, for the first five years of their

[21] *From the administrative point of view it is impractical to register members outside of the collection period.*

contract with an insurance company, ASHWINI paid the full premium amount upfront. The fees paid by the adivasis thus constitute a repayment, rather than an advance payment for services to be rendered. What is more, although the initial insurance contract between ASHWINI and NIAC was for five years, the "contract" between ASHWINI and the individual tribals had to be renewed (through payment of premium) annually.

ASHWINI is striving to improve these low premium payment figures, but their investigations have revealed that the biggest barrier to this is the lack of cash available to the adivasi community during the collection period. Accordingly, the aim of changing attitudes and encouraging a savings mentality which would allow the adivasi to build up cash reserves for emergencies has been factored in to the other activities of ACCORD.

### Improving Financial Sustainability

The motivation to generate more revenue from the beneficiaries of the scheme was strengthened by the period of self-appraisal and reorientation set in motion by NIAC's unwillingness and ASHWINI's failure to renew their insurance policy in 2002-3. A four-strong team of external consultants[22] commissioned by the SRTT conducted a fundamental review of ASHWINI's operations and the insurance scheme with NIAC. While clearly recognising the strong need for a long-term mutual insurance system within the adivasi community, the team came to several conclusions and recommendations regarding its sustainability.

1. The scheme's inability (as a welfare-based project) to sustain itself financially without the help of external donors
2. The limited usefulness/appropriateness of a policy with a formal insurance company.[23]
3. The need to increase the revenue raised from the adivasi community.
4. The need to reduce subsidies - particularly for O/P care.

For its future orientation, the review recommended "a combination of a strong and well designed mutual insurance scheme strengthened by reinsurance for ASHWINI to cover low-probability, high cost treatments."

The uncertainty and the review it initiated both gave ASHWINI a stronger perspective on the financial aspects of its scheme.[24]

Graphical illustrations are now used by staff at HSC and sangam level to communicate the costs of ASHWINI's operations. The situation of all villages involved in the system is kept up to date and explained to the members through regular meetings. An example of such a "village analysis" is provided below:

[22] *Including two consultants from WHO.*

[23] *For-profit insurance companies will not be prepared to provide an insurance policy for which claims exceed premium payments. Thus a formal insurance policy can only be of strategic benefit if, for example, an insurer is prepared to offer coverage as a social commitment.*

[24] *Financial constraints have hindered ASHWINI in the past. For example, renovation of the deteriorating buildings of GAH was deferred for several years due to resource constraints. Eventually, enough donations were generated from friends of ASHWINI to complete the necessary construction work.*

**Table 9 : Premium Situation by Village**

| Village | N0 Patients | Bill | Payment | AMS's Help |
|---|---|---|---|---|
| Aroad | 5 | 2.874 | 20 | 2.854 |
| Chelakunu | 8 | 4.526 | 85 | 4.441 |
| Chelivayal-G | 1 | 330 | 5 | 325 |
| Cholomalai | 5 | 1.184 | 120 | 1.064 |
| Hatty-BK | 1 | 128 | 0 | 128 |
| Kariyashola | 8 | 6.633 | 40 | 6.593 |
| Kollivayal | 2 | 5.323 | 5 | 5.318 |
| Koomamoola-BK | 5 | 3.379 | 25 | 3.354 |
| Koomamola-P | 2 | 1.314 | 10 | 1.304 |
| Kottavayal | 6 | 6.863 | 30 | 6.833 |
| Kozhikolly | 31 | 18.762 | 215 | 18.547 |
| Moochikunu | 23 | 12.865 | 110 | 12.755 |
| Mundakunnu | 5 | 4.234 | 515 | 3.719 |
| Pulyamvayal | 10 | 5.236 | 30 | 5.206 |
| Thekampadi-P | 2 | 1.787 | 10 | 1.777 |
| Valakolli | 3 | 4.227 | 15 | 4.212 |
| Valavayal | 13 | 4.918 | 515 | 4.403 |
| **Total** | 130 | 84.583 | 1.750 | 82.833 |

Through the use of graphs, animators can overcome the high level of illiteracy within the adivasi community to explain why premiums are necessary and how they have been used. This has been particularly useful in cases where tribals have paid their premiums without having to make a claim and expect their premium back. For example, staff might draw the attention of the person to somebody else within their family or village who required treatment of a value far greater than their own contribution.

An alternative considered was for stricter premium enforcement – although still determined in conjunction with AMS and the adivasi community – sustainable pricing for services to non-tribals and a heavier reliance on donor funds.

The fact that premiums are still collected on a family basis is considered a systemic flaw by the staff of ASHWINI and ACCORD. The original concept was to mobilise a premium for the whole community by pooling money, linking in with the traditional rice collections at major events which had been common in adivasi culture. As part of ASHWINI's efforts to strengthen the communal base and feeling of ownership and to generate increased revenue from the adivasi community, there are efforts to introduce new group payment methods. These include a system based on collective contributions by individual villages. A sangam will be asked how much they think they can pay towards the health scheme. On this basis, collection is made and the entire village is registered as paid members. There are also a number of members in the tea leaf cooperative which can pay premiums for their members directly.

### *6.2 Costs*

The major cost factors for ASHWINI are salaries, medicines and training.

Salaries are paid to the doctors, health animators, nurses, and laboratory and admin staff. The two main doctors at GAH take a negligible salary, with no relation to the market salary of a doctor. Furthermore, the two doctors financed by Skillshare International essentially work for the salary of one single doctor. Due to the fact that the majority of

staff are from within the community, wages are kept low and many work on a voluntary basis.

Medicines are primarily bought from LO-COST, a cheap supplier. State Government does provide some medicines and ASHWINI do also receive donations of this kind. Significant spending is also made for the purchase of fixed assets, when the need arises.

### *6.3 Surplus Allocation*

ASHWINI is a non-profit organisation. Any revenue generated is reinvested directly back into its services.

### *6.4 Reserve Funds*

ASHWINI has no reserve fund or any other financial measures to protect it if it were to experience any major problems. As such it is vulnerable to covariant risk and in such a case would be heavily reliant on external sources of funding, be they government, donor or from charities.

Efforts are currently underway from the management of ASHWINI to mobilise a Corpus Fund to cover the core costs of the health programme – primarily staff salaries and administration costs for the hospital.

## 7. Linkage to Formal Insurance Companies (Ics)

### *7.1 Ics Linked to Scheme*

Linking the scheme to a formal insurance company first became a theme in 1991 after GAH started its operations. It was clear that the costs of the hospital would not be within the financial bounds of the adivasi community. A group insurance scheme was conceived with the aim of making the scheme more sustainable while fitting in with the traditional solidarity basis of the adivasis. Many insurance companies were approached, but their products were aimed at the health risks faced by affluent urban customers with subsequently high prices. Policies catering for poor rural populations suffering from malnutrition, maternity-related illnesses and sick young children were not available.

Thus it was necessary to negotiate an individual policy tailored to the needs of the adivasi community. This has been a problematic issue, but ASHWINI were able to link to an insurance scheme from 1992-2002 with the New India Assurance Company and from 2003 with Royal Sundaram Alliance. In between these two periods, ASHWINI was running for a few months without a policy.

### *7.2 Relationship Between ICs and Scheme*

The policy with RSA (and previously with NIAC) is effectively a reinsurance scheme as ASHWINI itself provides the primary “insurance”, i.e. health coverage for the adivasi community.

### New India Assurance Company (1992-2002)

After two years spent discussing a specific policy for the adivasi people ASHWINI finally linked to the New India Assurance Company (NIAC) in 1992. The relationship with NIAC spanned two five-year terms.

The *composite tribal group insurance scheme* covered all members of AMS (growing from 5.000 in 1992 to some 12.000 in 2002). Despite the lengthy negotiations, many of ASHWINI's requirements could not be met by NIAC. The premium to NIAC can be divided into two compenents: Rs. 15 cover the member for the health component of the policy, while Rs. 7 provides coverage for a family again the death of the head of the family and for damage to their hut and dwellings. Under the conditions of the contract with NIAC, life insurance and hut & dwelling insurance were provided in addition to health insurance. This was due to the requirements of NIAC rather than those of ASHWINI and the adivasi population. As such, these services have essentially remained unused by ASHWINI and were terminated in 1997.

The policy covered only hospitalisation expenses up to a ceiling of Rs. 1500 per year. Out-patient treatment at GAH and the HSCs were provided for by ASHWINI as were hospitalisation expenses above and beyond Rs. 1500. Chronic illnesses such as diabetes and tuberculosis were also not covered by NIAC.

Despite the fact that a major focus of ASHWINI's work on improving health services for pregnant women, pregnancy-related admissions were initially not covered under the policy. ASHWINI was able to renegotiate this to cover pregnant women for their first two births in 1997. The change in policy was only possible after long discussions and a great deal of political lobbying.

As the policy with NIAC drew to a close in 2002, financial assistance was offered to ASHWINI by the Sir Ratan Tata Trust (SRTT) to extend it for a third term. NIAC was unable to continue the policy under its previous terms and efforts to renegotiate a satisfactory compromise proved unsuccessful. The conditions for the new policy would have included an increase in premium from Rs. 15 to Rs. 40 per person. The previous policy had made NIAC a significant loss – they had reimbursed Rs. 673.486 more than they had received in premiums over the second five-year period.

The financial details of the NIAC policy, over the period 1997 – 2002, are as follows:

**Table 10: Financial Detail of NIAC Policy**

| | |
|---|---:|
| Total Premium Paid | 594.566 |
| Total Claims | 1.363.373 |
| Rejected Claims | 95.321 |
| % of Rejected Claims | 7 % |
| Total Reimbursements | 1.268.052 |
| Claims Ratio | 213 % |
| Deficit on Premium | 673.486 |

This illustrates both the social and the political nature of ASHWINI's agreement with NIAC. Such a policy would not have been possible based on purely commercial conditions.

Royal Sundaram Alliance (2003 onwards)

ASHWINI spent several months without a formal link to an insurance company before it was able to conclude an insurance policy with Royal Sundaram Alliance Private Company (RSA) in May 2003. RSA is participating as a social commitment – it expects to make a loss for this year – and to gain experience in the rural market. The scheme is currently a one-year pilot policy, although RSA plans to develop the policy further.

The premium was set at Rs. 20 per person. The total premium paid for the 12-month policy to cover the 12.226 members of AMS amounted to Rs. 244.520.

RSA only covers limited services. As with NIAC, the policy was individually tailored after extensive negotiations between the two parties. RSA did previously have an insurance policy directed at women's SHGs, called Shakthi Health Shield, however it wasn't appropriate for ASHWINI's specific requirements. ASHWINI provided RSA with a list of illnesses for which they desired coverage together with some historical data, on the basis of which RSA developed an individual policy. Coverage of illnesses was increased to cover all common illnesses, but still some exclusions like psychiatric admissions remain and claims were capped at a maximum of Rs. 1000.

Similar to NIAC, the current policy does not cover OP care and community health programme, which is financed by ASHWINI.

### *7.3 Payment of Ics*

As mentioned previously, payment of NIAC was done through a lump sum amount at the beginning of each five-year period. This essentially meant that ASHWINI was subsidising the insurance policy in advance. The main reason for this arrangement was that ASHWINI was able to get a substantial discount both group and long term discount from NIAC by paying in this way.

Under the current arrangement with RSA, ASHWINI has paid for the (pilot) year's coverage through a lump sum at the beginning of the policy.

## 8. The IS' Administration and Management

### *8.1 Statutes and Regulations*

Both ACCORD and ASHWINI are registered as charitable societies under the Societies Registration Act since the outset of their activities (1986 and 1990 respectively).[25]

### *8.2 Democratic and Co-operative Character of Management*

Although ASHWINI is in legal terms a separate entity, it is strongly rooted in the social framework of the adivasi community. All members of the *Executive Committee* are

[25] *To maintain this status, ASHWINI has to submit an audited statement and annual report and operate on a not-for-profit basis.*

adivasis and the *General Body of the Society* consists of senior AMS activists, doctors, nurses and HAs. The majority of ASHWINI's (and ACCORD's) staff are from the community (target group) itself.

Although there are no formally stipulated arrangements for general assemblies or meetings, meetings are understood as a central tenet of participation in the health scheme. Meetings are held at all levels of the health service's "chain". These are fixed to particular days during particular weeks of the month (for instance, every second Tuesday of a month, every last Saturday of a month etc.).

- Senior adivasi staff from all the programmes meet on a weekly basis
- All staff (paid staff, volunteers and village leaders) for ASHWINI and ACCORD meet weekly at the regional level
- Monthly meeting at a regional level of all the village leaders
- Monthly meeting of all CHP staff
- Monthly meeting of all GAH staff
- Monthly meeting of CHP and GAH staff
- Monthly meeting of all staff from all sectors of ASHWINI and ACCORD
- Informal meetings are called whenever the need arises, for example to discuss the premium rate or at a time of crisis.

An important point to note is that all meetings are *open to all who wish to attend*, in order to keep discussions and decision-making procedures as open and participative as possible.

The HSCs coordinate discussion through meetings at the village level at which villagers voice their concerns and opinions. Once consensus is reached at the regional level, these opinions are then aired during the central group meeting in Gudalur.

Members are informed of their rights and obligations by HSCs and field staff. For new members, staff either go into the field to do this or do so when these members first come to the centre.

### *8.3 Financial Management*

There is no cross-subsidisation between ASHWINI and ACCORD. However, lot of the resources including the infrastructure and human resources (like administrative staff and professionals) are shared between ASHWINI and ACCORD. At the inception of ASHWINI, funds were transferred together with a start-up grant from BILANCE, a donor.

As GAH and the HSCs are themselves part of ASHWINI's operations, no formal "payment" arrangement is necessary.

### *8.4 The Function of Control*

Monitoring and controlling of ASHWINI's activities is primarily done by ASHWINI staff at hospital, HSC and sangam level and discussed during monthly meetings. There is also a

*Working Committee* consisting of senior nurses and HAs, which is responsible for strategic planning, budgeting and other policy issues.

All members of AMS are listed on a computer registration system according to village and family.[26] Once AMS members have paid a premium for health insurance, their contribution is logged on the member's register and they are issued with a health insurance card with its own unique number. Cards are issued annually on a one per family basis with each member of a family having to have paid an individual premium for their name to appear. The card needs to be presented every time a member goes to HSC or GAH.

It is important to note that details of premium payment are not used as a basis for coverage from the external IC, but rather for ASHWINI'S fee calculations and internal monitoring and operations.

The integrated nature of ASHWINI and GAH avoids the risk of excessive charging from a third party health care provider. The administrative functions are divided between the community and the ASHWINI / ACCORD staff as follows:

**Table 11: Function of Control within the Scheme**

| Function | Commun. Leaders | ACCORD staff | ASHWINI staff |
|---|---|---|---|
| Creating awareness about insurance | X | X | X |
| Setting the annual premium | X | | X |
| Collecting the annual premium | X | X | X |
| Monitoring the premium collection | | | X |
| Providing the benefits | | | X |
| Submitting claims | | | X |
| Monitoring reimbursements | | | X |
| Negotiating with insurance companies | | X | X |

### 8.5 Infrastructure and Equipment

Investments in both equipment and infrastructure have been financed entirely from donor funds or donations from well-wishers and charities. ASHWINI have also received donations of medical equipment from various sources. Buildings at regional levels run multi-purpose Area Centres, which include the HSCs. The GAH is run from the land and buildings legally owned by ACCORD. Costs of maintenance and further expansion / improvement are being met by ASHWINI.

## 9. Actors in Relation to The IS

### 9.1 Technical Assistance

Action Health (now Skillshare International) has supported ASHWINI since 1999. Skillshare finance one doctor to work full-time with ASHWINI as Health Trainer,

[26] *The catalyst for introducing a register of members for AMS was in fact the need to have a formalised list of beneficiaries for the health insurance policy with NIAC. This has since developed to encompass a number of registers, including a contributions register and a benefits monitoring register.*

primarily to train the health animators and health volunteers. Currently, this arrangement is being used to fund *two* doctors – a husband and wife team – who are thus working on a partly voluntary basis.

### *9.2 Other Actors*

Government Assistance

ASHWINI does receive assistance from the Government of Tamilnadu for implementing certain programmes. Specifically, these have been for an immunisation programme (through the provision of vaccines), a family planning programmes (incentives for conducting sterilisations, a tuberculosis programme (stocks for testing patients for TB and medicines) and a sickle cell programme (stocks for diagnosis and testing patients)

For 2002-3, ASHWINI also received some government funding for their tuberculosis control (Rs. 50.000) and family planning programmes (Rs. 10.000).

External Assistance

Since January 2002, ASHWINI's health programme has received support from the Paul Hamlyn Foundation. This is channelled into ASHWINI's community health programmes through the financing of salaries of health animators and of some of the hospital's running costs, as well as involvement in field activities such as growth monitoring, health education and nutrition. The Foundation's involvement with ASHWINI is due to end in December 2004.

Sir Ratan Tata Trust provides financial assistance specifically for the insurance programme. This takes the form of funding the salaries of two of the coordinating staff for the insurance programme and providing a budget for reviewing the programme's progress. The Trust also provides grants to cover the insurance premiums for adivasis.

The Trust has also allocated some funding for reviewing the insurance programme and for networking other community groups regarding micro-insurance schemes.

## 10. The Actors' Point of View vis-à-vis the IS

### *10.1 The Community's Viewpoint*

Focus Group Discussions with the insured members reveal that they are very positive about the insurance programme. They see it as a method to avail of free health care.

"*When we are ill and need to go to a hospital, we can go without worries about money"*

Some people feel that there is no use paying because they do not get any benefit. But those are only thinking of themselves and not of the community.

### *10.2 The Doctor's Viewpoint*

The doctors are happy that the people pay some amount for their health care. This small premium does not put a burden on the patient at the time of illness. Hence, there is no financial barrier.

## *10.3 The Insurance Company's Viewpoint*

Representatives from the RSA were specifically pleased with the way the health insurance is progressing. They feel that they have linked up with a genuine NGO and that even if the company makes a loss, at least the money reaches the poor.

## Conclusion of the author

When considering the transformation achieved, it is clear that the health scheme has to be taken in the context of ACCORD's long involvement with the adivasi and the many non-health programmes which it also runs. In terms of providing social protection for a previously disenfranchised population who were completely cut off from formal health services, the activities of ACCORD and ASHWINI have been a resounding success. The scheme has essentially succeeded in providing the adivasis with a *universal health care system*. The health scheme has drastically increased the awareness of the adivasi community of health matters, effected a significant change in their attitudes towards health care and created a level of knowledge and skills in the community which has given the adivasis the ability to cater for the majority of their health needs themselves. Coupled to this is the emphasis of the scheme on creating a sense of self-responsibility within the community.

There are several factors, to which the scheme's success can be attributed. The first factor is the *high degree of ownership* by the target group of the scheme. The scheme *evolved slowly and gradually* based on the demand from the community itself and specifically caters to the health issues most important to the adivasi people. The bond between the initiators of the scheme and the tribals has developed over many years of close cooperation, in which ACCORD's many programmes have sought to develop a strong feeling of *communal solidarity.* The scheme also started at the grass-roots level on a relatively small scale and developed according to their needs. Ownership is also strengthened by the *strong participative nature* of the scheme. The structure of meetings means that all staff and beneficiaries have the possibility of airing their opinions or grievances and having these taken into account within the scheme. The scheme is almost entirely staffed by adivasis which has led to a *real skill transfer* within the community. The focus of the community health programme on providing *preventative and primary health care* entirely through tribal staff has devolved responsibility to the community itself, providing it with the knowledge and training in the individual villages to take care of many of the adivasis most pressing medical needs. Approximately half of the villages covered by the scheme actually have a member of their community trained and functioning as a health worker for the individual village. By creating this awareness of health issues at the decentralised level, the scheme reduces the costs of health care, by teaching simple ways to prevent becoming ill and by treating instances of illness before they have become too serious.

Great care has been taken to ensure that the programme is *socially and culturally acceptable* to the adivasis. Traditional solidarity principles were also built in to the design of the scheme. *Moral hazard has been eliminated* by automatically granting coverage to tribals who have secured membership of the community association, AMS.

Integrating GAH into the scheme has allowed ASHWINI to offer a much wider range of services than they would otherwise have been able to. They also retain complete control over the quality and the costs of these services. The *multi-tier system* with GAH at the central level, HSCs at the regional level and health workers at village level has created a functioning *reference system*, where the sick can be "passed along" the chain of health care depending on their needs.

The main drawback of the scheme is that it is *not financially self-sustainable*. This was admittedly never an aim of its designers - it was not deemed feasible to expect the adivasi

themselves to cover the costs of the scheme. Put simply, they currently just do not have the economic means. This means the scheme is *very strongly dependent on donors* and vulnerable to the loss of its various sources of funding. The fact that the scheme does not have any financial reserves to act as a buffer leaves it *vulnerable to covariant risk*. Should ASHWINI have to deal with a sudden outbreak of illness which is costly to treat, it will again be dependent on external financial assistance.

Another potential threat to ASHWINI's operations lies in the issue of staff. The success of the scheme can largely be attributed to several visionary people who have contributed to its development. Currently the scheme is *strongly dependent on the doctors* working within GAH and with the CHP, who have enormous responsibility for its smooth functioning. Should these members of staff cease to work for ASHWINI, finding suitable replacement will pose an enormous challenge.

The final issue concerning financial sustainability is that the insurance policies which ASHWINI have negotiated are *not commercially viable arrangements*. The policy with NIAC was a loss-maker for the insurance company, and it is uncertain as to whether this will continue to be the case for the policy with RSA. At the same time, it is clear that these companies were prepared to make a *social commitment* to support the scheme and did not enter into the policy for the financial returns.

These arrangements have however enabled ASHWINI to significantly reduce its costs. It has also made excellent use of *strong linkages* to external public and private institutions, charities and experts whose time is often given either at a substantially discounted rate or for no charge at all. This added to the fact that the most qualified technical staff take a wage far below their market value and that other staff costs are kept low by using unpaid volunteers from the community, enables ASHWINI to keep its costs very low in relation to the services it provides. It may not be a financially self-sustainable institution in its current form, but it has succeeded in expanding health care drastically beyond the limits capable for a scheme financed solely by the beneficiaries themselves.

# ANNEXES

# ANNEX 1: Gudalur Adivasi Hospital

## Details of Admissions Between April 1, 2002 and March 31, 2003

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 1 | A.P.D | 1 | 200 | 200 |
| 2 | Abdominal Colic | 1 | 455 | 455 |
| 3 | Abdominal Pain | 3 | 569 | 190 |
| 4 | Abortion | 1 | 255 | 255 |
| 5 | Abortion Quadreplets | 1 | 1.784 | 1.784 |
| 6 | Abruptio Placentae | 1 | 1.769 | 1.769 |
| 7 | Abscess | 1 | 385 | 385 |
| 8 | Abscess Arm | 1 | 312 | 312 |
| 9 | Abscess Scalp | 1 | 937 | 937 |
| 10 | Abscess Thumb | 1 | 1.060 | 1.060 |
| 11 | Acid Peptic Disease | 8 | 3.736 | 467 |
| 12 | Acute Appendicitis | 3 | 2.470 | 823 |
| 13 | Acute Bacillary Dysentry | 3 | 588 | 196 |
| 14 | Acute Bronchial Asthma | 1 | 1.191 | 1.191 |
| 15 | Acute Chocystitis | 1 | 264 | 264 |
| 16 | Acute Disentery | 6 | 3.337 | 556 |
| 17 | Acute Gastriti | 2 | 623 | 312 |
| 18 | Acute Gastritis | 1 | 297 | 297 |
| 19 | Acute Gastro Entiritis | 13 | 8.175 | 629 |
| 20 | Acute Gastro Entetis | 1 | 425 | 425 |
| 21 | Acute Gastroentritis | 2 | 476 | 238 |
| 22 | Acute Labryntitis | 1 | 173 | 173 |
| 23 | Acute Peptic Ulcer | 1 | 682 | 682 |
| 24 | Acute Psychosis | 1 | 300 | 300 |
| 25 | Acute Pyelonephritis | 4 | 3.691 | 923 |
| 26 | Acute Rheumatic fever | 1 | 478 | 478 |
| 27 | Alcoholic Gastritis | 1 | 195 | 195 |
| 28 | Amebic Coltis | 1 | 131 | 131 |
| 29 | Amenorrhea | 1 | 270 | 270 |
| 30 | Amoebic Hepatitis | 3 | 1.403 | 468 |
| 31 | Anaemia | 2 | 652 | 326 |
| 32 | Anaemia | 2 | 2.706 | 1.353 |
| 33 | Anaemia Iugr | 1 | 919 | 919 |

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 34 | Anxiety Disorder | 1 | 381 | 381 |
| 35 | Anxiety Neurosis | 1 | 275 | 275 |
| 36 | APD | 3 | 925 | 308 |
| 37 | Appendicectomy | 1 | 1.945 | 1.945 |
| 38 | Appendicular Abscess | 1 | 1.336 | 1.336 |
| 39 | ARI | 2 | 632 | 316 |
| 40 | Arthritis | 1 | 159 | 159 |
| 41 | Arthritis Knee | 1 | 197 | 197 |
| 42 | Aspiration of Round Worm | 1 | 80 | 80 |
| 43 | Asthma | 4 | 1.710 | 428 |
| 44 | Atrial Fibrillation | 1 | 1.169 | 1.169 |
| 45 | Bacillary Dysentry | 10 | 3.314 | 331 |
| 46 | Bacillary Disentry | 1 | 291 | 291 |
| 47 | Breast Abscess | 3 | 2.484 | 828 |
| 48 | Bronchiactasis | 1 | 290 | 290 |
| 49 | Bronchitis | 2 | 589 | 295 |
| 50 | Bronchopneumonia | 7 | 2.955 | 422 |
| 51 | CVA | 1 | 200 | 200 |
| 52 | CA Oesophagus | 1 | 220 | 220 |
| 53 | Carcinoma | 1 | 1.897 | 1.897 |
| 54 | Carcinoma Oesophagus | 2 | 863 | 432 |
| 55 | Carcinoma Pancreas | 1 | 185 | 185 |
| 56 | Cardiac Failure | 3 | 4.805 | 1.602 |
| 57 | CCF | 5 | 2.158 | 432 |
| 58 | Cellulitis Leg | 1 | 218 | 218 |
| 59 | Cerebellar Degeseeration | 1 | 357 | 357 |
| 60 | Cervial Lymph Adenitis | 1 | 400 | 400 |
| 61 | Chest Infection | 1 | 126 | 126 |
| 62 | Chest Pain | 2 | 506 | 253 |
| 63 | Chronic Dysentery | 1 | 221 | 221 |
| 64 | Chronic Lacynitis | 1 | 445 | 445 |
| 65 | Circumcision | 1 | 644 | 644 |
| 66 | Cirrhosis Liver | 1 | 495 | 495 |
| 67 | Cold Abscess | 1 | 1.166 | 1.166 |
| 68 | Complete Abortion | 2 | 671 | 336 |
| 69 | Concestive Heart Failure | 4 | 4.915 | 1.229 |
| 70 | COPD | 1 | 380 | 380 |
| 71 | Corneal Injury | 1 | 249 | 249 |

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 72 | Corneal Ulcer | 2 | 491 | 246 |
| 73 | Cortical Vein Thrombosis | 1 | 1.045 | 1.045 |
| 74 | Costo Chronditis | 1 | 195 | 195 |
| 75 | Cut Injury Finger | 1 | 466 | 466 |
| 76 | Cut Injury Knee | 1 | 2.020 | 2.020 |
| 77 | Cut Injury Leg | 1 | 904 | 904 |
| 78 | Delivery | 22 | 34.636 | 1.574 |
| 79 | Delivery G2 | 17 | 20.895 | 1.229 |
| 80 | Delivery G3 | 2 | 2.283 | 1.142 |
| 81 | Delivery G4 | 4 | 5.187 | 1.297 |
| 82 | Delivery G5 | 2 | 2.864 | 1.432 |
| 83 | Delivery PIH | 1 | 1.311 | 1.311 |
| 84 | Delivery Preterm | 1 | 1.017 | 1.017 |
| 85 | Delivery-Primi | 11 | 15.485 | 1.408 |
| 86 | Delivery-Breech | 2 | 2.469 | 1.235 |
| 87 | Depression | 6 | 1.717 | 286 |
| 88 | Diabetes Ketoacidosis | 1 | 895 | 895 |
| 89 | Diabetes Mellitus | 1 | 1.462 | 1.462 |
| 90 | Diabetis mellitus | 1 | 835 | 835 |
| 91 | Dysentery | 5 | 917 | 183 |
| 92 | Dysfunctional Uterine | 1 | 305 | 305 |
| 93 | Dysphagia | 2 | 846 | 423 |
| 94 | Ectopic Pregnancy | 1 | 140 | 140 |
| 95 | Eczema | 1 | 175 | 175 |
| 96 | Enteric Fever | 5 | 4.015 | 803 |
| 97 | Epididimo Orchitis | 1 | 451 | 451 |
| 98 | Epilepsy | 2 | 1.411 | 706 |
| 99 | Epistaxis | 1 | 260 | 260 |
| 100 | Extensive Pneumonia | 1 | 428 | 428 |
| 101 | Facial Nerve Palsy | 1 | 340 | 340 |
| 102 | False Labour | 9 | 2.300 | 256 |
| 103 | Fever | 1 | 535 | 535 |
| 104 | Fracture | 1 | 813 | 813 |
| 105 | Fracture Wrist | 1 | 306 | 306 |
| 106 | G2 for Observation | 1 | 714 | 714 |
| 107 | Gall Stones | 1 | 1.166 | 1.166 |
| 108 | Gastric Outlet Obstetrics | 1 | 6.182 | 6.182 |
| 109 | Gastritis | 3 | 679 | 226 |

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 110 | Gastro Enteritis | 1 | 123 | 123 |
| 111 | Giardiasis | 1 | 120 | 120 |
| 112 | Gluteal Abscess | 1 | 535 | 535 |
| 113 | Haemorrhoidectomy | 1 | 1.560 | 1.560 |
| 114 | Hanson' s Disease | 1 | 214 | 214 |
| 115 | Head Injury | 1 | 81 | 81 |
| 116 | Heart Failure | 1 | 287 | 287 |
| 117 | Hemiparesis | 1 | 235 | 235 |
| 118 | Hepatitis | 1 | 335 | 335 |
| 119 | Hepatitis B | 4 | 4.812 | 1.203 |
| 120 | Hydradinitis | 1 | 325 | 325 |
| 121 | Hydramnious | 1 | 2.777 | 2.777 |
| 122 | Hyper Emesis | 1 | 369 | 369 |
| 123 | Hypertension | 6 | 2.643 | 441 |
| 124 | Hysteria | 1 | 85 | 85 |
| 125 | IHD | 1 | 363 | 363 |
| 126 | Incomplete Abortion | 1 | 311 | 311 |
| 127 | Infected Chaalazion | 1 | 210 | 210 |
| 128 | Infected Chalazion | 1 | 361 | 361 |
| 129 | Infected Wound | 1 | 425 | 425 |
| 130 | Injury Leg | 1 | 669 | 669 |
| 131 | Intertrigo Hand | 1 | 280 | 280 |
| 132 | Interval Sterilisation | 1 | 732 | 732 |
| 133 | Intra Abdominal Bleed | 2 | 2.600 | 1.300 |
| 134 | Ischemic Heart Disease | 1 | 1.140 | 1.140 |
| 135 | Ischemic Heart Disease | 1 | 122 | 122 |
| 136 | Keratitis | 1 | 144 | 144 |
| 137 | Kerosene Poisoning | 1 | 95 | 95 |
| 138 | Kwashiosker | 1 | 675 | 675 |
| 139 | LSCS | 2 | 7.097 | 3.549 |
| 140 | Labyrinthitis | 2 | 250 | 125 |
| 141 | Laceration Arm | 1 | 507 | 507 |
| 142 | Laceration Leg | 2 | 1.341 | 671 |
| 143 | Laceration Scalp | 1 | 165 | 165 |
| 144 | Lower Respiratory Infection | 3 | 1.647 | 549 |
| 145 | Lower Respiratory Infection | 1 | 216 | 216 |
| 146 | LRI | 5 | 2.219 | 444 |
| 147 | LRTI | 2 | 734 | 367 |

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 148 | LSCS | 2 | 6.294 | 3.147 |
| 149 | LSCS with Sterilisation | 1 | 4.266 | 4.266 |
| 150 | Lumbar Sympathactomy | 1 | 2.720 | 2.720 |
| 151 | Malnutrition | 2 | 482 | 241 |
| 152 | Mastitis | 1 | 376 | 376 |
| 153 | Medical termination of Pregnancy | 1 | 223 | 223 |
| 154 | Menieres Syndrome | 1 | 524 | 524 |
| 155 | Meningitis | 1 | 111 | 111 |
| 156 | Minearl Diease | 1 | 210 | 210 |
| 157 | Mouth Ulcer | 1 | 445 | 445 |
| 158 | Multigravida | 1 | 307 | 307 |
| 159 | Multiplke Vitamin Deficiency | 1 | 480 | 480 |
| 160 | Mygraine | 1 | 154 | 154 |
| 161 | Normal delivery | 2 | 2.952 | 1.476 |
| 162 | Nephrotic Syndrome | 1 | 405 | 405 |
| 163 | Observation | 1 | 81 | 81 |
| 164 | Oesophagitis | 1 | 5.884 | 5.884 |
| 165 | Otitis Externa | 2 | 1.429 | 715 |
| 166 | Paranoid | 1 | 404 | 404 |
| 167 | Paraplegia | 1 | 1.077 | 1.077 |
| 168 | Paratyphoid Fever | 1 | 511 | 511 |
| 169 | Parotid Tumour | 1 | 105 | 105 |
| 170 | Parotitis | 1 | 270 | 270 |
| 171 | Penetrating Injury | 1 | 351 | 351 |
| 172 | Perineal Abscess | 1 | 466 | 466 |
| 173 | Perperal Infection | 1 | 623 | 623 |
| 174 | Phimosis | 1 | 830 | 830 |
| 175 | PIH | 1 | 3.064 | 3.064 |
| 176 | Pleural Effusion | 1 | 664 | 664 |
| 177 | Pneumonia | 1 | 539 | 539 |
| 178 | Poison Ingestiom | 1 | 82 | 82 |
| 179 | Polymyositis | 1 | 0 | 0 |
| 180 | Post Partum Pelvic Infection | 1 | 257 | 257 |
| 181 | Post Tuberculosis | 1 | 791 | 791 |
| 182 | PPS | 10 | 9.023 | 902 |
| 183 | Preterm | 1 | 467 | 467 |
| 184 | Preterm delivery | 2 | 3.019 | 1.510 |
| 185 | Previous C:S | 1 | 81 | 81 |

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 186 | Primi Delivery | 5 | 6.745 | 1.349 |
| 187 | Prostatitis | 2 | 668 | 334 |
| 188 | Psychosis | 7 | 1.746 | 249 |
| 189 | Pulmonary Tberculosis | 9 | 6.289 | 699 |
| 190 | PUO | 1 | 417 | 417 |
| 191 | Pyclo Nephritis | 1 | 465 | 465 |
| 192 | Pyeio Nephritis | 1 | 437 | 437 |
| 193 | Pyeio Nephritis | 1 | 295 | 295 |
| 194 | Pyomyositis | 1 | 3.327 | 3.327 |
| 195 | R/O Tuberculosis | 2 | 414 | 207 |
| 196 | Reaction to Septran | 1 | 215 | 215 |
| 197 | Reflux Oesophagitis | 1 | 300 | 300 |
| 198 | Renal Colic | 1 | 1.127 | 1.127 |
| 199 | Renal Failure | 1 | 590 | 590 |
| 200 | Respiratory Infection | 2 | 1.082 | 541 |
| 201 | Rhamatoid Arthritis | 2 | 848 | 424 |
| 202 | Rheumatic Fever | 1 | 122 | 122 |
| 203 | Rheumatic Heart Disease | 1 | 138 | 138 |
| 204 | Schizophrenia | 1 | 466 | 466 |
| 205 | Sciatica | 1 | 860 | 860 |
| 206 | Septic Arthritis | 1 | 1.353 | 1.353 |
| 207 | Severe Anemia | 1 | 1.312 | 1.312 |
| 208 | Severe Gastritis | 1 | 285 | 285 |
| 209 | Sickle Celle Crisis | 6 | 1.955 | 326 |
| 210 | Sinusitis | 5 | 1.250 | 250 |
| 211 | Stroke | 6 | 6.033 | 1.006 |
| 212 | Supraventricular | 1 | 750 | 750 |
| 213 | TAO | 13 | 25.664 | 1.974 |
| 214 | TIA | 1 | 105 | 105 |
| 215 | Tendon Injury | 1 | 2.512 | 2.512 |
| 216 | Threatened Abortion | 1 | 290 | 290 |
| 217 | Thrush | 1 | 245 | 245 |
| 218 | Tooth Abscess | 2 | 576 | 288 |
| 219 | Trauma | 3 | 2.654 | 885 |
| 220 | Tremor | 1 | 187 | 187 |
| 221 | Tuberculosis | 9 | 3.285 | 365 |
| 222 | Twins Delivery | 1 | 3.185 | 3.185 |
| 223 | Typhoid | 21 | 13.850 | 660 |

| No | Diagnosis | N0 Admissions | Total Costs | Average cost |
|---|---|---|---|---|
| 224 | Typhoid fever | 1 | 761 | 761 |
| 225 | Ulcer Tongue | 1 | 184 | 184 |
| 226 | Uncontrollable Diabetes | 1 | 771 | 771 |
| 227 | Ubstable Angina | 1 | 366 | 366 |
| 228 | Upper Respiratory Infection | 2 | 620 | 310 |
| 229 | Ureteric Colic | 1 | 1.130 | 1.130 |
| 230 | Urinary Tract Infection | 6 | 1.918 | 320 |
| 231 | Urinary Tract Infection | 1 | 239 | 239 |
| 232 | UTI | 2 | 1.487 | 744 |
| 233 | Vasectomy | 2 | 1.338 | 669 |
| 234 | Vertigo | 1 | 503 | 503 |
| 235 | Viral fever | 3 | 605 | 202 |
| 236 | Viral Gastro Enteritis | 5 | 975 | 195 |
| 237 | Webbled Neck and Pain | 1 | 275 | 275 |
| 238 | Wound Infection | 1 | 450 | 450 |
| | | 518 | 389.355 | 752 |

## ANNEX 2: Gudalur Adivasi Hospital

### Summary of Patients Admitted

| | All Patients | | | Tribal Patients | | | | | | | | | Non-Tribal Patients | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Insured | | | On-Insured | | | Total Tribals | | | | | |
| Year | Admiss | T.Costs | C/Adm | Admiss | T.Costs | C/Adm | Admiss | T.Costs | C/Adm | Admiss | T.Costs | C/Adm | Admiss | T.Costs | C/Adm |
| 93-94 | 948 | 354.949 | 374,42 | 556 | 192.157 | 345,61 | 313 | 126.907 | 405,45 | 869 | 319.064 | 367,16 | 77 | 35.398 | 459,71 |
| 94-95 | 735 | 344.097 | 468,16 | 422 | 181.141 | 429,24 | 258 | 133.794 | 518,58 | 680 | 314.935 | 463,14 | 50 | 25.223 | 504,46 |
| 95-96 | 805 | 429.048 | 532,98 | 417 | 212.238 | 508,96 | 272 | 151.624 | 557,44 | 689 | 363.862 | 528,10 | 116 | 65.186 | 561,95 |
| 96-97 | 1.233 | 736.323 | 597,18 | 461 | 244.085 | 529,47 | 263 | 143.000 | 543,73 | 724 | 387.085 | 534,65 | 509 | 349.238 | 686,13 |
| 97-98 | 1.216 | 870.454 | 715,83 | 449 | 266.073 | 592,59 | 255 | 164.009 | 643,17 | 704 | 430.082 | 610,91 | 511 | 439.972 | 861,00 |
| 98-99 | 1.108 | 861.758 | 777,76 | 516 | 354.522 | 687,06 | 298 | 182.219 | 611,47 | 814 | 536.741 | 659,39 | 294 | 325.017 | 1.105 |
| 99-00 | 997 | 741.520 | 743,75 | 657 | 432.559 | 658,39 | 220 | 143.164 | 650,75 | 877 | 575.723 | 656,47 | 119 | 165.797 | 1.393 |
| 00-01 | 964 | 756.041 | 784,27 | 616 | 461.690 | 749,50 | 227 | 144.200 | 635,24 | 843 | 605.890 | 718,73 | 121 | 150.151 | 1.241 |
| 01-02 | 1.029 | 765.723 | 744,14 | 669 | 481.834 | 720,23 | 236 | 147.797 | 626,26 | 905 | 629.631 | 695,72 | 124 | 136.092 | 1.097 |
| 02-03 | 883 | 720.816 | 816,33 | 518 | 389.830 | 752,57 | 259 | 188.683 | 728,51 | 777 | 578.513 | 744,55 | 106 | 142.303 | 1.342 |