A Research Study on Village Health Funds

VHF

Viability of Community Health Funds in Thar Desert

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VHF -Viability of Community Health Funds in Thar Desert

2010

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FOREWORD

Unavailability of healthcare is a major concern in many parts of India including the remote and rural areas of the Thar Desert. Medical facilities are scarcely located and often times are not accessible and unaffordable for a large number of people living in rural areas. Hence, there is high mortality and high morbidity in the region presenting difficult challenges and affecting the socio-economic status.

A Village Health Fund (VHF) is a hypothesis that will focus on mobilizing the community to develop a small saving fund. This fund will develop further as the time goes by and will be used by the community as per the need with a mutual understanding. The fund will be maintained by the local community but will be strengthened by external support both in form of financial resources and technical expertise.

GRAVIS, an NGO working in Thar, has been working for a long time on issues revolving around community-based healthcare. Among many activities of the organization are running a fully equipped hospital and setting up a cadre of Village Based Health Workers. A research study on Village Health Funds is an initiative that GRAVIS took up to explore the feasibility aspects of setting up Village Health Funds in Thar and its replication.

Dr. Prakash Tyagi
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EXECUTIVE SUMMARY FROM THE AUTHOR

GRAVIS is working on a number of projects including health care in Thar Desert. One of the important aims of the organization is to empower the village communities in creating a self reliant and decentralized community system. The health care work of the organization includes a myriad of activities ranging from providing basic health training to persons as health workers to encouraging health care by spreading awareness.

One of the methods to be employed by GRAVIS involves introduction of micro-financing in rural health sector. This method would involve creation of village health funds and promoting community participation in covering health risks in rural areas of Thar Desert. Such scheme would function as a complement to the government run schemes in this area.

The pilot project of such village health fund would be based upon the insights gathered from the target populations and experiences gained from health funds and insurance schemes operational in different parts of the country as well as elsewhere in the world. This scheme will also involve complementary tasks like providing health education to the villagers and appointment of a committee to act as an interface between the community and health care in rural Thar.

This report provides an insight into the present health care scenario in Rajasthan, especially in Thar Desert. It also looks into specific problems faced by rural population of Thar Desert in light of the environmental as well as economic realities of the area. The report also identifies the problem areas in relation to health care in addition to making recommendations to improve the same.

The report proposes the modalities for the establishment and execution of such funds in addition to the benefits accrued. It also deals with the possible linkages of the scheme with other operational schemes like NRHM and others for a more comprehensive coverage. However, the main focus of the report is on establishment of a committee constituted of villagers as well as observers who would take upon themselves the task of spreading awareness among villagers as well as managing the funds.

The fundamental intent of the report is to put in order the underpinnings for implementation of a sustainable health care scheme in the poor pockets of Thar Desert. It is high time now that the poor population of rural areas realise that it is better to shoulder the responsibilities of government with respect to basic necessities like health and education and carve out better lives for themselves through community effort and external support from agencies like GRAVIS and others and of course the State with the onus of providing primary health care facilities lies.

This report has benefitted from the contributions of Mr. Akshay Dayal of Rice University and GRAVIS team.

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Chapter 1

BACKGROUND

1.1 Healthcare in rural and low-income areas

Healthcare technology and infrastructure worldwide has been developed at a dizzying rate over the last century. Health indicators have risen at a quickening pace for most of the world. However, as this development has taken place, disparities in health care have become stark. The gap between developed and developing countries has ballooned to an alarming size; of the $2.8 trillion that the world spends on health care, only 11 percent reaches low- and middle- income countries. Few of the world's 1.3 billion poor people have insurance or other risk-sharing mechanisms to cushion the burden of medical expenses.

Though inequalities between developed and developing countries are large, there is also a separate but equally important disparity between urban and rural healthcare. Rural healthcare lags in quality, affordability, and accessibility for several reasons. First, distances are typically greater in rural areas than in urban areas, involving increased costs, communication difficulties, and transportation times for patients, medicines, and doctors alike. Second, rural areas have by definition low population densities, often making rural medical infrastructure less economical in terms of number of individuals that can be served. Third, attracting and retaining well qualified medical personnel is more challenging in rural environments. Often, the best medical talent prefers to stay in urban areas where greater social and financial opportunities are available, leading to significant staffing shortages. For example in India, as per the norms adopted by the Government of India, the rural population of 5000, 30000 and 120000, respectively must have one sub centre, one primary health centre and one community health centre. However, as on March 2007 India had 1,45,272 Sub Centres, 22,370 PHCs and 4,045 CHCs that shows a clear deficit of 95000 Sub centres, 18000 Primary health centres and about 6000 community health centres.

The inadequacy of rural health infrastructure is also evident from the fact that as on March, 2007, in case of Sub Centres, overall 66382 buildings were still required to be constructed. Similarly, for PHCs 3618 and for CHCs 199 buildings were needed. Not only this, the overall shortfall in the posts of HW(F) / ANM was 12.6% of the total requirement. Similarly, in case of HW(M), there was a shortfall of 55.4% of the requirement. For Doctors at PHCs, there was a shortfall of 7.8% of the total requirement.

At the Sub Centre level the extent of existing manpower can be assessed from the fact that about 5% of the Sub Centres were without a Female Health Worker / ANM, about 37.2% Sub Centres were without a Male Health Worker and about 4.7% Sub Centres were without both Female Health Worker / ANM as well as Male Health Worker. The current position of specialists manpower at CHCs reveal that overall about 50% of the sanctioned posts of specialists at CHCs were vacant. Moreover, there was a shortfall of 64.8% specialists at the CHCs as compared to the requirement for existing infrastructure on the basis of existing norms.

1. Tabor, Steven R, Community Based Health Insurance and Social Protection Policy, Social Protection Unit, Human Development Network, The World Bank, **March 2005.**
2. Rural Health care System in India, http://www.mohfw.nic.in/Bulletin%20on%20RHS%20-%20March,%202007%20-%20PDF%20Version/Rural%20Health%20Care%20System%20in%20India.pdf

1.2 Rural Health in India and in Rajasthan

India has 16% of world's population, 18% of worldwide mortality and 20% of worldwide morbidity. Yet health expenditure in the country is only 1 % of the global expenditure. Allocation for the healthcare in the 5 m- year plan has declined from 3.35% in the first plan to 1.4% in the tenth plan, despite the fact that the WHO recommends 3 to 4%. According to the rough estimates made by the private insurance companies of the total healthcare expenditure an Indian spends 9% for the doctor's fee, 18% for the medicines, 24 % for the diagnostics and pathological tests, 14% of hospitalization, 20% of lodging and traveling etc. and another 15 % on other miscellaneous.

However these patterns vary significantly especially among the rural and urban settings.

India is attracting world's attention not just because of its population explosion but also because of its poor health scenario, especially in rural areas. Despite the existence of numerous growth related policies, there has been no notable improvement in the health sector. The economic, social and gender disparities have made the health improvements ever more challenging. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where 27% of the population live. Further, not only the communicable diseases like hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections

{Source: Sample Registration System, Government of India, 199798 (reproduced with permission).}

are on a rise but non-communicable diseases like cancer, blindness, mental illness, hypertension,

Table 1 : India : health indicators

Sector	Indicator	Rural	Urban	Combined	Ref. year
1	Population	716.0	286.0	1002.0	2000
2	Birth rate	30.0	22.6	28.3	1995
3	Death rate	9.7	6.5	9.0	1997
4	IMR	80.0	42.0	72.0	1998
5	MMR (per 100 000)	438.0	378.0	408.0	1997
6	Stillbirth rate	10.8	5.3	10.5	1995
7	% Deliveries attended by untrained people	71.0	27.0	59.0	1995
8	% Deaths attended by untrained people	60.0	22.0	54.0	1995
9	Total fertility rate	3.8	2.8	3.5	1993
10	% children (1223 months) who received all vaccinations	31.0	51.0	-	19921993

diabetes, have also reached a record high. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100 000 live births in India.

3. *Id.*
4. Patil, Ashok Vikhe et al, Current Health Scenario in Rural India, *Aust. J. Rural Health* (2002) **10**, 129135, http://www.sas.upenn.edu/~dludden/WaterborneDisease3.pdf.
5. Ashok Vikhe Patil et al, Current Health Scenario in Rural India, *Aust. J. Rural Health* (2002) **10**, 129135, http://www.sas.upenn.edu/~dludden/WaterborneDisease3.pdf.

Though the statistics have shown marginal improvement, the situation is still worrisome in rural areas of India as these survival rates in India are comparable even today only to the poorest nations of sub-Saharan Africa.

It is notable that even though the 1980s saw the beginning of liberalisation and privatisation of the Indian economy, the 1990s have accelerated the pace under the umbrella of SAP, we witness that the availability of drugs is inadequate in all of the PHC, SC and hospitals that have been set up by the government over the years. Though economic restrictions allow for very limited resource allocation for the rural areas, even the infrastructure in place is not properly used merely because of the sharp cutback in public expenditure on health, and the focus on privatisation of health services. This worsens the health situation of the poorest of the population. However, it will be noticed that the government apathy towards health is not the only reason for poor health in these areas. There are a number of other factors that affect the health of poor population of rural India, some of which have been studied in this report.

Rajasthan is one of the largest states in India. The western half of Rajasthan is covered by Thar desert that is the largest inhabited desert in the world. However, the erratic rains and perpetual droughts have turned the area into one of the most backward regions of the country. This makes the community health care even more difficult in the region. Health care never gets the requisite priority as the region is faced with a number of other problems including low productivity, feudal society, social evils and the like. It is quite easy to figure out that the population of this area is more concerned with gathering food and fodder rather than spending on health.

It has also been recorded that the community health care schemes is severely lacking in this area. Further, the government health staff seems to be quite reluctant in motivating the rural population on health issues. This in turn results in low level of awareness amongst the rural population with respect to free health facilities provided by the government. The biggest problem in this regard is that a nationwide policy on healthcare can't be expected to work out well in a country with such huge regional disparities and this is where the need for an area-

Table 2 : Demographic, Socio-economic and Health profile of Rajasthan State as compared to India figures

S. No.	Item	Rajasthan	India
1	Total population (Census 2001) (in million)	56.51	1028.61
2	Decadal Growth (Census 2001) (%)	28.41	21.54
3	Crude Birth Rate (SRS 2007)	27.9	23.1
4	Crude Death Rate (SRS 2007)	6.8	7.4
5	Total Fertility Rate (SRS 2007)	3.4	2.7
6	Infant Mortality Rate (SRS 2007)	65	55
7	Maternal Mortality Ratio (SRS 2004 - 2006)	388	254
8	Sex Ratio (Census 2001)	921	933
9	Population below Poverty line (%)	15.28	26.10
10	Schedule Caste population (in million)	9.69	166.64
11	Schedule Tribe population (in million)	7.10	84.33
12	Female Literacy Rate (Census 2001) (%)	43.9	53.7

Table 3 : Health Infrastructure of Rajasthan

Particulars	Required	In position	shortfall
Sub-centre	9554	10742	-
Primary Health Centre	1555	1503	52
Community Health Centre	388	349	39
Multipurpose worker (Female)/ANM at Sub Centres & PHCs	12245	12271	-
Health Worker (Male) MPW(M) at Sub Centres	10742	2528	8214
Health Assistant (Female)/LHV at PHCs	1503	1358	145
Health Assistant (Male) at PHCs	1503	714	789
Doctor at PHCs	1503	1542	-
Obstetricians & Gynaecologists at CHCs	349	110	239
Physicians at CHCs	349	241	108
Paediatricians at CHCs	349	71	278
Total specialists at CHCs	1396	651	745
Radiographers	349	269	80
Pharmacist	1852	2355	-
Laboratory Technicians	1852	2065	-
Nurse/Midwife	3946	8425	-

(Source: RHS Bulletin, March 2008, Ministry of Health & Family Welfare, GOI)

1.3 Rural health in Thar Desert

The harsh environment of Rajasthan's Thar Desert imposes additional challenges on healthcare. Average annual rainfall in the Thar is usually less than 200 mm; the most arid regions of the desert see less than 100 mm of yearly rain.[4] Though the region's economy is heavily agricultural, only a few crops can withstand the climate.

As the world's most densely populated desert, the Thar also takes its toll on the health of its twenty million residents. Those in rural areas face the brunt of the environmental challenges associated with living in the region. The disparity of medical care between the urban and rural areas has helped exacerbate poor community health in rural areas. Prevalent diseases include tuberculosis, malaria, silicosis, eye and skin diseases, sexually transmitted infections (STIs), and a variety of gastrointestinal conditions. Malnutrition, vitamin deficiencies, hyperacidity, and dehydration are also common due to the poor availability of a balanced diet and water scarcity.

1.4 Medical needs in the Thar Desert

Residents of rural areas of the Thar Desert face a number of serious health challenges. Infectious diseases such as gastro-intestinal disorders, pulmonary tuberculosis, malaria, and diarrhea are common in village communities. Diseases often spread quickly through village communities due to lack of preventative health awareness as well as the concentration of efforts of the people towards fulfilling their basic needs of food, clothing and fodder that pushes aside all other requirements like health, education etc.

6. http://www.rajasthan-india-tours-travel.com/rajasthan-sand-dunes/thar-desert.html ; it is one of the most populous as well, but I think 'most densely populated' works better.
7. http://www.expressindia.com/news/ie/daily/20010218/ina18021.html.

Even non-communicable diseases are quite rampant. These diseases like eye conditions such as glaucoma, cataracts, and night blindness are prevalent in many communities, especially in the older members of the population. Some of the health problems like lung diseases and silicosis run with the primary occupation of the inhabitants, especially those working in stone mines. Reproductive health is often poorly managed resulting in high pregnancy rate, high miscarriage rate, death at the time of labor etc. due to both economic and cultural reasons. Additionally, maternal and child care is inadequate. According to figures more than 80% of the children under three are anemic. Water borne diseases like diarrhoea, amoebiasis and typhoid are also common in the area, which can actually be attributed to the lack of awareness about the cleanliness and hygiene.

The problem has recently been worsened by emergence of AIDS as a new threat to the health of Thar inhabitants. The biggest problem faced by the authorities in this regard is lack of awareness amongst the population as well as unwillingness on their part to talk about sexually transmitted diseases etc. AIDS infection averages a high 8.2 per cent in some pockets of rural Rajasthan.

One of the major reasons for such a deplorable state of health in these areas is the lack of health facilities. The challenges before the health authorities in Thar region are multi-pronged. It is not only the erratic rains and frequent droughts that lead to poverty and consequently to malnutrition and poor economic condition for a large part of the population, but also the inadequacy and inefficiency of the health plans working in addition to the unhygienic living conditions, lack of vegetation, harsh weather conditions and lack of proper planning by the state.

Additionally there are problems of lack of state resources. While the medical needs of Thar Desert residents are many, available medical resources are few. Doctors are often unavailable, and many villagers resort to local quacks and healers that are at best only marginally helpful. Medical facilities such as clinics and hospitals are scarce. When advanced medical care is necessary, villagers must traverse long distances through the desert. Transportation in itself can be a prohibitive barrier or expense and for many poorer village residents.These adversities call for action on the part of the villagers themselves with support of NGO's and other voluntary organizations. This is to say that it might be easier to blame the failures on the State but that is not a solution to the problem. The solution lies in figuring out techniques for ensuring better health and improved standard of living for the inhabitants. This is also to say that there is a need for community participation in realizing the goals of a healthy Thar.

1.5 GRAVIS' health-related work

GRAVIS works on a variety of projects to address inadequate community healthcare in the Thar Desert. One of the main aims and objectives of the organization is 'To empower village communities through activities related to agro forestry, water, livestock development, cottage industries, housing, education, health with emphasis on poorer and weaker sections of society in order to reduce economic and social disparities and create a self reliant and decentralized community system. GRAVIS' community health work to date includes:

a. training village health workers (VHWs) in basic medical care, safe delivery practices, and

8. http://gravis.org.in/content/view/55/61/

chronic disease diagnosis and treatment,

b. founding a hospital in Tinwari to serve local village communities,

c. building awareness of preventative health measures in local communities,

d. encouraging greater prenatal and postnatal care to ensure female reproductive health,

e. creating awareness of the dangers of silicosis, especially among mineworkers, and

f. educating villagers on available medical facilities and treatment options for various health conditions

g. referring complicated cases and health conditions that require advanced medical interventions, to the hospitals in the city having the latest technologies and infrastructure to cater to such needs.

The plan will be implemented on a phase by phase basis whereby the problems are to be identified first followed by study of the existing models and deriving benefit from them in coming up with a model that suits the needs of Thar area. The program will start with pilot projects in some regions and expanded to others depending upon success of the program and responses from the local communities.

Main focus of the program would be to take into account the health needs of the rural areas of Rajasthan and work out a plausible solution for them. The solution to be devised will include not just NGO participation but also active participation on part of the community itself, so as to ensure efficient working of the program. The model to be followed under the program might also look up to the State authorities and the existing programs for assistance in realizing the health goals for Thar.

1.6 Alma Ata and National Policy Framework

India faces large problems with managing rural healthcare. Through initiatives such as the National Health Policy (which addressed the 1978 Alma Ata declaration) and the National Rural Health Mission, rural health has repeatedly been made a development priority.

National Health Policy was launched in 2000 to give a big push to the health goals of Indian government in light of the Alma Ata declaration. The public health investment in the country over the years has been comparatively low, and as a percentage of GDP has declined from 1.3 percent in 1990 to 0.9 percent in 1999. The aggregate expenditure in the Health sector is 5.2 percent of the GDP. Out of this, about 17 percent of the aggregate expenditure is public health spending, the balance being out-of-pocket expenditure. The central budgetary allocation for health over this period, as a percentage of the total Central Budget, has been stagnant at 1.3 percent, while that in the States has declined from 7.0 percent to 5.5 percent. The current annual per capita health expenditure in the country is no more than US $ 27 (about 1250 INR) out of which only US $ 7 (about 325 INR) are contributed by the Government. Given these statistics, it is no surprise that the reach and quality of public health services has been below the desirable standard. Under the constitutional structure, public health is the responsibility of the States. In this framework, it has

9. http://www.searo.who.int/LinkFiles/Country_Health_System_Profile_4-India.pdf
10. National Health Policy, http://nposonline.net/policies.shtml#nhp.

been the expectation that the principal contribution for the funding of public health services will be from the resources of the States, with some supplementary input from Central resources. In this backdrop, the contribution of Central resources to the overall public health funding has been limited to about 15 percent. The fiscal resources of the State Governments are known to be very inelastic. This is reflected in the declining percentage of State resources allocated to the health sector out of the State Budget. If the decentralized pubic health services in the country are to improve significantly, there is a need for the injection of substantial resources into the health sector from the Central Government Budget. This approach is a necessity despite the formal Constitutional provision in regard to public health, -- if the State public health services, which are a major component of the initiatives in the social sector, are not to become entirely moribund. The NHP-2002 has been formulated taking into consideration these ground realities in regard to the availability of resources.

The backdrop of National Health Policy as derived from the Alma Ata Declaration, 1978 that lays down certain guidelines expressing the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world. It mandates that all governments formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors. To this end, it will be necessary to exercise political will, to mobilize the country's resources and to use available external resources rationally.

The declaration also laid down the requisites for primary health care in following words- Primary health care:

1. reflects and evolves from the economic conditions and sociocultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;
2. addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;
3. includes at least: education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs;
4. involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;
5. requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care,

11. National Rural Health Mission, http://india.gov.in/citizen/health/national_rural.php.

making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate;

6. should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;
7. relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

The Alma Ata Declaration not only motivated governments to lay down policies but also come up with more concrete steps in implementing the policies. The National Rural Health Mission (NRHM) is a government scheme that aims at providing valuable healthcare services to rural households all over the country. It specially focuses on the 18 States of Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarakhand and Uttar Pradesh.

The major objectives of the National Rural Health Mission are:

Decrease the infant mortality rate and maternal mortality rate

Provide access to public health services for every citizen

Prevent and control communicable and non-communicable diseases

Control population as well as ensure gender and demographic balance

Encourage a healthy lifestyle and alternative systems of medicine through

The mission envisages achieving its objective by strengthening Panchayati Raj Institutions and promoting access to improved healthcare through the Accredited Female Health Activist (ASHA). It also plans on strengthening existing Primary Health Centres, Community Health Centres and District Health Missions, in addition to making maximum use of Non Governmental Organizations.

Results, however, have been hard to come by. Government facilities in rural areas are often understaffed, undersupplied, underfunded, or riddled by poor service and corruption. It is also to be understood that health care means a lot more than mere provision of doctors and dispensaries. It includes proper infrastructure and medicinal facilities for the ill and ailing. It also includes the level of development of the community, their exposure to health ailments, general awareness related to health and access to treatment. This is one of the reasons why the general administrative measures taken by government do not succeed in cases of rural areas. It is quite unimaginable for the legislators sitting in ivory towers to understand the practical needs of these communities in light of their lifestyles and occupation.

The result of this discrepancy is disappointing inequality in medical care and in an unfortunate upward trend in medical costs. Considering that the Indian government's healthcare spending is extremely inadequate at just about US $2-3 per capita relying on the government to improve rural healthcare on its own is not a viable solution. (The government's spending on healthcare is

around 0.9 per cent of the total GDP, which limits the extent and effectiveness of the coverage it can provide.)

Insufficient government-provided healthcare has spurred the development of a more thorough private healthcare sector. However, the ability to receive private care is highly dependent on income. Overall, the rise of private healthcare without concurrent programs to increase affordability has created a wide income disparity in the healthcare sector.

This calls for a more holistic approach towards healthcare in rural areas. Prevention of diseases through community participation, raised awareness and increased accessibility to quality healthcare could lead the way for ensuring a better health situation in the rural communities.

Where there are still lacunae in the system, GRAVIS and other NGOs have attempted to improve healthcare awareness, quality, access, and affordability. GRAVIS healthcare projects includes Gravis hospital and auxiliary health team with doctors, nurses, technicians etc. serving over 1,00,000 residents as well as a diagnostic lab for detection of lung disorders. They also conducted over 50 health training sessions across Thar in 2008-2009. Availability might be improving, but affordability of healthcare is still a major concern throughout the Thar Desert. Simple financial instruments such as the availability of loans and insurance have traditionally been unavailable to the poor.

1.7 Current financial mechanisms to meet the medical needs

The exploratory studies conducted in these area as well as the experiential information coming from the rural areas in this region have indicated that the rural poor is primarily resource deficient to meet even the basic health care needs. The villagers are normally at the verge of financial crisis whenever a health related exigency arises in the family. Given that the primary health care centres and other health facilities are not readily available in many of the rural areas, fee of the private doctor, expenses for medicines, hospital's charges in case of admission and transport costs, are the major items on which the villagers end up spending about ten to fifteen thousand rupees in a year, according to unofficial estimates.

Chronic diseases like tuberculosis and silicosis and the reproductive health facilities cost to the extent that poor have to take loans from the fellow villagers, which is available normally at higher rates of interest. The urgency of the situation attracts further higher rates in most of the cases. Mortgaging of small pieces of lands, whatever are there with the villagers, to meet the health related expenses is also a common sight in the rural areas of Rajasthan.

It can be inferred that the problem of financing health care in rural Rajasthan remains unresolved and is further exacerbates the health situation. At the community level also the efforts to deal with such are either inadequate or insufficient. There are health care workers and primary health care centres for the clusters of villages, however there efficiency and effectiveness has been far from satisfactory.

Further, lack of awareness among the villagers about their entitlements in terms of access to

12. Harvey and Tyagi, Community Health in the Thar Desert, (Jodhpur: Gravis, 2005), 6.
13. India's healthcare spending to cross US$ 44.9 billion by 2012, http://www.ibef.org/artdisplay.aspx?cat_id=194&art_id=14971.
14. GRAVIS Annual Report, http://www.gravis.org.in/annual_reports/annual-report-2008-2009.pdf.

health care facilities, also contribute to the problem of financial vulnerability of the rural poor. Many a time, the villagers can't take advantage of a particular health schemes run by state or non-governmental organizations that are operating in their area even if they qualify for benefits under the scheme because they are not aware of either the scheme or the fact that they are the beneficiaries of the scheme.

However, one group that remains untapped in many efforts to increase affordability of the health facilities is the rural poor themselves. Through community organization, villagers can be empowered to improve their financial access to medical facilities. The most promising model for financial self-help is the microfinance model, which has become increasingly popular in recent years.

The advent of microfinance has vastly improved the financial tools available to rural residents of developing countries. Specifically, the most successful implementations of microfinance have been self-sustaining group funds, where group members contribute to a savings fund and then have the ability to borrow money from the community fund when the need arises. Such a fund can called as either, the community health fund of a village health fund, in a rural setting.

Although, there have been instances in the region wherein the concept of community fund has been successfully translated at the ground level, especially through Self-help groups (SHGs) that have used this concept to empower women financially and socially, the success of such village funds begs the question of whether this model could successfully be applied to other areas of concern for rural residents. The lack of affordable healthcare is a ripe example of a financial problem with no viable financial solution thus far for most villagers.

This study aims to explore ways to address healthcare affordability through community savings efforts in the Thar Desert. Specifically, this study aims to study the viability of village health funds (VHFs), which apply the successful aspects of microfinance and self-help groups to the healthcare sector. At a very basic level, a VHF would collect voluntary deposits from members of a rural community. The VHF would then be able to help finance healthcare expenses for members of the village community needing assistance.

Chapter 2

VILLAGE HEALTH FUNDS: CONCEPT AND EXISTING MODELS

2.1 Village Health Fund

A Village Health Fund can be any scheme or a programme managed by the community itself other than government, or any other profit making organisations, that provides risk-pooling to cover the costs (or some part thereof) of health care services. Beneficiaries are associated with, or involved in the management of these health funds. It is voluntary in nature, formed on the basis of an ethnic of mutual aid, and covers a variety of benefit packages. Village Health Funds can be initiated by health facilities, NGOs, trade unions, local communities, local governments or cooperatives and can actually be supported by any of these organizations. They tend to be pro-poor since they strengthen the demand for health care in poor rural areas, and enable low-income communities to articulate their own healthcare needs.

Many community finance schemes have evolved in the context of severe economic constraints, political instability, and lack of good governance. Usually government taxation capacity is restricted by internal factors, formal mechanisms of social protection for vulnerable populations absent, and government oversight of the informal health sector lacking. In such difficult contexts, community involvement in financing health care provides a critical first step towards improved access to health care by the poor and social protection against the cost of illness.

Village health funds can also be seen as the means of ensuring community participation is to ask the members of community to address the problem collectively. This is to say that if members of a community are asked to contribute to health funds that would help funding the health needs of the members as and when needed or calling upon some of the members to contribute as health workers in the understaffed village hospitals and health centers in addition to allowing them participation in policy decisions etc. might help these poor communities in tackling their health problems.

Such schemes can go a long way in shouldering the burden with the government schemes in providing the villages with a more comprehensive health security. This will not only complement the government schemes operating that area but also ensure that the villagers are not held up due to lack of instant remedy for their health problems on account of lapses in the existing schemes. One of these schemes that has worked in several parts of the world, including certain parts of rural India, is that of creating village health funds managed and disbursed by the members of the same community, with or without the assistance of outside NGO's or other voluntary organizations. The idea is based upon village self financing for addressing the health problems within the village.

The Alma Ata Declaration of 1978 proclaiming 'health for all by the year 2000', is but one example of consensus that health is a fundamental human right. In light of budget constraints, however, the challenge has centered on how to most cost-effectively allocate resources to achieve health goals, especially in case of developing countries and more so for the rural regions of these countries. In such a case, it is hardly wise to see health care financing as a government endeavor. One of the alternatives to this is community based financing.

1. Tabor, Steven R, Community Based Health Insurance and Social Protection Policy, Social Protection Unit, Human Development Network, The World Bank, **March 2005.**
2. Rural Health care System in India, http://www.mohfw.nic.in/Bulletin%20on%20RHS%20-%20March,%202007%20-%20PDF%20Version/Rural%20Health%20Care%20System%20in%20India.pdf

2.2 Main features and Characteristics of Village Health Fund (VHF)

A village health fund (VHF) falls under the umbrella concept of community financing, which basically means different resource mobilization mechanisms that can differ in the extent of their prepayment and risk sharing, in their resource allocation mechanisms, organizational and other characteristics. However, there are numerous common threads running through all these plans including the predominant role of the community in mobilizing, pooling and allocating resources, collective approach, poor beneficiary population, and voluntary as well as self induced participation. VHF particularly would be a small savings fund created by a village to help finance health expenses for members of the community in need on the basis of a mutual agreement among members of the village. Regular contributions by able and willing members of the community would help maintain and/or enlarge the fund in addition to the token amounts charged upon the target population. Such funds are normally substantiated with the other funds available in the health schemes run by the government and in majority of the cases their initiation and establishment are facilitated by the civil society organizations.

The community would, based on a framework of mutual understanding and decision-making, have the authority to collectively disburse funds from the VHF depending on need.

The main purposes served by community based health funds are:

(a) it provides the financial resources to promote better health and to diagnose, prevent, and treat known illness;

(b) it provides an opportunity to protect individuals and households against direct financial cost of illness when channeled through risk-sharing mechanisms; and

(c) it gives the poor a voice and makes them active participants in breaking out of the social exclusion in which they are often trapped.

The idea derives support from international health initiatives as well. Commission on Macroeconomics and Health (CMH) report recommended a six-pronged approach to domestic resource mobilization at low-income levels: *"(a) increased mobilization of general tax revenues for health, on the order of 1 percent of GNP by 2007 and 2 percent of GNP by 2015; (b) increased donor support to finance the provision of public goods and to ensure access for the poor to essential health services; (c) conversion of current out-of-pocket expenditure into prepayment schemes, including community financing programs supported by public funding, where feasible; (d) a deepening of the HIPC (Highly Indebted Poor Countries) initiative, in country coverage and in the extent of debt relief (with support form the bilateral donor community); (e) effort to address existing inefficiencies in the way in which government resources are presently allocated and used in the health sector; and (f) reallocating public outlays more generally from unproductive expenditure and subsidies to social-sector programs focused on the poor*."

15. The special contributions are to be made by certain individuals who have better financially and will be kept in the same fund as token amount that will be payable by everyone in the village.
16. *In January 2000, Dr. Gro Harlem Bruntland, Director General of the World Health Organization (WHO), established a Commission on Macroeconomics and Health (CMH) to provide evidence about the importance of health to economic development and poverty alleviation.*

Evolution of community based health funds were amongst the first social protection institutions to be established in the industrial market economies. In the developing countries, the institution of community-based health insurance is of a far more recent origin. In Sub-Saharan Africa, the majority of the community based health funds came into existence only in the 1990s.

Many of Africa individual community based health funds are small, with around 100 beneficiaries, while others, such as Tanzania's Community Health Fund, have nationwide coverage with networks that cover one million or more beneficiaries. Even though Africa has been a pioneer in community health funds, promotion of these organizations remains largely driven by external organizations.

Compared to Africa's community health funds, Asia's schemes are larger (with the smallest having several thousand members), older, and involve considerable cost-sharing with Governments. Community based health funds play an important role in the health systems of Bangladesh, China, India, Nepal, Philippines, and Papua New Guinea.

They are also present, to a lesser extent, in Cambodia, Vietnam, Thailand, Indonesia and Sri Lanka. Several of Asia's community health funds are owned and operated by large micro-finance organizations (i.e. Bangladesh's Grameen, India's SEWA), by cooperatives (i.e. OHPS ORT Plus Scheme of the Philippines), by large hospitals (i.e. Dhaka Community Hospital Health Card Programme), by community development movements (i.e. Sarvodya Foundation schemes of Sri Lanka and India), by local governments (i.e. China's county level pre-paid health insurance programs), or by mission groups (i.e. Nepal's United Mission Lalitpur Medical Insurance Scheme)

Community health funds play an important role in the health systems of Argentina, Colombia, Ecuador, and more recently, Mexico[7]. They also play a role in the health care systems of Bolivia, Guatemala, Honduras, Nicaragua, Peru, and Uruguay. In Latin America, community or rural health funds are closely linked to trade unions and social funds. Argentina has the oldest and most extensive system of village health funds in the region.

Size: Most village health funds in developing countries are small, with only a few having membership pools comparable in size to those managed by commercial health insurance companies.

Coverage: The total coverage of community health funds in the developing countries, as a whole, is not known with any certainty. Given that many such funds are still in the early part of their growth phase, or have only been recently introduced, it would be safe to conclude that less than 10% of the rural/informal sector population in the developing world participates in them. Four Million people were covered by such schemes in year 2005-06. The population of India in that duration being 1.1 billion, it can be estimated that approximately 3% of Indian population was covered by such schemes during that year.

17. (ILO 2000).
18. Tabor, Steven R, Community Based Health Insurance and Social Protection Policy, Social Protection Unit, Human Development Network, The World Bank, **March 2005;** Dr. N. Devadasan, Viability of Community Health Insurance Schemes, http://www.iphindia.org/joomla/articles/Publications/viability.pdf.

Common Features

Simplicit*y*: A defining characteristic of rural health funds is that they are simple. Many people in the informal sector cannot cope with complex procedures or forms, some cannot even read or write. Therefore, funds at the village level are designed in a way that makes them simple (flat premiums, one-size benefit packages), easy-to-use and understandable for their members. Written contracts, if used, are brief. Forms are kept short, and record keeping is generally manual.

Accessibility: Village health funds are also designed to be accessible to their members. They are run and operated near their client base, close top the community simply because the poor or the rural population have neither the means nor the time to travel from their place of residence to distant insurance service centers.

Self-management Another unique feature of rural or village health funds is its community base.

Unlike commercial insurance (where the insurer determines the offer of insurance) or social health insurance (where the government determines the benefit package), the benefit package for a village depends on what the beneficiaries decide that they need, and the size of the benefit packaged is capped by the resources that they can commit. These health funds typically represent their members in negotiations with health providers, drug suppliers and others. Because of the community decision-making, benefit packages can be changed rapidly, without the need to receive approvals from outside regulators or supervisors.

Revenue-Generating Capacity. Sometimes community health funds are related to groups that have some revenue-generating capacity. Even in the rural parts of very poor countries, there are groups who have sufficient incomes to pool resources to mitigate against adverse health risks.

Key policy questions			
Technical design characteristics	. . .	▪ **Revenue collection mechanisms Level of prepayment compared with direct out-of-pocket spending Extent to which contributions are compulsory as opposed to voluntary Degree to which contributions are progressive Subsidies for the poor and buffering against external shocks** ▪ **Arrangements for pooling revenues and sharing risks Size Number Redistribution from rich to poor, healthy to sick, and gainfully employed to economically inactive** ▪ **Purchasing and resource allocation Demand (for whom to buy?) Supply (what to buy, in which form, and what to exclude?) Prices and incentive regime (at what price and how to pay?)**	
Management characteristics	. . .	▪ **Staff Leadership Capacity (management skills)** ▪ **Culture Management style (top-down or consensual?) Structure (flat or hierarchical?)** ▪ **Access to information Financial, resources, health information, behaviour**	
Organizational characteristics		**Organizational forms (extent of economies of scale and scope, and contractual relationships?) Incentive regime (extent of decision rights, market exposure, financial responsibility, accountability, and coverage of social functions?) Linkages (extent of horizontal and vertical integration or fragmentation?)**	
Institutional characteristics .		**Stewardship (who controls strategic and operational decisions, regulations?) Governance (what are the ownership arrangements?) Insurance markets (rules on revenue collection, pooling, and transfer of funds?) Factor and product markets (from whom to buy, at what price, and how much?)**	
Outcome Indicators	**Health**	**Protection against impoverishment**	**Social inclusion**

External Support. Many community health funds depend on continuing access to some form of external subsidy and many depend on the presence of outside facilitators. Such support may be provided from donors, central and local government, international NGOs, SHGs, or cooperatives, etc.

Complementing the Public Effort. Community based health funds tend to complement the publicly financed health care service. Public sources contribute a large part of the financing of the health care risks of members, by providing preventative care services, and by subsidizing some portion of their health care service delivery costs.

Core characteristics of community based health funds

Preker, Alexander, at al., "Effectiveness of Community Health Financing in Meeting the Cost of Illness", Bulletin of World Health Organisation (2002), 80, (2), Page 145.

Goals and Objectives

Community health funds in rural areas are formed with a variety of goals and objectives, other than to improve access and quality of heath care. Community health funds provide (some) coverage for a defined set of primary health care expenditures, such as clinic and drug expenses. Most also cover part of the costs of hospital treatment. Community health funds also contribute to improving the quality of health services. By improving demand for health services, community health funds also contributes to higher rates of health facility capacity utilization, and by augmenting funding, community health funds improve the capacity of health facilities to provide drugs, equipment and other essential health supplies. By helping to improve beneficiary education, they foster health awareness and stimulate demand for improvements in community health conditions and for primary health care.

At times schemes are started as a way of mobilizing or stabilizing funds for the health infrastructure and other health care providers. VHFs also provide (some) coverage for a defined set of primary health care expenditures, such as clinic and drug expenses. Most also cover part of the costs of hospital treatment. VHFs also contribute to improving the quality of health services. This is accomplished by striking agreements with health service providers to improve drug and medical supply availability; to improve cleanliness; to be more responsive to clients; to reduce waiting times; and to focus more attention on health education and community awareness. Thanks to collective bargaining power, VHF monitoring and supervision of health providers also increases demand-side pressure for better management of health delivery services. By improving demand for health services, VHFs also contribute to higher rates of health facility capacity utilization, and by augmenting funding, VHFs improve the capacity of health facilities to provide drugs, equipment and other essential health supplies. By helping to improve beneficiary education, they foster health awareness and stimulate demand for improvements in community health conditions and for primary health care.

Institutional Arrangements

How village rural funds are structured and organized has an important influence on their performance. Some are "owned" by the community, by local or central government, by hospitals or clinics, by international NGOs or donors, by cooperatives or trade unions. Those that are owned and managed by the local communities tend to concentrate their efforts on improving ible

access and quality of local health care services. Those that are owned and operated by health care providers tend to focus more on augmenting and stabilizing health care revenues. Those that are owned or operated by NGOs and cooperatives, by comparison, tend to concentrate more attention on building membership ranks for participation in a set of complementary services. When village health funds are operated by communities, all of the management functions are undertaken by the community members themselves, both with managers serving on a voluntary and paid basis. When these funds are owned and operated by health care providers (doctors, clinics or hospitals) or NGOs, accounting is conducted by the provider or NGO who is also responsible for all technical coverage issues, such as pricing, risk management, and care terms. In that case, the provider or NGO also absorbs all the risk. These risks basically involve financial risks like costs of medicines and services of doctors etc.

Coverage: Most of the rural health funds cover a combination of both high-cost and low incidence health events (such as emergency treatment of delivery complications, and limited hospitalization for illness and injury), and low cost, frequent events resembling primary care (including drugs, laboratory, supplementary care for mild illness beyond that provided by government). What is covered tends to change over time, depending mostly on the amount of accumulated reserves, and the community-specific perception of priority risks and benefits.

The provision of transport services for health emergencies is an important coverage issue in Africa, and the same is also relevant for the rural areas of Rajasthan. Lack of emergency transport services is directly linked to high maternal mortality rates, especially in remote rural areas in India as well as Africa.

VHFs have also proved of immense importance especially in sudden emergency situations where they has outscored and preceded the national and international relief. One such example is the SEARO fund created by WHO of US $1.1 Million by contributions from its member states that was used in Myanmar after cyclone Nargis hit it. It saved a lot of lives before external help from UN and other arrived.

Inclusion of the Poorest Groups. The members of these health funds are normally drawn from the informal sector, where information on incomes and expenditures is scant and subject to wide margins of error. There is very little information on whether or not the poorest groups join health funds, although within the low-income communities in which they are offered, those with higher incomes are more likely to join. Some of the larger health funds add a small surcharge or collect donations to help pay the premiums of the selected categories of poor households.

Community based health funds are a new and emerging social protection technology in many parts of the developing world. Track records are short and empirical evidence upon which inferences about impact and sustainability can be reached, are limited. Despite this, of late the rural health systems across the globe have been witnessing an unprecedented increase in the number of such schemes and the potential of the health funds largely remains unexplored.

Even though community financing has not been considered a sufficient step for eradicating the health problems of poor communities that still require a strong government presence and other

19. Ground Breaking Approach to Disaster Relief, http://www.who.int/bulletin/volumes/86/9/08-010908.pdf

external support to overcome the basic problems but it has proved to be a successful initiative that can form a strong foundation of health care in the rural areas which can then be built upon by NGO's and other bodies and finally linked with the government programs in the region. A VHF would be entirely maintained and managed by the community. However, GRAVIS hopes to form relationships with partner organizations that can aid in the effort to established successful VHFs (see below). GRAVIS, along with its partners, would be able to strengthen the funds with both financial resources and administrative and technical expertise.

However, in order to start successful VHF, communities will need to establish detailed rules and guidelines to cover broad issues such as basic goals, membership restrictions and requirements, financing and repayment rules, governance structures, and more. This study will help develop feasible guidelines for communities to use in this process.

The organization is also looking forward to spread awareness about the village health insurance scheme as put forth by the World Bank. This would not only reduce the health risks of the population but also allow the villagers to cope up with severe health problems at a short notice. A Village Health Fund (VHF) is any program managed and operated by a community-based organization, other than government or private for-profit company, that provides risk-pooling to cover the costs (or some part thereof) of health care services. Beneficiaries are associated with, or involved in the management of community-based schemes, at least in the choice of the health services it covers. It is voluntary in nature, formed on the basis of an ethnic of mutual aid, and covers a variety of benefit packages. Village Health Funds can be initiated by health facilities, NGOs, trade unions, local communities, local governments or cooperatives and can be owned and run by any of these organizations.

Several of Asia's Village Health Funds are owned and operated by large micro-finance organizations (i.e. Bangladesh's Grameen, India's SEWA), by cooperatives (i.e. OHPS ORT Plus Scheme of the Philippines), by large hospitals (i.e. Dhaka Community Hospital Health Card Programme), by community development movements (i.e. Sarvodaya Foundation Schemes of Sri Lanka and India), by local governments (i.e. China's county level pre-paid health insurance programs), or by mission groups (i.e. Nepal's United Mission Lalitpur Medical Insurance Scheme) (ILO 2000).

2.3 Existing Models

The idea of a community health fund is not new to the rural areas. In light of the fact that the government schemes has proved to be unsatisfactory in most of the cases in rural areas, several NGO's and the village communities themselves have taken the initiative of coming together and creating a village health fund that can be used by the members of the scheme in cases of unforeseen medical emergencies. Some of these health fund models like ACCORD-AMS-ASHWINI also provide for health insurance via general insurance bodies. Some of these models across India have been discussed below.

20. Tabor, Steven R, Community Based Health Insurance and Social Protection Policy, Social Protection Unit, Human Development Network, The World Bank, **March 2005.**

Table 4 : Existing Models of VHF

Sl No.	Self Employed Women's Association (SEWA)	Tribhuvandas Foundation	Aga Khan Health Services, India	Navsarjan	ACCORD-AMS - ASHWINI (AAA)	Ulhas Jajoo's Scheme	Raigarh, Ambikapur Health Association, RAHA	Goalpara cooperative health society	Students health Home	Saheed Shibsankar Saba Samiti (SSSS)
About the Organi-zation	SEWA is a labour union of 6,00,000 women workers in informal industry in Gujarat	Tribhuvandas Foundation was named after founder chairman of Amul dairy	AKHS'I is a functionary of Aga Khan Development network and is a non-profit health care system in developing world	Navsarjan is an organization unearths atrocities against dalits and fights it	ACCORD is a local NGO working for indigenous groups; AMS is federation of village unions; ASHWINI manages health programs	Started by a students group led by Ulhas jajoo in MGIMS, Sevagram in 1976	Federation of three referral hospitals and 65 independent health centres with outreach community care	Shanti-niketan based society with a dispensary, community health activities	A collaboration of polyclinic and 28 regional health clinics	Burdwan based organization
Scheme	Vimo SEWA (or SEWA insurance scheme) started in 1992. Comprehens-ive insurance package including life, health and asset insurance	Sardar Patel Aarogya Mandal came into existence in 2001 for covering expensive hospitalization	Scheme 1- tied up with dairy cooperative,which deducted from per litre milk and gave it to the scheme. Scheme 2- community health fund on premium basis for non-members of dairy coop.	Scheme involves buying of 'mediclaim policy' from New India Assurance and pay premium	Composite tribal health insurance package developed in collaboration with New India Assurance Corporation launched in 1992/ Royal Sundaram Alliance replaced NIAC in 2003	To have a village health worker, establish a village fund to act as pre-payment schme subscription for free primary health care and subsidized referral care	Community health activities started in 1974. Including management of insurance scheme, training and support for health centres, outpatient care.	Doctor provides outpatient care twice weekly	Polyclinic with 70 beds, regional clinics. Conducts health education campaigns and blood donation camps	Dispensary, occupational health activity, fair price medicine shop and awareness programs
Unit of Memb-ership	Members, spouses and children (individually)	Household	Family	Individual	Individual	Family	Individual	Household	Institutional and individual	Individual
Who can be a Mem-ber	Adults between 18 to 60 years of age	Only those who are members of both, Milk Cooperative (doodhmandali) as well as TF can enrol	Members of diary cooperative under S 1 and others under S 2	Membership fee Rs 400 Annum	Only adivasis residing in Gud-alur taluk who are members of AMS & between 6 months to 60 years	Residents of Sevagram				

Total Members	Over 1,00,000	83,000 families		574 individuals	12,000 plus	90-95% of villagers	75,000	150 out of 175 households	630 institutes- 550 000 students covered	
Can non members avail benefits	No	No discrimination at primary level, as they are poorest	878 households				Yes, at a Cost	Yes, at a cost	No	No
Premium	Rs. 85	Three paisa per litre of milk deposited, plus Rs. 1 per year.	3 to 5 paisa per litre of milk deducted per family and dairy pays 30,000 to AKHS'I. Rs 125 to 200 per family for others	Rs 175	Rs 22 per person	At least 12 payalis of Jowar (equivalent to 1.25 Kgs at Rs 4 per kg)	Rs. 5 or 2 Kg rice	Rs. 18 in cash or in kind (rice or labor)	Rs. 2 for institutions and Rs. 6 for individuals	Rs. 2 or Rs. 5
Benefit	Only inpatient care, Hospitalization cover, plus one time payment for denture and hearing aid.	Both inpatient and outpatient care. Free hospitalization of selected referral hospitals	Only outpatient care (except in case of delivery)	Only inpatient care, free hospitalization upto 15,000 at a particular hospital	Reference to hospitals in Kozhikode or Coimbtore. Most common ailments treated. Under other scheme, outpatient services at nominal rates were also given	Free treatment for emergency and unpredictable illness. 25% of cost to be paid by patient for diseases like hernia, cataract, pregnancy etc.	Community care- Free CWH services and drugs, free health centre services including MCH clinic. Hospital- free care after paying entrance fee up to Rs. 100	Free doctor consultation and drugs at low cost. Free periodic public health activities	Polyclinical/ regional clinic, free consultations. Drugs, diagnostic tests, operations, bet stay at nominal charges	Outpatient clinic- free consultation, drugs t cost, free MCH care
Cap on Reimbursement	Rs. 2000	Rs 7 to 10,000 but TF can make reimbursement up to 1,00,000 in exceptional cases	Data unavailable	Rs 15,000	Rs. 1,500					

Services Excluded	Pre-existing conditions, normal delivery, conditions related to HIV/AIDS	Angiography, angioplasty, bypass surgery, all cancers, major orthopedic operations, kidney transplant, AIDS/TB	All hospitalization other than delivery	All exclusion of mediclaim policy	Pre-existing, self-inflicted illnesses, substance abuse- under general insurance. For comprehensive insurance, no exclusion for hospitalization	No specific exclusions but part payment for certain ailments				
Problem faced in implementation	Payment in kind become difficult to manage; 75% people should enroll- a difficult target	Fixed fees, poorest can't benefit (though foundation helps in some cases)	Very low participation due to absence of hospital cover in scheme	A lot of claims got rejected and people became disenchanted; several scheme managers though scheme was time and money consuming and returned to their primary focus of dalit rights; problem of fraud by doctors by giving inflate bills and unnecessary hospitalization	No risk pooling between rich and poor as target is por population; quite successfull scheme	Smaller part of population thinks health is priority; a lot of awareness programs need to be conducted	Some centres do not have enough membership to share risks' payment in kind become difficult to manage	Fixed fees, poorest can't afford to pay (though some doctors offer help); payment as community services difficult to manage		Combination of fund raising methods makes it difficult to assess the success of a particular method.
Committee	CHW manages everything and collect premiums	Village Milk societies are responsible for administration	AKHS workers	Navsarjan Volunteers collaborate with doctors	ACCORD, AMS and ASHWINI collectively manage		Individual health Centres	Village health committee	Individual institutes	Village dispensaries

The Mitra Peoples Health Fund

One of the role models in community health fund was initiated by Mitra Peoples Health Fund that started as a small project in certain chosen villages. Mitra presently has three kinds of community health insurance / health fund initiatives running in 3 different clusters of villages. Each has evolved out of the dialogue in that set of villages, and is therefore localized and delightfully different. No attempt has been made to homogenize or force conformity. Each is allowed to grow or wither according to its own genius. Mitra provides inputs technical and administrative.

Table 5 : The Mitra Peoples Health Fund

Indicator	Daklguda Model	MAS Model	Dukum Sahada Model
Started	2003	2005	2006
No of Villages Participating	7	4	7
Unit of Entry	SHG & Family	Village & Family	Village & Family
Units	16 SHGs	4 Villages	7 Villages
Families	129	143	212
Individuals	577	668	998
Premium	Rs. 30 per Family member	Rs 10 per family-member	Rs 10 per family-member
Size of Health Fund at start of this year	17,310	6,680	9,980
Benefits	It provides free care at the Community Level (Swasthya Sevika level and Community Health Nurse level), and subsidizes care at the Christian Hospital, Bissamcuttack (Outpatient level and In-patient level).	The Fund covers the cost of medicines as available at the Community Level that is, Swasthya Sevika level and Community Health Nurse level. It does not cover hospital treatment.	The Fund covers the cost of medicines as available at the Community Level that is, Swasthya Sevika level and Community Health Nurse level. It does not cover hospital treatment.
Committee/Administration of funds	Women's Group Federation Committee with 50 members	The Mitra team stationed at Kachapaju administers the whole project, and the report is shared with village leaders annually	A Committee consisting of two or three people from each village oversee this Health Fund,

CARE India

Within India, CARE successfully implemented a community health financing scheme as part of an initiative called the Maternal and Infant Survival Project (MISP). This financing scheme is similar to GRAVIS's proposed VHF concept and hence, has been discussed separately. MISP targeted 447 villages in the state of Madhya Pradesh and aimed to develop a sense of community empowerment and awareness regarding maternal and infant health. The program was funded by the Canadian International Development Agency (CIDA) and executed in collaboration with the Government of India.

Health funds were developed in villages through Community Based Organizations (CBO) in villages. The CBOs, some of which existed before the MISP project, are composed mainly of interested women

in the community due to the nature of the health issues involved. These CBOs could be considered comparable to community groups organized by GRAVIS such as village development committees (VDCs) and women's self help groups (SHGs).

Following group discussions regarding pressing day-to-day problems, some CBOs decided independently to begin a savings fund for health, and proceeded to elect a secretary, construct fund rules, and maintain and document the fund's activities. By April 2000, 203 villages had established savings funds of between Rs 500 and Rs 2000. The membership of each fund was between 10 and 20 people.

Each CBO's set of rules for its health fund covered the following topics:

eligibility criteria, determining whether non-members could request funds

purpose criteria, to spell out when, if ever, funds could be used for non-health related purposes

interest rates, which sometimes included grace periods for all loans and higher interest rates for non-members

minimum fund balances required to begin disbursing loans.

Loans from health funds have helped make healthcare facilities more accessible. In the case of obstetric complications or emergencies, women have been able to borrow money on short notice to fund transportation to a hospital. Women have also successfully borrowed funds to care for their children and cover hospital transportation and expenses as necessary.

CBOs also had peripheral benefits for their communities. Because their members were almost entirely female, and their focus was on maternal and child health, the establishment of CBOs helped to empower local women and bring greater equity between the healthcare of young boys and young girls. CBOs have also fostered a great sense of unity among its members and communities as a whole. Some CBOs also performed other health-related tasks in the village such as promoting health awareness and selling simple health supplies such as safe delivery kits and oral rehydration salts (ORS). These activities helped CBOs become a stronger presence in their villages. By making a small profit on the sale of medical goods, these activities also helped health savings funds grow over time.

Table 6 : Comparative Models Outside India

Schemes	**CHF in Tanzania**	**School Health Exams & Pilot Village Health Fund Project, Thailand**	**Bukidnon Health Insurance Programme of the Philippines**	**Lalitpur Medical Insurance Scheme (LMIS)**
About the Organization	Government of Tanzania	Project to asses the access of students of South Thailand to health care	Participation of the local government and the Philippine Medical Care Commission	The United Mission in Nepal (UMN) is a non-profit making organization providing health care services in Nepal.
Scheme	a district-level voluntary prepayment scheme, introduced in parallel with user fees at public health facilities started in district of Songea	Basic dental treatment to establish a starting point from which to assess the effectiveness of future preventative programs. The health loan fund pilot determines the villagers' willingness to pay into their community bank in order to build a village "health insurance" program		In 1976, under its Community Development and Health Project (CDHP) activities, it introduced a Micro-insurance Scheme to the community people of the Lalitpur. The scheme was known as Lalitpur Medical Insurance Scheme (LMIS).

Unit of Membership	Individual	Individual		Family
Who can be a Member				Membership of the scheme is open to all of the local inhabitants irrespective of their age, caste, ethnicity, educational / income status and sex.
Total Members	Targets at 85% of Rural Population, especially engaged in informal sector	1472 Students of Villages of Krabi	24,000 subscribers (till 1998)	
Premium	Members pay fixed annual fee per household but no co-payment when using services available at primary level health facilities	Patients will pay for treatment according to their ability and the money will be put towards a village health fund, making them eligible to take out loans for health services, medications and transportation to government hospitals.	The provincial government operates an indigent patient scheme in which the first year's insurance premium is supported by the Province and the second year's (and thereafter) by the municipality. A means-test is applied at enrollment, covering per capita power and water consumption, distance to the nearest health service provider, health awareness and a bonus for families that grow vegetables	
Benefit		Dentists and assistants from the local region will provide their services free of charge	a package of in-patient, out-patient and dental services from accredited providers.	the scheme covers hospital care, general medicine, preventive care, gynae-obstetrical care, laboratory examination costs (limited) and radiology costs into its health services.
Committee Constituted of	District Council required to establish autonomous Council Health Service Board (CHSB) with members from local government and			Each health post has employed a Mukhiya. The Mukhiya is generally a local person selected by the CDHP and employed to work as a regular staff member of the HMG/MOH Health

	community to manage CHF (monitoring, mobilizing and administering funds, setting exemption policy and targets). CHSB works with Council Health Management Team (CHMT) to ensure quality of care and facility supervision. Secretary of CHSB is District Medical Officer (DMO), head of CHMT.			Post. The Health Post In -charge (HPI) and Mukhiya are responsible persons for day-to-day management of the health post. The Health Committee members are selected from the local inhabitants in consultation with the VDC members. However, in some places, they are selected through an electoral process (for example in Ashrang and Bhattedanda).
Problem faced in imple-mentation	Low level of Enrol-ment due to a widespread inability to pay membership contributions, the poor quality of available services, a failure among communities to see the rationale for protecting against the risk of illness, and a lack of trust in CHF managers	Local government support for health services in schools has not been enough to meet all the needs of schools in Southern Thailand. There are still many schools which do not even have basic household medicines or a qualified health administrator. It is vital that students are given general health examin-ations because access to basic health services is so unreliable.		

22. shortage of drugs and essential medical supplies; inappropriate diagnosis due to lack of diagnostic equipment, particularly laboratory equipment; staff-related problems; limited range of services provided and lack of possibility to use health facilities of members' choice, coupled with referral problems.

Chapter 3

SUGGESTED STRUCTURE AND GUIDELINES

3.1 Where do We Stand Today?

It is quite easy to identify a problem and equally difficult to figure out a solution for the same. A lot of research and field study has gone into the status of health in rural Rajasthan, particularly in Thar desert where the lives are marred by not just poverty, illiteracy and access to resources but also by the unfavorable climatic conditions and lack of vegetation. The government schemes and policies do not serve the purpose of these remote sandy terrains as the schemes are not formulated in way to capture the health requirements specific to these areas.

As the report suggests, the limitations of government schemes in permeating into the lives of residents of Thar has encouraged people to look for alternatives to the reliance on government to take care of their health needs. Health might not be on the priority list of the poor populations but it has been increasingly identified as vitality. The desert populations are opening up to the idea of establishing community health funds and taking collective steps to ensure that the entire village is protected against serious health ailments and have timely access to health facilities to prevent fatalities.

However, it is quite difficult for these poor desert populations to come up with a community health framework of their own, not just because they are more concerned with their daily bread and butter in wake of their perpetual poverty on account of chronic drought more than health but also because community health schemes require periodical deposits for availing the services under the scheme. This is where the need for a body like GRAVIS kicks in that can help in enablement of the community to come up with a workable community health fund scheme.

The role of GRAVIS would not be limited to preparation of a framework for community health initiative but also to help creating awareness about the advantages of a community health fund scheme. The rural population needs to realize that the contributions they are required to pay for the services are negligible compared to the benefits that they are receiving under the schemes. It not only protects them from financial breakdown at the time of medical emergencies but also enables them to raise loans for other purposes under the scheme.

The main focus of GRAVIS is to hold consultations with members of these communities and deliberate upon the course of action in coming up with a comprehensive health care framework addressing the needs of rural communities at minimum costs and without having to wait for the government to take action.

There are a lot of examples of the sort spread across the country as well as abroad but the health needs for every area are different, an overarching legislation or a national policy might not work well but a more focused scheme is more likely to work out well. There are a number of community health funds and insurance schemes that have been looked up to for assistance in coming up with a working model that is best suited for addressing the health concerns of the residents of Thar desert.

3.2 VHF Guidelines for Rural Thar

The village health funds could not only provide solutions for the financial needs of the community in Thar Desert, but can also be used for mobilizing the rural community and making them aware about the issues concerning health. The field visits and interactions with the

community members, community leaders, members of the self help groups and health professionals provided some insights as to what extent the village health funds can be useful in resolving the problem financial insecurity relating to the health problems. The rural community itself also suggested a set of ground rules on which such a fund can be structured and administered.

Generally the rural community in Thar, especially the community leaders and groups of individuals already working on various other social issues, recognized the need of a health fund at the village level and are very receptive of the idea of initiating such a fund that could take care of their financial needs related to health. There is a feeling among the community leaders that if explained the critical need of VHF, almost all the villagers would subscribe to this idea.

Composition of Governing Body for the funds

The Village Health Fund must be governed by a group of individuals rather than by one individual. The Committee to govern VHF should comprised of nine or eleven members drawn from

a. representatives of all the hamlets in the village
b. representatives from the Self Help Groups, ICDS workers, village development committees, village education committees, etc.
c. Apart from these it could also be suggested to have few members as observers without decision making powers such as:
    a. Two health workers who can aid these members in taking decision
    b. One or two representatives from an NGO working in the village for providing technical support
    c. representatives from various government run programmes and schemes related to health

This committee must be elected by the villagers through voting. The tenure of the committee should be three years and there should be provision for re-election of the members.

In addition to this, other committees at the village level, like Village Education Committees and Village development Committees, also must be utilized for the possible advice, expertise and experience that they might be able to provide. This measure would actually help mainstream the rural systems within the village.

Tasks and responsibilities

Initially the members would have a variety of tasks and responsibilities. Although, some of these can be done collectively, and few of others must be divided among them, which, if required, they may delegate to the other members as well. This initial list of task would include:

a. coordination and organizing the meetings
b. appointment of the chairperson to conduct the meeting
c. one person to record the proceedings and circulate the same
d. draft guidelines to be scrutinised and adopted
e. ensuring that the contribution is being deposited

f. book keeping and record keeping
g. keeping the cash to meet exigencies at the village level
h. identifying the areas of intervention for which support is required from government as well as non governmental agencies, and follow up on the same
i. coordination with the civil society organizations for getting possible support from them

At a later stage the committee would be involved in taking the decision with regard to the disbursement of funds, elaboration of rules and notifying the list of members, disclosure of accounts, etc.

Meetings, quorum and decision making

The Committee must meet every month to take stock of the situation and more than 50% of the members must participate for the meeting to be conducted. With regard to taking any crucial decision, attempt must be made to build consensus, otherwise the decision must be taken with a ¾ majority of the present members at the time decision is being taken. There must also be a provision to take an interim decision at the time of emergencies, however the same must be later ratified by the committee.

Minimum amount to be paid as contribution

Most of the villagers in the Thar desert survive on an income that is merely sufficient for their subsistence. However, recognizing the fact that on an average every household spends about ten thousand rupees in a year on an average on various health related expenses, there is a rowing concern about it and the villagers are open to part atleast Rs. 30 per month to be deposited in the health fund that could take care of their out of pocket expenses when need arises.

However, if the committee deems fit, it could dispense with the requirement of payment in cash and allow certain individuals or the whole village to make payment in kind. This payment can be made in crops or milk or other goods the villagers produce. In case of crops, the committee shall also allow payment to be made in the season. The committee should also try and generate some employment by engaging villagers to act as health workers or assist the health workers for certain remuneration. It could also provide for voluntary assistance on a rotational basis and exempt the volunteers from making payment for a particular period.

Unit of membership

Considering that the income levels are very low in the area, it is suggested that the unit of membership for the health fund should be the household, and not an individual. This however, needs to be tested in case of multi-family households (joint families with larger number of individuals). One of the suggestions that could be explored is to consider husband, wife, their children and parents, as one unit. Such a provision would be a motivating factor for the families to become a member of the fund and pay the contribution, and hence expansion of the group would become relatively convenient and the group would also become inclusive.

Extent and scope of support

The VHF must be used to meet the out of pocket expenses as well as in the emergency situations that require immediate redress. In the rural areas of Thar, as mentioned elsewhere in the report, the cost of transportation, doctors' charges, expenses on medicines, and other such emergency

situations demand immediate availability of liquid cash and these are the times when villagers find themselves without any options other than mortgaging their belongings or land and take loan on very high interest rates, that ultimately lands them into a financial crisis that takes the toll on their livelihood.

The limitation on the use of VHF must be clearly laid down considering the size of the funds and to avoid the exhaustion of the funds.

Eligibility for disbursement of funds

Normally only the members should be allowed to take the benefits of the scheme, so that non-members, who are not able to avail some health benefits of the scheme, feel motivated to become members. This will also serve as one of the major disadvantages of not becoming a member of the scheme. There is a general agreement among the rural community, that the amount should be disbursed as interest free loans and to be repaid in installments. The requests that come to the committee must be examined in light of the gravity of the situation and the urgency of the matter must be taken into consideration. Primarily, the nature of the illness that demands immediate intervention, economic family status of the individual and the family and atleast a quick assessment of the financial resources available with the family, would be vital to such a decision. From the point of view of the adequate administration and sustainability of the fund, cases with the track record of the regular payments of the contribution can be given priority.

In cases of emergencies, disbursements can also be made to the non members, however, the committee should have the discretionary powers in such cases. , however, nominal interest must be levied in that case.

Mode of Repayment

The recovery of the loan can be done through the nominal monthly installments paid through the bank or the post office where the account for the fund is being maintained. The period of repayment must not go beyond a suggested period of three years in normal cases.

Expenses not to be covered by the fund

In order to keep the fund animated and to avoid any possible misuse or misappropriation of this facility, it is critical that the limit of the support be lucidly defined. In normal cases, such an amount should not exceed Rs. 2000. Although all necessary measures should be taken to help the aggrieved, the monitory benefits should not exceed beyond such a prescribed amount to include hospital charges and expenses on perennial diseases, etc.

Extension of benefit for nonmembers

Despite the non cooperation demonstrated by the non members, the rural community is of the view that the benefits of the VHF should be extended to them as well, especially in case of emergencies. However, it may be suggested that non members may not be entitled to the other benefits such getting loans for the purposes other than the health, on optimum interest rates. Few other such mechanisms must be evolved to encourage the non members to become part of the VHF.

Management of funds

The cash collected for the funds must be deposited in a bank or Post Office in the vicinity and could be drawn after the approval from the Committee to this effect. Atleast three of the members, the president/chairperson, vice president and the treasurer should be the joint signatories.

Availability of funds at the village at a given time

However, in case of emergencies, a small amount of about Rupees ten to fifteen thousand should be kept within the village to meet the expenses during that time. For example, during the Bank Holidays or the late hours when the Bank facilities could not be used, there must be a provision of liquid cash be available within the village at all times. Committee should be empowered to take the decision to keep this amount with some trustworthy person in the village, chosen by the villagers by consensus.

Record keeping and combating fraud

Health insurance is subject to the risk of fraud, or deceptions deliberately practiced by people, providers and committee members, to secure unfair or unlawful gains. To combat such fraud, providers need provisions to deny service to the uninsured, to bill only for services rendered, and to render only those services that are truly required. Lack of professional management can make VHF vulnerable to fraud. Community members are not professional managers, yet have a great deal of financial responsibility. Several of them become frustrated with all the work involved and found themselves tempted by the contributions.

Encouraging a high level of community participation and over-sight, specification of suitable management policies and procedures, proper record keeping and accounting, and regular member review of accounts, are among the many ways that VHFs prevent fraud. Proper record keeping plays an especially important role. Improving record keeping forms and procedures can help to prevent fraud from occurring in the first place.

A sound record keeping system should include VHF membership cards for each member, and their family details including all insured children, patient register, a membership register, a financial ledger and a receipt book for cash received. It is also required to generate a daily and a monthly status report, summarizing all transactions of the fund.

Possible link with NRHM

Envisaging that the health fund at the village level, will have a modest start and also given that there is a provision under NRHM that a sum of Rs 10,000/ is given to each sub center for undertaking any health promotional activities during exigencies, the VHF can also get benefited from this fund, however, the bureaucratic obstacles need to be overcome. The flexibility of this untied fund can be explored in way that it could augment the pool of financial resources to be spent on the community health at the village level.

Possible links with Other Players

The committee members can also approach insurance companies directly for assistance with the scheme. Schemes like AAA that make use of direct links with insurance companies have proved to be successful. As has been already mentioned, villagers in a better financial state

could be asked to make voluntary contributions to the fund that can be used in times of distress.

Another possible link that can help in achieving the goals of the scheme can be with the other schemes operating in the neighboring area whether state funded or otherwise. This would not only help in strategizing and exchange of know how in operation but also enable different schemes to take financial assistance from one other on a loan basis.

Identification of villages for possible intervention

Three categories of villages can be chosen initially for a pilot project - some that are very much willing and interested in the idea and GRAVIS has a strong presence there, some others where awareness is being generated but they are not sure/keen on this and third category of the remotest and poorest villages who might initially be non receptive of this idea.

Other suggestions

The VHF in the rural areas of Thar desert can take varied shapes and forms, however, few of the models examined in the previous chapters can provide a sound basis for the understanding the functioning of the VHF as well as few pragmatic suggestions that could be incorporated. The *CARE* model can also be looked at as having most affinity with the envisaged rural health fund in the villages of Thar.

Additionally, the card system from the Lalitpur experience that can easily form part of any VHF to make it efficient. People can produce their cards at the hospitals and the medical shops where they get free medical care and medicines.

The possibility of group insurance for the members of the VHF should also be explored for the sustainability of the scheme and to make sure that the benefits of such a fund could be expanded to accommodate larger expenses and long term health care.

Areas where support is required

A range of skill building for the community is required to initiate and run the VHF. Support from GRAVIS will be required in the following identified areas, atleast to start with:

Although, the initial experience has demonstrated the receptiveness of the community leaders towards the idea of VHF, a fundamental change in the mindset is required among the community especially with regard to the importance of health and investing in it. The concept of the VHF needs to be communicated to them through continuous interactions and awareness generation programmes that can be facilitated by GRAVIS. The outcome of these interventions should be behavioural change which is required for any such programme to be successful and sustainable.

Regular interface with the village community should also be aimed at inculcating leadership skills and qualities, especially among the rural youth who can act as ambassadors of change. These identified villagers must be constantly trained and motivated to spearhead health awareness among the rural community.

Rigorous trainings and capacity building would be required for the members of the committees especially in the technical aspects of managing the funds, book keeping, account maintenance, etc. The committee members would also require regular support

while interface with the external players, such as the government departments, health officials, prospective groups insurance companies.

In order to meet the capacity building needs of the community and the prospective members of the committees, generation and dissemination of the awareness generation as well as training manuals to run the fund could also be taken up by GRAVIS, given its expertise in this area.

Additionally, even after the funds have started and established, regular follow up, constant monitoring and support would also be required from GRAVIS.

Sustainability Measures

Last but not the least, there is a need to ensure that the scheme is sustainable and does not prove to be a failure after a few years of initiation. This would require presence of backup plans in addition to careful initial planning to make sure that the villagers get constant coverage of the health benefits under the scheme.

One of the ways of ensuring sustenance would be to create a reserve fund other than the general fund, in which at least 10% of the total accumulation is set aside for extremely urgent cases. This would ensure that even in times when the villagers are unable to pay on account of natural calamities like drought or others, there are sufficient funds for taking care of the health needs of the community.

Further, the committee could also opt for measures like acknowledging and encouraging the villagers who have been key participant in working of the scheme by rewarding them with exemptions and other gifts. This would maintain the villagers' interest in the scheme. And as mentioned earlier those villagers who are in a position to make more than the minimum contributions should also be encouraged to do so.

Part of the fund thus accumulated should be invested in safe funds so as to get maximum returns and keep the fund alive. GRAVIS should facilitate this process in consultation with the finance advisor.

The Way from Here

With the blueprint of the scheme in place, it is time to begin with spreading health awareness among the villagers. In light of the fact that health expenditure is one at the lowest in the priority list, there is a need for vigorous awareness campaign highlighting the importance of such a scheme. This might take a bit of time as the villagers in these areas are more concerned about other basic necessities like food and clothing rather than health and education. However, with dedicated efforts, over the time, a conducive environment could be built. From the very beginning, it will also be important to develop linkages with the government and local health care providers.

List of references

1) A Case Study of Lalitpur Medical Insurance Scheme (LMIS), Nepal, http://www.ilo.org/public/english/protection/socsec/step/download/30p1.pdf
2) Dave, Priti, *Community and self-financing in voluntary health programmes in India* , Health Policy and Planning, 6:1 (1991:Mar.), http://heapol.oxfordjournals.org/cgi/content/abstract/6/1/20.
3) Energizing Rural Health Facilities (in Songea), www.districthealthservice.com/cms/upload/innolink_8_3831.doc.
4) GRAVIS Annual Report, http://www.gravis.org.in/annual_reports/annual-report-2008-2009.pdf.
5) GRAVIS, http://gravis.org.in/content/view/55/61/.
6) Harvey and Tyagi, Community Health in the Thar Desert, (Jodhpur: Gravis, 2005).
7) India's healthcare spending to cross US$ 44.9 billion by 2012, http://www.ibef.org/artdisplay.aspx?cat_id=194&art_id=14971.
8) Kamuzora, Peter and Gilson, Lucy, Factors influencing implementation of the Community Health Fund in Tanzania, http://heapol.oxfordjournals.org/cgi/content/abstract/22/2/95
9) Melita, Jakab and Krishnan, Chitra, Community Involvement in Health Care Financing, http://www.karmayog.org/redirect/strred.asp?docId=2467.
10) Mitra Community Health Insurance Project, http://www.karmayog.org/redirect/strred.asp?docId=2061.
11) National Health Policy, http://nposonline.net/policies.shtml#nhp.
12) National Rural Health Mission, http://india.gov.in/citizen/health/national_rural.php.
13) Patil, Ashok Vikhe et al, Current Health Scenario in Rural India, *Aust. J. Rural Health* (2002) 10, 129135, http://www.sas.upenn.edu/~dludden/WaterborneDisease3.pdf.
14) Tabor, Steven R, Community Based Health Insurance and Social Protection Policy, Social Protection Unit, Human Development Network, The World Bank, March 2005.
15) Tyagi, Prakash, Making Health a Reality for Thar Desert Communities, http://sanford.duke.edu/centers/civil/papers/tyagi.pdf.

Annexure : Experience from the Field study conducted during December 2009

Possibilities for an effective plan	Tinwari Hospital (45 kms from Jodhpur city) run by GRAVIS	Panchla PHC Public Health Centre	SHG members of different villages (Gagadi)	Members of Village Development Committees
Participants of the discussion	Health professionals of the Hospital in one of the remote areas of Thar		All women's self help group	
Unit of Membership	--	family	family	
Total Members	people from as long as 70 kms come for treatment to this hospital, no other big hospital in the vicinity - coverage of the hospital is about 30-35 villages	More than 15 villages covered		
Benefit (coverage required)	Common diseases are TB, Fluorisis, and other reparatory problems because many of them work in mines; Malaria and other water borne diseases because there is no awareness among people for use of clean water	Unmet needs in health care are: transport, medicines for chronic diseases, emergency situations at the time of child birth and accidents	Common expenditures are illness, deliveries, Malaria, expenses in private hospitals, medicines (1/2 of medicines are free in govt hospitals),	
Plausible source for funds as premium or otherwise	**NRHM** untied funds 10,000 are also there but that so far has not been utilized, and the proper benefits to the poor patients are elusive.		Minimum amount could be Rs 30 per month, though some of them will find that also little difficult	Rs. 30 -40 per month should be an ideal amount but some of them may not be able to pay even that much
Managing Funds		Keeping the money an amount of Rs 5000 must be kept within the village and rest of it can be deposited in a PO. A reliable person who will be chosen by the villagers should keep this money		4 to 5 thousand should be kept in village for emergencies and rest should be deposited in a bank
Maximum Coverage		Upper limit of the help could be Rs 1000, beyond that it should be left at the discretion of the committee		Upper limit for disbursement should be around 1000 to 1500 rs.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ASHA	Accredited Female Health Activist
ANM	Auxiliary Nurse Midwife
CBHI	Community Based Health Insurance
CBO	Community Based Organisation
CHC	Community Health Centre
CHF	Community Health Fund
CHW	Community Health Worker
CIDA	Canadian International Development Agency
CMH	Commission on Macroeconomics and Health
GRAVIS	Gramin Vikas Vigyan Samiti
HW	Health Worker
HW (F)	Health Worker (Female)
HW (M)	Health Worker (Male)
ICDS	Integrated Child Development Services
ILO	International Labour Organisation
IMR	Infant Mortality Rates
LMIS	Lalitpur Medical Insurance Scheme
MISP	Maternal and Infant Survival Project
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organisation
NHP	National Health Policy
NRHM	National Rural Health Mission
ORS	Oral Rehydration Salts
PHC	Primary Health centre
PO	Post Office
RAHA	Raigarh, Ambikapur Health Association
SC	Sub centres
SEARO	South East Asian Regional Office (of WHO)
SEWA	Self Employed Women's Association
SHGs	Self Help Groups
SSSS	Shaheed Shibsankar Saba Samiti
UMN	United Mission in Nepal
VDC	Village Development Committee
VHF	Village Health Fund
WHO	World Health Organisation