

2006 | ASIAN DECENT  
2015 | WORK DECADE



International  
Labour  
Organization

**SERIES:**

**SOCIAL SECURITY EXTENSION  
INITIATIVES IN SOUTH ASIA**

**INDIA:  
NAANDI FOUNDATION SCHOOL  
HEALTH INSURANCE SCHEME  
(ANDHRA PRADESH)**

**“MOBILIZING CORPORATE SECTOR CONTRIBUTION”**

**ILO Subregional Office for South Asia**



*Decent Work for All*

Asian Decent Work Decade

## INTRODUCTION

The fourteenth Asian Regional meeting of the ILO recently organized in Busan, Republic of South Korea (August 29th – September 1<sup>st</sup>) endorsed an Asian Decent Work Decade (2006-2015), during which concentrated and sustained efforts will be developed in order to progressively realize decent work for all in all countries. During the proceedings, social protection was explicitly mentioned as a vital component of Decent Work by a number of speakers including the employers and workers representatives. The need to roll out social security to workers and their families in the informal economy, to migrant workers and to non regular workers in the formal economy was also perceived as a major national social policy objective. The need to enter into a more intensive dialogue with respect to the design and financing of national social security systems to equip them to cope with the new requirements and challenges of a global economy also emerged as a major outcome of the meeting.

The challenge of providing social security benefits to each and every citizen has already been taken up in India. In 2004, the United Progressive Alliance (UPA) Government pledged in its National Common Minimum Programme (NCMP) to ensure, through social security, health insurance and other schemes the welfare and well-being of all workers, and most particularly those operating in the informal economy who now account for 94 per cent of the workforce. In line with this commitment, several new initiatives were taken both at the Central and at the state level, focusing mainly on the promotion of new health insurance mechanisms, considered as the pressing need of the day. At the same time, and given the huge social protection gap and the pressing demand from all excluded groups, health micro-insurance schemes driven by a wide diversity of actors have proliferated across all India. While a wide diversity of insurance products has already been made available to the poor, health insurance is still found lagging behind in terms of overall coverage and scope of benefits, resulting in the fact that access to quality health care remains a distant dream for many.

Given this context, the ILO's strategy was to develop an active advocacy role aiming at facilitating the design and implementation of the most appropriate health protection extension strategies and programmes. Since any efficient advocacy role has to rely on practical evidence, the ILO first engaged a wide knowledge development process, aiming at identifying and documenting the most innovative approaches that could contribute to the progressive extension of health protection to all. One such innovative and promising approach is the "whole care" protection programme developed for poor school children by the Naandi Foundation in Andhra Pradesh which also includes a co-contribution mechanism involving the Corporate sector.

## TARGET POPULATION

Naandi Foundation is an autonomous, not-for-profit trust dedicated to changing lives of the under-served populations in India through public-private partnerships. Set up in 1998, Naandi's mission is to develop innovative alliances between state governments, corporates, and civil society so that together innovative strategies to eradicate poverty can be created and developed to improve the quality of life of marginalized communities.

Since 2002 and under the banner of Child Rights, Naandi, in partnership with the state government of Andhra Pradesh has been providing quality education and nutrition (mid-day meal programme) to the State school children in Hyderabad.

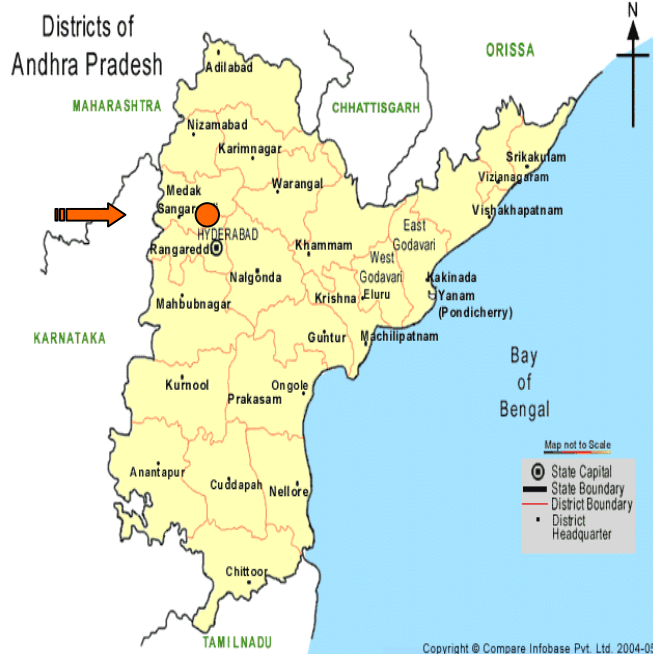


During the course of this programme, the education team observed frequent absenteeism and a generic low-energy index among children. This was due to general ill health and lack of efficient treatment for the children who primarily came from lower socio-economic backgrounds

There is worldwide consensus that education does not work in isolation and that health could be used effectively as a tool to promote schooling which in turn improves knowledge and skills and ensure better social status once reaching adulthood. In 2005, Naandi Foundation pioneered a comprehensive health programme for poor children studying in these public schools. This programme was piloted with the objective of studying the common diseases patterns in this age group and arriving at a minimal cost at which comprehensive medical and preventive health care can be provided to the children.

## TARGET POPULATION

All government schools selected for the education program were located in 5 “Mandals” in the old part of Hyderabad city that are known to be very poor and congested. These schools cater largely to children of urban slum dwellers belonging to the Muslim community who live in extremely unhygienic surroundings that increased their susceptibility to malnutrition, worm infestations, skin ailments, dental problems and congenial deformities in some cases. Some persistent conditions led to growth retardation, treatment for which went beyond their reach. The profile of students covered under the programme includes vast numbers (over 57%) of under-privileged girl children, a vivid testimony of existing gender differences in parental investment.



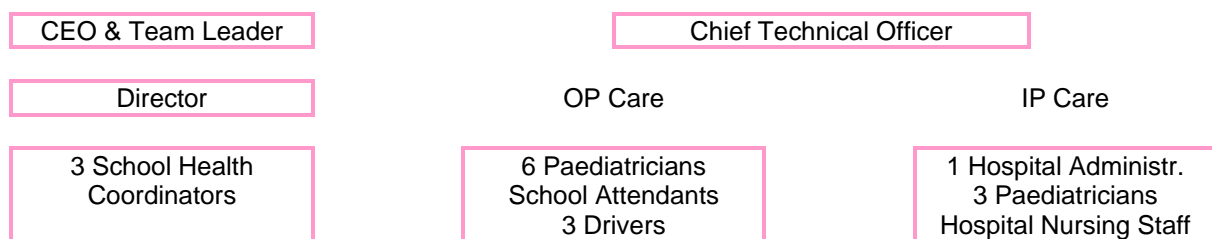
Through observations at the government schools in which its programme on quality education was in process, Naandi identified some fundamental obstacles to a child enjoying the basic right of good health.

- A generic prevalence of ill health among the children, making them more susceptible to disease
- Timely medical care neglected in the household the children come from. As a result, illnesses are diagnosed later, if ever
- The cost of treatment becomes prohibitive for poverty-ridden families
- The existing health insurance are not completely customized to meet the preventive, promotive and curative needs of government school-going children

Despite these established facts, there was no state health programme designed specifically for the age group 6-14 years. This age group is neglected to the extent of there being no indicators (national or international) for measuring their health status.

## ORGANIZATION

The scheme is presently organized in the following manner:



## THE INSURANCE PLAN

### Eligibility

Young children in the age group of 6 to 14 years enlisted in public schools (total of 289) targeted by Naandi education and mid-day food programmes

### Exclusions

None. The scheme even extends the benefits to children living with HIV.

### Plan Benefits

The insurance plan provides “whole care” coverage without any limitation or service cap while operating at all levels: primary, secondary and tertiary level. Surgical interventions extend to corrective, cosmetic and dental surgery. Additional health services include the organization of health camps, and meals for the accompanying parent of a sick child during the hospitalization period.

### Premium Rate

Premium was set at Rs 120 per child per year at no cost to the family. The premium is fully paid through regular contributions from:

- Pay-roll deduction scheme where employees of corporate firms are invited to allow a direct deduction from their salaries of just Rs 10 or multiples of 10 every month
- Consolidated donation made by the parent companies, matching the contribution made by their employees
- Regular contributions made by foreign individuals and Indian community living abroad

### Plan Distribution

Educational officers and teachers are trained on the school health programme in order to enlist their full support during the health camps, screening process and children enrolment.

From the outset, the programme organizes comprehensive health camps where each child covered under the scheme undergoes thorough medical examination by a paediatrician, dental surgeon and community eye health worker, leading to the creation of a data base of individual child health profile and overall disease burden. At the same time, photo ID membership cards are provided to each child.





### General Overview

Starting date	February 2005
Ownership profile	Private trust
Target group	Young children in Government schools
Outreach	Hyderabad city
Intervention area	Urban, semi-urban
Risks covered	Single risk: Health
Premium Insured/Y	Rs 0
Co-contribution	Rs 120 (various co-contributors)
Total premium	Rs 120
No of insured	60,000
Percentage of girls	57%

### Operational Mechanisms

Type of scheme	In-house
Insurance company	No
Insurance year	February to January
Insured unit	Individual
Type of enrolment	Voluntary/automatic
One-time enrolment fee	None
Premium payment	Yearly/monthly
Easy payment mechanisms	-

### Scope of Health Benefits

Tertiary health care	
Hospitalization	
Deliveries	No
Access to medicines	
Primary health care	

### Level of Health Benefits

All health services	No upper limit
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### Service Delivery

Health prevent./educ. programmes	Yes
Prior health check-up	Yes
Tie-up with H.P.	Yes
Type of health prov.	Private
Type of agreement	Formal agreement
No of associated HP	5
TPA intervention	No
Access to health care services	Referral
Co-payment:	No
HC payment modality	Pure cashless

## Service Delivery

The scheme relies on the following three-level health care system:

- Primary level services are provided through 24 OP clinics in nodal schools, including 6 mobile OP clinics with weekly ophthalmologist and dental clinics and access to essential medicines. Each clinic is linked with 10-12 government schools within a radius of 3-4 km. An experienced paediatrician diagnoses the children and dispenses medicines to the accompanying guardian free of cost.
- Secondary level services are provided through a base hospital with 12 general beds, an intensive care unit (7 beds) with round the clock out-patient department (OPD) and a toll free number. Diagnosis, investigations, medicines, surgeries, hospital stay and food for the patient and guardian – are all provided here at zero cost to the child's family.
- High quality multi-specialty care: Tertiary level services are provided through a network of private care providers specialized in: diagnostic laboratory tests, cardiac problems, orthopaedic, dentistry and ophthalmology

## Administration

The scheme is fully administered by the Naandi staff.

## MAIN ACHIEVEMENTS

### Coverage

The health camps began in November 2004 and were completed in March 2005. At the end of March 2005, the total number of children that attended the health camps was 33,000. Another round of camps was held in the new academic year in June, taking the total number of children enrolled up to 60,000.

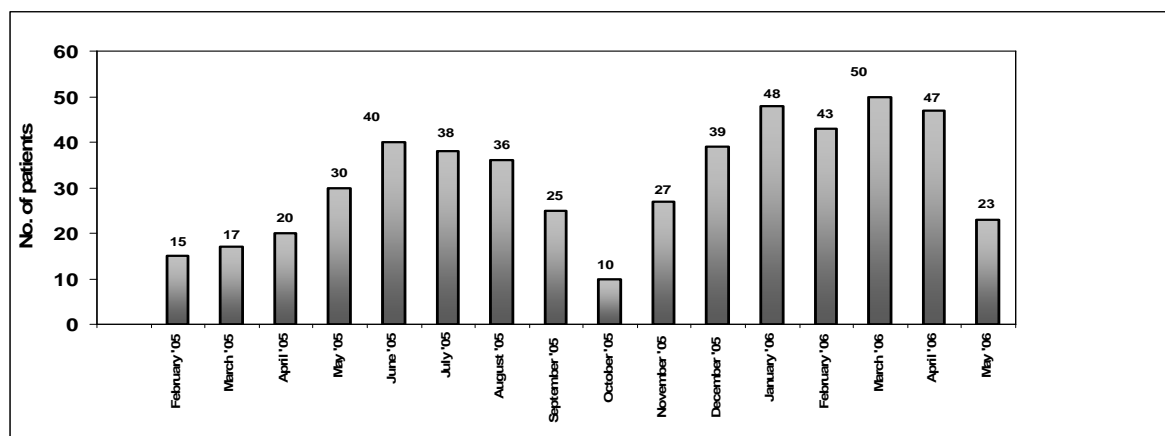
### Services Provided

#### Out Patient Services

Out of a catchment of 2500 children for each clinic the average attendance each day ranges from 1 to 2% for each clinic i.e. 20-25 patients access the clinic each day, this may go up to 50 children during the monsoons. In the first year of operation, some 67,000 children have been examined at OP clinics.

#### Admission in the Base Clinic

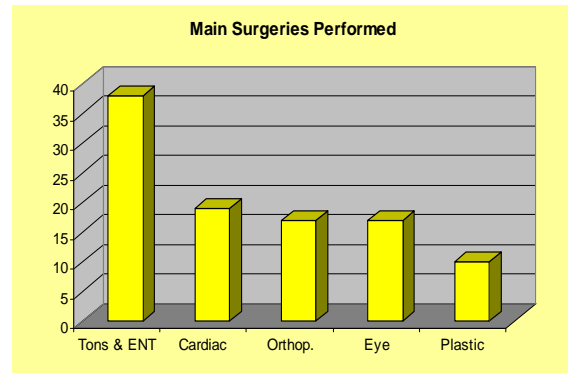
In the first year of operation, 344 children were admitted in the base hospital for a total duration of 2.231 days (average stay: 6.7 days). The following figure provides a better illustration of the in-patient care utilization profile, which may be seen to be increasing slightly over time.



## Surgeries Performed

Over the same period, the scheme could cover a total of 113 surgical interventions with most of these falling into the following five main categories:

	N°	% Total	Cum.%
1 Tonsillitis & ENT	38	33.6	33.6
2 Cardiac	19	16.8	50.4
3 Orthopaedic	17	15.0	65.4
4 Eye	17	15.0	80.4
5 Plastic surgery	10	8.8	89.2



## Administration Costs

The overall cost (health services + administration) of running the programme has come to Rs 9.8 per child per month in the first year of operation, thus justifying the premium level set at Rs 10 per child per month. So far, administration costs have been kept at a level of about 15% of the premium.

## CHALLENGES

The insurance plan has still to address the following key challenges:

- There is a need to strengthen the community buy-in for the programme. At present it is still largely the teachers and the Mandal coordinators who are responsible for making sure that the children access the outpatient clinics. Ensuring that all the 60,000 families who are impacted are aware of the full benefits is still to be achieved
- There is a need to set up a strong information system in order to track the progress of the children under this programme and analyze all trends
- On reaching 14 years of age the children are not covered any more under the Hyderabad model
- Although on-going discussions show some progress, the Government of Andhra Pradesh is still not providing any co-contribution to ensure the health of the state's schoolchildren

## THE LINKAGE EXPERIENCE

Developing efficient partnership arrangements is already seen as a key element for the successful implementation of any health insurance scheme. Evidence also suggests that building efficient linkages between community-based initiatives and government programmes in order to exploit their respective strengths is another major requirement. This necessary synergy may be developed at various levels.

Scope of Linkages	
Financing:	😊
Operations:	😊
Service Delivery:	😊
Governance:	No
Policy Planning:	😊
Legal framework:	No

The Naandi scheme was the first to develop a linkage experience with the corporate sector. It played a truly pioneering role in exploring the various ways in which the private sector could contribute to the health care of poor young children. Through efficient partnership arrangements, it succeeded in reducing the cost to a minimal level which allowed it to provide a unique comprehensive and all-inclusive package of health care benefits with even wider ramifications in terms of health behavior of poor families as well as in school attendance and overall improvement in children education.

## 1. Financing

The scheme designed a successful long-term arrangement, under which a regular financing could be mobilized from the corporate sector. The present cost of Rs 10 per child per month however, does not reflect additional administration costs which in this case, were borne by Naandi Foundation through the direct involvement of its staff. According to Naandi's estimates, a similar programme could be run anywhere in the country for a minimum of 40,000 children within a radius of 25 km, with an escalation in unit cost not beyond Rs 15 per child per month (Rs 180 per year).

## 2. Operations

The scheme benefits from the active support provided at all levels by the Ministry of Education. A major outcome of this partnership was that the image of the government school has already changed into one of an institution that fulfils the basic needs of children – education, nutrition and health. In addition, the positive feedback from parents, has resulted in a wide ripple effect on the whole community, taking the enrolment in the new academic year to an all-time high.

## 3. Service Delivery

From the outset, Naandi Foundation has advocated that health is a fundamental right of children. This stand proved to be highly successful in the development of long-term partnership arrangements with various private sector health facilities as well as with renowned specialists who came forth at an individual level to contribute their services. These multiple partnerships resulted in a significant decrease in the costs of the insurance scheme.

## 4. Governance

The scheme still has to evolve into a closer partnership with the Ministry of Health and Family Welfare in order to plan, organize and develop together a far wider intervention.

## 5. Policy Planning

The Government of Andhra Pradesh is examining plans allowing for Naandi to extend its wings to cover all schools in various locations of the state – a mix of urban, rural and tribal districts – reaching out to 300,000 children. Building on this model of delivering free healthcare to children, the government of Andhra Pradesh is now devising a state-wide strategy for ensuring healthy school-going children.

Impressed by this effective method of healthcare delivery to children, the government of Rajasthan invited Naandi to implement the programme in various cities. In early 2007, the state government first partnered with Naandi to cover 44,000 government school children in Udaipur. A second intervention the same year reached 75,000 children in Jodhpur with plans to cover the entire state eventually.

### The Udaipur Scheme

The programme targets children between LKG – 12<sup>th</sup> Standard (3 to 18 years) enlisted in public schools (total of 222) with a significant percentage of tribal population. The Government of Rajasthan allocated a wing of a public facility to serve as base hospital and contributes 50% of the costs of the insurance plan, whose premium was set at Rs 182.5 per child per year. The public-private partnership model has been similarly extended to referral institutions which provide subsidised high quality multi-speciality health care and to the corporate sector whose staff contribute to the premium to be paid for each child. In June 2007, the scheme already covered 44,000 children and had registered the following achievements over a two-month period:

- At the school level:
  - Total of 8,860 children accessed general OP services
  - Total of 776 children accessed eye OP services
  - Total of 609 children accessed dental OP services;
- At the base hospital level: 1,256 cases of OP services and 32 hospital admissions
- Total of 3 referrals to speciality hospitals

The Government of Madhya Pradesh has invited Naandi Foundation to start the School Health Programme in 2 tribal districts of the state with a commitment of sharing half the costs. A partnership with the Government of West Bengal is being finalized at the moment to cover all school children in the city of Kolkata- roughly 250,000 children, in a phased manner. An intervention in Jharkhand is also being prepared through preliminary contacts with the Ministry of Health & Family Welfare Society and Jharkhand Health Society.

## 6. Legal Framework

Being a self-funded scheme, without any tie-up with an insurance company, the Naandi school health programme remains out of the purview of the micro-insurance regulations issued in November 2005 by the Insurance Regulatory and Development Agency (IRDA) of India.

## CONCLUSION

The Naandi school health programme is the only social security net for disadvantaged children in the entire country that provides a comprehensive health care benefit package including diagnosis, out-patient care, in-patient care, surgeries, medicines, etc. all covered at a very minimal cost per child per day under the scheme. No other insurance programme – in terms of costs or coverage – has matched this scheme so far. All other health insurance schemes operating in India still provide a very sketchy coverage of diseases, focusing on hospitalization costs only while applying harsh limitations on the types of health services as well as various disqualification criteria. As such, it already has the potential to be replicated in many other urban and semi-urban settings all across India.



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