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NOTIFICATION

No. B. 16011/18/10-HFW, the 3rd December, 2013. Mizoram State Health Care Scheme under Asian Development Funding has been implemented in Mizoram for the forth policy year. As such Evaluation of the Scheme was conducted by the Mizoram University (MZU) in 2013.

The Evaluation Report of the Scheme as conducted by Mizoram University (MZU) in 2013 as Annexed is hereby published for information of all concerned.

Esther Lal Ruatkimi,
Secretary to the Govt. of Mizoram,
Health & Family Welfare Department.

Chapter – 1

PREAMBLE

1.1.Introduction

The level of access to health care by the population is one of the most important indicators of human development. Large portion of the population in the poor countries are deprived of institutional health care because of acute poverty. As these people have to pay from their own pocket for their health expenditure, they remained shied away from entering into proper health care, institutional or non-institutional, and thereby, rate of hospitalization is very low even for critical illnesses. According to the report of Public Health Foundation of India (PHFI-2011)[i], most of the low- and middle income economies till recently have relied heavily on Out-Of-Pocket (OOP) payments of households, which are regarded as both inefficient and iniquitous. As a consequence, OOP causes financial catastrophe and impoverishment of vulnerable households. Because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it (Devadasan, et. al., 2004)[ii]. Moreover, the major problems faced by workers in the unorganized sector, who constitute about 93 percent of the total workforce in India, is the frequent incidence of illnesses and the need for medical care and hospitalization of such workers and their family members. Since these workers do not have any kind of social security, they have to depend on their savings or take loans for treatment. Studies have shown that often the health care related expenditure push families below poverty line (giz, 2012)[iii]. On an average, the poorest quintile of Indians is 2.6 times more likely than the richest to forgo medical treatment when ill and an estimated one quarter of all Indians fall into poverty as a direct result of medical expenses in the event of hospitalization (Peters, et. al., 2002)[iv]. Against this backdrop, one should consider health care financing as not only a welfare measure, but also poverty alleviation in developing countries like India.

The role and relevance of tax or social health based intervention has come to occupy central stage in recent years in several countries that are undertaking measures to reform health system. A tax-based health financing mechanism, as in UK, Cuba and Sri Lanka or a broad based social health insurance programmes as in Germany,

France, Mexico, etc. is being prescribed as a key instrument of health financing strategy for many low income countries like India, if it were to achieve universal health coverage. Thus, community health insurance (CHI) has emerged as a possible means of improving access to health care among the poor; and protecting the poor from indebtedness and impoverishment resulting from medical expenditures. In India, there has been a visible shift in government thinking on health care from provision of health care facilities to health care finance in the last few years. This change is reflected in the growing inclination of both Central Government and many State Governments, towards using health care scheme as a means of improving access to health care delivery for large vulnerable sections of the population (Gupta, et. al, 1992)[v]. A number of national level and State specific health insurance schemes have come up consequently.

Meanwhile, according to Ahuja (2004)[vi], health care financing in India can be considered almost unique in several aspects. One, the share of public financing in total health care financing in the country is considerably low – just around 1 percent of GDP compared to the average share of 2.8 percent in low and middle income countries relative to India's share in disease burden. Two, the beneficiaries of this limited public health financing are not only the poor as one would expect in the case of limited public spending, but also the well-off section of the society. Third, over 80 percent of the total health financing is private financing, most of which takes the form of out of pocket payments and not pre-payment schemes. One of the important challenges facing the Indian health policy is how to convert predominantly private out of pocket spending into health insurance premium where this amount is collected from much larger group of insured individuals rather than from the limited number of households affected by illness.

It was earlier believed that universal health care coverage through social health insurance could be achieved only when economies have reached a critical level of income (higher-middle income or advanced economy status). The basis for such reasoning is grounded in the argument that scarce resources required for competing needs may limit countries from allocating a higher proportion of its GDP to health sector. However, recent experience among middle-income countries (such as, S. Korea, Mexico, Brazil, etc.) and even in lower-middle income economies (such as,

Thailand) demonstrates that Political Will is one of the key determinants of achieving universal coverage even among the low– and middle–income economies. At the same time, one should not overlook the hindrance to achieving universal health insurance as illustrated in recent experience of China. Wagstaff & Lindelow (2008)[vii] reports that insurance appears to encourage people to seek more care from the expensive tertiary care providers, sidetracking primary care providers in the process. Further, it is also confirmed by Wagstaff, et. al (2009)[viii], who show that both outpatient and inpatient expenses of the households seems to have gone up considerably post-insurance.

Another policy challenges for the implementation of community health insurance is the rise of *moral hazard*. Moral hazard refers to the additional health care availed by families after being insured, or in other words, changes in the behaviour of the patient or the providers because of insurance coverage. Studies also observed that in case of publicly funded insurance schemes where the third party payment is made to a private provider, moral hazard appears to be loaded heavily in favour of private providers. Further, community health insurance schemes are subject to inherent problems of information *asymmetry* or *adverse selection* on account of lack of inbuilt mechanism for Management Information System (MIS) resulting in the failure of the scheme to deliver its objectives of health care delivery to the poor. Keeping in view all these aspects of its implementation, having an assessment study is very crucial for any community health care insurance scheme.

1.2.Health Care Insurance in India: Overview

In India the programme for health insurance dates back to the late 1940s and early 1950s when the civil servants (Central Government Health Scheme-CGHS) and formal sector workers (Employees' State Insurance Scheme-ESIS) were enrolled in a contributory but heavily subsidised health insurance programmes. However, these programmes, especially the former were confined to only a small segment of the society. After over half a century of experience, CGHS (3 million) and ESIS (55.5 million) put together currently cover an estimated 58.5 million beneficiaries, roughly about 5 percent of India's population. However, as part of liberalisation of the economy since the early 1990s, the government opened up the insurance sector (including health insurance) to private sector participation in the year 1999 with the

passing of the Insurance Regulatory and Development Authority (IRDA) by the Parliament. This development had thrown open the possibility for higher income groups to access quality care from private tertiary care facilities.

During the last five years (since 2007) India has witnessed a plethora of new initiatives, both by the central government and a host of state governments entered the bandwagon of health insurance. One of the reasons for initiating such programmes can be traced to the commitment that the governments in India have made to scale up public spending in health care. Given the commitment to upscale government expenditure on health (central and state governments put together) from the present 1 percent to 2-3 percent of GDP, the central and state governments were devising designs to spend the additional resources through innovative schemes. Among others, these include enhanced access and availability of essential health care services, protecting households from financial risk through schemes such as, National Rural Health Mission (NRHM), and Rashtriya Swasthya Bima Yojana (RSBY). In addition to these central health programmes, several states have undertaken state specific health care insurance scheme. Table 1.1 presents the list of well known Health Insurance Schemes in India.

Table 1.1: Scheme-Wise Insurance Coverage

Scheme	Level	Unit of Enrolment	No. of Families (Million)	No. of Beneficiaries (Million)
CGHS	National	Family	0.87	3.0
ESIS	National	Family	14.3	55.4
RSBY	National	Family	22.7	79.45
Rajiv Aarogyasri Scheme	Andhra Pradesh	Family	22.4	70
Vajapayee Arogyasri Scheme	Karnataka	Family	0.95	1.4
Yeshasvini	Karnataka	Individual	NA	3
Total				247

Source: Public Health Foundation of India, *Critical Assessment of the Existing Health Insurance Models in India,* 2011.

1.3.Evolution of Health Care Scheme in Mizoram

The government of Mizoram has implemented Health Insurance cover to its population, excepting government servants and their dependents, under Mizoram State Health Care Scheme (MSHCS) since April 2008. The objective of the Scheme is

to improve access of families to quality medical care for treatment of diseases involving hospitalization and surgery through an identified network of Health Care Providers. All eligible family members are covered under this scheme. For its implementation and monitoring, a society named Mizoram State Health Care Society was formed and the Chief Minister was the Chairman of the Governing Board. Initially the scheme was implemented using insurance providers, Reliance General Insurance Company Limited (RGICL), and by 2011-12, the scheme has been implemented on Self Finance Basis by the Society.

Meanwhile, Rashtriya Swasthya Bima Yojana (RSBY), a BPL scheme for unorganized sector under the Ministry of Labour & Employment, implemented all over the country was linked with MSHCS from 2010. Under the two schemes, a BPL family can avail the usual RSBY cover of Rs. 30000 and an additional cover of Rs. 70,000/- from MSHCS for hospitalized illness and another cover of Rs. 2 lakhs under MSHCS for critical illness, thereby making the total cover up to Rs. 3 lakhs. Moreover, APL families could avail critical illness cover only up to Rs. 3 lakhs under MSCHS by paying a required amount of premium. Meanwhile, the benefit of RSBY is being extended to all Job Card holders of Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) since January 2013 and hence, there are three categories of beneficiaries of Mizoram State Health Care Scheme with certain provision of convergence between them. They are (i) RSBY BPL Smart Card Holder, (ii) MNREGA Job Card Holder and Street Vendor, and (iii) APL.

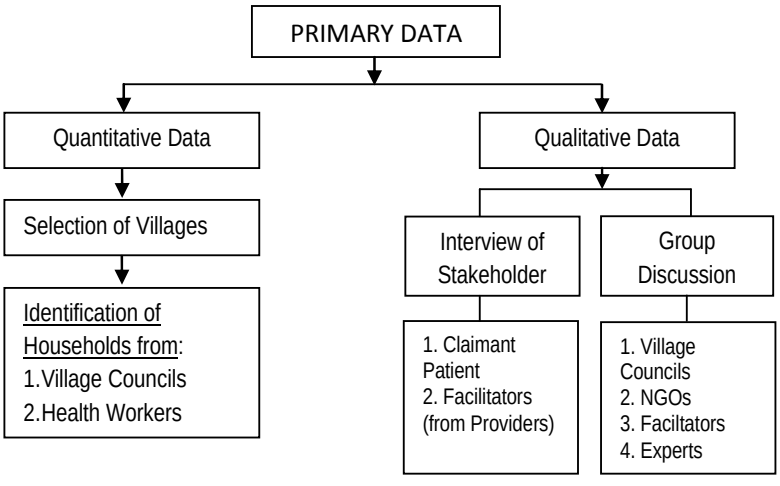
1.4.Objectives of the Study

The central objective of this study is to analyse the various aspects of the implementation of Mizoram Health Care Scheme. Focus was given on the analysis of the problems faced by the beneficiaries as well as service providers, beneficiary's satisfaction and the challenges ahead. As per the terms of reference of our engagement, the reference period for this assessment study is 2013 (i.e. January to August 2013).

1.5.Methodology

The present study is basically ex post facto in design and cross sectional in nature. It is mainly based on the primary data collected through quantitative and qualitative methods. Quantitative data are collected by sample survey of households using interview schedule. Purposively, three districts, namely Aizawl, Lunglei and Saiha were selected, and a multi-stage sampling procedure was adopted on which localities formed the first stage unit and households or families being the second and final stage sampling unit (FSU). Firstly, selection of villages was made sector-wise (rural or urban) i.e. stratification by sector. Secondly, selection of beneficiary households was made by making sub-stratification on the basis of enrolled and non-enrolled families. The lists of all households in the selected villages/localities were obtained from the concerned village councils, while the enrolment lists were obtained from the Health Worker concerned and accordingly, we differentiated enrolled and non-enrolled households. These two sets of household lists (enrolled and non-enrolled) had constituted the sampling frame, and hence, simple random sampling was applied to each of these cases. As far as possible, attempt were made to include claimant beneficiaries in the sample. Justification for making such sub-stratification is to ensure representativeness in the sampling process.

Fig. 1. Data Collection Process



Qualitative data are collected mainly by interview method and focus group discussion. Interviews were conducted among the following groups of persons: patient who have availed the facilities of the scheme, dealing persons (clerk) in the service provider hospitals and knowledgeable persons. At the same time, information had also been collected by conducting discussion with leaders of NGOs, medical personnel, facilitators of health care scheme and village level authorities. Points raised and discussed in the interviews and discussions were recorded. These were further screened and the pertinent information are included in the report.

The survey covered 679 households from rural (410) and urban (269) areas of Mizoram. Out of these households, 582 are enrolled families while the remaining 97 are non-enrolled families under the Health Care Scheme. In the same way, 174 households (83-hospitalized patients and 91-non hospitalized patients) represent beneficiaries who have experienced illness during the reference period (i.e. since January 2013 till August 2013). District wise details of samples are given in Table 1.2.

Table 1.2: No. of households covered in the Survey

District	Rural	Urban	Total
Aizawl	305	141	446
Lunglei	60	62	122
Saiha	45	66	111
Total	410	269	679

It was found during the study that some beneficiaries- BPL and MNREGA Card holder- of RSBY have also enrolled themselves in the MSHCS. In such cases, it is very difficult to differentiate between RSBY and MSHCS beneficiaries because the two are operating side by side on top up basis. That is, BPL families can also enjoy MSHCS facility for critical illness without paying premium. However, as far as possible, attempt was made in the study to evaluate the cases of MSHCS only. Thus, most of our analysis will reflect the cases of MSHCS, rather than RSBY. Scheme-wise enrolment details of the sample households are presented in Table 1.3.

Table 1.3: Status of Enrolment among the sample households in Mizoram

Types of Enrolment	Enrolment Status			Enrolment Status (%)		
	RSBY	MSHCS	Total	RSBY	MSHCS	Total
RSBY BPL Smart Card	109	7	116	93.97	6.03	100
RSBY MNREGA	205	1	206	99.51	0.49	100
APL	4	256	260	1.54	98.46	100
Total	318	264	582	54.64	45.36	100

To supplement the information obtained from the sample survey, secondary data were collected from the implementing agency (Mizoram State Health Care Society). The information collected from the MSHCS includes details of claims received, accepted and deducted amounts, profiles of the patients, duration of illness, time taken for settlement of claims, nature of treatments, illness and average bills case wise. As far as possible, the enrolment status and financial position of the scheme had also been collected from the Society.

1.6. Field Data Collection: Period & Limitations

Due to severe time constraint, all out efforts were made to complete the whole exercise of field works as soon as possible. The evaluation exercise could be completed within 1 month and 20 days. It is unfortunate to mention here that we were not given enough time to perform comprehensive analysis of field data, and hence, its ramification upon the quality of the report is feared. However, readers are requested to bear in mind that the team had shown its best to ensure unbiasedness and quality in every step of the evaluation process. Table 1.4 presents the periodic flow of the evaluation study.

Table 1.4: Flow Chart of Evaluation Activities (w.e.f. 1st August 2013)

Sl. No	Activities	Day 1	Day 2 - 10	Day 11 - 26	Day 27 - 38	Day 39 - 47	Day 48 – 51
1	Signing of Agreement						
2	Training of Field Officers						
3	Field Test of Schedules						
4	Collection of Secondary data & Case Studies						
5	Aizawl District (primary data collection)						
6	Saiha District (primary data collection)						
7	Lunglei District (primary data collection)						
8	Data Processing & Report Writing						

1.7.The Study Area

The three districts selected for this study were Aizawl, Lunglei and Saiha. Aizawl district has constituted 71.21 percent of the total enrolment (i.e. 8030 families) during the current year, while Lunglei and Saiha districts contributed 8.2 percent and 7.96 percent respectively. Thus, the three selected districts constituted 87.37 percent of the total enrolment. To enable us to have an overview of the population characters in these districts, in comparison to other districts, the data of Population Census 2011 has been presented in Table 1.5. It could be observed from this table that the three selected districts constitute 56 percent and 56.86 percent of the total population and number of households respectively.

Table 1.5: Basic Population Indicators of Mizoram 2011

District	No. of Households	Persons			Sex Ratio	Density/ Sq.km	Literacy (%)
		Male	Female	Total			
Mamit	17731	44567	41190	85757	924	28	81.37
Kolasib	17270	42456	40598	83054	956	60	93.53
Aizawl	82524	201072	202982	404054	1009	113	98.00
Champhai	25520	63299	62071	125370	981	39	92.20
Serchhip	12622	32824	32051	64875	976	46	98.28
Lunglei	33058	79252	74842	154094	944	34	85.85
Lawngtlai	22984	60379	57065	117444	945	46	57.62
Saiha	11144	28490	27876	56366	978	40	85.80
Mizoram	222853	552339	538675	1091014	975	52	89.40

Source: Population Census, 2011 (Provisional Report) & Primary Census Abstract, 2011, Directorate of Census Operation, Mizoram

1.8.Structure of the Report

This chapter provides a brief outline of the role and relevance of health care schemes and its implications. The broad objectives along with the data sources and methods of data collection have also been presented in this chapter. In Chapter-2, we give a brief outline of health care schemes in Mizoram. Chapter-3 presents the review of Mizoram State Health Care Scheme during the study period (January to August 2013). Chapter-4 presents basic profiles of the sampled health care beneficiaries and analysis has also been made on the health care seeking behaviour, risk behaviour and communication habits. Chapter-5 presents the analysis of the perceptions of the beneficiaries on the scheme. The brief report of case studies of hospitals and patients are presented in Chapter-6. Finally, Chapter 7 summarizes the observations and recommendations.

End Notes

[i] Public Health Foundation of India (2011), *A Critical Assessment of the Existing Health Insurance Models in India*.

[ii] Devadasan, N. Ranson K, Damme WV, Acharrya A, Criel B (2006), 'The landscape of Community Health Insurance in India: An overview based on 10 Case Studies', *Health Policy 78,* 224-234

[iii] Gitz (2012), *Evaluation of Implementation Process of Rashtriya Swasthya Bima Yojana in Select District of Bihar, Uttarakhand and Karnataka.*

[iv] Peters, DH, AS Yazbeck et al (2002), *Better Health System for India's Poor: Findings, Analysis and Options,* The World Bank, Washington DC.

[v] Gupta, et. al (1992), *Financing of Health Care in Non-State Sector in India,* National Institute of Health and Family Welfare, Department of Planning and Evaluation, New Delhi.

[vi] Rajeev Ahuja (2004), 'Health Insurance for the Poor', *Economic and Political Weekly,* July 10.

[vii] Wagstaff A and Lindelow M (2008), 'Can insurance increase financial risk? The curious case of health insurance in China', *Journal of Health Economics 27, 990-1005.*

[viii] Wagstaff A, Lindelow M, June G, Ling X, Juncheng Q (2009), 'Extending health insurance to the rural population: an impact evaluation of China's new cooperative medical scheme' *Journal of Health Economics, 28, 1-19.*

Chapter – 2

OVERVIEW OF HEALTH CARE SCHEMES IN MIZORAM

2.1.Introduction

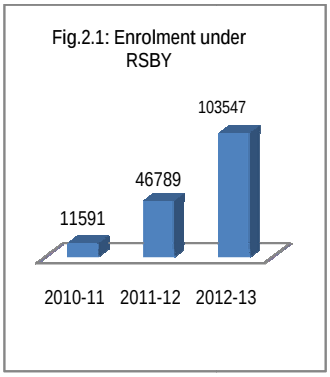
The Government of Mizoram is committed to providing health insurance cover to its population and had implemented for all its population, except government servants and their dependants, a Health Insurance Scheme called the Mizoram State Health Care Scheme (MSHCS) since April 2008. To oversee and implement directly or indirectly the implementation of the scheme, a registered society named Mizoram State Health Care Society was formed with the Chief Minister as the Chairman of the Governing Body. Initially, the scheme was implemented for a period of one year starting from 1st April 2008 through an insurance company. An agreement was signed between the Government of Mizoram and Reliance General Insurance Company Limited (RGICL). A network of both public and private hospitals recognized and approved by the State Government in and outside Mizoram was created to provide cashless treatments to the beneficiaries. Any person who is a bonafide citizen of India and residing in Mizoram, with the head of his/her family being in the voters list, is eligible to be covered under the scheme, irrespective of age. It covered expenditure towards hospitalization and surgical procedures up to a maximum of Rs.1 lakh per family per annum on floater basis.

The premium was heavily subsidised by the State Government and the required amount was made from the State Plan fund. While the premium payable per family was Rs.100 for Below Poverty Line (BPL) families and Rs.200 for Above Poverty Line (APL) families, the actual premium payable to the Insurance Company (RGICL) was Rs.1929 per family. As the original target of the scheme was 1.5 lakh families, a sum of Rs.28.93 Crores was paid to the Insurance Company as premium for a period of one year with effect from 1st April 2008. Since 2010, Rashtriya Swasthya Bima Yojana (RSBY), a BPL scheme for the unorganized sector under Ministry of Labour, was implemented across the country by the Central Government, and the scheme was also linked with Mizoram Health Care Scheme on top up basis. Both the schemes were initially implemented with an Insurance provider; but from

2011 the Mizoram State Health Care Scheme has been implemented on Self Finance Basis by the Society. In an attempt to increase the breadth of health care coverage, the RSBY facility was extended to all Job Card holders of Mahatma Gandhi Rural Employment Guarantee Act (MNREGA) from the fiscal year of 2013-14 and hence, it is expected that about 1.5 lakhs Job Card holders (families) in rural areas would be covered by the benefits of health care insurance in the near future.

2.2.Enrolment Status

Needless to say, the Mizoram State Health Care Society has been the sole agency for any government sponsored health care scheme in Mizoram right from its inception in 2008. Hence, it has to implement the centrally sponsored health care scheme in addition to its own health scheme. To have a better understanding of the role of this Society in providing health care insurance in the State, one should also consider its performance in case of RSBY scheme, which goes side by side with MSHCS. An attempt is made here to examine the status of the state in implementing RSBY and MSHCS. Due to our inability to get detailed information pertaining to the first year of health care implementation (i.e. 2008-09), we have presented data from the year 2010-11 only. Moreover, the policy periods are not comparable to the fiscal year. The first year (2010-11) covers September 2010 to August 2011, the second year (2011-12) covers September 2011 to December 2012 and the third year (2013-14) covers the period of January 2013 to March 2014.



It would be observed from Table 2.1 that the actual enrolment under RSBY scheme has seen significant increase each year since its implementation in Mizoram. It has increased from 11591 families in 2010-11 to 46789 in 2011-12 and 103547 in 2013-14. However, the annual enrolments for this scheme were well below the target that the achievement rates were only 17.19 percent in 2010-11, 63.59 percent in 2012-13 and 43.09 percent in 2013-14. An examination of the district wise absolute enrolment rate reveals that the scheme did not cover the

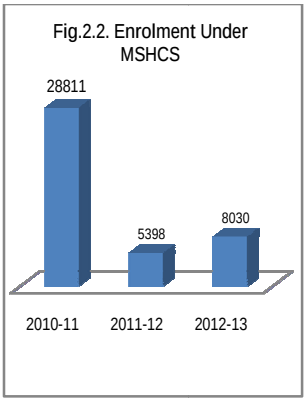
whole state in the first year as there was no enrolment in Kolasib, Serchhip and Saiha districts. However, the entire state was covered from the second year and the achievement rates ranged from 44.84 percent in Lawngtlai district to 71.65 percent in Kolasib district; and during 2013-14, Aizawl district has the highest achievement rate, while Mamit district recorded the lowest achievement rate.

Table 2.1. Enrolment Status under RSBY Scheme

District	2010-11 Sept,2010 – Aug.,2011			2011-12 Sept.2011– Dec., 2012			2013-14 Jan., 2013 – Mar.2014		
	Target	Actual	Achievement (%)	Target	Actual	Achievement (%)	Target	Actual	Achievement (%)
Mamit	6502	1026	15.78	7172	3920	54.66	20368	7784	38.22
Kolasib	6511	-	-	6511	4665	71.65	23286	10990	47.20
Aizawl	19076	7828	41.04	22830	15840	69.38	50179	23973	47.77
Champhai	8972	1159	12.92	9061	6343	70.00	38846	16407	42.24
Serchhip	3068	-	-	3068	2360	76.92	18744	7337	39.14
Lunglei	10259	1125	10.97	11354	7269	64.02	45388	17963	39.58
Lawngtlai	7910	453	5.73	8184	3670	44.84	22733	9244	40.66
Saiha	5120	-	-	5433	2722	50.10	20748	9849	47.47
MIZORAM	67418	11591	17.19	73577	46789	63.59	240292	103547	43.09

Source: Mizoram State Health Care Society, dated 30.8.2013

The enrolment status of Mizoram State Health Care Scheme (MSHCS) has been presented in Table 2.2. The total enrolment at the beginning, i.e. 2010-11, was 28811 which was drastically reduced to 5398 during the next year and as on 30th August 2013, the total enrolment stood at 8030. It may be recalled that the scheme was implemented through Insurance Company till 2011, but there were lots of criticism charged against these insurance companies over delayed payment of bills and rejections of medical re-imbursements for petty reasons. As per the record of Mizoram Economic Survey 2012-13, during 2010-11, rejected and pending bills had



constituted, respectively, 4.7 percent and 21.5 percent of the total claims received, which together constituted more than 35 percent of the total claim amount. The magnitude was big enough to lose public confidence for the implementing agencies and the scheme itself, and hence, enrolment had drastically decreased in the next year. However, the enrolment has increased afterward, probably in response to the running of the scheme by the Society on self-finance basis. This reflects the building up of public confidence on the scheme and consequently, enrolment is expected to increase in the coming years so long as the implementing Society gets public confidence.

Table 2.2. Enrolment Status under MSHCS

District	Sept, 2010 – Aug. 2011	Sept.2011 –Dec., 2012	Jan., 2013 – Mar., 2014
Mamit	655	148	240
Kolasib	3090	468	468
Aizawl	15018	3318	5718
Champhai	800	403	359
Serchhip	1410	187	286
Lunglei	3536	475	653
Lawngtlai	2772	336	67
Saiha	1530	63	239
MIZORAM	28811	5398	8030

Source: Mizoram State Health Care Society, dated 30.8.2013

2.3.Funding of Health Care Schemes in Mizoram

To start with, the State Government had given budgetary allocation for the implementation of Mizoram State Health Care Scheme to the tune of Rs.50 crores in 2008. Of this amount, a sum of Rs.28.93 crores was paid to the Reliance General Insurance Company (RGICL) as premium, for a period of one year, at the commencement of the scheme (i.e. 1st April 2008) along with 12.36 percent education cess. As agreed upon by the State Government and RGICL, the former was required to pay a premium of Rs.1929 (exclusive of service tax) per family to the latter. Roughly, the total premium paid at the beginning was a big sum sufficient for the targeted 1.5 lakh families, even after excluding the receipts as registration fees. At the same time, the total enrolment for the scheme turned out to be 80,182 families, which

was a little more than half of the target, showing the actual premium payment per family to be more than Rs.3600 resulting in huge loss for the Government.

As it was observed by Aloke Gupta (2008)[1], lump sum payment of premium at the commencement of the scheme was on a higher side when compared to some other large health insurance schemes. As against this, a review of the scheme on completion of the first quarter of its implementation showed that the claim frequency was very low at 1.6 percent of total enrolment with 4.66 percent of the paid premium. In addition, pending claims started piling up towards the later part of the scheme resulting in loss of confidence upon the RGICL by the beneficiaries as well as the facilitator resulting in a backlog between the insurance company and the government. Consequently, the scheme was discontinued with effect from 31.3.2009. After this, the scheme was relaunched with a new insurer from September 2010 and continued till August 2011. Finally, the scheme was revamped based on self-financing basis from 1st September 2011 and has been in operation since then.

With the approval of assistance from Asian Development Bank (ADB) under Mizoram Public Resource Management Programme (MPRMP), an amount of Rs.117.80 crores was released by Government of India during November-December 2009 for Health Insurance Corpus, and the same was drawn in the later part of March 2010. The amount was kept in the custody of the State Finance Department for investment and sustenance of the scheme. Keeping in view the long term sustainability of the scheme, the Finance Department decided to invest the amount and had invested in 4 financial institutions. At the same time, as the MSHCS was left with sufficient reserved fund from the preceding years that its balance as on 1.6.2011 was Rs.2.26 crores in addition to Rs.10 crores being invested on Bajaj Allianz (which matured in December 2011), the interest earned on corpus fund of Rs.117.80 crores was reinvested at the prevailing interest rates instead of allocating it to MSHCS. Including the interest earned from the corpus fund and the remaining amount of State's budgetary allocation for the scheme in the preceding years, the total corpus fund for MSHCS had finally turned out to be RS.149.60 crores. In other words, the total corpus fund over and above the approved amount of Rs.117.80 crores of ADB

[1] Aloke Gupta (2008), *Evaluation of Mizoram Health Care Scheme,* Health Insurance Consultant, New Delhi.

assistance can thus be taken as the State Government's contribution in augmenting the corpus fund for MSHCS. This is a commendable effort of the state government in implementing health care scheme in Mizoram.

The details of bank deposits of health corpus as on 3rd September 2013 is given in Table 2.3:

Table 2.3: Investment of Health Care Corpus Fund in 4 Financial Institutions

As on 3.9.2013

Sl. No	Financial Institutions	Amount (Rs. In lakhs)
1	Mizoram Rural Bank	6176.75
2	Mizoram Urban Co-operative Bank	500.00
3	Union Bank of India	629.60
4	Industrial Development Bank of India	7654.04
	Total	14960.39

Source: Finance Department, Govt. of Mizoram, 3rd September 2013

At the same time, the interest accrued to these deposits are allocated to the Mizoram State Health Care Society for meeting expenditure on settlements of claims and expenses on direction & administration of the scheme on quarterly basis. The year wise break up of interest earned on the deposit of Health Care corpus fund of Rs.149.603 crores is presented in Table 2.4.

Table 2.4: Interest Earned from the Deposit of Health Corpus Fund of Rs.149.603 crores

Year	2010-11	2011-12	2012-13	2013-14 (projected)
Amount (Rs. In lakhs)	735.76	1045.27	734.31	1354.67

Source: Finance Department, Govt. of Mizoram, 3rd September 2013

It would be observed that the projected interest amount for the current year (2013-14) is Rs.1354.67; and as against this the amount utilized for settlement of claims under the scheme as on 8.8.2013 was Rs.328.07 lakhs indicating that only 24.22 percent of the projected amounted have been spent during the first 7 months. Roughly, assuming the existing trend for the entire policy period (2013-14), the total

claim outgo by the end of this year would be around 41 percent of the total projected interest amount to be earned from the investment of health care corpus fund leaving considerable balance for the coming years. In summary, the existing strategy of corpus fund management by the State Finance Department (FMU) has significantly enhanced the fiscal sustainability of MSHCS and, at present, the total expenditure requirement for the implementation of the scheme is deemed within the resource limit of the State Finance.

Unlike MSHCS, the scheme of RSBY has been funded by the Central Government and the State Government has also been contributing its matching share from annual plan budget of Department of Medical and Health Education. Alongside the state matching share, there is considerable amount of beneficiary contribution towards the scheme. The annual budget for financing the scheme has been increasing by more than double every year since its inception. It has increased from Rs.54.52 lakhs in 2010-11 to Rs.455.4 lakhs in 2011-12 and Rs. 941.29 lakhs in 2013-14. With all MNREGA Job Card Holders being made eligible for this scheme since 2013-14, RSBY scheme has significantly penetrated the entire state, especially rural areas. At the same time, since all RSBY BPL families are kept under MSHCS purview for cases beyond the usual coverage of RSBY and with all other RSBY beneficiaries being admissible under MSHCS on top up basis, it is very difficult to have a clear idea on the level of penetration by the two schemes in rural and urban areas. The funding pattern of RSBY scheme, since its inception in Mizoram is presented in Table 2.5.

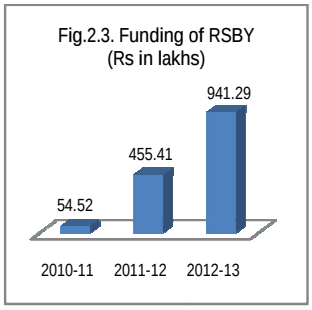


Table 2.5: Funding Pattern of RSBY Scheme in Mizoram

Rs in lakhs

Sl. No	Funding Source	2010-11	2011-12	2012-13
1	Central Share	49.23	412.68	700.48
2	State Share (DMHE Annual Plan)	1.71	28.70	209.75
3	Beneficiary Contribution@30/household	3.59	14.04	31.06
	Total	54.52	455.41	941.29

Source: Mizoram State Health Care Society, dated 30.8.2013

The funding corpus for RSBY received from the Central Government has increased from Rs. 49.23 lakhs in 2010-11 to Rs. 700.48 lakhs in 2012-13. A notable feature of the funding of RSBY scheme is the significant jump of the State Share from Rs. 1.71 in 2010-11 to Rs.209.75 lakhs in 2012-13 which is more than 100 times it was at the start of the scheme. This is remarkable taking into account the problems of small states like Mizoram, which usually have difficulty in making payment towards the State Matching Share for most of the Centrally Sponsored Schemes (CSS) implemented in their respective states. The existing trend may be taken to denote the growing effort of the State Government in providing health insurance as a means of improving access to health care delivery for the poor. Meanwhile, with the widening of its geographical coverage and the increasing enrolment, more funds will be required for meeting expenditure incurred in connection with administration and capacity development (training, etc). Moreover, a receipt from beneficiary contribution, primarily meant for administrative and capacity development expenses, have no doubt increased significantly; but is still very little to meet all these requirements. Thus, if goes on like this, the funding corpuses obtained from Central Share and State Share have to be utilized for administrative expenses giving warnings on the long term sustainability of the scheme.

2.4.Status of Claims & Settlements

Table 2.6 presents the status of claims under MSHCS and RSBY during 2010-11 and 2011-12. During 2010-11, MSHCS received 8494 medical reimbursement claims and out of this 8092 (95.26%) were accepted; while 6266 claims were paid and the remaining 1826 were pending. The average size of claims turned out to be Rs.12408 per patient. The accepted claim amount was Rs.868.52 lakhs of which Rs.186.58 lakhs were kept as pending bills. At the same time, there were only 966 claims under RSBY scheme. Out of this, 931 claims (96.38%) were accepted amounting to Rs.46.08 lakhs only with Rs.5195 being the average claim size. In line with the declining enrolment, claims received by MSHCS reduced to 4205 in 2011-12, less than half as it was in the previous year and 3843 (91.39 percent) claims were accepted amounting to Rs.770.29 lakhs with average claim size of Rs.19489 per

patient. Meanwhile, number of claims in case of RSBY has increased from 966 to 9073 and of these 7222 (79.6%) claims were accepted; while the total accepted amount was Rs.477.17 lakhs (85.6%) with average claim size of Rs.6145.

Claims frequency, number of claims received as percentage of total enrolment, were 29.48 and 8.33 for MSHCS and RSBY respectively during 2010-11 which was increased respectively to 77.89 and 19.39 during 2011-12. In a nutshell, the average claim sizes under RSBY were significantly lower than its counterparts MSHCS during the period under study; however, there is a mixed result in respect of average deduction rate of claims.

Table 2.6: Status of Claims Received by MSHCS - RSBY & MSHCS

Particulars	2010-11 (Sept.'10 -Aug.'11)				2011 - 12 (Sept.'11 - Dec.'12)			
	MSHCS		RSBY		MSHCS		RSBY	
	Claims (no)	Amount (Rs in lakhs)	Claims (no)	Amount (Rs in lakhs)	Claims (no)	Amount (Rs in lakhs)	Claims (no)	Amount (Rs in lakhs)
MR Bills Received	8494	1053.97	966	50.18	4205	819.5	9073	557.51
MR Bills Accepted	8092	868.52	931	46.08	3843	770.29	7222	477.17
Bills Paid	6266	681.93	784	38.31	3797	597.5	6525	436.88
Bills Rejected	402	185.45	35	7.49	362	49.21	1851	80.33
Bills Pending	1826	186.58	147	7.77	46	172.78	697	40.29
Average Claims Size (Rs)	-	12408	-	5195	-	19489	-	6145
Claims Frequency	29.48	-	8.33	-	77.89	-	19.39	-

Claims Frequency - Number of claims received as a percentage of total enrolment

Source: i) Economic Survey, Mizoram, 2012-13; ii) MSHCS dated 8.8.2013

2.5.Concluding Remarks

There has been a growing effort of the State Government to provide health care facility to all its citizens, especially to those who are not entitled under medical attendance rules of government or other bodies. This is reflected in the State's ability to raise its matching share contributions towards the significantly increasing budget of RSBY since 2010 alongside its task of implementing MSHCS which runs on almost 90 percent premium subsidy by the State Finance. In fact, it is a commendable

achievement of the State Government considering its limited financial resources. Moreover, a quick overview of the funding of MSHCS has revealed the success of the State's Finance Department in the management of health care corpus fund obtained from ADB's Assistance. This is indicated by the significant amount earned as interest from the investment of that corpus fund. Meanwhile, enhancement of administrative capability of the implementing agency would be of crucial importance considering the growing enrolment under RSBY scheme and the eligibility of these beneficiaries under the MSHCS for critical illnesses.

Chapter – 3

REVIEW OF MIZORAM STATE HEALTH CARE SCHEME, 2013

3.1. Salient Features

3.1.1. Objective- The objective of the Scheme is to improve access of families to quality medical care for treatment of diseases involving hospitalization and surgery through an identified network of Health Care Providers. Each family shall cover all eligible family members under this Scheme.

3.1.2. Eligibility- Any non- Government Servant (Central or State) or their dependents who is a bonafide citizen of India and residing in Mizoram, with the Head of the Family thereby being in the Voters list or the Head of the Family having Voter ID Card are eligible under this Scheme, irrespective of age. The Scheme also covers dependents of Government Servants (Central or State), who are not covered under the existing Medical Attendance Rules such as Grandchild, daughter/son-in-law, overage children, sister/brother, uncle/aunty, niece/nephew, etc. The Scheme also cover contract workers, muster roll, etc who are not entitled to medical reimbursement under the existing rule. However, the Scheme does not cover persons and their dependents working under church organizations who are eligible for claiming their medical reimbursements from their respective church organization. As the health care facilities under RSBY scheme are extended to all MNREGA Job Card holders, MSHCS has now been merged with RSBY and those who are eligible for RSBY have to pay additional premium if they want to enrol themselves in the State Health Care Scheme. Thus, there are three broad categories of enrolments: (1) RSBY BPL Smart Card, (2) RSBY APL (MNREGA Job Card Holder & Street Vendor), and (3) APL.

3.1.3. Premium & Coverage- The scheme covers hospitalization within the State of Mizoram both in public or private hospital for critical illness. Treatment outside Mizoram is also covered subject to the family floater limit. The coverage period

is one year, from January 2013 to March 2014. Premiums and coverage for the three above mentioned categories are as follows:

1. RSBY BPL families do not need to pay premium except registration fee of Rs.30, but the facility is limited to 5 members only. The Scheme provides coverage for meeting expenses of hospitalization and surgical procedures up to Rs.70000 per family per year subject to limits, in any of the network hospitals, after having exhausted RSBY cashless cover of Rs.30000. The expenses over and above RSBY cashless cover should be on reimbursement and the cover is on family floater basis for only critical illness.

2. RSBY APL families do not need to pay premium, except registration fee of Rs.30, if they are supposed to avail only RSBY cashless facility of Rs.30000. Unlike RSBY BPL, they have to pay a premium as mentioned below to avail medical reimbursement facility for the medical expenditure, on critical illness only, which is over and above RSBY cashless cover.

Sum Assured	Premium per family up to 5 members	Additional Premium for families above 5 members (Per Additional Member)
Rs.70,000	Rs. 500/-	Rs. 100
Rs.1,70,000	Rs. 750/-	Rs. 200
Rs.2,70,000	Rs. 1,000/-	Rs. 300

3. APL families have to pay the following premium to avail health care benefits:

Sum Assured	Premium per family up to 5 members	Additional Premium for families above 5 members (Per Additional Member)
Rs.1,00,000	Rs. 500/-	Rs. 100
Rs.2,00,000	Rs. 750/-	Rs. 200
Rs.3,00,000	Rs. 1,000/-	Rs. 300

3.1.4. Pre and Post Hospitalization – The scheme covers the cost of treatment of the patient one day prior and ten days post hospitalization.

3.1.5. Minimum Period of Hospitalization- The minimum period for which a beneficiary is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease/ailment contracted/injuries sustained under the Scheme is at least 24 hours

3.1.6. Enrolment Procedure- Beneficiary enrolment is the responsibility of the Mizoram State Health Care Society. Enrolment was opened for a period of 2 months in each district and beyond this period, enrolment would not be opened whatsoever. Enrolment of the Head of the Family who is in the current electoral roll or having Voter ID Card of the State published by the Election Commission of India shall be used as proof of eligibility for enrolment under the Scheme.

3.1.7. Transport Allowance- Provision for transport allowance as part of the sum insured is allowed for the patient along with one attendant by any public service vehicle at the rate as may be fixed by the State Transport Authority from time to time. In case of an emergency/exceptional case, hiring of private vehicle may also be allowed, provided it is duly certified by the Medical Officer in-charge of the Hospital. The cost of travel that would be reimbursable for a patient that has to be shifted from residence to hospital in case of admission in Emergency or from one Hospital/Nursing Home to another Hospital/Nursing Home for better medical facilities. Expenses for travel (Fares only) would have a ceiling of Rs.1000 within the State and Rs.10000 for travel outside the State per claim. Reimbursement for travel outside the State would be considered for treatment of named Critical Illnesses only. Further, only the lowest fare available for the journey is admission for reimbursement.

3.1.8. Package Rate- The rates for hospitalization expenses, including bed charges (General Ward only), nursing, diet charges, surgeons, anaesthetists, medical practitioner, consultants fees, anaesthesia, blood, oxygen, O.T. charges, cost of surgical appliances, medicines and drugs, cost of prosthetic devices, implants, X-Ray and diagnostic tests, etc under the scheme are as per notified by the Government of Mizoram and are applicable for all medical/surgical cases for hospitals within the State of Mizoram (vide No.A.17014/7/07-HFW, Dt. 22nd July, 2008). For hospitals outside Mizoram, the existing CGHS rates will be adopted. Costs of drugs would be as per distributor prices.

3.1.9. Provider Network- Both public and private health care providers which provide hospitalization and day care services, with desired infrastructure would be

eligible for inclusion under the Scheme, subject to such requirements for empanelment as accepted by the Mizoram State Health Care Society. All Government Hospitals (including Primary and Community Health Centers) will be automatically eligible for empanelment under the Scheme. However, claims from beneficiaries taking treatment at Government Hospitals would only be allowed for expenses incurred by them on drugs, consumables, etc., purchased from the market (on production of Cash Memos/Bills) and on minimal investigation/laboratory charges levied by the Government Hospitals (on production of Cash Memos/Bills/Receipts). Expenses such as Diet, Nursing, Bed Charges, Doctor Consultation, Surgical Charges and other expenses which the Government Hospitals provide free will not be payable under the Scheme.

3.1.10. Mizoram State Health Care Society- the key function of the Society are i) management of fund/corpus received from the State Government and other sources, ii) capacity building to improve implementation of the scheme, iii) supervision of provider networks, iv) settlement of claims, and v) coordination of enrolments and premium collection and all other key logistics of the scheme. Presently, the Society office has 24 staffs: 3 doctors (CEO, Dy. CEO & OSD), 9 district coordinators, 6 claims supervisors & processors, 2 data entry operators, SIS, data manager, account clerk and chowkidar.

3.2.Review of Contemporary Health Care Schemes

This section tried to examine the salient features of other health care schemes in India to have a better understanding of the features of Mizoram Health Care Scheme 2013. It is known that there are a number of health care schemes, implemented by Central, State, NGOs, Private Corporate bodies, in the country. However, only 4 existing schemes are examined here to save time and space. Table 3.1 presents the salient features of the 4 selected schemes, namely RSBY, Yeshasvini Cooperative Farmers Health Care Scheme (Karnataka), Chief Minister Kalaigner's Insurance Policy Scheme for Life Saving Treatment (Tamil Nadu), Rajiv Aarogyasri Community Health Insurance Scheme (Andhra Pradesh) and RSBY Plus (Himachal Pradesh). It is expected that a study of the main features of these schemes would

enable us to identify the merits and demerits of MSHCS in comparison with other schemes.

RSBY, being the national policy implemented by Ministry of Labour and Employment, covered the entire country; while the remaining schemes are state specific schemes. Targeted population or eligible population varies from one scheme to another. While the target population for RSBY scheme were all BPL families, MNREGA Card holders and street vendors; the targeted population for Chief Minister Kalaigner's scheme and Rajiv Aarogyasri are BPL families and all families having income below the limit set by the implementing State Government. Meanwhile, the coverage for Yeshasvini scheme is limited to only a member of the rural cooperative societies. At the same time, RSBY plus covered all beneficiaries of RSBY on top up basis to cover the medical expenses over and above RSBY cover. With the exception of Yeshasvini Cooperative Farmers Health Care Scheme, which is funded through beneficiary contribution and State government's contribution, all other schemes have been funded entirely by the State Governments.

With the exception of RSBY plus the remaining health care schemes presented in this tables are implemented by the Government department or trust established by the government with the task of execution being entrusted to the insurance companies. At the same time, RSBY Plus has been implemented by the State Health Department with 100 percent funding from the State government. The model of RSBY Plus is somewhat similar to MSHCS where the implementing agencies underwrite the risk of health care insurance and there is a provision to top up RSBY facility. However, the major difference between the two schemes lies in its coverage. While the RSBY Plus covers RSBY beneficiaries only; as against this, MSHCS covers not only RSBY enrolees, but also the APL families. As it is done in other health care schemes, the MSHCS has its own benefit package i.e. only for critical illnesses notified by the State Health and Family Welfare Department, and in respect of package rates, it simply adopt the CGHS rates.

Table 3.1. Snapshot View of other Health Care Schemes

Sl. No	Name of Schemes	Main features
1	Rashtriya Swasthya Bima Yojana (RSBY)	1. Launch year: 2010 2. Geographical coverage: Entire country (all states of the Indian Union) 3. Eligible Population: BPL families and MNREGA Card holders and Street Vendors, contractual postmen, domestic works and railway coolies 4. Unit of Enrolment: Families 5. Benefit Package: All hospitalization charges (except certain specified charges) including transportation cost of Rs.100 per visit maximum up to Rs.1000 6. Maximum Insurance Cover: Rs.30,000 per family 7. Premium Rate: Rs.30 per family 8. Funding Source: Central and State Government in the ratio of 75:25 respectively, and for North East it is 90:10 9. Implementing Agency: Ministry of Labour & Employment and State Nodal Department (Health Dept.) 10. Executing Agency: State Health Care Society (in Mizoram) and Insurance Company (other States)
2	Yeshasvini Cooperative Farmers Health Care Scheme (Karnataka)	1. Launch Year: 2003 2. Geographical Coverage: Entire state of Karnataka (especially rural areas) 3. Eligible population: Members of Rural Cooperative Societies 4. Unit of Enrolment: Individuals 5. Benefit Package: All hospitalization except certain specified items 6. Maximum Insurance Cover: Rs. 2 lakhs per person 7. Premium Rate: Rs.150 per person (2009-10) 8. Funding Source: Beneficiary contribution and Govt. Contribution in the ratio of 58:42 9. Implementing Agency: Govt. + Trust + TPA 10. Executing Agency: Third Party Administrator (TPA)
3	Chief Minister Kalaigner's Insurance Policy Scheme for Life Saving Treatment (Tamil Nadu)	1. Launch Year: 2009 2. Geographical Coverage: Entire State of Tamilnadu 3. Eligible Population: BPL and families having annual income of less than Rs.72,000 4. Unit of Enrolment: Families 5. Benefit package: surgical procedure for various treatments of cardiology, oncology, etc 6. Maximum Insurance Cover: Rs. 1 lakh over 4 years per family 7. Premium Rate: Rs.469 + service tax (2009-10) 8. Funding Source: Entirely by State Government 9. Implementing Agency: Tamil Nadu Health System Society 10. Executing Agency: Insurance Company
4	Rajiv Aarogyasari Community Health Insurance Scheme (Andhra Pradesh)	1. Launch Year: 2007 2. Geographical Coverage: Entire State of Andhra Pradesh 3. Eligible Population: All the families in the State who hold a white ration card (BPL) and families with annual income less than Rs.75,000 4. Unit of Enrolment: Families 5. Benefit Package: Positive list of 938 identified hospitalization procedure 6. Maximum Insurance Cover: Rs.1.5 lakh per family per year with additional bugger of Rs.50000 7. Premium Rate: Rs.267 per family (2009-10) 8. Funding Source: 100% by State Government 9. Implementing Agency: Aarogyasri Health Care Trust (Trust) 10. Executing Agency: Trust and Insurance Company
5	RSBY Plus (Himachal Pradesh)	1. Launch Year: 2010 2. Geographical Coverage: Entire State of Himachal Pradesh 3. Eligible Population: All beneficiaries enrolled under RSBY 4. Unit of Enrolment: Families 5. Benefit Package: A top up scheme of RSBY to cover mainly tertiary care not adequately covered by RSBY 6. Maximum Insurance Cover; Rs.1.75 lakh beyond the 30,000 limit covered by RSBY 7. Premium Rate: Rs.364 per family 8. Funding Source: State Government 9. Implementing Agency: Health Department of Himachal Pradesh 10. Executive Agency: State Department + Contractual Staff

Source: Compiled from various scheme documents published in books, journals and websites.

In summary, it is safe to conclude that MSHCS is one of the most universal health care schemes in the country in terms of breadth (percentage of population covered) and depth of coverage (the extent of benefit coverage). It simply covers all families, whether BPL or APL, if they are not government servant or dependants of government servants, and if they are not working in any corporate/NGO body which provide health insurance facilities.

3.3.Key Indicators of the Scheme

The indicators of the scheme in this analysis includes claim amount and deduction; distribution of claim size; speed of claim settlements; profiling of patients by sex, age and location; disease profiling and analysis of claim by hospital types. The records, either in soft or hard, of the Office of the Mizoram State Health Care Society formed the basis of our analysis. The soft copy of claimant information database and the hard copies of bills submitted by patients were further processed and classified to suit our analytical framework. The period covered in the analysis is from 1st January to 8th August 2013 and the number of cases or patients being analysed are 1994. However, it may be noted that patients suffering from Hepatitis and Cancer were admitted in the hospitals several times for treatments (to take chemotherapy, etc). Due to the difficulty in aggregating expenses to each of this patients for their treatments in all hospitalizations, it was decided to assume each claim received by the Society as admitted and separate hospitalization cases. The results are given as follows:

3.3.1. **Summary of Claim Profiles**

Table 3.2 presents the summary of claims and settlement under the scheme during 2013. Out of the 1994 claimed received by the Society, 1875 (94.03 percent) are treatment within Mizoram and the remaining 119 (5.97 percent) are referral cases (treatment outside the State). Up to 8th August, a medical reimbursement bills amounting to Rs.340.92 lakhs have been approved and disbursed to the patients, which is 84.44 percent of the total claimed amount. Of this approved amount, Rs.70.92 lakhs (20.8 percent of total) was spent on referral cases. This indicates that

the claims of only 5.97 percent patients have constituted 20.8 percent of total claim amount. The expenditure on tertiary health care, i.e. referral cases, is on the higher side considering the number of patients. This has necessitated mechanism for continuous review and monitoring of health care expenses on treatment outside the State to check moral hazard on the part of patients and care providers.

Fig 3.1. Average Bill Per Patient (Rs)

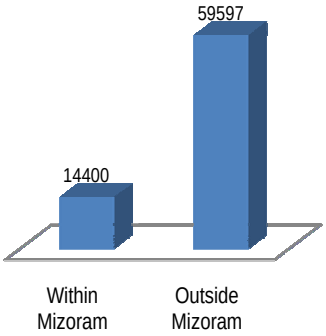


Fig 3.2. Deduction Rate Per Patient (%)

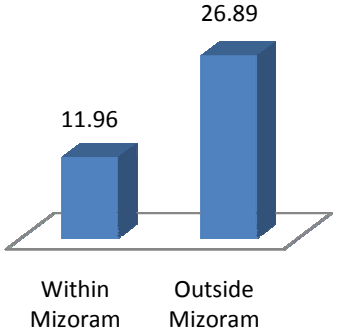


Table 3.2: Summary of Claims of Medical Re-imbursement under MSHCS in 2013

Up to 8.8.2013

Place	No of Cases/ Patients	Amount Claimed (Rs in lakh)	Amount Deducted (Rs in lakh)	Approved Amount (Rs in lakh)	Deduction Rate (%)	Approved Amount per Patient (Rs)
Within Mizoram	1875	306.67	36.67	270.00	11.96	14400
Outside Mizoram	119	97.01	26.09	70.92	26.89	59597
Total	1994	403.68	62.77	340.92	15.55	17097

Note: Deduction Rate implies deducted amount as a percentage of claimed amount

Source: Computed from the Data of MSHCS, 2013

The average amount paid to each claim or patients Rs.17097 --- Rs.14400 for treatment within Mizoram and Rs.59597 for treatment outside Mizoram. The overall rate of deduction per patient per treatment under the scheme is 15.55 percent of the total claimed amount. The deduction rate in case treatment outside State (Referral cases) is significantly higher than that of treatment within the State that it is 26.89 percent for referral, while it is 11.96 for treatment within Mizoram. High hospital

charges and travelling costs over and above the approved rates may be the main reason for high deduction rate for referral patients.

3.3.2. **Distribution of Reimbursement based on Size**

Table 3.3 presents the distribution of reimbursement (approved) claims based on size and amount of claims outgo to each of these ranges. It would be observed from this table that the size of 78.23 percent of claims are below Rs.15000 utilizing 46.41 percent of total claims outgo; while the claim sizes of the remaining 21.76 percent are greater than Rs.15000 utilizing more than half (i.e. 53.59 percent) of the total claim outgo. A closer look of this table reveals that the claim size of the 7.52 percent of the patients is below Rs.5000 utilizing only 1.39 percent of the total claim outgo; and as against this, the top 4.52 percent patients have utilized a big proportion of 27.42 percent of the total claims outgo. Almost 80 percent claim received and approved are below Rs.15000; while more than 90 percent of claims are below Rs.30000. Thus, the health insurance package or assured amounts being adopted by the scheme since January 2013 may be considered as appropriate to meet the medical expenses of most of the beneficiaries.

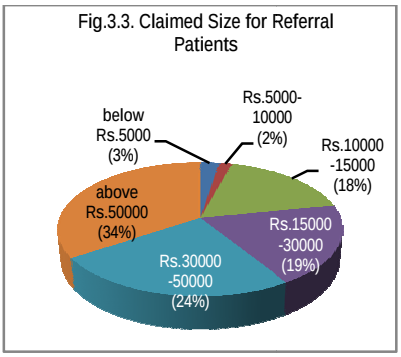
Table 3.3: Distribution of Reimbursement Claims (approved) based on Size in 2013

(1st January - 8th August 2013)

	Patients/Cases		Amount Paid	
Claim Size (Rs)	No.	Percent	Rs in lakhs	Percent
below 5000	150	7.52	4.75	1.39
5000 – 10000	461	23.12	32.28	9.47
10000 - 15000	949	47.59	121.21	35.55
15000 - 30000	249	12.49	52.49	15.40
30000 - 50000	95	4.76	36.71	10.77
above 50000	90	4.51	93.47	27.42
Total	1994	100	340.92	100

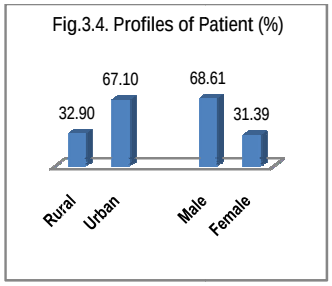
Source: Computed from the Data of MSHCS, dated 8.8.2013

Looking at Figure 3.3 which shows the distribution of the size of claims (approved) for treatment outside the State, it may be observed that the claims of more than three quarter (77 percent), out of 119 claims, are above Rs.15000 and more than half (58 percent) of claims are above Rs.30000. Further, more than one-third of the claims (34 percent) are above Rs.50000. It is thus clear that referral cases have constituted higher size claims under the scheme.



3.3.3. **Patients Profile**

The majority of the patients under the scheme are males. Out of the 1994 patients (inpatients claimant), 1368 (68.61 percent) are males and the remaining 626 (31.39 percent) are females. An examination of the residential location of the patients revealed that 67.10 percent are from urban areas, while the remaining 32.90 percent are from rural areas. As it was justified by the observations of the field survey, most of the rural patients are enrolled under any one of the RSBY schemes (RSBY BPL or RSBY MNREGA). Meanwhile, enrolment under MSHCS is very low. It should be noted that all RSBY BPL Smart Card holders are also the liability of the MSHCS in case of critical illness beyond the RSBY coverage. Even though the percentage of rural patients availing health care facilities turned out to be very low in comparison with their urban counterpart, a completely different rural-urban break up of patients would come up if we consider the RSBY patients.



The age profile of patients under MSHCS is presented in Table 3.4 and Figure 3.5. It is interesting to note that more than half of the patients (53.76 percent) are above 35 years of age. Of the five age groups being examined, the age group of 19-35 years constituted the largest percentage of the total patients followed by 35-60 years. Further, only 5.17 percent of the patients are below 19 years of age. In a nutshell, an

examination of the age distribution of the patients under the scheme revealed that the main chunk of the patients are in the middle or working age, while the percentage share of lower and upper age brackets are comparatively low, and thereby, the real risk groups are the middle ages, rather than children and the aged.

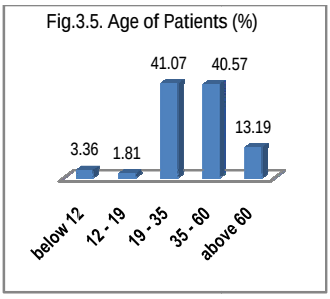


Table 3.4: Age Group of the Patients under MSHCS, 2013

Up to 8.8.2013

Age Group (years)	No. of Patients			% of Patients		
	Male	Female	Total	Male	Female	Total
below 12	34	33	67	2.49	5.27	3.36
12 – 19	15	21	36	1.10	3.35	1.81
19 – 35	626	193	819	45.76	30.83	41.07
35 – 60	522	287	809	38.16	45.85	40.57
above 60	171	92	263	12.50	14.70	13.19
Total	1368	626	1994	100	100	100

Source: Computed from the Data of MSHCS, 2013

3.3.4. **Disease Profiles and Costs**

In order to analyse the disease profiles of the patients and the average costs (or average claimed amount) of the 1994 patients under the scheme, the unprocessed records of the Society were examined and processed to suit our analytical frameworks. It was recognized that there can be a number of diseases or illnesses which the patients suffered from; however, for ease of the analysis these patients are broadly classified into the 10 broad categories of illness as set out in the policy guidelines of MSHCS and it is presented in Table 3.5. This table shows that the majority of patients (63.09 percent) fall under medicine, followed by Cancer (25.93 percent) and thus, around 90 percent of the patients suffered from disease under medicines and oncology (cancer).

Table 3.5: Distribution of Claimant Patients over 10 broad classification of Critical Illness in 2013

Up to 8.8.2013

Sl. No	Diagnosis (Category of Illness)	No. of Patients	Percent	Ave. Claimed (Rs)	Ave. Approved (Rs)	Deduction rate (%)
1	Cardiology & Cardiothoracic Surgery	7	0.35	99690	78273	21.48
2	Oncology (Cancer)	517	25.93	23999	20024	16.56
3	Medicines	1258	63.09	15956	14417	9.65
4	Surgery	64	3.21	52554	38053	27.59
5	Ophthalmology	19	0.95	41832	37840	9.54
6	ENT	3	0.15	24437	17686	27.62
7	Orthopaedic Surgery	62	3.11	30425	18835	38.09
8	Paediatrics	37	1.86	12036	9880	17.92
9	OBS & Gynaecology	26	1.30	23622	11807	50.02
10	ICU Care	1	0.05	12290	7573	38.38
	Total	1994	100	20245	17097	15.55

Source: Computed from the Data of MSHCS, 2013

At the same time, the average claim outgo for cardiology & cardiothoracic surgery is highest at Rs.99690 per patient per treatment, followed by surgery; while it is lowest in case of paediatrics (Rs.12036 per patient). The approved amount of reimbursement bills for cardiology & cardiothoracic surgery is highest at Rs.78273 per patient, followed by surgery at Rs.38053 per patient. Interestingly, the 7 cases under cardiology & cardiothoracic surgery are all referred cases. At the same time, bill deduction rates (in percent) have shown varying pattern that it is lowest in case of ophthalmology (9.54 percent) followed by medicines (9.65 percent), while it is highest for OBS & Gynaecology (50.02 percent) after ICU care (38.38 percent).

Claim deduction rates for OBS & Gynaecology, orthopaedic surgery and ICU care appears to be very high in comparison with others. This may be due to price escalation, in respect of medicines and treatment, after fixation of package rates and unscrupulous charges made by service providers. Thus, a re-look into the existing set of package rates for those diseases which have shown high deduction is necessary. It is considered necessary to have a mechanism to regularly review the package rates for all categories of critical illness to cope with price escalation side by side with the monitoring of the rates adopted by the network of service providers.

Table 3.6: Details of Claimed under illness category of medicine

up to 8.8.2013

Sl. No	Illness Categories (Medicine)	No. of Patients	Percent	Approved Amount per patient (Rs)
1	CNS	22	1.75	35006
2	Connective Tissue Disease	17	1.35	31543
3	Endocrinology	9	0.72	17543
4	GI Tract	14	1.11	17602
5	Haematology	8	0.64	19667
6	Hepatology	1083	86.09	11940
7	Infective Diseases	4	0.32	15856
8	Nephrology	76	6.04	35291
9	Respiratory System	24	1.91	24209
10	Urology	1	0.08	10500
	Total/Overall Average	1258	100	14417

Source: Computed from the Data of MSHCS, dated 8.8.2013

As it is presented in Table 3.5, patients under medicine group have constituted more than 60 percent of the total claimed cases. It may be useful to have further classification of medicine cases and this is presented in Table 3.6. Interestingly, Hepatitis cases contributed more than 86 percent of the total number of claims under medicine group, and 54.31 percent of the total number of claims. It may be noted that in this analysis every claim submitted at the Society for reimbursement (whether or not the same patient) is taken as separate claims, and hence, the same patients may have claimed a number times. As per the guidelines of MSHCS 2013, many health services which formerly required hospitalization are allowed to be treated on a day care basis. The patients suffering from the enlisted diseases like Hepatitis (B & C) can be reasonably assumed to have benefited the scheme most. The majority of hepatitis patients being interviewed during the course of data collection responded positively by accepting the scheme as helpful, excellently implemented and worthy to be continued.

3.3.5. **Claim Profiles by Service Providers**

Distribution of patients over different types of service providers (Hospital) and cost profiles is presented in Table 3.7. More than half (53.76 percent) of the patients are treated at Aizawl Civil Hospital and this is followed by Regional Cancer Centre (18.46 percent); while Private Hospitals cases have contributed 13.34 percent of the total cases. And around 10 percent of the patients are treated at Mission hospitals. At the same time, Community Health Centres (CHC) has contributed less than 1 percent of the total cases, while claims from District Civil Hospitals have constituted 4.21 percent of the total cases.

Table 3.7: Claim Frequency and Claimed/Approved Amount per Patients per Hospitalization- by Hospital type

Up to 8.8.2013

Hospital Type	No. of Cases	Cases (%)	Claimed (Rs)	Deducted (Rs)	Approved (Rs)	Deducted (%)
Community Health Centre	4	0.20	27635	604	27032	2.2
District Civil Hospitals	84	4.21	13822	1632	12190	11.8
Civil Hospital, Aizawl	1072	53.76	13358	390	12968	2.9
Regional Cancer Centre	368	18.46	15716	1179	14537	7.5
Kulikawn Hospital	2	0.10	15436	3934	11503	25.5
Churches Hospitals	183	9.18	31886	8776	23110	27.5
Private Hospitals	266	13.34	46463	13507	32957	29.1
Other	15	0.75	52943	5243	47700	9.9
All Cases	1994	100	20245	3148	17097	15.5

Source: Computed from the Data of MSHCS, dated 8.8.2013

Surprisingly, there are no claims received from Primary Health Centres indicating the participation of PHC and CHC in the scheme is extremely low. Some officials (doctors and staffs) working in PHC and CHC who were interviewed during the course of data collection are of the opinion that some beneficiaries, under their jurisdiction, seek care from distant and more expensive providers located in the State capital or District Capital whenever they fall ill, even for treatment of minor illness for which they used to approach PHC or CHC in their pre-enrolment period. One may conclude that the implementation of health care scheme has encouraged secondary

and tertiary cares, rather than primary care. It seems there has been moral hazard among the beneficiaries during the post-enrolment period. However, as the scheme covers critical illnesses only, these hospitals (providers) are not in position to provide treatment for such illnesses considering the limited availability of manpower and facilities in these hospitals. At the same time, the reason for non-participation of primary care provider networks in the scheme needs to be sorted out and addressed to ensure universalization of health care access across the state.

Average cost (approved amount) per patient per treatment is highest in the treatment category of 'Others'. Here 'others' mean all treatments taken from service providers other than the empanelled hospitals. It was reported that there were some instances when patients had to go to the non-empanelled providers because of lack of required facilities in the empanelled hospitals. 'Others' is followed by treatment in private hospitals, including private hospitals outside the state. Costs per patients are comparatively low for those treated in civil hospitals and Kulikawn Hospital. At the same time, deduction rate is highest in case of patients treated in private care providers at 29.1 percent followed by Mission Hospitals, while it is lowest in case of patients treated in CHC at 2.2 percent after Aizawl Civil Hospital at 2.9 percent.

3.3.6. **Turn-around Time (TAT) analysis**

Acceleration of the turn-around time (TAT) or flow of works of activities like enrolment, issuance of ID Cards, claims settlement and payment to the patients should be an all time objective of any health insurance scheme to provide better service to the beneficiaries. In order to analyse TAT for claims settlement, the claim documents submitted by the sampled patients to the office of the Society have been processed to arrive at the average number of days taken to clear the bills by the Society and average number of days required to finalize the bill submission either by hospital or patients or both. The results are presented in Table 3.8.

Table 3.8: Average Turn Around Time for Bill Processing

Sl. No	Speed Indicators	Average No. of Days	Std. Deviation
1	Time taken by MSHCS to finalize bills from date of receipt	15	10
2	Gap between DOD and bill approval	60	25
3	Time taken by hospital/patients to finalize and submit bills from DOD	28	25

DOD- date of discharge

Source: Calculated from a sample of 245 claimed documents obtained from MSHCS

Interestingly, the average turn-around time (TAT) as indicated by the average number of days required by the Society to approve the medical bills from the date of receiving claims is 15 days with a standard deviation of 10. That is, the expected range of clearing claims by the Society is 5 days to 25 days from the date of submission of bills. It should be noted that necessary condition for any successful health care insurance should be the existence of the system that expedite settlement and disposal of claims. The speed of claims disposal by Mizoram Health Care Society is fast enough that it could clear the bills within one month of receiving and hence, this is a commendable achievement of this Society. However, we should not overlook the volume of cases that entered into the process that it is still below 2000 in the half way mark. One cannot say for sure that the existing claim disposal as speedy had all eligible or targeted families in the State been enrolled in the Scheme.

Another interlinked indicator of TAT are bill preparation time (by hospital) from the date of discharge (DoD) from the hospital and overall bill waiting period between DoD and final approval of bills. The overall bill waiting period as calculated from DoD till final approval turned out to be 60 days (average) with a standard deviation of 25 days. In addition, the average number of days taken to pursue bills, i.e. taking the countersignature of doctors on cash memos, bills, etc, is 28 days from DoD. This is in the longer side considering few requirements being imposed upon by the rules of the scheme. However, there may be a significant reduction in the length of

bill preparation time by excluding the claims of referral patients. Speeding up of the bill preparation time by enhancing their efficiency in these service provider networks will greatly relieve the hardship of the poor patients.

3.4. Flow of Information

As mentioned earlier, the Mizoram State Health Care Society, for being the executing agency, is undertaking the role of coordination and supervision of works under the scheme. It is entrusted with the management of fund corpuses received from the State Finance Department and premium collected from the beneficiaries. Provision of health care benefits admissible under the scheme is implemented through the network of empanelled hospitals and presently there are more than 90 hospitals empanelled for the scheme. Since the scheme adopted the reimbursement system, patient beneficiaries have to clear all requirements (e.g. bill preparation, taking doctors' signature on bills, etc) from these empanelled hospitals before submitting reimbursement bills to the office of the Society for approval. Once approved, the referral and other patients, respectively, can collect their reimbursement bills from the Society's Office and through the hospitals where they were treated.

The task of enrolment and premium collection of the scheme are undertaken by Health Worker within the jurisdiction of their respective Health Sub-Centre. At the same time, the responsibility of coordinating the preparation of reimbursement bills, before submission to the Society, is in the hands of the staff of the hospital, mostly account clerks and medical supervisors; while the doctors have to endorse all bills in conformity with treatments and medical attendance rules of the scheme. Thus, it appears that it is the responsibility of the Society to impart necessary training to all these stakeholders of the scheme. Accordingly, all information pertinent to the implementation and the progress of the scheme are supposed to be communicated to these personnel. It is unfortunate to mention that an examination of flow of works and information among these functionaries show that there is no systematic flow of works and information. This is a serious setback for the successful implementation of the scheme. A summary of certain indicators of information flow is presented in Table 3.9.

Table 3.9: Information flow chart under HCS

Sl. No	Particulars	Doctors	Health Workers	Dealing staff (Hospital)	Patients/ Beneficiaries
1	Training on Health Care Scheme	√	√	×	×
2	Detailed Information regarding the package rates and coverage	√	×	×	×
3	The position of bill submitted by the concerned patients (approved or rejected)	√	×	√	√
4	Reason for rejection or deduction of claims	×	×	×	×
5	Financial position of the scheme	×	×	×	×
6	Balance of assured amount for the concerned claimant patients	×	×	×	×

In addition, while collecting the key indicators of the scheme in respect of the progress of implementation, breadth and depth of coverage, funding and expenditure position, profiles of patients, claimed amount analysis, etc, it was observed that no management information system (MIS) reports are being generated by the Society regarding the implementation of the scheme. With the exception of list of enrolled beneficiaries, certain information about claimant patients and claimed amount kept in the computer system, no MIS reports are generated or shared relating to pending claims, ageing analysis, diagnostic analysis of claims, disease profiles with costs, geographical cost variations, demographic profiling of diseases, periodic analysis of claimed settlements, etc. Moreover, the Society could not provide detailed break up of annual or quarterly expenditure and funding position of the scheme.

In fact, the officials of the Society have shown their sincere effort to ensure the speedy disposal of claims, transparency and customer friendly working practice. However, their efforts are inherently limited by lack of proper in-build MIS. In fact, the existing mechanism for reviewing of delayed or denied claims or explanation of deduction made on claims and audit is well below expected. As a result, lots of problems are believed to have cropped up between the facilitator Society and the service provider networks (hospitals) on account of lack of MIS reporting resulting in information asymmetry. All these cases should be a serious concern for the State Government if it is to ensure sustainability of the scheme. Important MIS reports covering the above mentioned attributes should be demanded on a regular basis to study the impact of the scheme in enabling access of beneficiaries to healthcare providers as well as on the health status of the beneficiaries.

3.5.Concluding Observations

It should be noted that MSHCS is one of the most universal health care schemes ever adopted in the country in terms of breadth of coverage (eligible population). However, due to one reason or the other, the enrolment rate is extremely low and almost 90 percent of total enrolment is from urban areas. Further, participation of PHC and CHC in the scheme is found very low, and the field observation suggests possible element of moral hazard on the part of the beneficiaries towards seeking high end treat in urban areas post-insurance. At the same time, treatment for such enlisted critical illnesses under MSHCS is practically impossible in these hospitals due to inadequacy of manpower and care facilities. Age profiling of the patients revealed that the real risk group belongs to the middle age group (i.e. between 19 to 60 years), rather than children and the aged.

On an average, significantly high claim outgo per patient per treatment is also observed in case of referral patients. While the claim outgo for more than 90 percent cases are below Rs.30000 suggesting the suitability of the insurance coverage as set out by the scheme; the claim size of 58 percent referral patients is greater than Rs.30000. At the same time, average deduction rate turned out to be 26.89 percent for referral patients and 11.96 percent for others. This has necessitated the continuous review of package rates, especially for treatment outside the State, to those cases which showed high deduction rate. It is recognized that review of package rates comes under the purview of the State Government (Health Department) which usually adopts the latest CGHS package rate.

Analysis of the turn around time (TAT) revealed that the time taken for processing the bills is fairly quick. It was observed that the Society took the average 15 days with standard deviation of 10 days to finalize all medical bills from the date of receipt. One of the indicators of the successful implementation of any health care scheme should be the existence of the system that expedite settlement and disposal of claims. Consequently, the fairly quick settlement of claims must be a commendable success of the Mizoram Health Care Society. However, one should not overlook the volume of claims that entered into the process that it is still below 2000 in the half

way mark. Thus, the same speed may not be feasible had all eligible or targeted families in the State been enrolled in the Scheme.

An imperfect aspect of the implementation of health care scheme in Mizoram could very well be the absence of MIS reporting system. The study observed that the implementing society has generated no MIS report relating to amount paid, deducted & reason for deductions, geographical cost variations, disease profiling, funding position, etc. Further, the claimant patients were not informed, in writing or otherwise, of the amount deducted and reasons, balance amount while disbursing the bills. To cope with the problems that are arising out of asymmetric information, MIS report covering all key attributes of the scheme should be demanded on regular basis.

Chapter – 4

PROFILE OF THE BENEFICIARIES

4.1.Introduction

As mentioned earlier, the two schemes - RSBY and MSHCS are being implemented side by side by the same agency, Mizoram State Health Care Society. The beneficiaries of the former can also enrol in the latter by paying additional amount of premium and hence, are eligible to avail MSHCS facility once the RSBY cover of Rs.30000 is exhausted. Similarly, RSBY BPL families are also admissible under the MSHCS without paying any extra fees/premiums for critical illnesses only beyond the limit of RSBY cover. Meanwhile, the majority of the respondents contacted during the field work are unaware of the technical difference between the two schemes, most probably because the two are being implemented by the same agency. Consequently, to analyse the profiles of health care beneficiaries all families who were enrolled under any one of the schemes are taken into consideration. However, as far as possible, the information pertaining to only the beneficiary respondents of the MSHCS are presented for the analysis of the implementation of the same.

4.2. Basic Status of the Beneficiaries

To have a better understanding of the standard of living of the beneficiaries, their status in the society and housing condition were examined. Table 4.1 presents the poverty status of the beneficiaries. The majority, 67.87 percent, of the beneficiaries belong to above poverty line (APL) families, while below poverty line (BPL) and Antyodaya Anna Yojana (AAY) constituted 29.9 percent and 2.23 percent respectively. Scheme specific figures also revealed that there is a higher percentage of APL enrolment than the poor even in case of RSBY. It may be noted that since 2013 all card holders of MNREGA are included under RSBY schemes. It may be noted that the classification poverty status of the families are made according to their Ration Card issued by the State’s Food & Civil Supplies Department for PDS.

Table 4.1: Family Status of the Beneficiaries

Status	No. of Families			Percent		
	RSBY	MSHCS	Total	RSBY	MSHCS	Total
APL	211	184	395	66.35	69.70	67.87
BPL	98	76	174	30.82	28.79	29.90
AAY	9	4	13	2.83	1.52	2.23
Total	318	264	582	100	100	100

Table 4.2: Housing Status of Health Care beneficiaries

Housing Status	No. of Families			Percent		
	Rural	Urban	Total	Rural	Urban	Total
Katcha	21	3	24	6.58	1.14	4.12
Semi-Pucca	276	163	439	86.52	61.98	75.43
Pucca	22	97	119	6.90	36.88	20.45
Total	319	263	582	100	100	100

It was observed that the majority of the beneficiaries of MSHCS lived a normal life by looking at their housing condition and ownership status. Table 4.2 showed that more than 95 percent of the beneficiaries lived in semi-pucca and pucca structure. A third quarter of the enrolled families covered in the survey, 439 (75.43 percent) lived in semi-pucca structure, while a little more than 4 percent of the beneficiaries lived in katcha house. Further, more than 80 percent of the beneficiaries live in owned house (98.5 percent in rural areas and 62.4 percent in urban areas), and at the same time, almost 20 percent are living on rented house.

Table 4.3 presents the age group distribution of the beneficiaries both in rural and urban sectors. The age profiles show a more or less normally distributed with around one-third of the total members up to 18 years of age, while the top class (above 60 years of age) constituted around 8.15 percent of the total enrolment. Meanwhile, the age patterns of male and female beneficiaries do not have so significant difference.

Table 4.3: Age Profile of the Beneficiaries

Age Group (Yrs)	No. of Persons			Percent		
	Male	Female	Total	Male	Female	Total
up to 12	254	231	485	19.58	17.23	18.39
13 – 18	167	174	341	12.88	12.98	12.93
19 – 35	405	429	834	31.23	31.99	31.61
36 – 60	360	403	763	27.76	30.05	28.92
above 60	111	104	215	8.56	7.76	8.15
Total	1297	1341	2638	100	100	100

4.3. Economic Conditions

An examination of the main source of income of the beneficiaries (as presented in Table 4.4) showed that daily wage labour (18.90 percent), agriculture & allied activities (21.99 percent) and business & self-employment (25.95 percent) taken together constituted 66.84 percent. This indicates that workers in unorganized sectors are the real stakeholders of the scheme and hence, the target group of public health care scheme in the State has been all people working in unorganized sectors in addition to poor households.

Table 4.4: Main Source of family Income

Income source	No. of Families	Percent
Salaried	16	2.75
Salaried (Contractual)	66	11.34
Daily Labour	110	18.90
Agriculture & Allied activities	128	21.99
Business	151	25.95
Working under Private/NGO	77	13.23
Other	34	5.84
Total	582	100

At the same time, those families which have salary (from employment under government sector) and contractual employment as their main source of income have also appeared in the enrolment figure. The figures reflect the universal eligibility coverage of the scheme where any person who is outside the medical attendance rules of central and state governments and other organized bodies. The distribution of monthly income of the families from all sources is presented in Table 4.5. Average monthly income of the family for the entire area turn out to be Rs.14979; Rs.11589 and Rs.19092 in rural and urban areas respectively. Meanwhile, the average family size was 4.54 in each of the rural and urban areas.

Table 4.5: Distribution of Monthly Family Income

Income Groups (Rs)	No. of families			Percent		
	Rural	Urban	Total	Rural	Urban	Total
below 5000	53	5	58	16.61	1.90	9.97
5000 - 10000	131	59	190	41.07	22.43	32.65
10000 - 15000	43	42	85	13.48	15.97	14.60
15000 - 20000	30	55	85	9.40	20.91	14.60
20000 - 30000	51	67	118	15.99	25.48	20.27
30000 - 50000	7	29	36	2.19	11.03	6.19
above 50000	4	6	10	1.25	2.28	1.72
Total	319	263	582	100	100	100

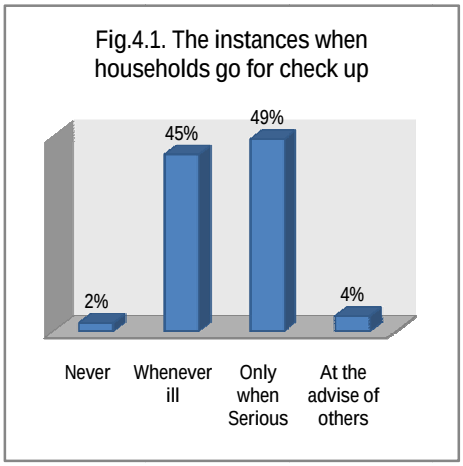
Average Monthly Family income

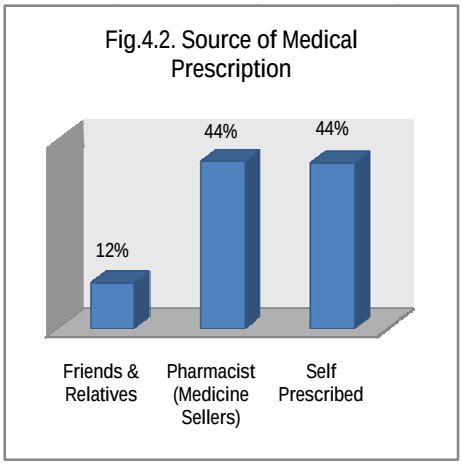
Rural Areas = Rs.11589, Urban Areas = Rs.19092 & Mizoram= Rs.14979

Table 4.5 showed that the average monthly income of the majority (i.e. 57.22 percent) of the beneficiaries is less than Rs.15000, with the income of the 42.65 percent families being less than Rs.10000. This indicates the entry of poor households in the scheme. Comparative analysis between rural and urban areas revealed that the majority of the urban households (62.36 percent) fall in the range of Rs.15000 to Rs.30000; while the average rural households (71.16 percent) are in the range of Rs.5000 to Rs.15000. Low income, accompanied by lack of adequate medical facilities among the hospitals in rural areas has hampered the success of providing proper health care to the target population.

4.4. Health Care Seeking Behaviour of the Beneficiaries

It is unfortunate to note that out of the 582 enrolled families covered in the study, only 29 families (5 percent) said they have regular medical check up; while the remaining 553 families (95 percent) said they do not have medical check up regularly. It may be noted here that if the family has medical check up at a regular interval, short or long periods, they are said to have regular medical check up. The selected families were asked the instances when they go for medical check up and where they get medical prescription from for normal illnesses. The percentage distributions are presented in figure 4.1 and figure 4.2. Surprisingly, almost half (49 percent) of the respondent said that they went for medical check up only in cases of serious illness, while 2 percent of them said they hardly (never) go for check up. Around 45 percent of the respondent said they go for check up whenever they fall ill and another 4 percent said they usually go for check up at the advice of relatives and friends.





In addition, figure 4.2 depicted that around 44 percent of the families took the medicines usually as prescribed by a pharmacist and 12 percent of them said they were prescribed by friends & relatives; while another 44 percent took the medicine which they think it good (i.e. self prescribed). The two figures clearly depicted the poor health care seeking behaviour of the people in Mizoram that almost all of the families seek medical check only when seriously ill and a big portion (44 percent) of

the medicine consumption is self-prescribed. This is very dangerous considering the risk of medicine consumption in one's health condition unless prescribed by medical practitioner. Thus, strong governmental effort is necessitated to intervene on this unfavourable behaviour of the population.

Meanwhile, the places normally visited by the households irrespective of enrolment in the health care scheme are presented in Figure 4.3. It could be observed that Government Hospitals are the most frequented places by these households for medical check up. 82 percent of the respondent said that they normally visited government hospitals when they fall ill, and this is followed by private hospitals (11 percent), private clinics (4 percent) and mission hospitals (3 percent).

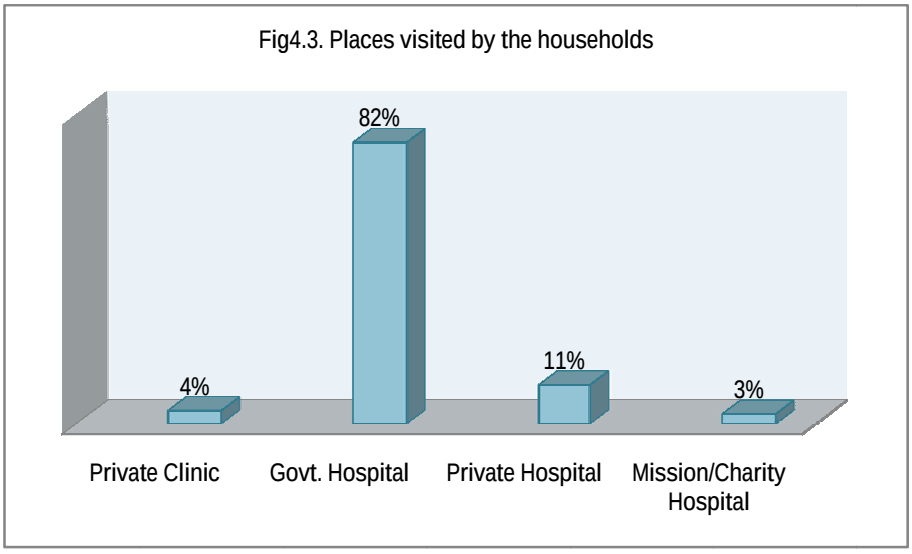


Figure 4.3 clearly revealed the key role being played by the government hospitals in the service of health care delivery to the population, the poor in particular. This may be due to the failure of the private health provider network to penetrate the entire state. At the same time, low purchasing power of the population side by side with the high service charges in the private institutions may result in heavy dependence of the population public hospitals. In this situation, one should not overlook the tremendous role played by Out-Patient-Department (OPD) of Government Hospitals to provide health care services to the population.

4.5. Risk Behaviour of the Beneficiaries

An analysis of the risk behaviour of the population would be of much importance for the implementation of any health care insurance policy. 'Risk behaviour' here means the tendency of consumption of elements that are injurious to health by the people. Unfavourable risk behaviour seriously adversely affects the sustainability of the health care insurance in that area. The risk factors considered in this study are smoking, consumption of tobacco and liquor. The incidence of these unfavourable factors among the sample beneficiaries are presented in Table 4.6.

Table 4.6: Risk Behaviour of the Beneficiaries

Risk Factors	Cases	No. of Members		Total	Percent		Total
		Rural	Urban		Rural	Urban	
Smoking	Yes	478	319	797	33.15	26.67	30.21
	No	964	877	1841	66.85	73.33	69.79
	Total	1442	1196	2638	100	100	100
Chewing Tobacco (including khaini, tuibur, etc)	Yes	585	501	1086	40.57	41.89	41.17
	No	857	695	1552	59.43	58.11	58.83
	Total	1442	1196	2638	100	100	100
Liquor	Never	1270	1070	2340	88.07	89.46	88.70
	Milk drinker	169	120	289	11.72	10.03	10.96
	Heavy drinker	3	6	9	0.21	0.50	0.34
	Total	1442	1196	2638	100	100	100

It is observed that 30.21 percent of the beneficiaries are smokers with the incidence in rural areas being higher than its counterpart urban areas. It is 33.15 percent and 26.67 percent in rural and urban areas respectively. At the same time, it is found that consumption of chewing tobacco is more prevalent than smoking among the beneficiaries that more than 41 percent of the beneficiaries take chewing tobacco and this incidence is higher in case of urban areas (41.89 percent) than in rural areas (40.57 percent). However, comparatively (in relation to other factors) consumption of liquor is low in the study areas that drinkers constituted a little more than 10 percent

of the total sample. Meanwhile, as the information is self-declared the possibility of getting wrong information cannot be ruled out because the State is declared dry state following the implementation of MLTP Act since 1997. To have a clearer picture of the incidence of these factors, attempt is made here to classify it age-group wise. This is presented in Table 4.7.

Table 4.7: Risk Behaviour of the Beneficiaries by Age Group

Percent

Risk Factors	Cases	Age Groups (Yrs)				
		up to 12	13 - 18	19 - 35	36 - 60	above 60
Smoking	Yes	0.41	1.76	38.25	46.26	54.42
	No	99.59	98.24	61.75	53.74	45.58
	Total	100	100	100	100	100.00
Tobacco (including khaini, tuibur, etc)	Yes	1.03	7.62	51.80	65.27	58.14
	No	98.97	92.38	48.20	34.73	41.86
	Total	100	100	100	100	100
Liquor	Never	99.79	99.71	79.14	84.40	98.60
	Milk drinker	0.21	0.29	20.38	14.94	1.40
	Heavy drinker	0.00	0.00	0.48	0.66	0.00
	Total	100	100	100	100	100

Table 4.7 revealed that smoking incidence is directly related to the age of the members. More than half of the aged (i.e. above 60 years) members are smokers which are followed by the two previous age groups. In case of tobacco consumption the real risk groups belong to 19 years and above that it is 51.80 percent in 19-35, 65.27 percent in 36-60 and 58.14 percent in case of above 60 years. With the exclusion of the first two age groups, smoking incidence will come up to around 46 percent; while the incidence of tobacco consumption would increase to a high of 58.40 percent.

4.6. Media Habits

The media habits of the respondent beneficiaries have been examined in this section. An understanding of the media habits of the beneficiaries would enable the policy maker to choose the most effective means for the dissemination of information regarding the scheme. Democratization of information regarding the detailed guidelines, coverage, package rate, etc would be of much help to attain symmetric information among the beneficiaries. The means of communication considered for this purpose are newspaper, radio and television. The result is presented in Table 4.8.

Table 4.8: Media Habits of the Respondent beneficiaries of MSHCS

Attributes	Cases	No. of Respondents	Percent
Read newspaper regularly	Yes	566	83.36
	No	113	16.64
	Total	679	100
Listen Radio Regularly	Yes	37	5.45
	No	642	94.55
	Total	679	100
Watch Local TV News Regularly	Yes	634	93.37
	No	45	6.63
	Total	679	100
Always read advertisement in Newspapers	Yes	378	55.67
	No	301	44.33
	Total	679	100

Table 4.8 presents the favourable behaviour of the respondents towards newspapers and news telecasts at local TV channels. 83.36 percent of the respondents said they read newspaper regularly, while 93.37 percent said they regularly watch news broadcasts through local television networks. However,, aversion behaviour has been shown by the respondents towards radio programmes that 94.55 percent said they do not listen to Radio regularly. At the same time, significant portion of the respondents (55.67 percent) said they read advertisement being published in newspapers. The results suggested announcement through TV news and newspaper

would most effective means. Accordingly, the respondents were asked to name the best time/place for making announcement through local TV channel. The result is presented in Table 4.9.

Table 4.9: Best time for public announcement through Visual Media according to the Opinion of the Respondents

Attributes	No. of Respondents	Percent
Before & after news	402	59.20
During Film	201	29.60
During Reality Show	6	0.88
Scroll	70	10.31
Total	679	100

The majority (59.20 percent) of them said the best time for making announcement is just before and after news followed by announcement during film show. It may be noted that the ongoing health care scheme of the state covered the entire state with the majority of the residents are made eligible. To ensure the smooth implementation of the scheme, awareness levels of the beneficiaries as well as non-enrolled households should be enhanced. To this end, making an announcement in the form of advertisement or otherwise through television would be of much help especially at the time of news and film show.

4.7. Concluding Remarks

Attempt is made in this chapter to evaluate the socio-economic and behavioural conditions of the beneficiaries of the state health care schemes. It is observed that the health care seeking behaviour of the beneficiaries are unfavourable that 95 percent of them said they do not have regular medical check up and almost 50 percent of them said they seek institutional health care only when serious illness befall them. Moreover, around 44 percent of them said they used to consume self-prescribed medicine in normal illnesses. Aversive behaviour towards institutional

health care can have ramifications on the failure of the public health care schemes to serve its purposes.

The study also observed the unfavourable risk behaviour among the beneficiaries being examined that there has been mass prevalence of tobacco consumption in the study areas. Smoking incidence among the adult beneficiaries turned out to be almost 50 percent, while more than 58 percent of the adult beneficiaries are consuming tobacco and its products, i.e. chewing tobacco, khaini, tuibur, gutkha, tiranga, etc. This should be a serious concern for the State Government, the Health Care Society in particular, because the middle aged or working ages belong to the real risk group. One may conclude that the age distribution of patients, being analysed in the Chapter-3, was the reflection of this unfavourable risk behaviour of the insured.

Chapter – 5

STAKEHOLDER'S PERCEPTION ON THE SCHEME

5.1. Introduction

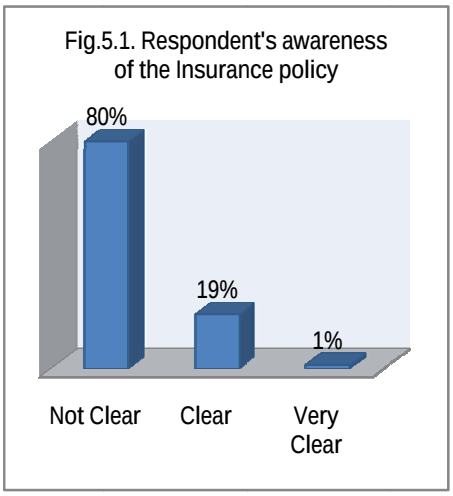
With an aim to evaluate the level of penetration that the implementation of MSHCS has on its target population, this chapter presents various attributes of the scheme as perceived by the beneficiary households. The whole analysis is based on the information collected through the administration of interview schedule among the selected beneficiaries from rural and urban areas of Mizoram. The pertinent information obtained from the focus group discussions and case studies are also presented. As it was mentioned in previous chapters, the key indicators of the MSHCS, like enrolment, funding and bill settlements, have undergone up and down trends since its inception in 2008. A breakthrough in the system of administration took place in 2011-12 when the implementing agency, Mizoram State Health Care Society, stepped out to run the scheme on self-finance basis and it underwrite all health insurance risks that may come out of it.

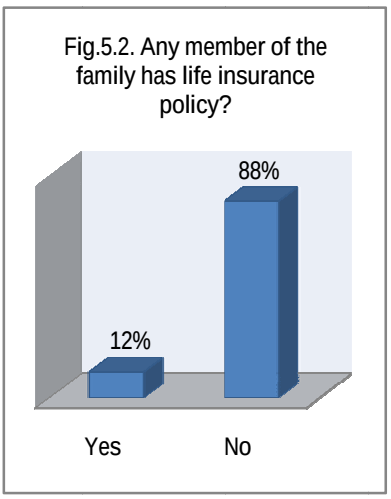
Though the scheme is one of the most universal health care schemes across the country in terms of eligibility, the level of enrolment is very low especially in rural areas. When the scheme was introduced for the first time in the State in 2008 there was considerable public response towards the scheme and this was reflected by the number of enrolment. Around 50 percent of the targeted population (1.5 lakh families) enrolled in the scheme. However, the enrolment levels decreased afterward and it is now a little more than 5 percent of the target population. Meanwhile, enrolment under RSBY scheme has shown significant progress since 2010-11 with the existing achievement rate of enrolment being 43.09 percent target population in the scheme. Considering all these aspects it is necessary to have an evaluation of the public perception towards the scheme and their level of awareness. This would enable us to identify the reason for low enrolment level and the expected trends in the year ahead. Further, as the public confidence on the network of care providers (empanelled hospitals) to carry on with the scheme would determine its sustainability, attempt will also be made to analyse public perception on the network of hospitals.

As it was noted earlier, it is very difficult to classify the health care beneficiaries according to their enrolments under MSHCS, RSBY and both schemes. This is due to the possibility of enrolment of RSBY beneficiaries in the MSHCS on top up basis and the health care facilities that the BPL families enjoyed from MSHCS above the cashless cover of Rs.30000 without paying additional charge or premium. In fact, most often the beneficiaries do not know in which policy they are enrolled. Accordingly, while analysing the general perceptions of the health care beneficiaries in respect of awareness and care providers no classification were made between the beneficiaries of the two schemes. In the analysis of the specific perceptions towards MSHCS, attempt was made to cover the beneficiaries of the same.

5.2. Awareness of Insurance Policy

An understanding of the importance and working of MSHCS, for being an insurance policy, greatly depends on the individual's understanding and appreciation of insurance policy. To examine this, the respondents were asked certain questions pertaining to rules, process and requirements of insurance policy, other than health care insurance, and their understanding levels are rated according to their response to these questions. The result of the evaluation is presented in Figure 5.1. They were also asked if any member of the family has life insurance policy and the result is presented in Figure 5.2.





It is observed that 80 percent of the respondents were not clear about what the nature, working or relevance of insurance policy, while around 20 percent are rated to be clear on the insurance policy. In an enhancement to this finding, 88 percent of the respondents said no one in the family has a life insurance policy. This clearly suggest the level of insurance policy coverage of the people or insurance penetration in the state is very low, so also the awareness level. It is believed that this would have affected the awareness level of MSHCS, which follows the insurance model.

5.3. Information Sources & Reason for Enrolment

Table 5.1 present the sources of information that the respondents come to know of the scheme. As expected, the local authorities, village and local councils, have played dominant role in the announcement of the scheme, most probably, announcement of enrolment time, which constituted 57.44 percent. Health workers are the grassroots level functionaries of the scheme in terms of enrolment and renewal. Thus, they do play a good role in disseminating information regarding the scheme that 34.76 percent of the respondents said they had come to know about the scheme from the health workers. Unlike the observations of Giz (2012), which observed word of mouth to be the major source of information about the health insurance scheme in some states of India, word of mouth (friends & others) is not a significant source of information in the State.

Table 5.1: Source of Information about the Health Care Schemes

Sources	No. of Households	Percent
Advertisement in TV/Newspapers	23	3.39
Village/Local Council	390	57.44
Health Workers	236	34.76
Friends & Relatives	28	4.12
NGOs	2	0.29
Total	679	100

Though it is very difficult to classify the reason why the respondents joined the scheme on the basis of their responses. They are classified into five categories. As noted earlier, recognition should be given to some beneficiaries of RSBY who are eligible for MSHCS facilities (i.e. BPL Smart Card) while analysing the related data pertaining to the scheme. However, to have a clear demarcation line, only those families who paid the required premium (Rs.500 and above), rather than Rs.30 in case of RSBY, are included in the analysis. The result is presented in Table 5.2. Further, on an interview of the non-enrolled households, it was tried to sort out the reason for why they were not enrolled in the Scheme. In the process we were came up with 7 major causes for non-enrolment in the scheme. Detailed break up is presented in Table 5.3.

Table 5.2: Reasons for Joining MSHCS (MSHCS enrollees only)

Reasons	No. of Respondents	Percent
As advise by friends & relatives	15	5.68
It's good for family	152	57.58
Advise by Medical Staff (Doctors, HW, etc)	55	20.83
To avoid unforeseen medical expenses due to illness	40	15.15
Others	2	0.76
Total	264	100

Table 5.3: Reason for Non-Enrolment in the Scheme (Non-enrolled households only)

Reason	No. of Respondents	Percent
We don't need the policy	4	4.12
We were out of station during enrolment	10	10.31
We did not know the enrolment period	11	11.34
We did not have money to pay for premium	6	6.19
They said the policy is only for critical illness (but don't know what is critical illness)	18	18.56
We were not informed about the policy coverage and other details	43	44.33
We don't know how useful it is	5	5.15
Total	97	100

Among the enrolled households being interviewed the biggest proportion (57.58 percent) of them are found to have enrolled in the scheme out of the knowledge of its importance for the family. That is, 57.58 percent of the enrolled beneficiaries said they joined the scheme for they think the policy was good for their family; while 15.15 percent said to avoid the risk of unforeseen medical expenses. The two attributes can be taken together because the meanings are more or less the same. Thus, more than 70 percent joined the scheme for it is good for the family. At the same time, 20.83 percent of the respondents said they joined the scheme at the advice of a medical staff (health workers and doctors).

An examination of the reasons for non-enrolment among the non-enrolled families revealed that lack of proper understanding about the scheme and the benefit packages that the scheme offered remains the main reason for non-enrolment in the scheme. Thus, 74.23 percent of the non-enrolled respondents said they did not join the scheme due to lack of proper awareness about the scheme and enrolment process which are put under three cases, they are (i) they were not informed of the benefit packages and other details (44.33 percents) and (ii) they were informed that the policy is only for critical illness (18.55 percent), and (iii) they did not know the enrolment period. For the second case, while the households were informed that the policy is meant for critical illnesses only, they were not clearly informed of what the critical illnesses are. At the same time, 10.31 percent said they did not enrol because they were out of station during the time of enrolment. It was observed during the field work in rural areas that enrolment were opened for about a week or two according to the convenience of the Health Workers knowingly or unknowingly the admissible period for enrolment being 2 months. This has made those families who had to stay in their working places, jhum field, etc, out of the enrolment.

5.4. Awareness Level of the Scheme

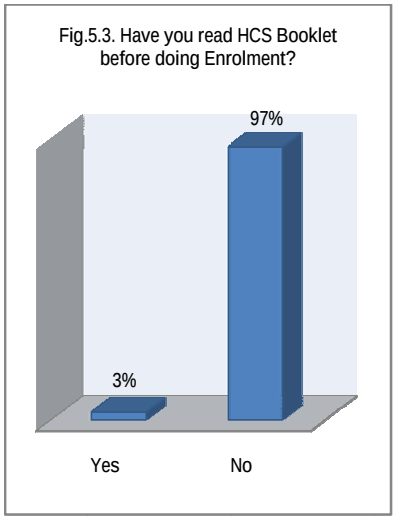
To have a better understanding of the awareness level of the scheme among the beneficiaries of the scheme, attempt is made here to analyse their familiarity and basic understanding of the scheme. The result of the exercise is presented in Table 5.4. It could be observed from this table that more than half of the respondents (50.76 percent) said they had come across the scheme for more than 2 years; while 22.73 percent said they have been acquainted with the scheme from this year only.

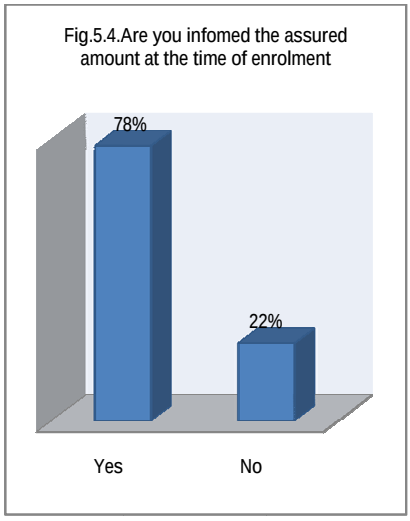
Table 5.4: Awareness Background of the Scheme (MSHCS enrollees only)

Attributes	Cases	No. of Respondents	Percent
How long have you been acquainted with MSHCS?	I've come to know this year only	60	22.73
	Since last 2 years	70	26.52
	More than 2 years ago	134	50.76
	Total	264	100
Have your enrolled in the scheme earlier?	Yes	163	61.74
	No	101	38.26
	Total	264	100
In your Opinion, MSHCS and RSBY are	Same	39	14.77
	Separate, but works side by side	59	22.35
	Cannot differentiate	166	62.88
	Total	264	100

Further, 61.74 percent said that they had enrolled in the scheme during the previous year (s) and all of them said they got the policy renewed on time. Meanwhile, more than one-third (38.26 percent) are newly enrolled beneficiaries. As it was noted earlier, RSBY scheme has been implemented in the state since 2010-11 and the MSHCS was also implemented side by side with this centrally sponsored scheme. So, the respondents were asked a simple question reflecting their understanding of the schemes. It is found that 62.88 percent of the respondent does not know the difference between the two. Care should be given while disseminating information on the health care scheme not to confuse the population. This is because there is a limited benefit packages and eligibility in case of RSBY, while there is more benefit packages and liberal eligibility criteria under MSHCS.

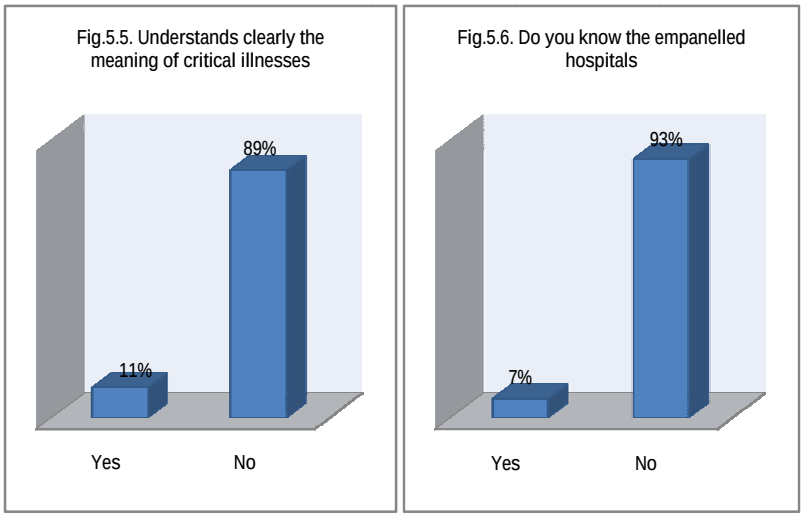
It is observed that 97 percent of the respondent families said they did not read the information booklet published by the health care Society before undergoing enrolment; while 3 percent only said they read the same. The Booklet entitled 'Rashtriya Swasthya Bima Yojana (RSBY) & Mizoram State Health Care Scheme (MSHCS)' published by the office of the implementing Society was supposed to be widely circulated during the enrolment period to create public awareness about the scheme. This book presents a detailed guideline scheme in respect of eligibility, benefit packages and procedure for submitting reimbursement claims in local language. However, it is unfortunate to note that the booklet was not circulated among the targeted population and its ramifications in the enrolment and awareness can be clearly visualized.





At the same time, awareness level of the assured amount is quite considerable that 78 percent of the respondents said they were informed of the assured amount at time of enrolment. The knowledge of assured amount is very crucial while determining the rate of premium. It was reported that there were some instances that while collecting premium for the family having more than 5 members the additional amount payable per additional family members should be determined on the basis of assured amount, in some cases the highest rate (i.e. Rs.300 per additional member) were collected irrespective of the assured amount by the Health Workers. The beneficiaries unknowingly had to pay such extra premium amount. However, the cases were rectified with a good cooperation of the concerned Health Workers. These

are all the adverse effect of information asymmetry among the beneficiaries as well as the grassroots level functionaries of the scheme.



As per the guidelines of MSHCS, the scheme covers hospitalization on account of critical illness only. The list of critical illness as notified by the Health Department has been published in the information booklet. However, a significant portion to the tune of 89 percent of the respondent said they did not know what the critical illnesses were. Following the misconception of critical illness, a number of families kept away from entering into the scheme because they think the policy covers serious illness only. At the same time, there are some respondents who think the present list is deemed to be too narrow and in one case in particular, it was stated there are some illnesses that are rare among the Mizo.

Another pertinent issue determining the awareness level of the beneficiaries is the knowledge of service providers or empanelled hospitals within and outside the State. Unexpectedly, more than 90 percent (Fig.5.6) of the respondents said they do not know the empanelled hospitals under the scheme. R. Lalchhuanthanga, a committed Health Staff under Darlawn CHC, said that when illness befall the beneficiaries they approach the hospitals they think good for their cases without enquiring the empanelment status of that hospital. Once they come to know of the fact that the hospital they are in is not among the empanelled under the scheme, they

become frustrated and loss confidence upon the scheme. So, he suggested the list of empanelled hospitals be made known to every beneficiary of the scheme.

5.5. Beneficiary's Responses to the Scheme

To assess the beneficiary's responses and satisfaction to the scheme, all enrolee respondents of the scheme were asked certain questions pertaining to the individual observations on its implementation, enrolment, the way it is being implemented and intention to enrol or not enrol next year. The results are presented in Table 5.5. It is clear that the beneficiaries are satisfied with the objectives and principle of the scheme as 94.70 percent of the respondents said the scheme was good for the people and should be continued.

Table 5.5: Beneficiary's responses to the scheme

Attributes	Cases	Respondents	Percent
The MSHCS is good for the people and should be continued	Yes	250	94.70
	No	2	0.76
	No Idea	12	4.55
	Total	264	100
The way it is implemented	Good	181	68.56
	Not Good	83	31.44
	Total	264	100
Enrolment Period & Time	Good	225	85.23
	Not Good	17	6.44
	No Idea	22	8.33
	Total	264	100
Will you enroll next year?	Yes	261	98.86
	No	3	1.14
	Total	264	100

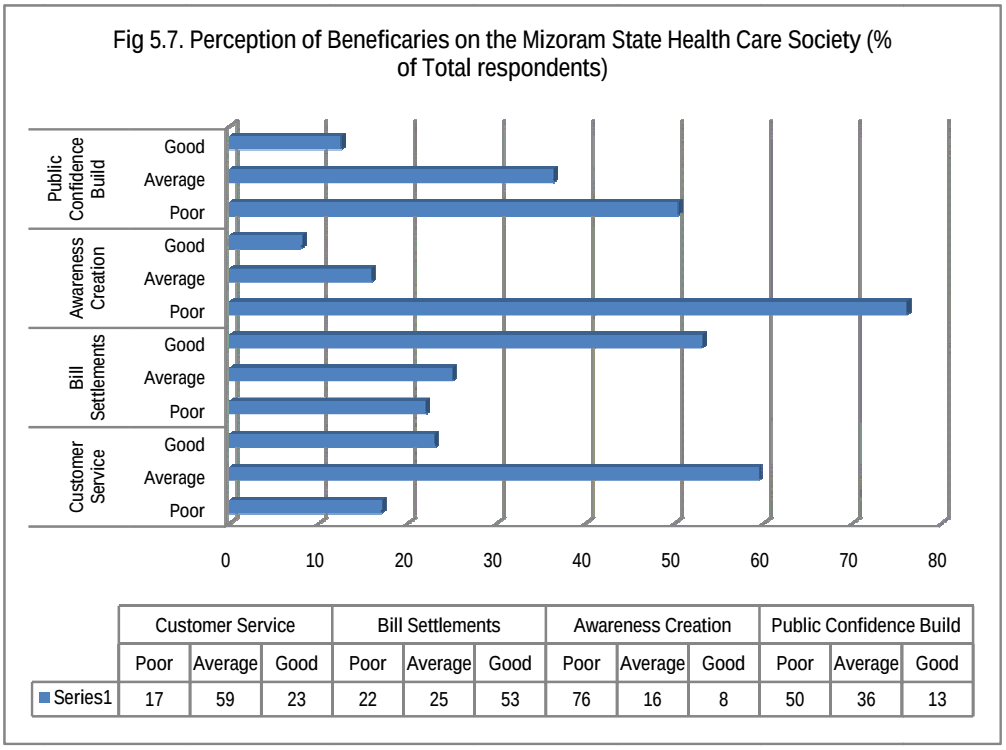
However, on the modus operandi of its implementation a setback of certain magnitude have been identified that almost one-third of the respondent (31.44

percent) said the way the scheme is being implemented is not good. This may be a reflection of lack of awareness level of the scheme among the beneficiaries as observed in the previous section. Meanwhile, a bigger portion (68.56 percent) is satisfied with the way the scheme is being implemented. Another issue towards the success of any insurance policy should be the time and duration of enrolment process. Impressively more than 95.23 percent of the respondent said the existing enrolment period and time is good. It may be concluded that we are safe to go on with the existing time frame of enrolment process. Lastly, almost cent percent of the respondent said they will enrol in the scheme next year. Taking all these parameters (attributes) it may be concluded that the beneficiaries of the scheme are generally satisfied with the scheme and how it is being implemented.

5.6. Perceptions on the Providers

The success and failure of the health care scheme greatly depend on the capacity of the implementing agency and a network of care provider hospitals (empanelled hospitals) to handle the scheme efficiently. Apart from the capacity for settlement of claims and undertaking of administrative works, the implementing agency should earn public confidence to carry on with the scheme. Loss of public confidence is always a serious concern for any insurance company. Though it is very difficult to capture all these aspects, attempt is made here to evaluate the perceptions of the respondent beneficiaries on the basis of their individual observations and past experiences. It is to be noted that only the observations of the enrolee respondents are taken into account. The result is presented in Figure 5.7.

Firstly, it is to be observed that the performance of the Mizoram State Health Care Society (Society) is found to be most impressive in case of bill settlements. That is more than half (53 percent) of the beneficiaries said their performance in settlement of bills is good, 25 percent said average and the remaining 22 percent said it is poor. It is believed that the impressive speed of claim disposal as observed in Chapter-3 has been reflected by the perceptions of the beneficiaries.



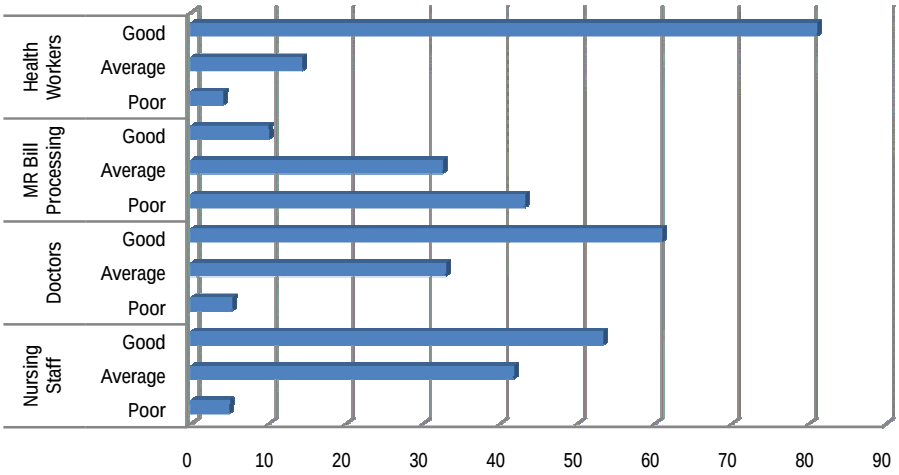
	Customer Service			Bill Settlements			Awareness Creation			Public Confidence Build		
	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good
Series1	17	59	23	22	25	53	76	16	8	50	36	13

Secondly, the Society has shown average performance, according to the perceptions of the beneficiaries, in respect of the customer service. It is observed that 59 percent of the respondents said it is average and 23 percent said 'good', while another 17 percent said its performance is poor. Thirdly, the Society's performance is very poor in respect of awareness creation among the stakeholders that 76 percent said that it is poor, while only 8 percent said it is good. Lastly, on the front of building public confidence, 50 percent said it is poor, 36 percent said average, while the remaining 13 percent said it is good.

To sum up, it is clear that, on the opinion of the beneficiaries, the performance of the implementing agency of the scheme is not up to the mark, except in case of claim settlement. Even in case of claim settlement, to which it achieved good performance, the volume of bills that entered into the process is quite minimal. As it was observed in Chapter-3, the total claims approved till August 2013 was 1994 only. Their performance in this case is also highly questionable had all the eligible

beneficiaries enrolled in the scheme. In the same way, beneficiary's perception on the performance of the hospitals is presented in Figure 5.8.

Fig 5.8. Beneficiary's Perceptions on the Care Provider Hospitals (% of the total respondents)



	Nursing Staff			Doctors			MR Bill Processing			Health Workers		
	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good	Poor	Average	Good
Series1	5	42	53	5	33	61	43	33	10	4	14	81

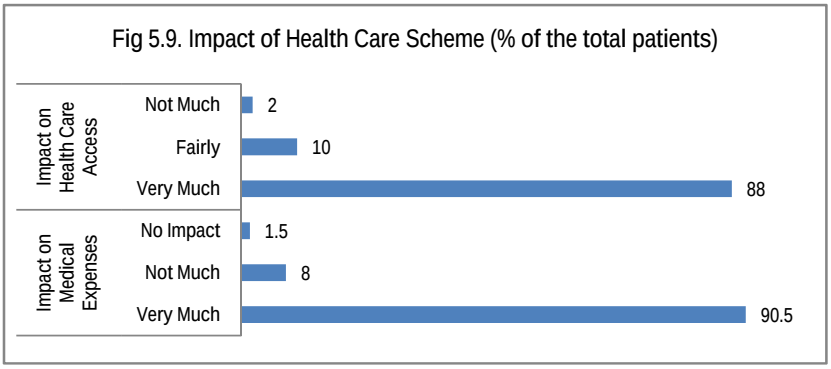
It is interesting to observe that the performances of the medical staffs, doctors, nurses and health workers in health care delivery, on the perceptions of the respondents, are quite impressive. More than half (53 percent) of the respondents said the performance of the nursing staffs are good and another 42 percent said it is 'average'. It is found that 61 percent of the respondents said the performance of the doctors is 'good', while another 33 percent said 'average'. The health workers, who are the key staff to deliver public health care services at the grassroots level, performed very well in the evaluation. 81 percent of the respondent said their performance is 'good' while another 14 percent said 'average'.

However, the performances of these health care institutions are unimpressive in respect of bill processing for the patients. 43 percent of the respondents said it is 'poor' and another 33 percent said 'average', while only 10 percent said it is good. This is unfortunate from the MSHCS point of view because its persistence would be a serious setback for the success of this scheme to deliver health care services among the population. An analysis of TAT revealed that on the average these hospitals require 28 days to complete bill processing from DoD, which is almost double the average time required by the Society to settle the MR bill they received. Further, it was reported that the staff entrusted to initialize the bill processing at these hospitals attained no prior training for their work. What they know are mostly learnt along the process of the job. So, capacity development on the part of the non-medical staffs who are dealing with the health care scheme would be of much help.

5.7. Impact of the Scheme

Another area of interest for the evaluation of any public scheme is the impact that the scheme has on the stakeholders. Attempt is made here to assess the impact of this scheme according to the perception of the sample patients who have claimed the medical reimbursement during the reference period (i.e. January – August 2013). Given the severe time constraints and vague information regarding the residential details of these patients as furnished by the office of the Society, it was not possible to visit most of the selected patients in the survey. But in any case we could generate certain information indicating the impact of the scheme on the stakeholders. The results are presented in Figure 5.9.

Fig 5.9. Impact of Health Care Scheme (% of the total patients)



It appears that the scheme has had significant impacts on the beneficiary patients in terms of expenditure burden on medicines and treatment cost and health care access of the family. A significant percentage (90.5 percent) of the respondent said the burden of the family on medical expenses has significantly reduced after availing the health care facility from MSHCS. In an interview, Mark Lalmuanpuia said 'the income we obtained from various sources is just enough to cover for our every day needs. Financial constraints arise whenever any member of the family suffers illness which demands intensive care'. This is where the impact and significance of the scheme comes in.

In addition, the implementation of health care scheme significantly enhances the health care access of the people. 88 percent of the total respondent patients said they could avail such expensive medical treatment due to the scheme, which would be very hard to avail for them if the scheme was not in place. Meanwhile, another 10 percent said it fairly improve the family health care access, while another 2 percent said 'not much'. The above figure is clearly justified by the interview of C. Lalengliana, a father of a son who is a renal allograft recipient and had availed the benefit a couple of times. He said that if they had not enrolled in the scheme, they would encounter many financial constraints and might not be able to take up further treatments. He did not recall facing any problem while submitting medical bills and is of the opinion that the time taken for processing the bill is fairly swift. In another case, S.Lalremruati, a widowed and patient of Hepatitis C, said that she would not get the required treatment and might have died of the diseases had the scheme been unimplemented. She added that it was the 'God's Programme for the poor'. In summary, it is thus safe to conclude that the scheme has a significantly positive impact upon the lives of the poor patients.

5.8. Concluding Remarks

The analysis of the various aspects of beneficiary's perceptions clearly revealed low level of awareness among the target population. The majority of the beneficiaries joined the scheme without any clear knowledge of the benefit packages and the basic guideline. It was observed that the majority of the beneficiaries did not read HCS Booklet issued by the Society, nor were they informed of the assured amount and other benefit packages. At the same time, there has been confusion of the scheme with its counterpart RSBY scheme which, in many cases, resulted in the failure of the family to enrolment in the scheme. Another pertinent issue is the insufficient knowledge about critical illness that for most of the cases that it was taken as serious illness, thereby, resulting in non-enrolment in many cases.

The performances of the hospitals in providing health care services to the patients are quite impressive that the majority of the respondents said they are good, except for MR Bill preparation/processing. It clearly reflects the public confidence on the medical staff in their service of health care delivery. However, their performance in case of bill preparation for onward submission to Health Care Society is quite unimpressive. It was also observed that the hospital staffs who were entrusted with the task of bill preparation at the hospital levels attained no prior training to carry on with their work resulting in inefficiency. Thus, capacity building on the part of the hospital staff would be very crucial towards the successful implementation of the scheme. Meanwhile, the implementing agency, Mizoram State Health Care Society has not performed very well in front of customer service, awareness creation and gaining public confidence, while it performed well in case of bill settlements. So, enhancement of administrative efficiency and capacity should be given priority to serve the purpose of the scheme.

The scheme has significantly positive impact upon the lives of the beneficiary that most of the beneficiaries interacted said the scheme has enhanced their health care access and significantly reduced family expenditure burden on illness. A big portion of the respondent (88 percent) said the scheme has enhanced their care access, while 90.5 percent said it has reduced their expenditure burden, which might be met with by borrowing. Thus, more than 94 percent of the total respondents considered the scheme is good and should be continued; and 98.86 percent of them said they would

enrol the next year. It may thus be concluded that the scheme has been successfully implemented and its positive impacts are clearly visible on the lives and thinking of the stakeholder patients and their families.

Chapter – 6

REPORT OF THE CASE STUDIES

6.1. Case-1: Civil Hospital, Aizawl

Civil Hospital, Aizawl is the largest hospital of the State. It started its run of the Mizoram State Health Care Scheme in 2010 but its work became substantial only in 2011. The RSBY and MSHCS are currently being operated and worked by 5 (five) staff of which 2 (two) are permanent workers while the other 3 (three) are employed on a contract basis. The counter/help desk stays open for 24 hours so that patients can come at any time of the day or night. The staffs include pharmacists which greatly help in the smooth and efficient running of the counter/help desk. However, it was noted that there is a shortage of staff and that an additional system operator would help immensely.

The workers attained no prior training for their work. What they know are mostly learnt along the process of the job and they can now be considered experts because they have become very fluent in the system and process of the two schemes. From the beginning of the current year (2013) till the end of August, they processed 1516 RSBY and 1689 MSHCS cases.

As far as RSBY is concerned, problems they encounter are mostly because of the failure to inform beneficiaries about the significance of the smart card. Some of the beneficiaries, especially those from the rural areas, are not aware of why they were asked to give their fingerprints at the time of enrolment and/or why there is a smart card. As such, on going to the hospital, they often fail to bring their RSBY smart card or even if they do, some show up without the individual who gave her/his fingerprint at the time of enrolment. The latter happens if only one or some members of the household were asked to press their fingerprint.

There is also a pharmacist who sits at the MSHCS desk. It was reported that there is no big problem that is being faced by MSHCS till date. However, some suggestions were made for its improvement. It is felt that the ‘critical illness’ being covered by the Scheme is too narrow. Moreover, there are a variety of illnesses that are rare among the Mizoram population. Therefore, while broadening the scope of the list is one suggestion, another is replacing the ones that are not relevant with other

critical illnesses that are not on the list but are rampant. A notable point was made about Chronic Hepatitis C Infection which was professed as a self-inflicted disease. The workers stated that it was disheartening to see poorer sections of the population not able to claim their medical bills because their ailments are not listed on the illnesses covered by the Scheme while some from prominent families could do so for illnesses that result from their poor choice of lifestyles and the like. It was felt that it would be an added bonus if this Scheme could act as an avenue for equity. Moreover, if such alterations or widening of the scope of the list could be done, the public would not try and enrol in the RSBY scheme. They would enrol in MSHCS and the current fall in the number of enrolled beneficiaries would be minimised.

Even the staff members are at a loss what to do in regard to promoting awareness among the public. A couple of years have passed since its initiation, but hosting awareness programmes still remains a tricky business because it is hard to grasp the attention of the whole public using only a few methods. They joked that they ought to make a short film/documentary that shows what to do right from the time of registration/enrolment, what to do during the time of admission in hospitals to the time they are discharged. On a serious note, they stated that it should be done with different and specific techniques so as to reach even the remotest part of the State.

Of the two schemes, the MSHCS was felt to be easier to process because it does not need to go through all the steps that are needed in the RSBY. However, the RSBY has been earning substantial revenue for the hospital while the MSHCS is solely for the beneficiaries and only the exact amount of the bill is disbursed.

There was no hesitation on the part of the Help Desk when they were asked if they think the health insurance schemes should be continued in the future. It was further stated that the schemes are especially beneficial for the poorer section of the population who cannot afford to seek medical care from their own pockets. Moreover, the RSBY and MSHCS have greatly enhanced the physical and mental well-being of the State as a whole.

6.2. Case-2: Synod Hospital, Durtlang

Run by the Mizoram Presbyterian Church, the Synod Hospital, Durtlang is one of the most prominent hospitals of the State. They had undertaken the Mizoram Health Care Scheme since 2010. A counter is manned by 3 individuals who process the RSBY, the Mizoram Health Care Scheme, Medical Reimbursements of Govt. employees, etc. They work from 9:00 AM to 4:30 PM (a total of seven and a half hours) on a normal day and as such, patients needing hospital care could be admitted in hospital beds promptly. On a monthly average of 1323 admitted patients in the hospital, the RSBY accounts for about 15.57% and the Mizoram State Health Care Scheme about 3.5%.

An attention-grabbing fact is that they were not given any training beforehand and had attended a training programme only once. So it can be stated that their know-how is solely attained along the course of the job. This may be one of the reasons why they are of the opinion that they have a long way to go before they could consider themselves as experts although they are now quite fluent in what they ought to and must know.

Availing the benefits of RSBY smart card had been made possible since September, 2010. The process of admission for the card holders is the same as any other. Firstly, the beneficiaries are asked to press their fingerprint on a device for identification. The clerk then undergoes the process of registration and blocking after which they are admitted into the hospital. On leaving the hospital, the same fingerprint process is done. They are then acknowledged of the amount left in their account. However, this is done only to those who specifically ask of it as the counter is a busy one.

The biggest problem faced by the Synod Hospital medical reimbursement counter is slow internet connection. This poses great hindrance because the RSBY is run by software. Another great problem is on the part of the card holders. In some cases, during the enrolment process, only the head of the family would give his/her fingerprint while enrolling. So, this evidently becomes a problem when the head of the family becomes seriously ill and could not turn up at the counter to give his/her fingerprint. Another scenario is when the head of the household had died but was the only one who gave his/her fingerprint before. In addition to this, the card holders, in

times of emergencies, often fail to grab the very card that is needed for their registration. So, RSBY smart card holders encounter problems because of lack of awareness. It was also felt that the current package does not cover all their expenditure. Moreover, the maximum number of admission days is too short a time for some critical illnesses. Therefore, it is suggested that there be a higher package rate and the number of admission days be re-examined.

The Mizoram State Health Care Scheme, on the other hand, does not entail problems like that of RSBY. On submission of their reimbursement forms, it is being checked by the dealing clerks and after clarification, the medical reimbursement bills leave the hospital counter and sent to the Society mostly within 15 days. Usually they are sent to the Society before the total number of beneficiaries submitting their bills reaches 10 (8 on an average).

There have been some instances of the patients not being able to pay their hospital bills on being discharged. In such cases, the workers, after obtaining the green signal from the Society, transforms their bills into a credit one. All these show that their linkage with the Society is good and fair.

Problems arise with regard to Health Care Scheme when the name entered on the hospital sheet is not identical to that written in the enrolment form. For instance, during the time of their enrolment, same part of a person’s name is written in short but when admitted in a hospital, they give their full name. Evidently, this poses a problem on the part of the workers and the beneficiaries. The same goes for the age of the beneficiaries. This is viewed as a consequence of the ignorance of the public regarding the importance of such in the health insurance.

Among the hundreds that have been admitted, there have been a couple of instances in which people have tried to misuse the scheme. Once there was a woman who was admitted in the Hospital using her sister’s name but was later found out when that sister came to visit her. Another instance was when a person used a smart card of one who had already died. So, in order to avoid such practices, people should be made aware of the importance of enrolling in the Scheme and should give the name of the whole family irrespective of whether they were in the village or not during the time of the enrolment.

One of the suggestions put forwarded by the Hospital regarding the MSHCS is that the list of critical illness under the scheme be broadened. It was further stated that if the illnesses that is covered by the scheme is not expanded, the number of enrolled beneficiaries will continue to experience a downward trend. Another suggestion is that the Scheme would run smoother if it was managed and administered by at least one medical personnel.

Overall, the respondents felt that the Mizoram State Health Care Scheme is a good scheme and many have and will continue to benefit from it. With some of the modifications cited above, it is felt that the Scheme will be more successful in catering to the health needs of the common people.

6.3. Case-3: Primary Health Centre (PHC), Lengpui

Lengpui PHC can bed 15 patients at a time and serves as a health centre for the inhabitants of the locality (Lengpui) and for a number of neighbouring localities in and around the area. It boasts of 4 doctors and 7 staff nurses. The total number of inpatients it had hospitalised from January to August of 2013 is 149.

It was professed that the inhabitants of Lengpui as a whole are very conscious about basic health care. However, most of them, even when they fall seriously ill, cannot attain proper health care because of financial constraints. This may be one of the reasons why the MSHCS was received with open arms since its initiation.

An account clerk from NRHM looks after the MSHCS and RSBY Help Desk. The clerk has had training before managing the Schemes and also had attended another one after. So, it was professed that they know the ins and outs of the Scheme rather well. The Help Desk remains open within office hours.

All the registration and blocking of RSBY cards are being done accordingly. However, the hospital is not able to provide ‘cashless’ treatment. This is because they have had an unfortunate experience in the past where the reimbursement of bills was too slow to relay with new ones. An alarming statement made by the workers is that they had not received any reimbursement of bills for the current year. Moreover, the

hospital is unable to provide the mandate of Rs 100/- as travelling allowance to be given to the patients on discharge because of shortage of funds.

While the structure and system of RSBY was found to be a good one, it cannot be denied that there are problems in its implementation. It was further stated that if everyone followed the guidelines accordingly, then the Scheme would achieve an even higher substantial level of benefit. In addition to these, when there are failures in the system (machine), they had to pay certain amount of money for rebooting the computers. This would especially hard for the health centres in the rural parts of the State because they seldom put money aside for such circumstances from their limited funds.

On submission of reimbursement forms of the Mizoram State Health Care Scheme, they are being checked by the dealing clerk and the doctors and then sent to the Society for processing. Since it is but a Primary Health Centre and the magnitude of patients is not as great as that of District Hospitals, the reimbursement forms are being submitted to the Society within a couple of days even if it is the medical bills of one patient.

It was suggested that the coverage of the health insurance be broadened. The respondent also went on to say how disheartening it is to see poor patients who relatively spent a huge amount of money not able to claim reimbursement because their illness is not among the critical ones listed by the Scheme. It was also suggested that there should be effective regulation and monitoring of the Scheme in every part of the State.

It was also felt that the public should have a more sustainable outlook regarding hospitalisation. All things remaining the same, they should not opt for private hospitals (which are costlier compared to ones run by the govt) simply because they had enrolled in the Scheme. One must learn to live according to one’s standard.

Furthermore, the general public should try and learn every aspect of the Scheme. If this is attained, there would be lesser disappointment among the beneficiaries. The path to achieve this would be by promoting awareness programmes. It was strongly suggested that this awareness be undertaken by the

concerned department or Society because there is none other who are more proficient in it.

The true potential benefit of the Scheme has not been achieved or availed by the beneficiaries. However, it was without any hesitation that the workers advocated for the continuation of the Scheme. It was found that the Scheme is much appreciated by the beneficiaries of the locality, especially the poor.

6.4. Case-4: New Life Hospital, Aizawl

The New Life Hospital was established in 2009. It boasts of 43 hospital beds, 5 resident doctors, 38 staff nurses, 7 office staffs, and 7 lab technicians. The total number of hospitalised cases from January – August, 2013 is 2277. Although initially hesitated, the Hospital is currently waiting for the approval to be one of the empanelled hospitals of Mizoram State Health Care Scheme.

It is not to say that the Hospital had blindly hesitated to be among the empanelled hospital list. Rather, it used to manage the MSHCS way back in 2009 but stopped around the time the infamous scandal about the Scheme surfaced. They had not undertaken it since. However, as already mentioned, processing is underway so that it be among the empanelled hospitals.

The main reason of hesitation by the hospital to undertake RSBY or MSHCS is because the Schemes have the potential to suffer losses. The package rate is relatively low for the private hospital whose hospitalisation rates are high as compared to that run by the government. For instance, the price of admission for a night cost Rs. 250-300/-. When this is coupled with the charges of the doctor visits, a package rate of Rs. 500/- is more or less exhausted, leaving no amount for purchasing medicines, let alone diet charges. While this is not a problem for the government-run hospitals where almost everything can be attained at subsidised rates, it poses a great hindrance for the private ones. Moreover, even if the hospitals under the wing of the government incur losses, they have the government as its guarantor. The private hospitals, on the other hand, do not have any guarantor and have to fend for themselves and so, must operate in a commercial manner if they are to continue their run. It was stated that a higher package would be very much appreciated for the

empanelled private hospitals, if not for all. The respondent however knew that this might be a difficult task. Alternately, it would be a great help if the State government was able to provide facilities and medicines at subsidised rates for the private hospitals. This would be a substantial assistance for the functioning of both the RSBY and MSHCS. It was also suggested that the MSHCS be done as the likes of private investment providers. Specifically, the beneficiaries could enjoy higher coverage by paying a higher premium fee.

In addition, it was noted that cost-free medical care spoils the mentality of the people. It often leads to moral hazard in one form or the other among the beneficiaries. They tend to seek medical care from private hospitals that are viewed as more efficient and well-equipped than those run by the government just because they had been insured through the MSHCS or RSBY.

In spite of all these, the RSBY and MSHCS are noted as very good schemes for the people of Mizoram and its continuation is very much desired by the hospital.

6.5. Case – 5: Mr. C. Lalengliana, Khatla, Aizawl

This is the third year that Mr. C. Lalengliana and his family are enrolled as beneficiaries of the Mizoram Health Care Scheme. His son is a renal allograft recipient and had availed the insurance a couple of times. A family of five, their main source of income is the money earned from his pension and the income earned from being a sub-operator of a local cable for their locality.

On asking whether he thinks the Scheme is a good one, the respondent answered in the positive. He stated that it is a very good scheme for those not employed in the formal sector, even more so for the poor. He added that if they had not enrolled in the Scheme, they would encounter many financial constraints and might not be able to take up further treatments.

He went on to say that they would definitely enrol in the Scheme in the coming year as well. The amount of premium fee they pay is not considered costly knowing the benefit it brings about. However, he is fully aware that everyone might

not share his view. Especially for ones that are even poorer than them, they might find it hard to scrape up even the lowest premium fee of Rs. 500/-.

He did not recall facing any problem while submitting medical bills and is of the opinion that the time taken for processing the bill is fairly swift. It was felt that taken on an average, the bills claimed under MSHCS takes lesser time than that of the government employees'. While acknowledging that it may seem like a long time for the even poorer sections of the State, he added that any discontent that may arise among the beneficiaries could be because they do not fully understand the complex system that bills have to go through to finally be approved and disbursed.

Although he admitted that he did not know entire spectrum of the Scheme, he did have some suggestions to improve it. The regulations about the illnesses and the empanelled hospitals were found to be too narrow and so, the respondent recommended that it would be that much easier for the beneficiaries if they could submit bills and claims from any hospital, at least the ones in the vicinity of Mizoram. It was also suggested that the Scheme would be attain an added value if a patient could extend the amount of insurance that they are entitled. This can be done by making it *go-forward* type in which the spill over could be billed in credit for the next year. However, even the respondent felt that this would be a difficult and an impractical one even. In regards to educating the general mass about the Scheme, the respondent felt that no matter what type of programme it is, the most efficient way would be that done by the Sub-Centres, Primary Health Centres, etc. and the concerned Society because it was felt that there is none other who are more adept with the Scheme.

6.6. Case-6: Ms. Lalthanzami, Chhinga Veng, Aizawl

The sole breadwinner of a family of 4 (four), Miss Lalthanzami runs a small business in the busiest part of Aizawl market selling blankets and woollen clothes. This is just enough to suffice their daily needs but when a family member falls ill with critical conditions, there is little amount of money left for medical care. This speculation and precaution is what led the family to enrol in the Mizoram State Health Care Scheme.

Miss Lalthanzami's mother was one of the unfortunate ones who at the age of 69 contracted chronic Hepatitis C infection. She passed away on the 20th of May, 2013. On the course of her mother's fight against the disease, Miss Lalthanzami submitted a number of medical bills to the Mizoram State Health Care Society for reimbursement. As such, she knows full well the billing system of the health care scheme, at least where her mother's illness is concerned. Their reimbursement bills are usually submitted within a week of their date of discharge. However, they sometimes had to wait for a long time for the bill to be disbursed. She hypothesised that this may be on the part of the hospital and not with the Society, whom she stated to be working efficiently. She, on the other hand, is fully aware of how busy the hospital is and has no complains about it. All in all, she is glad that the Scheme is being managed by the Society and that the bills are out much faster than govt. employees' medical reimbursement bills.

On a different note, the respondent is of the opinion that the general public is not fully aware of the mechanism of the Scheme. The small percentage that are, are also because they had claimed and availed the reimbursement. Being asked which would be the best possible way of making the public aware, she answered that the department/persons dealing the Scheme could host public meetings on a local council level. Moreover, the fact that almost every locality has its own newsletter that comes out on a regular basis could be exploited. The workings of the Scheme, its scope and its dimensions could be displayed in such newsletters.

It is worth noting that the respondent highly praised the structure of the Scheme in which every household that enrolled in it do their bid and pay registration fee/premium. This inculcates a feeling of ownership among the public which cannot be attained if the Scheme did not require payment of registration fees/premium.

6.7. Case-7: Mr. Mark Lalmuanpuia, Zarkawt, Aizawl

Enrolled in Mizoram State Health Care Scheme since 2011, Mark Lalmuanpuia's family comprises of 6 (six) members. Their main source of income is a shop situated in the hub area of Aizawl city that sells inner garments and stationery items. The income obtained from various sources is just enough to cover for their

everyday needs. Saving is not possible but a small amount. Therefore, financial constraints arise when a member of the family suffers illnesses which demands intensive care. This is where the significance of the Scheme comes in.

High praise was given to the Scheme and the Society by the respondent. It was stated that any type of difficulty that they may have encountered during the process of billing are not that significant. However, a couple of suggestions were given to further enhance the reach and working of the Scheme. One of them is the duration of processing the bill. It usually takes a longer time than expected which again for the poor beneficiaries can be perceived to be longer than it actually is. It was felt that a shorter duration of the billing process would help in gaining popularity and confidence among the public.

It was also pointed out that the Mizoram public are not aware of the system of the Scheme. Proposal on how to create awareness, however, was not solidly given by the respondent because it was felt that there is no single way of providing information to the public with different lifestyles and unique practices. Nevertheless, it was stated that the booklet published by the Mizoram State Health Care Society could very well be the most significant of the lot. Here, too, the mere availability of the booklet for every household is not enough. The public has to do their part in studying and learning about the system of the Scheme, what illnesses are being covered by the insurance, etc.

Although some alterations could be made, the respondent felt that the list of critical illness listed under the Scheme is good as it currently is. It was further stated that they would definitely enrol in the Scheme in the coming year as well.

6.8. Case-8: Mr. P.C. Lalfala, Falkland, Zemabawk, Aizawl

A civil pensioner, P.C. Lalfala, was the Deputy Director of the Directorate of School Education, Govt. of Mizoram till 2012. He and his family enrolled in the Mizoram State Health Care Scheme right after he was relieved of his government duties. Even while he had the formal employment, he was an enthusiast of the Scheme since he knows well the benefits of health insurance.

He stated that MSHCS is an excellent scheme and was of the opinion that the people would greatly benefit from it. At the same time, the respondent felt that the public is not fully aware of the system of the Scheme. This leads to frustration as most of the public are of the notion that a mere admission in a hospital bed entitles the reimbursement. Although clearly written in the guidelines, people seldom go through them to try and learn the true workings of the Scheme. In other words, discontentment occurs among the beneficiaries as a consequence of lack of awareness of the scheme and its system. Mr. Lalfala felt that this is the main problem faced by the Scheme that hinders its popularity and confidence.

What would bring about a remarkable change in the attitudes of the people about the Scheme is broadening the scope of 'critical illness' that is currently being covered by the Scheme. However, this would not an easy task and might not even be possible. Therefore, it was also suggested that the best alternative would be to educate the masses. Here too, it was suggested that most efficient way of teaching the public about the Scheme would be to exploit the media. One can broadcast talk shows in the local cable TV for most of the urban areas and in Doordarshan Kendra and radios for the rural parts of the State. He further stated that these are just suggestions and that it is really hard to know how to tackle any problem from the outside. Therefore, any reformation would best be those done by the concerned department.

Mr. Lalfala stated that there is some kind of gap between the people and the concerned department and the Scheme. Even the interviewee is not sure what is and what causes this gap. However, he strongly feels that this gap is caused by the lack of information and awareness about the Scheme. He further advocated that if this gap can be bridged, the Scheme would earn its rightful confidence among the public.

Chapter – 6

CONCLUSIONS & RECOMMENDATIONS

7.1. Conclusions

There has been a growing effort of the State Government to provide health care facility to all its citizens, especially to those who are not entitled under medical attendance rules of government or other bodies. This is reflected in the State's ability to raise its matching share contribution towards the significantly increasing budget of RSBY since 2010 long with its task of implementing MSHCS. Further, there is an impressive return on the investment of Health Insurance Corpus Fund received from ADB by the State Finance Department indicating the healthy financial position for MSHCS. In fact, it is a commendable achievement of the State Government in providing health care insurance for its population. At the same time, it is to be noted that the revenue generated from premium collection, being earmarked for administration and capacity development, by the implementing Society is comparatively low. This has resulted in the continued reliance of the implementing agency on the corpus fund for administration and capacity development. Thus, with the increasing fund requirement for administrative expenses and capacity development, it is feared that the existing trend would pose problem on the sustainability of corpus fund management and hence the scheme.

The MSHCS is one of the most universal health care schemes ever adopted in the country in terms of breadth of coverage (eligible population); as against this, its achievement in case of enrolment is rather low. Meanwhile, the majority of the respondents are in favour of furthering its depth of coverage by broadening the list of critical illness and upward revision of package rate.

The participation of primary care providers, PHC and CHC, in the scheme was found to be very low. Roughly, the result suggested the presence of moral hazard on the part of the beneficiaries towards seeking high end treatment in urban areas post-insurance. However, these hospitals are found technically unfit for providing treatment of such enlisted critical illnesses under the scheme. Moreover, almost half of the claim received by the Society is related to Chronic Hepatitis C Infection, which was professed as a self-inflicted disease in a number of cases as a result of their poor

choice of lifestyle. It is said that it was unfair to shun poorer sections of the population from availing medical claims because their ailments are not listed on the illnesses covered by the Scheme, while some from prominent families could do so for illnesses that result from their poor choice of lifestyles and the like. Meanwhile, there are some poor patients suffering from Hepatitis C (Ref. Case-6) who would not have received proper treatment if the scheme were not in place. So, a re-thinking of such case is invited to serve the basic purpose of the scheme without compromising its sustainability.

On an average, significantly high claim outgo per patient per treatment is observed in case of referral patients. While the claim outgo for more than 90 percent cases are below Rs.30000 suggesting the suitability of the assured amount as set out by the scheme; the claim size of 58 percent referral patients is greater than Rs.30000. At the same time, average deduction rate turned out to be 26.89 percent for referral patients and 11.96 percent for others. This has necessitated the continuous review of package rates for referral cases and to the cases which showed high deduction rate. However, as far as possible, transparency should be maintained while reviewing the package rates.

Analysis of turn around time (TAT) revealed that the time taken for processing the bills is fairly quick. The Society took an average of 15 days with standard deviation of 10 days to finalize all medical bills from the date of receipt. One of the indicators of the successful implementation of any health care scheme should be the existence of the system that expedite settlement and disposal of claims. Consequently, the fairly quick settlement of claims must be a commendable success of the Mizoram Health Care Society. However, one should not overlook the volume of claims that entered into the process that it is still below 2000 in the half way mark. Thus, the same speed may not be feasible had all eligible or targeted families in the State been enrolled in the Scheme.

An imperfect aspect of the implementation of health care scheme in Mizoram could very well be the absence of MIS reporting system. The study observed that the implementing society has generated no MIS report relating to amount paid, deducted & reasons, geographical cost variations, disease profiling, funding position, etc. Further, the claimant patients were not informed, in writing or otherwise, of the

amount rejected and reasons, balance amount while disbursing the bills. To cope with the problems that are arising out of asymmetric information, MIS report covering all key attributes of the scheme should be demanded on a regular basis.

There persist unfavourable health care seeking behaviour among beneficiaries of the scheme that 95 percent of them said they do not have regular medical check up and almost 50 percent of them said they seek institutional health care only when serious illness befall them. Moreover, around 44 percent of these respondents said they used to consume self-prescribed medicine in normal illnesses. This aversive behaviour towards institutional health care can have ramifications on the failure of the public health care schemes to serve its purposes.

The persistence of high risk behaviour was also observed among the beneficiaries. There has been mass prevalence of tobacco consumption in the study areas. Smoking incidence among the adult beneficiaries turned out to be almost 50 percent, while more than 58 percent of the adult beneficiaries are consuming tobacco and its products, i.e. chewing tobacco, khaini, tuibur, gutkha, tiranga, etc. This should be a serious concern for the State Government, the Health Care Society in particular, because the middle aged or working ages are the real risk group.

Low awareness level of the scheme is another problem. The majority of the beneficiaries joined the scheme without having any clear knowledge of the benefit packages and its guidelines. It was found that majority of the beneficiaries did not read HCS Booklet issued by the Society, nor were they informed of the assured amount and other benefit packages at the time of enrolment. At the same time, there has been confusion of the scheme with its counterpart RSBY scheme which, in many cases, resulted in non-enrolment.

The performance of hospitals in providing health care services to the patients is fairly impressive that the majority of the respondents said they are good, except for MR Bill preparation/processing reflecting the public confidence on the medical staff in their service of health care delivery. However, unimpressive performance is observed in case of bill preparation for onward submission to Health Care Society. The hospital staffs entrusted with the task of bill preparation at the hospital level attained no prior training to carry on with their work resulting in inefficiency. Thus,

capacity building on the part of the hospital staff would be very crucial towards the successful implementation of the scheme.

At the same time, the Mizoram State Health Care Society had not performed well in the front of customer service, awareness creation and gaining public confidence, while it performed well in case of bill settlements. Its capability in respect of financial and human resource management is also highly questionable for a larger volume of works. So, enhancement of its administrative efficiency and capacity would be of crucial importance.

The scheme has significantly positive impact upon the lives of the beneficiaries that most of the beneficiaries interacted with said that the scheme has enhanced their health care access and significantly reduced family expenditure burden on illness. A big portion of the respondent (88 percent) said the scheme has enhanced their care access, while 90.5 percent said it has reduced their expenditure burden, which had to be met with by borrowing. Thus, more than 94 percent of the total respondents considered the scheme as good and should be continued; and 98.86 percent of them said they would enrol the next year.

In a nutshell, it must be concluded that the scheme has been successfully implemented and the positive impacts are clearly visible on the lives and thinking of the stakeholder patients and their families.

7.2. Recommendations

Though a lot of positive aspects have emerged from this study, there are still large areas for improvement under the scheme. Following are the main recommendations of the study:

1. It is recommended that multi-pronged approach be adopted to promote awareness about the benefits of the scheme. The target population should be made aware of how to enrol in the scheme and the benefit packages that are admissible under the scheme. Some of the suggested approaches are:

    i) Repeated public announcement made during news broadcast in the Local Cable and Doordharshan Kendra would be much effective for wider publicity of enrolment time and procedure,
    ii) An interview of those patients who have availed the benefits in the DDK or local channel can also be an effective means to create public confidence on the scheme,
    iii) Wide circulation of information booklet published by the Society, and
    iv) Making available the list of all empanelled hospitals in all Sub-Centres.

2. It is recommended that more efficient strategy for capacity development be made for the functionaries of the Mizoram State Health Care Society. This would include hospital staff who are involved in the day to day activities of the scheme, Health Workers, and other medical staff who are directly or indirectly involved in the scheme.

3. Periodic MIS on operational aspects like paid and unpaid claims, age analysis of the patients, total amount claimed and paid, funding position and patterns, etc are essential for concurrent review of effectiveness of the scheme. Of equal importance is reporting of the health care related data like disease profile of the insured, age and sex disease profile, district wise profiles, cost parameters relating to different diseases, etc. Thus, it is

recommended that MIS reporting system be developed to ensure information symmetry and sustainability in the management.

4. A periodic review of package rates should be put in place to reflect current cost levels so as to benefit the health care providers as well as the beneficiaries.

5. A system of redressal for grievances and complaints should be put in place to address the problems of the patients.

6. The most popular suggestion received during the study was broadening of the scope of critical illnesses. It is said that the present list is deemed to be too narrow to capture even the most frequently contracted illness among the population of Mizoram. If this is the case, a re-look into the existing list of critical illness be made to suit the need of the people and this is expected to be positively responded to by enrolment.

7. Enrolment process should begin well in advance before the expiry of the current policy, and care should be given to correctly record the details of the beneficiaries (i.e. name, age, sex, etc).

8. It is further recommended that a mechanism for continuous assessment of customer/patient's satisfaction be instituted to assess the weakness and strengths of the health care scheme.

Enrolment Status (1-yes, 2-no)	
Reason, if no (give code)	

INTERVIEW SCHEDULE
(*Confidential*)

SECTION – A: FAMILY PROFILES

A1. Identification of sample

1. Village		2. RD Block	
3. District		4. Sector (1= Rural, 2 = Urban)	
5. Date of Interview		6. Family Status (1=APL, 2=BPL, 3=AAY)	
7. Family size		8. Housing Status *(1-Katcha, 2-Semi-Pucca & 3-Pucca)*	9. Main source of drinking water *(1-PHE supply, 2-Public Well, 3-Hand Pump, 4-Stream, 5-Rain water & 6-others)*
10. Distance of the nearest hospital (Km)		11. Status of the nearest hospital (Govt. -1 & Private – 2, NGO/Charity-3)	

A2. Name of Respondent: _____Relationship with head of the family ☐ (1-self, 2-husband, 3-wife, 4-father, 5-son, 6-doughter, 7-in-law, 8-grand father/mother, 9-other)

A3. No of policy held by the family ☐ (since a family can have more than 1 policies)
Details:

Policy Status	Has received enrolment Card/Smart Card? (1-yes, 2-no, 3-informed but not collected)	Premium Amount (Rs) (Inclusive of Registration Fee)	Insurance Cover (Rs)

Policy Code: 1-RSBY BPL Smart Card, 2-RSBY MNREGA, 3-APL

A4. Details of the family members (Policy – 1, if enrolled)

Sl. No	Name	Age	Enrolled? (1-yes, 2-no)	Sex	Marital Staus	Relationship with head of family	Educational status	Occupation	Smoking? (1-yes, 2-no)	Chewing Tobacco (1-yes & 2-no)	Liquor (1-never 2-sometimes & 3-regular)
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10*	*(11)*	*(12*

Col. (5): 1-Male, 2-Female; **Col. (6):** 1-Married, 2-Single, 3-Separated, 4-Widowed, 5-other; **Col. (7):** 1-self, 2-husband, 3-wife, 4-father, 5-son, 6-doughter, 7-in-law, 8-grand father/mother, 9-other; **Col.(8):** 1-Illiterate, 2-Literate without schooling, 3-Primary level, 4-Middle (Secondary), 5-High School, 6-Higher Secondary, 7-Graduate, 8-Post-Graduate; **Col. (9):** 1-Children, 2-Student, 3-Agriculture, 4-Daily Labour, 5-Govt. Employee, 6-Working under Private/NGO, 7-Business/self-employed, 8-Domestic work, 9-other.

A5. Details of the family members (Policy – 2, if enrolled and has 2 policies)

Sl. No	Name	Age	Enrolled? (1-yes, 2-no)	Sex	Marital Staus	Relationship with head of family	Educational status	Occupation	Smoking? (1-yes, 2-no)	Chewing Tobacco (1-yes & 2-no)	Liquor (1-never 2-sometimes & 3-regular)
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*	*(11)*	*(12)*

A6. Does anyone in your family have chronic illness? ☐ (1-yes, 2-no)

A6.1. If yes, give details

Sl. No A4/A5	Name	Nature of illness	How long (years)

Natna: 1-High Blood Pressure/Blood Sugar/Asthma, 2-heart problem, 3-transplant, 4-hepatitis, 5-AIDS/HIV, 6-cancer, 7-others.

A7. Does any one in your family have any type of disability? ☐ (1-yes, 2-no)

A7.1. If yes, give details

Sl. No A4, A5	Name	Nature of Disability

Disability: 1-Physical, 2-Visual, 3-Hearing, 4-Speaking, 5-Mental, 6-Other

B1. Main source of family income and amount

Main source		Amount (Rs)	1-Monthly & 2-yearly
1-Salary (under Govt.) 2-Salary (casual works under Govt) 3-Daily wages 4-Agriculture and Allied activities 5-Business 6-Salary (privat/NGO) 7-Other			

B2. Details of family Expenditure:

Sl. No	Items Head	Reference Period	Amount (Rs)
1	Food items	Last Month	
2	Pan, Tobacco & Intoxicants	Yesterday	
3	Education	2013 (till June)	
4	Medicine and Health related	Last Month	
5	Conveyance	Last Month	
6	Housing and Furniture	2013 (till June)	
7	Sanitary Items (soap, etc)	Last Month	
8	Clothing and cosmetics	Last Month	
9	Bills and Rent (including house rent, electric bill, phone bill, internet bill, etc)	Last Month	
10	Other	Last Month	

SECTION – C: HEALTH EVENTS FOR ALL FAMILY MEMBERS DURING 2013

C1. Does anyone of your family suffered from health problem this year? ☐

C1.1. If, give details (1-yes, 2-no)

Sl. No. (Ref. A4/ A5)	Policy (1 or 2)	Reason for illness?	Name, if disease	Did you approach doctor for check up?	If yes in Column 5, place	How long he/she suffered? (days)	Outcome?	Hospitalization?	If yes in 9, hospital status	No of days in hospital?	Nature of Treatment in Hospital	How many times hospitalized?
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)

Col.(3): 1-Disease, 2-Accident & 3-Other Problem; **Col.(4)**: 1-Heart, 2-Cancer, 3-Medicine, 4- Surgery, 5-Eye, 6-ENT, 7-Bones & joint, 8-Paediatrics, 9-Skin, 10-Mental Problem, 11-Gynae, 12-Dental Surgery & 13-ICU Care; **Col.(5)**: 1-Yes, 2-No; **Col.(6)**: 1-Hospital OPD, 2-Private Clinic, 3-Other; **Col.(8)**: 1-Restored, 2-Died, 2-Undergoing treatment, 4-Referred outside, 5-Resulted in Disability; **Col.(9)**: 1-Hospitalized & 2-Not-hospitalized; **Col.(10)**: 1-PHC, 2-CHC, 3-District Hospital, 4-Civil Hospital, 5-Other Govt. Hospital, 6-NGO/Charity/Church, 7-Private Hospital; **Col.(12)**: 1-Normal Treatment, 2- Surgery, 3-Therapy, 4-A other

C2. Expenditure during pre and post hospitalization (hospitalized only) (Claimed details not require for non-enrolled)

Sl. No (Ref. A4&A5)	Expenditure (Rs)			Claimed Amount (Rs)		Approved Amount (Rs)		Days taken to clear the bill
	Medicine	Investigation	Food , Conveyance and others	Cashless	Re-imbursement	Cashless	Re-imbursement	

C3. Expenditure in connection with health event (non-hospitalized)

Sl. No (Ref. A4&A5)	Name	Reason for non-hospitalization	Expenditure (Rs)		
			Medicine	Conveyance	Investigation and others

Reason for non-hospitalization: 1-financial problem & 2-did not advised by doctor

C4. Have you received transportation cost from the hospital? (1-yes, 2-no) ☐ (Not required for non-RSBY)

C5. Health Expenditure caused indebtedness? (1- yes, 2-no) ☐

SECTION –D: COMMUNICATION NEEDS ASSESSMENT

D1. Do you read newspaper regularly? (1-yes, 2-no) ☐

D2. Do you listen to Radio regularly? (1-Yes, 2-No) ☐

D3. Do you watch TV news regularly? (1-Yes, 2-No) ☐

D4. Do you read regularly the advertisement given in newspaper? (1-Yes, 2-No) ☐

D5. What, in your opinion, will be the most effective time for giving advertisement/announcement in TV Channel?

1- Before and After News
2- While Movie Show
3- Reality Show
4- Scroll

☐

SECTION – E: AWARENESS ABOUT THE HEALTH CARE SCHEME

E1. Does anyone of your family have LIC Policy? *(1-yes, 2-no)* ☐

E1.2. If yes, how many members? _____

E2. Clarity of the respondent on the Insurance Policy *(1-No clear, 2-Some Extent, 3-Great Extent)* ☐

E3. When did you come to know Mizoram Health Care Scheme?

1- This year
2- 2 years ago
3- 4 years ago
4- Long time back

☐

E4. Excluding 2013, had you enrolled in the HCS before? (1-yes, 2-no) ☐

E4.1. If yes, which year_____, and got it renewed when required? (1-yes, 2-no) ☐

E5. From where did you come to know the HCS information?

1- Announcement/Advertisement in TV/newspapers
2- Village Council
3- Medical Staff (Health Worker) and information booklet
4- Friends
5- NGOs

E6. Reason for joining/enrolment into HCS

1- As advised by neighbours, relatives and friends
2- It is good for our family
3- As advised by medical staffs (including doctors)
4- To avoid the risk of unexpected medical expenditure
5- Others

E7. In your opinion, RSBY and Mizoram State Health Care Scheme are

1- Same
2- Different, but goes side by side
3- I cannot differentiate the two

E8. (Field Officer's Perception) Knowledge of the family about the HCS and its features and importance of having medical insurance? (1-Poor, 2-Some Extent, 3-Good Extent)

SECTION – F: SERVICE PROVIDERS

F1. Give the following grades to the hospital where you/your family members were admitted?

1- Poor
2- Average
3- Good
4- Very Good

F2. About the hospital staff (including doctors)?

1- Poor
2- Average
3- Good
4- Very Good

F3. Supposing that you are ill and there is no Health Care/RSBY scheme available, which hospital would you approach?

1- The same hospital I used to visit
2- Other Private Hospital
3- Other Govt. Hospital
4- I will not go to hospital
5- No idea

F4. Did you face any problem while claiming Medical Re-imbursement? (1-yes, 2-no, 3-NA)

F4.1. If yes, where did you face that problem?

1- Hospital
2- Health Care Office
3- Other Place

F4.2. If yes, whom do you blamed for your problem?

1- Doctor
2- Hospital staff
3- Health care office staff

F5. Did any person asked you to give money (excluding normal fee) while claiming your Medical Re-imbursement? (1-yes, 2-no, 3-N

F.5.1. If yes, which of the following?

1- Doctor
2- Hospital staff
3- Health care office staff
4- Pharmacists

F6. Do you think the Mizoram Health Care Scheme is good, for your family and relative, and it should be continued for the ure? *(1-yes, 2-no)*

F7. Do you find the enrolment procedure of HCS complicated and difficult? *(1-yes, 2-no)*

F7.1. If yes, at what point?

1- Fee (Premium) is high
2- Many formalities
3- Staffs are unfriendly
4- There is no detailed information

F8. The existing enrolment time is good? (1-yes, 2-no)

F8.1. If no, which is the best season for enrolment?

1- Winter Season (December-January)
2- Pre-Monsoon Season (February – May)
3- Monsoon Season (June – August)
4- Post-Monsoon (September – November)

F9. Will you enrol next year? (1-yes, 2-no)

F12. Give suitable grades to the Health Care Society and its Staffs according to the following points

Customer Care	Time taken to clear MR Bills	Dissemination of information among the stakeholders	Public confidence gained

1-Poor, 2-Average, 3-Good, 4-Very Good, 5-Excellent

F13. Give grades to the Public Health Care Providers (medical Staffs) in Mizoram on the following points

Hospital Staff			**Other Medical Staff**	
Dedication of Staff (nurse, etc)	Dedication & Commitment of Doctors	Preparation of MR Bill	On the Performance of Health Worker	FTD/ASHA

1-Poor, 2-Average, 3-Good, 4-Very Good, 5-Excellent

SECTION – G: ON FACILITY & FAMILY'S HEALTH CARE SEEKING BEHAVIOUR

G1. Availability of Health Care Facility

1. How far is the nearest Hospital from your village/locality (km)	
2. Where do you mainly go for medical check up? (1-Private Clinic, 2-Govt. Hospital, 3-Private Hospital, 4-NGO/Charity Hospital, 5-Other)	
2. How far is the place (Sl. 2 above) (km)	
3. How long does it take to reach the nearest hospital from your house-by vehicle (minute)	
5. Average waiting period of Doctors while going for check up (minute)	

G2. Behaviour of the family on health care?

1. Has your family medical check up regularly? (yes-1, no-2)	
1.1. If yes, how often? (1-once in a month, 2-once in two months, 3-once in three months, 4-once in six months, 5-once in a year)	
1.2. Place (health sub-centre-1, Govt. Hospital-2, Private Hospital-3, Private Clinic-4, Other Medical Practitioner-5)	
2. *If no for medical check up (1),* When do you go for check up (1-never, 2-whenever ill, 3-only on serious illness, 4-at the advise of others)	
2.1. If you do not consult doctor, who prescribe you the medicine? (1-relatives and friends, 2-pharmacist/medicine seller, 3-self prescribe)	

G3. Any other:_____
_____

G4. Will you mind if we disclose the information furnished by you? (1-agreed, 2-disagreed) ☐

G5. *Perception of the Field Officer: The information furnished by the respondent is (1-not reliable, 2-reliable & 3-very reliable)* ☐

Signature of the respondent Name & Signature of Field Officer

ANNEXURE – II

SPECIFICATION OF SCHEME BENEFITS 2013

Name of the Scheme

1. Mizoram State Health Care Scheme.

Objective of the Scheme

2. The objective of the Scheme is to improve access of families to quality medical care for treatment of diseases involving hospitalization and surgery through an identified network of Health Care Providers. Each family shall cover all eligible family members under this Scheme.

Covered Benefits

3. **Hospitalization** - The Scheme shall provide coverage for meeting expenses of hospitalization and surgical procedures of BPL beneficiary members up to Rs. 70,000/- per family per year subject to limits, in any of the network hospitals, after having exhausted RSBY cover of Rs. 30,000/- only. The cover shall be on family floater basis.

4. **Critical Illness** - A buffer floater amounting to Rs. 2,00,000/-, over and above the normal cover can be availed of individually or collectively, by members of the BPL family suffering from below listed critical illness. APL families will avail benefits only under this critical illness cover within a sum insured of Rs. 3,00,000/-. This buffer floater will be made available for beneficiaries with identified critical illness (excluding related ailments except where specified) as given under:

I. CARDIOLOGY AND CARDIOTHORACIC SURGERY

1. Coronary By-pass Surgery (CABG).
2. Valve Replacement / Repair or Valvuloplasty.
3. Correction of Congenital Heart Diseases eg. VSD, ASD, TOF, etc.
4. Angioplasty and PTCA Stent.
5. Permanent and Temporary Pacemaker Implantation.
6. Surgeries for Repair of Aneurysm.
7. Electrophysiologic Study and Radiofrequency Ablation.
8. Pericardial Surgery & Pericardial Effusion requiring Drainage.
9. Acute Coronary Syndrome (Unstable Angina, Myocardial Infraction).
10. Heart Failure / Cardiogenic Shock.

II. ONCOLOGY

1 Surgical Management of all Malignant Tumours.

2 Radiation Treatment of Malignancies.
3 Chemotherapy / Targeted Therapy for Treatment of Malignancies.
4 Complications and Toxicities of treatment of Malignancies.

III. MEDICINES

1. NEPHROLOGY

1. Kidney Failure.

2. RESPIRATORY SYSTEM:

1. Respiratory Failure.
2. Pulmonary Thromboembolism.

3. GI TRACT

1. GI bleed requiring Surgical Intervention
2. Non alcolohic Acute Pancreatitis with Complications.

4. ENDOCRINOLOGY

1. Diabetic Ketoacidosis.
2. Other Metabolic emergencies (eg: Thyrotoxic Crisis, Myxoedemic Coma, Pheochromocytoma, Cushing's Disease, etc).

5. CNS

1. Acute Stroke - any Cerebro Vascular incident producing permanent Neurological Sequelae.
2. Acute Myelopathies requiring Medical Board Referral.
3. Hydrocephalus requiring Surgical Intervention.
4. Myasthenic Crisis.

6. HEPATOLOGY

a) Liver Abscess requiring Surgical Intervention.
b) Hepatic Encephalopathy.
c) Hep B &C on Interferon / Antiviral Therapy treated only at Civil Hospital, Aizawl & Lunglei.

7. HEMATOLOGY

1. Complicated Cytopenias (eg : Aplastic / Hypoplastic Anaemias, Neutropenias, Thrombocytopenias).
2. Hemoglobinopathies requiring Splenectomy (Thalassemia/Sickle Cell Anemia).
3. Thromboembolic Disease (eg : DVT, Mesenteric Artery thromboembolism, Pulmonary Thromboembolism, etc).
4. Bleeding disorders (eg : Hemophilia).

8. CONNECTIVE TISSUE DISEASE

1. SLE, Mixed Connective tissue disease, etc.

9. INFECTIVE DISEASES

1. Complicated Malaria (identified according to WHO criteria).
2. Multi Drug Resistant Tuberculosis.

10. ***ORGAN TRANSPLANT*** **:** Renal / Bone Marrow / Liver/Heart / Stem Cell (for treatment of Malignancies, etc), and including 'the' donor only.

IV. SURGERY

1) ***UROLOGY/NEPHROLOGY***

1. Nephrectomy and Surgery for Perinephric Abscess.
2. Urinary Stone cases requiring surgery under GA

2) GASTROENTEROLOGY

1. Acute Abdomen requiring major/emergency surgery : eg – Gut Perforation, Acute Appendicitis, Volvulus, Intussusception, Peritonitis, Intra- Abdominal Abscess, Acute Cholesystitis with Cholelithiasis etc.
2. Pseudocyst of Pancreas requiring Surgery.

3) ***NEUROLOGY AND NEUROSURGERY***

1. Life saving surgeries on Brain (eg:Intracranial Hematomas/Abscess) and Spinal Cord.

4) PLASTIC SURGERY

1.Treatment of major burns with complications.

V. OPHTHALMOLOGY

1. Surgery and other procedures for Detachment of Retina.
2. Surgery for Glaucoma.
3. Vitreous Heamorrhage, Vitrectomy.
4. Laser treatment of Retinopathies (to SSN referred cases only).
5. Orbital fracture and penetrating eye ball injury
6. Intracranial blood disorders involving eye
7. High Myopia with impending retinal damage

VI. ENT

1. Mastoidectomy.
2. Middle Ear Disease requiring Operation in Children (excluding Intracranial Implants like Cochlear Implants, etc).
3. Stapedectomy.

VII. ORTHOPAEDIC SURGERY

1. Joint Replacement (Hip / Knee, etc).
2. Surgery for correction of Fractures of Bones and Joints.
3. Arthroscopic Repair of Ligaments

4. Major limbs amputations (legs / arms / foot) due to any diseases excluding single digits / terminal Phalanged Amputations (with Prosthesis).
5. Correction of Locomotor disabilities due to Congenital & Acquired Contractures.
6. PIVD with Severe Cord Compression requiring Surgery.

VIII. ICU CARE

1. Any seriously ill patient requiring ICU admission to sustain life (excluding routine post-operative patients and uncomplicated surgeries).

IX. PAEDIATRICS

1. CNS - Meningitis / Encephalitis.

2. *Respiratory System* - Severe Pneumonia with related complications.

3. *Nephrology* - Complicated Nephrotic Syndrome.
- ARF.

d**.** *Newborns* - Birth Asphyxia and related complications.
- Preterm / VLBW requiring NICU care.
- Congenital Malformations requiring Major Surgery.

X. DERMATOLOGY

1. Steven Johnson's Syndrome – drug induced.

XI. PSYCHIATRY

1. Psychiatric Emergencies (eg : Manic / Ac Psychotic Disorder).

XII. OBS AND GYNAECOLOGY

1. Emergency life saving operations (eg : Ruptured Ectopic Pregnancies, DUB, Twisted Ovarian Cyst, etc).

b**.** LSCS complicated by Rupture Uterus, Re-opening of Abdomen.

XIII. DENTAL SURGERIES

a. Post Traumatic Maxillofacial fractures requiring Surgery.

<u>Eligibility of Beneficiaries</u>

11. Any non- Government Servant (Central or State) or their dependents who is a bonafide citizen of India and residing in Mizoram, with the Head of the Family thereby being in the Voters list or the Head of the Family having Voter ID Card shall be eligible to be covered under this Scheme, irrespective of age. The Scheme

will also cover dependents of Government Servants (Central or State), who are not covered under the existing Medical Attendance Rules such as Grandchild, daughter / son-in-law, overage children, sister / brother, uncle / aunty, niece / nephew, etc. The Scheme will also cover personnel and their dependents working under the Government of Mizoram eg: Contracts, Muster roll, etc who are not entitled to medical reimbursement under the existing rule in force. The Scheme will not cover persons and their dependents working under church organizations and who can thus be eligible for claiming their medical reimbursements their respective church organization

12. Coverage under the Scheme would be provided for all family and their members as per the photo ID Card / Smart Card issued to them. Prior to issue of Photo ID Card / Smart Card, copy of enrollment form with Voter ID may be used as proof of coverage.

13. **Family** – A family would be defined as anyone living under one roof, irrespective of their relationships and duly ascertained by the Family Ration Card. Any addition / deletion of family members e.g. death, birth, divorce, marriage, adoption etc. the same will have to be recommended by the concerned Health Worker / Medical Officer / Senior Medical Officer / Chief Medical Officer and certified by the Mizoram State Health Care Society.

14. **Proposed Payment of Premium**: The family members will be restricted to 5 members for APL families, while for BPL families, this number limit will not be applicable. Payment of premium for a family of 5 or families whose number is above 5, payment of Premium may is as below:

Table III: Details of Premium Payment:

BPL, family members< 5	**APL**	**APL, family members < 5**	**APL, Additional family member > 5**
Nil	Sum insured up to Rs. 1 lakh	Rs. 500/-	Rs. 100 per additional member
	Sum insured up to Rs. 2 lakhs	Rs. 750/-	Rs. 200 per additional member
	Sum insured up to Rs. 3 lakhs	Rs. 1,000/-	Rs. 300 per additional member

15. **Dependents** - The dependents should be living in the same household. "Dependents" are those who depend upon the Head of the household for their basic subsistence / care.

Insured Benefits

16. Pre-existing conditions to be covered, subject to minimal exclusions as per clause 19.

17. **Transport Allowance** - Provision for transport allowance as part of the sum insured will be allowed for the patient along with one attendant by any public service vehicle at the rate as may be fixed by the State Transport Authority from time to time. In case of an emergency / exceptional case, hiring of private vehicle may also be allowed, provided it is duly certified by the Medical Officer i/c of the Hospital. The cost of travel that would be reimbursable for a patient that has to be shifted from residence to hospital in case of admission in Emergency or from one Hospital / Nursing Home to another Hospital / Nursing Home for better medical facilities. Expenses for travel (Fares only) would have a ceiling of Rs. 1,000/- within the State and Rs. 10,000/- for travel outside the State per claim. Reimbursement for travel outside the State would be considered for treatment of named Critical Illnesses only. Further, only the lowest fare available for the journey shall be considered for reimbursement.

18. Relevant medical expenses incurred for the period up to 1 clear day prior to hospitalization and up to 10 clear days from the date of discharge from the hospital shall be part of the benefit. This pre-hospitalization coverage would also include all pre-admission investigations pertaining to the particular hospitalization and not subject to the 1 clear day pre-hospitalization coverage and duly certified by the treating doctor. However, in cases of organ transplantation patients, post hospitalization coverage would be extended up to 30 clear days.

19. **Maternity and New Born Benefit:**
    - **a.** This means treatment taken in Hospital / Nursing Home arising from childbirth including normal delivery / caesarean section and / or miscarriage or abortion induced by accident or other medical emergency except voluntary medical termination of pregnancy.
    - **b.** Newborn child shall also be covered from day one up to the expiry of the Policy and expenses incurred for treatment taken in hospital as in-patient. This benefit shall be a part of basic sum insured and new born will be considered as a part of insured family member till the expiry of the policy. However, hospitalization prior to delivery can be taken under medical procedures and will not be included under this benefit.
    - **c.** The maximum benefit allowable under this benefit will be up to Rs. 10,000/- . For complicated cases such as Cesarean Section, the amount covered will be

subject to actuals, provided certification from the treating doctor is included in the claim. This benefit shall be a part of basic sum insured.

Note:

I. *For the Policy period, new born will be provided all benefits under the Scheme and will NOT be counted as a separate member.*

II. *Verification for the new born can be done by any of the existing family members who are getting the Scheme benefits.*

20. **Minimum period of hospitalization:** The minimum period for which a beneficiary is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease / ailment contracted / injuries sustained under the Scheme shall be at least 24 hours

21. **Day Care Procedures**: Given advances in treatment techniques, many health services formerly requiring hospitalization can now be treated on a day care basis. Examples of such services which are included for coverage under hospitalization benefits are:

a. Dialysis
b. Parenteral Chemotherapy
c. Hepatitis B
d. Hepatitis C
e. Drug Resistant TB
f. Radiotherapy
g. Epilepsy
h. Eye Surgery
i. Lithotripsy (Kidney stone removal)
j. Tonsillectomy
k. D&C (not MTP)
l. Dental Surgery following an accident
m. Hysterectomy
n. Surgery of Hernia
o. Surgery of Hydrocele
p. Surgery of Prostrate
q. Gastrointestinal Surgery
r. Genital Surgery
s. Surgery of Nose
t. Surgery of Throat
u. Surgery of Ear
v. Surgery of Appendix
w. Surgery of Urinary System
x. Treatment of Fractures / Dislocation (excluding hair line fracture), Contracture releases and minor reconstructive procedures of limbs which require hospitalization
y. Laparoscopic Therapeutic Surgeries
z. Any surgery under General Anaesthesia

aa. Any disease / procedure mutually agreed upon by the Society and the Insurance Company / TPA before treatment

The above listed procedures can also be treated / claimed under normal hospitalization benefits.

22. **Fraudulent Bills / Claims**: If fraudulent bills are detected from beneficiaries, hospitals or Government Staffs, the following actions will be initiated:

For Beneficiaries: the fraudulent claim/s will be rejected and further claims from the particular family will not be entertained for the current Policy period or as may be determined b the Executive Committee.

For Hospitals: the bills of the hospitals will be out rightly rejected. Further, if the hospital is found to be directly attributable to the false claims as referred to in the Specification of Scheme Benefits or included later under the clause, the concerned hospital will be de-panelled.

For Government Staff working in Hospitals, etc : Appropriate Government proceedings will be initiated against them.

Benefit Exclusions

17. Common exclusions from the benefits would include:

Conditions that do not require hospitalization or that can be treated at home or conditions that do not fall under Day Care Procedures specified in paragraph 16.

i) Sterilization and Fertility related procedures.

ii) Circumcision unless necessary for treatment of a disease not excluded hereinabove or as may be necessitated due to an accident.

iii) Vaccination or Inoculation.

iv) Change of life or cosmetic or aesthetic treatment of any description other than as may be necessitated due to an accident or as a part of any illness.

v) Cost of spectacles, contact lenses and hearing aids.

Vi) Dental treatment or surgery of any kind unless requiring hospitalization.

Vii) Convalescence, general debility, 'run-down' condition or rest cure.

Viii) Congenital external diseases, except where intervention is required to maintain the functionality of the individual.

Ix) Sterility, venereal or sexually transmitted diseases.

x) Intentional self-injury, unlawful activity associated injury (intentional/unintentional), suicide and direct consequence of use of intoxicating drugs/alcohol.

xi) All expenses arising out of any condition, directly or indirectly, caused to or associated with human T-Cell Lymphotropic Virus type III (HTLV III) or Lymphadinopathy Associated Virus (LAV) or the Mutants Derivative or Variations Deficiency Syndrome or any Syndrome or condition of a similar kind commonly referred to as AIDS / HIV, if otherwise treatable under Mizoram State Aids Control Society (MSACS) Programme.

xii) Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a Hospital / Nursing Home or at home under domiciliary hospitalization as defined.

xiii) Expenses on vitamins and tonics unless forming part of treatment for disease or injury as certified by the Medical Practitioner.

xiv) Domiciliary Treatment, Naturopathy Treatment.

xv) Disease or injury directly or indirectly caused by or arising from attributable to war, invasion, act of foreign enemy, warlike operations (whether war be declared or not), disasters (man made, natural).

xvi) Disease or injury directly or indirectly caused by or contributed to by nuclear weapons / materials.

Rates

18. The rates will include Bed charges (General Ward only), Nursing, diet charges, Surgeons, Anesthetists, Medical Practitioner, Consultants Fees, Anesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray and Diagnostic Tests, etc as notified by the Government of Mizoram and will be applicable for all medical/surgical cases for hospitals within the State of Mizoram vide No.A.17014/7/07-HFW, Dt. 22nd July, 2008. For hospitals outside Mizoram, rates will be as per current CGHS rates will be adhered. Costs of drugs would be as per distributor prices.

Specific Provisions for the Scheme

19. Enrolment Procedure

a) Beneficiary enrollment is the responsibility of the Mizoram State Health Care Society. **Enrollment period will be opened for 2 months in each district only and beyond this period, enrollment would not be opened whatsoever.**

b) Enrollment of the Head of the Family in the current electoral roll or having Voter ID Card of the State published by the Election Commission of India shall be used as proof of eligibility for enrollment under the Scheme.

c) For BPL families, a Certificate / Card as proof thereof issued by GoM authorized Department (identified from time to time) and certified by a Gazetted Officer or Health Worker in remote villages of the Government of Mizoram has to be attached.

d) Coverage under the Scheme would be provided for all family and their family members as per the Enrollment / Photo ID Card.

e) The period for enrolment would be from the date of commencement of enrolment for a period of 60 days only, beyond which it would not be possible to enroll. Enrolment period would be widely publicized.

f) Enrollment under the Scheme at the time of hospital admission within the enrolment period will also be considered.

20. Cashless Access Service

a) Within the limits of coverage, BPL beneficiaries only shall be provided cashless treatment for all conditions, illness or disease covered under the Scheme. The Health Care Provider shall be reimbursed according to the packaged cost specified in Paragraph 18.

b) For APL beneficiaries, the facility of cashless treatment shall be restricted only to Critical Illnesses as listed in Paragraph 4. The basis of reimbursements shall be limited to the rates specified in Paragraph 18.

21. The Mizoram State Health Care Society shall formulate Rules and Procedures relating to the following:

- **a.** Pre-authorization requirements, when applicable.
- **b.** Access to network and out-of-network providers.
- **c.** Emergency care and treatment of beneficiaries.
- **d.** Any other matter as may be deemed necessary by the Mizoram State Health Care Society.

22. Referral of Patients from Mizoram to Hospitals outside the State:

The existing Medical Boards constituted by the Government of Mizoram at Aizawl and Lunglei will be utilized under the Scheme for referring cases outside the State of Mizoram. However, Final Authority shall lie with the Society and the recommendations of the Boards for utilization of hospitals referred by it will not be binding on the Mizoram State Health Care Society. The Mizoram State Health Care Society may recommend other hospitals with similar facilities but providing the same treatment at lower rates as negotiated by the Society.

23. Eligible Health Care providers

i). Both public and private health care providers which provide hospitalization and/or daycare services, with desired infrastructure would be eligible for inclusion under the Scheme, subject to such requirements for empanelment as accepted by the Mizoram Health Care Society.

ii). All Government Hospitals (including Primary and Community Health Centers) will be automatically eligible for empanelment under the Scheme. However, claims from beneficiaries taking treatment at Government Hospitals would only be allowed for expenses incurred by them on drugs, consumables, etc., purchased from the market (on production of Cash Memos / Bills) and on minimal investigation / laboratory charges levied by the Government Hospitals (on production of Cash Memos / Bills / Receipts). Expenses such as Diet, Nursing,

Bed Charges, Doctor Consultation, Surgical Charges and other expenses which the Government Hospitals provide free will not be payable under the Scheme.

24. Empanelment of Private Hospitals for Inpatient and Day Care Services:

i) Hospitals and other Health Facilities shall be empanelled that conform to the eligibility criteria as detailed below:

a. It has a minimum of 15 beds.

b. It is equipped with properly functioning of Computer, Telephone and Fax facilities.

c. It is fully equipped and engaged in providing medical and / or surgical care, including a Pharmacy and Laboratory and Diagnostic Services that could handle at least testing of clinical (blood and urine) specimens, X-rays and ECG.

d. The facilities undertaking Surgical Operations have a fully equipped Operating Theatre which it owns and is located on the premises of the facility.

e. The facility employs fully qualified Doctors and Nursing Staff on a 24 hour a day basis.

f. The facility employs fully qualified laboratory technicians.

g. The facility has the requisite system and procedures of maintaining patient's records required to be provided to the patient or his representative, the Insurance Company / TPA, Government / Nodal Agency as and when required.

h. The facility preferably agrees to packaged costs for each identified medical / surgical intervention/procedures provided as covered benefits under the Scheme.

i. The Hospital should be in a position to provide following additional benefits to the BPL beneficiaries related to identified systems:

i.) Free OPD consultation.
ii.) Fixed / agreed discounts on diagnostic tests and medical treatment required where hospitalization is not required.

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