DOI: 10.15740/HAS/AU/11.1/34-37
Agriculture Update
Volume **11** | Issue 1 | February, 2016 | 34-37
Visit us : *www.researchjournal.co.in*
e ISSN-0976-6847

RESEARCH ARTICLE :

A study on constraints and suggestion for better implementation of Yashaswini Health Scheme

PAVITHRA C. HAMPANAVAR AND L. MANJUNATH

ARTICLE CHRONICLE :
Received :
17.12.2015;
Revised :
28.12.2015;
Accepted :
13.01.2016

SUMMARY : Health is one of the vital indicators of human development. Health standards in India have improved considerably since independence. The efforts of the government and other agencies engaged in expanding the health infrastructure have paid off well as evidenced by the improvement in some of our health indicators. Government has made deeper inroad into rural areas with focused schemes like the Yashaswini and even started a scheme for health insurance for the poor population. Creating bridge between farmers and their need to live a healthy life, Yashaswini Scheme has brought quality healthcare to the farmers' doorstep in the state. A study was conducted to analyze awareness and usefulness of Yashaswini Health Scheme during 2012-13 in Belgaum district of Karnataka state. Purposive random sampling technique was used for the selection of four blocks *i.e.*, Ramdurg, Savadatti, Gokak and Bailhongal. One hundred and twenty farmers from eight villages were selected from four talukas. Cent per cent of respondents expressed that 'the card is valid for only one year and needs to be renewed' and 'some of the clients live in more remote areas and have to travel long distance to reach the network of hospitals'. Cent per cent of respondents were expressed that 'scheme should be for any farmers' and 'more number of hospitals should be included' in the scheme.

KEY WORDS :
Constraints, Suggestion, Yashaswini health scheme

How to cite this article : Hampanavar, Pavithra C. and Manjunath, L. (2016). A study on constraints and suggestion for better implementation of Yashaswini Health Scheme. *Agric. Update*, **11**(1): 34-37.

Author for correspondence :
PAVITHRA C. HAMPANAVAR
University of Agricultural Sciences, DHARWAD (KARNATAKA) INDIA

See end of the article for authors' affiliations

BACKGROUND AND OBJECTIVES

Health is primarily a personal responsibility and demands personal care to enjoy it. Health is an essential requirement of all irrespective of age, caste, creed, race, religion and economic standard. Health means not the mere absence of disease but it is the "complete state of the physical, mental and social wellbeing". Health of an individual can be affected by general health condition of the society and *vice-versa*. Therefore, health of the community needs higher attention while considering the development of a region or a country (Anonymous, 2010).

A person in good health may not remember sickness and its implications, but when he falls sick and simultaneously into the debts of treatment, he regrets why he had not insured his health (Gumber and Kulkarni, 2000). Providing health insurance or health security for poor people continues to be one of the most important unresolved policy issues for the world.

Health insurance in a narrow sense

would be 'an individual or group purchasing health care coverage in advance by paying a fee called premium'. In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. The health insurance market in India is very limited covering about 10 per cent of the total population. The existing schemes of health insurance are voluntary health insurance schemes or private-for-profit schemes, employer-based schemes insurance offered by NGOs (Non-Govt organization's) / community based health insurance and mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

Commercial insurance companies so far have showed little interest in providing health insurance for rural farmers and workers in the informal sector because of potentially low profitability and high risk. It is non-government organizations (NGOs) and charitable institutions (not-for-profit) that have played an important role in the delivery of affordable health services to the poor.

Urban areas are not only concentrated but are also attracting centres for economic activities and for services like health. As a result, large population of hospitals, dispensaries, clinics and medical centres are found in urban areas than in rural areas. On the contrary, villages being smaller size, most of the health services like hospitals, dispensaries and clinics became uneconomical as their capacities remain under utilized. Moreover, health problems are rampant in rural areas, not merely because of lack of medical facilities but because of general poverty, lack of balanced and nutritious diet to large proportion of rural population and more over lack of knowledge with regard to health and hygiene.

There are many programmes, agencies, schemes and medical services to the rural people who live in inglorious surroundings. In the year 1952, as a part of community development programme, Primary Health Centre (P.H.C) and sub centres were established gradually in all parts of the country. With the intention of taking primary health care services to the door steps of the rural people, the policy planners at the national level and the implementers at the state level created a number of sub centers under each P.H.C besides increasing the number of Primary Health Centers.

Primary health care is being provided to rural population in the country through a network of 20,531 P.H.C., 1, 30,390 sub centers and over a thousand community health centres by 5.86 lakh trained dais and 4.10 lakh health guides besides a large number of rural dispensaries working under state or union territory administrators.

Even though, there are many schemes, programmes, medical services to serve the people, there is a great bulk of illness in our country. The common factors which contribute are personal ignorance, poverty, isolation, lack of resources and lack of knowledge. These factors, many of which result in high fertility and overcoming, poor sanitation and hygiene, together with inappropriate nutritional concept and lack of adequate water supplies, result in high infant, child and maternal death rates, as well as high incidence and prevalence of infectious diseases in all villages (Abbad and Sahu, 2006). Prevalence of high rate of poor health and increasing cost of health services lead to the emerges of Yashaswini scheme.

The Yashaswini scheme was conceived in 2003 by Dr. D. Shetty, a well-known heart surgeon and a group of private physicians who wanted to demonstrate that it was possible to extend access of the most sophisticated health care services to the poor. The concept relied on a preliminary survey conducted among various public and private hospitals operating in Karnataka which revealed that occupancy rates remained everywhere as low as 35 per cent. The problem of access was, therefore, not due to the lack of infrastructure or professional staff, but to the impossibility for the poor to pay for the expected services. To overcome this cash problem, a new insurance scheme targeting the poor rural communities and aiming to cover the most expensive segment of the health expenditure structure (surgical interventions) was designed in close collaboration with the Government of Karnataka and the Department of co-operatives.

A private Trust was set up, regrouping several prominent public and private individuals with the Principal Secretary of the Co-operative Department acting as chair of the Trust. The scheme targeted the poor farmers organized into co-operative societies that could play an active role, together with the Department of co-operatives staff operating at the field level, in distributing the insurance plan and collecting the premium. The Trust approached various insurance companies in order to get them involved in the implementation of the scheme. These companies

however, showed little interest for a scheme that seemed prone to low profitability and high risk. Having failed to enlist any support from that side, the Trust opted for a self-funding scheme.

Built upon the insurance model, the scheme intended from the outset to achieve a wide coverage spread all over the state of Karnataka. The only institution organizing a broad movement in the state was represented by the cooperative societies. According to the National Cooperative Union of India (NCUI), the State of Karnataka ranks 6th in terms of total cooperative membership. More than 12 million people are registered in cooperative societies with a stronger representation in the rural sector where Primary Agriculture Cooperative Societies (PACS), rural credit and savings cooperatives, sugarcane production and dairy cooperatives already regroup about 8.2 million. The existence of regular financial transactions between the societies and their members, such as in the case of regular milk supply or savings and credit operations was an additional advantage allowing for the adoption of various easy payment mechanisms.

An International labour organization survey aiming at identifying social protection priority needs of cooperatives members in Karnataka was carried out in two milk cooperatives and two credit cooperative societies operating in rural areas in 2004. Most members were poor farmers belonging to scheduled castes, scheduled tribes or "other backward castes" (OBC). They usually had to rely on different occupations to generate the scarce resources they are living with. Some common patterns emerging from the survey were their heavy dependence on loans that are needed not only in time of crisis, but also to cover their regular expenditures, their need for social protection mechanisms to cope with these risks as well as their still weak understanding of insurance principles due to the very limited intervention of insurance companies in these areas.

The Yashaswini insurance scheme may rightly claim to be one of the most cost-effective insurance schemes throughout the world. In Year III, the Administration Cost Ratio (ACR) was 1.5 per cent only, while the Administration Cost per Insured (ACI) was kept at the amazingly low level of Rs. 2.3.

With this background the present study was conducted to identify the constraints and obtain suggestions for better implementation of Yashaswini Scheme.

RESOURCES AND METHODS

The present study was undertaken in four talukas of Belgaum district of Karnataka, *i.e.*, Ramdurg, Savadatti, Gokak and Bailhongal. Two villages from each taluka were selected based on the maximum area covered under this scheme. Thus, in total eight villages were selected for the study. From each village 15 farmers were selected randomly giving equal representation for all the eight villages. Thus, the total number of respondents for the study was 120. With respect to the type of study, variables under consideration, size of respondents and phenomenon to be studied, the expost facto research design was followed.

Keeping in view the objectives and variables of the study, a structured interview schedule was developed by consulting experts and referring to the relevant literature. Pretesting of the schedule was carried out in non-sample area for its practicability and relevancy. The data collected were scored, tabulated and analyzed using frequency, mean and percentage.

OBSERVATIONS AND ANALYSIS

The findings of the present study as well as relevant discussion have been presented under following heads.

Constraints experienced by the farmers :

It was evident from Table 2 that, cent per cent of respondents expressed that 'the card is valid for only one year and needs to be renewed' and 'Some of the clients live in more remote areas and have to travel long distance to reach the network of hospitals' followed by, 90.00 per cent and 46.66 per cent of respondents revealed that'should be the member of rural co-operative society at least since 6 months', 'upper age limit is only upto 75 years' and 'Lack of guidance and help from the co-operative societies', respectively. This may be due to the reason lack of education amongst the subscribers about what exactly is covered and what is not. In addition, there are a number of small administrative problems, pertaining to administration, the use of identity cards and

Table 1: Satisfaction level of respondents towards benefits under Yashaswini health scheme (n=120)

Sr. No.	Level of satisfaction	Frequency	Percentage
1.	Good	29	24.16
2.	Medium	79	65.83
3.	Poor	12	10

Table 2 : Constraints for better implementation of Yashaswini health scheme **(n=120)**

Sr. No.	Constraints	f	%
1.	The card is valid for only one year and needs to be renewed	120	100.00
2.	Some of the clients live in more remote areas and have to travel long distance to reach the network of hospitals	120	100.00
3.	Process of approval needs to be hastened	116	96.66
4.	Should be the member of rural co-operative society at least since 6 months	108	90.00
5.	Upper age limit is only upto 75 years	108	90.00
6.	Lack of guidance and help from the cooperative societies	56	46.66

Table 3 : Suggestions for better implementation of Yashaswini health scheme **(n=120)**

Sr. No.	Suggestions	f	%
1.	Scheme should be for any farmers	120	100.00
2.	More number of hospitals should be included	120	100.00
3.	Included hospitals must be supervised for their facilities and treatments given by the separate monitoring body	119	99.16
4.	Card for 5 to 10 years validity period is better	113	94.16
5.	There should not be any age limit	108	90.00

the need to have people enroll permanently or at least for a three year period instead of an annual enrolment process. But these are "teething" issues. Despite of some criticisms, the success of the Yashaswini scheme is undoubted. First, knowledge of the scheme is spreading in rural areas, first through word of mouth from existing patients and through the network of district hospitals. Second, the department of cooperation and the Yashaswini Trust are both intending to explore new ways of patient and subscriber education.

Suggestions offered by the farmers :

It was evident from Table 3 that, cent per cent of respondents expressed that 'scheme should be for any farmers', 'more number of hospitals should be included', 99.66 per cent stated that 'process of approval needs to be hastened', 94.16 per cent and 90.00 per cent of respondents revealed that 'card for 5 to 10 years validity period is better' and 'there should not be any age limit', respectively. Similarly the impact of Janani Surksha Yojana on selected family health behaviours in rural Uttar Pradesh who studied by Khan *et al.* (2010).

Authors' affiliations :

L. MANJUNATH, University of Agricultural Sciences, BANGALURU (KARNATAKA) INDIA

REFERENCES

Abbad, J. and Sahu, K. P. (2006). Maternal and child health care in Madhya Pradesh. *J. Family Welfare,* **52**(1) : 1-6.

Anonymous (2010). Health-An Overview. *Kurukshetra,* **59** (4) : 18-21.

Dasgupta, S., Roy, K. P., Mandal, N. M., Roy, R. P., Mallik, S., and Mandal, A. K. (2005). Routine primary immunization : Status in two district of West Bengal. *Indian J. Public Health,* **49**(4) : 223-226.

Gumber, Anil and Kulkarni, V. (2000). Health insurance for informal sector, Case study of Gujerat. *Econ. Polit. Wkly*, **35** (40): 3607-3613.

Khan, M. E., Avishek, Hazra and Isha, Bhatnagar (2010). Impact of Janani Surksha Yojana on selected family health behaviours in rural Utter Pradesh. *J. Family Welfare*, **56**(3): 21-25.