THE NANO HEALTH ENSURANCE CONCEPT DOCUMENT

(HEALTH SECURITY FOR ALL)

by

C.V. Krishnaswami

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Nano Health
Ensurance Concept

C.V.Krishnaswami
Introduction

The Nano Health Ensurance was conceived because of a direly felt need for a world class health insurance facility/model that would be inclusive of all economic sections of any society globally, as well as, exclusively catering to the special needs of the premium groups of the premium payers; in short this concept is a versatile solution resulting from the amalgamation of all the validated, salient features of 3 outstanding experiences in the fields of Community Health Care dispensation and community economic uplift – in India, U.S.A. & Bangladesh.
Nano Health Insurance Concept

INSPIRED BY

Dr. K.S. Sanjivi's VHS MODEL

Mohamed Yunus's (GRAMEEN BANK MODEL)

BMJ

Kaiser Permanente Model (USA)

HEALTHTRACK INFOSOLUTIONS

Healthtrack’s EMR
This model projects PREVENTIVE, PROMOTIVE as well as CURATIVE aspects of Health care and has as its goal, the lessening of the tertiary care burden. It also has a national plan for outreach primary care centres with a central facility to train the personnel (Hand picked from the locality, where the PHC is situated) and mould them into multipurpose community health workers on the lines of what was much later labeled as ANGANWADI HEALTH WORKERS.

These community health nurses were trained comprehensively in preventive health care activism, in areas like environment, hygiene, vaccination surveillance and implementation, proper and balanced nutrition, particularly for children and expectant mothers in the community. They also take care of emergencies and give first aid, CPR and can train a team locally to form a local primary self help group before transporting to the nearest higher medical facility/Hospital.

1. The Voluntary Health Services Model (Chennai, India) which grades its beneficiaries into 4 economic groups and has a premium of a small 0.5% of the annual income of its beneficiaries.
The Voluntary Health Services has completed 50 years of service in the Non Governmental Organisation (NGO) sector successfully and is both nationally and internationally, known for its expertise and integrity in dispensing its goals.

Thus the USAID had recognized Voluntary Health Services as the nodal centre in India for spreading its AIDS awareness programme throughout south India for its AIDS prevention programme and entrusted several million $ for this purpose; which was successfully achieved. This has been followed by the Bill Gates foundation which is presently routing a very large donation for helping to treat HIV/AIDS victims as well as for preventive efforts, in this vitally important Public Health problem.
This aspect of instant availability of personal Health Records drastically reduces the dangers of Adverse Drug Reactions (ADR) and medical errors which together accounted for more than 200,000 documented deaths in 2007 \textit{(vide - Death by Medicine by Gary Null)}. 

Thus it can be seen clearly that the success of real health care provider-model should lie in an IT based model that has a comprehensive and validated \textit{Online Interactive Electronic Patient Health Record System}. 

2. \textbf{The KAISER PERMANENTE MODEL} – A Californian non-profit organization, whose health care delivery model has been studied and admired way back in 2002 by The British Medical Journal who compared it with the National Health Service model of the UK and stated that the Kaiser Permanente model was superior to the National Health Service \textit{primarily because of the increased use of the Information technology by the former and it’s online personal Health Records that can be accessed by its doctors and nurses in emergencies and other situations}, so that the quality of treatment improved considerably because of the background information available at the click of the mouse. \textit{(My illness, my Record by Tessa Richards BMJ/10 March 2007/Vol 334) Page 516.)}
The Nano Health Ensurance concept takes inspiration from all the above 3 efforts in transforming the society’s aspirations into reality by proposing a Health Ensurance concept that would tap as premium 1% of the annual income of the highest economic groups giving them premium care in terms creature of comforts and facilities they expect in their health care needs, while including GRATIS the 2 other groups viz. the Subsidized group and smallest economic group – Nano group – with each premium group registration.

3. **GRAMEEN BANK MODEL**: Lastly the most successful and inclusive model in the banking sector which captured world-wide attention for economic upliftment of the community in the III world Country, Bangladesh and won the Nobel Prize for the year 2006 was the GRAMEEN BANK MODEL of Dr. Mohammed Younus which transformed the poorest of the poor in Bangladesh into self-sustaining and growth oriented units.
The medical facilities and services however will be the same for all the 3 groups under one roof (The multi specialty e-hospital)

In popular parlance the Nano Health Ensurance concept could be compared to an international jetliner which takes the premium First class, the business class, the economy plus and the economy class all in the same plane to the same destination successfully.
Focus on public health issues, VP tells medicos

Express News Service
Chennai, September 20

VICE-President M Hamid Ansari on Saturday said the main determinants of healthcare should be accessibility and cost and called upon medical graduates to focus on public health issues and view access to healthcare as an essential right of every individual.

Addressing the 18th convocation of the Tamil Nadu Dr MGR Medical University here, Ansari said, “Health and health policies are not usually looked at from the prism of social justice.

Pointing out to the burgeoning private sector in health care, the VP said, “Surprisingly, we have not been able to evolve a coherent

policy on the role of the private sector; nor have we succeeded in articulating the public duties of private professionals in key sectors such as healthcare.” The government spending on healthcare, Ansari said, was a fraction of the private expenditure on health. As many as 11,371 students received their degree certificates. Apart from MBBS students, nursing students, doctors of Indian medicine, graduates of biomedical sciences, dentistry and pharma medicine graduated.

V-C Dr K Meer Mustafa Hussion highlighted the achievements of the university. State ministers M R K Panneerselvam and T P M Mohideen Khan also participated.
BORDER CROSSING Tessa Richards

My illness, my record

Full access to personal health records should be a right, not a privilege

Few doctors would disagree that continuity of care matters, or that recent changes in medical training and practice have reduced it. Those who have escaped the frustration of dealing with a patient who has run the gauntlet of professional opinion and whose notes are "missing" lead a charmed existence.

Newly qualified professionals’ frustration: what about the patient’s? When illness, or fear of it, prompts a patient to consult a doctor, it’s often a high stakes event. When the doctor has no access or limited access to the records, and the patient can’t provide the relevant details, it’s stressful to say the least.

I speak from the heart: As patient and patient advocate, my medical odyssey has taken me to more than 15 hospitals and dozens of surgeries across England over the past three years. Not in pursuit of second opinions, but because of the way we live and the health of our illnesses.

My sons move between school and home; my father’s chequered decline has necessitated several moves; I have important medical teams. Our medical records have often failed to keep up with the itinerary. On occasions, decisions have not been optimal because of the lack of important data. Furthermore, when we seek access we are often cast in the role of troublesome supplicant.

The rhetoric may be of empowering patients and informed shared decision making, but the reality often belies this.

Enrols with Kaiser Permanente can access and personalize their personal health records on-line. When patients move states, continuity is maintained through local Kaiser doctors who can access the common record. Other large US health providers and independent organizations also provide on-line personal health records. A few, it is fair to say, seem to use these for commercial purposes as much as patient partnership.

In the future, NHS Connecting for Health may surprise us all and deliver on its promises. These include patients’ access to a limited “summary care record” accessed via www.healthspace.nhs.uk; Meanwhile the European Union’s quest to put personal health records on common European health cards continues.

On a less ambitious scale, a raft of other initiatives are underway (www.ehiprimarycare.com). Last week the NHS department for quality improvement in Scotland launched a new, patient-held national maternity record. The department’s information officer, Fiona Dagge-Bell, describes this as the first country-wide patient held record. It’s in paper form at the moment, and an electronic record will be introduced soon; this, Dagge-Bell says, will be a foretaste of how records are “cradle to grave” patient held ehealth records that are being developed by the Scottish executive.

Her view is: “It’s high time people became their own health information brokers.” Brian Fisher, a GP from South London, agrees. He has been showing patients their paper notes for more than 20 years. Three years ago he developed a system with EMIS (the company that provides the software for about 60% of general practices in England) to enable his patients to access their full GP record in a kiosk in the practice’s waiting room. The system has now gone on line, and he is seeking other practices to join a collaborative project on patient-held ehealth records.

He acknowledges that sharing the medical record and promoting online discussion with patients is a “culture shift” that many doctors find worrying: nor will all patients want or be able to participate. But he is convinced that in time it will make the balance between doctors and patients less “lopsided” and medical care safer. In his experience, patients have not only welcomed access to their records but been liberated by it.

Currently the consumers and communication group of the Cochrane Collaboration is conducting a systematic review of randomised controlled trials of patient held electronic personal health records, and also a wider review which will include data from qualitative and unpublished studies. Next week the Nuffield Trust will publish a policy report that collates and comments on international experience of electronic personal health records.

Dr Claudia Pagliari, senior lecturer in the department of primary care Medicine in Edinburgh University, who is conducting the Cochrane review, emphasizes the importance of learning from the full gamut of initiatives. She accepts that there are risks in giving patients the option to hold their own health data. “They will want to know how to share it,” she says, “but research and accumulating experience suggests that most will accept the risks for the benefits it brings.”

When asked Susannah Potton, media relations consultant at Kaiser Permanente, about published evidence on the impact of shared medical records she seemed puzzled that I should even raise the question. Kaiser’s philosophy, she said, was that records need to be shared “so that there is a holistic view of the care given.” And who could disagree with that? The technology may need further tuning, but its time has come.

Tessa Richards is assistant editor, BMJ trichards@bmj.com
Full access to personal health records should be a right, not a privilege.

I speak from the heart. As patient and patient advocate, my medical odyssey has taken me to more than a dozen hospitals and GP surgeries across England over the past three years. Not in pursuit of second opinions, but because of the way we live and the nature of our illnesses.

My sons move between school and home; my father’s chequered decline has necessitated several moves; I have been under six different medical teams. Our medical records have often failed to keep up with the itinerary. On occasions, decisions have not been optimum; partly, perhaps, because I have not always been able to explain who last saw whom, why, and with what result.
In the United States, everyone who enrolls with Kaiser Permanente can access their personal health records on line. When patients move states, continuity is maintained through local Kaiser doctors who can access the common record. Other large US health providers and independent organizations also provide on-line personal health records.

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BMJ/10 March 2007/Volume 334
“Experience with private medical insurance in USA and elsewhere has also shown that it is not without disadvantages. The US insurance sector has been obsessed with the concern over profits and costs. It has brought in the health management concept, which has capped costs of medical care. Complaints are that in this process, the human relations between the medical practitioner and the patient also seem to be affected. Horror stores abound about patients being asked to leave their beds even before they feel fully cured – just because the HMO had set an arbitrary limit of so many days. While the HMO was an inevitable economic and organizational response to the need to cap the untrammeled rise of costs of medical care in the present-day environment of costly technologies and high cost of professionals, no one had anticipated in full its unsavoury features. Those enthusiasts, who advocate the extension of the HMO concept to India, should be careful to adapt it to our conditions before we become victims of excessive concentration on profits and resulting restrictive practices”
…”When Dr. K.S. Sanjivi thought of Voluntary Health Services and its extension to the villages, he had a dream. We have to revisit his ideas and see how they can be fitted into the new economy of India. To the extent we can incorporate telemedicine and internet; we may be able to extend the reach of modern medical facilities from the “Centre” to the periphery. Following Dr. Sanjivi’s clarion call, there is need to involve much more than we have done so far – the village level multipurpose worker in brining new knowledge to the villages”…..

…..”The solution for the problems of health cannot be more of the same. Consideration of pure economics cannot be allowed to block good solutions in the field of health. An economically vibrant society cannot afford to have its citizenry deprived of health and denied access to modern medicine at affordable rates. We need a viable and sustainable solution, which is affordable to even the poor.”
Health Security Economics

The American Healthcare Model is a failure by their own Admission

Spring 2006

Professionals Section Quarterly

Numbers of Uninsured Rising

Proportion of adults uninsured for some time in the previous year with chronic illness, such as diabetes and asthma, who skipped or went without medications → 59%

Percentage of uninsured adults with medical debt → 51%

Percentage who used up all their savings to pay their bill → 49%

Percentage of adults that incurred medical bills or dept problems who were insured at the time of the dept → 68%

Percentage of working — age Americans with moderate to middle incomes ($20,000 - $40,000) who lacked health insurance for at least part of the year in 2001: 28%

in 2005: 41%

From “Gaps in Health Insurance: An All – American Problem,” Prepared by the commonwealth fund from telephone interviews conducted by Princeton Survey Research Associated from a random, nationally representative sample of 4,360 adults age 19 and older.

Spring 2006
No workable alternative

Mr. McCain, on the other hand, wants to blow up the current system, by eliminating the tax break for employer-provided insurance. And he doesn’t offer a workable alternative.

Without the tax break, many employers would drop their current health plans. Several recent bipartisan studies estimate that under the McCain plan, around 20 million Americans currently covered by their employers would lose their health insurance.

As compensation, the McCain plan would give people a tax credit — $2,500 for an individual, $5,000 for a family — that could be used to buy health insurance in the individual market. At the same time, Mr. McCain would deregulate insurance, leaving insurance companies free to deny coverage to those with health problems — and his proposal for a “high-risk pool” for hard cases would provide little help.

So what would happen? The good news, such as it is, is that more people would buy individual insurance. Indeed, the total number of uninsured Americans might decline marginally under the McCain plan — although many more Americans would be without insurance than under the Obama plan.

But the people gaining insurance would be those who need it least: relatively healthy Americans with high incomes. Why? Because insurance companies want to cover only healthy people, and even among the healthy only those able to pay a lot in addition to their tax credit would be able to afford coverage (remember, it’s a $5,000 credit, but the average family policy actually costs more than $12,000). Meanwhile, the people losing insurance would be those who need it most: lower-income workers who wouldn’t be able to afford individual insurance even with the tax credit, and Americans with health problems whom insurance companies won’t cover.

And in the process of comforting the comfortable while afflicting the afflicted, the McCain plan would also lead to a huge, expensive increase in bureaucracy: insurers selling individual health plans spend 29 per cent of the premiums they receive on administration, largely because they employ so many people to screen applicants. This compares with costs of 12 per cent for group plans and just 3 per cent for Medicare.

In short, the McCain plan makes no sense at all, unless you have faith that the magic of the marketplace can solve all problems. And Mr. McCain does a much-quoted article published under his name declares that “Opening up the health insurance market to more vigorous nationwide competition, as we have done over the last decade in banking, would provide more choices of innovative products less burdened by the worst excesses of state-based regulation.” I agree: The McCain plan would do for health care what deregulation has done for banking. And I’m terrified. — New York Times News Service
Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a “charity.” You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.
3. The N.H.S. (U.K.) Model 60 years on

<table>
<thead>
<tr>
<th>Positive Aspects</th>
<th>Negative Aspects</th>
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<tbody>
<tr>
<td>National Health as the goal</td>
<td>wide gap in personalized vs NP care. Less Affluent Economics cannot afford this £105 BN per year. Government spends (Average £3500 for every + working..........</td>
</tr>
<tr>
<td>All Diseases/ailments are covered Health needs including deliveries and Women's &amp; Children's. Welfare covered (Dental/Nursing Care recent including after 60 years)</td>
<td>Unisystem (Modern Medicine only) Many grey areas in medicine and chronic insurable ailments are not given any other option. Maternity services not customized.</td>
</tr>
<tr>
<td>All age groups are covered</td>
<td></td>
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<tr>
<td>Several Regional Trusts take care of special requirements of these regions.</td>
<td>Long wait-list for even simple surgical conditions like Hernia, Cataracts, etc... Laser PC even for vision threatening stage may sometimes have to wait for long periods.</td>
</tr>
<tr>
<td>Truly egalitarian in creature-comfort terms (LIG, MIG, HIG all have same level)</td>
<td>For those who can afford and who pay more and are used to Deluxe comfort levels the service is a let down.</td>
</tr>
<tr>
<td>Academic Institutions give the advantage of higher quality of scientific expertise.</td>
<td>Academics investigations can sometimes be counter productive (UCH eg).</td>
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An Outdated Model

The NHS was nothing but a “politically controlled state monopoly that is inefficient, outdated, and unsustainable,” he said, claiming the UK taxpayer does not see an adequate return on its almost £105n (€133bn; $209bn) annual investment – an average of £3500 for every working Briton. “Yet we have some of the worst survival rates in Europe for cancer and strokes. Spending on the NHS under this government has more than doubled in less than seven years. Where on earth does all the money go? Are we twice as healthy?”

“There is a limit to which younger taxpayers are going to subsidise the new gerontocracy”

Karol Sikora
The Indian Scenario

**GENERALLY SPEAKING PRESENTLY WE HAVE DISEASE INSURANCE SCHEMES** (Not Health Insurance Schemes)

<table>
<thead>
<tr>
<th>Encourages</th>
<th>Premium and Limit oriented</th>
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<tbody>
<tr>
<td>Deceit/Mistrust</td>
<td>Diseases oriented</td>
</tr>
<tr>
<td>Falsehood</td>
<td>ORGAN oriented</td>
</tr>
<tr>
<td>Aggression</td>
<td>Questions oriented</td>
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<tr>
<td>LITIGATION</td>
<td>Rejection oriented</td>
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<tr>
<td>Unethical-Medical &amp; Practices</td>
<td>Profit Oriented</td>
</tr>
<tr>
<td>Trade etc..</td>
<td></td>
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Nano Health Ensurance is a **revolutionary, completely transparent** & inclusive **Health ensuring** model where the affordable persons pay 1% of their total income and this automatically covers the **Health Ensurance** of **1 – 4 persons of their choice** like

Close relatives (Parents, Siblings)

(and)

Dependants and Domestic Helpers (Children’s Nannies & Drivers, etc...)

This concept is **Trust**, **Transparency**, **Truth**, and **Total Health**
The Premium amount envisaged for all the groups is 1% of their Annual Income.
Insurance scheme tweaked

Express News Service
Chennai, September 5

UNION Minister of Finance P Chidambaram announced significant changes in the Universal Health Insurance Scheme (UHIS), which was launched in 2003-04 for BPL families.

At the inauguration of the first Apollo Reach Hospital here on Friday, Chidambaram said while there was no substitute for a comprehensive public health system, today it was necessary to marry the public and private sectors to supplement each other. Regarding the UHIS, he said, that from Friday, pre-existing illnesses, which were previously not covered by the scheme, would now be covered. Also, the scheme would now extend maternity benefits. While previously the scheme only allowed for the loss of wages of the earning head of the family, it would now be extended to the spouse of the earning head as well.

The New Indian Express, 6-9-2008.
A SIMPLE MATHEMATICAL CALCULATION

- India has over 70% of its population (1 billion) earning LESS THAN Rs.20 per day (Below Poverty Line Persons) (GoI Report)

- If these Below Poverty Line people are made to pay Rs.1 per day 5% of their daily income.

- From the Total Annual Budget Allocation of the country, GoI spends around 5% for Health (All aspects included) Is it fair to ask a Below Poverty Line person to spend 5% of his income for limited Health cover?
# Envisaged Premium Categories in the Nano Health Ensurance Plan

<table>
<thead>
<tr>
<th>Premium / Day in INR</th>
<th>% Of Income</th>
<th>Number of Persons Ensured</th>
<th>Annual Income from Premium</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1%</td>
<td>100,000</td>
<td>Rs 3.6 Crores</td>
<td>Free / Nano Group</td>
</tr>
<tr>
<td>5</td>
<td>1%</td>
<td>100,000</td>
<td>Rs 18 Crores</td>
<td>Free / Subsidised Group</td>
</tr>
<tr>
<td>10</td>
<td>1%</td>
<td>100,000</td>
<td>Rs 36 Crores</td>
<td>Premium ‘D’</td>
</tr>
<tr>
<td>30</td>
<td>1%</td>
<td>100,000</td>
<td>Rs 100 Crores</td>
<td>Premium ‘C’</td>
</tr>
<tr>
<td>60</td>
<td>1%</td>
<td>100,000</td>
<td>Rs 200 Crores</td>
<td>Premium ‘B’</td>
</tr>
<tr>
<td>100</td>
<td>1%</td>
<td>100,000</td>
<td>Rs 360 Crores</td>
<td>Premium ‘A’</td>
</tr>
</tbody>
</table>
**Additional (FREE) Beneficiaries for Premium Groups with NHE model.**

<table>
<thead>
<tr>
<th>Premium Group</th>
<th>Free Beneficiaries</th>
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<tbody>
<tr>
<td>Premium Group ‘A’</td>
<td>2 SG + 2 NG</td>
</tr>
<tr>
<td>Premium Group ‘B’</td>
<td>1 SG + 2 NG</td>
</tr>
<tr>
<td>Premium Group ‘C’</td>
<td>1 SG (or) 2 NG</td>
</tr>
<tr>
<td>Premium Group ‘D’</td>
<td>1 NG</td>
</tr>
</tbody>
</table>
5. WHAT ARE THE HIGHLIGHTS OF N.H.E.?

a. Once you are registered there are no more tedious forms to be filled or permission required; **No questions are asked about past, present or future illnesses or diseases.** Once registered, all health problems are automatically covered fully. You are treated as a dignified and respected partner in our Health Care Services Venture. Your positive feedbacks and inputs will be sought to be implemented by the organization to better the Quality of service Quotient.

b. Unnecessary medical or surgical or other interventions (which cause more harm than good) are scrupulously avoided.

c. You get an exclusive, unique and secured on-line EMR which could be retrieved anywhere in the world, anytime you are faced with medical problem or emergency to assist your doctors (a very important life-saving medical tool) not available in most insurance systems in the world.
6. WHERE WILL THE NHE BE AVAILABLE?

The NHE e-Hospital which will be called the IAHS&R THE MODEL NHE e-HOSPITAL (BASE HOSPITAL & RESEARCH & TRAINING CENTRE) will be located in Chennai & Called THE INSTITUTE OF AUTHENTIC HEALING SCIENCES & RESEARCH –TIAHS&R)

Which will be a fully electronic Tele-Medicine oriented multispecialty hospital, staffed by highly qualified and experienced national and internationally renowned Physicians, Surgeons and specialists in all areas of modern medicine.

Renowned and experienced Healing Professionals for other forms of authenticated healing sciences from India and abroad.
As the record maintenance and progress of all patients treated in this Institute are continually kept electronically updated, it automatically facilitates authentication and comparative advantages of the various systems, and the result of this scientific analysis will be periodically published in *The Journal of the Sciences of Healing Outcomes*, a super peer reviewed Journal already in existence (e-format).

The N.H.E. participants are therefore in a position to decide for themselves (in consultation with the doctors) the best options for their various health problems, at any given point of time.

The N.H.E. plans to join hands with the **WORLD ACADEMY OF AUTHENTIC HEALING SCIENCES** (Mangalore, India and Washington DC, U.S.A.) which is a most progressive organization in the field of human health endeavour.
7. APPLICATION OF NHE CONCEPT:

_In Stage I_ it is planned to make NHE available in its main _E-Hospital-The Institute of Authentic Healing Science & Research_ and some satellite clinics in _urban Chennai_.

In Stage II, III and IV the concept could be customized to suit any small (100-150 bed), Medium (200-400bed), or large (750-1500bed) hospitals and medical teaching institutions all over Tamil Nadu, later in the All India level and internationally.

This model could be applied successfully in small, medium or large numbers in the Public (Governmental), Private (Corporates) and NGO (Voluntary) Sectors.

This model could be customized to suit any Healthcare Dispensation of any state or country based on the principles enunciated above.
9. MERITS OF NHE

a. This is an all inclusive Insurance concept, it envisages health as a societal commitment and is inclusive of all economic levels and illness and healing outcomes as a holistic model combining the modern science with Ancient wisdom. It also fosters the concept of family bondage, brotherhood of people and welfare in society (Governmental or Corporate Social Responsibility).

b. Improves quality of medical care (EMR) and trust between medical profession, patients and healthcare provider.

c. Reduces the risk of ADR – which accounts for several lakhs in treatment morbidity and related mortality every year.
d. Gives patients several authenticated health care options and should be welcomed by all modalities of healthcare systems.

e. This is a more authentic medical statistical model then the existing medical science and will provide vital inputs when applied at the National level.

f. No Administrative hassles (Filling forms, answering queries etc).

g. Complete medicare coverage with virtually no exclusion criteria (excepting Cosmetology or non medical interventions like Botox etc.)
10. LIMITATIONS:

a. Extensive use of I.T. – Infrastructure needed.

b. Training of all the participants in this venture (doctors, Insured persons, administrative staff, etc.).

c. Certain contagious diseases like cholera, Pox, HIV/AIDS etc. will be excluded from/cover by NHI. But-customized packages could be worked out for special situations and cases.

d. Certain highly specialized medical/surgical modalities (eg. Stem-cell therapy/complex cardiac surgeries etc) would be out-sourced to affiliated and accredited institutions only if recommended by our panel of experts, when the charges will be borne by the N.H.E.
e. For NHI concept to become a national success it needs the backing of all participants who should co-operate in improving their own health and also enabling in giving HEALTH CARE FOR their kith and kin.

**Sarve Jana Sukino Bhavanthu (Sanskrit) (Let all beings be healthy and happy) – Vedas.**

सर्वे जना सुकृतीर्भवन्तः
Thank You