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Social Entrepreneurship that Facilitates Societal Transformation a Study of Yeshasvini Cooperative Farmers Health Care Scheme

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To overcome these unsolved and newly emerging problems and thereby achieving the equitable access to health care for all, governments, public sector organizations and social entrepreneurs have worked together to integrate health and healthcare into their policies. Such an integrated healthcare policy is focused in the present paper i.e., Yeshasvini Cooperative Farmers Healthcare Scheme, a micro insurance health scheme, launched in 2002 for millions of farmers and their families in Karnataka, belonging to various State Cooperatives, by Government of Karnataka, pioneered by a reputed social entrepreneur Dr. Devi Prasad Shetty and his team at Narayana Hrudayalaya, Bangalore.

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Social entrepreneurs are the change agents, who facilitate for the societal transformation in order to provide benefits to the poor and marginalized populations. The various social entrepreneurs in the private health care sector like Narayana Hrudayalaya Hospital of Cardiac Care, Arvind Eye Hospital, Shantha Biotech Lab and Water Health International play an important role in providing healthcare to the poor people.

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I. Introduction

The concept of entrepreneurship which is applied to the context of social problem solving is called social entrepreneurship. Solutions to social problems such as sustainable alleviation of health, education, economic, political and cultural problems associated with long-term poverty and illiteracy, often demand fundamental transformation in all societal systems that underpin current stable status.

One of such social problems is lack of healthcare accessibility to poor people. Right to good health is also a fundamental human right. It must be achieved equitably for all. But the achievement of such an equitable access to healthcare for all is prevented by unsolved and newly emerging problems like demographic shift to ageing population, poverty, environmental degradation, economic crisis in many developed countries, and emergence of new types of epidemic diseases and so on.

To overcome these unsolved and newly emerging problems and thereby achieving the equitable access to health care for all, governments, public sector organizations and private social entrepreneurs have worked together to integrate health and healthcare into their policies. Such an integrated healthcare policy is focused in the present paper i.e., Yeshasvini Cooperative Farmers Healthcare Scheme, a micro insurance health scheme, launched in 2002 for millions of farmers and their families in Karnataka, belonging to various State Cooperatives, by Government of Karnataka, pioneered by a reputed social entrepreneur Dr. Devi Prasad Shetty and his team at Narayana Hrudayalaya, Bangalore. Under this scheme even poor can avail of top-class health care at a minimal cost.

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The credit for coining the term "social entrepreneurship" goes to Bill Drayton, founder of Ashoka, the world's first organization to promote social entrepreneurship.

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II. Objectives

1. To study the concept of social entrepreneurship as a powerful tool to solve social problems.
2. To analyze and interpret the functioning and growth of Yeshasvini Cooperative Farmers Healthcare Scheme.

III. Research Methodology

Research is descriptive and explorative in nature to meet the research objectives. Primary and secondary data is used for the study. Surveys and interactions with office bearers of Yeshasvini Trust, Cooperative Department, Government of Karnataka, and select Network Hospitals of Yeshaswini Scheme at Bangalore, are made to collect the necessary primary data. The secondary data is collected from website of Yeshasvini Trust, Government of Karnataka, and other published reports, journals and websites. Data collected is logically analyzed and presented by tables and graphs.

IV. Hypotheses

H1 : Building of local capacities and providing innovative packages to the marginalized populations is essential for the success of social entrepreneurship.

H2 : Operation of social enterprises on large scale basis will help to solve social problems more effectively.

V. Definition of Key Terms

Table : 1

Author/s & Year	Definition
	ENTREPRENEURSHIP
Drucker (1960)	The tendency to create value through identification and exploitation of opportunities. This includes starting and managing one's own business.
Gibb (2005)	A way of thinking, reasoning and acting that results in creation, enhancement realization and renewal of value for an individual, group, organization society.
Stephen Robbins & Mary Coulter (1999)	A process by which people pursue opportunities, fulfilling needs and wants through innovation, without regard to the resources they currently control.
Schumpeter(1951); Drucker (1985)	A major theme of entrepreneurship has been the creation of value through innovation
	SOCIAL ENTREPRENEURSHIP
Alvord, Brown & Letts (2004)	Creates innovative solutions to immediate social problems and mobilizes the ideas, capacities, resources, and social arrangements required for sustainable social transformations
Mort, Weerawardena & Carnegie (2002)	A multidimensional construct involving the expression of entrepreneurially virtuous behavior to achieve the social mission, a coherent unity of purpose and action in the face of moral complexity, the ability to recognize social value-creating opportunities and key decision-making characteristics of innovativeness, pro-activeness and risk-taking
	SOCIAL ENTREPRENEURS
Dees (1998)	Social entrepreneurs play the role of change agents in the social sector, by: • Adopting a mission to create and sustain social value

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	• Recognizing and relentlessly pursuing new opportunities to serve that mission • Engaging in a process of continuous innovation, adaptation, and learning • Acting boldly without being limited by resources currently in hand, and • Exhibiting a heightened sense of accountability to the constituencies served and for the outcomes created
Thompson, Alvy & Lees (2000)	Social entrepreneurs are people who realize where there is an opportunity to satisfy some unmet need that the state welfare system will not or cannot meet, and who gather together the necessary resources and use these "to make a difference"
	SOCIAL ENTERPRISE
Dees (1994)	These are private organizations dedicated to solving social problems, serving the disadvantaged and providing socially important goods that were not, in their judgment, adequately provided by public agencies or private markets. These organizations have pursued goals that could not be measured simply by profit generation, market penetration, or voter support.
Haugh & Tracey (2004)	These are businesses that trade for a social purpose. They combine innovation, entrepreneurship and social purpose and seek to be financially sustainable by generating revenue from trading. Their social mission prioritizes social benefit above financial profit, and if and when a surplus is made, this is used to further the social aims of the beneficiary group or community, and not distributed to those with a controlling interest in the enterprise.

a) For-Profit Vs Not-For-Profit Social Enterprises :

Social enterprises may be for–profit or not-for-profit organizations.

- For-profit social enterprises are driven by social as well as financial goals. Not-for-profit social enterprises purely focuses on the social impact of their activities, not on wealth creation, they are society-oriented organizations.
- The primary source of funds for social ventures of for-profit social enterprises is their earnings. Not-for-profit social enterprises rely on donations and charitable contributions.
- Recruitment policy is to select people on the basis of their skill and performance but in not-for-profit social enterprises people participate voluntarily.
- The performance of for-profit social entrepreneurs is measured on the basis of social value delivered along with financial returns. They are run in an entrepreneurial setting. But the performance of not-for-profit is evaluated merely on the basis of social value they have delivered.

b) Business/Economic Entrepreneurship Vs Social Entrepreneurship :

- The concept of entrepreneurship is applied to the context of business and economic ventures in case of business entrepreneurship but in case of social entrepreneurship, the concept of entrepreneurship is applied to the context of social problem-solving.
- The test of successful business entrepreneurship is the creation of a viable and growing business. The test of social entrepreneurship, in contrast, may be a change in the social dynamics and systems that created and maintained the problem.
- The concept of social entrepreneurship is relatively new; the initiatives of social entrepreneurship are focused on the problems of poor and marginalized populations.
- Social entrepreneurship may be for profit or not for profit venture but business entrepreneurship is always a for profit venture.
- Rather than for profit or not for-profit, the main difference between these two lies in the relative

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priority given to economic wealth creation versus social wealth creation.

- In business entrepreneurship, social wealth is a by-product of economic value created and in social entrepreneurship; the main focus is on social value creation. However this does not mean that social entrepreneurial initiatives should not embrace on "earned income" strategy.

VI. World's Most Remarkable Social Enterprises

Ashoka founded by Bill Drayton in 1980, based in Arlington, VA, USA, to provide seed funding for entrepreneurs with a social vision. Ashoka is the world's largest community of leading social entrepreneurs-men and women with ground-breaking solutions to the world's greatest challenges. Ashoka seeks out, vets and supports leading social entrepreneurs locally, facilitates collaboration, spreads ideas, innovations and models, and builds entrepreneurial "eco-systems" for social innovations. Currently it operates in over 70 countries and supports the work of over 2000 social entrepreneurs, elected as Ashoka Fellows. Since 2003, Ashoka and the American India Foundation (AIF) have partnered to co-invest in social entrepreneurs in India.

Bangladesh Rural Advancement Committee (BRAC) was established in 1972 by Fazle Abed, a Bangladeshi corporate executive, to focus on breaking the cycle of poverty in Bangladesh. It was started as a relief and resettlement organization, but BRAC pioneered the development of comprehensive, locally organized approaches to rural development and poverty alleviation. It provides a range of services like rural capacity-building, education, health services, micro credit to millions of rural people. It organizes the poor for self-help and builds local capacities for economic development, healthcare and education.

The Grameen Bank (GB) was established in 1976 by Muhammed Yunus, a Bangladeshi economic professor, and his colleagues. It provides group lending for poor people without collateral. The Grameen Bank forms small groups of five people to provide mutual, morally binding group guarantees in lieu of collateral. In addition to group lending, it created other businesses like fisheries, handloom factories, renewable energy plants to serve poor. It expanded poor women's roles in income generation through micro credit around the world.

The Self-Employed Women's Association (SEWA), founded in 1972 by Ela Bhatt, an Indian to organize groups of women to address economic, social, political, and health issues. SEWA is the first and largest trade union of informal sector workers. It provides improved working conditions, access to health care, credit, and savings for the more than 90% of India's self-employed/unorganized, female laborers. It influenced the creation of self-employed labor division in the Indian government. It influenced the International Labor Organization to pass standards for home worker including minimum wage and working conditions. SEWA has several "sister" institutions, including a bank that provides financial resources, an academy that provides teaching, training and research, and a housing trust that coordinates housing activities for its members.

Aravind Eye Hospital : Arvind Eye Hospital was founded in 1976, by Dr.G.Venkataswamy, in an eleven bed hospital manned by 4 medical officers, today it is one of the largest facilities in the world for eye care. Technology and affordable connectivity options have made Aravind's model economically justifiable, and hence sustainable. Its network of hospitals and vision centres treat more than 2.7 million patients and perform more than 300,000 eye operations every year – 70% for fee.

The Narayana Hrudyalaya Private Limited (NHPL) : Founded in 2001 by Dr.Devi Prasad Shetty at Bangalore, Karnataka. "The Wal-martization of Healthcare" strategy is adopted by Dr.Devi Shetty and his team to reduce cost of treatment without compromising with quality of treatment. Company is currently ranked fourth behind Fortis Healthcare, Apollo Hospitals and Manipal Group. By 2020, NHPL expects to take the company to 30,000 beds from the present 5,700 beds. Its existing hospitals are at Bangalore, Kolar, Dharwad, Mumbai, Hyderabad, Ahmedabad, Jaipur, Jamshedpur, Raipur, Kolkata, and hospitals opening soon are at Mysore, Bhubneshwar, Siliguri and New Delhi. Its presence at abroad will be Cayman Islands and Malaysia.

Dr.Devi Shetty, who has been in the medical profession for close to 25 years and worked at Guy's Hospital in London, the Birla Heart Research Foundation in Kolkata (formerly Calcutta) and the Manipal Heart Foundation in Bangalore before branching out on his own, was formerly personal physician to Mother Teresa, focuses on "Process Innovation and Wal-Mart Approach" to reduce the cost of treatment.

Cardiac surgeries in the United States can cost up to US$50,000. In India, they typically cost around US$5,000-US$7,000. Depending on the complexities of the procedure and the length of the patient's stay at the hospital, the price tag increases. At Narayana Hrudayalaya, however, surgeries cost less than US$3,000, irrespective of the complexity of the procedure or the length of hospitalization. About 45% of Shetty's patients pay even less. Of these, about 30% are covered under a micro-insurance plan for health care called Yeshasvini that reimburses Narayana Hrudayalaya at about US$1,200 a surgery.

SELCO India : It was founded by Dr. Harish Hande, a social entrepreneur in the power sectore. It uses solar technology to provide hundreds of thousands of

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households with 'clean' lighting and about 70% of the beneficiaries are small farmers.

Indian Railways : Lifeline of India, 15,000 trains cover a distance equaling three & half times the distance to moon, 8,000 railway stations with 1.6 million employees, carries 13 million passengers & 1.3 million tonnes of freight daily.

Indian Post : Indian postal service has the most widely distributed post office system in the world with total of 155,618 post offices of which 90% are in rural areas.

Micro Credit : 200 + Indian Micro finance institutions (MFI).

India has the world's largest Micro finance industry serving over 50 million Indians. The *Bhartiya Samruddhi Investments and Consulting Services* founded by Vijay Mahajan was the first microfinance project to lend to the poor. *SKS Micro Finance* founded by Vikram Akula offers micro loans and insurance to poor women in India.

World's most remarkable social entrepreneurs include *Water Health International (WHI)*, to provide safe and pure water to the people at an affordable cost and to make them aware of various water diseases. *Dristee*, for-profit social enterprise to solve the problem by implementing a sustainable, scalable platform of entrepreneurship for enabling the development of rural economy and society with the use of ICT(Information and Communication Technology). *Project Shakti* of Hindustan Liver Ltd., NGOs and Self Help Groups, etc. are initiated to alleviate poverty significantly.

VII. Analysis and Interpretation of "Yeshasvini" – A Self Funded Healthcare Scheme

Though India has made great strides in healthcare since independence, average life expectancy has nearly doubled to around 64 years, infant mortality rate and the maternal mortality ratio have fallen significantly, but the overall access and quality of healthcare for a vast majority of Indians remain sub-par. This is because of the low share of government (Table 2) in total healthcare expenditure and the lack of skilled human resources (Table 2 &3).

Table : 2

Contrasting Conditions					
	Expenditure on health as % of GDP		Hospitals	Nurses	Physicians
Countries	Government	Private	Per 10,000 Population		
Germany	7.8	2.7	82	108	35
UK	7.2	1.5	34	103	21
USA	7.3	7.9	31	98	27
Japan	6.7	1.6	138	41	21
Russia	3.1	1.7	97	85	43
Brazil	3.7	4.7	24	65	17
South Africa	3.3	4.9	28	41	8
Thailand	3	1.1	22	15	3
China	2	2.3	41	14	14
Vietnam	2.8	4.4	29	10	12
India	1.4	2.8	9	13	6
Global median	5	3.3	24	28	12

Source : World Health statistics 2008.

India ranks last in respect of government expenditure on health as percentage of GDP, i.e. 1.4% against the global median: 5%. Per 10,000 populations, India has 9 hospitals, 13 nurses and 6 physicians, against the global median: 24, 28 and 12 respectively.

The *Rural Health Statistics for 2011* show a shocking shortfall of human resources in the country's government run healthcare system– be it doctors, nurses or other personnel:

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Table 3 : Shortfall of human resources in government run health care system in India.

	Target	Actual	Shortfall (%)
Doctors	1,09,484	26,329	76
Specialists	58,352	6,935	88
Nurses	1,38,623	65,344	53
Radiographers	14,588	2,221	85
Lab technician	80,308	16,208	80

Source : Rural Health Statistics 2011, 12th Plan draft chapter.

In many states infrastructure is largely present but the absence of doctors and nurses renders the whole facility meaningless.

In addition to low share of government spend on health care and acute shortage of skilled human resources, World Health Organization's (WHO) world health statistics states that around 74 per cent (as of 2008) of India's private healthcare expenditure takes place in the form of out-of-pocket expenditure (OOP) and OOP spending on medicines and health care services will push millions of Indians (about 3.2%) below the poverty line.

The size of the Indian healthcare delivery market was Rs.2.6 lakh crore in 2011 – 12 and it is expected to double to Rs.4.7 lakh crore in 2016-17. This is due to increase in population along with the rise in life expectancy, awareness on preventive and curative healthcare, and also rapid increase in lifestyle-related ailments such as cardiac diseases, oncology (cancer) and diabetes. In value terms, cardiac ailments account for around 22-25 per cent of the overall market in 2011-12 and it is expected to go up steadily in the next five years. Likewise, oncology, at present, accounts for around 4-5 per cent of the overall market and is likely to grow to 5-7 in the next five years. This rise in lifestyle-related ailments will demand for increase in healthcare services associated with these diseases.

"In India, around 2.5 million people require heart surgeries every year but all of [the country's doctors] put together perform only 80,000 to 90,000 surgeries a year.... We clearly need to relook and change the way things are being done." Dr.Devi Shetty.

Introduction of health insurance coverage under *Private-Public Partnership (PPP) Model* will help to provide healthcare accessibility to all. Such an effort of health insurance coverage was pioneered by Dr.Devi Shetty, launched by Government of Karnataka in 2002, named as "Yeshasvini Cooperative Farmers Healthcare Scheme", which is India's largest Micro Health Insurance program and the world's self-funded health insurance scheme for farmers at a monthly premium of 5 rupees (now Rs.10).

"Yeshasvini Cooperative Farmers Health Care Scheme" (Yeshasvini Scheme) was introduced by the State Government to the Co-operative farmers of Karnataka. Then the Hon'ble Chief Minister of Karnataka Sri S.M.Krishna inaugurated the scheme on 14th of November 2002 and the scheme was operationalzed with effect from 1st June 2003. Karnataka has become role model state with the introduction of 'Yeshasvini Self Funded Health Care Scheme'. Yeshasvini Scheme was implemented through network hospitals to provide cost effective quality healthcare facilities to the co-operative farmers spread across the State of Karnataka. The Yeshasvini Cooperative Farmers Health Care Trust was registered under the Indian Trust Act 1882. The Government of Karnataka provides matching contribution to the Trust for implementation of the scheme. Studies have shown that on average only 0.08 per cent of the people covered under the scheme would require operations, this means the cost of their treatment is borne through the contribution of the others who do not need medical help, hence Yeshasvini scheme works effectively as a self funded healthcare scheme.

VIII. Salient Features

- To avail the benefit of Yeshasvini Scheme, a person should be a member of Rural Co-operative Society of the State for a minimum period of 6 months.
- All family members of the main member are eligible to avail the benefit of the scheme though they are not members of a rural co-operative society.
- Each beneficiary is required to pay prescribed rate of annual contribution every year. Presently [2012-13] member contribution is Rs.210/-.
- The period of each enrollment commences from January/February and closes by June every year.
- The scheme is open to all rural co-operative society members; members of self help group/Stree Shakti Group having financial transaction with the Cooperative Society/Banks, members of Weavers, Beedi Workers and Fisherman Cooperative Societies.

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- The higher age limit fixed is 75 years for availing benefit under the scheme.
- The Scheme Commences from 1st of June and ends 31st of May every year.
- The Scheme covers entire state of Karnataka particularly Rural Areas excluding Corporations and Urban cities.

Source : www.yeshasvini.kar.nic.in

IX. Implementation Procedure

- The Scheme is implemented through the recognized Network Hospitals of the Trust.
- There are 511 Network Hospitals throughout the State including Private and Govt. Hospitals.
- The Trust identifies and approves Network Hospitals to provide medical/surgical facilities as per the approved empanelment criteria.
- The entire scheme is being implemented as cashless hospitalization arranged by Third Party Administrator (TPA) through network hospitals.
- A Yeshasvini beneficiary is eligible for benefits of the Scheme only at the Network Hospitals recognized by the Trust.
- The Yeshasvini beneficiary approaches the Network Hospitals.
- Network Hospitals Coordinator examines the UHID card of the beneficiary; enrollment fee paid by the beneficiaries for the current period and facilitates the patients to undergo preliminary diagnosis and basic tests.
- Based on the diagnosis if the surgical intervention is required hospital admits the patients and sends pre-authorization request to the TPA online along with proof of documents.
- Doctors/Specialists of the TPA examine the preauthorization request received from Network Hospitals and approval is given to preauthorization within 24 hours, if all the conditions are satisfied.
- Network Hospitals extend cashless treatment and surgery to the beneficiary subject to the limits prescribed under the scheme.
- Network Hospitals after discharge forwards the original bill, discharge summary with signature of the patient and other relevant documents to TPA for processing and settlement of their claims.
- Trust arranges payment to Network Hospitals through TPA within forty five days of the receipt of the bills from the Network Hospital.
- Yeshasvini beneficiary is required to produce Enrollment Card and other documents at the time of admissions, so that the Network Hospitals can send preauthorization for approval. If the beneficiary does not produce the identity card at the time of admission he is not entitled to avail the benefits under the scheme.
- In case of emergency, the coordinating officer of the Network Hospital will take undertaking letter from the beneficiary or his/her ward that in case he/she is not covered under the scheme the cost of the surgery will be paid by the beneficiary only.
- Network hospitals in the State have adopted web enabled issue of E-preauthorization. Network hospitals are obtaining E- Preauthorization from the TPA for all ailments/surgeries.
- Daily 85% of the E- preauthorization proposals received by the Third Party Administrator from various Network hospitals are approved on the very same day.

Source : www.yeshasvini.kar.nic.in

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Chart : 1

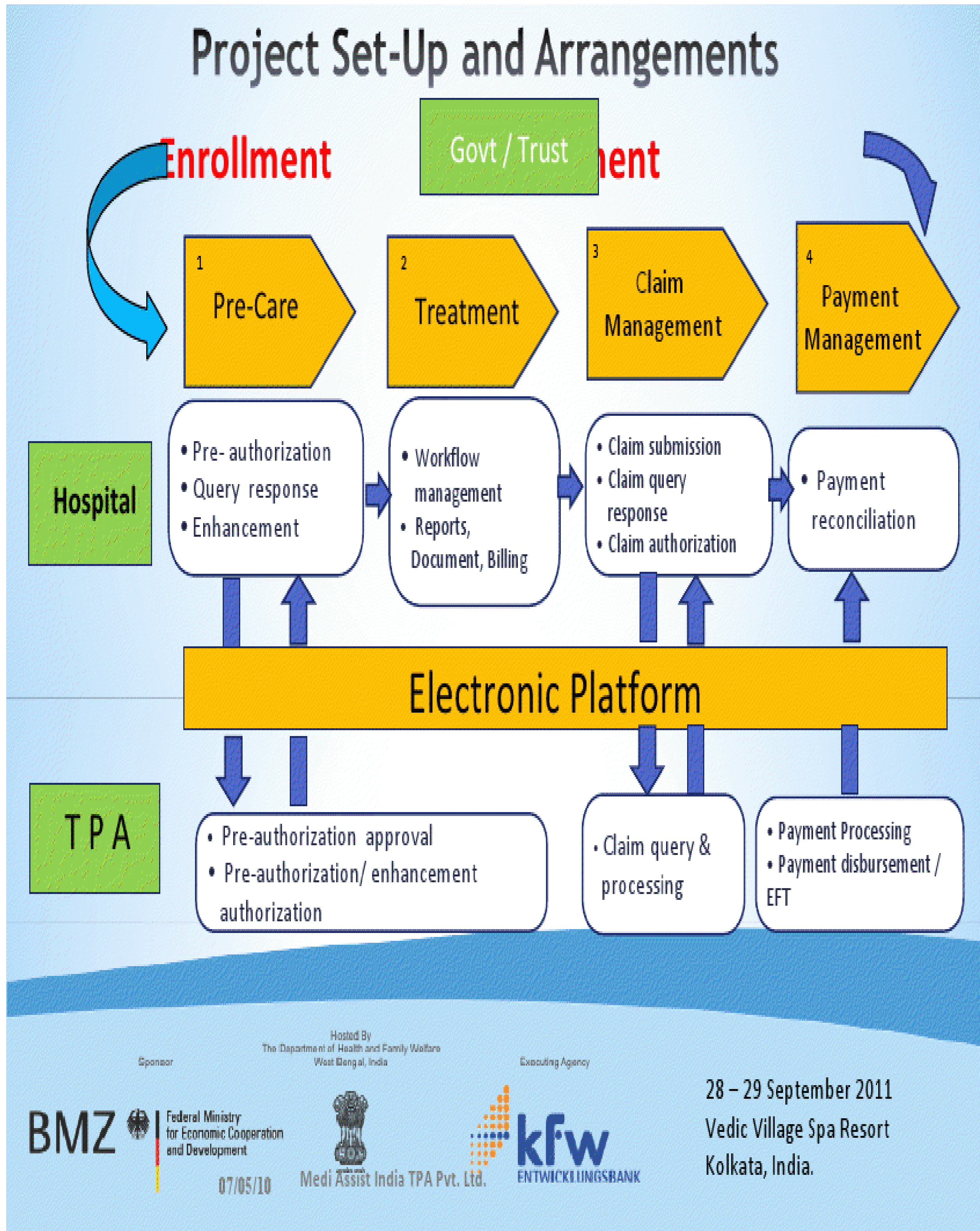

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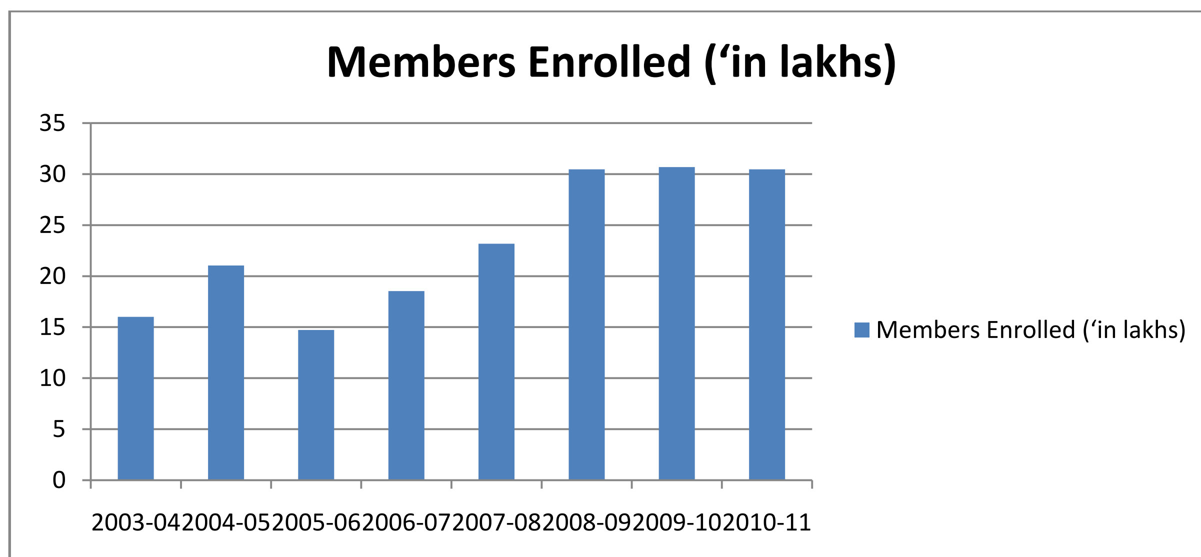
Table 4 : Progress of Yeshaswini Scheme.

Year	Members Enrolled ('in lakhs)	Members Contribution ('in crores)	Government Contribution ('in crores)	No. of free OPD availed	No. of surgeries availed	Surgery amount reimbursed to Hospitals ('in crores)
2003-04	16.01	9.49	4.5	35814	9047	10.65
2004-05	21.05	12.87	3.57	50174	15236	18.47
2005-06	14.73	16.94	11.00	52892	19677	26.16
2006-07	18.54	21.56	19.85	206977	39602	38.51
2007-08	23.18	27.75	25.00	155572	60668	54.09
2008-09	30.47	36.10	30.00	191109	75053	61.03
2009-10	30.69	41.36	30.00	134534	66796	55.08
2010-11	30.47	41.68	30.00	157480	73963	57.23
Total	185.14	207.75	153.92	984552	360042	321.22

Source : www.yeshasvini.kar.nic.in

Graph : 1



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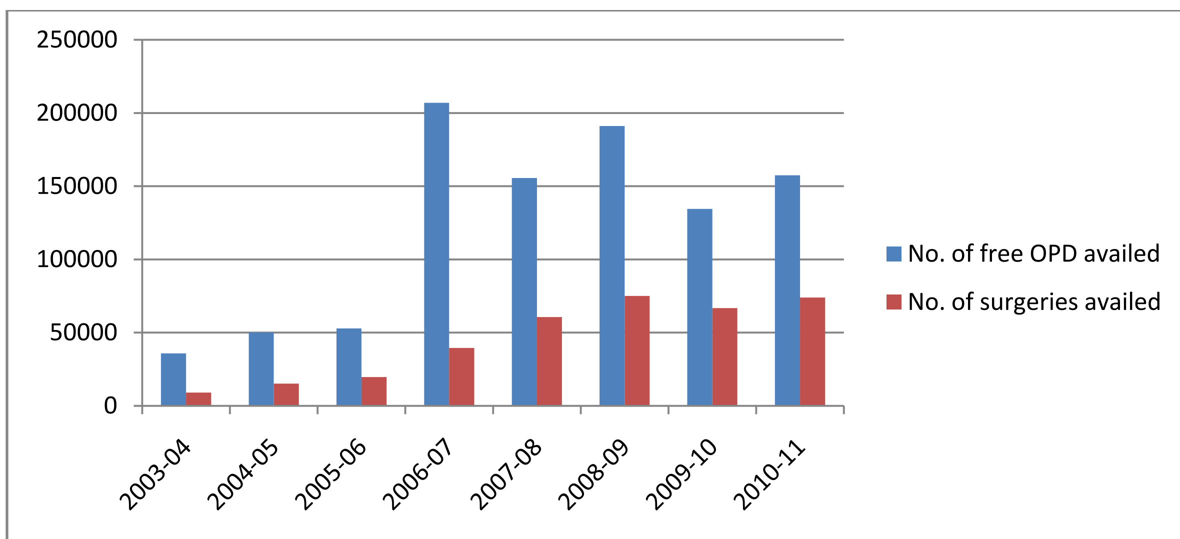
Graph 2 : Contributions towards Yeshasvini Trust.

Graph 3 : OPD & Surgeries availed.



a) Overview of Yeshasvini Cooperative Farmers Healthcare Scheme

- It is a successful micro insurance scheme in Karnataka (PPP), started in the year 2003 with 16.01 lakh million lives, and increased to 30.47 lakh during 2010-2011, i.e. 1.9 times increase.
- Increase in members' contribution to Yeshasvini Trust is 4.39 times and that of Government is 6.67 times, which shows government's active support for the functioning of this scheme.
- Members and Government together contributed Rs.361.67 crores (Rs.207.75 crores + Rs.153.92 crores) towards Yeshasvini Trust, and the total surgery amount reimbursed to Network Hospitals is Rs.321.22 crores, with a surplus amount in the Trust Rs.40.45 crores.
- During 2003-04 to 2010-11, 9,84,552 free OPD availed and 3,60,042 surgeries availed by the beneficiaries.
- The amazing success was possible through the partnership with Government of Karnataka, Service Providers (Network Hospitals – 511 (Govt.25% & Private 75%), Bank & TPA (Third Party Administration – Media Assist India TPA Pvt. Ltd.)
- This scheme provides cashless facility to eligible Yeshasvini card holders across 511 hospitals in Karnataka for nearly 1600 identified surgeries.
- Apart from the identified surgeries, medical emergencies like snake bite, dog bite, bull gore, electric shock, insect bite is covered.
- Retention of enrolled beneficiaries, enrollment of new beneficiaries, making the scheme self reliant

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and revision of healthcare package rates are some of the challenges of Yeshasvini Trust.

b) Testing of Hypotheses

H1 : Accepted. State cooperative farmers are enrolled as members of Yeshasvini Trust by introducing the innovative package named as Yeshasvini Cooperative Farmers Healthcare Scheme, which is functioning successfully.

H2 : Accepted. The scheme is open to all rural co-operative society members; members of self help group/Stree Shakti Group having financial transaction with the Cooperative Society/Banks, members of Weavers, Beedi Workers and Fisherman Cooperative Societies. Thus Yeshasvini scheme is operating on large scale basis to solve health problems of marginalized populations more effectively.

X. Conclusion

India has some of the most advanced and innovative social entrepreneurs. India is a key country in developing innovative models which are exported around the world. Yeshasvini, one of such innovative models, pioneered by Dr.Devi Shetty for the cooperative farmers of Karnataka, is functioning successfully through the partnership with Cooperative Department, Government of Karnataka, Network Hospitals, Banks and TPA (PPP model).

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