Draft Terms of Reference for the Evaluation of Yeshasvini Co-operative Health Care Scheme in Karnataka for the period 2010-11 to 2014-15

1. Study Title

The title of the study is "*Evaluation of the Yeshasvini Co-operative Health Care Scheme in Karnataka for the period 2010-11 to 2014-15*"

2. Department implementing the scheme:

The Co-operation department of the Government of Karnataka is implementing the scheme through the Yeshasvini Co-operative Farmers Health Care Trust, which was registered as a "*Trust*" on the 10th of November 2003,under the Indian Trusts Act 1882. The main aim of the Trust is to implement, establish, provide, administer, and supervise, either directly or indirectly, the Yeshasvini Co-operative Health Care Scheme for the welfare of co-operative members, irrespective of castes, creed and religion and language, in the State of Karnataka.

3. Background Information:

"*Yeshasvini Cooperative Health Care Scheme*" (Yeshasvini Scheme) was introduced by the State Government for the benefit of the Co-operative members of Karnataka. This was inaugurated on the 14th of November 2002, and the scheme was operationalised with effect from 01st June 2003.

The roots of Yeshasvini lay in the concept of "*Rural health care scheme*" which was initiated by Dr. Devi Prasad Shetty of Narayana Hrudayalaya, Bangalore. This was further, modified by the Co-operation Department. The scheme is being implemented with financial assistance of Government of Karnataka through network hospitals to provide cost effective quality healthcare facilities to the co-operative members spread across the state of Karnataka.

The Hon'ble Chief Minister of Karnataka is the Chief Patron and the Hon'ble Minister for Cooperation is Patron. The Government of Karnataka provides matching contribution to the Trust for implementation of the scheme

A. Self-funded Scheme:

1. Yeshasvini is one of the largest Self-funded Healthcare Scheme in the country.
2. It is a low priced product providing a wide range of surgical cover, nearly 823 defined surgical procedures to the beneficiaries and their family members.
3. It is a contributory scheme wherein the beneficiaries contribute a small amount of money every year to avail any possible surgery during the period for themselves and their family members.
4. The beneficiaries and their family members are offered cashless treatment subject to conditions of the scheme at the Network Hospitals spread across the State of Karnataka.

B. **Eligibility criteria to avail the benefit:**

1. To avail the benefit of Yeshasvini Scheme, a person/farmer should be a member of any of the co-operative Societies of the State defined in the Deed of Trust of "*Yeshasvini Cooperative Farmers Health Care Trust*" dated 10th November 2003.
2. All family members of the main member are eligible to avail the benefit of the scheme, though they may or may not be members of any rural co-operative society.
3. Each beneficiary/member farmer is required to pay prescribed rate of annual contribution every year. In 2013-14 member contribution was

fixed as Rs.210 per annum. This has been enhanced to Rs.250per year from 2015-16.

4. The period of enrollment commences in Jan/Feb and closes by 31 may every year.
5. The scheme is also open to members of Self Help groups/Sthree Shakti Groups having financial transaction with the Cooperative societies/Banks, members Cooperative Societies of Weavers, Beedi Workers and Fisher folk.
6. An upper age limit is fixed at 75 years for availing benefit under the scheme. (***This has been removed in the recent vide Government Order number CO/79/CLS/2015dated19.03.2015***).
7. The Scheme Commences from the 01st of June and ends on the 31st of May every year.
8. The Scheme covers the entire State of Karnataka, particularly rural areas, excluding Corporations and Urban cities.
9. The benefit of this scheme has been extended to Corporation and urban areas vide Government of Karnataka order number CO/80/CLS/2015dated 19th March 2015. Contribution of the urban/corporation area members is Rs. 710 per year.

C. Medical Benefits Covered Under the Scheme:

1. 823 types of surgical procedures are covered under this scheme. They are identified by Yeshasvini Trust, defined in the list of surgeries with cost at tariffs fixed by the Trust, inclusion of implants, exclusion list and other circulars are available in Website of Yeshasvini. (www.yeshasvini.kar.nic.in)
2. Medical emergencies such as dog bite, snake bite, drowning, and accidents occurred while operating agricultural implements, bull gore

injures and electrics shocks, Normal Delivery, Neo natal care and Angioplasty procedure have been covered from 2006-07.

D. Product Features:

1. **Surgery Package includes:** Cost of Medicines, consumables during hospital stay, cost of Operation Theater, Anesthesia, Surgeons fees, Professional charges, Consultant fees, nursing fees, General Ward bed charge, etc. Yeshasvini Trust reimburses this expenditure to the Network Hospitals. Package rates for each of the surgery is fixed under the scheme.
2. Concessional out Patient consultation in all participating hospitals.
3. Discounted tariffs for lab investigations and tests.
4. The plan excludes coverage for: Medical and follow up treatment, implants, Prosthesis, Joint replacement surgeries, Kidney and Heart Transplants, Chemotherapy, Cosmetic surgery, Burn cases, Dental surgeries, Road accidents and Medico-legal cases, Diagnostic investigations, Autoimmune diseases, Skin grafting, Dialysis, Artificial limb cost, deviated nasal septum, nails, screws and stents, etc. for Orthopedic and Urological Surgeries.
5. Yeshasvini Scheme is a surgicare scheme and does not cover inpatient medical treatment where surgical intervention is not required. If beneficiaries avails inpatient medical treatment at the Network Hospital, it is their responsibility to pay the charges as per hospital rates and the Trust is not liable to reimburse the treatment charges.
6. Yeshasvini beneficiaries are entitled only for general ward admission. If the beneficiaries opt for a higher category of bed, they will have to pay the differential amount to the hospital.

7. No specific time for inpatient is prescribed to the Network Hospitals for surgical procedures.
8. In normal health care scheme pre-existing diseases like Diabetes, Hypertension, Heart related diseases, Kidney diseases etc., are not covered.
9. The most novel feature of the scheme is that the entire money transactions with the network hospital from the time of admission till discharge of the patient is cashless, limited to the package.

E. **Administration of the Scheme:**

The Yeshasvini Co-operative Health Care Trust is headed by Hon'ble Chief Minister of Karnataka with Hon'ble Minister for Cooperation being the Patron. The Trusts' Governing Body consists of six senior Officers of the Government of Karnataka, headed by the Principal Secretary to Government, Cooperation Department and five Reputed Doctors representing different areas of the State.

1. The Trust board meets once in a quarter and reviews the scheme implementation, takes policy decisions, decisions about fund management, disbursement and other financial controls of the scheme.
2. The Trust sub-committee meets at least once in a three calendar month and reviews the scheme implementation and accords approval for network hospital claims. The claims are to be sent within 10 days from the date of discharge of beneficiaries. Recently the time has been extended to 30 days. For delay of more than 30 days up to 60 days there is a10% cut in payments made to hospitals, for 61 to 90 days there is a 20% cut and claims sent after 90 days are rejected.

3. The Department of Cooperation supports communication and publicity of the scheme and the admission of beneficiaries to the scheme.
4. The Cooperative societies take the responsibility of enrolling members.
5. The Management Support Service Provider (MSSP) licensed under the Insurance Regulatory and Development Authority of India (IRDA) renders administration of scheme, including approval of preauthorization and claims settlement.
6. Network hospitals deliver the surgical benefits to the members of the scheme subject to conditions.

F. **Empanelment Procedure for recognition of Network Hospitals**

Network hospital means hospitals with which the Trust enters into an understanding for providing cashless facility to the beneficiaries under the scheme at pre-agreed tariffs for each of the surgeries to the Trust. The empanelled committee consisting of a medical trustee, CEO of the trust, the Deputy Registrar of district conducts inspection. If the hospital confirms to norms of the trust, the proposal is sent to the Deputy Commissioner of the District who intern inform to the trust.

1. Network hospitals are recognized on an annual basis by the Trust in accordance with the guidelines and minimum criteria fixed by the Trust from time to time. The criteria for accreditation of network hospitals is available in the Website of Yeshasvini. (www.yeshasvini.kar.nic.in)

Hospitals applying for empanelment as Network hospital if situated in the Corporation limits should have super/multi specialties with at least a minimum of

50 beds. Hospitals situated in District Head Quarters are required to have at least 25 beds and Hospitals/Nursing Homes/Single Speciality/Eye/Ortho/ENT situated in Taluka Head Quarters should be having a minimum of 10 beds. All the hospitals are required to have Intensive Care Unit for Adult and Paediatric patients and also have facilities prescribed and the availability of professional to conduct surgeries.

Hospitals willing to be empanelled under the scheme apply to Trust decides the empanelment of such hospital.

Total Number of Network Hospitals under Yeshasvini Scheme: 540

District Name	No. of Network Hospitals	District Name	No. of Network Hospitals
Bangalore Urban	61	Dakshina Kannada	26
Bangalore Rural	7	Udupi	22
Ramanagar	11	Belgaum	49
Tumkur	27	Bijapur	23
Kolar	11	Bagalkote	44
Chikkaballapura	8	Dharwad	19
Chitradurga	12	Gadag	6
Davanagere	21	Haveri	16
Shimoga	22	Uttara Kannada	18
Mysore	22	Bellary	8
Chamrajnagar	4	Bidar	11
Mandya	25	Gulbarga }	16
Hassan	20	Yadgir }	
Chikkamagalur	7	Koppal	8
Kodagu	5	Raichur	11

4. Objectives of the Scheme:

The backbone of Indian economy is the farming community. This community needs to be treated well. It is necessary to create a bridge between co-operative members and their need to live a healthy life. It was realized that the arrangement

for medical and surgical care for co-operative members were inadequate, more particularly in cases where serious and complicated ailments needed surgical treatment in super specialty hospitals and nursing homes. Hence the scheme was formulated. The objective of the scheme is to provide quality healthcare to the rural/urban (very recently) co-operative members who contribute a small amount of money every year for a wide range of surgical cover. The beneficiaries are offered cashless treatment subject to condition of the scheme from network hospitals spread across the State. This is a unique scheme and embodiment of Co-operative Principle of "**One for all and all for one**".

5. Previous literature/Evaluations/Reports: (Inclusive and not Exhaustive)

A. Draft report titled "*The Karnataka Yeshasvini health insurance scheme for rural farmers & peasants: towards comprehensive health insurance coverage for Karnataka*?" by Sarosh Kuruvilla, Mingwei Liu and Priti Jacob prepared for "the Social Science and Development Conference in Karnataka".

B. Research Study titled "*A Critical Assessment of the Existing Health Insurance Models in India*" done by the Public Health Foundation of India sponsored under the scheme of Socio-economic Research of the Planning Commission of India.

C. Study titled "*A comparative study of the health insurance schemes in Karnataka*"of D Rajasekhar and R Manjula of the Centre for Decentralisation and Development, Institute for Social and Economic Change, Bangalore, November 2011, submitted to the Planning department, Karnataka.

D. Paper titled "*Impact Evaluation of India's 'Yeshasvini' Community Based Health Insurance Programme*" by Aradhna Aggarwal,

Working Paper No.2, September 2009.The Paper had been prepared within the GDN's Global Research Project *Promoting Innovative Programs from the Developing World: Towards Realizing the Health MDGs in Africa and Asia*. The project was funded by the Bill & Melinda Gates Foundation, United States.

E. Article titled "Paying *to be treated well*" of "*the alternative. in*" available at [http://www.thealternative.in/society/paying-to-be-treated-well]

6. Purpose and Objectives of the Study:

The purpose of the study is to find out how the scheme is being implemented and to what extent quality health care facilities are provided to the co-operative members in the State. The study also intends to find out if there are any loopholes in implementation of the scheme and if the study suggests for its continuation, measures to be taken for further improvement of the scheme.

7. Implementation Process:

1. The Scheme is implemented through the recognized Network Hospitals of the Trust.
2. There are 540 Network Hospitals throughout the State, including Private and Govt. hospitals.
3. The Trust identifies and approves Network Hospitals to provide medical/surgical facilities as per the approved empanelment criteria.
4. The entire scheme is being implemented as cashless hospitalization arranged by Management Support Service agency (MSP) through network hospitals. Earlier Family Health Plan Ltd (FHPL) and MEDI ASSIST INDIA TPA Private Ltd were the Management Support

Service agencies. Presently, MDINDIA Networxs Private Ltd is the Management Support Service agency.

5. A Yeshasvini beneficiary is eligible for benefits of the Scheme only at the Network Hospitals recognized by the Trust and he/she has to approach the Network Hospitals only.
6. Network Hospitals Coordinator examines the UHID (Unique Health Identification) 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.
7. Based on the diagnosis, if the surgical intervention is required, the Network hospital admits the patients and sends pre-authorization request to the MSP online along with proof of documents.
8. Doctors/Specialists of the MSP examine the pre-authorization request received from Network Hospitals. Approval is given to pre-authorizations within 24 hours, if all the conditions are satisfied.
9. The Network Hospital extends cashless treatment and surgery to the beneficiary subject to the limits prescribed under the scheme.
10. Network Hospitals after discharge of the patient beneficiary, forward the original bill, discharge summary with signature of the patient and other relevant documents to MSP for processing and settlement of their claims.
11. Trust arranges payment to Network Hospitals by RTGS or EFT with in forty five days of the receipt of the bills from the Network Hospital.
12. 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/she is not entitled to avail the benefits under the scheme.

13. In case of emergency, the coordinating officer of the Network Hospital takes an 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.
14. Network hospitals in the State have adopted web enabled service of E-pre-authorizations. The Network hospitals are obtaining E-Pre-authorization from the MSP for all ailments /surgeries.
15. Daily 95% to 98% of the E- preauthorization proposals received by the Management Support Service Provider from various Network hospitals are approved on the very same day.

8. Scope of the Scheme

The scope of the scheme is 30 Districts of the State in 540 network hospitals enrolled by the trust. The evaluation period is from 2010-11 to 2014-15.

9. Progress achieved so far:

Since 2003-04 till 2014-15, on an average 30 lakh beneficiaries have been enrolled. The contribution of members since inception is Rs. 433.55 crores and Government contribution is Rs. 334.92 crores. 15.08 lakh beneficiaries have availed the OPD benefit and 7.35 lakh beneficiaries have undergone surgeries. Rs. 683.65 crores has been utilized so far on surgeries prescribed in the scheme.

10. Evaluation Questions(inclusive not exhaustive):

(a) Related to enrolment:

1. What are the figures (preferably district wise) of annual enrolment since the commencement of the scheme? What is the population eligible (preferably district wise) to be covered under the scheme in these years? Analyzing the time line trend of the eligible but not covered population, what is the year in which at least 90% of the eligible population (district wise preferably) be covered?
2. In the event of reliable data being available district wise for the above question, please report the outlier districts? What are the reasons for their being so?
3. What are the measures taken by the State Government/Department of Co-operation, the Co-operative societies whose members are eligible to become beneficiaries of the scheme and the Yeshasvini Trust to bring in awareness of the scheme and enrolment in it amongst the eligible population? Are these measures yielding adequate results? (This may be inferred from the annual gap in the enrolment to eligible population data that is to be used in answering question 1 above).
4. Are uniform procedures being followed by the Co-operative societies in enrolment of members?(Pages 33 and 34 of study cited as 'C' in paragraph 5 above cited lack of uniformity in enrolment which was likely to be addressed to in 2008-09).
5. A NABARD evaluation report cited in study cited as 'C' in paragraph 5 above cites enrolment renewal rates being 43 per cent in 2005-06, 62 per cent in 2006-07 and 42per cent in 2007-08. What has been the enrolment renewal rates in the subsequent years? Which factors motivate people to become members and/or promote enrolment renewal and which factors discourage members from renewing enrolment? Is poor renewal of enrolment attributable to the phenomena of "*People who have a disease join in the first year, get*

themselves cured and then withdraw", the article cited as 'E' in paragraph 5 above quotes Dr. Devadasan and seconded by an ILO study of Yeshasvini?

6. Should enrolment be for a period more than one year as is being followed now? If yes, what should be the revised enrolment period and why?
7. Should enrolment be linked with biometric identification or some unique document (say BPL/APL cards) or numbers (say Aadhar)? Why?

(b) <u>About Network Hospitals:</u>

1. As per page 37 of report of study cited as 'B' of paragraph 5 above, of the total Network hospitals, 94% are in the private sector and 6% in the Government sector. This shows that there a preponderance of private hospitals in Network hospitals of Yeshasvini. The said report further states in the same page that-

   "*Hospital wise claims data points towards the trend in government schemes tilting the funds to the already flourishing private sector while the public sector is starved for funds*".

   Analysing the data of payments made to hospitals year wise, What percentage of the money paid each year, in the period 2010-11 to 2014-15, went to private hospitals and what portion to government hospitals? In the light of these figures, can it be said that the findings cited before are true for Yeshasvini as of 2014-15?
2. Which are the top ten hospitals in terms of claims amount received every year (claims amount received as well percentage of total claim amount paid in the year to be given) in the period 2010-11 to 2014-15? How many of these have remained in the top ten in all the ten years? Which are they?
3. Which are the top ten hospitals in terms of numbers of claims (beneficiaries treated) every year in the period 2010-11 to 2014-15? How many of these have remained in the top ten in all the ten years?Which are they? What have

been their share in terms of percentage of total beneficiaries treated in the year and the percentage of total claim amount received by them in that year?

4. Do all Network hospitals have a functional Yeshasvini help desk located at the entrance of the hospital and a board or hoarding displaying the details of the scheme to be set up at a prominent and visible place?

(c). About the Claims:

1. The basic data about number and average cost of claim (surgical procedures) for the first 5 years of Yeshasvini taken from page 47 of study cited as 'C' in paragraph 5 above is as follows-

Sl no.	Title	Year 1	Year 2	Year 3	Year 4	Year 5
1	Membership	1601152	2021661	1473576	1854731	2318778
2	Number of Claims(surgery)	8996	14963	19439	39179	59564
3	Rate of claim per 1000 members	5.6	7.4	13.2	21.1	25.7
4	Average cost of claim	11827	12085	13266	9762	8026
5	Free OPD usages	35814	50174	52892	76032	126619
6	Percentage of OPD usage of membership	2.24	2.48	3.59	4.10	5.46

What have been the incidences of claims (surgeries) per thousand members and the trend in the period 2010-11 to 2014-15? Similarly, what have been the incidences of OPD usage (now subsidized not free) per thousand members and the trend in the period 2010-11 to 2014-15?

2. How do the incidences of surgeries compare with those of the national/ commercial health insurance figures? Are they significantly (statistically) different? If yes, what are the reasons for it?

3. What is the percentage wise numbers and claim amounts settled for Cardio-vascular (Cardiac, Cardiology and CVS), Endo. ENT, Gastro, General, Neo-natal, Neuro, OBG, Ophthalmological, Ortho, Throrasic, Urological and GST surgeries in each of the financial years in the period 2010-11 to 2014-15? Is there a consistent rise or fall in incidences of any of the categories of surgeries?
4. How do these sector wise incidences of surgeries compare with those of the national/ private health insurance figures? Do they indicate a high frequency of top-end, low frequency, high cost surgical procedures when compared with national/commercial health insurance figures? If yes, what are the reasons for it?

(d). The service to beneficiary and opportunity cost of scheme:

1. How, on what basis and on the basis of what/whose information or referral did the beneficiary decide about which Network Hospital to approach for OPD/surgery? (Greater and detailed answers are to be solicited if the Network hospital was outside the district in which the beneficiary resided/a place not nearest to his/her residence).
2. What is the rating of the beneficiaries of the services provided by the Network hospital in terms of time taken, elaborate nature of advice given, processing of papers for OPD/surgery etc.? Did the hospital he/she visited have a useful Yeshasvini help desk located at the entrance of the hospital and a boardor hoarding displaying the details of the Yeshasvini scheme?
3. What is the average time taken between admission and approval of pre-authorization for surgery?
4. Is the pre-authorization approval of surgery and its cost details communicated to the beneficiaries? If yes, is it oral or a written communication?

5. In case of surgeries, do beneficiaries have to make out-of-pocket payments too? If yes, for what purpose, to who all and what is the quantum? Is it a percentage of claim or as lump sum?
6. Before the coming of Yeshasvini scheme how was the expense for surgery and OPD for serious diseases met with?
7. After the coming of Yeshasvini scheme, how do non-eligible people and eligible but non-members met the expense of surgery and OPD for serious diseases?

(e) General:

1. Pre-authorization once given is valid for one month as per scheme guidelines. Are there instances where the surgeries have been done after the expiry of pre-authorization date? If yes, what are the reasons?
2. Whether the claims were sent within the stipulated time from the date of discharge of the beneficiary from the hospital to the MSP? If not, furnish reasons for not submitting the bills and How many claims were rejected by the trust during the study period and what is the quantum of claims?
3. The financial figures of the scheme for the period 2003-04 to 2014-15 is appended as ***Appendix-1***. It can be seen that lately Government contribution to the scheme is almost equal to member's contribution. Probably based on this, the ILO Report concluded that the scheme faces "significant challenges to remain viable" and that the current rates of premium were unsustainable. (Cited on page 47of the report cited in study cited as 'C' in paragraph 5). Is viability really a threat to the scheme? If yes, what will be the breakeven premium at current rates of enrolment and at 90% of the eligible members enrolling themselves for the scheme?

4. How are the rates of surgeries fixed under the scheme? Are they scientific and robust? If yes, why are they consistently and significantly less than the rates fixed in the case of CGHS, Rajiv Arogyashree of Andhra Pradesh and Kalaignar of Tamilnadu, and generally less than the rates of Vajpayee Arogyashree and RSBY schemes of Karnataka? (Details can be seen on page 38of the report cited in study cited as 'B' in paragraph 5)Should the rate fixing system under Yeshasvini and the rates both need to be changed, at least to the extent that they are the same for all Karnataka schemes?
5. Should the Vajpayee Arogyashree and RSBY schemes of Karnataka be merged with Yeshasvini so that hospitals, administration and monitoring? (Premia and eligibility but can be different for different target groups).
6. Yeshasvini scheme provides reimbursement of surgeries but not medical expenses sans surgery. Are medical ethics are being violated under the scheme by performing un-required surgeries (going for surgery were medication would have sufficed)?
7. What is the perception of people regarding increasing the network of private hospitals under Yeshasvini vis-à-vis including/improving Government Hospitals under scheme?
8. How many beneficiaries under the scheme have opted for treatment in special wards and paid the extra charges to the hospitals over and above the charges fixed under the scheme?
9. Should the scheme be continued? If yes, with what changes so as to make it more effective and better?

11. Evaluation Sampling Methodology:

The evaluation study should follow the following methodology in general –

(a) Questions 1 to 5 of part a, 1 to 3 of part b, 1 to 4 of part c and 1 to 3 of part e, are to be answered on the basis of analysis of the data available with the department of cooperation and the TPAs of the scheme. These questions will need no sampling at all.

(b) For answering question 6 and 7 of part a, 4 and 5 of part d, and 4 to 6 of part e, the methodology of Focused Group Discussions or email interviews with scheme administrators, Network Hospital Administrators and officers of the department of Cooperation dealing with scheme may be resorted to.

(c) For answering question 4 of part b, Physical Inspections of Network Hospitals may be done and answers to question 2 of part d of the evaluation questions may be used. (If information of about 50% of the Network Hospitals is so obtained, it will suffice)

(d) For answering questions 1 to 7 of part d, personal interviews of at least 100 beneficiaries of the scheme in 2010-11, 200 of 2011-12, 300 of 2012-13, 400 of 2013-14 and 500 of 2014-15 may be conducted such that 25% of the beneficiaries of each year [300 in total for the period 2010-11 to 2014-15] are those who availed the facility of free/subsidized OPD only, and the rest 75% (1200 in total for the period 2010-11 to 2014-15) are surgery beneficiaries. Amongst the surgery beneficiaries too, at least 50% should be those who availed the facility of a Network Hospital located outside their district of residence.

At least 100 persons of which 50 eligible but not members and another 50 neither eligible nor members need to be interviewed to get answer for question no. 6 & 7 of part d.

12. Qualification of Consultant

Consultants should have and provide details of evaluation team members having technical Qualifications/capability as below-

i. Principal Investigator should be a person with MBA in Healthcare Management/Masters of Health Administration/ Masters of Hospital Administration (M.D or MHA) or an MBBS with at least ten years of practice.

ii. One data scientist/big data analyst for the purpose of analyses of available data.

iii. One team member to be a Social/Development Scientist with at least five years of field experience of research/evaluation.

And in such numbers that the evaluation is completed within the scheduled time prescribed by the ToR.

Consultants not having these number and kind of personnel will not be considered as competent for evaluation.

13.Deliverables time Schedule

Co-operation Department, Karnataka Government Secretariat & Chief Executive Officer, Yeshasvini Trust, to co-operate and provide the year wise list of beneficiaries who have undergone surgeries and taken OPD treatments. Instruction should be given to all the District co-ordinaters and Deputy Registrar of Co-operative societies of all the Districts to co-operate with the consultant during course of the study. It is expected to complete the study in 6 months' time excluding the time taken for approval. The evaluating agency is expected to adhere to the following timelines and deliverables.

1. Work plan submission : One month after signing the agreement.
2. Field Data Collection : Three months from date of work plan approval.
3. Draft report Submission : One month after field data collection.
4. Final Report Submission : One month from draft report submission.
5. Total duration : 6 months.

14. Qualities Expected from the Evaluation Report

The following are the points, only inclusive and not exhaustive, which need to be mandatorily followed in the preparation of evaluation report:-

a. By the very look of the evaluation report it should be evident that the study is that of Karnataka Evaluation Authority (KEA) which has been done by the Consultant. It should not intend to convey that the study was the initiative and work of the Consultant,
b. The Terms of Reference (ToR) of the study should from the first Appendix or Addenda of the report.
c. The results should first correspond to the ToR. In the results chapter, each question of the ToR should be answered, and if possible, put up in a match the pair's kind of table, or equivalent. It is only after all questions framed in the ToR that is answered, that results over and above these be detailed.
d. In the matter of recommendations, the number of recommendations is no measure of the quality of evaluation. Evaluation has to be done with a purpose to be practicable to implement the recommendations. The practicable recommendations should not be lost in the population maze of general recommendations. It is desirable to make recommendations in the report as follows:-

(1) Short Term practicable recommendations

These may not be more than five in number. These should be such that it can be acted upon without major policy changes.

(2) Long Term practicable recommendations

There may not be more than ten in number. These should be such that can be implemented in the next four to five financial years, or with sizeable expenditure, or both but does not involve policy changes.

(3) Recommendations requiring change in/of policy:

These are those which will need lot of time, resources and procedure to implement or those which intend to drastically modify the scheme.

15. Cost and Schedule of Budget release

Output based budget release will be as follows-

a. The **first instalment** of Consultation fee amounting to 30% of the total fee shall be payable **as advance** to the Consultant after the approval of the inception report, but only on execution of a bank guarantee of a scheduled nationalized bank valid for a period of at least 12 months from the date of issuance of advance.
b. The **second instalment** of Consultation fee amounting to 50% of the total fee shall be payable to the Consultant after the approval of the Draft report.
c. The **third and final instalment** of Consultation fee amounting to 20% of the total fee shall be payable to the Consultant after the receipt of the hard and soft copies of the final report in such format and number as prescribed in the agreement, along with all original documents containing primary and secondary data, processed data outputs, study report and soft copies of all literature used to the final report.

Taxes will be deducted from each payment as per rates in force. In addition, the evaluator is expected to pay services tax at their end.

16. Selection of Consultant Agency for Evaluation

The selection of evaluation agency should be finalized as per provisions of KTPPAct and rules without compromising on the quality.

17. Contact persons to get further details about the study

Sri. M.Venkataswamy, Officer On Special Duty & Ex-officio Deputy Secretary to Government Co-operation Department, 6th Floor, 3rd Gate, M.S.Building, Bangalore, Phone No. 080-22032368 (Mobile No. 94800238548) and Sri.R.M.Nataraja, Chief Executive Officer, Yeshasvini Trust, Room No. 607, 6th Floor, 3rd Gate, M.S.Building, Bangalore, Phone No. 080-22032046 (Mobile No.9980831386) will be the contact persons for giving information and details for this study.

The entire process of evaluation shall be subject to and conform to the letter and spirit of the contents of the government of Karnataka order no. PD/8/EVN(2)/2011 dated 11 th July 2011 and orders made there under.

The Terms of Reference were approved by the Technical Committee of KEA in its 21st Meeting held on 29th September 2015.

28/10/15

Chief Evaluation Officer
Karnataka Evaluation Authority

APPENDIX -1

Year	Member (in lakh)	Contributions of Members (Rs. In Crores)	Govt. Contribution (Rs. In Crores)	Members treated in OPD	Member availed Surgery	Amount spent on surgeries (Rs. In Crores)
2003-04	16.01	9.49	4.50	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
2011-12	30.70	45.08	30.00	116690	77526	60.00
2012-13	30.36	58.99	35.00	110842	83802	77.80
2013-14	37.97	52.33	45.00	123205	86359	84.56
2014-15	38.72	69.40	71.00	172442	127052	140.07
Total	**322.89**	**433.55**	**334.94**	**1507731**	**734781**	**683.65**