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THE COMPREHENSIVE HEALTH INSURANCE SCHEME IN KERALA (CHIS): AN EXPLORATORY STUDY IN KOLLAM DISTRICT

India has seen growth and vigor in its economic sector but this has not been the case with human development indicators. The rates of mortality of high risk groups still remain a cause of concern. The differences in the rates of mortality based on factors such as caste, religion and class across the country are a stark reminder of the gaps that divide the different classes of Indian society.

The increasing levels of inequality and the resultant lack of access to health care has prompted the intervention of the state in a number of ways, targeted approaches, incentives, subsidizing, free provisioning and even mass campaigns to increase the uptake of services.

The provisioning, access and the use of medical services have been the focus of attention of researchers, policy makers and civil society organizations. The rising prices of services, have nudged out people on the margins, those on the lower rung continue to find it exceedingly impossible to claim health care. The attempts at targeted approach are intended to reach people who are poor and classified as BPL under official records.

The inequalities in access, affordability and the availability of health care are important determinants in the determining the health of the population. (Kumar et al 2010)[1] The determining factors are in turn affected by other factors like governmental policy, law of the land and the will of the administrators.

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[1] A K Shiva Kumar, Arnab Acharya, K Nagaraj, Rama Baru, *and* Sanghmitra Acharya *Inequities in access to Health Services in India: Caste, Class and Region Vol - XLV No. 38, September 18, 2010*

The idea of Health insurance is considered as an alternative as well as a paradigm shift in the technology of Health financing.[2] Within countries, the poorest households seem to suffer the most because of their lack of ability to access and afford health care. They have limited resources to purchase services from the private providers and this leads to seek services from the state funded system, which might be short staffed and not maintained. Policy makers in several countries low to middle income countries are trying to argue for the inclusion of Health insurance as an alternative method to scale up the efforts to improve health outcomes in countries.[3]

Origins of Social Health Insurance.

National Health plans were established in different countries around early 1900's, in England it was established in the year 1911, 1914 in Sweden, and 1930 was the year when it was established in France. All these plans were mainly for the salaried people who would be looked after by the employer or the government. The dependents in most cases were left out from benefits and these schemes were meant only for the salaried classes, meaning that those who held other jobs had to take care of themselves. Around the later 1980's almost every developed country had a health insurance coverage plans for its citizens. Major conferences have been convened at Berlin (2005)[4] and Paris (2007)[5] on Social health insurance in developing countries. Based on the evidences from these seminars, the world health assembly has passed a policy resolution, where by the WHO would advocate Social Health Insurance in low Income countries so that equitable services could be provided to the poor in the low and middle income countries.(WHO 2005).

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[2] *Escobar, M, et al 2011, The Impact of Health insurance in Low and middle Income countries., Brookings Insitution press,Washington DC (pg xi)*

[3] *Ibid.*

[4] *Berlin Recommendations: Final Version. Report on actions recommended by the International Conference on Social Health Insurance in Developing Countries, Berlin, December 5-7, 2005. www.shi-conference.de/downl/Berlin%20Recommendations%20for%20Action_July%202006.pdf.*

[5] *Colombo, F., and N. Tapay. 2004, Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems. Organisation for Economic Co-operation and Development (OECD) Health Working Paper No. 15. Paris: OECD.*

The effect of health insurance on the use of Health services have been generally demonstrated and accepted as having a positive effect. In a review of studies done on Health insurance and the effects of the "insured" status, it was seen that there is a positive co-relation between having Health insurance and using more medical care. But this was the case of Developed world; there were hardly any studies on such a co relation for the developing world (Hadley 2003).[6]

Whether health insurance is a recommended strategy to improve healthcare access in low and middle income countries is asuject of debate and very little documentation is available in this regard. This makes the task harder to ascertain whether any efforts in this regard have borne fruit or not.

The advocates of health insurance argue that besides providing a succor from the economic effects of illness, health insurance is also meant to improve access to health care. The claims by advocates of insurance have opined that any sort of insurance coverage helps the patients to seek medical care. The case of ACCORD Ashwini (where the ASHWINI (Association for Health Welfare in the Nilgiris) is a Charitable Organisation providing comprehensive health care for Tribals settled in Gudalur Valley situated in the tri-junction of the three South Indian States of Tamilnadu, Kerala and Karnataka. Under this scheme where the members of the AMS were covered under the Health Insurance scheme for seeking treatment has been hailed as an example where health insurance can lead to the increased use of medical care (Devadasan et al 2005). According to the authors, the insured people were twice more likely than the uninsured to seek medical attention. The scheme was a motivating factor for the tribals to seek healthcare at the 20 bedded hospital and at the 8 sub centres spread across the mountainous region in Gudalur.

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[6] *Hadley,J. 2003. "Sicker and Poorer- The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income" Medical care Research and Review 60 (2) 3-75.*

The development of policy initiatives by the government to help people who need medical attention have taken different shapes, the provision of free treatment at the public hospitals to subsidized treatment at private hospitals and now use of smart card technology to claim benefits up to a preset limit. The evolution of different schemes for citizens have necessitated that the government provide or ensure the provision of services and also provide for the needs of all the citizens of the land.

Types of Insurance in India

In India, the formal sector employees receive assured social insurance type of benefits, that includes the central government employees as well as the state government employees. The employees have dedicated hospitals where they can seek treatment and also seek referrals to tertiary care hospitals. The employees can claim reimbursements for the treatment sought and also buy medicine supplies with their entitlements. The ESI and maternity benefits act cover only some and selected group of individuals and their families. The Employees State Insurance Act (ESI act) of 1948 is a social insurance scheme covering those employed in public sector undertakings and any industry that uses power and employs more than 10 people. It provides four types of benefits namely- medical, sickness, maternity and work injury. It places a limit on the coverage of people based on their income levels. However these income levels are revised in accordance with the market rates.

The Central Government Health Scheme(CGHS) was introduced in the year 1954 and provides treatment facilities under all systems of medicine, and treatment is available to the currently in service members as well as those who have retired from service. The service of CGHS is available mostly in big towns. Most of the major towns in India are covered under the scheme. The central government employees who are the entitled to seek treatment are provided with a unique identification card, which must be used in all transactions.

The Employees State Insurance Scheme (ESI) and the CGHS are two schemes run by the government for their employees in regular employment and it is quite different from those that are offered by the private and other Non Governmental Organizations.

The private insurance market has seen a spurt since the opening up of the insurance sector for foreign players in 1999. The health insurance sector was opened up for private players because it was noticed that there was poor uptake of insurance among the masses and because of the lack of competition, the premium rates were high and the number of people who took up insurance was low. A number of private and foreign players have launched schemes for individuals and for groups. The insurance market is partially regulated. The level of foreign investment in Insurance sector is regulated as 49:51 shares, where the 51 percent of the shares are held by Indian companies and the rest of the shares are held by foreign players. Some of the foreign players who operate with their Indian counterparts are BUPA, Lombard, Ergo and Allianz.

The Idea of Health Insurance

The present study is about the centrally sponsored Health insurance scheme which was adapted and modified in Kerala to be called the Comprehensive Health Insurance Scheme(CHIS). The presence of an old tradition of welfare funds targeted at certain sections of the society presents a picture of the state which has been adept at evolving new schemes and also adapting to centrally run schemes for the benefit of the population in the state.

The development of policy initiatives to help those below the poverty line to seek medical attention has taken different forms. One of them is the **Rashtriya Swasthya Bima Yojana** (**RSBY**) allows for the provision of free treatment in public hospitals and subsidized treatment in private hospitals with the help of smart card technology to claim benefits up to a preset limit. The idea of the RSBY is premised on a PPP model which included an embedded business model to help the insurer, the service provider as well as

the patient.[7] The inherent business model of RSBY made it attractive for the insurers; the provision of 75:25 financing was also attractive for the state governments. Where the 75% of premium was covered by the Central government and the rest was provided by the State government. Some of the other policy initiatives include the schemes focusiing on providing better healthcare services to the rural areas under the NRHM scheme (National Rural Health Mssion)

The political context of RSBY traces its origin to the first term of the UPA which came up with the Common Minimum Programme(CMP). The common minimum program was part of the election manifesto of the Congress lead government. The scheme though announced in the year 2007 by Manmohan Singh, the Prime minister, in 2007, but the scheme came into effect in 2008. [8]

RSBY

The RSBY (stands for Rashtriya Swasthya Bima Yojana) The National health Insurance Scheme, was introduced in various states in the year 2008 in a phased manner, aiming to cover the entire nation by the year 2012- 2013, it was initiated by the Central government, launched by the Ministry of Labour to provide Health Insurance for workers belonging to unorganized sector falling below the Below Poverty Line. This scheme was part of the Unorganized Workers Social Security Act of 2008. This scheme was envisioned to include the workers of the unorganized sector and those who worked in home based industries and their families. The scheme has an upper limit of Rs.30,000 for a family of five, which can be claimed in a year, in case of illness and which also extends to diseases that are pre existing in nature except certain basic exceptions.

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[7] *Harlankar. S,, HindustanTimes-Print. Available at:http://www.hindustantimes.com/StoryPage/Print/567469.aspx [Accessed July 23, 2011].*

[8] *Rajasekhar, D., Berg, E., Ghatak, M., Manjula, R., & Roy, S. (2011). Implementing health insurance: the rollout of Rashtriya Swasthya Bima Yojana in Karnataka. Economic and Political Weekly, 46(20), 56-63.*

Under this scheme the provision of healthcare services was under the PPP model where service was solicited from both private as well as public service providers. Private providers who wised to take part in the scheme were required to empanelthemselves under the scheme by taking part in the empanelment drive and then agree to provide services according to the preset charges.

Over the years the target population as well as the the groups who are covered under the scheme have been increasing to include different groups of workers like the migrant workers, maid servants, and also homeless rickshaw pullers.[9]

Implementation

Finance and the roll out of the scheme

The financing of the scheme has been divided among the central as well as the state governments in the ratio of 75:25, where in the central government provides 75% of the premium amount and the rest of the premium is to be provided by the state government. In the states of Jammu and Kashmir and the north eastern states, the amount of contribution of the central government is 90% and the rest is to be paid by the state government[10]. The state government is also entrusted with the responsibility of collecting the registration amount from the users at the time of enrollment. The contribution of the users varies from Rs.30 for the Below Poverty Line population to the entire premium amount in case of APL families.

An amount of Rs.30,000 is the upper limit for all claims of hospitalization expenses, different procedures are priced differently and are also administered differently. The patient is required to carry the card while seeking treatment, and registration at the point of service. The holder of the card is made to get his thumb read on the biometric reader and briefly mention his illness to the RSBY kiosk operator. The kiosk operator has to later mark the patient as a registered case and allot a package

[9]Rashtriya Swasthya Bima Yojana for RickshTaxi drivers, rickshaw pullers, Rag pickers http://articles.economictimes.indiatimes.com/2013-06-04/news/39740731_1_rag-pickers-taxi-drivers-rsby

10 *Official documents: RSBY policy guidelines*

according to the description of the patient's ailment and later has to get all the prescriptions marked for being reimbursed or charged from the card. The scheme also has provisions for supply of medicines at the cost of the empaneled hospitals during the period of hospitalization and up to 5 days after discharge from the hospitals. It is the right of the patients to receive equal treatment on par with other categories of patients in empaneled hospitals.

CHIS

In Kerala the RSBY and Comprehensive Health Insurance Scheme are jointly implemented by the State goovernment's Labour and Rehabilitation Department, Health and Family Welfare Department, and the Local Self government Department. The Labour and Rehabilitation department is the nodal agency which administers the scheme. A separate agency the Comprehensive Health Insurance Agency of Kerala (CHIAK) under the Labour Department, was entrusted with the implementation of the scheme. During the first year of implementation 135 hospitals in the Public sector and 165 in the Private sector, including hospitals in the co-operative sector were part of the scheme. This process of taking part in the scheme is called empanelment. In government sector all the hospitals in the level of Community Health Centre and above were empaneled under the scheme. In addition, the five medical colleges from different districts in the state were also empaneled. The insurer for the first and the second year was United India insurance company. The insurers were invited to submit competitive bids and at first when the insurer was enlisted a private insurer had made the cut, but because of the intense resistence by the public vigilante groups. It was decided that a government undertaking would be enlisted, and that is how the United India Insurance bagged the deal to be the insurance provider.

The state also expressed its desire to extend the scheme to the rest of the population by opening up the ceiling on premium payments, and allowing the full payment of premium, which worked out to be Rs.506 plus Rs.60 for the smart card. By this time, most of the other states had implemented the basic version of the scheme and

had rolled out pilot projects in select districts of the state. The government in Kerala had decided to expand the scheme to encompass the whole state and to run the scheme in all the Fourteen districts of the state.

The state government put out notifications inviting competitive bids for the insurance partner for scheme. During the first year of the scheme the insurer was United India Insurance that managed to keep the contract for the continuing years as well. Most of the ground work, which included installing the thumb print readers, and also installing the computers with printers and setting up the kiosks in every emapaneled hostel was done by the private Third Party Administrator (TPA) (MDIndia) from Pune. The responsibility of this institution included the deployment of field staff for the installation, upkeep of the software and electronic interface of the program. The TPA also works as a mediator between the Insurer and the service provider, helping with the settling of insurance claims of the Hospitals for the treatment that was offered. This would include the paper work for claims and the enrolment of patient under the correct package as prescribed by the RSBY rate list for different pricedures. Most of the other procedural formalities involved in the working of the scheme are also undertaken by the TPA. The TPA was also chosen after a process of tender. The company also retained their contract from 2008 to 2011 years and has expanded the range of services offered.

The CHIS in Kerala

The RSBY scheme was implemented in Kerala on October 2nd 2008. Two districts that were selected by the state government for the initial round of implementation[11]. The scheme was to be launched in two districts in Kerala namely, Kollam and Alappuzha in the initial year. The state goverenment that was lead by the Left party called the Left Democratic Front (LDF) which follows communist idealogy decided to extend the scheme to implement the scheme in the whole of the state. The central government had agreed to let the state go ahead and implement the scheme in all the 14 districts in the

11 *Government of Kerala , G.O No.17571/J2/07/LBR*

state during the first year. The State government of Kerala through its Health and Family Welfare Department issued orders on 17.8.2008 with regard to the implementation of RSBY for the unorganized sector workers who were in the Below poverty line (BPL) category and CHIS for the non Below Poverty Line category under the Labour department in government. It is interesting to note that the state also had a seperate poverty line calculations based on the Nine parameteres that included the lack of land, women heade house holds, or households with no sanitation facilities and those belonging to people with no regular employment.

The transistion from targeted insurance to Comprehensive Insurance.

The RSBY scheme was modified as the ***Comprehensive Health Insurance scheme*** (CHIS) in Kerala. Unlike the RSBY that covered only those below the poverty line, CHIS expanded its coverage to include APL families as well. This scheme was to include all those people who were classified as being below poverty line according to the Central government's Planning Commission guidelines and also those who were eligible under the list prepared by the state government. The implementation of the scheme required that the state government should take efforts to verify the eligibility of those who were below the poverty line workers and their families and then enlist them into the scheme. The state government had to ensure that the requisite number of human resources required for the formation of a nodal agency, as envisioned by the directives of the Central government and the state government's labour welfare department, be adhered to. The nodal agency in Kerala was called ***CHIAK (Comprehensive Health Insurance Authority Kerala)***

The CHIS in Kerala had been conceptualized as a cashless insurance scheme, where the beneficiary, the owner of a smart card can seek treatments from empaneled hospitals which include the Community health centres, ESI hospitals, District hospitals and willing private hospitals. Under CHIS, existing diseases were also covered and there was an extensive list of rates for different surgical procedures to be followed by the empaneled hospitals. The scheme also offered a personal accident insurance claim in

case of an accident to the card holder. The accident insurance coverage is for an amount of Rs. 25,000 per annum.

The empanelment of private hospitals was based on several conditions with regard to their capacity of their infrastructure and manpower. The requirements for empanelment of the private providers were overseen by the TPA as well as the insurance agency. It was also required by the agency CHIAK that insurance agency employ field staff to look into various issues that might come up during the roll out of the scheme. This included conducting technical classes for the use of the software as well as the process of manual claim submission in case of software failure.

The cashless system was ensured by the tie-ups with medical stores and other diagnostic service providers who provide services to the beneficiaries. The diagnostic service providers can be private players who agreed to provide these services at subsidized rates. At the public hospitals these tie- ups would mean subsidized medicines from Medical fair price shops within the vicinity of the hospital. The same provision in private hospitals meant that the (Hospitals) provide the medicines and the required care during the inpatient care and also provide medicines for five days after being discharged from the hospital.

If enrollment and utilization of a scheme are any measures to go by, then surely the RSBY scheme has managed to gather a lot of interest and also a lot of beneficiaries. Most of the beneficiaries also reported the ease in the operation of the scheme as a feature that has attracted attention and also the cashless feature as the reason that motivated them to seek treatment in private as well as public hospitals. Increasing number of workers have mentioned the ease of claims and the seemingly easy methods of uptake of the services at even private hospitals as one feature that has attracted a lot of interest and also savings considering the increasing costs of medical expenses and also the increasing amounts of incidental indebtedness caused by catastrophic medical expenses.

Objectives of the study

This study was undertaken to look at the CHIS scheme in Kollam district, this was the broad objective of the study. The scheme under study had been operating in the district since October 2nd 2008.

The specific objectives of the study were to:

(a) To understand the socio-political context of CHIS

(b) To study the eligibility, design and implementation of CHIS in Kollam

(c) To study the experience of beneficiaries of different providers. The different providers being;

i) Public sector provider.

ii) Private (Not for profit).

iii) Private (for profit).

Taking into consideration the various objectives, the tools used were interview methods with key informants and also used semi structured interviews to talk and gather information about the scheme from people who have been closely associated with the scheme.

To meet the first objective i.e. to study the socio political context of CHIS, the researcher interviewed officials involved in the design and implementation of the programme from the state government as well as the nodal agency which was entrusted with the duties of acting on the scheme and working out the implementation and empanelment details. In order to get a complete picture an effort was also made to talk to the TPA, who were involved in the grass root level implementation of the scheme.

In order to meet the second objective i.e. to study the eligibility, design and implementation of the scheme in Kollam, the researcher interviewed the district nodal

officers and the PRO's appointed by the state government, who were working at the different empaneled hospitals in the district. The local nodal officer of the RSBY scheme was also interviewed for details about the scheme and its status in the district.

The specific objective of getting to know the experience of the beneficiaries was met by interviewing the patients who had been seeking care at the specific hospitals. In one instance the researcher had visited the residence of the beneficiary to gather details about the experience of the patient and patient's view about the scheme.

The case studies of patients who had sought treatment from the RSBY empanelled hospitals was done on three different hospitals which had different ownership patterns. One hospital was public hospital which was the Taluka hopsital(Block hospital) another hospital was completely privately owned and for profit hospital. While another hospital though privately owned was not for profit Hospital and it had a shareholding pattern of ownership. During data collection it was seen that there was difference in the experiences of people who sought treatment in the three different hospitals.

The CHIS in Kerala had been worked out as a scheme, where everybody irrespective of their status could get themselves treated at private as well as public hospitals. The condition that people from the above poverty line could also apply was what made the scheme a comprehensive one. The inclusion of the people from the state's BPL list also ensured that no body was left out of the safety net; this meant that the state was willing to let the private and the public hospitals that were ready to empanel themselves and to provide treatment at subsidized rates.

The comprehensiveness assured that along with BPL beneficiaries some APL beneficiaries had also applied for the cards and also sought the services of the hospitals in their respective districts.

Brief background about the study area

The field area chosen for fieldwork was Kollam District, in Kerala. The area is well known for its cashew and coir industries, known as the part of erstwhile Travancore state (before independence). This area is noted for the important role it played in the formation of workers movement in the coir industry. However over the last several decades the coir industry had experienced a decline in production and export, because there was a lack of labour available for coir processing and with the competition of coir products from the neighbouring states. The industry had faced a lot of workers union strikes and loss of market. Apart from coir, the other major industry was cashew processing. Cashew processing and fishing export are the major labour intensive activities that contribute to the local economy.

The patient, around whom the entire process revolves, is supposed to be the ultimate beneficiary and in this case the patient is expected to get medical facilities of his requirement at his point of preference. The entire process revolves around the beneficiary using his card, starting a registration process, meeting the doctor, getting his diagnosis and starting his treatment. In this study the researcher focused on getting to know the CHIS experience in Kollam district, which was among the first few selected districts in Kerala where the scheme was to be implemented, before the state government decided to implement it in the whole of the state. The district also represents the largest share of CHIS beneficiaries and largest fund out flows as claims from the insurer in the claims segment. The claims also present a very unique picture, the claims by private hospitals out weigh the public ones and the difference is way higher than those in other districts.

Healthcare.

Kollam town has a large number of Private as well as public hospitals, the town also . While the main district hospital is situated right at the centre of the town, the mother and child hospital is also situated adjacent to the district hopsital. The area is also dominated by caste specific and religion specific cluster of medical service providers.

Some of the prominent private hospitals that operate near the public hospitals are mamanged by caste specific trusts, like the Sree Narayana trust Mission Hospital, a predominant backward caste charitable trust. Another private hospital The Benziger Hospital is owned and managed by the Latin Catholic Diocese Of Kollam.

Some other hospitals that are situated in and around the district hospitals have been around for more than 30 years and attract large number of patients. The District hospital has seen expansion and increase in number of patients over the years and this has lead to the vigorous expansion in the infrastructure. The number of hospitals with modern facilities have seen a constant increase, new private medical colleges have sprung up in non descript villages.

Data collection

The study was exploratory in nature and looked at the scheme from the provider as well as the beneficiary perspective using descriptive methods. The area of study was Kollam District in Kerala. The data collection included visits to all the empaneled hospitals and the interview of all the people involved with the scheme in the hospital, the insurance provider – United India Insurance Company was also approached for getting to know about the scheme and their responses to the reported problems of high claim ratio as reported in the press. The beneficiary perspective was looked at by interviewing patients who had sought treatment at the hospital and by visiting their homes after getting to know their details while they were exiting the hospital. The co-operation of the service provider was ensured by talking to the hospital administration. The source of data for the scheme and its implementation was collected from the official website of the CHIAK, and the articles on the scheme were collected from vernacular press and also from the independent research that has been done on this scheme.

The data collection for the study included the 24 hospitals that were listed on the website of the RSBY/CHIS as being empaneled in the scheme. The maximum numbers of hospitals were private hospitals whose number came to 14 and the remaining 10 were

government hospitals. The data collection was done during the months November 2010 to April 2011.

The method of selecting the 3 different types of hospitals was purposive, keeping in mind their ownership pattern and also the bed strength, which was close to 50. Thus the selection of 3 hospitals which provided CHIS services included a private for profit hospital, a Private not for profit hospital and a public sector provider.

The data collection was done among the patients who were currently seeking treatment and were about to get discharged. Interviews were conducted using interview method, where the beneficiary was asked questions about his/her experience at the hospital and about the services and the changes if any that they wished to see.

During the second stage of data collection, done during the time period from March to April 2011, in depth interview method was used with the service providers, and their representatives, and with patients it was in depth interview method.

The present situation of the the RSBY scheme is shown as under, and it has been noticed that a lot of the private hospitals have dropped out and have lead to the situation where some hospitals stopped midway and let the patients in the lurch. Most of the patients were kept unaware of the decision to de-empanel thus causing major disruptions in the process of administration of the scheme. The table drawn from the RSBY website fails to mention the number of reimbursements made and it also fails to mention the date on which th data was compiled.

During the time of data collection the number of beneficiaries in Kollam according to official records as of 19/11/2010, the data for Kollam district shows that there are almost 19151 Above Poverty Line patients and 1,84160 BPL patients. The claim settlement for the district of Kerala according to the same record stands at Rs.1088.50 Lakh. The major amount of which went to the private sector which gathered

around Rs.778.15 Lakh, followed by the public sector which gathered Rs.310.35Lakh. The numbers presented above depict a picture of preference for the private sector in Kollam district. This trend has been noticed in Thiruvananthapuram, Calicut, Kannur and Kasargod districts in Kerala.

The current implementation report presents the following picture. It has to be kept in mind that the number of people who used the scheme is still high in Kollam district and the number of cases of claims is still high in Private hospitals. The number of new registrants during the year 2011-2012 in the study district is also among highest 3 in the whole state. The number of beneficiaries under the BPL category are also the highest in the study area.

Estimated No. of Beneficiaries during 2011-2012					
Sl. No.	**Cards issued during 2010-11 ***				**New Registrants ****
	District	**BPL**	**APL**	**Total**	
1	TRIVANDRUM	165637	10288	175925	223207
2	***KOLLAM***	***184160***	***19151***	***203311***	***127387***
3	PATHANAMTHITTA	58335	4522	62857	59887
4	ALLAPUZHA	182186	12374	194560	126282
5	KOTTAYAM	92200	12356	104556	102110
6	IDUKKI	75801	4248	80049	47824
7	ERNAKULAM	145867	20128	165995	104268
8	THRISSUR	141293	12185	153478	128758
9	PALAKKAD	130664	4066	134730	95017
10	MALAPPURAM	140609	184	140793	132010
11	CALICUT	174794	26387	201181	173394
12	KANNUR	118744	6477	125221	81456
13	WAYANAD	53547	3600	57147	41296
14	KASARGODE	70933	4238	75171	31565
Total		**1734770**	**140204**	**1874974**	**1474461**
* These cards are to be renewed					
** New cards are to be issued to these families.					
Total beneficiaries will be around 35 lakhs.					

Table 1:- The number of beneficiaries in different districts of the state as of 2011- 2012

It has been seen in the data on the implementation working and the roll out of the scheme, it was noticed that there were marked differences in the ways in which the schemes were implemented over Kerala, in certain districts the empanelment of private hospitals was noticed to be way higher than the public hospitals. The case of Kollam was no different; the number of private hospitals exceeded that of public hospitals. The number being 17 in private hospitals to 10 in the public sector. By the time the dat was collected 3 of the hospitals had opted out of the scheme.

Public-private mix in provisioning

The data on the implementation working and the roll out of the scheme, it was noticed that, in certain districts the empanelment of private hospitals was noticed to be way higher than the public hospitals. The case of Kollam was no different. The number of private hospitals exceeded that of public hospitals with fourteen in the private sector and ten in the public sector. Four years down the line, the equations have changed considerably; the insurance provider is Reliance Insurance, the TPA has changed. And the enrolment for APL population has been stopped as well.

RSBY-CHIS Implementation Second Year Status										
As on 19/11/2010										
Sl. No.	**Cards issued**				**Hospital Services**			**Claim Settlement**		
					(No. of Beneficiaries)			(Rs. In Lacs)		
	District	**BPL**	**APL**	**Total**	**Govt.**	**Pvt.**	**Total**	**Govt.**	**Pvt.**	**Total**
1	TVM	165637	10288	175925	9,193	15,034	24,227	385.91	568.21	954.12
2	**KLM**	**184160**	**19151**	**203311**	**7,327**	**17,739**	**25,066**	**310.35**	**778.15**	**1088.50**
3	PTA	58335	4522	62857	3,063	2,008	5,071	137.58	84.75	222.33
4	ALP	182186	12374	194560	6,832	4,697	11,529	237.29	204.98	442.27
5	KTM	92200	12356	104556	5,073	3,649	8,722	190.52	74.14	264.66
6	IDU	75801	4248	80049	1,498	6,876	8,374	86.46	54.19	140.65
7	EKM	145867	20128	165995	3,452	18,572	22,024	313.47	154.66	468.13
8	TCR	141293	12185	153478	4,080	15,900	19,980	153.31	149.84	303.15
9	PGT	130664	4066	134730	4,643	7,358	12,001	140.57	103.74	244.31
10	MAL	140609	184	140793	4,268	5,652	9,920	139.48	18.79	158.27
11	CAL	174794	26387	201181	4,120	12,049	16,169	68.47	349.99	418.46
12	KAN	118744	6477	125221	2,804	3,334	6,138	86.91	127.16	214.07
13	WAN	53547	3600	57147	641	244	885	13.37	4.48	17.85
14	KSD	70933	4238	75171	1,552	3,491	5,043	36.42	103.52	139.94
Total		**1734770**	**140204**	**1874974**	**58546**	**116603**	**175,149**	**2300.11**	**2776.60**	**5076.71**
FIRST YEAR DATA										
Enrollment - 1178022 families										
Number of Beneficiaries - 1.42 lakhs										
Claim settled - Rs. 45 Crores(Public Rs.18 crores and Private Rs. 27 crores)										

Table 2 :- Presents the

The worrisome trend was that the private hospitals had empanelled themselves during the initial offer. However it was noticed that many of these hospitals tended to de-empanel themselves. The private hospitals were of the opinion that the rates were too low to continue providing services at the rates prescribed by the agencies. The hospitals had devised their own methods and evolved methods to extract money from the patients. The methods in some cases were very crude and in some it was hardly noticeable leading to the subversion of the scheme.

FINDINGS

a) Diluton of rules

The patient or his bystander has to report back after his diagnosis has been done to get the correct package rate to be opted for against the name of the patient and to start his treatment. Under the scheme the patient is to be provided with medication for a day before his admission and as also 5 days after his discharge, this benefit was done away with since most hospitals were starved for cash and were unable to provide food during the period of the stay of the patient. The patient is thus forced to shell out money for food and other petty expenses during the period of hospitalization. The condition in certain private hospitals was no different. The patients were asked to report back with certain medicines as it was not available at the hospitals and had to be bought from outside. In case of extremely poor patients the hospital bought these and charged the patients indirectly by keeping them for an extra day citing some other reason, thus deducting the cost of the medicine from the card.

b) Benefits of public scheme for private hospitals

At one of the private hospitals, long after its de empanelment it has not removed the signage pointing to the RSBY counter. The hospital also refused to divulge any details about the reasons for their de empanelment from the scheme.

In this whole procedure the Private hospital stands to gain the exchequers money through thee model of healthcare delivery which places emphasis on production of receipts as an indicator of service delivery. The blind and rather unconventional method of allowing the private hospitals to compete with the public hospitals using the same scheme has been able to produce mixed results. Taking the case of Kollam district, the initial enthusiasm had died down by the time the scheme had rolled into its second year. The scheme had also become very popular leading to a large number of people seeking the services of the different hospitals.

The inherent tendency of the masses to seek healthcare at private institutions is once again reinforced by the findings that the "preference for private provisions with public funding has been lapped up. The trend depicted an interest in the idea of people being given the option of near free treatment to be put to use in private hospitals. The preference and the steady comparison of people being treated at the public hospitals as being neglected, and being not treated at all, against the clean and round the clock service at the private hospital. The patient, who was now a consumer, armed with a smart card has a choice of seeking medical attention from any of the 2 types of providers; it was seen to prefer the private. And to verify this are the numbers about the revenue earned by the private hospitals over the public hospitals.

c) Subversion of funds

The provision of Rs.100 as Travelling Allowance for every visit to a maximum of 10 trips a year was also subverted at the main district hospital, where the staff associated with the scheme would ask the patients to sign a receipt which said that they had received the TA of Rs.100 but were provided with only Rs.95, the rest deducted as a charge for the paperwork that the kiosk and staff operators did. The receipt would mention the entire amount while the cash in hand received by the beneficiary would only amount to Rs 95. This according to sources was an allowed practice. According to the Medical superintendent, this practice of deducting money was legitimate as the kiosk operator was doing all the paperwork, and was entitled to some remuneration for the work done.

The subversion of funds and the methods of claiming money for fake hospitalizations and other "adjustments" had been draining the state's coffers, but unless a sturdy mechanism is evolved this would continue to rollout. The patient who would be in a hurry to get himself/herself discharged may not notice that there has been a deduction from the amount due to him and would be unknowingly signing on the receipt.

The public hospitals have been directed to plough back the amounts that they receive as RSBY claims, to help in the upgrading of the services being offered, and

infrastructure. From what could be seen at different hospitals, there has been no development at all. Most of the Community health centers had no services to look after more than 5 patients and there were hardly any that offered inpatient services. They "preferred" small ailments.

d) Private players within the public hospitals

The scheme envisaged as cashless has ceased to cashless, as the scheme had originally been designed to involve no money transactions. But as the scheme progressed the provision of other auxiliary services like scanning and other procedures were slowly sublet to private operators because of lack of these services at the public hospitals. The most jarring of these instances was the case of private scanning services being referred to at the Kottarakara taluk hospital. The diagnostic procedures are referred to the private provider, so is the medicines also, as the medical store within the hospital is short of supply of most essential medicines.

e) The dilution of standards for emapnelment of hospitals

The provision of services at some providers, like the Star Hospital at Oachira, where the OT was in a precarious condition, was based only on small operations and procedures that helped the hospital in finding some resources. The hospitals like these thrived on small day procedures and those which did not warrant for an admission to the hospital. These procedures would also not place a demand on the beds but still earn them money on account of the procedures performed. The condition of such hospitals had not been looked at during the time of empanelment. The provision of services in such hospitals is more of a health risk than safeguarding health. The condition of the wards and other essential services must be taken in to consideration, but disregard for such things had lead to such a situation.

The empanelment procedure should take into consideration the services that are available at a particular hospital and the services that it can provide. The provision of services in such hospitals continues to be unmonitored and pose great risk to patients and

their safety. In case of another hospital there were no qualified doctors, there had been roped in for the time there was inspection for empanelment and had been ordered. After the empanelment they had been discharged from services.

f) Public subsidy for private preference.

The bigger question of public subsidy and public funding for private provisioning is still large; as the trend points to the preference as well as utilization of such services higher that the publicly provided ones. The preference for government paying for the people to seek treatment at private hospitals was prompting the higher number of people opting for private services. The trend of small and single doctor hospitals joining the fray to provide services, in a ploy to attract patients and then later withdrawing from the scheme has been noticed through out the district. It explained for the de empanelment of more than 5 hospitals with in a year of its operation and working with the scheme. The condition of several other hospitals is also quite similar, some are considering de empanelling themselves, some face de empanelment as a result of fraudulent acts.

The fact that most of the private hospitals empanel to attract patients and later de-empanel themselves should raise an alarm with the authorities who are involved in the administration of such schemes and also look into aspects of fraud, wrong doing and also diversion of funds.

The above discussion was about the providers, the insurance provider is another stakeholder in the process. A long interview with the bureaucrats at the helm of the insurance provider acknowledged the fact that the association with the scheme was based purely on Corporate Social Responsibility initiative, but; it has now spun out of control. The response of an official at the helm of affairs at the insurance provider (who did not want to be named) *"We are primarily life insurers, our area of interest is Life insurance, Health insurance is a costly affair, everybody falls sick some time or the other, life insurance is not like that…"*

The preference for a profitable business model is the primary concern of the Insurance provider. As has been reopted by the insurance authorities, the preferred life insurance over health insurance because of the large number of claims and also the worload involved. Affordable healthcare is what brings the patient into the equation and the profit motive is what brings the service providers into this equation. The permutations and combinations can be numerous, but what can be seen in the present scenario is that the private providers have the last laugh on the matter.

Equity Considerations

. The scheme had been working since 2008, and it has been noticed that the scheme warranted the use of technology and the participation of people to get them registered and use the services. The coverage has notched up, and as per official records, the scheme would cover the total target population by the year 2011 and would continue to add more private providers in remote areas to widen the scheme and to extend its reach. The provision of services were equal for paying and non paying patients, the target population i.e. the Below Poverty Line, this was the primary aim of the scheme. The aim of the smart card is to provide equitable services on par with other private services and this is to be ensured by both the private as well as public sector providers alike, who have empanelled themselves.

The smart card marks the user from the non eligible person. In case of Kerala the scheme was a comprehensive one, where the beneficiary could be both the APL population who volunteered to take part and the BPL population who are the target population, in Kollam district which was adjudged the best CHIS implementing district in Kerala[12]. The provision of services has seen a surge since more and more private players empanelled themselves and provision of services in certain hospitals have seen manifold increase in their clientele, also increase in revenue. The case of Ashtamudi hospital which is a privately owned but not for profit hospital, is also interesting considering that this particular hospital has been working as a not for profit hospital but still managing to

[12] Kerala kaumudi, Kollam Edition. November 2011.

attract patients in large numbers and also expanding with the resources thus received. Most of the resources that have been received in installments in the hospital have been utilized to put up new infrastructure and also to upgrade the facilities that were already available.

Role of TPA

The Third Party Administrator earns its commission by playing the middleman to the insurance provider and to the service provider. The service provider pays the TPA its annual empanelment charges amounting to 34,000 Rs and the hospital administration does not know whether this money is sent to the government is taken up the TPA, this was similar in all the hospitals visited for data collection. The TPA also charges service taxes on their services from the other parties involved in this scheme.

DISCUSSION AND CONCLUSION

The essential question here is **"Who benefits from the Scheme?"** Who stands to gain by this model? Is it the TPA – acting as middle men? Are the private hospitals the beneficiaries? Does the target population stand to gain any benefits? Is it beneficial for the government is trying to provide services to people who fall out of the group of people who can afford to buy healthcare? The answer to the questions lies in analyzing the trends that have been noticed and the ways in which they have played themselves out. In the present case, the scheme was meant to be a cashless scheme where the patient just had to carry his smartcard and the rest was assured, he just had to seek treatment. But in practice it was seen that this was not the case, the patent or his bystander had to produce innumerable copies of his documents, claim his entitlement and show proof that he needed in patient care, and above all he had to prove that he that the was indeed the patient.

At the end, it a point to ponder whether in this whole equation whether the patient stands to gain any benefit at all from the whole health insurance scheme or whether he is just a fulcrum trying to balance the interests of the other parties involved in the scheme namely the insurance provider and the service providers.

The choice of service provider rests with the patient, but the kind and the type of service provided totally rests with the service provided. So when it comes to services, the patient still is at the mercy of the providers.

The recent developments in the state and its effect on the welfare schemes can be gauged by the changes that have been brought about by the new government. The new order under the new government says that no new APL cards would be made from this year on and there would be no more renewal of APL cards from the next year onwards. This signals an end to the comprehensive nature of the scheme and also the reluctance of the new government in allowing the achieving the Universal Healthcare provisioning idea. The scheme has been put in the side burner and a new scheme has been announced, it has been announced during the recent budget session, where the new finance minister promised a better and more effective scheme.

The new scheme would be the replica of the Rajiv arogyasree programme that has been running in Andhra Pradesh. The new scheme in Kerala would be called the Rajiv arogyasree as well.

The change in guard at the helm of affairs has been looked at with caution by the people associated with the CHIS, as the fear that any change in the current setting would affect the working of the scheme as well as their job. As the new scheme had been allocated budget to start its functioning as soon as possible, it remains to be seen whether it is gains popularity like it has in AP, or remains dud. In recent political history, there have been numerous times when the newly formed government has done away with the scheme right after coming in to power. The very recent example from a neighboring state

has been the case of Tamil Nadu, where the Jayalalitha Government had done away with existing Kalingar Maruthava Thittam.(Srividya 2011)[13]

The recent news has been that the CHIS scheme would not be made mandatory for the private hospitals to empanel themselves and it would be made optional for the private hospitals to take part in the scheme. The option of not being involved in the scheme and the option that this scheme is limited to the public hospitals signals a slow death knell for the scheme. The recent update on the scheme indicates that the nodal agencies are developing a new list of empanelled hospitals, it remains to be seen whether the new list has more of private hospitals or public hospitals.

The developments on the political front have meant that the scheme might undergo changes according to the whims of the new government. The comprehensiveness has already been compromised with, now the inclusiveness and the coverage has been made optional. From the viewpoint of the current card holders the future is uncertain, being a centrally sponsored scheme it might continue to exist, but, when there are parallel scheme being brought out by the government, the fate of old one hangs in balance. The scheme has been had been running for almost 2 years, and continues to generate headlines for its wide coverage and adaptation in even far off countries[14] is being looked down upon in one of the states where it has been running successfully ever since its launch.[15]

In studies conducted by the Rajagiri School of Social Sciences, it was found that the people's perception and the provider perception about the scheme were favorable and most of the participants wanted the scheme to continue.

13 R Srividhya, Name game takes sheen off govt health schemes. Available at: http://www.mydigitalfc.com/insurance/name-game-takes-sheen-govt-health-schemes-207 [Accessed May 21, 2011].

14 Anon, News report links Maldives to Indian health insurance scheme | Minivan News. Available at: http://minivannews.com/news-in-brief/news-report-links-maldives-to-indian-health-insurance-scheme-22113 [Accessed July 3, 2011].

15 Nayar, L., www.outlookindia.com | The Card Reads You. Available at: http://www.outlookindia.com/article.aspx?264636 [Accessed May 19, 2011].

The analysis of the scheme and its working would be incomplete without the discussion about the process of empanelment and the ways in which some single doctor dispensaries were empanelled, the way in which the conditionality for empanelment were disregarded. The dilution of norms during empanelment, were overlooked, this had lead to some hospitals making it to the empanelled list and functioning for a long time. Some hospitals were found to have no qualified doctors; they were roped in for the period of inspection and were sent off after the hospital got its accreditation. These incidences point to the absence of any strict checks before empanelment.

The overall picture points to the situation where the private hospitals have been reaping the benefits of public subsidies. The private hospitals have been making efforts to increase their presence in the area by increasing the processes covered and by increasing the ways in which they increase their margin of profit. In short the scheme aimed at helping the poor to seek quality care has been tweaked to such an extent that the benefits accruing to the private sector from the scheme dwarf any other advantages that have arisen out of the scheme. The legacy of exploitation continues but in a more curt way and in an organized manner.

The access to Healthcare is provided to the target population has increased no doubt, but the sophisticated ways of conning have become more fine tuned. It has also lead to the patients preferring to visit the private providers more than they trust the public sector. If utilization of services is measured then the scheme has been a runaway hit; it has lead to the praise from WB.(Misra, 2011.)[16], has inspired other countries to replicate the scheme, and has also led to the increase in the number of cases using this while being migrant laborers.

16 Misra U Out of touch: The World Bank is a few steps behind - Forbes India -. Available at: http://www.moneycontrol.com/news/features/outtouch-the-world-bank-isfew-steps-behind_557712.html [Accessed June21, 2011].

The future of scheme depends on the political will of the government, as well as the capacity of them understanding the need and the effectiveness of such a scheme. Until that is achieved, the scheme may be scuttled and its working tampered with. The introduction of new schemes is not the answer to the inequalities that exist; the ones that were started must be run effectively to notice a change in the conditions. In the current scenario, every year during the budget session, new promises are made and new schemes announced, by the time they materialize it is time for another election and change in policies and programmes. Until the administration decides to stick with one scheme and its working, it is difficult to gauge the impact made by the scheme and the necessary changes to be brought about to make it more effective.

The scheme has undergone few changes in the recent times, the insurance provider has changed from United India Insurance to Reliance Insurance. The third party administrator has also changed from MD India to a gurgaon based company called the FINO. But according to the new rules and regulations, the central government has made a new rule which mentions that private insurance providers will no longer be allowed to operate under the RSBY scheme.

The scope of the schem has also been increased to include the largest number of workers in the unorganised sector. These include the Domestic workers, the rickshaw pullers and also the migrant workers. In the recent past in the light of allegation of wongdoing, there have been several istances where the stake holders have mentioned their unwillingness to continue with such a scheme and have asked for renewal of rates of the scheme or to avoid the inclusion of private sector to increase the profit margins of the public sector.

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