

**RASHTRIYA SWASTHYA BHIMA YOJANA-COMPREHENSIVE
HEALTH INSURANCE SCHEME (RSBY-CHIS) IN KERALA: A
STUDY ON THE EFFECTIVENESS AND UTILIZATION OF THE
SCHEME WITH SPECIAL REFERENCE TO ERNAKULAM AND
WAYANAD DISTRICTS**

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By

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Certificate

This is to certify that the thesis entitled “RASHTRIYA SWASTHYA BHIMA YOJANA-COMPREHENSIVE HEALTH INSURANCE SCHEME (RSBY-CHIS) IN KERALA : A STUDY ON THE EFFECTIVENESS AND UTILIZATION OF THE SCHEME WITH SPECIAL REFERENCE TO ERNAKULAM AND WAYANAD DISTRICTS” is a bonafide research work done by P.P. Mini, under my guidance and supervision. Thesis is approved by the Doctoral Committee for the submission for the degree of Doctor of Philosophy in Economics.

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Date:

Declaration

I, hereby, declare that the thesis entitled "RASHTRIYA SWASTHYA BHIMA YOJANA-COMPREHENSIVE HEALTH INSURANCE SCHEME (RSBY-CHIS) IN KERALA : A STUDY ON THE EFFECTIVENESS AND UTILIZATION OF THE SCHEME WITH SPECIAL REFERENCE TO ERNAKULAM AND WAYANAD DISTRICTS" is a record of bonafide research work carried out by me under the guidance of Dr. P. Arunachalam, Professor, Department of Applied Economics, CUSAT, Kochi- 22. I further declare that this thesis has not previously formed the basis for the award of any degree, diploma, associate ship, fellowship or other similar titles of recognition.

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ABBREVIATIONS

ACCORD	-	Action for Community Organization Rehabilitation and Development
AMS	-	Adivasi Munnetra Sangam
APL	-	Above Poverty Line
ASWINI	-	Association for Health Welfare in the Nilgiris
BPL	-	Below Poverty Line
CBHI	-	Community Based Health Insurance
CGHS	-	Central Government Health Scheme
CHAT	-	Choosing Health Plans All Together
CHC	-	Community Health Care Centre
CHIAK	-	Comprehensive Health Insurance Agency Of Kerala
CHIS	-	Comprehensive Health Insurance Scheme
CII	-	Chamber of Indian Industries
CSSM	-	Child Survival and Safe Motherhood
DALYs	-	Disability Adjusted Life Years
DKM	-	District Key Manger
ESIS	-	Employees State Insurance Scheme
FKO	-	Field Key Officer
GDP	-	Gross Domestic Product
GIC	-	General Insurance Corporation
GNP	-	Gross National Product
HDI	-	Human Development Index
IMR	-	Infant Mortalty Rate
IRDA	-	Insurance Regulatory and Development Authority
KPIS	-	Key Performance Indicators
KPMG	-	Klynveld Peat Marvick Goerdeler
KSSP	-	Kerala Shasthra Sahithya Parishath
LIC	-	Life Insurance Corporation

MFIs	-	Micro Finance Institutions
MMR	-	Maternal Mortality Rate
MoLE	-	Ministry of Labour and Employment
NFHS	-	National Family Health Survey
NGOs	-	Non Governmental Organizations
NREGS	-	National Rural Employment Guarantee Scheme
NSSO	-	National Sample Survey Organization
OPD	-	Out Patient Department
PDS	-	Public Distribution System
PHCs	-	Primary Health Centres
RBI	-	Reserve Bank of India
RSBY	-	Rashtriya Swasthya Bhima Yojana
SC	-	Scheduled Caste
SEWA	-	Self Employed Womens Association
SHGs	-	Self Help Groups
ST	-	Scheduled Tribe
TAC	-	Tariff Advisory Committee
TPA	-	Third Party Administrators
UHS	-	Universal Health Insurance Scheme
WHO	-	World Health Organization

Chapter 1

Introduction



- 1.1 Background of the Problem
- 1.2 Statement of the Problem
- 1.3 Significance of the Study
- 1.4 Objectives of the Study
- 1.5 Hypotheses
- 1.6 Methodology
- 1.7 Period of the Study
- 1.8 Limitations of the Study
- 1.9 Scheme of the Study

The saying ‘health is wealth’ is very much true in the present fast-paced life and it signifies the importance and necessity of a well developed health care system. Ill health not only leads to financial bankruptcy but also gives a lot of sufferings to the affected individual and his/ her family. Good health is one of the most important pre requisite to human productivity which in turn leads to overall development of a society. Providing good health care system to its population is one of the basic duties of any government and what percentage of the GDP the government is spending on health care is indicative of the government’s commitment in fulfilling this duty. Health and socio economic developments are so closely intertwined that it is impossible to achieve the one without the other. Health is a fundamental human right and it is the responsibility of the governments, both at the centre and states, to provide health care to all people in equal proportions. Total health care boosts economic growth, reduces poverty and lowers mortality rates. The

saga of success of many countries lies in their special effort to provide the entire population with good health care facilities.

Health is considered a crucial factor in determining the Human Development Index (HDI) of a country and investment in health sector is therefore a major social investment linked to social goals. Rapid economic development, increasing stress and changing life styles has refocused popular attention on the health sector. Cost of treatment has gone up substantially due to exemplary advancement in medical technology and surgical procedures. Diseases considered incurable a couple of years back are now within the ambit of cure. The treatment is costly no doubt, but the good aspect is that it is now available. The medical facilities now come with a cost that the common man cannot afford. Issues on health and health care, of late, are gaining importance due to factors such as medical inflation, increasing life expectancies with advancement of preventive health care, increasing life style diseases and uncertainties with regard to employment and earnings. With a virtual absence of a health security system in India, and a high proportion of national health spending met by households, the need for a widespread health insurance system is urgent and pressing. This explains the growing relevance of health insurance in the present context.

1.1 Background of the Problem

1.1.1 Health Sector and its Financing:

Developing countries account for 84 per cent of the world's population and 93 per cent of the worldwide burden of diseases. These figures starkly contrast the fact that these very nations account for only

18 per cent of global income and a meager 11 per cent of global health spending. Furthermore, there are 237 Disability-Adjusted Life Years (DALYs) (DALYs are a measure by which international development agencies quantify the burden of disease. It accounts for the years of life lost due to the effect of disease) / 1000 population lost annually around the world. But, the high income countries have a loss of only about 160 DALYs, while low income countries have around 300 DALYs/1000 population (WHO data, 2008).

In the developing world, South Asia, which is predominantly represented by India, ranks among the lowest in health spending. According to 2001 report issued by the world bank, public spending on health in India is a mere 1 per cent of India's GDP, poor in comparison with the average distribution of 2.8 per cent in low and middle income countries. According to Nagaraj of the Madras Institute of Development Studies, "The Indian health sector is among the most privatized in the world. Very few nations have lower public health spending than our own. Those include Myanmar, Burundi and Azerbaijan. In India, private spending as a share of total health expenditure is 78.7 per cent. Myanmar, Cambodia, Togo, Sudan, Guinea and Burundi were some nations where private spending is higher than that of India". Out of this private spending, the corporates' share is just 3 per cent, external funding just 2 per cent, and share of NGO's just 0.3 per cent (National Health Accounts, 2004-05). The rest of the more than Rs. 100,000 crore that is spent on health comes from ordinary households. It's what the Indian people pull out of their own torn pockets. And their spending growing at about 14 per cent a year.

Over the last 60 years, India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators (Satia, et. al., 1999). Against the world average of 4 hospital beds per 1000 population, India has 1.5 beds. To add 2.5 more beds, we require Rs. 5 lakh crore by 2025. India has 6 lakh doctors and 16 lakh nurses. We Need another 15 lakh doctors and 30 lakh nurses to come near the halfway mark of global standards. In India, there is one doctor for every 1000 population where as it is 548 in the US, 166 in the UK, 209 in Canada and 249 in Australia (Venugopal, 2009). According to Rural Health Statistics in India (2006), India has a shortfall of 20,000 Sub Centres, 4,800 Primary Health Centres and 2,653 Community Health Centres. Given this considerable gap in public health infrastructure, any financing program should include private and public hospitals to ensure that all beneficiaries have adequate and proximate access.

Overall, public spending is inadequate to meet the needs of India's people and is even too difficult to provide the most basic health care to the population. Furthermore, the government allocates the bulk of public spending to primary health care funds that are spread too thinly to provide effective care. While the government's inadequate health spending alone contributes significantly to the insufficient health care provided to its population, substandard distribution of these funds worsens India's health spending problems. Of the money allocated for public health spending by the government, a disproportionately large amount is spent on salaries, and staff logistics, while only a fraction of a percent is spent on actual user fees. In addition to the deficient allocation, limited public spending by the government is not, as one may assume, distributed solely

among the underprivileged, but is also utilized by well-off sections of society. In fact, when dealing with curative public services, the wealthier section of Indian society receives almost 3 rupees of care for every 1 rupee of care provided to the poorest fifth of the population (Peters, et. al., 2002). Parallel to the difference in monetary allocation of care, there are also large health spending disparities in the distribution of types of service between classes of society. Health spending for the poorer sections of the population focuses greatly on primary health care services such as immunization and other out patient procedures, whereas in patient care is less likely to reach poorer populations (World Bank, 2001).

The level of health care spending in India is currently over 6 per cent of its GDP and is considerably higher than that of many developing countries. This higher level of spending is due to price differences, and also represents a real difference in health care spending. Total health spending indicates that in a break up of this 6 per cent, as much as 4.7 per cent is accounted for by the private sector. Out of this 4.7 per cent, 4.5 per cent comprises out-of-pocket expenditures of households and 0.2 per cent includes contributions from private employers and other non government organizations (Pilania, 2007). Although state facilities exist, the lack of their funding and blatant shortcomings, force India's population, even the rural poor, to rely on private providers for their health care needs. This is because the poor generally have higher rates of morbidity and are more prone to diseases, they are often required to pay more for their health care.

Studies show that people in rural areas are dissatisfied with public health facilities due to factors like distance, absence of doctors, difficulty

to obtain prescribed medicines, lack of emergency equipments and lifesaving drugs, long waiting hours, unsympathetic treatment from the staff etc. (Mavalankar, et. al., 2003). Public hospitals face high rates of doctor absenteeism, shortage of consumables, and do not focus on low-income families alone. Further, the quality of public healthcare is adversely affected by the lack of accountability and incentives (Das & Hammer, 2007). Traditionally, public health financing in India has been largely restricted to the supply side, focusing on hospital infrastructure and staff costs. This widespread dissatisfaction with the public system causes rural population to seek private care or go to traditional healers for their health needs. The data shows that only 20 per cent of outpatient and 45 per cent of inpatient care is obtained from government health infrastructure while the rest is obtained from private sources (Ramani and Mavalankar, 2005). This may have two outcomes—either the patient does not access care or the patient accesses care, but is impoverished in the process (Kawabata, et. al., 2002). Twenty-four percent of all Indians who are hospitalized each year fall below the poverty line due to hospitalization (Peters, et. al., 2002). Data from the National Sample Survey (NSSO, 2004) shows that from the bottom two quintiles of the rural population, 47 per cent borrowed to finance hospitalization, often at high interest rates and from informal sources.

Thus a very rapidly growing private health market has developed in India. This private sector bridges most of the gap between what government offers and what people need. However with proliferation of various health care technologies and general price rise, the cost of care has also become very expensive and unaffordable to large segment of population. The government and people have started exploring various health financing options to manage problems arising out of growing set

of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases (Mavalankar and Bhat, 2000). Against this background, health insurance is increasingly being viewed as an important financing tool for improving the access to health services. There is now a growing realization that even the poor can make small periodic contribution that can go towards meeting their health care needs (Zeller and Sharma, 1998). Hence health insurance is getting popularity in India.

Thus it appears that India's poor have problems with accessing hospital care, and those who do access hospital care have the risk of falling into iatrogenic poverty (Meessen, et. al., 2003). Seen in this background, it is tragic that in India, the standard of health is still at low ebb and a mere 10 per cent of the total population is covered under any scheme of health care. Of this, most are employees in the formal sector (Ellis, et. al., 2000). The informal sector is totally unprotected and has to depend on the aforementioned poorly financed public sector or the expensive private sector to take care of its needs. Health insurance is very essential in a country which is among the top 15 economically strong countries in the world (in terms of GNP) and still have an insurance penetration (Insurance penetration is defined as the ratio of premium underwritten in a given year to the gross domestic product) as low as 2.32 per cent ranked 52nd in the world (Pilania, 2007).

The moral imperative that justifies strengthening of health insurance in India is the growing impoverishment of those with low resilience to absorb economic shocks caused by having to incur unplanned and lumpy expenditure for medical treatment. Irrespective of income class, one episode of hospitalization is estimated to account for

58 per cent of per capita annual expenditure pushing 2.2 per cent of the population below poverty line (WHO, 2002). With 40 per cent of the hospitalized having had to borrow money or sell assets, during the decade 1986-1996, there was a doubling of persons unable to seek health care due to financial reasons (NSSO, 1998).

1.1.2 Kerala Paradox:

Among the states in India, Kerala surpasses all the other states in levels of human development. Kerala has many enviable standards in health care. The health status of any state can be measured in terms of birth rate, death rate, infant mortality rate, expectation of life at birth etc. Kerala is far ahead of other states in the country and ranks first in attaining low birth rate, death rate, fertility rate, infant mortality rate and in attaining high expectation of life especially of females. The literacy of Kerala is high and people are aware of their needs, conscious of their safety and are generally demanding the services. They are enjoying a better healthier life than their counter parts in the country. The major factors contributing to such a unique situation are a wide network of health infrastructure and manpower, policies of successive state governments and other social factors like women's education, general health awareness and clean habits of the people.

Even though Kerala is known for better health care indicators in the country, and its performance is comparable with some of the developed countries, it has reached a stage, where we are finding it extremely difficult to sustain the development made during the last 200 years. Moreover, due to resource crunch, the state could not provide adequate resources for health care delivery and keeping in tune with the

epidemiological and demographic transition that have swept the state since independence. All evidence suggests that liberalization has challenged the equity foundations of the Kerala model based on low cost health care. While on the one hand, public health care and medical expenditure have been declining, the cost of medicines has increased. The recent health statistics of Kerala tell a dismal story of degenerating public health system. For example, the percentage of fully vaccinated children in the age group of 12-23 months in Kerala came down from 80 per cent in 1998-99 (NFHS-2) to 75 per cent in 2005-06 (NFHS-3). The proportion of anemic women in the age group of 15-49 years has increased from 22.7 per cent to 32.3 per cent and that of underweight children from 27 per cent to 29 per cent during the same period. Infant mortality rate in the state which reached 10 per 1000 live births in the mid 1990s has increased to 14 as per the latest SRS data (www.nfhsindia.org).

The people of Kerala are now facing the problem of high morbidity, both from communicable and non communicable diseases. According to the available morbidity statistics, the morbidity rate (The number of persons falling sick per 1000 population) in Kerala is much more than at the all India level. The morbidity rate for Kerala is twice the all India average in the rural areas and over 50 per cent higher in the urban areas. According to the NSSO 60th round (2004), the morbidity rate in the rural area was 255 and in the urban area, it was 240 per 1000 population. With increased levels of literacy and extension of medical services, it is conceivable that even minor ailments are reported as illness. It may also be noted that morbidity correlates with density of population and that Kerala having the highest density, thus has high morbidity too. The increase in old age population is also a factor for

high morbidity in Kerala (Department of Health and Family Welfare). Communicable diseases like malaria, dengue, chikun guniya etc. are reemerging in the state due to underfunded public health system.

As a result of increased privatization, preventive and promotive health care which is usually given by the public sector is gradually been neglected. While the public domain of health care declined, private hospitals, nursing homes, scanning centers, diagnostic centers and the like registered a phenomenal growth in recent years unleashing a high cost health regime. More than 60 per cent of the beds are in the private sector, with those in the public sector providing indifferent patient care and the services due to overcrowding, lack of equipments, medicines and so on. The PHCs and sub centers which historically have been the key institutions for the delivery of primary health care are not increasingly utilized by the public. Even the low income categories use only 35-40 per cent of the government health care services (Oommen, 2008).

Today, studies show that about 80 per cent of all outpatients and about 50 per cent of all inpatients seek health care from the private sector (Ramankutty, 1996). No wonder while the poor spend over 40 per cent of their income on health care, it is as low as 2.4 per cent among the rich (Kunhikannan and Aravindan, 2000). The KSSP study 2006 put the per capita medical expenditure at Rs.1772 for 2004 as against Rs. 549 for 1996 and Rs. 89 for 1987. High economic costs of health care often preclude those who do not have the ability to pay and the highly developed for-profit private health care system deters many who do not have the capacity to pay for accessing quality care. Several field studies show that the impact of high health care cost is most severe for the lower socio economic groups who

have been pushed below the poverty line and into deep indebtedness. Using NSS 55th round data, George examines the incidence and intensity of impoverishment of urban and rural Kerala due to out of pocket expenses on health care and comes to the conclusion that around 14 per cent of individuals in rural and 11 per cent in urban Kerala incurred expenditure on health care in excess of 15 per cent of their income and that these ‘catastrophic expenses’ were concentrated mostly among the poor (George, 2005). With nearly 70 per cent of the poor taking to the private sector health care, and the cost of medical expenses mounting, the poor borrow heavily for survival and run fast into indebtedness (Varadarajan, et. al., 2004).

From the above, it is clear that both the Indian and Kerala health financing scene raise number of challenges and exploring health financing options becomes critical. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases. Given that government is unable to provide more resources for health care, and institute cost recovery, one of the ways to reduce the underfunding and augment the resources in the health sector is to encourage the development of health insurance. It is considered one of the financing mechanisms to overcome some of the problems of our system.

1.1.3 Health Insurance Sector:

Risks and uncertainties are part of every man life’s great adventure. Risk is a condition in which there is a possibility of an adverse deviation from a desired outcome that is expected or hoped for. There exists several techniques for meeting the problem of risk, of which

insurance is the most practical method for handling major risks. Insurance is based on the principle of risk pooling. The principle of insurance works on the concept of large number of people exposed to a similar risk makes a contribution to a common fund those who suffer losses due to the occurrence of any uncertainties or risk are compensated from this fund. It is the transfer of financial responsibility for the risk at the point of occurrence and conventionally involves the insurer in a commitment to pay provided the terms and conditions of the policy are met, payment of the premium secures a source of funds, in the event of loss. The concept of insurance can be simply stated as a contract of indemnity or an assurance to a person, group or a body to indemnify a specified loss fatal, physical or financial, or to indemnify any specified damage to property or assets owned by him or them upon occurrence of an event. Insurance is an arrangement to deal with unpleasant contingencies. It is a contractual arrangement which provides partial or total protection against adverse, typical financial outcomes. While there are many outcomes or risks, which are insurable, there are many more against which there can be no insurance.

Of all the risks facing households, health risk poses the highest threat to lives and livelihoods. Health problems thrusts expenditure on households at a time when there is a resultant fall in income due to the health problem. Moreover the uncertainty of the timings of illness and unpredictability of its costs make financial provision for illness difficult for households. Health insurance coverage separates time of payment from time of use of medical services, thus putting medical services within the reach of the insured households. As in other classes of insurance, the principle underlying health insurance remain the same;

that is, from the total pool of premium contribution the 'fortunate' take care of 'unfortunate'. But this pre supposes the adequacy of number of persons covered (law of large number) and premium. Health insurance, as it is different from other segments of insurance business, is more complex because of serious conflicts arising out of adverse selection, moral hazards, covariate risks and information problem.

Strictly speaking health insurance is neither a life nor a general insurance. But it is unique in nature. If one look at the very nature of health insurance, the dependency of the insurance companies with other sectors is very high like hospitals, pharma industry, doctors, paramedics etc. which is not the case in other lines of business. Moreover, in general insurance the concept of insurable interest (an interest in a person/ property that would cause one a loss if that person/property was injured.) is stressed only at the time of claim of the policy whereas in life insurance the insurable interest is stressed upon at the time of inception of the policy. For e.g. If a person A is only a friend of person B, life insurance policy cannot be taken by A on B. But B's vehicle can be insured by A and only when there is a claim, the ownership of the vehicle will be questioned. In case of health insurance, insurable interest is seen both during inception and claims. In India, health insurance is generally handled by non-life insurance sector. Recently there is the introduction of stand-alone health insurance companies in India.

The Insurance Act 1938 is the basic law that governs the transaction of insurance business in India. This act has been amended from time to time to bring about required changes in the insurance

sector as also to push the government agenda. The latest amendment was made in 2000 which created Insurance Regulatory and Development Authority (IRDA) and vested powers with it to issue regulations from time to time to regulate the market and to protect the policyholders interest. This amendment opened up the insurance market in India to private players in 2000. As a result many new comers entered into the insurance market. Multinational insurers have entered the Indian market, not only because of the opportunity that it presents but also because the business in their home market are almost saturated. The introduction of private players in the insurance sector has led to greater competition among all the players. As a result of this competition, the customers are presented with a plethora of choices in various categories. The customer service has improved and the private insurance players are increasingly eroding the market share of public sector insurance companies. However, till date it is the public sector insurers who are commanding a major share of the Indian market. In health insurance sector, the private players have already acquired a market share of about 25 per cent. The private players, it needs to be noted, have taken the market share from existing clients and have not made much of the breakthrough either in bringing the new product or by bringing a set of new customers.

There are various types of health insurance coverage in India. Based on ownership, the existing health insurance schemes can be broadly divided into categories such as :

1. Mandatory Health Insurance Schemes like Employees State Insurance Scheme (ESIS), Central Government Health Scheme (CGHS) etc.,

2. Employer Based Schemes,
3. Insurance Offered by NGOs / Community Based Health Insurance Schemes (CBHIs),
4. Voluntary Health Insurance or Commercial Health Insurance Schemes, and
5. Social Insurance or Government Sponsored Schemes like Universal Health Insurance Scheme (UHIS), Rashtriya Swasthya Bhima Yojana (RSBY) etc.

The **CGHS** is a contributory health scheme to provide comprehensive medical care to the central government employees and their families. The **ESIS** is also a contributory and mandatory health insurance scheme for workers of the factories employing ten or more employees. The Railways, Defense and Security forces, plantations sector and mining sector provide medical services and /or benefits to its own employees. These are the cases of Employer Based Schemes. **CBHIs** are typically targeted at poorer populations living in communities. Such schemes are generally run by trust hospitals or Non Governmental Organizations (NGOs). Some examples of CBHIs are SEWA of Gujarat, ACCORD in Tamil Nadu, The Mallur Milk co operative in Karnataka etc. In India, the network of health security schemes like ESIS, CGHS and community and employer based schemes is limited.

In **Voluntary Health Insurance Schemes** or **Private Insurance Schemes**, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expense. Of the various schemes offered, Mediclaim is the main product

under voluntary health insurance schemes. It is provided by both the public and the private insurance companies in India. Mediclaim policy has been introduced in the Indian market in the late 1980's; and thus it remains one of the youngest classes to be introduced in the industry. Only about 24 million persons are presently covered for health through voluntary health insurance, in a country of over 1.2 billion people. But when one looks at the percentage of population who actually go for voluntary health insurance, particularly in rural areas; one could easily realize that something is grossly wrong with the way voluntary health insurance is being accessed in the country. Quite often, the reason that is attributed to this malady is affordability of insurance by the masses. It is perhaps true that the rural side of India does not present a picture of affluence, but it would be incorrect to believe that the masses cannot afford even the basic form of insurance. On the contrary, it is commonplace to observe some member or the other in many families to be hospitalized in a nearby town and in most of these cases; they end up paying huge amounts of hospital bills. Going further, the funding for such casualties is provided by the ubiquitous moneylender; and thus they become unfortunate victims of a debt trap.

According to KPMG CII report released during Health Insurance Summit held on 9th Dec. 2008, just about 15 per cent (180 million) of the Indian population was covered under some or the other prepaid scheme in India in 2007 and a little less than 2 per cent (24 million) are covered under the voluntary health insurance schemes. So what comes out prominently is that there is a 'limited public spending on health care and low coverage in India'. This brings us to some of the ramifications of the limited public spending because that leads to an increase in the out

of pocket expenses; and one is forced to make direct payments to access healthcare from the market. Knowing the background in the country, it is no surprise that this has actually led to a situation of heavy burden of debt in many cases.

In spite of the general public outcry of unsympathetic attitudes of insurers towards their claim settlements, more and more consumers seem to believe that the most important individual insurance each of them really needs is the health insurance cover. The demand for health insurance is irresistible; but what is holding down the supply is its affordability to the public. What may be holding back many uninsured consumers is the prohibitive cost of purchasing the health cover. With insurers recently raising premiums for health insurance rather steeply due to high incidence of claims, the current health covers have become even more unaffordable to many insured as well. Besides being high premiums, these policies do not differentiate between people living in urban and rural areas where the cost of medical care are different. Thus the present policies are less attractive to the poor and rural people. Given the premium is on higher side, it has remained limited to upper middle class, urban tax payer segment of the population. There are also problems and negative unintended consequences of health insurance. There are reported fraud and manipulation by clients and providers which have implications for the growth and development of this sector. As some policies, reimburses charges without limits, it has also pushed up health care cost in private sector. All these effects will tend to increase the prices of private health care, thus hurting the uninsured.

As a result, to address such issues, former and present governments in India have introduced various demand side financing mechanisms to provide financial security for vulnerable segments of the society in the last 4-5 years. Health insurance schemes like the **Universal Health Insurance Scheme (UHIS)** launched by the Ministry of Finance in 2003, State level health insurance schemes launched by the States of Punjab, Assam etc. are some examples. However, most of these Central or State Government funded schemes have had problems due to poor policy design, lack of clear accountability at the state level, lack of sustained efforts in implementation, weak monitoring and evaluation, unclear roles and responsibilities of different stakeholders, and poor awareness among beneficiaries about the schemes. However, there are exceptions like the Arogyasri scheme in the state of Andhra Pradesh.

The central government felt that there was a need for a national level health insurance scheme in the country for providing financial security to the vulnerable sections of the society. Learning from the experiences of other major government and non-government health insurance schemes in India, it was decided to launch a health insurance scheme which later came to be known as **Rashtriya Swasthya Bima Yojana (RSBY)**, for BPL workers, as defined by the planning commission, and their families in the unorganized sector. The annual insurance cover is for a maximum amount of Rs. 30000 for a family of five, including the worker, spouse, children and dependent parents, and the annual insurance premium not exceeding Rs.750 is to be decided through tender process. Under the scheme, the Union government will meet 75 per cent of the premium (not exceeding Rs.565), and also the cost of a smartcard for each family, estimated at Rs. 60 for card. The beneficiaries have to pay an annual registration charge of Rs. 30 per family (which is

part of the insurance premium to be paid to the insurance provider), and the state government is to pay the rest of the premium, together with the administrative cost. The scheme as originally envisaged was to cover the entire country in stages by the end of 2012-13. But government of India gave sanction for the implementation of the scheme in all the 14 districts of Kerala during 2008-09 itself.

1.2 Statement of the Problem

Quite a large number of studies have revealed that risk owing to low level of health security is endemic for informal sector workers. The vulnerability of the poor informal worker increases when they have to pay fully for their medical care with no subsidy or support. On the one hand, such a worker does not have the financial resources to bear the cost of medical treatment, on the other; the health infrastructure leaves a lot to be desired. Large number of people, especially those below poverty line, borrows money or sells assets to pay for the treatment in private hospitals. Thus health insurance could be a way of overcoming financial handicaps, improving access to quality medical care and providing financial protection against high medical expenses.

Rashtriya Swasthya Bima Yojana (RSBY), one of the welfare schemes formulated by the Government of India under the Unorganized Workers Security Act, 2008 to provide quality medical services to those in the BPL list through hospitals in the Government and private sector is being successfully implemented in all the 14 districts of the state from the 1st year of introduction in the country. As per the Planning Commission estimates there are 11.79 lakh BPL families in the state, all of whom are being covered under the RSBY. The state Government has estimated another 10 lakh families eligible to be included in the BPL list. The state Government has decided to extend the benefits of

RSBY to those 10 lakh poor families also, meeting the entire expenditure from State Government funds. In addition the state Government has decided to extend the same scheme to benefit APL families also. The entire premium in this case will have to be borne by the beneficiary. Accordingly the State Government has formulated the Comprehensive Health Insurance Scheme (CHIS) on the same lines of RSBY to benefit these 10 lakh poor families and also the APL. The scheme was started on 02-10-2008 in the Alappuzha district and then extended to all other districts. Already 28.1 lakh of families have enrolled in the scheme.

The RSBY-CHIS is jointly implemented by the Labour and Rehabilitation Department, Health and Family Welfare Department and the Local Self Government Department. The Labour and Rehabilitation Department is the Nodal Department which administers the Scheme. A separate Agency, namely, Comprehensive Health Insurance Agency, Kerala (CHIAK) was formulated for implementation of RSBY-CHIS. United India Insurance Company was the insurer for the first 3 years for a premium of Rs. 748/ per family. Tender Evaluation Committee recommended to award the insurance contract again for a period of 3 years from 2012-13, to United India Insurance Company Ltd. The Premium per family quoted by United India Insurance Company now is Rs.1274/-.

In addition to the coverage of Rs. 30,000 available under the Central Scheme, the state government has decided to give additional coverage of Rs. 70,000 to the BPL beneficiaries for the treatment of serious disease affecting kidney, heart etc and cancer treatment. It has been implemented from 1st Dec, 2010, in the name of CHIS-PLUS. Amount in addition to Rs. 30,000 available

under RSBY-CHIS will be allotted to the respective hospitals directly by CHIAK through non insurance route.

Now 3 years has been completed since the launch of the scheme and there are only few studies regarding the effectiveness and utilization of the scheme. The time is ripe now to understand the effectiveness and utilization of the scheme with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses and also to find out the extent of satisfaction of the beneficiaries on the services received by them. In these contexts, it is felt necessary to make an attempt to understand the effectiveness of the Comprehensive Health Insurance Scheme (CHIS) in Kerala, with special reference to Ernakulam and Wayanad districts, as these two districts are having the highest and lowest utilization of the scheme respectively. This is a fact finding study, concerned with the performance of RSBY-CHIS in terms of its effectiveness in the state of Kerala by conducting a survey among the hospitalized beneficiaries under RSBY-CHIS. It is an attempt to present an integrated picture of the main features of the scheme, its implementation, awareness level of the beneficiaries, evaluation of its effectiveness, to find out the extent of satisfaction of the beneficiaries on the services received by them and further modifications needed in the scheme according to the opinion of the beneficiaries. Therefore, performance of the Comprehensive Health Insurance Scheme (CHIS) in terms of its effectiveness on the beneficiaries, the impact thereof and the factors, if any, affecting the proper utilization are considered as the research problem of this study.

1.3 Significance of the Study

Health insurance has become a necessity for the common man, next to food, clothing and shelter. The financing of health expense is

either catastrophic or sometimes even frequently contracted illnesses, is a major cause of mental agony for the common man. The cost of care may sometimes result in the complete erosion of the family savings or may even lead to indebtedness as many studies on causes of rural indebtedness bear testimony (Jayalakshmi, 2006). A suitable cover by way of health insurance is all that is required to cope with such situations. Health care insurance rightly provides the mechanism for both individuals and families to mitigate the financial burden of medical expenses in the present context. Hence a well designed affordable health insurance policy is the need of the hour.

Further a health insurance plan can also serve as an income protection plan for the poor (Krishnan, 1995). With inadequate management of public facilities, consumers are forced to visit private facilities and incur large out of pocket expenditure for care that could otherwise have been available at no or little cost from government facilities. In such a scenario, health insurance serves as a means of financial protection against the risk of unexpected and expensive healthcare (Razvi, 2000). Health insurance is not only a mechanism for financial protection of the enrollees to meet costs of health care, but it also has the potential to influence provider behavior. Presence of financial protection could itself contribute to increased access to healthcare as the cost barrier is overcome by many who would not be able to afford healthcare otherwise. Further, by acting as large purchasers of health care, health insurance schemes could have negotiating power which can potentially influence provider behavior, something an individual purchaser of healthcare cannot achieve. It, thus, has implications on the accessibility, costs and quality of healthcare.

Therefore, it is very significant to study the extent to which the beneficiaries in Kerala make use of the benefits provided by a social health insurance scheme like RSBY-CHIS. Based on the above pertinent points, this study assumes national relevance even though the geographical area of the study is limited to two districts of Kerala. The findings of the study will bring forth valuable inputs on the services availed by the beneficiaries of RSBY-CHIS and take appropriate measures to improve the effectiveness of the scheme whereby maximum quality benefit could be availed by the poorest of the poor and develop the scheme as a real dawn of the new era of health for them.

1.4 Objectives of the Study

The overall objective of the study is to find out the performance of RSBY-CHIS in Kerala, in terms of its effectiveness on the beneficiaries.

The research is carried out with the following specific objectives.

1. To study the socio-economic profile of the beneficiaries of the scheme.
2. To study the awareness level of the beneficiaries regarding the features of the scheme.
3. To evaluate the effectiveness of the scheme with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses.
4. To study the satisfaction level of the beneficiaries in the utilization of the scheme.
5. To suggest suitable measures to make the scheme more effective and useful to the beneficiaries.

1.5 Hypotheses

1. There is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.
2. There is no significant difference between BPL and APL beneficiaries as far as the level of awareness on the feature of the scheme is concerned.
3. There is no significant difference in the effectiveness of the scheme in between Ernakulam and Wayanad beneficiaries.
4. There is no significant difference in the effectiveness of the scheme in between BPL and APL beneficiaries.

1.6 Methodology

This study is based on both primary and secondary data.

1.6.1 Primary data:

The main source of data for this study is the sample survey conducted among the hospitalized beneficiaries under the scheme.

Sampling design: The total sample size is 900 hospitalized beneficiaries under the scheme. Samples are selected using stratified sampling method. All the districts in Kerala are divided into different strata based on their hospitalization rate under the scheme. Table 1.1 gives a picture of the hospitalization rates of the scheme in different districts of the state. At the all Kerala level, the hospitalization rate is 9.34 as is revealed from table 1.1. So all the districts in the state are classified into two groups, i.e. districts which are having hospitalization rates above the all Kerala rate of 9.34 in one group

and districts which are having hospitalization rates below the all Kerala rate of 9.34 in another group. Thus there are 5 districts, i.e., Trivandrum, Kollam, Idukki, Ernakulam and Thrissur, which are having hospitalization rates above the all Kerala rate and from among these districts, Ernakulam which is having the highest hospitalization rate (13.26), is taken for study. Likewise, there are 9 districts, i.e., Pathanamthitta, Alappuzha, Kottayam, Palakkad, Malappuram, Kozhikode, Kannur, Wayanad and Kasargod, which are having hospitalization rates below the all Kerala rate and from among these districts, Wayanad which is having the lowest hospitalization rate (1.54), is taken for study. The details are given in table 1.1.

Table 1.1 RSBY-CHIS Implementation Status for the Year 2010-11

Cards issued				Hospital Services	
District	BPL	APL	Total	Hospitalized Beneficiaries	
				(in no.)	(in per cent)
TVM	165637	10288	175925	23,227	13.20
KLM	184160	19151	203311	25,066	12.32
PTA	58335	4522	62857	5,071	8.06
ALP	182186	12374	194560	11,529	5.92
KTM	92200	12356	104556	8,722	8.34
IDU	75801	4248	80049	8,374	10.46
EKM	143507	19569	163076	21,624	13.26
TCR	141293	12185	153478	19,980	13.01
PGT	130664	4066	134730	12,001	8.90
MAL	140609	184	140793	9,920	7.04
CAL	174794	26387	201181	16,169	8.03
KAN	118744	6477	125221	6,138	4.90
WAN	49146	8001	57147	885	1.54
KSD	70933	4238	75171	5,043	6.70
Total	1734770	140204	1874974	175,149	9.34

Source: Website of CHIAK

In Ernakulam district, there were 1,63,076 Smart Card Holders (143507 BPL and 19569 APL Smart Card Holders) for the year 2010-11. Out of this, 21,624 (13.26 per cent) hospitalized beneficiaries were there, which constitutes the highest percentage of hospitalized beneficiaries among the districts in Kerala. Likewise, in Wayanad district, there were 57147 Smart Card Holders (49146 BPL and 8001 APL Smart Card Holders) for the year 2010-11. Out of this, 885 (1.54 per cent) hospitalized beneficiaries were there, which constitutes the lowest percentage of hospitalized beneficiaries among the districts in Kerala. Thus there are 21,624 hospitalized beneficiaries in Ernakulam district and 885 hospitalized beneficiaries in Wayanad district and totally there are 22509 hospitalized beneficiaries which constitute the population for the study. By applying proportionate allocation, i.e. size of the sample in each stratum is taken in proportion to the size of the stratum, a sample of 35 hospitalized beneficiaries (30 BPL and 5 APL) from Wayanad district, which is having lowest utilization rate, and 865 hospitalized beneficiaries (765 BPL and 100 APL) from Ernakulam district, which is having highest utilization rate, and thus a total of 900 samples are selected at random. There are 5 public and 1 private hospital empanelled under the scheme in Wayanad district, whereas 10 public and 12 private hospitals empanelled under the scheme in Ernakulam district. So care has been taken to see that the samples include the hospitalized beneficiaries of all network hospitals in Ernakulam and Wayanad districts. If one considers the sample size as a percentage to the total number of hospitalized beneficiaries in these two districts selected for the study, it works out to 4 per cent. Data were collected by using the post-hospitalization interview schedule given in the RSBY website after making necessary changes, which is attached as an Annexure-1.

1.6.2 Secondary data:

Secondary data were collected from official websites of RSBY, CHIAK, IRDA, United India Insurance Company, etc., from officers of United India Insurance Company, PROs of various hospitals, Kudumbasree workers and also from different journals and periodicals published from time to time. The researcher also made discussions with officials of United India Insurance Company, TPAs, and RSBY-CHIS staff at the hospitals to gather their views.

1.6.3 Tools of analysis:

Statistical techniques were used for the analysis of the data relating to the hospitalized beneficiaries. They are tables, bar charts, pie diagrams etc. and mathematical tools like percentage and weighted average were also used. All the required statistical tables are generated by SPSS. All the statistical analysis has been done with the help of SPSS package. Chi-square test, Mann-Whitney U test, Repeated Measures Analysis etc. were used for testing of hypotheses.

1.7 Period of the Study

Comprehensive Health Insurance Scheme (CHIS) on the same lines of RSBY was started in Kerala on 02-10-2008 in Alappuzha district and then extended to all other districts. Therefore, the study was undertaken from 2008 onwards. Survey of literature was carried out and available secondary data were also collected during the successive periods. The initial survey or the pilot study had been conducted in January, 2012. After fine tuning the Interview schedule on the basis of the experience/ outcome of the pilot survey, the main survey was conducted during April-May, 2012.

1.8 Limitations of the Study

- Basically a representative study as it is limited to Ernakulam and Wayanad districts.
- Due to lack of time and availability of respondents, the sample size has to be restricted to 900.
- Many of the respondents of the study did know about the provisions of the RSBY-CHIS, which restricted them from answering many of the queries in the schedule.
- Further, the respondents were quite irritant and indifferent to answer the long schedule, as it had taken a great deal of their precious time. They have some suspicion about the study, as to an attempt to reduce the available benefits from the governmental sources. Therefore, it was a difficult task to elicit required information tactfully from the family members of the hospitalized beneficiaries. First of all, the purpose of the study had to be convincing to them so as to eliminate their suspicion as stated above, to start responding to the questions.

1.9 Scheme of the Study

The study is organized into eleven chapters. The first chapter introduces the topic of study and explains the methodology. The second chapter reviews the literature on the subject. The third chapter presents theoretical framework. Health sector and its financing in India with special reference to Kerala is the content of the fourth chapter. The fifth chapter explains the health insurance industry in India. The sixth chapter gives an account of the Rashtriya Swasthya Bhima Yojana-Comprehensive Health Insurance Scheme (RSBY-CHIS) and its implementation in Kerala. The seventh chapter discusses the

socio-economic background of the sample beneficiaries. The eighth chapter presents awareness level of the sample beneficiaries regarding the features of RSBY-CHIS. The ninth chapter gives details about and economics of RSBY-CHIS and non RSBY-CHIS hospitalization. The tenth chapter analyses the satisfaction of the beneficiaries on the experience under RSBY-CHIS hospitalization. The last chapter presents the findings of the study and the suggestions for improvement of the scheme.

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Chapter 2

Review of Literature



- 2.1 Demand for Health Insurance
 - 2.2 Health Insurance : Opportunities and Challenges
 - 2.3 Micro Health Insurance
 - 2.4 Community Based Health Insurance
 - 2.5 Importance of Health Insurance
 - 2.6 Third Party Administrators in Health Insurance
 - 2.7 Social Health Insurance
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This chapter deals with important studies already done on this area. They have been discussed here one by one under various headings for better understanding.

2.1 Demand For Health Insurance

Bhatt and Jain (2007), in their study on “Factors Affecting the Renewal of Health Insurance Policy” made an extension of their previous work on factors affecting the decision to purchase health insurance to understand the factors affecting the renewal of insurance policy. Health insurance policies are generally one year policies and to remain part of the insurance pool, policyholders are required to renew their policies each year. Understanding the factors that affect the demand and renewal decisions to continue in health insurance program is imperative for future and growth and development of the insurance sector. The study reveals that the factors affecting health insurance renewal are not the same as factors affecting health insurance purchase decision. It states that the

households which have higher health expenditure and income have higher probability of renewing of health insurance policy. It presents a challenge for insurance companies that how to attract people who are not renewing health insurance policies right now. The study also suggests customer satisfaction is significant factor in influencing renewal decision of policyholders. This should prompt insurance companies to provide a good experience to the customer during the period of the policy.

Bhatt and Jain (2006), in their study on “Factors Affecting Demand for Health Insurance in a Micro Insurance Scheme” made an analysis of factors determining the demand for private health insurance in a micro insurance scheme setting. The study indicates that income and health care expenditure are significant determinants of health insurance purchase. Age, coverage of illnesses and knowledge about insurance were also found to be affecting health insurance purchase decision positively. For the decision regarding amount of health insurance purchase income was found to be having significant, but non linear relationship. In addition, number of children in the family, age and perception regarding future health care expenditure were also found to be significant. The study also discusses implications of these results.

Vinayamoorthy (2006), in his study on “Indian Insurance : Modern Marketing Approach”, focused on the marketing approach to be adopted by the modern insurers to withhold their existing customers and attract new ones. He states that in the global era, insurance companies are increasingly willing to spend more on the customer satisfaction and brand building exercises. Though it is one of the highly regulated industries, it still provides lot of scope for creativity and innovations. In order to achieve

the competitive edge over others standardize the process and bring about quality improvement and get feedback from the customers regarding the quality of services rendered. This will result in customer satisfaction, customer retention, customer acquisition, and employee retention and cost reduction.

Chakravarti (2005) in her study on “Reasons Behind Low Penetration of Health Insurance Schemes in India with Special Reference to Kolkata” stated that the possible hindrances in the delivery system of health insurance are hazards in claim settlement, adverse selection, information lag and lack of outpatient coverage. This article also suggests that efficient claim settlement system, increased promotional measures and introduction to outpatient coverage in some cases will have a positive impact on demand for health insurance. The study also points out that there is an increased need to encourage some special health insurance policies, especially for the vulnerable.

Phatak and Malaiya (2005) in their article on “Study of Factors Influencing Health Insurance Cover” made an attempt to study the factors influencing the decision of health insurance coverage. The study revealed that 8 factors influence the health insurance purchase decision namely, tax rebate, sense of security, risk coverage, economies like peace of mind, timely treatment, planned life etc., plan features like wide coverage, simplicity and convenience, awareness etc., cashless facility, increasing life style diseases and health care expenses and also saving habit of the people. Hence factors like wider range of coverage of health related problems, lower premiums, greater government incentives, convenient and cashless hospitalization for insured person etc. need to be

advocated to increase the level of health insurance coverage in India, only then we can hope to improve our low level of health insurance penetration and increase the number of persons having access to health care.

Chowdhury (2005), in his study on “Recent Welfare Schemes” pointed out that the high premium rates of insurance policies is the reason for low demand for health insurance policies among poor people.

Gupta (2000), a health economist, in her study on “Private Health Insurance and the Willingness to Avoid Health Cost” analyzed whether individual and household will be willing to participate in health insurance.

2.2 Health Insurance: Opportunities and Challenges

.Banerjee (2010) in his study on “Health Insurance: Issues, Challenges And Way Forward” examined the issues, challenges and the future of health insurance in India. He stated that India is about 1.2 billion of population and granting that not all may not be insurable for various reasons, it makes a strong case for a potentiality of at least 50 crore plus people to be under some health insurance scheme apart from government sponsored schemes for the weaker sections. Unfortunately even after opening of market the penetration has been poor and roughly only about 3.5 crore people are covered under various schemes, making the market quite big, only being scratched at the surface without being properly tapped. However, since last 2/3 years, health insurance has picked up with aggressive selling coupled with awareness making the second largest portfolio after motor insurance. But, the existing products are having certain features that are hampering the progress not to mention the unaffordable premium level because of adverse claim experience. Health

insurance has to expand fully and all the players, especially the private sector players, have to be totally involved in writing and developing the business with the seriousness it deserves. The void between those who are insured and those uninsured/uninsurable has to be filled by a funding scheme as in some countries, to make health insurance an umbrella cover over the entire population.

Thomas (2010) in his study on “A Health Check - Claims Handling System” observed that if a minuscule percentage of the health policyholders is responsible for the huge claims ratio, there must be something wrong with the way the claims are being managed which calls for a close scrutiny. As per IRDA published data, one finds that during 2008-09, 20,81,297 claims were lodged in respect of 3,27,10,604 insured people grouped in 45,75,725 policies. This indicates that in a group of 1000 insured people, only 64 claims are lodged. Though 6.4 per cent appears a healthy figure from a frequency point of view, when we consider that the health claims ratio hovers around 100 per cent over the last few years, one is startled that these 6.4 per cent of claimants take away 100 per cent of the money that the insurers laboriously garner throughout the year. This indicates the industry has to look more closely at the health insurance claims management system, which works mainly through TPAs in India. After assessing the TPA system, insurers should take responsibility and decide to enjoy the fruits of the system if they find it good; to improve it if they find it lacking; or to discontinue it if it is not worth having. Whichever way the assessment goes, insurers should take charge of the situation and take decisive action.

Udayachandran (2010) in his study on “Need for Variety Product - Indian Health Insurance Sector” found that the growth of the health insurance sector is dependant not only on the product quality but also on such factors like health care delivery, regulatory supervision and public perception. Product flexibility is indispensable to the sustenance and growth of the sector in general; and insurers in particular. A pertinent fact in this context is that a lot more clarity is required on the health insurance product front, which can be infused by an open approach by the regulator. Exploring an assured benefit policy under health can be a useful and benefiting proposition for the insuring public. Premium payment mode is another area that needs a contemporary approach. While many of the group policies, especially in the micro insurance sector, are given a special facility for staggered payment, no retail policies are brought under this special dispensation. The fact remains that there is a felt need for a staggered payment option for retail policies also, which shall be a defining moment for the mass of people waiting in the financial periphery to avail health insurance protection.

Jayaprakash (2009), in his study on “Empowering Health Insurance Through Empirical Studies” found that empirical studies are necessary to find out the factors influencing the health insurance and health care sector. The time is ripe to promote health consumerism models and gauge the effect. The scope of health insurance does not lie only within the limits of health care and insurance, but also in economics. Economics can bring big changes in the health care and health insurance promotion. Economics and its sub branches can help to explain the concept of consumer behavior and help to predict the behavior of the people towards health, health care, and health insurance. India has still a long

way to go in terms of an integrated management of health insurance as regulatory boundaries are yet to be resolved, functional interdependencies are not well defined, and a proper data warehouse on claims history is not in place. There is a need for increasing integration of economics with health insurance and creating a repository of such studies, so that it benefits not only the companies, but also the government and most importantly the public who are in dire need of increased health care.

Venugopal (2009), in his study on “Health Insurance in India” dealt with the issues and challenges faced by the health insurance industry in the country. He stated that one of the important gains of liberalization of insurance in India has been the much needed thrust to health insurance. Although health is one of the most critical areas for developing countries, less than 1 per cent of the population in India has some sort of health insurance or the other. One of the main reasons for this poor coverage is that there were more claims than premiums received. One of the reasons for this high incidence of claims in health insurance appears to be the collusion between the patient, doctor and sometimes the intermediary. There are instances of inflated medical bills while claiming the reimbursements and at times unhealthy liaison between the physician and the testing lab, for the purpose of reports. This kind of unholy nexus leading to higher claims has made insurance companies hike their health insurance premiums from 15 to 100 per cent. With all these, the health care costs too are rising by 20 per cent every year. This article suggests the transformation of health providers as stake holders in the health insurance companies to prevent unnecessary over treatment to patients to boost up the claim for illnesses. Health insurance

for the masses in India and spread of awareness towards it is the crying need of the hour.

Krishnamurthy and Adams (2008), in their study on “Developing Sustainable Health Insurance in India-Learning From International Experiences” examined the key actuarial and business practices in the buoyant health insurance sector. It states that India has the great opportunity to spearhead a viable and competitive health insurance sector and encourage the development of a sound high quality health delivery system. What is required is a good understanding of the actuarial and other risks in the business, a long term vision for those entering it, simple product design, supportive regulation and sustained customer education.

Pauly (2008) in his article on “The Evolution of Health Insurance in India and China” found that health insurance in rapidly developing countries such as India and China needs to be segmented. As India and china continues on their path to development, they may increasingly face the problem of providing drug benefits, whose cost is difficult to control or constrain, especially in a setting where the country is producing for the world market. Deciding how to pay or control the drug bill will be the greatest challenge to any kind of insurance in developing countries in the near future. This paper also provides the empirical observation of a very high out of pocket share (at the point of use) in both countries -80 per cent in India and 60 per cent in China - along with the perceptive observation that there has been a “lack of clarity” in both governments’ policies towards private insurance and private production of medical care. In many such

countries, more than half of out of pocket health spending comes from the bottom 80 per cent of the income distribution.

Krishnamurthi (2008), in his study on “Health Insurance – The Challenges Ahead” found that in today’s world, marked by several health hazards, health insurance has become an essential pre requisite for all. A suitable cover by way of health insurance will ensure reimbursement of the cost of treatment or hospitalization for ailments. A wide range of choice is available for those who are on the lookout for suitable covers. However, the field of health insurance is riddled with several problems and this calls for remedial measures from the government. Among these the most important ones are high and unrealistic premiums that can be easily brought down if the business base is broadened and deepened, number and quantum of high claims reflecting the poor status of health, prevalence of some serious diseases like AIDS, etc. which deter the insurers and the pace of life and change in its style out beat the pace of innovation in health insurance products.

Kipp and Snook (2008), in their study on “Designing New Health Insurance Products - Technical Considerations” suggested that in order to be more successful in the area of health insurance, Indian insurers have to classify the risks in accordance with the individual’s profile and price them accordingly. In the case of hospital cash benefits, the actuary will need to tailor the pricing assumptions to the target population being insured. In the plans for the elderly, products which have a significant co-pay are favored by insurers. In the case of critical illness plans, precise definition of the covered illnesses and good underwriting are extremely important. In short actuaries and underwriters will play an important role ensuring the ongoing

solvency and financial capacity of the health insurance industry by protecting insurers from adverse selection and bad pricing decisions. Creating disciplined objective, and to the extent possible, automated processes to assist the actuarial and underwriting functions in advance of the new health benefits will be the key to long term success.

Gupta (2008), in his study on “Health Insurance in India - Emerging Trends and Issues” found that the health insurance scenario in India is dismal, particularly in rural areas. One of the important measures to improve the situation is group health insurance schemes for rural and social sectors funded by the central and state governments. Health insurance at affordable premiums for the senior citizens also needs priority. The premium for the senior citizens should be fixed prudently and judiciously by individual risk assessment and by taking into consideration factors like the health of the person, illness, history, medical report, lifestyle of the individual, family history, past claims if any and not merely on the basis of age of the senior citizens. One of the important reasons for increasing the health insurance premium by insurers is high claims ratio in health insurance portfolio due to fraudulent and exaggerated/inflated claims. Thus effective monitoring, implementation, prompt settlements of claims by insurers and wide publicity of social health insurance schemes are important for improving the state of health insurance in India.

Gupta (2008), in his study on “Health Insurance Products of General Insurance Companies” examined the health insurance policies offered by different insurers in the Indian insurance market to the insurance consumer and thereby enabling the consumer to purchase the quality product for the premium paid by him. The parameters chosen for

the study are age for insurance, coverage, sum insured, pre existing diseases, waiting period, cashless facility, family discount in premium, free health check up, cumulative bonus, tax benefit and products for specific purpose and specific class of people. He states that a cross examination of various policies helps insurance consumers to be aware of the coverage and exclusions of the health insurance policy being purchased.

.Rao (2008), in his study on “Developments in Health Insurance: An Analysis of Health Insurance Data” reviewed the current status of the health insurance market in general terms, and in particular an analysis of TAC’s health insurance statistics for the year 2005-06. Based on the data, the author states that with a majority of 94 per cent of lives medically insured not making health insurance claims at all, insurers need to re examine their product design, pricing structures and risk management procedures to restructure the health insurance scenario. Blaming consumers and not introspecting their internal inadequacies, is not a business oriented approach. The problem for insurers rests with their poor underwriting techniques and risk assessment expertise at the acceptance stage. Insurers must devise systems of their own to locate frauds likely to be committed by health care service providers and TPAs. This would penalize only those that put in claims but has no effect on the 94 per cent of the policy holders that do not make claims.

Vyasulu (2008), in his study on “The Case Against Health Insurance” found that medical insurance is now being actively promoted by the government as a means of providing and covering the cost of health care. But such insurance is riddled with problems and faces some

very India-specific constraints. It may contribute to the growth of the insurance industry, but it is a second best solution that represents the abdication of responsibility by the state to provide health care for all the citizens. The tax concessions that the government is providing- both to encourage buying health insurance, and for investing in hospitals- suggest that it is ready to abdicate responsibility for providing health care to its citizens, because this is not a short term consumption expenditure, but a long term investment in its people, and their capacity to be productive citizens. It is unfortunate we are taking the easy way out with private provision through insurance as against the better one of universal state coverage based on taxes.

Banerjee and Parhi (2007), in their study on “Health Insurance: Competition Among the Players is Yet to Touch the Pricing Arena” made a comparative analysis of premium rates charged by various non life players under the health policies, to ensure the reasonability or otherwise of rates. It finds that the rates charged by companies may not truly reflect the pricing fundamentals they subscribe to. Competition is yet to reach the pricing arena in health insurance. The oligopoly nature of market has turned to restrict the free play of market forces through product differentials. Companies do not have any clue at present regarding the imminent pricing structure of the competitors, so they are really operating in darkness. When the price of the rival is not known and the data on health insurance claim is not being shared freely in the market, pricing may not reflect the reality of the market place.

Pilania (2007), in her study on “Emerging Issues in Health Insurance in India” provided an insight into the future of the health

insurance industry and prescribes a few avenues for budding insurance companies in the Indian markets. With competition growing endlessly, insurers need to be in the continuous process of product innovation. The insurers must handle services through a customer friendly distribution network. They should hunt for the untapped markets and try to harness the yet unexplored part of the nation. Health insurance industry to be successful general awareness among the insuring public is vital. It seems that the health insurance sector in India is full of abundant opportunities but simultaneously challenging due to the diverse nature of the country.

Ramakrishnan (2007), in her study on “Health Cover Needs a Check Up” asserted the need to fix the health insurance industry in India. She has stated that health insurance is perhaps the only service, where an increase in sales has resulted in greater underwriting losses for insurance companies and it is having the unique distinction of being a segment, where all constituents- insurers, third party administrators, healthcare providers and insured- are unhappy with the present set up.

Sekhar (2007), in his study on “Lemons Problem and Health Insurance Fraud - How Information Asymmetry can Lead to Health Insurance Fraud?” found that the most common form of fraud is the one which results from asymmetry of information from the demand side. Fraud as a result of agency flow, can happen when the self interests of the insured and agent differ. Acquiring additional information can reduce asymmetric information problems. All affected parties should obtain more information to reduce information asymmetry. Since public interest is affected by asymmetric information, governments check the imbalance to provide substantial attention to the financial position of insurers through

tight regulations. The very purpose of a company's underwriting and claims settlement process is to minimize moral hazard and adverse selection. So they need to commit resources not merely to develop the health insurance portfolio but also the detection of frauds.

Narayanan (2007), in his study on "Mediclaim – A Complete Check Up" focused on some key aspects which one should consider before zeroing in on an apt mediclaim policy. It states that health insurance should no longer be a choice, but a necessity in view of the escalating cost of medical treatment. Until a few years ago, the only health insurance policy available was from the government general insurance companies. But now, with the opening up of the market, there are many private non life insurers which offer a wide variety of mediclaim policies. As the longevity of average Indian goes up, health expenses are also prone to escalate. Therefore it's better to be cautious and avail oneself of the mediclaim benefits before health problems become a major drain on one's savings/resources. The health insurance sector does indeed bring out a whole new meaning to the old age adage: 'health is wealth', as medical insurance has become a necessity. However, the final decision making is for the customers when it comes to purchasing a mediclaim policy. They have to weigh the pros and cons of all the available policies before opting for one.

Rao (2007), in his study on "Health Insurance: What More Should Insurers Do?" found that health insurance needs a sophisticated risk management approach. The health insurance sector growing at a compound annual growth rate of about 50 per cent - the highest growth rate among all non life insurance segments. However, despite the

growth, the insurers have been losing money overall. They do not seem to know the specific sources of leakages and how to restructure the features of the product, to make it more popular and financially less painful to them.

Gupta and Trivedi (2006), in their study on “Health Insurance: Beyond a Piecemeal Approach” found that instead of different ministries taking initiatives to provide health insurance coverage for the areas of population that are under their jurisdiction, it is important for planners to understand that parallel schemes run on public money can only introduce inefficiencies and wastage in to the system. It is necessary to plan the spread of health insurance on a national scale and to set up an apex body that would be in charge of implementing health insurance in the country. The exact structure and composition of the body can be worked out by an expert group appointed by the government which would also chalk out a blue print of how the country can move towards greater health coverage. The expert group and ultimately the new body will need to also extend public finance considerations to existing schemes like the CGHS, ESIS, railways etc. which have similar functions, i.e. to extend health insurance coverage to select groups of population. There is an urgent need to consolidate the existing schemes to fulfill the objective of “health for all” through the mechanism of health coverage for all.

Ganesan and Jayaprakash (2006), in their article “Wait Lifting” found that despite the opening up of the insurance industry in India to private participation, the growth of health insurance in India is not remarkable. Though there are a few major policy developments that have

happened since 1999, it is a question of whether the perception of the end customer has changed since 1999. Insurance is still viewed only as part of a tax saving instrument and health insurance as an instrument with no returns, there is a gap in the marketing mechanism to make people realize the cost benefit analysis with respect to the premiums paid for health insurance. The real mechanism of insurance should assure the safeguard of economy by making the people facing the risk come together and form a common platform and insurance companies should be means for it. At the same time, customers expect insurance companies to safeguard their risk and help them to plan for their risk exposures. As long as there is equilibrium between these two sides, there should be no problem. But it is far away from reality. The reasons are many as neither insurance company is equipped with enough safeguarding weapons due to lack of information nor the customers are equipped with the knowledge about their exact needs.

Ahuja (2005) in his article on “Health Insurance for the Poor in India: An Analytical Study” brought out the role of nodal agency in providing insurance to the poor. Besides, it identify and examine important conceptual issues that come up in different types of micro insurance arrangements emerging in the country. Analysis of these issues is needed for better understanding of these schemes, and this should help in their design as well as in devising an appropriate government policy. Micro insurance that deals with insurance for the poor is emerging in India. This is partly the result of policy intervention and partly due to the development of micro-finance activity in the country. In extending the reach of insurance to the poor, the role of nodal agency is deemed crucial. This paper, while bringing out the role of nodal agency in extending health insurance, discusses how health insurance for the

poor is different from health insurance in general. Depending on the functions that a nodal agency performs, all micro insurance arrangements taking roots in the country can be categorized in to three distinct types: intermediate type, manager type and provider type. Each type has its own strengths and weaknesses. All these types may be appropriate for a large and diverse country like India. We analyze selected conceptual issues that are generic to all types of health insurance initiatives as well as those that are specific to a particular type. A good understanding of these issues is important to remove some of the weakness in the design of these schemes. More empirical studies are needed to further our understanding of these schemes so that these schemes can be shaped better.

Upadhyay and Roy (2005) in their study on “Health Insurance: Contemporary Issues and Policy Implications of Government of India” presented an analysis of the policy implications of government of India on health insurance. It gives an explanation of the UHIS launched by the government of India in July 2003 considering the interests of the poor. The analysis shows that the government is giving more stress in an ever increasing manner for a meaningful health insurance policy for the community as a whole. However more efforts from voluntary organizations and local self governments is necessary for bringing a breakthrough in the entire process. This particularly more due to limited resources of the government. Along with this there should be strong need for the community participation such as NGOs or SHGs. Various schemes of health insurance coupled with governments’ health schemes can bring more people under the purview of health insurance. For this purpose a strong mass consciousness needs to evolved and a fair movement may be started in this regard.

Rao (2004), in her study on “ Health Insurance: Concepts, Issues and Challenges” made an attempt to explore, whether health insurance system can be made to generate better health outcomes, enable participation of civil society, widen choice of provider, provider accountability, optimize utilization of existing capacities and promote more need based deployment of resources. Notwithstanding the urgency to reform and restructure the health system, cost of care can be contained if referral systems could be enforced and the unfinished agenda of controlling infectious diseases achieved. The existing financing and payment systems are not suitable for countering market failures typical of insurance. Time has therefore come to shift attention to the important and critical health system issues and develop more effective strategic approaches by developing quickly the much needed expertise and skills required to address the shifts in human behaviour in response to the emergence of new financial instruments. It is wise to understand that insurance has the power to save millions of lives, but it can also harm, extensively.

Ganesan and Jayaprakash (2005), in their study on “Slapping Lapses in Life and Health Insurance” detailed about the various types of lapses occurring in life and health insurance and provides indicative reasons for the same. It explains the risk of lapses which have the potential of creating a big problem due to the prevailing competitive environment in the Indian health insurance sector which has the potential of spoiling the goodwill and brand equity of insurance, the insurers and of course the Indian economy.

Babu and Jayabal (2004), expressed their view in their article on “Health Insurance - Potential and Strategies”. This article discussed the health status in India, health insurance market in India, opportunities and challenges in the market and finally certain strategies to capitalize on the potential. It states that pricing of health care services is the biggest hurdle for development of the health insurance sector. Fraud in health insurance has risen alarmingly in the recent times. Moreover, the general and health insurance companies do not have proper underwriting skills and therein no proper statistical data support to develop a model for the health insurance business. Insurance companies should introduce innovative products, use updated information technology, use innovative financing technologies, etc. They advocated for regional training to the rural people by insurance companies.

Bhat and Saha (2004) in their study on “Health Care Proposals: Health Insurance not a Panacea” found that given the complexities of insurance markets, unregulated private medical sector and private voluntary insurance are sure ways of leading the health system to be cost ineffective, inaccessible and highly inefficient. Expanding the insurance services without considering whether medical services are available or not is sure way of making the scheme dysfunctional from the beginning. Cost and quality of these services are other important factors. It seems that the government is trying to divert the attention from inefficient health care delivery system and use health insurance ‘mantra’ as it is going to solve all problems. Health insurance markets are fundamentally complex in nature. In health sector, we have neither invested to build capacities to manage these mechanisms nor have we developed adequate regulatory and administrative infrastructure to ensure that such

systems work efficiently. Unless a comprehensive approach is taken for provision and access of health security to the poor, merely increasing the subsidy level in insurance schemes is unlikely to help in generating a demand among the people towards health insurance schemes.

Mahal (2002) in his study on “Assessing Private Health Insurance in India: Potential Impacts and Regulatory Issues” found that the entry of private health insurance companies in India is likely to have an impact on the costs of health care, and the quality and cost effectiveness of such care. In this paper the author assess whether the regulatory steps envisaged in the IRDA Bill including especially the provision for entry of private firms will influence the progress towards achieving India’s health policy goals, and the likely direction that this effect will take. The author’s assessment is that the entry of private health insurance could have adverse implications for some of the goals of health policy, particularly for equity. However, an informed consumer and well defined and implemented insurance regulation regime could potentially address many of the bad outcomes. It also suggest that there are specific things the government could do to yield better outcomes. These include steps to ensure financial stability of insurers, enhance consumer protection, control risk selection and strengthen legislation complementary to health insurance, such as mal practice law and accreditation. New legislation in improving standards in health care provision may also be needed.

Bhatt and Reuban (2001), in their study on “Analysis of Claims and Reimbursements Made Under Mediclaim Policy of the GIC of India – A Case Study of One of the Branches of the GIC’s Subsidiary

Company in Ahmedabad” made an empirical study about the claims and reimbursements made under the mediclaim insurance policy offered by one of the GIC run company in Ahmedabad city. The analysis suggests that the number of policies and premiums collected have grown at significant rates. The growth had implications for the management of scheme in terms of problem of adverse selection or provider induced demand and falling premiums per insured person. It was found that the number of claims increased by about 93 per cent when policies sold grew at 32 per cent. The study estimates that about 1/3 of claim amount increase is because of the problem of adverse selection or provider induced demand. The analysis of breakup of reimbursements suggests that about 40 per cent of reimbursements are made towards doctor’s fees. This is followed by diagnostic charges, which accounts for about 30 per cent. This makes the insurance claims highly vulnerable to provider- induced use of resources. The study also analyses reasons for the delay and cases where reimbursements have been less than claims submitted.

Mavalankar and Bhatt (2001), in their study on “Health Insurance in India: Opportunities, Challenges and Concerns” analyzed about the opportunities, challenges and concerns of Indian health insurance market in rural areas. Their research report provides the present situation of health insurance in India.

Ellis et.al., (2000), in their study on “Health Insurance in India: Prognosis and Prospects” attempted to review a variety of health insurance systems in India and their limitations. It also attempts to develop a prospectus of strategy for greater regulation and increase health

insurance coverage by making suitable changes - particularly improvements in delivery of health care and its financing, efficient functioning of the ESIS and CGHS, amending the mediclaim system to tap the huge market potential, modification of the benefits and claims system of mediclaim policies, alterations in the exclusion clause and enhanced competition within a strict regulatory regime.

Mavalankar and Bhatt (2000), in their study on “Health Insurance in India” presented a review of health insurance situation in India, the opportunities it provides, the challenges it faces and the concerns it raises. They states that health insurance is gaining to develop rapidly in the liberalized scenario and the challenge is to see that it benefits the poor and the weak in terms of better coverage and health services at lower costs without the negative aspects of cost increasing and over use of procedures and technology in provision of health care. The experience from other countries suggest that if health insurance is left to the private market it will only cover those which have substantial ability to pay leaving out the poor and making them more vulnerable.

2.3 Micro Health Insurance

Dror et. al., (2009) in their study on “Micro Insurance : Innovations in Low Cost Health Insurance” found that micro insurance- low cost health insurance based on a community, co-operative or mutual and self help arrangements- can provide financial protection for poor households and improve access to health care. This report is based on a study of 3 micro insurance arrangements operating in 2 Indian states. The three differ in target membership, benefits and claims management practices. Out of these 3 schemes, two are member operated and one a commercial

scheme. The study confirms that hospitalization was more common among insured households than among the uninsured and there is an overwhelming preference for private hospitals, physicians and pharmacies. All the 3 schemes enrolled poor households and raised their use of hospital services as intended. Financial exposure was greatest, and protection was least, in the commercial scheme which imposed the lowest caps on benefits and where income was the lowest. Low caps and loss ratios are counterproductive in extending insurance coverage, financial protection and high renewal rates among the poor in India. It concludes that the micro insurance units, despite less funding and professional resources than commercial insurers enjoy, have provided no less and may be more, protection to their insured population through mobilization of context-relevant social processes.

Jeyaseelan (2007) in his study on “Micro Health Insurance - A Way of Ensuring Financial Security to the Poor” found that the provision of micro credit has enabled the poor households to increase their income and build their assets. But still they are vulnerable to withstand unexpected health risk events and remain exposed to multiple risks, which take away the gains made due to their associations with SHGs. Provisions of savings and credit services have helped them in managing smaller risks, which they frequently face. But, or securing against most unexpected bigger loss events like accidental injuries, surgery or prolonged hospitalization, micro health insurance will be the best option to ensure them a social and economic security. It also states that out of the many non life products launched during the year 2005-06, only one product was under micro health insurance that too by a stand - alone health insurance company. Many proactive measures like creating a

database, capacity building of stakeholders and customized product process designing have been suggested to take forward the sector to benefit a large number of poor households.

George (2007) in his study on “Critical Appraisal of Micro Health Insurance Laws” critically reviewed the laws and rules thereof related to micro health insurance with special reference to the rural and social sector obligations of insurers and the regulations governing the sector, including those of TPAs. The underlying perspective is to serve those who are dependent on the informal economy for their livelihood and for whom expenses on health are a major burden. It states that fixing the obligations to rural areas to a percentage of the policies sold instead of the premium income and ensuring that at least a certain part of these policies are sold to the categories mentioned under social sector obligations can ensure some amount of equity in access to health insurance in rural areas. Constituting a separate authority to regulate micro insurance schemes, with the participation in its management, of informal sectors, trade unions, co-operatives, SHGs, NGOs, CBOs etc. who are better informed and sensitive to the needs of the micro insurance sector, will enhance the development of this sector and also ensure transparency and accountability. The proposed authority should reduce the capital adequacy for registering micro health insurance organizations to a level proportionate the membership, benefit package, claims ratio, cost per member and administrative cost of such schemes. The government or IRDA might like to take into consideration these suggestions while formulating the new laws to introduce priority sector insurance companies to serve the poor.

Sekhar (2007), in his study on “Extending Micro Health Insurance Schemes to Lower Middle Class” found that a majority of the lower middle class population are uninsured because they are neither able to afford a formal insurance scheme nor do they have any access to other health insurance schemes in operation. This is because most of them are temporary workers employed in the unorganized sector where the possibility of availing a health insurance scheme is low. Besides, firms in the organized sector are largely ill-equipped to provide health insurance coverage to their employees. As such, there is a need for evolving a health insurance scheme for the lower middle class. One viable solution for this group is the micro health insurance scheme. As the income level of this group is reasonably good, and the policyholder’s education level to understand the nuances of the insurance is high, it is easy to teach them about the application and performance of the policy, especially a micro health insurance scheme.

Sekhar (2007), in his study on “Micro Health Insurance Frauds” found that not only the insurance companies but also the health care providers and the insured are said to indulge in questionable practices in order to make more money. These anti social activities result in frauds and those who indulge in these activities have not spared even the not-for-profit organizations that operate micro health insurance schemes. It is necessary to arrest these planned frauds in order to realize the objectives of micro insurance thereby making health care services affordable and accessible to the poor. The most common form of fraud is the demand side fraud which insurance customers commit to derive an unwarranted profit out of an insurance. There are several measures to check the

frauds in health insurance activities. Complying with these fraud controls can certainly result in a workable micro health insurance scheme.

Ahuja and Khasnobis (2005), in their study on “Micro-Insurance in India: Trends and Strategies for Further Extension” analyzed the early evidence on micro-insurance already available in this regard, highlight the current initiatives being contemplated to strengthen micro insurance activity in the country, and suggest specific ways that can help promote insurance to the target segment. Authors state that given irregular and uncertain income stream of the poor, flexibility in premium collection is needed to extend the micro-insurance net far and wide. Moreover, MFIs are playing a significant role in improving the lives of poor households. Quite apart from this, linking micro-insurance with micro-finance makes better sense as it helps in bringing down the cost of lending. Given this, there is a case for strengthening the link between micro-insurance and micro-credit. At present microfinance business in the country is unregulated. Regulation of MFIs is needed not only to promote micro-finance activity in the country but also to promote the linking of micro-insurance with micro-finance which as demonstrated in the paper makes a good sense.

Jajoo and Bhan (2004) in their study on “Jowar Rural Health Insurance Scheme: In the Spirit of Sarvodaya” described the trajectory of moral and social upliftment of villagers in the Sevagram region of Maharashtra that had its roots from the initiatives and success of a micro health insurance scheme first introduced to ensure uniform health care to the poor and needy in a Nagpur village. With its increasing acceptance across more villages, the scheme was extended to cover income generation programs as well as women’s self help groups addressing the village as one social unit for development. At the next stage, the health

insurance scheme moved towards action oriented individuals who could play leadership roles in the community. This empowerment and leadership conferred on select individuals helped initiate the anti-liquor movement in the villages around Sevagram. Jowar health insurance scheme is an attempt to identify revered individuals, to empower by bringing them together, inculcate a culture of decision making by consensus and initiate acts of common faith. Looking back at the experiment that this scheme has been, a model indeed has been developed, which is ideal and is replicable in an ideal kind of society envisaged. This is a ‘micro’ experiment for a ‘macro’ ideal.

2.4 Community Based Health Insurance

Devadasan (2007) in his article “The Feasibility of a Community Based Health Insurance (CBHI) at Wayanad, Kerala” explained the results of the feasibility study with the following objectives; to understand whether a community health insurance would be feasible in the four panchayats of Wayanad district; to understand the conditions for a community health insurance to be feasible; and to determine the CBHI model that would be optimal for the given conditions. The author is of the opinion that a CBHI is possible at Wayanad district, Kerala, India. The main factors in support of this statement are; an organized and capable community that needs some form of health insurance coverage to protect them from high medical costs, a legal and representative body, SNEHA, that will manage the CBHI, a network of providers who are willing to link up with the insurance scheme and can be contracted to provide quality health care at reasonable costs, a supportive government policy, and insurance policies that are pro poor and can be used by the women to reduce the risk of a CBHI. To succeed however, some enabling

factors need to be in place: more awareness among the community, a product that is affordable and acceptable to the community, a technically and financially sound SNEHA that can administer the CBHI as well negotiate effectively with the providers and the insurance companies, technical and financial support to SNEHA through CDS / WWA especially in the initial few years, an effective MIS that monitors the program closely and makes mid term corrections where necessary, transparent transactions, especially financial ones and an intermediate model of CBHI.

Jayalakshmi (2006), in her study on “An Experiment in semi Urban India –The Pratima Initiative in Karimnagar” made a case study about the experiment of the health care provider, Pratima Institute of Medical Sciences in Karimnagar (PIMS). In its efforts to make available health care facilities, the PIMS have taken upon themselves to make available the benefits of all hi tech health care services and to reach the wider segments of population. This mission and vision of the corporate provider ‘Pratima hospital’ is achieved with the introduction of some novel schemes like Mother and Child Welfare Scheme, Scheme from Your Well wishers, Karimnagar Health Welfare Scheme etc. The unique achievement of these schemes is that there was no formal marketing effort of any nature undertaken by the organization, on the other hand the schemes reached the needy by word of mouth. This case study proposes some schemes that can take care of the problems that are preventing Indian health insurance from growing. The study suggests the replication of successful schemes, like those experimented in Karimnagar, Andhra Pradesh, in other parts of India. Government machinery should monitor the implementation of the schemes and insurance companies should act as sole facilitator in the promotion of the schemes.

Devadasan et. al., (2005) in their study on “Does Community Health Insurance Increase Access to Health Care for the Poor? Evidence from India” made an effort to develop community based evidence on whether the CBHIs actually improve utilization of health services for their members. To assess the effect of CBHI on access to health care they conducted a panel survey among the members of ACCORD-AMS-ASWINI CBHI program. The survey revealed that health insurance remove or reduce the financial barriers to health care and the insured do access health care more than the non insured. One of the reasons for this effect is of course the fact that the patient does not have to pay out of pocket at the time of illness. This is not just a financial barrier, but also a psychological barrier as patients state that they are afraid of the unknown bill when they go to a hospital. This is especially true in the Indian context, where fee for service is the normal payment mode. This study also demonstrated the role of trust in health insurance. It was very clear that those who trusted ACCORD-AMS-ASWINI tended to enroll for the health insurance, compared to those who did not trust. Community health insurance can increase access to health care for the poor, if certain conditions like trustworthy organizers and a credible and effective health care provider are met, indicating that a well managed CBHI has the potential to improve access to health care for their poorer sections of society.

Acharya and Ranson (2005), in their study on “ Health Care Financing for the Poor: Community Based Health Insurance Schemes in Gujarat” advocated that CBHI schemes serve as a mechanism of enhancing access to health care services and reducing the frequency of medical indebtedness and thus contributing positively to overall health

system goals. They states that health indicators in India may have seen substantial improvements in recent decades but quality and affordable health care services continue to elude the poor. Government provided health services only partially meet the needs of the rural and urban poor in the informal sector and making equitable and affordable medical care accessible to this segment remains a challenge. It is here that CBHI schemes could provide valuable alternatives. While such schemes are still in their infancy, to ensure a wider coverage and acceptance, CBHI schemes could be attached to decentralized agencies of governance such as panchayati raj institutions.

Devadasan et. al., (2005), in their study on “Protecting Against Catastrophic Health Expenditure - The Role of Community Health Insurance in India” documented the effects of health events on insured and non insured households and explores whether community health insurance has a prospective effect against catastrophic health expenditure. It states that while high medical costs can be catastrophic for most people, it is worse for the poorer sections of society. There is evidence that community health insurance reduces out of pocket expenditure on health care for those enrolled and protects some of the households from catastrophic health expenditure. However, community health insurance requires the skills for negotiating with the providers and purchasing appropriate care. Unfortunately this is lacking in most community health insurance schemes in India. If community health insurance schemes need to perform better and improve their efficiency, they need to introduce technical expertise in the management of the scheme.

Devadasan et. al., (2004), in their study on “Community Health Insurance in India – An Overview” found that community health insurance is an important intermediate step in the evolution of an equitable health financing mechanism such as social health insurance in Europe and Japan. Social health insurance in these countries, in fact evolved from a conglomeration of small ‘community’ health insurance schemes. Historically, during the peak of the industrial revolution worker’s unions developed insurance mechanisms which were eventually transformed. Community health insurance programs in India offer valuable lessons for policymakers and the practitioners of health care. The purpose of this paper is to describe Indian community health insurance schemes and 12 such schemes are documented here. The statement that the poor in India cannot understand the complexities of health insurance and will not accept any insurance product is only a prejudice and it is clear that what is required is a good product. Some of the conditions that have allowed these schemes to succeed are: an effective and credible community based organization or NGO, an affordable premium, a comprehensive benefit package, a credible insurer and last but not the least, the administration load of the scheme on the community should be minimal.

Devadasan et.al., (2004) in their study on “ACCORD Community Health Insurance : Increasing Access to Hospital Care” found that India’s poor have problems with accessing hospital care and those who do access hospital care have the risk of falling into poverty. One possible solution to this problem is community based health insurance schemes. While currently there are more than 20 such schemes in our country, there is very little empirical evidence about their performance. This paper describes one such scheme managed by ACCORD (Action for

Community Organization, Rehabilitation and Development), AMS (Adivasi Munnetra Sangam) and the ASWINI (Association for health welfare in the Nilgiris). This scheme is described in detail in this article and it also look at its performance vis-à-vis access to hospitalization. It also looks at some of the determinants of this performance and come up with recommendations for improved performance of community health insurance schemes. The study reveals that there is a higher utilization of health care by those insured in the AAA CHI program. One major determinant for this performance is that the CHI was introduced within the context of an overall development intervention as ACCORD was engaged in various development initiatives and the CHI was part of this. Yet another reason for the program to ‘succeed’ was the creation of a benefit package that suited the needs of the people. Thus for a CHI to be effective it is imperative that the benefit package is tailored to meet the needs of the community.

Ahuja (2004) in his article “Health Insurance for the Poor in India” found that Community Based Health Insurance (CBHI) is more suited than alternate arrangements to providing health insurance to the low-income people living in developing countries. The universal health insurance scheme is only one of the forms that CBHI can take. While analyzing the scheme, the paper examine alternate forms of CBHI schemes prevalent in the country. The development of private health insurance market in the country will not leave the poor unaffected. Insurance sector reform can affect the poor through its effect on the provision of health services (i.e., cost, quality and access) used by the low-income people as well as through its access to financing of health care. In this paper author also explore how insurance sector reforms alter health insurance prospects facing the poor in India, and what changes on the health

front affecting the poor have happened or are likely to happen as a result of insurance sector reforms. The author conclude that in diverse settings of India all forms of CBHI have a role to play and therefore need to be encouraged by the government through appropriate interventions. Formal insurance providers can also be reigned to serve low income population. At the same time, developments in formal health insurance market need to be guided so as to minimize cost escalation of health care provision.

2.5 Importance of Health Insurance

Iyer (2010) in her study on “Evolution of Health Insurance in India Towards Healthy ‘Health Insurance’ ” stated that health insurance can play an invaluable role in improving the overall health care system. The insurable population in India has been assessed at 250 million and this number will increase rapidly in coming two decades. But insurance awareness levels are low in India and majority of insurance companies have not concentrated on media coverage on the health insurance offered. There is a general lack of confidence in insurance products; more so in health insurance products and there exists a huge scope for mobilizing a huge amount of health insurance premium. For effective and successful health insurance the author suggests that premium subsidies should be accorded after proper analysis, greater emphasis should be made on risk based underwriting, health service providers should be regulated with standardization of treatment procedures and costs, and there should be initiatives to float their own TPAs (in house TPAs) by insurance companies.

Joglekar (2008) in his article “Can Insurance Reduce Catastrophic Out-Of-Pocket Health Expenditure?” found that in India, the out-of-pocket health

expenditure by households accounts for around 70 percent of the total expenditure on health. Large out-of-pocket payments may reduce consumption expenditure on other goods and services and push households into poverty. Recently, health insurance has been considered as one of the possible instruments in reducing impoverishing effects of large out-of-pocket health expenditure. In India, health insurance has limited coverage and the present paper studies whether it has been effective so far. Literature defines out-of-pocket health expenditure as catastrophic if its share in the household budget is more than some arbitrary threshold level. In the paper, the author argue that for households below poverty line any expenditure on health is catastrophic as they are unable to attain the subsistence level of consumption. Thus, we take zero percent as a threshold level to define catastrophic health expenditure and examine the impact of health insurance on probability of incurring catastrophic health expenditure.

Gupta (2007), in his study on “Wider Coverage Gains Urgency” expressed the view that health issues are acquiring urgency due to factors like medical inflation, increased life expectancy, increasing load of life style diseases, uncertainties in individual employability and earnings. He strongly recommends for popularizing health insurance products. He states that vigorous and robust development of the health insurance sector requires resolute actions taken by all players in health care financing- the regulator, the insurers, the health care providers and the insured. In addition to supply side changes, it is of equal importance to spread awareness about the need to plan for health care financing exigencies. Let not health insurance be promoted as a tax planning instrument.

Qaiser (2007), in his study on “The Role of Insurance in Health Care System in Developing Countries” made an attempt to examine the role that the health insurance system can play as a supplement to the government’s effort to provide health care services to the population as a social and economic upliftment measure. It also examines the issues and concerns on account of health care and how these can be addressed through health insurance initiative. But how the system can be adapted to meet the local needs is an area which needs attention of the government of the day in terms of legislation and regulatory initiatives and budgetary allocation for funding.

Jawaharlal (2007), in his study in “Health Care Versus Health Insurance” found that providing proper health care to the entire population is a monumental task in a vast country like India, with its massive population. The state should take the lead in putting in place measures to achieve this. However, there should be strong support in the form of coverage for a large chunk of the population as also viable private health insurance, if India were to achieve health for all. The total percentage of population under any sort of medical coverage is in single digit, which is woefully inadequate. It should be ingrained in to the general mindset that it is not impossible to spread the message of health insurance among the masses. It is in fact the need of the hour and only when that happens, can one look forward to health insurance in India taking a quantum jump in real terms.

Danis et. al., (2007), in their study on “Eliciting Health Insurance Benefit Choices of Low Income Groups” stated that an appropriate scheme of health insurance must respond to clients priorities, yet cover a

finite and affordable benefit package. A variety of methods have been developed so far to engage the public in prioritizing services. This paper deals with a plan that allows variably educated population who are inexperienced with health insurance to pick health benefits. The authors had developed a modified version of the “Choosing Health plans All Together” (CHAT) exercise (originally developed by Danis et al 2002, 04 & 06) and tailored it to the reality of several rural and semi urban slum locations in India. This study suggests that it is possible to create decision tools that allow rural and urban poor communities to participate in the design of insurance benefit packages and it provides evidence that participants in the CHAT exercise were able to address the main problem of composing a health insurance package within a severe resource limitation. The responses of participants in this field experiment suggest that when the problem of selecting health care benefits is presented in easily understandable terms and the decision process is simple, communities show interest and capacity to make choices.

Sudha (2007) in her study on “Health Security for Rural Poor - Study of Community Based Health Insurance System in India” highlighted the need for health insurance schemes in rural India especially in the context of increasing health expenditure burden over the poor and lack of public health care spending. Developmental schemes to curb the poverty cycle are numerous and each is distinct in its approach to mobilizing unprivileged communities. Development in the health sector is one of the most basic areas through which rural poor populations of developing nations, such as India, can gain ground in advancing their community. The lack of adequate health

care for these groups originates from their lack of education as well as from poor health care infrastructure in the nation. In this article the need for CBHI schemes is analyzed with a case study of Chaithanya - HDFC Chubb insurance scheme successfully implemented in Maharashtra. As this article details, the most viable and present solution to improve people's health care access in India, while making financing affordable, is to invest in CBHI schemes tailored to provide basic health care to those without. As a means to ensure effective and efficient implementation of CBHI schemes, the private and public sectors should come together in a joint project through which rural poor can receive health coverage through the reallocation of capital.

Ratna and sarkar (2007), in their study on "Health Insurance for Rural India" stated that in a country where only about 10 per cent of the population has health insurance, most of the Indians pay their health care expenses from their pockets. This burden is particularly high for those who suffer from both poverty illness. A number of reasons are frequently cited to explain the lack of efforts to extend health insurance to the poor. This article sets out to examine the myths and realities behind some of these commonly held beliefs in the backdrop of the data obtained from a field study conducted in 3 villages of east Godavari district of AP. Five myths have been discussed in this article and it states confidently that there is a solvent market for health insurance among India's poor. However tapping this huge market is dependent on product development that starts from a deep understanding of the clients' needs. Becoming familiar with the needs and priorities of the poor requires considerable innovations in the processes, the logistics for data mining, access to clients and selling and servicing of the health insurance

must be adapted to the context-specific social dynamics and local infrastructure.

Sumitra (2007), in her study on “ Health Insurance for the Rural Poor” emphasized the importance of extending health insurance to rural India, the opportunities therein and the strategies that can be adopted. It states that though India has made rapid strides in the health sector since independence, the cost of health care is burdensome for most families; in rural India the situation is still worse. As proper government health care services and primary health centers are not available, private hospitals become the only option for both rich and poor; where the cost of health care is exceedingly high. Rural India requires more attention than the urban. There is an urgent need to finance the health care expenditure of the rural poor. Insurance incursion levels in India are very low; only 22 per cent of the insurable population has been tapped and the situation in rural areas is worse. Therefore health insurance in rural areas should be seen as a social perspective rather than a business motive. But health insurance providers face a lot of hurdles and challenges in reaching the rural population due to various factors such as lack of health care facility, belief in non medicinal means, problem of accessibility to institutional health care, improper agent service and the problem of affordability. But still they have a lot of opportunities to penetrate in the rural India.

.Dror (2006), in his study on “Health Insurance for the Poor: Myths and Realities” stated that in a country where only about 3 per cent of the population are affiliated to health insurance, most Indians

must pay the vast majority of their health care costs out of pocket. This burden is particularly high for those who cumulate both poverty and illness. Health insurance could be one of the most suitable solutions for this negative nexus. However, for the time being there is very little supply of health insurance for the poor. A number of reasons are frequently evoked to explain the lack of more efforts to extend health insurance for the poor. This article sets out to examine the reality behind some of these commonly held beliefs. Based on a survey in 7 locations, this article finds that most Indians are willing to pay 1.35 per cent of income or more for health insurance and most people prefer a holistic benefit package at basic coverage over high coverage of only rare events. The needs of the poor, and their demand for health insurance, depend on local conditions. It also states that there is a solvent market for health insurance among India's poor. However tapping this huge market is contingent on product development that starts from a deep understanding of the client's needs and wants.

Ahuja and Narang (2005), in their study on "Emerging Trends in Health Insurance for Low Income Groups" provided a brief overview of the existing forms of and emerging trends in health insurance for the low income segment in India and stated that a plurality of approaches is indispensable for a country like India. In other words, the promotion of any one type of insurance arrangement should be due to its superiority over alternate insurance arrangements and should not be merely the result of government policy favoring one over another. For successfully running health insurance for the poor, coordination among multiple agencies is needed. For a large country like India, a plurality of approaches is indispensable. These approaches need to be encouraged and

guided by providing appropriate incentives and bringing them under the regulatory ambit so that there is no abuse of newly emerging financial mechanisms.

Ahuja (2004), in his study on “Health Insurance for the Poor” discussed different forms of CBHI schemes prevalent in India, and critically examine the UHIS launched in the country recently. It also analyses the factors that are holding back the development of private health insurance in the country and it explores how the development of the private health insurance market could possibly affect the poor. The development of private health insurance has both potential risks and benefits in the access of poor to health services. Appropriate regulatory changes can minimize risks and turn potential benefits into concrete gains for the poor. However, currently even the private health insurance market lacks development for the want of proper regulatory decisions both on the supply of health services and on the demand for health insurance. This paper suggests that neither market related nor government provided insurance is an appropriate way of reaching the poor and CBHI is a more suitable arrangement for providing insurance to the poor and concludes that in the diverse settings of India, all forms of CBHI have a role to play and they need to be encouraged by the government through appropriate interventions.

Ahuja and Indranil (2004), in their study on “Health Insurance for the Poor: Need to Strengthen Health Care Provisions” stated that health security is considered as being integral to any poverty reduction strategy. Health security has two aspects: health care financing and health care provision. Health insurance which addresses only the financing aspect in

itself is not sufficient to ensure that poor people who need health care actually receive it. It is necessary that appropriate and good quality services delivered efficiently are available to the poor. This calls for supply side interventions, in the absence of which the demand for insurance will remain thin. This paper empirically confirms that demand for insurance is limited where supply of health care service is weak. In particular interstate variations in demand for UHIS for the poor in India is explained by interstate variations in health care infrastructure and the proportion of the poor for whom the scheme is designed. It is necessary to address the supply side as well as design an insurance scheme based on a realistic assessment of the paying capacity of the poor. The findings of the paper have important policy lessons for the government as it attempts to promote health insurance for the poor.

Devadasan (2004) in his article on “Health Financing: Protecting the Poor” stated that the national health budget allocations are steadily decreasing and it is currently only about 0.9 per cent of GDP which is one of the lowest in the world. 33 per cent of this budget goes to the richest 20 per cent of the population whereas the poorest quintile gets only 10 per cent of the money. This results in understaffed health centers, with no or minimal medicines, poorly maintained equipment and poor quality of care. This pushes people into the private sector and there they have to spend their meager income on health care. Direct and indirect medical costs together push the patients and their households into poverty. One measure to protect the poor from increasing health care costs is to increase the government allocation for health care and most of this money needs to be allocated to the primary and secondary

health services which are used by the poor. Yet another way of protecting the poor is by regulating the health sector. And finally, health insurance should be developed as a measure of protecting the poor. CBHIs have been effective in enrolling large number of members and in increasing access to health care for its members. So currently what is feasible is developing alternate finance mechanisms like CBHIs in order to protect the poor from escalating health care costs.

Devadasan (2004) in his article on “Health Financing: Protecting the Poor” evaluated various measures that can be used to protect the poor. The poorer sections of the community can become further impoverished by health care costs. They need to be protected by various measures. One measure is to improve the efficiency of the health system. Yet another way of protecting the poor is by regulating the health sector. Such a regulation will improve the quality of care and this in turn will protect the patients including the poor. And there are some financing mechanisms that can protect the poor. The two common measures are demand side financing and health insurance. Demand side financing is a recently introduced measure where the money follows the patient. And finally the author discusses health insurance as a measure of protecting the poor and states that in our country the Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESI) are two health insurance schemes for the formal sector. They cover about 3 per cent of the population. Moreover the quality of CGHS and ESIs leaves much to be desired. Then is the standard Mediclaim policy – the only voluntary health insurance product for the rest of the population. It is costly and usually its subscribers are limited to the upper class in urban areas. While private insurance companies have started operations in our country, very few of them are providing health insurance products in the rural areas. To overcome these

deficiencies, some NGOs have been experimenting with health insurance schemes for more than 10 to 15 years. These community health insurances (CHI) are meant for the informal sector and is a not for profit insurance scheme. These CHIs have been effective in enrolling large numbers of members and in increasing access to health care for these members. Currently what is feasible for protecting the poor is developing alternate financing mechanisms like demand side financing and community health insurance.

Chakravarti (2004) in her study on “Health Insurance for Rural India: A Review” stated that in rural India, public delivery of health care is really poor in quality, presumably for reasons of inadequate financing. People in the rural areas have a poor access to health care services. As a result a substantial expenditure incurred on health by rural population is incurred on accidental expenditure; transportation and bribes, which do not directly contribute to any healthy gains. Under such circumstances health insurance coverage can be a viable and vital means for getting health care services. In order to make health insurance schemes attractive in rural areas, special attention is needed to restructure the system. The current premiums are too high in relation to claim payments. Revising the premium schedules will make health insurance more accessible to individuals from lower socio – economic categories. Another thrust area is distribution network. The current agency network is mainly urban-centric. Finally there is an immense need for massive propaganda to develop consciousness among the people regarding the need for financing health care in context of high out of pocket expenses on health.

Ahuja and Jutting (2004), in their study on “Are the Poor Too Poor To Demand Health Insurance?” stated that lack of demand for health insurance need not necessarily be the result of affordability per se, and thereby cannot justify the need of government subsidy, but may be the result of other institutional rigidities such as borrowing or credit constraints. In this setting they argue that the appropriate public intervention in generating demand for insurance is not to subsidize premium, but to remove these rigidities.

Gumber and Kulkarni (2002), in their study on “Health Insurance for the Informal Sector: Problems and Prospects”, pointed out that people who are insured under ESIS, CBHI etc. is slowly catching up. This is only for a small proportion. For others it is only SEWA type insurance schemes and that too only for a small section.

Gumber and Kulkarni (2000), in their study on “Health Insurance for Informal Sector: Case Study of Gujarat” attempted to explore some critical issues relating to the availability and needs of health insurance coverage for the poor and especially women, and the likely constraints in extending current health insurance benefits to workers in the informal sector based on a study undertaken on pilot basis. The survey shows that the poor prefer public sector management of health care facilities. The expectations of low income households from a new scheme indicate that coverage of illnesses, coverage of services, amount of the premium to be paid, as well as procedural aspects such as filing claims are critical in the decision to buy an insurance. This study demonstrates that while there is great interest, the concept of health insurance and paying for a

service which may or not be availed of is new to low income people. This calls for effective information, education and communication activities which will improve understanding of insurance by the public and hence help in developing a market for health insurance.

2.6 Third Party Administrators in Health Insurance

Nagarajan (2006) in his article on “TPAs in Health Insurance” examined the role played by TPAs in health insurance sector in India. He states that the key objective of TPA is to materialize cashless payment of claims of insured directly to the hospital. The success of the TPA mechanism depends upon the quantum of cooperation that will be extended by the approved hospitals in billing the TPA patient like the normal patients, one who have no health insurance. Usually the approved hospitals admit TPA patients on high category, which incurs higher charges and sometimes the sum assured shall be consumed by the bills. The TPA should see that ‘reasonable cost’ is collected by the approved hospitals. So some hospitals deem the TPA and the insurers as hurdles in realizing their lucrative medical bills. Even in case of cashless claim settlement card holders and normal patients there is a huge variation between cost of a similar treatment. TPAs have to sort out such problems and make it transparent that they are to align the interest of the approved hospitals, patients and insurers.

Bhatt, et al., (2005), in their study on “TPAs and Health Insurance in India: Perception of Providers and Policyholders” described the findings of a survey study, which was carried out with the objective to ascertain the experiences and challenges perceived by hospitals and policyholders in availing services of TPA in Ahmedabad, Gujarat. The

study found out that only small percentage (20 per cent) of the policyholders in the sample have knowledge about existence of TPAs. Policyholders rely more on their insurance agents than on the insurance companies or TPAs. TPAs are the interface between the insurer and the insured and they are in a position to educate the policyholders about their health insurance. Hospital administrators perceive significant burden in terms of effort and expenditure after introduction of TPA and no substantial increase in patient turnover after empanelling with TPAs. However there is an indication that hospital administrators foresee business potential in their association with TPA in the long run. There is a clear indication from the study that the regulatory body need to focus on developing mechanisms, which would help TPAs to strengthen their human capital and ensure smooth delivery of TPA services in emerging health insurance market.

Gupta et. al., (2004) in their article on “TPAs: Theory and Practice” attempted to understand the role of TPAs and examine the issues that need to be taken into account while evaluating their usefulness and functioning. From the perspective of the insurance companies, the TPAs benefit them by bringing down the claims ratio by reducing false claims as well as standardizing treatment costs. TPAs can play a huge role in making appropriate data available for actuarial calculations, because they are the recipients of morbidity data that are linked with individual characteristics such as age. It can be safely said that TPAs can potentially play an important role in making insured health care availability smoother, but it cannot be seen as a panacea for all the problems of the health sector, nor it can be blamed for these problems. The functioning of the TPA is limited, but if not regulated and

checked, there is some danger that consumer interests may not be as safe as under this system as one would wish.

Bhat and Babu (2004) in their article on “Health Insurance and TPAs: Issues and Challenges” discussed the role and importance of TPAs in the emerging health insurance market in India. It analyzes the existing TPA system, the issues and challenges TPAs face in an unregulated health sector and also IRDA regulations on TPAs and their implications. The IRDA in India has paved the way for insurance intermediaries, such as TPAs to play a pivotal role in setting up managed health care systems. TPAs have been set up to ensure better services to policyholders and to mitigate some of the negative consequences of private health insurance. The core product or service of TPA is ensuring cashless hospitalization to policyholders which requires skills to develop networks, manage finance and delivery of appropriate health care services to its clients. TPAs are bound to face a number of challenges: serious pressure from insurance companies to keep the claim ratio down, lesser role in containing costs and serious conflicts with health care providers. IRDA has defined the role of TPA as one of managing claims and reimbursements. Their role in controlling costs of health care and ensuring appropriate quality of care is less well developed.

2.7 Social Health Insurance

Swarup and Jain (2011) in their article “Rashtriya Swasthya Bima Yojana - A Case Study From India” pointed out that Government of India recognized inequities in its health delivery and financing infrastructure and introduced various measures to overcome it. One measure was to increase the budgetary allocations for health care. However, just increasing the budget for

health is not a solution in itself. Therefore governments in India have introduced various demand side financing mechanisms to provide financial security for vulnerable segments of the society in the last 4-5 years. Health insurance schemes like the Universal Health Insurance Scheme (UHS) launched by the Ministry of Finance in 2003, State level health insurance schemes launched by the States of Punjab, Kerala, Assam etc. are some examples. However, most of these Central or State Government funded schemes have had problems due to poor policy design, lack of clear accountability at the state level, lack of sustained efforts in implementation, weak monitoring and evaluation, unclear roles and responsibilities of different stakeholders, and poor awareness among beneficiaries about the schemes. The national Government felt that there was a need for a national level Health Insurance scheme in the country for providing financial security to the vulnerable sections of the society. Learning from the experiences of other major government and non-government health insurance schemes in India, it was decided to launch a health insurance scheme which later came to be known as Rashtriya Swasthya Bhima Yojana (RSBY). RSBY has managed to provide protection from health care expenditure to millions of poor in India. Realising its effectiveness in reaching out to the beneficiaries, Government of India has already decided to extend RSBY to many other category of unorganized sector workers who are not BPL. Many non-Government groups have also shown interest in using the RSBY platform. A number of developing countries are now engaged in a dialogue to see how this scheme could be adapted and implemented in their countries. In addition to health insurance, the smart card platform under RSBY is now also being seen as an instrument which can be used to deliver different social security benefits to the vulnerable sections of the society in an effective and transparent way.

Swarup (2011) in his article “Rashtriya Swasthya Bima Yojana - Scheme with a Difference” stated that RSBY, in fact, attempts to empower the consumer, the BPL family, by giving him a choice. The beneficiary has an option to select from any of the networked hospitals, both in the private and public domain, anywhere in the country. By giving the beneficiary a choice under RSBY, he determines the delivery point and that is his empowerment. A large number of insurance packages do not include pre-existing diseases. The RSBY does. It does to avoid inconvenience to the consumer in determining which disease was pre-existing and which was not. The scheme aims at being cashless to cater to the peculiar characteristics of the target group. The smart card is portable and valid in all the network hospitals throughout the country. This also takes care of the migrant nature of the beneficiary. All in all, the scheme is different. It is different in the context of its conceptual framework, it is different in the manner in which it is actually rolling out and it is likely to be different in the manner in which it will impact the lives of the poorest of the poor in this country. Some such evidence is already visible.

Swarup (2011) in his article “Rashriya Swasthya Bima Yojana (RSBY): The Evolving Scenario” attempted to evaluate, though with limited evidence and on the basis of provisional figures, how the scheme evolved during the second year in some of the districts. Nine districts in the country have completed second year of operation. Some interesting trends can be discerned on analyzing the available data. In absolute terms, there has been a phenomenal increase in the number of smart cards issued in these districts during the second year. This reflects an increasing awareness about the scheme and its utility. This could also be attributed to an improved database. The number of districts where second year has been completed is small and, hence, broad generalization may not be appropriate but some trends cannot be ignored. These are the lessons

inherent for all stakeholders, primarily in terms of raising awareness of beneficiaries and in setting up a robust surveillance system. The systems and processes seem to have stabilized but the expansion of the scheme has thrown up new challenges. Surveys are also revealing that beneficiaries are gradually becoming more and more demanding. Whereas satisfaction rating for the scheme was around 90 per cent (perhaps a record for any government scheme) during the initial phase of the scheme, recent surveys have revealed that this percentage has come down, even though marginally. Thus, whereas on the one hand number of those that are getting enrolled is increasing, on the other hand there is an increasing demand on the system. However, the most encouraging development under the scheme is the willingness of certain categories/groups of non-BPL workers to pay the entire premium and ride on the RSBY platform. The ever increasing number of women availing facilities under RSBY is also a source of encouragement.

Swarup (2011) in his article “Rashriya Swasthya Bima Yojana (RSBY): Some Initial Trends” attempted to analyze the initial trends on the basis of the available data. The initial reluctance of the Stake holders, primarily the Insurance Companies, has to be seen in the context of the complexities of scheme and the uncertainties there under. Only 6 insurance companies were actively involved in the roll out in the 145 districts that have completed one year. However, this has now gone up to 11 with more than this number participating in the tendering process. This reflects the improvement in comfort level of the insurance companies and their belief in the long-term commitment of the Government in the scheme. The primary objective of the scheme is to facilitate access to hospitals. The key test therefore, is whether such an access has improved. Hospitalization ratio in terms of percentage of persons hospitalized as against those that have been enrolled would provide some

indication. At an aggregate level it turns out to be 2.55 per cent under RSBY as against the national average of 1.7 per cent (NSSO 60th round) for the poorest 40 per cent in the country. This clearly demonstrates improvement in access. However, at a disaggregated level the picture perhaps is not as bright with a number of States being well below the national average, the worst being Chandigarh (0.08 per cent) and Himachal Pradesh (0.49 per cent). Kerala (5.21 per cent) records the highest percentage of visitors to the hospitals. What is even more interesting is the gender related trends in utilization of hospital services. This becomes even more important in a health care related scheme where the need for both the genders is same, perhaps more for women. The RSBY, unlike any other health insurance scheme covers maternity benefits as well. The gender related hospitalization ratios under the scheme clearly reveal that women have benefited more from the scheme. At an aggregate level, the hospitalization ratio for females is 2.91 per cent whereas for males is 2.35 per cent. Thus, even though the enrolment of women is low, once enrolled, they are able to utilize services much more than men. This is a significant and positive trend. But the expansion and growth of RSBY has thrown up new challenges. Evolving effective communication plans to reach out to the beneficiaries, quality of services to be delivered, capacity building of ever increasing number of representatives of a variety of stake-holders and controlling fraud/ abuse would be the challenges in the near future.

Krishnaswamy and Ruchismita (2010) in their article “Performance Trends and Policy Recommendations: An Evaluation of the Mass Health Insurance Scheme of Government of India” analyzed the Key Performance Indicators (KPIs) of the scheme and compare KPIs across various homogenous groups using administrative data on enrolments and claims, and socio-economic and health data from secondary sources. The study focus on three KPIs – 1.

Conversion Ratio: to measure depth of outreach subject to the quality of the BPL list; 2. Hospitalization Ratio: to gauge utilization; and 3. Total Expense Ratio: to evaluate profitability to the insurer. The study found out large variations in the KPIs across states and districts, and across years for those districts that have completed two years of the scheme. In year one, the overall Conversion Ratio for 229 districts was 51 per cent of targeted BPL families. It ranged from 11 per cent in Assam to 87 per cent in Tripura. RSBY's overall Hospitalization Ratio of 2.4 per cent in the first year is higher than the historically recorded hospitalization rates of low income segments (1.7 per cent as per National Sample Survey, 2004). It ranges from 0.1 per cent in Assam to 5.2 per cent in Kerala in year one. Year one was profitable for insurers with an average Total Expense Ratio of 77 per cent, implying that 23 per cent of the total premium after expenses remained with the insurer. There is however wide variation between states (ranging from 28 per cent in Assam and Goa to 136 per cent in Nagaland) and districts, and also between insurers (ranges between 39 per cent and 92 per cent). Rising claim ratios in RSBY will push future premiums higher, hence increasing the cost to the government and putting the scheme in jeopardy. It is therefore vital that we understand the factors that influence enrolments and utilization.

Sun (2010) in his article on "An Analysis of RSBY Enrolment Patterns: Preliminary Evidence and Lessons from the Early Experience" reviewed the early evidence of enrolment patterns in order to better understand what is driving the significant variation observed across villages, districts and regions as well as different demographic groups. The preliminary evidence for 24 districts suggests that enrolment rates are lower in more remote villages and higher in villages with a large number of BPL households. There is little or no

evidence of bias towards particular demographic groups or risk selection by insurers.

Arora and Nanada (2010) in their working paper on “Towards Alternative Health Financing: the Experience of RSBY in Kerala”, stated that implementation of Rashtriya Swasthya Bima Yojna (RSBY) in Kerala has led to a massive increase in health insurance coverage in the last two years. Perhaps the most outstanding feature of the scheme’s implementation in Kerala has been the synergies realized with the public health system and the ongoing efforts of the National Rural Health Mission (NRHM). This paper documents the early experience in this area and shows that the incentives created by the demand-side financing of RSBY can help improve public hospitals. The paper cites lessons from various innovations that were introduced at the state level that may be useful for other state governments and also sets out an agenda for the future which includes mechanisms to improve hospital quality.

Palacios (2010), in his article on “A New Approach to Providing Health Insurance to the Poor in India: The Early Experience of Rashtriya Swasthya Bima Yojna” stated that Rashtriya Swasthya Bima Yojna (RSBY) is one of the largest health insurance schemes in the world today with coverage for hospitalization being provided to around 60 million people. Most of the covered population are poor and live in rural India. More important than its scale, however, is the innovative approach to providing services to the poor which combines technology that can reliably identify beneficiaries and verify transactions with a public-private partnership where incentives for all stakeholders are appropriately aligned. The results from the first two years of

the program – voluntary enrolment rates of around 45 per cent and reasonable overall utilization rates – demonstrate that the model is both workable and scalable. However, there are large variations across the country and despite the strengths of its design, the RSBY requires more institutional capacity to supervise and improve the system over time. If this can be achieved, the positive externalities of RSBY may extend beyond health insurance and could fundamentally change the way the Government delivers benefits to India's poor.

Hou and Palacios (2010) in their working paper on “Hospitalization Patterns in RSBY: Preliminary Evidence from the MIS”, looked at the experience with hospitalization/ patterns during the first two years of the program. It stated that while average hospitalization rates for the program are comparably higher than those found in the most recent survey, RSBY claims exhibit large spatial variations across and within districts. This suggests the presence of local demand and supply side constraints which, if overcome, could result in much higher rates and therefore, higher claims ratios. This, in turn, would require insurers to raise premium above current levels in order to avoid financial losses. The empirical analysis suggests the need for special surveys in order to ascertain the causes of the large variation in utilization across villages so that appropriate remedies can be applied.

Rao (2010), in his study on “Government Insurance Schemes” stated that despite all the schemes generated by successive governments, health insurance still remains largely inaccessible to the poor and needy. At present there is very low penetration of health insurance in India. It is estimated that only 3 per

cent of Indians are covered under any form of health insurance. Furthermore, health insurance is not a product that can be purchased over the counter. It is a service that needs to be delivered.

Desai (2009) in her study on “Keeping the Health in Health Insurance” stated that the Rashtriya Swasthya Bima Yojana and National Rural Health Mission have the potential to transform the health and financial security of poor households. The experience of VIMOSEWA, a micro insurance program implemented by the Self Employed Women’s Association (SEWA), indicates that health insurance must be firmly linked to an effective public health system. A high percentage of claims for preventable illness, unnecessary expenditure on medicines, increasing hysterectomies and inequitable claims are four trends that are likely to be seen in the implementation of RSBY. To ensure that health insurance plays its intended role appropriate investment in prevention, particularly in water and sanitation, as also, community involvement and a strengthened public sector are essential. In the absence of a strong public health system- one that integrates water and sanitation interventions, ensures quality and free care, and provides affordable access to gynecologists, as one key instance- health insurance under RSBY may simply end up financing its gaps instead of addressing catastrophic conditions that are its primary objective.

Vijayaraghavan (2007), in his study on “Coverage of Employees Under ESI Schemes and Mediclaim Policy” stated that the ESIS provides immense benefits to the employees covered under the

scheme at least cost, while the mediclaim policy is costly with several riders. The employees who were earlier covered under ESIS with pre existing diseases lose their benefits after being brought under mediclaim policy. The managements should therefore cover the employees both under ESIS and exclusive mediclaim policy, so that when employees cease to be covered under ESIS, they are not haunted by their claim rejections because of pre existing diseases. This article probes the above point with reference to the industrial life of an employee.

Gupta and Trivedi (2005), in their study on “Social Health Insurance Redefined: Health for All Through Coverage for All” looked at the concept of social insurance, the form in which it currently exists in India, the issues and constraints in scaling up and innovations in social health insurance that may be possible in the existing system, especially in the context of other forms of health insurance. The article states that despite a government policy on health, the health sector is currently changing shape mostly due to market forces. In this set up, the need for greater health coverage takes on a more urgent tone and policymakers need to act now, rather than later, to prevent the high costs of inaction and objective of “Health for All” from becoming even more difficult to attain. The health system in India is ripe for moving towards “Coverage for All” system, which would take care of the “Health for All” objective to a great extent.

From the review of earlier studies above, one can conclude that health insurance is an urgent necessity and universal coverage is the need of the

hour. Rashtriya Swasthya Bhima Yojana - Comprehensive Health Insurance Scheme (RSBY-CHIS), is a move towards this end. But only a few studies are available about the effectiveness and utilization of this health security measure for the poor. So there is a research gap existing with regard to this sector and the present study is a humble attempt to fill this gap.

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Chapter 3

Theoretical Framework



3.1 Can All the Risks Be Insured?

3.2 Insurance as a Contract

3.3 Seven Principles of Insurance

3.4 How Health Insurance Works?

3.5 Health Insurance Policy: At A Glance

3.6 Health Insurance in Theory

The concept of insurance can be simply stated as a contract of indemnity or an assurance to a person, group or a body to indemnify a specified loss fatal, physical or financial, or to indemnify any specified damage to property or assets owned by him or them upon occurrence of an event. Insurance is an arrangement to deal with unpleasant contingencies. It is a contractual arrangement which provides partial or total protection against adverse, typical financial outcomes. The principle of insurance works on the concept of large number of people exposed to a similar risk makes a contribution to a common fund those who suffer losses due to the occurrence of any uncertainties or risk are compensated from this fund. It is the transfer of financial responsibility for the risk at the point of occurrence and conventionally involves the insurer in a commitment to pay provided the terms and conditions of the policy are met, payment of the premium secures a source of funds, in the event of loss. This chapter explains the nature of insurance contract, principles of insurance, the working of the concept of health insurance, and theories related to the economics of health insurance.

3.1 Can All the Risks be Insured?

While there are many outcomes or risks, which are insurable, there are many more against which there can be no insurance. Generally insurers confine themselves to covering pure risks only, and do not offer cover for speculative risks. However this principle is changing with the times. Again insurers will not cover all pure risks. To make insurance a viable business, insurers filter the risks that they cover, using some criterion. Generally insurers look for the following features in the risks that they would want to cover.

- The loss for which insurance is taken, as and when it happens, must be fortuitous. It should be accidental, unforeseen, beyond the control of the insured and result of chance factors. In life insurance although death is certain, the timing thereof is uncertain and unpredictable.
- The loss must be capable of definite financial measurement. The financial measurement of the loss is what decides the contribution to the fund.
- There must be a large number of fairly homogenous exposures. Insurance works on the theory of large numbers and probability. These work satisfactorily only if the size of the sample or population is large. The larger the size, the greater the predictability- spread of risks, therefore, allows a greater predictability of outcomes, and therefore aids in the functioning of insurance.
- The loss must not be catastrophic. For example, the fund created by way of premium was enough to pay for only 25 hospitalization cases. Had there been an outbreak of some infectious disease, and 500 persons were hospitalized, the fund would not have been able to provide

hospitalization expenses for everyone. However, in today's scenario, catastrophic perils are insured by spreading risks all over the world by the mechanism of re-insurance.

3.2 Insurance as a Contract

The actual process of transferring risks is achieved by means of a contract between the insurance company and the insured. It is therefore subject to the general requirements of a contract, namely offer, acceptance, consideration, capacity to contract, legality and performance. In an insurance contract the offer is made by you, when you fill or just sign a form given to you by a representative of the insurance company. The acceptance of it by the company and your paying the premium completes the contract. The contract gets performed either by lapse of time where there is no loss during the policy period or by settlement of the claim arising out of the loss if the loss arises during the policy period.

There are some peculiarities in the insurance contracts.

- An insurance contract is personal. This means that the policy is not transferred along with the property automatically.
- Insurance contracts are conditional. The contract is valid only when the conditions attached are fulfilled.
- Generally insurance contracts are unequal. Your insurance only promises to pay in the event of a loss. If there is no loss, nothing is done by the insurer. However the insured has to pay the premium up front.
- The terms and conditions of the contract are not totally negotiable. The terms are negotiable only in a limited way.

3.3 Seven Principles of Insurance

The seven principles of insurance are:-

1. Principle of Uberrimae fidei (Utmost Good Faith): Principle of Uberrimae fidei (a Latin phrase), or in simple English words, the Principle of Utmost Good Faith, is a very basic and first primary principle of insurance. According to this principle, the insurance contract must be signed by both parties (i.e insurer and insured) in an absolute good faith or belief or trust. The person getting insured must willingly disclose and surrender to the insurer his complete true information regarding the subject matter of insurance. The insurer's liability gets void (i.e. legally revoked or cancelled) if any facts, about the subject matter of insurance are either omitted, hidden, falsified or presented in a wrong manner by the insured. The principle of Uberrimae fidei applies to all types of insurance contracts.

2. Principle of Insurable Interest: The principle of insurable interest states that the person getting insured must have insurable interest in the object of insurance. A person has an insurable interest when the physical existence of the insured object gives him some gain but its non-existence will give him a loss. In simple words, the insured person must suffer some financial loss by the damage of the insured object. For example, the owner of a taxicab has insurable interest in the taxicab because he is getting income from it. But, if he sells it, he will not have an insurable interest left in that taxicab. From above example, we can conclude that, ownership plays a very crucial role in evaluating insurable interest. Every person has an insurable interest in his own life. A merchant has insurable interest in his business of trading. Similarly, a creditor has insurable interest in his debtor.

3. Principle of Indemnity: Indemnity means security, protection and compensation given against damage, loss or injury. According to the principle of indemnity, an insurance contract is signed only for getting protection against unpredicted financial losses arising due to future uncertainties. Insurance contract is not made for making profit else its sole purpose is to give compensation in case of any damage or loss. In an insurance contract, the amount of compensations paid is in proportion to the incurred losses. The amount of compensations is limited to the amount assured or the actual losses, whichever is less. The compensation must not be less or more than the actual damage. Compensation is not paid if the specified loss does not happen due to a particular reason during a specific time period. Thus, insurance is only for giving protection against losses and not for making profit. However, in case of life insurance, the principle of indemnity does not apply because the value of human life cannot be measured in terms of money.

4. Principle of Contribution: Principle of Contribution is a corollary of the principle of indemnity. It applies to all contracts of indemnity, if the insured has taken out more than one policy on the same subject matter. According to this principle, the insured can claim the compensation only to the extent of actual loss either from all insurers or from any one insurer. If one insurer pays full compensation then that insurer can claim proportionate claim from the other insurers. So, if the insured claims full amount of compensation from one insurer then he cannot claim the same compensation from other insurer and make a profit. Secondly, if one insurance company pays the full compensation then it can recover the proportionate contribution from the other insurance company.

5. Principle of Subrogation: Subrogation means substituting one creditor for another. Principle of Subrogation is an extension and another corollary of the principle of indemnity. It also applies to all contracts of indemnity. According to the principle of subrogation, when the insured is compensated for the losses due to damage to his insured property, then the ownership right of such property shifts to the insurer. This principle is applicable only when the damaged property has any value after the event causing the damage. The insurer can benefit out of subrogation rights only to the extent of the amount he has paid to the insured as compensation.

6. Principle of Loss Minimization: According to the Principle of Loss Minimization, insured must always try his level best to minimize the loss of his insured property, in case of uncertain events like a fire outbreak or blast, etc. The insured must take all possible measures and necessary steps to control and reduce the losses in such a scenario. The insured must not neglect and behave irresponsibly during such events just because the property is insured. Hence it is a responsibility of the insured to protect his insured property and avoid further losses.

7. Principle of Causa Proxima (Nearest Cause): Principle of Causa Proxima (a Latin phrase), or in simple English words, the Principle of Proximate (i.e. nearest) Cause, means when a loss is caused by more than one causes, the proximate or the nearest or the closest cause should be taken into consideration to decide the liability of the insurer. The principle states that to find out whether the insurer is liable for the loss or not, the proximate and not the remote must be looked into. For example: - A cargo ship's base was punctured due to rats and so sea water entered and cargo was damaged. Here there are two causes for the damage of the cargo ship - (i) The cargo ship getting punctured because of rats,

and (ii) The sea water entering ship through puncture. The risk of sea water is insured but the first cause is not. The nearest cause of damage is sea water which is insured and therefore the insurer must pay the compensation. However, in case of life insurance, the principle of Causa Proxima does not apply. Whatever may be the reason of death (whether a natural death or an unnatural) the insurer is liable to pay the amount of insurance.

3.4 How Health Insurance Works?

Let us look at an example to understand the working of health insurance. Suppose there are 1000 persons living in a colony, and each episode of hospitalization per person costs Rs. 10,000/- on an average. Assuming that an average of 25 persons get hospitalized once in every year, the total cost of hospitalization will be Rs.2,50,000/-. If all the persons contribute to a common fund, where all members share the cost equally, they would have to contribute Rs.250/- each. Thus no individual will suffer more than Rs.250/- cost, which is a certain payment. We can easily understand the advantage of this arrangement. A cost of Rs. 10000/-, the full value of hospitalization, may be ruinous for any individual, but a payment of Rs.250/- is more easily accommodated. Thus instead of an uncertain large cost, there is now a certain but small cost. Similarly health insurance is like a pool of funds created, to help members of the fund in the event of a cost.

The meaning of some common terms used in health insurance can be explained with the help of the example given above.

Premium: The contribution of Rs.250/- to a common fund is called premium.

Sum insured or coverage: The cost of hospitalization for each individual is Rs.10000/-. This is the maximum possible cost due to any single event of

hospitalization that will be paid from the common fund and is normally the equivalent of sum insured or coverage in health insurance policies.

Peril: The risk shared by all the individuals in the colony is the cost of hospitalization due to illness. Insurer call this peril, and insurance policies cover many perils such as earth quake, burglary, riot, etc.

Risk: The asset insured or offered for protection here is health of the person and is loosely called the risk. Thus a risk may be a vehicle, factory or person that would be affected by the occurrence of a peril.

Hazard: In our example we had the implied assumption that all members of the colony have similar health conditions. In the real world, however, people have different health conditions. Such differences cause variations in the frequency and severity of illness or other perils. The chance of loss occurring due to any peril, and the degree of severity of loss, if the peril occurs, depends upon the condition of the asset or risk. The totality of circumstances, state and condition of the asset that create or increase the chances of the peril happening or increase the losses as and when it happens is called a hazard. The premium for each risk is based on the hazard involved. Thus a person suffering from a chronic disease has a greater health hazard than a person having no such chronic diseases and therefore the premium charged is higher for the former.

From the policy holders, insurers collect a premium which are a fraction of the asset value and pay claims out of this. To function effectively, it is not sufficient if they collect just enough to pay claims. In addition to paying claims, insurers also provide for the following from the premium.

- Expenses such as survey fees, legal fees etc.

- Provision for unexpected losses in terms of contingent funds. For example, a given year may have very high losses, while the next year may have negligible losses. Insurers need to accommodate such variations in claims.
- Administrative costs.
- Agency commissions and costs of procuring business.
- Margin of profit and return on their capital.

To cover these expenses the premium is suitably loaded.

3.5 Health Insurance Policy: At A Glance

The main aim of health insurance policies is to offer protection against expenses incurred due to unforeseen illnesses of individuals. At present, there are a variety of health insurance policies offered by both public and private sector insurance companies. Mainly, there are two varieties of health insurance policies available in the market, and these are benefit policies and indemnity policies. Benefit policies refers to policies where a lump sum is paid in case the insured disease occurs. Currently some private insurance companies are offering facilities such as hospital cash, fixed payment in case of surgery, or critical illness etc. by just submitting the proof that the event occurred. In contrast, indemnity policies are the ones that have been issued by the public insurance companies for a long time. Under the scheme, the insured person has to submit bills for treatment and he will be paid the expenses as allowed under the scheme.

While purchasing a health insurance policy the following things should be taken into consideration.

- **Coverage:** It varies among insurers and one should look out for the following clauses particularly when comparing.
 1. Pre and post hospitalization expenses.
 2. Preexisting diseases and diseases followed immediately after issue of policy.
 3. Additional services provided such as cashless facility.
 4. Age up to which coverage is there.
 5. Minimum period of hospitalization required if any, to get benefits under the policy.

Usually the hospitalization expenses include - room rent, medicine, pathological tests, surgeon/doctor fees, operation theatre charges, blood, oxygen, artificial limbs etc.

- **Exclusions:** General exclusions are war and invasion, general debility, run down condition, AIDS, diagnostics or examination without any disease, pregnancy and child birth in individual policies, pre existing diseases, treatment for alcoholism/drug addiction, people outside the covered age band, dental and eye treatment, cosmetic surgery, etc.
- **Sum insured:** It may be selected according to requirements. This may cover all expenses or be subject to sub limits. When sub limits such as a limit on room rent etc. are attached, the premium may be lesser. Additional options insurers may give: ambulance costs, cost of travel of escort to the injured person, cumulative bonus given for claim free years, cost of medical checkup given by some insurers after a specified claim free period.

- **Premium:** is based on age and the sum insured selected. Larger groups may be able to get bargain rates based on past claims experience and size of group. In the case of individuals, the premium is tax deductible, if paid by cheque.

3.6 Health Insurance in Theory

The principal goal of insurance, as assessed by economists, is to transfer resources from low marginal utility of income people to those where the marginal utility of income is high. If insurance is actuarially fair, this process will continue until the marginal utility of money is constant across people. When unfair, insurance will be partial, and greater is risk aversion.

3.6.1 Conventional Theory

3.6.1.1 Health insurance: An economist's justification

Economists have theorized that people make economic decision by comparing marginal costs with the marginal revenues. In the individual case it is based on the marginal utilities foregone and gained. For example if you recall the first Rs.500/- investment you got would have had much more impact and would have seemed more valuable and utilitarian than if you were to receive the same amount, even with adjustment for inflation, today, after, say, 15-20 years. Why? As income and wealth grows each additional unit of wealth brings you lesser satisfaction than the previous units. Even if the total satisfaction or utility level go up, they go up at a lesser rate than previously. Economists call this phenomenon, Diminishing Marginal Utility. In other words, every additional unit of any item that you purchase or consume gives you lesser satisfaction than the previous unit consumed.

The question, “How and when insurance makes a sense?” can be answered by applying the Law of Diminishing Marginal Utility to a numerical example.

Table 3.1 Utility Table for a Person with Wealth of Rs.1 lakh

Wealth slabs	Total utility units	Marginal utility units
0-10000	10000	10000
10000-20000	19950	9950
20000-30000	29800	9850
30000-40000	39450	9650
40000-50000	48770	9320
50000-60000	57590	8820
60000-70000	65710	8120
70000-80000	72880	7170
80000-90000	78800	5950
90000-100000	83120	4320
Total for Rs. 1 lakh	83120	83120

In table 3.1, first column shows different wealth slabs of a person starting from 0-10000, second column shows total utility units of different slabs and third column shows respective marginal utilities. Any expense or loss will begin to eat away utilities from the bottom of the table and go up progressively. Thus an expenditure or loss of Rs. 10000 will mean 4320 foregone utility units, i.e. the difference between having Rs. 1 lakh and Rs.90000/-. An expense or loss of Rs.20000/- will mean foregone utility units of 10270 (4320+5950) and so on. Why should an expenditure of R.10000 cause a loss of only 4320 utility units ? When the person spends Rs.10000/- from Rs.1 lakh, he is left with Rs.90000/- which are worth 78800 utility units. This is 4320 units less than what he had with Rs.1 lakh.

3.6.1.2 Application of the Law of Diminishing Marginal Utility in Health Insurance

The choice facing the person taking health insurance is whether he should spend on premium or stay unprotected and risk losing his wealth. Let us assume that health insurance premiums are 2 per cent of hospitalization expenditure. Let us further assume that chance for hospitalization are 2 per cent per annum and hospitalization expenditure is Rs.1 lakh per year. The table 3.2 shows utilities foregone and gained in deciding to insure.

Table 3.2 Utilities Foregone and Gained in Deciding to Insure

Hospitalization expenses	Rs.1 lakh.
Premium rate	2 per cent
Premium paid	Rs.2000 (i.e. 2 per cent of 1 lakh)
Utility units foregone in insuring (counting from bottom upwards)	864 (i.e. $4320 \times 2000/10000$)
Utility units gained by recovering expenses from the insurer in case hospitalization happens to the insured	83120 units
Chances of this hospitalization expense occurring	2 per cent
Utility units gained by insuring (on an average)	1662.4 units (i.e. $83120 \times 2/100$)

Thus the person by insuring is paying a fixed price of 864 utility units for protecting himself against a total cost of 83120 units. This act, on an average, saves him 1662.4 units. Insuring is clearly a prudent option. Even if the price paid for insurance is 3 per cent of the hospitalization expenses, it will still cost lesser (1296 units) than the potential savings of 1662.4 units. In fact, the insurance company can charge up to 3.84 per cent (assuming same lenience in calculations) and yet expect you to take insurance when the average loss is 2 per cent. It is only when the cost of insurance exceeds even this 3.84 per cent,

that insurance becoming an unwise exercise. This difference is where insurance companies cover their expenses and make profits.

In short the economists argue that the value or utility of the cost so paid by the customer by way of premium is far less than the expected average value of losses the insured will otherwise encounter. In other words, the utility lost in paying for insurance is less than that gained by mitigating losses. Thus a cost benefit analysis at the time of taking insurance will always justify insuring. Regret about insurance premiums having been needlessly paid is mostly post facto when the outcomes are known.

Any good or service a person buys is worth at least as much to that person as the money that person spent on it. From this idea it follows that people will buy more of something the less they have to pay for it (according to the economists, the Law of Demand). The maximum amount of money someone will spend on a good or service is called that individual's valuation of that good or service. We can think of it as utility, in economics, they'll derive from that good or service. If you'd spend up to Rs.5/- for a cup of coffee at a coffee shop but not a paisa more, then Rs.5/- is your valuation of that cup of coffee. Though you may be willing to spend Rs.5/- for the first cup, you may not be for a second, or third, or tenth. If the price is lower, say Rs.2/-per cup, you might be more willing to buy more than one cup, however. You'll keep buying cups of coffee until the increase in benefit you'd get from the next cup is lower than the additional amount you'd have to spend on it. The word "additional" is synonym for another term economists use, marginal. So long as the marginal benefit exceeds the price, you'll keep buying. This just means you keep buying something (coffee, whatever) until you no longer think it is worth it, given how much you've already bought (or consumed). This should be

intuitive. It's how you decide how many cups of coffee to buy at the coffee shop, or how many bananas to buy at the super market, or how much of anything to buy.

It's true for health care too. Now, purchasing health care is more complicated because of insurance. But the same idea applies. You'll consume as much health care as you think worth it for the transaction price (your co-payment if you're insured). The lower the price, the more you'll consume. You'll keep using health services until the marginal benefit falls below the price you pay. Imagine you're fully insured. (You pay no co-payment.) You pay nothing for each health care service. How much will you use? Well, if it costs you Rs.0 for a service you'll use as much of that service until the marginal benefit is Rs.0. So long as the service is at least providing a tiny bit of benefit (to your health, or just because you enjoy the experience for some reason), you'll keep using it.

So long as you're benefiting from the service, the physician is likely willing to provide it, particularly if he perceives the benefit is at least not harming your health. To the physician and the patient, all of that health care is "welfare" improving in the sense that it improves your health, or doesn't harm it, anyway. The economist considers not just marginal benefit, but the (full) marginal cost. Imagine each health service costs a fixed amount, for example, each service costs Rs.100, no matter how many are provided. The insurance company may be paying most or all of that Rs.100, but it is still a cost. It reflects real resources used (physician time, supplies, etc.). But at some level of health care utilization, the marginal benefit falls below marginal cost. All the resources used to provide health care services beyond this level, cost more than they're valued by the patient. This is termed a "welfare loss" by economists

because it reflects a misuse of resources in the following sense. If the patient were handed enough cash to buy health care services beyond this level, she would not buy that many. She'd buy health care up to the level at which marginal benefit equals marginal cost, and use the rest of the money for something else (like coffee). So the cost for health care beyond the specified level, in this sense, "wasted." The patient only receives a benefit reflected by the marginal benefit and all the cost of providing care that is above this level is economic waste, even if it is health improving. To the economists, it is a welfare loss even as the doctor (and patient) may perceive it as a health (or welfare in another sense) gain.

Thus conventional theory holds that people purchase insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. But it gives the observation that health care spending is encouraged by health insurance. Conventional theory also holds that any additional health care that consumers purchase because they have insurance is not worth the cost of producing it and provided a ready evaluation of this increased spending: It represents a welfare loss and should be reduced. Conventional insurance theory also provided the policy solution: Impose coinsurance payments and deductibles to increase the price of medical care to insured consumers and reduce these inefficient expenditures. In the 1970s many insurers adopted co-payments to reduce health care spending. In the 1980s and 1990s economists also promoted utilization reviews and payments to providers as further ways to reduce moral hazard. The managed health care system we have now is largely a product of this theory.

3.6.2 Modern Theory by John A. Nyman:

John A Nyman presents a new theory of consumer demand for health insurance. It holds that people purchase insurance to obtain additional income when they become ill. In effect, insurance companies act to transfer insurance premiums from those who remain healthy to those who become ill. This additional income generates purchases of additional high-value care, often allowing sick persons to obtain life-saving care that they could not otherwise afford.

Regarding risk, the new theory relies on empirical studies showing that consumers actually prefer the risk of a large loss to incurring a smaller loss with certainty. Therefore, if consumers purchase insurance, it is not because they desire to avoid risk. Instead, the new theory suggests consumers simply pay a premium when healthy in exchange for a claim on additional income (effected when insurance pays for the medical care) if they become ill.

Health insurance is substantially more valuable to the consumer under the new theory. The new theory moreover implies that co-payments and managed care—central health policies of the last 30 years—were directed at solving problems that largely did not exist. Because these policies either reduced the amount of income transferred to ill persons or limited access to valuable health care, they may have done more harm than good. The new theory also provides a solid theoretical justification for insuring the uninsured and for implementing national health insurance with the help of the following example. Consider Elizabeth, who has just been diagnosed with breast cancer. Without insurance, she would purchase only the \$20,000 mastectomy required to rid her body of the cancer. If she had purchased an insurance policy for \$4,000 that paid off with a \$40,000 cashier's check upon diagnosis of breast cancer, she

might purchase the \$20,000 mastectomy and also a \$20,000 breast reconstruction procedure. For economists, this behavior implies that the additional \$40,000 in income from the insurance pool had increased her willingness to pay for the breast reconstruction so much that it is now greater than the \$20,000 market price, causing her to purchase the second procedure. This moral hazard is efficient because she could have spent the additional \$40,000 on anything she chose but opted to purchase the breast reconstruction. The purchase of this additional procedure represents a moral-hazard welfare gain to the extent that with the additional \$40,000 in income, she would have now been willing to pay more than the \$20,000 that it cost to produce the procedure. In this example, the additional care used, \$20,000 for breast reconstruction, was unambiguously welfare improving. Elizabeth valued it at more than its cost (the economist's definition of welfare improving). If she hadn't, she'd have spent the \$20,000 another way. However, because health insurance policies do not pay off with lump-sum payments, but rather pay directly for health care, the interpretation of the additional care used due to insurance is ambiguous. For example, if Elizabeth had instead paid \$4,000 for insurance that simply paid for her health care when ill, she might also purchase the same two \$20,000 procedures, resulting in the same payout of \$40,000 from the insurance pool. But it is not clear whether she is responding to the zero price by opportunistically purchasing a breast reconstruction procedure that she barely values, or responding in the same way that she would have responded if the insurer had written her a check for \$40,000. As a result, we cannot tell whether this additional moral-hazard spending represents a welfare loss or a welfare gain.

How much additional spending due to insurance is a welfare gain? In his book, Nyman calculates that the majority of it is, perhaps as much as 70 per

cent. A number of policy implications follow that differ from those implied by an assumption that all moral hazard is a welfare loss. Nyman lists them as: cost sharing is often not appropriate, particularly for cost-effective, life-saving or health-preserving interventions, subsidizing insurance premiums to encourage coverage is beneficial, and high health care prices are harmful because they discourage use of care. It is not incorrect to say that insurance promotes additional health spending. It does. If you believe Nyman's theory, it is incorrect to say that all that additional spending is wasteful, a welfare loss. A little is. Most is not.

From the theoretical analysis above, one can conclude that health insurance is very much useful to mitigate the burden of the people, especially the poor and vulnerable ones. The utility lost in paying for insurance is less than that gained by mitigating losses. Thus a cost benefit analysis at the time of taking insurance will always justify insuring. But the conventional theory gives the observation that health care spending is encouraged by health insurance and that any additional health care that consumers purchase because they have insurance, is not worth the cost of producing it and so it represents a welfare loss and should be reduced. But the new theory suggests consumers simply pay a premium when healthy in exchange for a claim on additional income (effected when insurance pays for the medical care) if they become ill. Health insurance is substantially more valuable to the consumer under the new theory and it is incorrect to say that all that additional spending is wasteful or a welfare loss.



Chapter 4

Health Sector and Its Financing in India with Special Reference to Kerala

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- 4.1 Why Does Health Matter?
 - 4.2 Right To Health Care in India
 - 4.3 Indian Health Status
 - 4.4 Health Status of Kerala
 - 4.5 Health Insurance as a Financing Tool
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Health is a multifaceted concept and thus it defies any precise definition. The narrow definition of health posits it as the absence of any disease. The broad definition of health however does not rest merely on the absence of disease, but the fulfillment of a whole range of personal, physiological, mental, social and even moral goals. WHO's constitution defines health as "a state of complete, physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO 1992).

The concept of care has changed over time, - from a static concept of 'physical condition' to the dynamic concept of 'ability to cope'. In other words, mere absence of diseases does not render a person healthy, and at the same time the presence of physical defect does not necessarily make a person unhealthy, i.e. health is a broader concept than a narrow biomedical model. Besides the absence of physical disease and/or defect, the concept of health takes into account the notion of wellbeing, continuity and stability of physical, mental, emotional and social health as well as nutritional aspects of food entitlements. Thus health is considered as an input of the totality of life, and a focal point of human development.

4.1 Why Does Health Matter?

For an individual, health has a double function. On the one hand, perfect health represents a value of its own, a target that needs to be reached as closely as possible. On the other hand, there are other aims in life as well, for example, good health gives good income in labour market. World Development Report 1993 explained good health as crucial part of wellbeing. It further asserted that spending on health can also be justified on purely economic grounds. Improved health contributes to economic growth in four ways: It permits the use of natural resources that had been totally or nearly inaccessible because of disease; It increases the enrolment of children in schools and makes them better able to learn; and it makes alternative uses of resources that would otherwise have to be spent on treatment (World Bank 1993).

Theoretical works as well as empirical evidence clearly show the positive linkage between good health and economic development. The health status of a population is now considered an important indicator of development, and health is increasingly being seen as a development issue rather than just a medical one. Health is a basic need along with food, shelter and education and is a precondition for productivity and growth. Health services have a major influence on the wellbeing of individuals and societies and are an important part of a nation's politics and economy.

In addition to loss of productivity as a consequence of ill health, there is another important fall out of the ill health. Ill health among the poorer sections of the population pushes them into poverty. Evidently there is a strong association between poverty and ill health, even though it is difficult to say which one causes the other. To quote Harrold S. Luft on this issue, " Almost any cross tabulation comparing health status and income levels will show low

income people who are sick and many sick people who are poor. From such a table, nothing can be said about causation. The problem, of course, is that many of those people who are poor and sick were not poor before they became sick”.

The WHO in a conference in 1988 at Alma Ata declared “The conference strongly reaffirms health is a fundamental right and the attainment of highest possible level of health is a most important worldwide social goal whose realization requires the actions of many other social and economic sectors in addition to the health sector.” The declaration urged upon all nations to make full use of all available resources as well as mobilize the human potential of all communities to implement the policy of ‘Health for All’.

4.2 Right to Health Care in India

Healthcare, in fact, is one of the basic needs of humanity and it has been there in some form or the other ever since the dawn of civilization. Health is at the center of global agenda and there is now a real concern to reach out to the poor and vulnerable sections of the society with an appropriate, cost effective and sustainable health at preventive and curative level. World Health Organization (WHO) is at the forefront to address the problems. Health care is the prevention, treatment and management of illness and the preservation of mental and physical wellbeing through the services offered by the medical and allied health protection. Healthcare, with global revenue of over Rs. 2.75 trillion is one of the world’s largest and fastest growing industries, consuming over 10 per cent of GDP of most developed nations.

In India, the objective of ensuring ‘Health for all’ has been dealt through institutional mechanisms. Mainly the state and local governments are responsible for ensuring health care. The objective of the policy is to make

health care facilities available for all at reasonable cost. However given that a large number of people are living below the poverty line, the very mention of reasonable cost excludes a vast majority of population from the purview of health care facilities (Chazhoor, 2007).

The right to health care in India can be analyzed under two heads. Firstly, the legal provisions for addressing the issue of the right to health care. Secondly, the administrative mechanism required for dealing the issue effectively.

4.2.1 Legal Framework:

In India, the right to health care is not mentioned specifically in the chapter of Fundamental Rights. However Article 21 states that no person shall be deprived of his life or personal liberty except according to the procedure established by law. Moreover, the Supreme Court in its judgment in the Bandhua Mukti Morcha case had clearly held that Article 21 read with the Directives of State Policy includes the right to health. This interpretation was made clear in the case of Consumer Education and Research Centre, Ahmedabad Vs. Union of India, decided in February, 1995. The judgment stated that the right to life and personal liberty includes right to live with dignity and thus the right to health.

Furthermore Article 47 (under the chapter on Directive Principles of State Policy) states that it is the duty of the state to raise the level of nutrition and standard of living of its people and to improve public health. Article 47 further states that the state shall regard the raising of nutrition and standard of living of its of people and improvement of public health as among its primary duties and in particular the state shall endeavor to bring about the prohibition of the consumption, except for medical purposes, of intoxicating drinks and of drugs which are injurious to health.

4.2.2 Administrative Measures:

Administrative measures with respect to the right to health care come under two heads, National Health Policy and Drug Policy.

4.2.2.1 National Health Policy:

The present health policy in India is based on the Sir Bhore Committee Report 1943, which recommended a three tier health care system. (i.e. primary health centre unit, community health centre unit and district hospitals). In 1983, the union ministry of Health and Family Welfare formulated National Health Policy and the aim was the attainment of Health for All by 2000 A.D. The policy laid stress on the preventive and rehabilitation aspects of health care. One of the major challenge in policy formulation was shift in the emphasis from the curative to the preventive and promotional system of health care.

4.2.2.2 Drug Policy:

In India, the union government has declared its Drug Policy from time to time. In 1974, the government had appointed the Hathi Committee to inquire into the conditions prevailing in the sphere of drugs and pharmaceuticals in the country. The committee recommended the creation of National Drug and Technical Authority to look into the licensing, quality control, pricing and marketing. In 1986, the government declared another drug policy. The Drug Policy of 1986 was titled 'Measures for rationalization, quality control and Growth of Drugs and pharmaceuticals industry in India. Another drug policy was announced in 1994. It recommended the government to create National Pharmaceutical Pricing Authority for the fixation of drug prices and for regularly updating the list of drugs to be kept under price control.

If one looks historically, the government of India, right from the time of independence has said, "Yes, the health of the Indians is our responsibility." Article 47 of the Constitution states very clearly - "the State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". Even in the national health policy 2002, the government acknowledges that it has a very key role in providing and financing health. So while the government has taken the responsibility of health care, in reality things are different.

In short, health is a human right, and so its acceptability and affordability has to be insured. While the well to do segment of the population, both in rural and urban areas have acceptability and affordability towards medical care, it cannot be said about the people who belong to the poor segment of the society. It is well known that more than 75 per cent of the population utilizes private sector for medical care. Unfortunately medical care becoming costlier day by day and it has become almost out of reach of the people. Today there is a need for injection of substantial resources in the health sector to ensure affordability of medical care to all. Health insurance is an important option which needs to be considered by the policy makers and planners.

4.3 Indian Health Status

Over the last 60 years India has achieved a lot in terms of health improvement. Death rate has reduced from 40 to 7 per 1000, infant mortality rate reduced from 161 to 58 per 1000, live births and life expectancy increased from 31 to 63 years. However many challenges remain and these are life expectancy 4 years below world average, high incidence of communicable and non communicable diseases, and threat from environmental degradation. We have the highest number of TB cases and will soon have the highest number of

HIV cases in the world. Malaria is still a problem in many parts of the country and many states still battle with polio, measles and tetanus. On the other hand, lifestyle diseases like hypertension, diabetes mellitus and road traffic accidents are on the increase. It is estimated that at any given point of time 40 to 50 million people are on medication for major sickness in India and about 200 million workdays are lost annually due to sickness. To state the obvious of the failure to control communicable and non communicable diseases is taking heavy toll on the productivity of the economy. A recent analysis of the World Bank concludes that ‘the hospitalized Indian spends more than half of his total annual expenditure on buying health care, more than 40 per cent of the hospitalized people borrow money or sell assets to cover expenses and 35 per cent fall below the poverty line.’ One of the reasons for this could be the low budgetary allocations.

Compared to other developed nations, healthy life expectancy is much low in India. In healthy life expectancy, Japan ranks first in the world followed by Singapore, U.S.A., China etc. India holds 8th rank in the world with healthy life expectancy of 52.5 years, as shown in table 4.1.

Table 4.1WHO’s Healthy Life Expectancy Estimate in 2009

Country	Healthy life expectancy in years
Japan	74.5
Singapore	69.8
United states	70.0
China	62.3
Argentina	60.7
Thailand	60.2
Brazil	59.1
India	52.5
Iraq	48.2
South Africa	45.2

Source: World Bank Data 2010.

The table 4.2 shows health indicators of select countries.

Table 4.2 Health Indicators of Select Countries for 2009

Country	GDP per capita in US dollars	Infant Mortality Rate (per 1,000 Live at Birth)	Life Expectancy at Birth M/F (in Years)
India	2753	53	62.6/64.2
China	5383	19	71.6/75.1
Japan	33632	3	79.4/86.5
United states	45592	7	77.1/81.6
Indonesia	3712	25	69.2/73.2
Vietnam	2600	13	72.6/76.6
Bangladesh	1241	47	65.5/67.7
Pakistan	2496	73	66.5/67.2
Sri Lanka	4243	17	70.6/78.1

Source: World Bank Data 2010

Still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators (Satia et al 1999).

The table 4.3 shows basic health indicators in India.

Table 4.3 Basic Indicators of Health in India

Factors /indicators	1951	2009
a) Demographic		
Infant mortality rate/1000	161	53
Crude birth rate /1000	102	23.8
Crude death rate /1000	40.8	7.6
Life expectancy at birth	31	64
b) Epidemiological shifts		
malaria(cases in million)	75	1.8
leprosy(cases per 1000)	38.1	2.94
small pox(no. of cases)	44877	Eradicated
c) Infrastructure in no.s		
Community health centre/ Primary health centre etc	725	163181
Dispensaries & hospitals	9209	43322
Beds (in private &public)	117198	870161
Doctors (Allopathic)	61800	503900
Nurses	18054	737000

Source: Health Information of India 2010, Central Bureau of Health Intelligence, Directorate General of Health Services, Ministry of Health & Family Welfare, India.

4.3.1 Insufficient Public Health Expenditure

India spends about 6.5 per cent to 7 per cent of GDP on health care. Out of which 1.3 per cent is in the government sector (this accounts for 22 per cent of overall spending) and 4.7 per cent by private sector (78 per cent of overall spending). For a state that promises 'Health for All', 6 per cent of GDP on health is woefully inadequate. Even the average spending of the low income countries including the Sub Saharan Africa exceeds 6 per cent of GDP. National level of spending on health care under five year plans has also decreased. It was 3.3 per cent in the first Five Year Plan and 0.7 per cent in 8th plan. The national spending also includes family planning, water sanitation for rural areas etc. At present majority of funds (approximately 50 per cent) go in salary and administration from government spending budget. No doubt in India, we have high deficits that curtail public expenditure. But when state is withdrawing from public sector, it is expected to assume a stronger role in social sectors like education, health, nutrition etc. The table 4.4 shows per capita expenditure on health as percentage of GDP which is also very low in India compared to other countries. It is about 5.1 per cent where as it is 13.9 per cent in U.S.A.

Table 4.4 Per Capita Expenditure on Health as Percentage of GDP for the Year 2005

Country	Percentage
U.S.	13.9
Singapore	4.0
Argentina	8.3
Brazil	8.0
South Africa	7.3
Thailand	3.9
China	5.5
India	5.1

Source: World Health Report of WHO 2006.

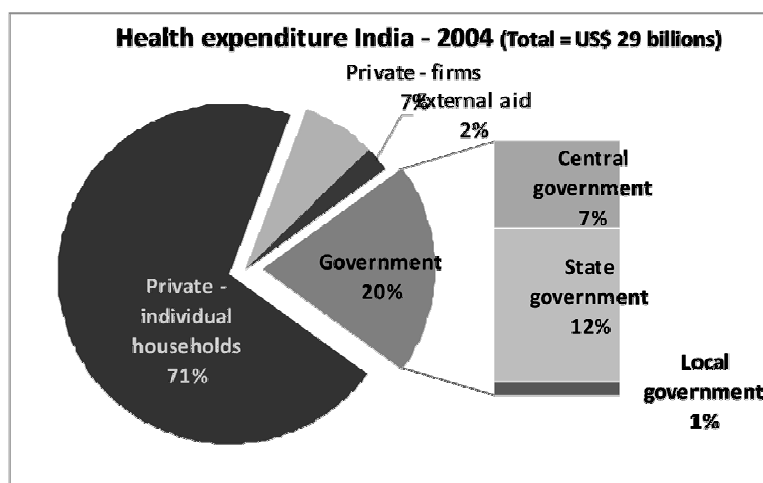
The problem in India is that health services are very expensive for the working class and for poor families. Over 70 per cent of the health care needs of our country undertaken by the private sector. The guiding principle of Bhore Committee that ‘no individual should fail to secure adequate medical care because of inability to pay for it’ looks unreachable still, after 60 years of Indian independence. The table 4.5 shows sources of funding for health in India.

Table 4.5 Sources of Funding for Health

Financing agent	Exp. in Rs. (Millions)	per cent Distribution
Ministry of Health and Family Welfare	24,629	2.3
Other Central Ministries/Departments	2,132	0.2
State Government Department of Health	141,699	13.4
Other State Ministries/Departments	2,311	0.2
Urban Local Bodies and Panchayat Raj Institutions	31,784	3.0
Social Security Funds	790	0.1
Central Government Employee Schemes	25,797	2.4
State Government Employee Schemes	5,119	0.5
Employee State Insurance Scheme	17,954	1.7
Public Health Insurance Providers (GIC Companies)	7,823	0.7
Private Health Insurance Providers	202	0.01
Households	744,225	70.4
NGOs	8,540	0.8
Private Firms and Public Firms	44,336	4.3
Total funds provided	1,957,341	100.0

Source: National Health Accounts 2001-2002

Figure 4.1: Health Expenditure in India (2004) by Source of Financing



Source: National Health Accounts (2009)

While 69 per cent of India's population lives in rural areas, less than 10 per cent of the total health budget is allocated to this sector. Even here the chief interest of the primary health care is diverted to family planning and ancillary vertical national programs such as Child Survival and Safe Motherhood (CSSM) which are seen more as statistical targets than as health services. According to one study, 85 per cent of the PHC budget goes on personnel salaries. This results in under staffed health centers, with no or minimal medicines, poorly maintained equipment and poor quality of care.

Out of the 22 per cent overall government spending for health, 33 per cent of this goes to the richest 20 percent of the population, whereas the poorest quintile gets only 10 percent of the money. This pushes people into the private sector and there they have to spend their meager income on health care. Studies show that about 80 per cent of OP care and about 40 - 60 per cent of IP care is provided by the private sector. Patients end up paying out of their pocket for health care, one of the basic needs of any population. This naturally affects access to health care, especially for the poor. For example, the hospitalization rate for the poorest quintile is only about 5 per thousand populations, whereas for the richest quintile it is about 35 that are practically seven times more. So people especially in rural areas have two options, either they spend their valuable money going to the private sector or they quietly sit at home and die. They sell their land, they sell their assets, they become indebted, all to pay the doctors' and the hospitals' bills. One can call it iatrogenic poverty.

The analysis of NSSO's (60th round) national morbidity healthcare survey data suggests that around 6.2 per cent of total households (6.6 per cent in rural areas and 5 per cent in urban areas) fell BPL as a result of total healthcare expenditure in 2004. Around 1.3 per cent of total households (1.3 per cent in

rural areas and 1.2 per cent in urban areas) fell BPL as a result of expenditure on inpatient care, while 4.9 per cent of households (5.3 per cent in rural areas and 3.8 per cent in urban areas) fell BPL as a result of outpatient care. In absolute terms, around 63.22 million individuals or 11.88 million households' impoverishment (79.3 per cent) is due to outpatient care which involves relatively small but more frequent payments, and only 20.7 per cent of impoverishment is due to inpatient care. Furthermore, much of the impoverishment (76.5 per cent of households or 77.4 per cent of individuals) occurs in rural areas. This is the reality, so to conclude people don't have access to care and those who access care are impoverished. The table 4.6 shows average medical expenditure per hospitalization case.

Table 4.6 Average Medical Expenditure (Rs.) per Hospitalization Case

Type of Hospital	Rural		Urban	
	2004	1995-96	2004	1995-96
Government Hospitals	3,238	2,080	3,877	2,195
Private Hospitals	7,408	4,300	11,553	5,344
Any Hospital	5,695	3,400	8,851	3,921

Source : 60th Round NSSO 2004.

4.3.2 Unbridled Growth of Private Sector in Health Care

In case of government funded health care system, the quality and access of services has always remained major concern. Therefore, over the last 30 years, there has been an unbridled growth of the private sector in health care services. With the state, almost over the same period of time shrinking its expenditure on public health, the private health care providers have mushroomed all over India. This private sector bridges most of the gap between what government offers and what people need. Most of the public funding is for preventive, promotive and primary care programs, while private expenditure is

largely for curative care. But the average expenditure for care is about 2-5 times more in private sector than in public sector. Over the period, the private health care expenditure has grown at the rate of 12.84 per cent per annum and for each one percentage increase in per capita income the private health care expenditure has increased by 1.47 per cent. Number of private doctors and private clinical facilities are also expanding exponentially. Moreover the spatial distribution of the private health care providers follows the market forces of demand and supply rather than the need of health care. Of those seeking treatment, 78 percent rural and 81 per cent urban patients are availing private non-institutional facilities and 58 per cent rural and 62 percent urban patients are going to private hospitals (NSSO 2004). Moreover, the dependence on the private sector is significant across all income ranges from the poorest to the richest, and utilization for public facilities is only very marginally higher among the poorest segments. The role of the government health services has diminished despite higher costs of private sector services.

4.4 Health Status of Kerala

Among the states in India, Kerala surpasses all the other states in levels of human development. The state of Kerala has received attention across the world for effective public intervention for human welfare, which has finally led to both high levels of human development and economic growth. The population of Kerala is uniformly scattered throughout the state and is fairly well advanced in its demographic transition. The rapidly declining growth in birth rate, highest mean age at marriage, a very high level of acceptance and awareness of family planning methods and fertility control, a moderate decline in the mortality rate etc. are the commendable achievements in health standards, which are almost comparable to that of developed countries in the world. Low

birth rate and death rate along with higher female life expectancy, low infant mortality with negligible gap between rural and urban and lower levels of disability are the special characteristics of Kerala's health status.

The health status of any state can be measured in terms of birth rate, death rate, infant mortality rate, expectation of life at birth etc. Kerala is far ahead of other states in the country and ranks first in attaining low birth rate, death rate, fertility rate, infant mortality rate and in attaining high expectation of life especially of females. The literacy of Kerala is high and people are aware of their needs, conscious of their safety and are generally demanding the services. They are enjoying a better healthier life than their counter parts in the country. The major factors contributing to such a unique situation are a wide network of health infrastructure and manpower, policies of successive state governments and other social factors like women's education, general health awareness and clean habits of the people.

Another contributory factor for the attainment of high health standards is the widespread growth of the three systems of medicine, i.e. ayurveda, homeopathy and allopathy, in public, private and cooperative sectors combined with people's health awareness. Traditionally, Kerala is famous for its ayurvedic system of treatment. Homeopathy is preferred for certain types of diseases and ailments peculiar to the infants and the aged. The present policy of the government is to promote all these systems of medicine keeping in view the acceptability of the people and their preferences.

Kerala's striking health indices are partly attributed to a health infrastructure developed by the governments committed to health care. For example, in 1955-56, the state's revenue expenditure on health was 8.48 per cent of total revenue expenditure compared to all state's average of 4.36 per

cent. In 1994-95 the state's revenue expenditure on health was 7.44 per cent to total revenue expenditure compared to all state's average of 2.63 per cent.

The basic health indicators of Kerala are given in table 4.7.

Table 4.7 Basic Health Indicators – Kerala and India 2008

Health Indicators	Kerala	India
Birth rate (per 1000 population)	14.7	23.1
Death rate (per 1000 population)	6.8	7.4
Infant mortality rate (per 1000 live births)	12	55
Neo natal mortality rate (per 1000 live births)	8.5	17
Maternal mortality rate (per lakh live birth)	95	254
Total fertility rate	1.7	2.9
Couple protection rate (any method)	62.3	52
Life expectancy at birth		
Male	71.4	62.6
Female	76.3	64.2

Source: Directorate of Health Services; Department of Health and Family Welfare, Kerala.

Though Kerala has attained better health care indicators, the people are now facing the problem of high morbidity, (The prevalence of morbidity has been defined as the number of specified disease (reported) prevailing in a population during the reference period to the total population exposed to the risk of that disease) both from communicable and non communicable diseases. The Human Development Report 2005 states that incidence of morbidity is higher in Kerala than India as a whole. For the population as a whole it is 25.11 per cent for Kerala as against 9.11 percent for all-India. Incidence of morbidity is higher in rural than in urban Kerala and vice versa for all-India. Communicable diseases are coming down in the state. However, non-communicable diseases are mounting irrespective of socio-economic

conditions. Most of the diseases prevalent in Kerala warrant constant medical attention and treatment and sustained medical treatment is beyond the wherewithal of the average households.

Thus the paradox is that on the one side Kerala stands as the State with all indicators of better health care development in terms of IMR, MMR, birth rate, death rate etc. on the other it outstrips all other Indian States in terms of morbidity especially the chronic illness. Kerala may have the best health indicators but necessarily not have the best public health care institutions. The success of Kerala health indicators is more due to the investment in the social capital rather than only in the public health care, resulting in a more accountable and integrated primary health care system. The private health care system cannot be an answer because of the high average cost of treatment. This warrants greater and sustained efforts by the State in widening the scope of public action. This co-existence of high level of morbidity with low levels of mortality and high life expectancy in Kerala is one feature, which has attracted much attention.

With increased levels of literacy and extension of medical services, it is conceivable that even minor ailments are reported as illness. States like Bihar and Uttar Pradesh, lagging far behind in terms of literacy and medical services, have also the lowest morbidity rates. It may also be noted that morbidity correlates with density of population and that Kerala having the highest density, thus has high morbidity too. The increase in old age population is also a factor for high morbidity in Kerala (Department of Health and Family Welfare). That the magnitude of morbidity is much higher in Kerala than in India as a whole has serious budgetary and policy implications with respect to provision of health care, its volume as well as type, in Kerala.

After the economic liberalization in 1991, budget allocation to total social sector in general and health sector in particular, was reduced in Kerala. This has drastically effected the health system in Kerala by way of increased privatized health care. As a result, cost of health care in Kerala increased almost four times from 1987 to 1996 (KSSP Survey), even after adjusting for inflation. Communicable diseases like malaria, dengue, chikun guniya etc. are re emerging in the state due to underfunded public health system. As a result of increased privatization, preventive and promotive health care which is usually given by the public sector is gradually been neglected. Infant mortality rate came down to 10 in the year 2002 and has increased to 11 in 2003 and 12 in 2004. Although this may not be statistically significant, Kerala is the only state where infant mortality rate has increased in two successive years. 'Good health at low cost in Kerala' faces serious challenges due to increased privatization.

Kerala is a state with a widespread system of health care facilities. State intervention to provide health care facilities has also been significant in the spread of homeopathic and ayurvedic systems of medicine. Medical facilities in the private sector under the three medical systems have expanded to a great extent. The private sector has now become the largest provider of health care in the state, in terms of number of medical institutions and beds. Higher literacy coupled with better availability and accessibility of health care infrastructure helped the state for attaining a better position in health care utilization as compared to other States in India (CDS-UN, 1975; Nag, 1983; Krishnan, 1985; Navaneetham and Dharmalingam, 2002). Meanwhile, some scholars have shown that Kerala's achievements have not been uniform across different geographical locations of the state and have also eluded some of the marginalized sections like fishermen and tribal (Shyjan, 2000; Vimalakumari, 1978). Another study noted the disparity in health status among socio-economic

groups, defined in terms of income, education, land ownership and housing and concluded that 'better health status is associated with higher socioeconomic status' and that the level of morbidity of the 'poor' was 40 percent higher than that of the 'rich' (Kannan et. al., 1990:). Kerala seems to have entered into the fourth stage of the epidemiological transition and studies have pointed out that lifestyle related diseases are on the rise in Kerala.

The table 4.8 shows Annual Per Capita Treatment Expenditure for various economic groups.

Table 4.8 Annual Per Capita Treatment Expenditure

Economic groups	Expenditure for treatment per capita/annual	per cent of family income
1 BPL POOR	1552	32
11 POOR	1309	18
111 MIDDLE	1801	13
1VUPPER MIDDLE	3238	10

Source: KSSP, 2006.

A close look at the present health status of Kerala will reveal that it may not come as a rude surprise to many, but Kerala no longer figures as on top of the list of the states which are making rapid advancements on health front. If the preliminary findings in the latest National Family Health Survey (NFHS 3) are anything to go by, all major health indicators for the state are now sliding down, a clear indication that Kerala has been resting on the glory of its past achievements for far too long. The key findings for Kerala from NFHS 3 show poor performance by the state as far as two key areas are concerned: immunization and child nutrition. The percentage of 'totally vaccinated children' in the state is now just 75 per cent. This is a slide by more than 5 per cent from the last NFHS (NFHS 2, 1998-99) figures, which was 80 per cent. As far as trends in children's nutritional status are concerned, most of the other

states seems to have made gains but in Kerala, the percentage of children under 3 years of age who are too thin for their height has gone up from 11 per cent to 16 per cent. The percentage of children under weight has also gone up from 27 to 29 per cent. Anemia is another major problem that the state has totally failed to tackle.

Another key finding of NFHS 3, which could have major implications for the state's morbidity pattern in the future, is the rapid upward trend in the percentage of obese or overweight men and women. Kerala now has the second largest population of obese adults in the country, after Punjab. The health indicators that we take so much pride in has been the result of long years of consistent fieldwork by our health workers, who ensured community participation in all health programs. In the later years the focus on field programs slackened and as the public health system failed to raise itself to the expectations of people, the people's response to public health initiatives also came down. However, what is significant from the NFHS 3 findings is that Kerala has not made any gains on the health front in the past few years, while several states like Andhra Pradesh, Tamil Nadu, Himachal Pradesh etc. have been surging ahead.

From the above analysis, we can conclude that both the Indian and Kerala health financing scene raise number of challenges, which are:

1. Increasing health care costs.
2. High financial burden on poor eroding their incomes.
3. Increasing burden of new diseases and health risks.
4. Neglect of preventive and primary care and public health functions due to underfunding of the governmental health care.

Given the above scenario, exploring health financing options becomes critical. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases. Given the socialist political thinking and populist policy it has been generally difficult for any government to introduce cost recovery in public health sector. Given that government is unable to provide more resources for health care, and institute cost recovery, one of the ways to reduce the underfunding and augment the resources in the health sector is to encourage the development of health insurance. It is considered one of the financing mechanisms to overcome some of the problems of our system.

4.5 Health Insurance as a Financing Tool

In the past insurance as a prepaid risk managing instrument was never considered as an option for the poor. The poor were considered too poor to be able to afford insurance premiums. Often they were considered uninsurable, given the wide variety of risks they face. However, recent developments in India, as elsewhere, have shown that not only can the poor make small periodic contributions that can go towards insuring them against risks but also that the risks they face (such as those of illness, accident and injury, life, loss of property etc.) are eminently insurable as these risks are mostly independent or idiosyncratic. Moreover, there are cost-effective ways of extending insurance to them. Thus, insurance is fast emerging as a prepaid financing option for the risks facing the poor.

In financing of health services a country may, in principle, choose between public financing through general taxation or private financing through health insurance. Public financing is justified where equity concern overrides

efficiency objective. Where the opposite is true, reliance is often placed on the private insurance market. Equity considerations in private insurance market can generate inefficiency and market failure as it involves tradeoff between desired distribution and the distorted incentives that accompany such redistribution. Therefore, where equity is the prime consideration it can best be achieved under public financing. In practice no health financing system is either purely public or private. Countries where private health insurance dominates, some public financing can still be observed. Similarly, some private insurance can be seen even in a public funded health system. All insurance systems, public or private, must strike a balance between economic efficiency and equity.

The choice between public health financing or private insurance is hardly available to countries like India because of their governments' limited ability to marshal sufficient resources to finance health spending, and also because the nature of employment (where majority of workers are self-employed, or do not have a formal employer or steady employment) is such as to provide little scope for payroll taxes (Ahuja, 2004). Given this, heavy reliance on private spending is necessary for financial reasons, notwithstanding the declared policy of the state to provide 'universal, comprehensive primary health services' to the entire population. Private spending may also be desirable on efficiency grounds. But the form that bulk of private spending takes need to change from out-of-pocket payments to private insurance. Insurance or pooling of risks through prepaid schemes has a number of advantages. Besides being more equitable, it is one of the significant drivers of improvement in the healthcare provision by encouraging investment and innovation. Also, it helps improve the quality and efficiency of public health care system by continually benchmarking it. Private insurance has certain pitfalls too such as leaving out the low-income individuals who may not be able to afford premium, denying

coverage to people who are sick, and limiting the coverage for high-cost conditions or services.

In a country like India where public health care suffers from poor management, low service quality, weak finances, and lack of responsiveness to patients' needs and demands, development of health insurance is likely to bring improvement in public health care system. Even the private health sector in India, that has grown in an undirected fashion, with virtually no effective guidance on the location and scope of practice, and without effective standards for quality of care or public disclosure on practices and pricing, will improve with the development of health insurance. The pitfalls associated with private health insurance can be reduced through appropriate regulation. To the extent that certain per cent of population can be covered through private health insurance, development of health insurance will tend to reduce the need for government financing of secondary and tertiary care. This would help government to develop and maintain smaller and well targeted system of health care financing to serve people who would not have access to private insurance, and to address public health priorities such as immunizations that are quasi-public goods (Srinivasan, 2001).

Before launching any major health initiative, there ought to be a well articulated vision of health care system for the country, and public health policy must be devised to realize that vision. Ideally, certain basic health services, including inpatient care, must be made available to every member of the society. These services must be paid through insurance, which means that every member must have health insurance cover or at least have 'access' to health insurance, with government subsidizing insurance premium, in full or in part, for those who cannot afford it. For the upper-and middle-income people, private

health insurance market with effective and sound regulation can take care of health financing. However, with the development of private insurance market, only half the country's population can at best be reached. The other half, which consists of low income population (30 per cent of the population below the poverty line and add to it another 20 per cent living dangerously close to this line), is likely to remain outside the ambit of private health insurance unless there is an explicit social obligation in this respect which can come only from insurance regulator.

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Chapter 5

Health Insurance Industry in India



- 5.1 Insurance Act 1938
 - 5.2 History of Insurance
 - 5.3 Health Insurance: Origin and History
 - 5.4 Recent Developments
 - 5.5 Insurance as an Instrument to Save on Tax
 - 5.6 Overall State of Health Insurance in the Country
-

The insurance sector in India has come to a full circle from being an open competitive market to nationalization and back to a liberalized market again. Tracing the developments in the Indian insurance sector reveals the 360° turn witnessed over a period of almost two centuries. The end of the year 2000 marks a significant change and growth of insurance industry in India. Monopoly of public sector insurance companies marks an end and private sector companies makes in read. Foreign insurance companies, both life and general, flocked, collaborated and helped astronomical growth of insurance industry in India. Within first 12 months of liberalization of Indian insurance industry, 10 licenses for selling life insurance products and 6 licenses for selling non life insurance products were issued to private sector insurance companies. The public sector giants, LIC and GIC started losing its market share at the cost of stupendous growth of private players. Now Indian insurance industry has 1 public player and 22 private players in the life insurance sector and 4 public players and 15 private players in the non-life insurance sector in addition to 2 specialized insurers and 3 stand alone health insurers (As on 31st August, 2010). Aggressive and penetrative marketing strategy coupled with wide product band width was an instant success among the ignorant masses. Most of the private

companies registered more than 100 per cent growth till then and are still continuing with such monstrous growth figures.

5.1 Insurance Act 1938

The Insurance Act 1938 is the basic law that governs the transaction of insurance business in India. This act has been amended from time to time to bring about required changes in the insurance sector as also to push the government agenda. The latest amendment was made in 2000 which created IRDA and vested powers with it to issue regulations from time to time to regulate the market and to protect the policyholders interest. This amendment opened up the insurance market in India to private players. This meant a more proactive role for the regulator to ensure the overall health of the sector as also to maintain a strict vigil on the conduct of the companies

Insurance Act 1938 had given definition for insurance, insurer, insured and health insurance as follows:

Insurance:- “ insurance is a contract in which the insurer (insurance company) agrees to, for a fee (insurance premium), to pay the insured party, all or portion of any loss suffered by accident or death or any incident.”

Insurer:- “insurer is an insurance company which agrees to pay someone who pays them for insurance for loss suffered, pursuant to the terms of an insurance policy. For this benefit the customer pays the company a fee called premium.”

Insured :- “ insured is the person or entity who will be compensated for loss by an insurer under the terms of a contract called an insurance policy ”.

Health insurance:- or accident insurance is defined as “ insurance against loss or sickness by accidental bodily injury. The loss may be the loss of income caused by any disease or accident or it may be expenses for doctor’s fees, hospital bills, medicines or the expenses of long term care.” This definition includes the forms of insurance that provide lump sum or periodic payments in the event of loss occurred by sickness or accident such as disability income insurance and accidental death and dismemberment insurance.

5.2 History of Insurance

Origin of insurance was in Mediterranean during 13th century. We can have references about insurance in ancient Babylonia, Greece and Rome. Marine insurance was the oldest form of insurance followed by life and fire insurance. In India, factors like globalization, break up of the traditional joint family system, increased competition, government role and policies contributed in changing the status and role played by insurance industry. We can divide the history of insurance industry in India into the following three time periods.

5.2.1 Insurance Business in Pre Nationalization Era:

5.2.1.1 Life insurance:

Life insurance in its present form came to India from U.K. with the establishment of the British firm, Oriental Insurance Company in Calcutta in 1818, followed by Bombay Life Insurance Company in 1823, Madras Equitable Life Insurance Company in 1829 and Oriental Government Security Life

Insurance Company in 1847. Some of the important milestones in the life insurance business in India are:

- 1912** - The Indian life insurance company Act enacted as the first statute to regulate the life insurance business.
- 1928** - The Indian companies Act enacted to enable the government to collect statistical information about life insurance.
- 1938** - Earlier legislation consolidated and amended to by the Insurance Act with the object of protecting the interest of the insuring public.
- 1956** - LIC formed by an Act of parliament viz. LIC Act, 1956, with a capital contribution of Rs.5 crore from the government of India. Till 1956, mushroom growth of insurance companies in India. In spite of it, per capita insurance in India was minimum. Even this limited growth marked by many malpractices shaking public confidence. So nationalization of life insurance by amalgamating all private companies under one corporation, i.e. LIC, in 1956 by merging 154 Indian insurers, 60 non Indian insurers and 75 provident societies.

5.2.1.2 General insurance:

General insurance business in India, on the other hand, can trace its roots to the Triton Insurance Company Ltd., the first general insurance company, established in the year 1850 in Calcutta by the British. Some of the important milestones in the general insurance business in India are:

- 1907** The Indian Mercantile Insurance Ltd. set up, the first Indian company to transact all classes of general insurance business.

1957 General Insurance Council, a wing of the Insurance Association of India, frames a code of conduct for ensuring fair conduct and sound business practices.

1968 The insurance Act amended to regulate investments and set minimum solvency margins and the Tariff Advisory Committee set up.

1972 Growth of industrialization led to increase in the number of companies in general insurance sector and in 1972 there were 107 general insurance companies. But out of these 107 companies, more than 50 per cent were in financially bad shape. So the passing of General Insurance Business (Nationalization) Act, 1972, which nationalized the general insurance business in India with effect from 1st January, 1973. 107 general insurers amalgamated and grouped into 4 companies, viz. The National Insurance Company Ltd., The New India Assurance Company Ltd., The Oriental Insurance Company Ltd. , and The United India Insurance Company Ltd. under General Insurance Corporation of India.

Thus since 1973, insurance sector under complete control of government of India through LIC, GIC and its subsidiaries.

5.2.2 Insurance Business in Post Nationalization Era:

Since nationalization, impressive growth of insurance sector in India due to factors like government monopoly, collapse of joint family system, emergence of nuclear family system, migration of youth to far away places, increased industrialization, more hazardous life, tax benefits, greater life expectancy etc.

In spite of all these, there is dissatisfaction in mid 1990's with regard to insurance business. Total insurance premium as a proportion of GDP amounted to only 1.8 per cent of which life premium accounted for 1.2 per cent and the

non life premium only 0.6 per cent which is negligible compared to other countries of the world. Another parameter is per capita expenditure on insurance premium which is very low in India. Coverage of number of lives is also as low as around 20 per cent in India. Thus there was huge untapped potential which has not been adequately exploited by the state monopoly.

5.2.2.1 Malhotra Committee

In 1990's, the government felt the need for reforming the insurance industry for providing better comprehensive coverage to the Indians and also to increase flow of long term financial resources to finance the growth of infrastructure. Accordingly, the appointment of a committee on reforms in the insurance sector in April 1993, by the government of India, under the chairmanship of shri R.N. Malhotra, former finance secretary and the Governor of RBI.

The committee's main recommendations are:

1. Monopoly power should be done away with.
2. Private sector to be allowed.
3. To set up an Insurance Regulatory and Development Authority.
4. Foreign companies to be permitted on a selective basis (in joint venture with an Indian partner).
5. Raising the capital base of LIC and GIC up to Rs. 200 crore, half retained by the government and the rest sold to the public with due reservation for employees.

The benchmark report of the Malhotra committee resulted in a revolutionary change of insurance sector with a paradigm shift in the perceived

differential value of insurance as a product, from customer's point of view. Malhotra committee, the pillar for liberalization stated that "customization would be one of the key advantages of privatization."

On the recommendations of the Malhotra Committee, the Insurance Regulatory and Development Authority Bill was passed by the parliament in 1993, with a view to activate an insurance regulatory apparatus for proper monitoring and control of the insurance authority.

5.2.2.2 The IRDA Act

On October 21, 1999 the government offered the Insurance Regulatory and Development Authority (IRDA) Bill for the consideration of the parliament. This has upheld the need to establish professional regulation of the insurance sector. The Malhotra committee had made a strong case way back in 1994 for activating professional regulation as a matter of priority. The bill no. 66 of 1999 is an improvement on its predecessor, bill no. 136 of 1996. The new bill is called the Insurance Regulatory and Development Authority while the earlier one was just the Insurance Regulatory Authority (IRA) Bill. It shows a resolve on the part of the central government to rid itself of many functions and powers in favour of a professional IRDA.

A financial institution is more of a trust institution than an 'owned entity'. The assertion of the developmental nature of regulation by insertion of 'development' in the title of the IRDA bill is a welcome measure. The IRDA is an authority for regulating the business of insurance to protect the rightful interests of the holders of insurance policies and to facilitate a healthy growth and development in insurance industry.

The IRDA consists of a chairman, 5 full time members and 4 part time members, all appointed by government of India. It gives a 5 year term each to the chairman and full time members. Clause no. 14 of IRDA bill refers to the duties, powers and functions of IRDA. The sub clause 1 of clause 14 assigns the duty of ensuring the orderly growth of the insurance market.

IRDA Powers and Functions: Subject to the provisions of IRDA Act (1999), IRDA will regulate, promote and ensure orderly growth of the insurance business and re-insurance business, which will include the following main functions:

- Issue to the applicant a certificate of registration, renew, modify, withdraw, suspend or cancel such registration;
- Protection of the interest of the policy holders in matters concerning assigning of policy, nomination by policy holders, insurable interest, settlement of insurance claim, surrender value of policy and others terms and conditions of contracts of insurance;
- Specifying requisite qualifications, code of conduct and practical training for intermediary or insurance intermediaries and agents;
- Promoting and regulating professional organizations connected with the insurance and re-insurance business;
- Levying fees and other charges for carrying out the purposes of the Act;
- Calling for information from, undertaking inspection of, conducting enquiries and investigations including audit of the insurers, intermediaries, insurance intermediaries and other organizations connected with the insurance business;

- Specifying the percentage of life insurance and general insurance business to be undertaken by the insurer in the rural or social sector.

The IRDA specifies a code of conduct for the insurance agents and also allows for a Tariff Advisory Committee to oversee premium rates, insurance plans and to prevent discrimination. However, there is no specific clause for the consumer, who has to use the CPA of 1986 to redress any complaints. The IRDA does not have much to say about the relationship between the insurer and the provider. Though the Tariff Advisory Committee can make recommendations the IRDA also does not have much to say about rating the premium. The IRDA does not also specify the benefit packages. It however allows for the entry of re-insurers in the market. Its main two functions are maintaining market standards, and overseeing solvency and financial regulations.

5.2.2.3 Tariff Advisory Committee

Insurance product pricing is a matter of considerable sensitivity and there are various views as to whether in the long run, hands on regulations of rate would better serve consumer interest or an off-site speed controller's role for the regulator would be a better option. Even now a good number of items are outside the tariff regime of the tariff advisory committee (TAC). The Malhotra committee had discussed the matter of insurance product pricing at a great length. In consideration of the current state of Indian market it did advice against total abolition of the tariff regime, but had suggested that the area under tariff should be progressively reduced to promote competition and to improve underwriting skills.

The committee recommended that TAC should function as a separate body under appropriate supervision of IRDA without actually becoming a part

of it. It had in mind the quasi judicial responsibility of IRDA in regulating the insurance product pricing and in clarifying the nature of its association with TAC. The exact nature of association of IRDA with TAC has not been stated in the bill, but it has been stated that the IRDA would supervise TAC. TAC's functions have a close bearing on the product pricing of the non life insurance sector, item (k), (l) and (m) of the bill make a sketchy one line mention of regulation of investment of funds, maintenance of margin of solvency, adjudication of disputes between insurer and intermediaries.

Thus the main challenge before IRDA is to maintain an equal distance between the private player and the government and to make decisions, which involve a subjective judgment of the social welfare function. The initial focus of IRDA must be financial soundness, healthy competition, protection to domestic market and prior experience of entrants.

5.2.3 Insurance Business in Post Liberalization Era:

As part of the liberalization process, the market for insurance business was thrown open for private players in 2000. As a result many new comers entered in the market for between life and non life business. Insurance industry had 10 & 6 entrants in the life and non life sector respectively in the year 2000-2001. The industry again saw two and three entrants in the life and non life business respectively in the year 2001- 2002. One additional entrant was made both in the life and in non life business in 2004 & 2005 respectively. At present there are 22 companies in the private sector and 1 company in the public sector in life insurance and 4 companies in the public sector and 15 companies in the private sector in non life insurance sector. In addition to it, there are 2 specialized insurance companies and 3 stand alone health insurance companies.

In implementing regulations in 2000 for the registration of insurance companies, IRDA defines health insurance as: the effecting of contracts which provide sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient, on an indemnity, reimbursement, service, prepaid, hospital or other plans, including assured and long term care. There is some debate whether the regulatory definition of health insurance actually enables either life or non life companies to write health insurance policies. However, in practice, both do. Since liberalization, most health insurance policies have been written by non-life insurance companies whereas life-insurers sell health insurance in the form of health riders to their life policies. Of late this line of differentiation has dimmed. This study is meant to cover health insurance policies underwritten by non-life insurance companies.

Another important development in the year 2000 was the restructuring of GIC by de linking it from its subsidiaries and converting them into independent insurance companies and the conversion of GIC into a national re insurer. With the entry of private and foreign players in the insurance business, people have got a lot of options to choose from. Radical changes are taking place in customer profile due to the changing life style and social perception, resulting in erosion of brand loyalty. To survive, the focus of the modern insurers shifted to a customer- centric relationship. But still Indian insurance sector, being in its development stage, offers multiple opportunities both to existing as well as new players.

5.2.3.1 Economic Policy Context and Imperatives of Liberalization of Insurance Sector

There are several imperatives for opening of the insurance and health insurance sector in India for private investment. Here we review some of these

imperatives. Economic policy reforms started during late eighties and speeded up in nineties are the context in which liberalization of insurance sector happened in India. It was very obvious that the liberalization of the real (productive) and financial sector of the economy has to go hand in hand. It is imperative that these sectors are consistent with policies of each other and unless both function efficiently and are in equilibrium, it would be difficult to ensure appropriate economic growth. Given these facts, liberalization of both sectors has to proceed simultaneously. Indian economic system has been developed on paradigm of mixed economy in which public and private enterprises co-exist. The past strategies of development based on socialistic thinking were focusing on the premise of restrictions, regulations and control and less on incentives and market driven forces. This affected the development process in the country in serious way. After the economic liberalization the paradigm changed from central planning, command and control to market driven development. Deregulation, decontrol, privatization, de licensing, globalization became the key strategies to implement the new framework and encourage competition. The social sectors did not remain unaffected by this change. The control of government expenditure, which became a key tool to manage fiscal deficits in early 1990s, affected the social sector spending in major way. The unintended consequences of controlling the fiscal deficits have been reduction in capital expenditure and non-salary component of many social sector programs. This has led to severe resource constraints in the health sector in respect of non-salary expenditure and this has affected the capacity and credibility of the government health care system to deliver good quality care over the years. Given the increasing salaries, lack of effective monitoring and lack of incentives to provide good quality services the providers in the government sector became indifferent to the clients. Clients also did not

demand good quality and better access, as government services were free of cost. Under this situation more and more clients turned to the private sector health providers and thus the private sector healthcare has expanded. Given the socialistic political thinking and populist policy it has been generally difficult for any government to introduce cost recovery in public health sector. Given that government is unable to provide more resources for health care, and institute cost recovery, one of the ways to reduce the under-funding and augment the resources in the health sector was to encourage the development of health insurance.

Another imperative for liberalization of the insurance sector was the need for long-term financial resources on sustainable basis for the development of infrastructure sector such as roads, transports etc. It was realized that during the course of economic liberalization, the funds to develop the infrastructure also became a major constraint. In these investments the benefits are more social than private. The major concern was how these finances can be made available at low costs. In past the development of social sector were financed using government channeled funds through various semi-government financial institutions. Under the liberalized economy this may not be possible. One hope is that if the insurance sector develops rapidly under privatization then it can provide long-term finance to the infrastructure sector. The financial sector, which consists of banks, financial institutions, insurance companies, provident funds schemes, mutual funds were all under government control. There was less competition across these units. As a result these institutions remained significantly less developed in their approach and management. Insurance sector has been most affected by the government controls. Government had significant control on the policies these insurance companies could offer and utilization of the resources mobilized by insurance companies. One can see that

most of the insurance products (e.g., life insurance products) were promoted as mechanisms to improve the savings and tax shelters rather as risk coverage instruments. Other segments of the insurance products grew because of the statutory obligations (e.g., Motor Vehicle, Marine and Fire) under various acts. The management and organization of insurance sector companies remained less developed and they neglected new product development and marketing. Thus one of the hopes in opening of the insurance sector was that the private and foreign companies would rapidly develop the sector and improve coverage of the population with insurance using new products and better management.

Last imperative for opening of the insurance sector was signing the WTO India. After this there was little choice but to open the entire financial sector - including insurance sector to private and foreign investors.

5.3 Health Insurance: Origin and History

Health insurance was initiated in the 20th century. Accident insurance was offered in 1863, but the coverage for expenses associated with sickness did not become popular until after world war I. Earlier medical expenses coverage was made popularized by hospitals. After that insurance companies had taken over the health insurance business and made efforts to popularize their products. Health insurance can be defined in very narrow sense where individual or group purchases in advance health coverage by paying a fee called premium. But it can also be defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditure at time of use of services. The health insurance existing in India covers a very wide spectrum of arrangements and hence the latter, the broader interpretation of health insurance is more appropriate.

Health insurance as it is different from other segments of insurance business is more complex because of serious conflicts arising out of adverse selection, moral hazards, covariate risks and information gap problem. Health insurance is very well established in many countries. But in India it is new concept except for the organized sector employees. There are various types of health insurance coverage in India. Based on ownership, the existing health insurance schemes can be broadly divided into categories such as :

1. Employer based schemes.
2. Insurance offered by NGOs/Community Based Health Insurance (CBHI),
3. Mandatory health insurance schemes or government run schemes like ESIS, CGHS etc.
4. Voluntary health insurance schemes or commercial health insurance.
5. Social health insurance or government sponsored schemes like UHIS, RSBY etc.

5.3.1 Employer Based Schemes

Employers in both the public and private sector offers employer based insurance schemes through their own employer-managed facilities by way of lump sum payments, re imbursement of employees' health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual allowance irrespective of actual expenses, or covering them under the group health insurance policy. The Railways, Defense and Security forces, plantations sector and mining sector provide medical services and /or benefits to its own employees. The population coverage under these schemes is minimal, about 30-50 million people.

5.3.2 Insurance Offered by NGOs/ Community Based Health Insurance (CBHI):

Community based funds refer to schemes where members prepay a set amount each year for specified services. The premiums are usually flat rate (not income related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large no. of high risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effects on the ability of insurance fund to meet the cost of benefits.

CBHIs are typically targeted at poorer populations living in communities. Such schemes are generally run by trust hospitals or non governmental organizations (NGOs). The benefits offered are mainly in terms of preventive care, though ambulatory and in patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for-profit insurers for the purchase of custom designed group insurance policies. However the coverage of such schemes is low, covering about 30-50 millions. (Bhat 1999) A review by Bennet, Cresse et al. (as quoted in Ranson & Acharya 2003) indicates that many CBHIs suffer from poor design and management, fail to include the poorest of the poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes. Some examples of CBHIs are SEWA of Gujarat, ACCORD in Tamil nadu, The Mallur Milk co operative in Karnataka etc.

5.3.3 Mandatory Health Insurance Schemes or Government Run Schemes

Mandatory health insurance is an earmarked fund set up by the government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk. The government run schemes include CGHS and ESIS.

5.3.3.1 Central Government Health Scheme (CGHS):

Established in 1954, the CGHS covers employees and retirees of the Central Government, and certain autonomous, semi autonomous and semi government organizations. It also covers Members of Parliament, governors, accredited journalists and members of the general public in some specified areas. The families of the employees are also covered under the scheme. Total beneficiaries stand at 43 lakh (10.4 lakh card holders, 2003) across 24 cities with membership in Delhi, being the highest. This scheme was designed to replace the cumbersome and expensive system of reimbursements. It aims at providing comprehensive medical care to the central government employees and the benefits offered include medical care at all levels and home visits/care as well as free medicines and diagnostic services. These services are provided through public facilities (including CGHS-exclusive allopathic, ayurvedic, homeopathic and unani dispensaries) with some specialized treatment (with reimbursement ceilings) being permissible at private facilities. The CGHS has been criticized from the point of view of quality and accessibility. Subscribers have complained of high out - of - pocket expenses due to slow reimbursement and incomplete coverage for private health care (as only 80 per cent of cost is reimbursed) if referral is made to private facility when such facilities are not

available with the CGHS. The CGHS is a high-cost enterprise with an inequitable spread of service delivery and no control systems for checking market failures such as moral hazard.

5.3.3.2 Employees State Insurance Scheme (ESIS):

The enactment of the ESI Act in 1948 led to formulation of the ESIS. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. Medical care is also provided to employees and their family members without fee for service. When implemented for the first time in India at two centers namely Delhi and Kanpur simultaneously in February 1952, it covered about 1.2 lakh employees. Presently the number of beneficiaries is over 35 million spread over 620 ESI centers across states. Under the ESIS, there were 125 hospitals, 42 annexes and 1450 dispensaries with over 23000 beds facilities. The scheme is managed and financed by the Employees State Insurance Corporation (a public undertaking) through the state governments, with total expenditure of Rs 3300 million or Rs 400/- per capita insured person.

The Act compulsorily covers: (a) all power using non-seasonal factories employing 10 or more persons; (b) all non-power using factories employing 20 or more employees and (c) service establishments like shops, hotels restaurants, cinema, road transport and news papers are covered. ESIC is a corporate semi government body headed by Union Minister of Labour as Chairman and the Director General as chief executive. Its members are representatives of central and state governments, employers, employees, medical profession and parliament. The financing of the scheme is done by Employees State Insurance

Corporation (ESIC) which is made up of contributions from: (a) employees who contribute at the rate 1.75 per cent of their wages (if daily wage is Rs.25 or less, his contribution is waived); (b) employers who contribute at the rate of 4.75 per cent of total wage bills of their employees to contribution on behalf and for employees having daily wage of Rs. 25 or less; and (c) State Governments contributes 12.5 per cent of total shareable expenditure worked out by prescribed ceiling on expenditure which is Rs. 600 per insured person per annum and expenditure incurred outside/over and above the prescribed limit.

The State Governments run the medical services of this scheme of social insurance meant for employees covered under the ESI Act 1948. This scheme - compulsory and contributory in nature - provide uniform package of medical and cash benefits to insured persons is implemented through special ESI hospitals and diagnostic centers, dispensaries and panel doctors. The delivery of medical care is through service (direct) system and/or panel (indirect) system. It provides allopathic medical care, but medical care by other systems like ayurvedic and homeopathy in the states is also provided as per the state government decision. The medical care consists of preventive, promotive, curative and rehabilitative types of services are provided by the scheme through its own network or through arrangements with reputed government or private institutions by concept of proper referral system and regionalization.

The ESI program has attracted considerable criticism. A report based on patient surveys conducted in Gujarat, (Shariff, 1994 as quoted in Ellis et al. 2000) found that over half of those covered did not seek care from ESIS facilities. Unsatisfactory nature of ESIS services, low quality drugs, long waiting periods, misbehavior of personnel, lack of interest or low interest on

part of employees and low awareness of ESIS procedures were some of the reasons cited.

5.3.4 Voluntary or Commercial Health Insurance Schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group employees) and the level of profits provided, rather than as a proportion of the consumers income. There are 4 public sector general insurance companies, which provide voluntary health insurance schemes. Since the liberalization of insurance sector in 2000, 15 private sector general insurance companies and 3 Stand alone Health insurance companies are also providing voluntary health insurance schemes. Of the various schemes offered, mediclaim is the main health insurance product of these companies.

Given its relative infancy, private health insurance has certainly progressed over the past 20 years, although there is much to do if it is to cover the current and future needs of a large number of individuals and families. Health insurance (21 per cent) ranks next to Motor (42 per cent) insurance segment, ahead of Fire (17 per cent), Marine (7 per cent), and Engineering (7 per cent) sectors in the overall general insurance portfolio. Insurance as the cliché says, is usually sold and not bought. But the motor and health insurances, constituting over 55 per cent of the total market, are bought by consumers, due to their self perceptions of risk hazards. Insurers have had little to do any selling but meet the demands made on them.

Health insurance has been predominantly within the non-life sector as a part of the miscellaneous accident portfolio. However, in the last couple of years, health insurance has emerged as one of the most promising growth segment with increase in not only number and variety of products but also in the number of insurance companies venturing into the health insurance market. The Indian industry already has three standalone health insurers who have been granted certificate of registration by IRDA, with the latest entrant being Max Bupa Health Insurance Co. Ltd. The health insurance industry, which had underwritten premium of over 8,000 crore in 2009-10 (6,625 crore in 2008-09) is expected to expand manifold because this sector is increasingly becoming an important line of business not only for standalone health insurers but also the existing players in the non-life industry. The health segment contributed 21.12 per cent of the total premium in 2009-10 (20.06 per cent in 2008-09) (www.irda.org).

To discover where it can or should develop, it is important to consider where it stands today. In what areas should the industry improve its capability, including the details of its offerings, its operations and its administration. Specifically, this means looking at what products are on the market, how and to whom they are marketed, how the industry relates to its customers and to the delivery system and its administrative capabilities. Virtually all health insurance products in the Indian insurance market are designed to meet the hospitalization expenses of the policyholder. This has not changed significantly since the introduction of health insurance in 1986. Health insurance policies do not cover dental services, vision services, preventive care, home health services or long-term care and, rarely, out-patient services. In many cases policies exclude certain kinds of care, even if a hospitalization occurs. In addition to basic hospitalization, the health insurance market has witnessed the introduction of

hospital cash (cash payments to the individual if they are hospitalized) and critical illness products, which cover a list of designated diseases. Additionally, some newly developed surgical procedures which do not require hospitalization, such as lithotripsy and laparoscopy, are now accepted by insurers for reimbursements under the hospitalization policies.

5.3.4.1 Hospitalization Policies

These policies are offered only by non-life insurers and are based on a product called Mediclaim, which reimburses for hospitalization expenses. This policy, first offered by Government-owned non-life insurance companies, has been marketed since 1986. Privately owned companies have also adopted it. Since its inception it has undergone changes in both premium charges and benefits design and has remained focused on coverage for hospitalization. In its present form, Mediclaim covers expenses incurred by a policyholder during hospitalization and/or domiciliary hospitalization due to illness, diseases or injury. After the introduction of Third Party Administrators (TPAs) in 2002, the policy was changed to a “cashless hospitalization benefit” with payments made directly to providers. Prior to the coming of TPA’s it was the responsibility of patients claiming reimbursement to submit bills directly to their insurer for payment. Cashless hospitalization allowed the TPA to prospectively guarantee payment to the hospital and thus remove the burden of filing claims from the patient.

Mediclaim Policy – Scope and Coverage: Mediclaim Policy, offered by the government-owned non-life insurance companies, has been marketed since 1986. It is a hospitalization expenses reimbursement policy. Since its inception, it has undergone both premium rate and benefit design changes. In its present form, it covers expenses incurred by a policyholder during hospitalization

and/or domiciliary hospitalization due to illness, diseases or injury.

Hospitalization expenses covered include:

- Room and boarding expenses incurred at a hospital/nursing home
- Nursing expenses
- Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees
- Anesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-Ray
- Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial limbs and Cost of Organs and similar expenses

Hospitalization benefit also allows relevant medical expenses incurred during period up to 30 days prior to hospitalization and 60 days post hospitalization.

Exclusions include:

- Pre-existing condition/disease
- Any disease/illness contracted within first 30 days of the commencement of the policy
- During first year the expenses on treatment for certain diseases
- Preventive treatment, e.g. vaccination
- Plastic surgery, cost of spectacles, contact lenses, hearing aids
- Dental treatment
- AIDS
- Maternity
- Naturopathy

Mediclaim is available to persons between the age of 5 years and 80 years (maximum age of coverage can be increased to 85 years if the policy has been continuing without any break). Children between the age of 3 months and 5 years of age can be covered provided one of the parents is covered simultaneously. The sum insured/benefit limit varies from Rs 15,000 to Rs 500,000, while the premium is calculated from a matrix of sum insured and age of the person. Mediclaim requires new enrollees above 45 years of age to undergo a pre-acceptance medical check-up. It excludes expenses on hospitalization for certain diseases during the first year. Additionally, it has stringent and often indeterminate pre-existing condition/disease exclusions. Policy also provides for Family Discount, Cumulative Bonus and Cost of Health Check-up. To encourage health insurance, the Government has allowed Income Tax benefit up to Rs 10,000 paid as premium. However, for senior citizens, the Income Tax benefit is higher at Rs 15,000 paid as premium. The policy now offers cashless hospitalization benefit after the introduction of Third Party Administrators (TPAs) in 2002.

5.3.4.2 Critical Illness Policies

Critical illness (CI) policies were the second type of product offered in India. Originally, these policies were sold exclusively by life insurance companies as riders to their basic products. Recently, non-life companies have started marketing them as a separate product. They are not as popular as the Mediclaim products and cover only specified illnesses of a potentially catastrophic nature, such as heart attacks, cancer, brain tumors, etc. These policies do not cover all catastrophic care but only those illnesses defined by each insurance company. The variation in coverage is likely to lead to confusion among policyholders but the industry has shown little interest in

adopting standard definitions so that policyholder confidence and interests are not compromised. These policies are generally a poor substitute for the more comprehensive Mediclaim health insurance policy since they do not cover hospitalization expenses due to accidents, infectious diseases or acute illnesses and are felt by some to be a marketing gimmick for selling to uninformed, unsophisticated semi-urban or rural policyholders. In many countries these policies would not be considered particularly effective health insurance since they do not pay for medical services but merely pay a set amount of money if policy holders can document that they have a particular disease. It is reported that critical illness coverage has met with a cautious response from policy holders, though some life insurers claim that almost 65 per cent of their policyholders have opted for critical illness riders.

5.3.5 Social Health Insurance or Government Sponsored Schemes like UHIS, RSBY Etc.

5.3.5.1 Universal Health Insurance Scheme (UHIS):

This scheme launched in July, 2003, is subsidized by the central government and is being operated through four public sector general insurance companies. It was redesigned in July, 2004, restricting it to BPL families only and again modified in September 2008. The modified policy covers preexisting diseases also. The scheme is designed for three sizes of households: the premium charged is,

1. Re. 1 per day per year for an individual
2. Rs. 1.5 per day per year for a family of up to five members, and
3. Rs. 2 per day per year for a family of up to seven members.

All these three categories – individual, family of five, and family of seven – belonging to BPL population has a subsidy of Rs.200, Rs.300 and Rs.400 respectively. It provides for reimbursement of hospital expenses up to Rs.30000 per individual/family. If an earning member falls sick, the scheme also provides for the loss of livelihood at the rate of Rs.50 per day up to a maximum of 15 days, and in case of death of the earning head of the family due to personal accident, Rs.25000 is given to the nominee.

The performance in terms of coverage under UHIS is not satisfactory. But, unlike many health insurance schemes, the claims ratio in UHIS is very low as it was only below 50 percent in all the years since its inception. This low claims ratio throws up several issues, such as the reach of the scheme to the intended BPL population, mode of settlement, health services offered, utilization of public health facilities etc.

5.3.5.2 Rashtriya Swasthya Bhima Yojana (RSBY):

Learning from the experiences of UHIS and other major government and non-government health insurance schemes in India, it was decided to launch a health insurance scheme which later came to be known as Rashtriya Swasthya Bima Yojana (RSBY), for BPL workers, as defined by the planning commission, and their families in the unorganized sector. The annual insurance cover is for a maximum amount of Rs. 30000 for a family of five, including the worker, spouse, children and dependent parents, and the annual insurance premium not exceeding Rs. 750 is to be decided through tender process. Under the scheme, the Union government will meet 75 per cent of the premium (not exceeding Rs.565), and also the cost of a smartcard for each family, estimated at Rs. 60 for card. The beneficiaries have to pay an annual registration charge of Rs. 30 per family (which is part of the insurance premium to be paid to the

insurance provider), and the state government is to pay the rest of the premium, together with the administrative cost. The scheme as originally envisaged was to cover the entire country in stages by the end of 2012-13. The scheme was implemented in all the 14 districts of Kerala as RSBY-CHIS in 2009 itself. The details of the scheme are discussed in chapter 6.

5.4 Recent Developments

5.4.1 Third Party Administrators (TPAs):

TPA was introduced through the notification on TPA- Health Services Regulations, 2001 by the IRDA. Their basic role is to function as an intermediary between the insurer and the insured and facilitate the cash less service of insurance. For this service they are paid a fixed percent of premium as commission. This commission is currently fixed at 5.6 per cent of premium amount. With the entry of TPAs, the insurance industry is taking a new turn towards 'Managed Care'. The TPAs are required to be registered under the Companies Act, 1956, and licensed by the IRDA, and be contracted by one or several insurance companies 'for the provision of health services'. The original role of a TPA was to provide the back-office administrative set-up to insurance companies— issuing ID cards to subscribers, processing claims, making payments, etc. This system, often referred to as 'cashless payment', has resulted in relieving the patients of the psychological stress of having to mobilize resources at short notice. By scrutinizing provider claims, TPAs also help in safeguarding the interests of the insuring company of any fraudulent claims by the providers.

Intermediation by TPAs ensure that policy holders get hassle free services, insurance companies pay for efficient and cost efficient services and health care

providers get their reimbursement on time. By doing this it is expected that TPAs would develop appropriate systems and management structures aiming at controlling costs, developing protocols to minimize unnecessary treatments/investigations, improve quality of services and ultimately lead to lower insurance premium. With the introduction of TPA, insurers outsource their administrative activities to TPAs. Their activities include issuing identity cards to policy holders, 24 hour help line for customer services, informing the customers regarding empanelled hospitals, arranging for specialized consultations and claim processing during admission of the policy holders.

5.4.1.1 Background:

The development of the TPA industry, how it came into being and its relationship to the insurance industry in India, is important to understanding its present role, its successes and failures and the directions the industry is taking today. The establishment of TPAs begins with the development of Mediclaim, which was introduced in 1986 by the public insurance companies and prompted by demand from employer groups which purchased traditional non-life insurance from these insurers. By the mid 1980's most employers had made some financial commitment towards reimbursing expenses for healthcare for their employees. Over time, these expenses increased and employer groups began to put pressure on the non-life insurers to issue a health insurance program that they could purchase to cover employee medical expenses. Mediclaim, as it was launched, was a simple hospital indemnity program that had a set of clearly defined benefits with caps on items such as room rent, surgeon's fees, nursing charges, etc. Since Mediclaim was an indemnity policy, consumers could select a hospital, pay a deposit to gain admission, and gain treatment from their physician at the hospital, including any surgical

intervention. Once treatment was provided and the patient was discharged, the consumer would have to submit a claim form to the insurance company, with a discharge summary and all medical bills together with supporting documentation for diagnostics, prescription for drugs, etc. The insurance company would review the submitted claim and issue a reimbursement as per the limits and sub-limits to the Mediclaim policy. By 1995 two million members had enrolled in the Mediclaim program sold by all four public sector insurers. In 1996, the Finance Minister, in his budget speech, announced that since the Mediclaim policy was a reasonable method of creating a large risk pool but benefits under the policy were not commensurate with current healthcare costs, he was urging the public sector insurance companies to remove the sub-limits under the plan and increase the annual maximum to as much as Rs 300,000 per annum. In response, the public sector insurance companies re-launched Mediclaim without any sub-limits or member risk-sharing and increased the annual maximum to Rs. 300,000. The result was an increase in enrolments and in the number of claims. At this point, a few organizations recognized that there was a gap in the offering for medical insurance in India and that some areas of the Mediclaim policy needed to be improved, for example,

- Having to pay a deposit upon admission to the hospital.
- Paying the entire hospitalization expense, then having to submit a claim to obtain reimbursement and then waiting for the insurer to process and reimburse the claim.
- Lack of knowledge as to how much of the overall expenses would be reimbursed by the insurance plan, even if the claim would be admissible.

- No easy customer service mechanism to gain clarity on policy details or questions on reimbursement and shortfalls.

A few organizations saw these problems with Mediclaim as a business opportunity and in 1996, with a view to providing employers with advice on health benefits and related administrative services, established businesses to facilitate access to the health care system for their clients' employees and dependents. Each covered member was issued a photo-ID card at enrolment that would allow them access to select hospitals without having to pay a large deposit. The company also offered direct settlement with hospitals, so patients did not have to pay their hospital bill at the time of discharge from the hospital. By 1997 many large multinationals were offering their employees access to these services. Initially, most of the business came from self-funded organizations but by late 1997 and early 1998 employers who purchased group Mediclaim insurance as the primary financial mechanism began using this service. This required "Medical service support organizations" to offer their services as an overlay to the insurance plan and to liaise with the insurance company for claims settlement on the employers' behalf, leading to the creation of TPAs in India. Several of these early organizations, including Sedgwick Parekh Health Management, Paramount Healthcare, and Medicare Services, remain important actors in the business today.

5.4.1.2 Regulations:

IRDA set up a working committee in 2000 to suggest regulations for this new type of intermediary dealing with the administration of health insurance. The committee was made up of representatives of the existing TPAs, several public and private sector insurance companies (non-life) and members of the IRDA. The committee deliberated on a white paper that was circulated by

IRDA and the result of these deliberations, over a period of one year, was a set of regulations notified as The IRDA (Third Party Administrators – Health Services) Regulations, 2001 on September 17, 2001. The regulations stipulated the eligibility, scope of services, capital requirements, and solvency margins, operating guidelines and code of conduct for TPAs. The regulations also maintained that TPAs were indeed intermediaries as per the scope of the IRDA Act, 1999, and therefore were fully under the jurisdiction of the IRDA.

5.4.1.3 Leadership and Management:

TPA regulations identify two positions that must be present in an approved organization: a Chief Executive/Administrative Officer who has to have taken a course in TPA management through the Administrative Staff College of India (endorsed by the IRDA), and another director who has a recognized medical degree (MBBS). Most TPAs have a lean management structure and are led by strong individuals who are of an entrepreneurial bent. Some of the larger ones are now building formal management structures with a CEO, COO, and Medical Director.

5.4.1.4 Call Center Services:

TPAs are required by regulation to provide 24x7 toll-free call-center services to their members for enabling admission to network hospitals and resolving general queries. Initially, most TPAs had set up a rudimentary system of answering a toll-free line at a single site even though they were providing multi-site service across the country. The call-centers were not manned with an adequate number of agents nor were enough telephone lines requisitioned to take up the initial onslaught of calls. As a result, phones went unanswered, leading to significant dissatisfaction among consumers and a lot of frustration for insurers. At the time of set up, TPAs were unable to gauge either required

call-center capacity or cost. Once the calls started coming in, the TPAs realized that the costs and needed capacity were going to be significant. They often chose to leave telephone lines unanswered thereby avoiding the cost of the call. The quality of call-center services, the lifeline of the cashless hospital admission process, were therefore another area of concern for the development of the TPA model in India.

5.4.1.5 Provider Networks:

A fundamental selling point for using TPA services is their promise of access to a provider network of hospitals where the primary negotiated benefits to the consumer would be cashless admission and direct settlement of the hospital bill by the TPA. As described above, this benefit has often proved illusory. In late 2002, the TPAs selected by the public sector insurance companies scrambled to contract with hospitals across the country. The four TPAs that had already been offering services prior to government regulation simply expanded their existing networks to ensure that all regions were covered. Most early TPA contracts with providers were simple agreements to provide deposit waivers for patients at admission and direct settlement of bills with the TPA. Some TPAs, which had been in the business earlier, used the opportunity to build more value into their contracts by negotiating discounts on a subset of services such as diagnostics, room and board and surgeon's fees. In most cases, these discounts brought in a reasonable amount of cost reduction as the discounts were based on published "rack" rates. In some cases, particularly with smaller hospitals, discounts were simply applied to an exaggerated fee rate. This was possible as these hospitals did not publish rates for services provided and could change them at a whim.

In many cases, hospitals were careless and would submit bills for similar episodes of care but with different rates for the same services provided. A vigilant TPA would then be able to confront the hospital and rectify the problem. Hospitals which were initially wary of TPAs became much more cooperative after the public sector insurance companies engaged TPAs to work with their members. The large corporate hospitals, in particular, assumed that TPAs would form a key source of revenue for them in the coming years. The selection of network providers is very problematic. Most TPAs use unsophisticated selection criteria and the lack of a national accreditation system hampers their ability to make any judgments on the quality of care. Often, hospitals are selected based on demand from customers so TPAs end up contracting with providers who may not have demonstrated either their charges/costs or their quality of care.

Contracting has evolved marginally since 2002 with the advent of efforts to “band” providers in categories and fix schedules of charges for each band by TPAs and providers alike. However, providers continue to arbitrarily modify their charges. Another burgeoning issue is a growing dichotomy in pricing for insured and uninsured patients, with insured patients bearing the brunt of inflated pricing as compared to their uninsured counterparts. The ability to arbitrarily charge uncontrolled fees for services remains a major lacuna in the health insurance system that has not been solved by the insurers, the TPAs or the government. Recently, TPAs report that hospitals have begun recognizing that TPAs are responsible for generating a reasonable share of their revenue, with smaller hospitals experiencing about 20 percent of hospital revenues coming through TPAs.

By 2006 the TPA system had settled into a kind of equilibrium. The larger TPAs have ironed out most of their teething problems and also overcome some of their initial operational capacity and delivery issues. Some of these larger TPAs have also begun to enjoy improved customer satisfaction rates which initially were very poor. However, issues such as a lack of consumer education on the processes of the TPA system, unclear expectations of the insurers from TPAs and the inherent mistrust that continues to exist between insurers and their selected TPAs creates a tenuous situation for most TPAs with their end customer, the consumer. In addition, TPAs have had to focus on increasing medical costs. The advent of the TPA system and the direct settlement arrangements between TPAs and hospitals has also led to uncontrolled price increases by hospitals. It is commonly known that hospitals maintain differential pricing for insured and uninsured patients, with insured patients having to pay from 25-50 percent higher charges and some even higher. As a result, the general focus on operational glitches has shifted to the alarmingly high claims costs paid by insurers. In late 2005, Bajaj Allianz General Insurance Company chose to bring the administration and management of its health insurance plans in-house, creating an internal health administration team that would perform the functions of a TPA from within. This continues to be the only non-life multi-line insurance company that insists on handling the TPA functions internally. Late 2006 saw the launch of the first “standalone” health insurance company, Star Allied and Health Insurance Company, which has also established its own administration team rather than using the service of TPAs.

The lack of deep relationships and clear dialogue between TPAs and hospitals has often led to contentious situations between the two, leading to further operational glitches, inaccurate billing and in many cases, outright fraud

and abuse. There have been recurring feuds and contentious discussion between various TPAs and hospitals, but what has recently been acknowledged by many private “corporate” hospitals is that the number of their patients that are insured and serviced by TPAs has increased to as much as 30 percent over the last three years. As per the IRDA estimates, the inpatient volume being administered by TPAs at hospitals across the country is 15 percent.

From a consumers’ standpoint, the services offered by TPAs are now well established. The number of complaints and the overall satisfaction rate has begun to increase. The level of trust between consumer and TPA, however, remains tenuous due to the perceived inconsistency in paying claims, once again reflecting a lack of consumer education and awareness of the insurance plan benefits and operational processes of the TPAs. The financial viability of TPAs based on the current insurance premium rating and the low fee rate that TPAs feel insurers are paying them, remains a question. It has been stated by a few TPAs that the 5.2–5.4 percent rates on the existing average premium of Rs 1,200 per member per annum is unsustainable and does not even cover their variable costs. There has been some speculation that TPAs have had to counter this by finding different revenue streams, including charging hospitals on their network a fee for each hospitalization), thereby impacting healthcare cost inflation and insurance premiums adversely.

However the system is currently going through troubles. Cashless policies where the insurer directly pays the hospital bills to the health care providers, have not yet fully materialized (Kalyani, 2004). At present, there are 27 TPA- Health Services registered with the IRDA. They, in their current form in India, are suffering from weak hospital networking, delay in issuing identity cards to policy holders, and poor standardization of billing procedures for

hospitals (Viswanathan and Narayanan 2003). The industry is feared to be suffering from an informal nexus among corporate houses, corporate hospitals, TPAs and insurance companies, in ensuring high claim ratio on corporate insurance and low on individual insurance (Gupta et. al., 2004).

At present, there are 27 TPAs working in Indian health insurance sector which is listed below.

Table 5.1 List of TPAs

Serial No.	Name of TPA
1	Park Mediclaim
2	Vipul Med Corp
3	Alankit Health Care
4	I Care Health Management & Services
5	Dedicated Healthcare Services
6	Medicare Services
7	MD India Healthcare Services
8	Heritage Health
9	Genins India
10	Rothshield Healthcare Services
11	E Meditek Services
12	Parekh Health Management
13	Safeway Services
14	Med Save Health Care
15	Good Healthplan
16	Health India Services
17	Medi Assist India
18	Anmol Medicare
19	Raksha
20	Family Health Plan
21	TTK Healthcare
22	Grand Healthcare Services
23	Paramount Health Services
24	Anyuta Medinet Healthcare
25	East West Assist
26	Focus Healthcare
27	Sri Gokulam Health Services

Source: IRDA Annual Report 2009-10

5.4.2 Bancassurance

‘Banc assurance’, a French term simply denotes banking channels selling insurance products. Government of India had issued a notification specifying insurance as a permissible form of business that could be undertaken by banks under Banking Regulations Act 1949. In addition, notification of IRDA on corporate agency regulation in October 2002, which allowed banks to act as agents of only one life and one non life insurer, paved the way for extensive adoption of banc assurance in India. After the IRDA notification of 2002, a large no. of public and private insurance companies have tied up with the private and public sector banks for selling insurance products. Already 27 public and private sector insurance companies have started the banc assurance activity.

Banc assurance helps insurance companies in more ways than one. They can leverage banks existing data base of customers to enhance the list of potential targets. They also finds banc assurance profitable due to low customer acquisition cost, quicker reach to untapped markets, introduction of new hybrid products and economies of scale in administration. With 75 per cent of the global population still to be insured, the traditional insurance channel through agents is proving increasingly inadequate and costly. It is also observed that the agents concentrate on high value policies and big customers. Middle level customers get little attention of the agents. Thus, by tying up with the banks, the insurance companies can tap much of the underserved market. But the major challenge for banc assurance lies in changing the mindset of bank employees and improving the quality of distribution through bank branches and leveraging it effectively to increase penetration.

Banc assurance is likely to generate approximately 40 per cent of private insurer's premium by 2010, and 50 per cent by 2012, according to a survey conducted by insurance consulting firm Watson Wyatt Worldwide. Swiss Re, the world's largest re insurer, states that two factors could restrict growth of banc assurance. Regulations governing cross share holding between banks and insurers are generally less liberal in emerging markets, which complicates adoption of more integrated business models. In addition, many banks are taking an opportunistic approach and they may charge high and unreasonable commission.

5.5 Insurance as an Instrument to Save on Tax

Insurance schemes are effective ways of saving on tax. Various tax exemptions given under the Indian Income Tax Act 1962 are :

Life insurance plans are eligible for deduction under section 80 C.

Pension plans are eligible for deduction under section 80 CCC.

Health insurance schemes are eligible for deduction under section 80 D.

Section 80 D for medical insurance: Individual assessee and hindu undivided family assessee are allowed deduction under this section. Premiums up to Rs. 15000/- paid by assessee by cheque out of his taxable income to effect or keep in force a health insurance for the medical expenditure, of himself, his spouse, and dependent children are exempted. In addition to the above mentioned Rs.15000/-, deduction is also available for the payment of health insurance premium for the medical expenditure of the individual assessee's parents to the effect of another Rs.15000/-. If any one of the parents is Indian citizen, then the deduction is available to the effect of Rs.20000/-. In the case of any one parent who is a senior citizen, then also deduction of Rs.20000/- is available. But if the

parents are non resident Indians, even if they are senior citizens, this deduction of Rs.20000/- is not available, only for Rs.15000/- is available.

From 2012-13 onwards, deduction of Rs.5000/- is available for health check-up of the individual assessee, his spouse, dependent children and his parents. But this deduction is available together with other deductions under section 80 D. It means that deduction is not available for health check-up alone. In short, under section 80 D a total of Rs. 35000/- is available for health insurance premium payment subject to certain conditions.

5.6 Overall State of Health Insurance in the Country

The table 5.2 reveals the present state of health insurance as a financing tool in the country.

Table 5.2 State of Health Insurance in India

Total Population (December 2007)	1.2 billion
Private medical insurance (Mediclaime)	(-) 17,000,000
Employees State Insurance Scheme	(-) 38,000,000
Central Govt Health Scheme (CGHS)	(-) 40,000,000
Indian Railways	(-) 7,000,000
Public Sector Enterprises	(-) 55,000,000
Community insurance	(-) 50,000,000
Uninsured	986 million

Source: Rise Of Health Insurance In India: 'What's Driving Your Revolution' By Deepak and Mendiratta, Healthcare Conference 2007, International Finance Corporation, Washington Dc

In short, health insurance, whether social and private, whether formal or informal, is extremely limited in India. Existing health insurance schemes in India are mandatory schemes, private (voluntary) schemes, employer based insurance, and the schemes in the NGO/voluntary sector. All these schemes put

together cover about 200 million people or about 20 percent of the population. This number falls far short of the private health insurance potential that is estimated anywhere between 400 and 500 million people. Although a number of private insurance companies have entered after the liberalization of the insurance market in 2000, no significant change in health insurance has been observed either in terms of new health insurance products or in terms of the volume of business.

.....*SVR*.....

Rashtriya Swasthya Bhima Yojana-Comprehensive Health Insurance Scheme (RSBY-CHIS) in Kerala



6.1 Rashtriya Swasthya Bhima Yojana (RSBY)

6.2 Implementation of RSBY-CHIS in the State of Kerala

6.3 CHIS PLUS

6.1 Rashtriya Swasthya Bhima Yojana (RSBY)

The workers in the unorganized sector constitute about 93 per cent of the total work force in India. One of the major insecurities for workers in the unorganized sector is the frequent incidences of illness and need for medical care and hospitalization of such workers and their family members. Despite the expansion in the health facilities, illness remains one of the most prevalent causes of human deprivation in India. It has been clearly recognized that health insurance is one way of providing protection to poor households against the risk of health spending leading to poverty. However, most efforts to provide health insurance in the past have faced difficulties in both design and implementation. The poor are unable or unwilling to take up health insurance because of its cost, or lack of perceived benefits. Organizing and administering health insurance, especially in rural areas, is also difficult.

To provide the insurance cover to Below Poverty Line (BPL), Central Government announced a Scheme named as Rashtriya Swasthaya Bima Yojna (RSBY). It is a health insurance scheme for the Below Poverty Line (BPL) families in the unorganized sector. It was formally launched on October 2, 2007.

6.1.1 Objectives

The objectives of RSBY are:

1. To provide financial security to BPL from hospitalization related expenses,
2. To improve access to quality health care,
3. To provide beneficiaries the power of choice to select a health care provider, and
4. To provide a scheme which is simple to use for the end user and transparent.

6.1.2 Features of the scheme

- a. Coverage and Benefits:** RSBY provides hospitalization coverage for up to Rs. 30,000 (approximately \$650) for a family of five on a floater basis. Transportation charges are also covered up to a maximum of Rs. 1,000 (approximately \$22) with a limit of Rs. 100/- (approximately \$2.2) per hospitalization. Pre and post hospitalization expenses up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital are also provided. All pre-existing diseases are covered from day one. No Age Limit on the enrollment of beneficiaries.
- b. Target Population:** RSBY aims to cover all the BPL families, estimated to be approximately 300 million, by 2012.
- c. Geographical Coverage:** All the States and the Union Territories are to be covered.
- d. Service delivery System:** A network of health care providers is created across India through empanelment based on defined criteria. Providers

are empanelled by the state selected insurance company based on prescribed criteria. A health care provider empanelled by any of the insurers in RSBY gets automatically empanelled by all the other insurers. For empanelment, hospitals have to agree to install necessary hardware and software to be able to process beneficiaries' Smart Card transactions. They have also set to up a dedicated RSBY desk with trained staff. Once a hospital is empanelled, a nationally-unique hospital ID number is generated so that transactions can be tracked at each hospital. Each empanelled hospital is connected with the district server of the insurance company. This facilitates transfer of data related to hospitalization on a daily basis.

6.1.3 Funding of RSBY

The funding for premium of the scheme comes jointly from central and state governments as per the following formula:

- a. 75 per cent (90 per cent in case of Jammu & Kashmir and North-eastern States) of Premium from Central Government
- b. 25 per cent (10 per cent in case of Jammu & Kashmir and North-Eastern States) of Premium from State Government
- c. Beneficiaries pay a small amount of Rs. 30 as registration fee which is aggregated at the State level and is used to take care of the administrative cost.

The insurance premium is determined at the state-level based on an open tender process. Registered insurers compete in competitive bidding.

6.1.4 Process Flow

RSBY involves a set of complex but well defined processes. The process flow for RSBY is as follows:

- a. Once the decision to implement RSBY is taken by a state Government an independent body “State Nodal Agency” is set-up.
- b. State Nodal agency collects/ prepares BPL data in the specified RSBY format.
- c. Once the BPL data is prepared, Insurance Company is selected through an open bidding process.
- d. Annually, an electronic list of eligible BPL households is provided to insurers by the state. An enrollment schedule for each village, along with dates, is prepared by the insurance company with the help of district officials. Insurance Company is provided a maximum of four months to enroll BPL families in each district.
- e. Insurance Companies are required to hire intermediaries to reach out to the beneficiaries before the enrollment. In addition, the BPL list is posted in each village at the enrollment station and prominent places prior to the enrollment camp. The date/location of the enrollment camp are also publicized in advance.
- f. Mobile enrollment stations are established at local centers (e.g., public schools) at each village at least once a year. These stations are equipped by the insurer with the hardware to collect biometric information (fingerprints) and photographs of the members of the household covered and a printer to print smart cards w/photo. The smart card, along with an information packet describing benefits, hospitals in network, etc. is

provided to all enrollees once they have paid the Rs. 30/- registration fees. The process normally takes less than 10 minutes.

- g. A Government official from the district (field key officer—FKO) needs to be present at the camp and must insert his/her own government-issued smart card and provide his/ her fingerprint to verify the legitimacy of the enrollment. This way each enrollee can be tracked to a particular official. In addition to the FKO, an insurance company/smart card agency representative is present at the enrollment camp.
- h. At the end of the enrollment camp, a list of enrolled households is sent to the state nodal agency by the Insurer. The list of enrolled households is maintained centrally.
- i. Before commencement of the enrollment process, insurance company empanels both public and private hospitals. Each empanelled household is provided with a smart card which also contains a national unique ID.
- j. A beneficiary, after receiving the smart card and after the commencement of the insurance policy, can visit any empanelled hospitals across the country to get the treatment.

6.1.5 Technology

The use of technology in RSBY is one of the highlights of the scheme. It is perhaps one of the few schemes in the developing world where technology has been leveraged for delivering social sector benefits. RSBY uses following technologies:

- a. Smart Card Technology – A Smart Card is given to each BPL family at the time of enrollment in the scheme. The Smart Card is prepared and printed on-the-spot in the village by the insurer and handed over to the

- beneficiary. This Card can be used by the beneficiary in any empanelled hospital across India to obtain treatment.
- b. Biometric Technology – Fingerprints of all beneficiaries are collected during enrollment at the village level. One thumb impression of each of the household beneficiaries is stored in the Smart Card. This fingerprint is used to verify the identity of the beneficiaries at the hospital.
 - c. Key Management System – Another unique feature of the scheme is its key management system which helps in reducing fraud and improves accountability. A government officer called a Field Key Officer (FKO) needs to be present at the enrollment station and his/ her role is to verify each beneficiary family using his/ her own Smart Card and fingerprints. This ensures that only the correct beneficiary is issued the card by the Insurer.
 - d. Online data transfer – RSBY has been able to position itself as a paperless scheme with the help of technology. Claims are submitted online by the hospitals and similarly insurer can make online payment to the hospitals. In addition to this, a robust backend data management system is being developed for RSBY which will ensure smooth flow of data from across India to both the state and central governments in real time. The aim of the scheme is to use technology not only for controlling fraud and monitoring utilization, but also to find innovative solutions. For example, enrollment software has been designed to ensure that the male of the household necessarily insures his wife.

6.1.6 Stakeholders and their Roles

There are six primary stakeholders in the scheme: The Central Government, State Government, State Nodal Agency, Insurance Company, Hospitals and NGOs. The roles of each of these stakeholders are clearly defined in the scheme. Different Stakeholders will have following role in the implementation of the continuous quality management system:

MoLE

1. Review and finalize the criteria for grading the quality levels in network hospitals
2. Review and finalize the reference manuals for the hospitals and assessors
3. Prepare / formulate the scheme for empanelment of (independent) assessors, including training curricula, identification of the institutions for imparting the training.
4. Review the feedback on the progress of implementation and modify the relevant parts of the scheme based on the feedback
5. The HC would also identify suitable national and state level training partners for assessor training.
6. Provide technical support to the State Nodal agency/s and RSBY Network hospital/s for this initiative.

State Nodal Agency

1. Identify districts with sufficient number of Public and Private Hospitals.
2. Undertake re-assessment of the empanelled Hospitals to ensure conformance to at least the revised empanelment criteria

3. Facilitate and coordinate training of assessors and other stake holders.
4. Provide technical support to the Hospitals.

Insurance Company

1. Study the profile of selected districts.
2. Identifying eligible hospitals in the public and private sectors inside and outside the states.
3. Arrangement with health service providers:
 - Finalising medical procedures and the cost of each procedure.
 - Procedure for settling claims-
 - Electronic submission
 - Formats for transmission
 - Time and frequency for settlement
 - Electronic settlement of claims
 - Identify hospital personnel for smart card related transactions in the hospital.
 - Impart training for use of smart card in the hospitals and for transmission of data to District server (Training can be imparted at the time of District-level workshop).
 - Ensure smart card transaction hardware (preferably PC based as per guidelines in Annexure 17 of the Tender Document) in each network hospital. The cost of the hardware to be borne by the hospitals.

- Make arrangements for installation of software for transaction on the machines in the hospital.
- Tie up maintenance of the hardware and the software (the cost would be borne by the hospitals).

4. Identify intermediaries/ MFIs/ NGOs:

(List could be available from the Central and State Governments).

5. Arrangement with intermediaries/ MFIs/ NGOs

- Clear articulation of the role (it can vary from place to place).
- Sensitisation and training (could be a part of District-level workshop)

6. Smart Card related issues:

- Clearly understanding the smart card mechanism
- Study and comply with the guidelines for smart card – the hardware and the software
- Identify smart card service providers who have the capability to deliver at the village level
- Arrangement with smart card service providers
- Issue of smart card
 - Working out a schedule of visit to the villages with the State Government (including tie-up with identified officials for authentication).
 - Publicity plan
 - Provision for a duplicate card in case of loss and on payment.

- Provision for add on card on payment
- Provide a brochure along with the smart card indicating the facilities, list of network hospitals and helpline.

- Maintenance Issue

7. Tendering Process

- Quote for the minimum facilities as listed out in the guidelines/ tender document. (All members of the family, irrespective of the age have to be covered)
- Quotes should include the cost of delivering smart cards.
- Service Tax to be included in the quotes

8. Signing of Contract/Agreement with the State Government

9. Identify personnel at the network hospitals and the District Headquarters for authentication cards and provide the details to District Key Manager (DKM) for issue of cards.

10. Organise District-level workshops. (The cost to be borne by the Insurance Company)

11. Set up a District-level office for the following:

- Install a server for receiving data from the hospitals daily and transmitting it to State & Central Governments.
- Issue of duplicate/split card.
- Permissible modification in the smart card.
- Act as a reference point for unlisted medical procedures

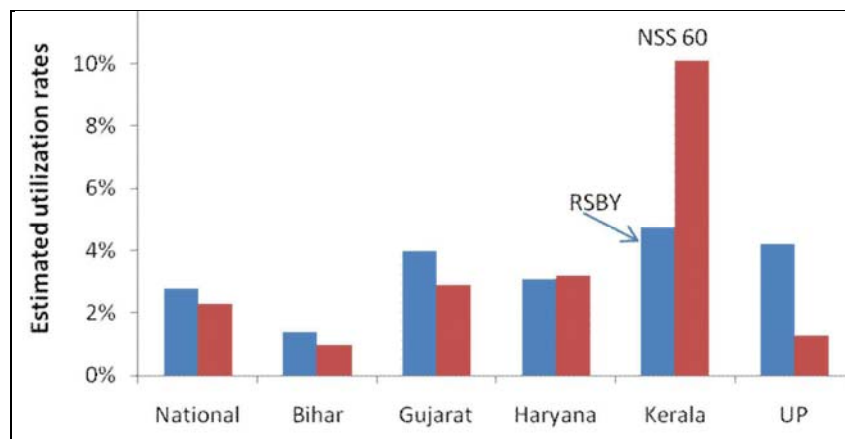
6.1.7 Current Status

In just three years of operations RSBY has been able to move from 2 States to 26 States in the country. The highlights of the performance of the scheme by end of May 2010 are as follows:

Smart Cards issued	–	App. 15.8 Million
Persons enrolled	–	App. 56 million
States that have started the RSBY process	–	26
States where enrolment has commenced	–	23
States where Service delivery has started	–	23

In the first year, RSBY's overall hospitalization ratio of 2.4 per cent (of all enrolled individuals in all 229 districts) is higher than the historically recorded hospitalization rates of low income segments (1.7 per cent as per National Sample Survey, 2004). It ranges from 0.1 per cent in Assam to 5.2 per cent in Kerala in year one. The all India rate for all income groups is 2.7 per cent. While the true population ratios may have changed since 2004, prima facie, it appears that RSBY is enabling people to undergo hospitalization more than they could have afforded to in the absence of the scheme. Overall in year one, hospitalization was higher among women (2.51 per cent) compared to men (2.34 per cent). This is contrary to historical rates as per NSSO, where men have marginally more hospitalization incidences than women.

Figure 6.1 Estimated utilization rates for national and selected states, NSSO and RSBY



Source: Xiaohui Hou and Robert Palacios (2010), 'Hospitalization patterns in RSBY: preliminary evidence from the MIS', RSBY Working Paper #6.

From figure 6.1 it is revealed that at an aggregate level, utilization rates turns out to be 2.55 per cent under RSBY as against the national average of 1.7 per cent (NSSO 60th round) for the poorest 40 per cent in the country. This clearly demonstrates improvement in access. However, at a disaggregated level the picture perhaps is not as bright with a number of States being well below the national average, the worst being Chandigarh (0.08 per cent) and Himachal Pradesh (0.49 per cent). Kerala (5.21 per cent) records the highest percentage of visitors to the hospitals. What is even more interesting is the gender related trends in utilization of hospital services. This becomes even more important in a health care related scheme where the need for both the genders is same, perhaps more for women. The RSBY, unlike any other health insurance scheme covers maternity benefits as well. The gender related hospitalization ratios under the scheme clearly reveal that women have benefited more from the scheme.

6.2 Implementation of RSBY-CHIS in the State of Kerala

Rashtriya Swasthya Bhima Yojana (RSBY), one of the welfare schemes formulated by the government of India, under the Unorganized Workers

Security Act, 2008 to provide quality medical services to those in the BPL list through hospitals in the government and private sector is being successfully implemented in all the 14 districts of the state from 1st year of introduction in the country. As per the estimates of Planning Commission, there are 11.79 lakh BPL (absolute poor) families in Kerala and all of whom will be covered under RSBY-CHIS. In addition, the State government has estimated another 10 lakh BPL (poor) families in Kerala. According to the recent enumeration there are 12,66,207 “absolute poor” and 11,01,206 “poor” families in the State. In this scenario the Government of Kerala has extended the benefits of Insurance scheme to the ‘Poor’ BPL population and all others included under “Above Poverty Line” by introducing alongside the CHIS with variation in premium. Thus the non RSBY population covering more than 3/4th families of the State are divided into two categories (a) those belonging to BPL (poor) list of the State Government but do not to the list of Central Planning Commission and (b) the APL families belonging neither to list of State Govt. nor prepared as per guidelines of Planning Commission.

The scheme was launched on 2nd October, 2008 and Alappuzha district was taken up as the first district. The RSBY-CHIS has now been introduced in all the 14 districts of the State. During the second year the state government has decided to bring the following categories also in addition to the BPL families.

1. SC/ST families.
2. Fisherman families.
3. Ashraya families.
4. Agricultural workers.
5. All workers in the beedi, handloom, coir, khadi, bamboo, kattuvalli, small plantations and other unorganized sectors.

6. Cashew workers (pensioners)
7. NREG workers who had worked at least 15 days.
8. Anganwadi workers/helpers.
9. Tailoring workers.
10. Asha workers.
11. Pensioners of building and other construction workers welfare board, head load workers welfare board, kerala motor workers welfare board and kerala abkari workers welfare board.
12. Domestic workers.

6.2.1 Premium and Registration fees for RSBY-CHIS

In RSBY, 75 per cent of the premium is met by the Central Government and 25 per cent by State Government while under CHIS (BPL poor as per state estimation), the State Government bears 100 per cent premium. The beneficiary pays Rs 30/- towards registration fees per family in both cases. In case of APL, the beneficiary bears the premium amount as well as registration fees. The competitive premium per family quoted is Rs.1274/- inclusive of service tax and cost of smart card.

6.2.2 Implementing structure

The Scheme is jointly implemented by departments of Labour & Rehabilitation, Health & Family Welfare, Rural Development, and Local Self Govt. The Labour Department is the Nodal department for implementation of CHIS. A separate agency “Comprehensive Health Insurance Agency of Kerala” (CHIAK) is created for implementation of the scheme. It is a society registered in accordance with the provisions of the Travancore Cochin Literary Scientific and Charitable Societies Registration Act, 1955. The chief aims of CHIAK are :

1. To provide health insurance cover to the workers and families in the unorganized sector under the Rashtiya Swasthya Bhima Yojana (RSBY) announced by the central government;
2. To provide health insurance cover to all sections of the society under the 'Comprehensive Health Insurance Scheme' (CHIS) announced by the state government;
3. To identify, formulate implement and support implementation of all projects aimed at the welfare of workers in Kerala;
4. To identify and negotiate with consultants of repute for implementation of any project of the central government or the state government towards minimizing heavy expenditure on medical care and hospitalization of the citizens which is a major insecurity leading to their poverty;
5. To provide technical, financial or other assistance for the formulation of programs meant for social security to workers;
6. To co-ordinate with various departments and agencies of the central or state governments, financial institutions, health insurance providers, health service providers cooperatives or non governmental organizations (NGOs) for implementation of any project meant for the welfare of workers;
7. To undertake or sponsor training programs, seminars, workshops etc. to create awareness of the various schemes available to the community;
and
8. To do such other things as may be incidental or conducive to the attainment of the above objectives.

In all the 4 years, “United India Insurance Company Limited” is the insurance provider for all 14 districts. Labour and Rehabilitation Department is the Nodal department while Health and Family Welfare, Local Self Government and Finance departments are the Major participating departments.

6.2.3 Features of RSBY-CHIS

The Insurer: United India Insurance Company was the insurer for all the years and the premium for the current year is Rs 1274.

Eligible Beneficiaries: Only those families whose names appear in the list provided by the State Government are eligible for enrolment under RSBY-CHIS. Up to a maximum of five members of a family can be enrolled which includes husband, spouse and three dependents. Dependents can be children, parents or any other family member whose name appears in the BPL list. If the family has more than three children, the head of the household will have to decide which three children are to be insured. There is no age limit in RSBY and anybody can be enrolled if they are in the BPL list. The head of the household need to be insured at the beginning and dependents’ names can be added later also. All eligible families, enrolled in to the scheme, are issued a smart Card for identification. New born is covered from day one in the scheme.

Hospitalization & Medical Coverage: “Hospitalization” shall Mean Admission in hospital upon a written advice of medical practitioner for a minimum period of 24 hours except in case of specified treatment (Day Care), where the admission in such hospital may be for a period of less than 24 hours. Expenses for treatment under out patient department is not available under the scheme. Besides, the scheme is available only for allopathic treatment and for treatment in general ward.

Cashless Treatment: RSBY-CHIS provides that no payment is to be made by an insured person for treatment taken in a network-hospital up to the limit of sum insured. All medical bills are settled between a hospital and the insurance company. The insured person only has to produce the Smart Card at the hospital and to give the biometric thumb impression. For treatments in excess of the limit of sum insured and also for treatments excluded under the scheme, the insured person shall have to bear the expenses.

Network Hospitals: These are the hospitals empanelled by an insurance company in consultation with the State Government to provide cashless treatment to RSBY-CHIS beneficiaries. The empanelment is done as per the standard empanelment guidelines of RSBY. Based on the ground realities, these guidelines may be relaxed by the State Govt. in special cases. During the first year, 130 hospitals in the government sector and 110 private hospitals (including hospitals in the co-operative sector) have joined the scheme. In government sector all hospitals in the level of CHC and above have been enrolled in the scheme. The list of empanelled hospitals in Kerala are given in Annexure-3.

Package Rates: The charges for medical/ surgical procedures/ interventions under the Benefit package, based on thorough market research, have been pre-determined. The state governments in consultation with all parties concerned fix the package charges for that particular year. The same can be amended with mutual consent for the next year. The package rates are given in Annexure- 2.

Smart Card: All eligible families, enrolled under RSBY-CHIS, are issued a smart Card on yearly basis i.e. a fresh card is issued every year. If required, one family can be issued two such cards, carrying details of two separate sets of insured persons, but the sums insured available for treatment under both cards

shall total up to Rs. 30,000/- only i.e., the overall limit per family. Smart Card enables identification of beneficiary through photograph and fingerprints, besides other information about a patient. The same can be read at the hospital using the card reader and a computer. More importantly, it enables cashless transactions at empanelled hospitals and portability of benefits across the country. This card necessarily needs to be shown by an insured person at a network hospital before seeking treatment.

Pre-existing Diseases: All Pre-existing diseases, unless specifically excluded, are covered under RSBY-CHIS from the day one itself. Any disease that was present at any time in the past (including a disease which the insured person may not have been aware of) is termed as pre-existing.

Maternity Benefits: All expenses related to the delivery of the baby in the hospital are covered. Both normal and caesarean deliveries are covered under RSBY-CHIS. A new-born is covered under RSBY-CHIS since birth automatically for the remaining period of the health insurance policy even if the new-born is the sixth member. However at the time of renewal of the policy, the household will have to take a decision whether to include the new born for the following year. Expenses incurred in connection with voluntary medical termination of pregnancy are not covered except when induced by an accident or other medical emergencies to save the life of the mother.

Exclusions: The scheme is not available for the following exclusions

1. Inborn disabilities;
2. Diseases out of drugs and liquor;
3. Infertility treatment and vaccination;

4. Suicide attempt, abortion, ayurvedic, homeopathic, unani, and siddha treatment, diseases out of disasters due to war, and treatment which does not require hospitalization.

Due to advances in medical technology, there are some procedures for which 24 hour hospitalization is not required. For example, dialysis, chemotherapy, radiation, lithotripsy, cataract and such 20 procedures. The scheme is available for these treatments, even if there is no 24 hour hospitalization.

Transportation Allowance: Provision for transport allowance (actual with limit of Rs. 100 per hospitalization) subject to an annual ceiling of Rs. 1,000 shall be a part of the package. This will be paid by hospitals to the beneficiary at the time of discharge.

Pre and Post Hospitalization Expenses: Pre and post hospitalization expenses up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital shall be part of the package rates.

Food Charges: Food only for the person who is hospitalized is covered in the package rate.

Accident Insurance: If there is death of the card holder due to accident, his/her dependent will get an amount of Rs. 2 lakh. The same relief is available to the dependents if there is more than 60 per cent burns to the card holder.

6.2.4 Unique Features of RSBY-CHIS

The RSBY scheme is not the first attempt to provide health insurance to low income workers by the Government in India. The RSBY scheme, however, differs from these schemes in several important ways.

- **Empowering the Beneficiary:** The RSBY-CHIS, in fact, attempts to empower the beneficiaries, by giving him a choice. The beneficiary has an option to select from any of the networked hospitals, both in the private and public domain, anywhere in the state. He is not tied down to a delivery point as in case of almost all the public sponsored social welfare scheme. The National Rural Employment Guarantee Scheme (NREGS) ties him down to a particular project and the Public Distribution System (PDS) to a shop. The beneficiaries under these schemes have no choice. By giving the beneficiary a choice under RSBY-CHIS, he determines the delivery point and that is his empowerment.
- **Inclusion of Pre-Existing Diseases:** A large number of insurance packages do not include pre-existing diseases. The RSBY-CHIS does. It does to avoid inconvenience to the consumer in determining which disease was pre-existing and which was not. Considering the number involved under RSBY-CHIS, it would have been practically impossible to determine pre-existing diseases and there would have been innumerable disputes. Though, the inclusion of pre-existing diseases may have had an impact on the premium, it made it much simpler to implement.
- **Cash less Transactions:** The scheme aims at being cashless to cater to the peculiar characteristics of the target group. The only cash transaction is in terms of transport expenditure of Rs.100 to be provided by the hospital to the beneficiary when he gets admitted. The beneficiary doesn't have to make any payment to anybody as all the aspects, medicines, food, lodging, etc. are covered in the package rates, the

payment of which is made by the insurance company to the hospital. The only payment (Rs.30) that the beneficiary has to make is at the time of issue of smart card. This also marks the first ever attempt to seek some contribution from the BPL family for delivery of benefits. It is believed that the beneficiary will 'value' the card if he makes some contribution and will also demand service as he would have paid (even though a small part of it) for the service.

- **Portability:** The smart card is portable and valid in all the network hospitals throughout the country. This also takes care of the migrant nature of the beneficiary. Thus, a migrant worker of Bihar, East U.P., Orissa and the like can claim benefit under the scheme at any network hospital of the State where he has migrated. This is the first ever effort made in this regard. None of the insurance schemes in operation in the country have such portability across such a wide network of hospitals. More than a thousand hospitals will be networked by various insurance companies which would be a record in itself. The RSBY also enables splitting of smart cards so that the migrating head of the family can 'carry' some of the health cover credit with him and leave the rest behind for his family. The amount to be split is at the choice of the beneficiary.
- **Paperless Transactions:** The scheme aims at paperless operation. Most of it has already happened. As mentioned earlier, no documentation is required by the beneficiary for issue of smart card or even at the time of admission to and discharge from the hospital. Most of the surgical procedures have been standardized, codified and costs frozen. Most of the claims of the hospitals are being settled electronically as the

requisite information in prescribed format flows through an electronic gateway. This is unique and unprecedented, as much as imperative, in the context of the paper work that would otherwise be generated in a scheme of this scale.

- **Business Model for all Stakeholders:** The scheme has been designed as a business model for a social sector scheme with incentives built for each stakeholder. This business model design is conducive both in terms of expansion of the scheme as well as for its long run sustainability.

Insurers: The insurer is paid premium for each household enrolled for RSBY. Therefore, the insurer has the motivation to enroll as many households as possible from the BPL list. This will result in better coverage of targeted beneficiaries.

Hospitals: A hospital has the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. Even public hospitals have the incentive to treat beneficiaries under RSBY as the money from the insurer will flow directly to the concerned public hospital which they can use for their own purposes. Insurers, in contrast, will monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims.

Intermediaries: The inclusion of intermediaries such as NGOs and MFIs which have a greater stake in assisting BPL households. The intermediaries will be paid for the services they render in reaching out to the beneficiaries.

Government: By paying only a maximum sum up to Rs. 1274/- per family per year, the Government is able to provide access to quality

health care to the below poverty line population. It will also lead to a healthy competition between public and private providers which in turn will improve the functioning of the public health care providers.

- **Public-Private Partnership:** It is also a rare occurrence that an attempt has been made to evolve a social sector scheme through public-private partnership. The funding of the premium as well as the standardization of various procedures comes from the Government but scheme allows both public and private players in the field of insurance and health services to play a critical role in making RSBY happen. The public and private institutions have to work in tandem to make this scheme a success.
- **Information Technology (IT) Intensive:** Ever since the advent of information technology revolution in the country, such tools have been used in the public domain as well. However, perhaps it is for the first time that IT tools are being used on such a large scale and in the rural setting, in an environment not very congenial for such applications. The process does not end with the issue of smart cards. That is just the beginning. IT applications have been put in place in all the networked hospitals. The scheme also entails a complete back-end data base management for its seamless operation. The scheme is a huge challenge in terms of hardware procurement (most of which has to be imported), its use, its maintenance, sophisticated and interdependent software and technical manpower mobilization.
- **Safe and Foolproof:** The use of biometric enabled smart card and a key management system makes this scheme safe and foolproof. The key management system of RSBY ensures that the card reaches the correct

beneficiary and there remains accountability in terms of issuance of the smart card and its usage. The biometric enabled smart card ensures that only the real beneficiary can use the smart card.

- **Robust Monitoring and Evaluation:** RSBY is evolving a robust monitoring and evaluation system. An elaborate backend data management system is being put in place which can track any transaction and provide periodic analytical reports. The basic information gathered by government and reported publicly should allow for mid-course improvements in the scheme. It may also contribute to competition during subsequent tender processes with the insurers by disseminating the data and reports.

All in all, the scheme is different. It is different in the context of its conceptual framework, it is different in the manner in which it is actually rolling out and it is likely to be different in the manner in which it will impact the lives of the poorest of the poor in this country. Some such evidence is already visible.

6.3 CHIS PLUS

The number of persons suffering from critical illnesses is on the increase in Kerala due to a multiplicity of factors like life style changes, changes in diet and environmental factors. When potentially fatal diseases of the heart, kidney or cancer affect a poor person, not only is his/her meager savings of his/her entire life drained off, he/she very often loses his/her livelihood. When the head of a family is affected by any of these diseases, the loss of livelihood has deleterious effect on the health and education of all family members especially small children and the aged. Medicines and surgical procedures for these fatal

diseases are very costly and the poor cannot afford them. It is in these context that the former Finance Minister of the State Dr. Thomas Isaac announced in the budget 2010-11 an additional treatment benefit of Rs. 70,000/- over and above the RSBY benefits to all the RSBY-CHIS card holders except APL card holders for treatment of Cancer, heart and kidney related diseases.

This scheme is not run with the assistance of the insurance company. On the contrary, it is a fully state government funded scheme. The scheme is implemented by CHIAK with the assistance of participating hospitals utilizing software developed by KELTRON. A RSBY-CHIS card holder who suffers from any of the three fatal diseases will have to contact any of the participating hospitals for availing treatment facility. As per the decision of the High Powered Supervisory Council package rates have been formulated for giving treatment under CHIS-PLUS. The total value of the treatment dispensed to the patient under CHIS-PLUS will be reimbursed to the participating hospitals by CHIAK after close scrutiny. The amount involved in the admitted claims will be transferred electronically to the RSBY-CHIS account of the hospital once in 15 days. The hospital wise money payable, transfer of money etc. will be run through the software platform.

Contrary to the practice in RSBY-CHIS treatment, neither transportation allowance to the patients nor incentives to the staff handling the scheme is envisaged under CHIS PLUS. Just like RBY-CHIS, the CHIS PLUS treatment will be in general ward only. The treatment under CHIS PLUS will be available to the RSBY-CHIS BPL card holders only. Thus the implementation of CHIS PLUS will certainly prevent a large number of premature deaths of poor people simply by providing treatment facilities to them through this cash less system of CHIS PLUS. The sense of security springing from the feeling that the

government will bear all expenses for the treatment of the fatal diseases will be of great psychological relief to the patients and their family members.

Government of India has evaluated that 'Kerala has issued highest number of RSBY smart cards in the Country. The State is also ahead of other States in putting in place procedures and practices which are worthy of appreciation in the implementation of the scheme'. As recognition of this achievement, government of India conducted the 2nd National Conference on RSBY at Thiruvananthapuram on 28th and 29th of October, 2009. At the National Conference the State of Kerala was given award for outstanding commitment in terms of initiative, innovation and institutional building in RSBY. CHIAK also received an award for best performance through Public Private Participation. During the 2nd year also the Central government had given the award for best utilization to the state of Kerala.

Now 3 years has been completed since the launch of the scheme and there are only few studies regarding the effectiveness and utilization of the scheme. The time is ripe now to understand the effectiveness and utilization of the scheme and also to find out the extent of satisfaction of the beneficiaries on the services received by them. In these contexts, it is felt necessary to make an attempt to understand the effectiveness of the comprehensive health insurance scheme (CHIS) in Kerala, with special reference to Ernakulam and Wayanad districts. This is a fact finding study, concerned with the performance of RSBY-CHIS in the state of Kerala by conducting a survey among the beneficiaries of CHIS. It is an attempt to present an integrated picture of the main features of the scheme, its implementation, extent of awareness about the program, evaluation of its effectiveness, comparison of the effectiveness of the scheme on APL and BPL beneficiaries, to analyze whether there are any regional

differences in the effectiveness of the scheme, various difficulties faced by the beneficiaries at present and further modifications needed in the scheme according to the opinion of the beneficiaries.

.....DOR.....

The Socio-Economic Profile of the Beneficiaries



7.1 The Socio Economic Profile:

Health insurance issues are acquiring urgency due to factors like medical inflation, increasing life expectancy, increasing load of lifestyle diseases and uncertainties in individual employability and earnings. Paradoxically living long and dying young are both creating new tensions in the society. With virtual absence of a public health security system and a high proportion of national health spending being met by households, the need for a wide spread health insurance system is urgent and pressing. Though Kerala has attained better health care indicators, the people are now facing the problem of high morbidity, both from communicable and non communicable diseases. Most of the diseases prevalent in Kerala warrant constant medical attention and treatment and sustained medical treatment is beyond the wherewithal of the average households. The private sector has now become the largest provider of health care in the state, in terms of number of medical institutions and beds. As one study shows, more than 60 percent of beds are in the private sector (Oommen, 2008). The private health care system cannot be an answer because of the high average cost of treatment. ‘Good health at low cost in Kerala’ faces serious challenges due to increased privatization. This warrants greater and sustained efforts by the State in widening the scope of public action.

As a result, provision of effective and free healthcare to the poorest 30 per cent families is taken up in the Eleventh Five Year Plan of the State by way

of strengthening the Public Health System and recognized the importance of health insurance, as an innovative answer to protect the poor from falling to a debt trap. Thus, a scheme named ‘Comprehensive Health Insurance Scheme’ (CHIS), incorporating the features of the central government scheme Rashtriya Swasthya Bhima Yojana (RSBY), was launched on 2nd October, 2008 in Alappuzha district. The RSBY-CHIS has now been introduced in all the 14 districts of the State.

In addition to RSBY population, as defined by the Planning Commission, the state government has decided to provide similar benefits to such other poor families which are not covered under RSBY and to those who opt to subscribe to the scheme by paying such amount as may be prescribed. Thus, the implementation of a more ambitious health insurance scheme in the state namely CHIS. The special feature of CHIS is that it extends to all the families other than the BPL families (absolute poor) as per the Planning Commission’s guidelines who come under the RSBY. The non RSBY population will be divided into two categories:

- a. Those belonging to the BPL (poor) list of the state government but not to the list as defined by the Planning Commission and
- b. The APL families that belong neither to the state government list nor to the list prepared as per guidelines of the Planning Commission.

In the case of families of the first category (a), the beneficiaries will have to pay Rs. 30 per annum per family as beneficiary contribution, and the state government will meet all the remaining expenses including the cost of the smart card. In the case of families of the second category (b), the beneficiary contribution will cover the entire amount of premium including the cost of smart card. In other words, the beneficiary contribution will be Rs.30 per family

per annum for RSBY families and for families belonging to category (a) and the entire amount for families belonging to category (b), i.e. Rs.1274 at present. In short, there are two categories of smart card holders, who are belonging to two different economic categories.

In these contexts, it is essential to study the utilization of the scheme and compare the effectiveness of the utilization by these two categories of smart card holders which will throw light upon special needs and requirements of these two categories of smart card holders. There is every chance for difference in the perceptions of BPL and APL smart card holders as they are paying two different levels of premium for the same scheme. So, the present study makes a comparison of the effectiveness of the utilization of the scheme by the BPL and APL smart card holders. The success of any scheme/program depends on the utilization of the same and the satisfaction of the customers. Hence, this study made an attempt to understand the experience of the people with the RSBY-CHIS along with an assessment of their satisfaction with the utilization of the scheme.

For this primary data were collected from 30 BPL beneficiaries and 5 APL beneficiaries from Wayanad district, which is having lowest utilization rate, and 765 BPL beneficiaries and 100 APL beneficiaries from Ernakulam district, which is having highest utilization rate. Thus a total of 900 (795 BPL and 105 APL) beneficiaries were included in the study. Data were collected by way of a pre-structured interview schedule. Being a post utilization study, samples are selected from the actual beneficiaries i.e. hospitalized persons under the scheme.

The data collected in this regard were analyzed under the following headings:

1. Socio-economic profile of the beneficiaries which is analyzed in this chapter,
2. Awareness about the features of the scheme in chapter 8,
3. Economics and details about RSBY-CHIS hospitalization and non RSBY-CHIS hospitalization in chapter 9,
4. Satisfaction on the experience under RSBY-CHIS hospitalization and problems encountered by the beneficiaries in chapter 10.

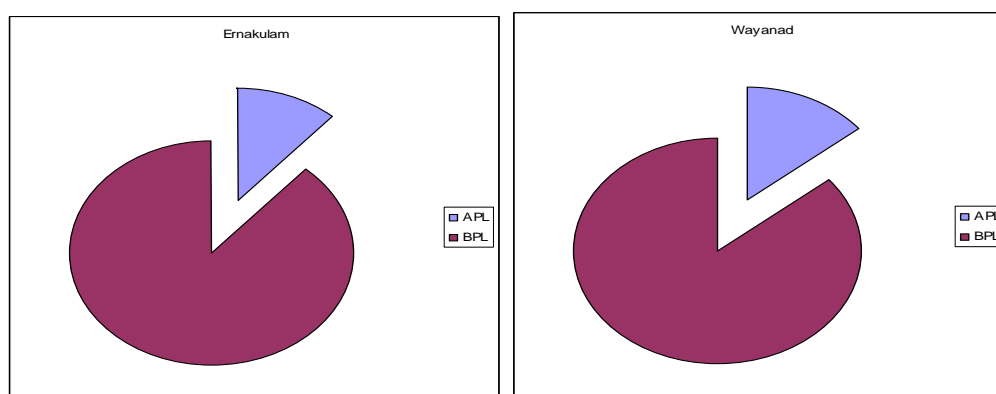
7.1 The Socio Economic Profile:

The primary data collected from sample beneficiaries are being analyzed in this chapter. To study the socio-economic profile of the hospitalized persons under the scheme, it is necessary to assess the general levels of living of the sample beneficiaries. Analysis of socio economic profile includes classification according to their age, gender, qualification, occupation, religion, family details, income, social and economic group, housing pattern and physical amenities and household annual expenditure on medical care. All the tables and figures in this chapter are derived from the sample survey. Sample size is 900. The total number of beneficiaries under various categories subjected to this study are shown in Table 7.1.

Table 7.1 Total Number of Beneficiaries

	APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Ernakulam	100	95.2	765	96.2	865	96.1
Wayanad	5	4.8	30	3.8	35	3.9
Total	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 7.1 Total Number of Beneficiaries

The sample beneficiaries include 100 APL and 765 BPL beneficiaries from Ernakulam district and 5 APL and 30 BPL beneficiaries from Wayanad district.

7.1.1 Gender Wise Classification

Gender wise classification of the beneficiaries are given in table 7.2.

Table 7.2 Gender Wise Classification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Male	460	53.2	18	51.4	62	59.0	416	52.3	478	53.1
Female	405	46.8	17	48.6	43	41.0	379	47.7	422	46.9
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 7.2 shows that there are 53.2 per cent male beneficiaries and 46.8 per cent female beneficiaries in Ernakulam district. There are 51.4 per cent male beneficiaries and 48.6 per cent female beneficiaries in Wayanad district. Among the total 795 BPL beneficiaries, there are 416 male beneficiaries, who constitute 52.3 per cent and 379 female beneficiaries, who constitute 47.7 per cent. In the case of 105 APL beneficiaries, there are 62 male beneficiaries, who constitute about 59 per cent and 43 female beneficiaries, who constitute about

41 per cent. This point to the fact that the male smart card holders are making maximum utilization of the scheme, irrespective of BPL-APL and Ernakulam-Wayanad classification. Although, the figures go in concurrence with the national trend, it is against the state trend where females outnumber males.

7.1.2 Age Wise Classification

Age wise classification of the beneficiaries are given in table 7.3.

Table 7.3 Age Wise Classification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Below 20 Years	10	1.2	2	5.7	10	9.5	2	0.3	12	1.3
20 – 30 Years	73	8.4	4	11.4	15	14.3	62	7.8	77	8.6
30 – 40 Years	148	17.1	5	14.3	21	20.0	132	16.6	153	17.0
40 – 50 Years	291	33.6	4	11.4	27	25.7	268	33.7	295	32.8
Above 50 Years	343	39.7	20	57.1	32	30.5	331	41.6	363	40.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 7.3 shows that there are only 1.2 per cent of beneficiaries below the age of 20 in Ernakulam district, whereas, it is 5.7 per cent in the case of Wayanad district. Likewise, there are about 9.5 per cent of beneficiaries below the age of 20 in APL category, whereas, it is only 0.3 per cent in the case of BPL category. The majority beneficiaries belong to the age group of above 50 years, among all the categories of beneficiaries. This point to the fact that the smart card holders of above 50 years are making maximum utilization of the scheme, irrespective of BPL-APL or Ernakulam and Wayanad classifications.

7.1.3 Educational Qualification wise Classification

The status of a community depends to a certain degree on the educational level of its members. Education not only qualifies people for better jobs, but also creates an awareness of opportunities open to them, which enriches life. Education is considered to be the most important factor in the ladder of social mobility. The beneficiaries are classified on the basis of their educational qualification as given in table 7.4.

Table 7. 4 Classification on the Basis of Educational Qualification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Below SSLC	263	30.4	11	31.4	26	24.8	248	31.2	274	30.4
SSLC	423	48.9	11	31.4	21	20.0	413	51.9	434	48.2
Under Graduate	135	15.6	9	25.7	21	20.0	123	15.5	144	16.0
Graduate	29	3.4	3	8.6	21	20.0	11	1.4	32	3.6
Post Graduate	10	1.2	1	2.9	11	10.5	0	0.0	11	1.2
Professional	5	0.6	0	0.0	5	4.8	0	0.0	5	0.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.4, it is clear that among the beneficiaries of Ernakulam district, 30.4 per cent have studied below S.S.L.C. level, about 48.9 per cent of them studied up to S.S.L.C. level, 15.6 per cent studied up to undergraduate level, 3.4 per cent studied up to graduate level, 1.2 per cent studied up to post graduate level and only 0.6 per cent studied up to professional qualification level. In the case of beneficiaries of Wayanad district, about 31.4 per cent below S.S.L.C. level, 31.4 per cent studied up to S.S.L.C. level, 25.7 per cent studied up to undergraduate level, 8.6 per cent studied up to graduate level, 2.9 per cent studied up to post graduate level and none of them having any professional qualifications. The majority beneficiaries in Ernakulam district have studied up to S.S.L.C. level, whereas majority beneficiaries are below

S.S.L.C. level in Wayanad district and there are no professionally qualified beneficiaries. Among the beneficiaries of APL category, 24.8 per cent have studied below S.S.L.C. level, 20 per cent having studied up to S.S.L.C. level, 20 per cent studied up to undergraduate level, 20 per cent studied up to graduate level, 10.5 per cent studied up to post graduate level and only 4.8 per cent having any professional qualification. In the case of beneficiaries of BPL category, there is 31.2 per cent below S.S.L.C. level, 51.9 per cent studied up to S.S.L.C. level, 15.5 per cent studied up to undergraduate level, 1.4 per cent studied up to graduate level and none of them having any post graduate and professional qualifications. It is surprising to note that majority beneficiaries in APL category are below S.S.L.C., whereas majority beneficiaries in BPL category are having S.S.L.C. as their educational qualification. It may be as a result of comparatively good information about the scheme among the educated BPL beneficiaries, when compared to the less educated BPL beneficiaries and thereby increased utilization by the former. Thus, educational profile of the family members revealed a low status, as around 75 per cent of the beneficiaries had only S.S.L.C. as their basic educational qualification.

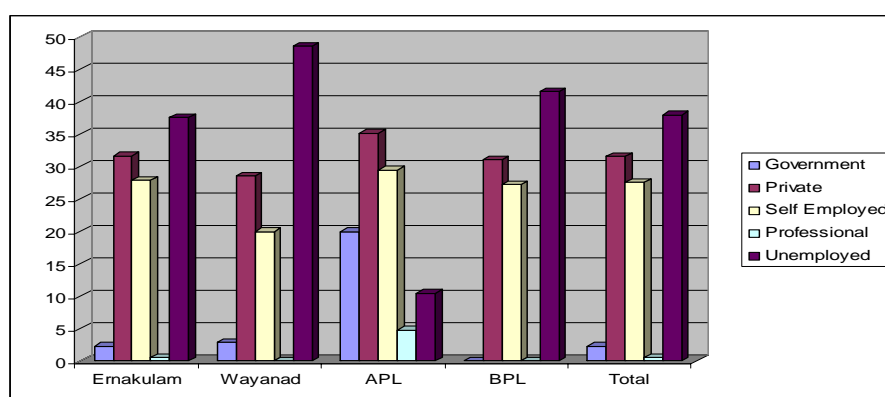
7.1.4 Classification on the basis of Occupation

Occupational classification of the beneficiaries are given in table 7.5.

Table 7.5 Occupational Classification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Government	20	2.3	1	2.9	21	20.0	0	0.0	21	2.3
Private	274	31.7	10	28.6	37	35.2	247	31.1	284	31.6
Self Employed	241	27.9	7	20.0	31	29.5	217	27.3	248	27.6
Professional	5	0.6	0	0.0	5	4.8	0	0.0	5	0.6
Unemployed	325	37.6	17	48.6	11	10.5	331	41.6	342	38.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 7.2 Occupational Classification

Among the Ernakulam beneficiaries, about 37.6 per cent beneficiaries are unemployed, about 27.9 per cent are self employed, about 2.3 per cent government employees, about 0.6 per cent professionals and 31.7 per cent private employees. The majority beneficiaries are unemployed in Ernakulam district. Next to unemployed, there is the category of private employees. Among the Wayanad beneficiaries, about 48.6 per cent beneficiaries are unemployed, about 20 per cent are self employed, about 2.9 per cent government employees, no professionals and 28.6 per cent private employees. The majority are unemployed, then comes private employees and self employed. Among the APL beneficiaries, about 10.5 per cent beneficiaries are unemployed, about 29.5 per cent are self employed, about 20 per cent government employees, about 4.8 per cent professionals and 35.2 per cent private employees. The majority beneficiaries are private employees in APL category. Next to private employees, there is the category of self employed. Among the BPL beneficiaries, about 41.6 per cent beneficiaries are unemployed, about 27.3 per cent are self employed, no government employees and professionals and 31.1 per cent private employees. The majority are unemployed, then comes private employees and self employed.

7.1.5 Classification on the basis of Family size

As per RSBY-CHIS, families having 5 members or 5 members of each of the families are entitled to get the benefit of the scheme. The size of the family hence is important to understand if all the members in the families under study avail the benefits of the scheme. The table 7.6 illustrates classification on the basis of family size

Table 7.6 Classification on the Basis of Family Size

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
2 – 4 Members	340	39.3	18	51.4	47	44.8	311	39.1	358	39.8
4 – 6 Members	318	36.8	11	31.4	33	31.4	296	37.2	329	36.6
6 – 8 Members	145	16.8	4	11.4	20	19.0	129	16.2	149	16.6
More than 8 Members	62	7.2	2	5.7	5	4.8	59	7.4	64	7.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Majority of the beneficiaries of both Ernakulam and Wayanad districts, fall in the category of 2-4 family members. Lowest percentage of family members both in Ernakulam and Wayanad, fall in the category of more than 8 members. Majority of the beneficiaries of both APL and BPL, fall in the category of 2-4 family members. Lowest percentage of family members both in APL and BPL, fall in the category of more than 8 members. This point to the fact that there is no significant difference with regard to the number of family members of the beneficiaries in between Ernakulam and Wayanad districts and also between BPL and APL categories.

7.1.6 Classification on the Basis of Monthly Income

Standard of living of the population is revealed by the income level, which is highly correlated with employment of the population. The distribution

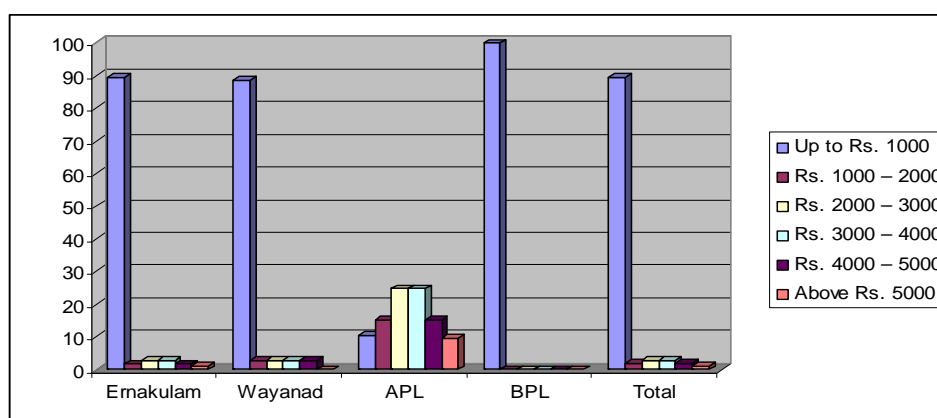
of beneficiaries based on the income level, therefore is an important background indicator. The beneficiaries are classified on the basis of their monthly income as given in table 7. 7.

Table 7.7 Classification on the Basis of Monthly Income

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Up to Rs. 1000	775	89.6	31	88.6	11	10.5	795	100.0	806	89.6
Rs. 1000 – 2000	15	1.7	1	2.9	16	15.2	0	0.0	16	1.8
Rs. 2000 – 3000	25	2.9	1	2.9	26	24.8	0	0.0	26	2.9
Rs. 3000 – 4000	25	2.9	1	2.9	26	24.8	0	0.0	26	2.9
Rs. 4000 – 5000	15	1.7	1	2.9	16	15.2	0	0.0	16	1.8
Above Rs. 5000	10	1.2	0	0.0	10	9.5	0	0.0	10	1.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 7.3 Classification on the Basis of Monthly Income



Among Ernakulam beneficiaries, about 89.6 per cent beneficiaries fall in the category of up to Rs.1000. Lowest percentage fall in the category of income above Rs.5000. Among Wayanad beneficiaries, about 88.6 per cent beneficiaries fall in the category of income less than Rs.1000. In all other classes of income, there are 2.9 per cent beneficiaries. There are no

beneficiaries who are having income more than Rs.5000 in Wayanad district. Among APL beneficiaries, about 48.2 per cent beneficiaries fall in the category of income between Rs.2000-4000 and there are 10.5 per cent beneficiaries in the category of income less than Rs.1000 which throws light in to the reality that many of them are actually BPL beneficiaries, but due to some technical reasons they may be denied with BPL benefits. Among BPL beneficiaries, 100 per cent beneficiaries fall in the category of income less than Rs.1000.

7.1.7 Classification on the Basis of Religion

The beneficiaries are classified on the basis of their religion as given in table 7. 8.

Table 7.8 Classification on the Basis of Religion

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hindu	244	28.2	12	34.3	37	35.2	219	27.5	256	28.4
Christian	335	38.7	11	31.4	31	29.5	315	39.6	346	38.4
Muslim	261	30.2	12	34.3	32	30.5	241	30.3	273	30.3
Others	25	2.9	0	0.0	5	4.8	20	2.5	25	2.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Among Ernakulam beneficiaries, about 28.2 per cent beneficiaries follow Hinduism, 38.7 per cent beneficiaries follow Christianity, 30.2 per cent follow Islam and 2.9 per cent follow others. Among Wayanad beneficiaries, about 34.3 per cent beneficiaries follow Hinduism, 31.4 per cent beneficiaries follow Christianity, 34.3 per cent follow Islam and none of them follow Others. Among APL beneficiaries, about 35.2 per cent beneficiaries follow Hinduism, 29.5 per cent beneficiaries follow Christianity, 30.5 per cent follow Islam and 4.8 per cent follow Others. Among BPL beneficiaries, 27.5 per cent beneficiaries follow Hinduism, 39.6 per cent beneficiaries follow Christianity,

30.3 per cent follow Islam and 2.5 per cent follow Others. These differences in the utilization of the scheme by different religious groups may be by chance and further studies are needed for finding out the reasons for such variations, if any.

7.1.8 Classification on the Basis of Social Group

The beneficiaries are classified on the basis of social group as given in table 7. 9.

Table 7.9 Social Group Wise Classification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
SC	151	17.5	0	0.0	5	4.8	146	18.4	151	16.8
ST	57	6.6	8	22.9	10	9.5	55	6.9	65	7.2
OBC	370	42.8	15	42.9	58	55.2	327	41.1	385	42.8
General	287	33.2	12	34.3	32	30.5	267	33.6	299	33.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Majority of the beneficiaries of both Ernakulam and Wayanad districts, fall in the OBC category. Lowest percentage of beneficiaries in Ernakulam district fall in the ST category whereas in Wayanad district no beneficiaries in SC category. Majority of the beneficiaries of both APL and BPL, fall in the OBC category. Lowest percentage of beneficiaries in APL category, fall in the SC category whereas in BPL category, the lowest percentage fall in the ST category. Although, one of the criteria for determining BPL families is social group, it is found here that those specified groups are found to be comparatively lower. The occurrence of more cases from the OBC and other categories might have been due to the introduction of CHIS scheme along with RSBY wherein more from the poor than from the absolute poor have come across and further studies are needed for finding out the reasons for such variations, if any.

7.1.9 Classification on the Basis of Ownership of House

The general characteristics of a beneficiary, like ownership and type of structure of houses, facilities like electricity, drinking water etc., give an idea about the standard of living of the sample beneficiaries. The beneficiaries are classified on the basis of ownership of house as given in table 7. 10.

Table7.10 House Ownership Wise Classification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Own	83	9.6	7	20.0	58	55.2	32	4.0	90	10.0
Parents	432	49.9	12	34.3	27	25.7	417	52.5	444	49.3
Relatives	116	13.4	6	17.1	0	0.0	122	15.3	122	13.6
Rented	196	22.7	6	17.1	20	19.0	182	22.9	202	22.4
Others	38	4.4	4	11.4	0	0.0	42	5.3	42	4.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.10 it is clear that among the beneficiaries of Ernakulam district, about 9.6 per cent are having owned house, 49.9 per cent are living in parent's house, 13.4 per cent living in relative's house, 22.7 per cent living in rented house and there are 4.4 per cent in the category of others. In the case of beneficiaries of Wayanad district, there is only 20 per cent having owned house, 34.3 per cent are living in parent's house, 17.1 per cent living in relative's house, and 17.1 per cent living in rented house and there are 4.4 per cent in the category of others. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are living in parent's house. It is clear that compared to Wayanad beneficiaries, Ernakulam beneficiaries are having only less housing facility, one of the basic needs of human beings. Among the beneficiaries of APL category, about 55.2 per cent are having owned house, 25.7 per cent are living in parent's house, none of them living in relative's house, 19 per cent living in rented house and there are no beneficiaries in the category of others. In

the case of beneficiaries of BPL category, there is only 4 per cent having owned house, 52.5 per cent are living in parent's house, 15.3 per cent living in relative's house, 22.9 per cent living in rented house and there are 5.3 per cent in the category of others. Majority beneficiaries in APL category are having owned house, whereas majority beneficiaries in BPL category are living in parent's house. It is clear that compared to APL category, BPL beneficiaries are having only less housing facility, one of the basic needs of human beings, and only 4 per cent are having own house.

7.1.10 Classification on the Basis of Roof of the House

The beneficiaries are classified on the basis of roof of the house as given in table 7. 11.

Table 7.11 Classification on the Basis of Roof of the House

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Terrace	50	5.8	3	8.6	53	50.5	0	0.0	53	5.9
Tile	413	47.7	16	45.7	37	35.2	392	49.3	429	47.7
Thatched	150	17.3	6	17.1	15	14.3	141	17.7	156	17.3
Asbestos Sheet	127	14.7	6	17.1	0	0.0	133	16.7	133	14.8
Tarpaulin Sheet	87	10.1	2	5.7	0	0.0	89	11.2	89	9.9
Others	38	4.4	2	5.7	0	0.0	40	5.0	40	4.4
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.11 it is clear that among the beneficiaries of Ernakulam district, about 5.8 per cent are living in concrete house, and 47.7 per cent are living in tiled roof house and there are 17.3 per cent, 14.7 per cent, 10.1 per cent and 4.4 per cent respectively in the categories of thatched, asbestos, tarpaulin and others. In the case of beneficiaries of Wayanad district, there is about 8.6 per cent living in concrete house, 45.7 per cent are living in tiled roof house, 17.1 per cent living in thatched roofs, another 17.1 per cent living in roofs made

of asbestos, 5.7 per cent each living in roofs made of tarpaulin and in roofs made of others. Majority beneficiaries both in Ernakulam and Wayanad districts are living in tiled roof house. Among the beneficiaries of APL category, about 50.5 per cent are living in concrete house, and 35.2 per cent are living in tiled roof house, 17.1 per cent living in thatched roofs, and there are none in the categories of asbestos, tarpaulin and others. In the case of beneficiaries of BPL category, none of them living in concrete house, about 49.3 per cent are living in tiled roof house, 17.7 per cent living in thatched roofs, 16.7 per cent living in roofs made of asbestos, 11.2 per cent living in roofs made of tarpaulin and 5 per cent living in roofs made of others. Majority beneficiaries in APL category are living in concrete house, whereas majority beneficiaries in BPL category are living in tiled roof house. The figures thus showed that a good number of the beneficiaries under study were living in houses of dilapidated condition, depicting their miserable situation.

7.1.11 Classification on the Basis of Type of Latrine

The life style of the people is closely associated with the type of toilet. The beneficiaries are classified on the basis of type of latrine as given in table 7. 12.

Table 7.12 Classification on the Basis of Type of Latrine

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Septic Tank / Flush system	151	17.5	5	14.3	80	76.2	76	9.6	156	17.3
Pit	457	52.8	22	62.9	10	9.5	469	59.0	479	53.2
No Latrine	232	26.8	6	17.1	10	9.5	228	28.7	238	26.4
Others	25	2.9	2	5.7	5	4.8	22	2.8	27	3.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.12 it is clear that among the beneficiaries of Ernakulam district, about 17.5 per cent are having latrine of septic/flush tank system, 52.8 per cent are having only pit type of latrine, 26.8 per cent are having no latrine at all, and 2.9 per cent are having latrine of others. In the case of beneficiaries of Wayanad district, about 14.3 per cent are having latrine of septic/flush tank system, 62.9 per cent are having only pit type of latrine, 17.1 per cent are having no latrine at all, and 5.7 per cent are having latrine of others. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having only pit type of latrine. Among the beneficiaries of APL category, about 76.2 per cent are having latrine of septic/flush tank system, and 9.5 per cent are having only pit type of latrine and another 9.5 per cent are having no latrine and there are none in the category of others. In the case of beneficiaries of BPL category, about 9.6 per cent are having latrine of septic/flush tank system, 59 per cent are having only pit type of latrine, 28.7 per cent are having no latrine at all, and 2.8 per cent are having latrine of others. It is revealed that majority beneficiaries in APL category are having latrine of septic/flush tank system, whereas majority beneficiaries in BPL category are having only pit type of latrine. The picture therefore is quite discouraging and it reiterates again the poor condition of the households.

7.1.12 Classification on the Basis of Type of Drainage

The drainage system has significant bearing on health and morbidity status of the population. The open and uncovered drainage creates pollution and contributes to breeding of flies and mosquitoes. The beneficiaries are classified on the basis of type of drainage as given in table 7. 13.

Table 7. 13 Classification on The Basis of Type of Drainage

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Open	472	54.6	16	45.7	15	14.3	473	59.5	488	54.2
Covered	101	11.7	5	14.3	38	36.2	68	8.6	106	11.8
Under Ground	88	10.2	4	11.4	42	40.0	50	6.3	92	10.2
No Drainage	179	20.7	8	22.9	5	4.8	182	22.9	187	20.8
Others	25	2.9	2	5.7	5	4.8	22	2.8	27	3.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.13 it is clear that among the beneficiaries of Ernakulam district, about 10.2 per cent are having underground drainage facility, 11.7 per cent are having covered drainage, 54.6 per cent are having only open type of drainage, there are 20.7 per cent in the category of no drainage and there are 2.9 per cent in the category of others. In the case of beneficiaries of Wayanad district, about 11.4 per cent are having underground drainage facility, 14.3 per cent are having covered drainage, 45.7 per cent are having only open type of drainage, 22.9 per cent in the category of no drainage and there are 5.7 per cent in the category of others. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having open type of drainage facility. Among the beneficiaries of APL category, about 40 per cent are having underground drainage facility, 36.2 per cent are having covered drainage, 14.3 per cent are having only open type of drainage, 4.8 per cent each in the category of no drainage and in the category of others. In the case of beneficiaries of BPL category, about 6.3 per cent are having underground drainage facility, 8.6 per cent are having covered drainage, 59.5 per cent are having only open type of drainage, 22.9 per cent in the category of no drainage and there are 2.8 per cent in the category of others. It is revealed that majority beneficiaries in APL category are having underground drainage facility, whereas majority beneficiaries in BPL category are having only open type of drainage.

7.1.13 Classification on the Basis of Source of Light

The beneficiaries are classified on the basis of source of light as given in table 7. 14.

Table 7.14 Classification on the Basis of source of light

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Electricity	297	34.3	11	31.4	80	76.2	228	28.7	308	34.2
Oil Lamp	313	36.2	12	34.3	10	9.5	315	39.6	325	36.1
Kerosene Lamp	203	23.5	8	22.9	10	9.5	201	25.3	211	23.4
Others	52	6.0	4	11.4	5	4.8	51	6.4	56	6.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.14 it is clear that among the beneficiaries of Ernakulam district, about 34.3 per cent are having electricity as source of light, 36.2 per cent are using oil lamp, 23.5 per cent are using kerosene lamp and there are 6 per cent in the category of others. In the case of beneficiaries of Wayanad district, about 31.4 per cent are having electricity as source of light, 34.3 per cent are using oil lamp, and another 22.9 per cent are using kerosene lamp and there are 11.4 per cent in the category of others. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are oil lamp as source of light. Among the beneficiaries of APL category, about 76.2 per cent are having electricity as source of light, 9.5 per cent are using oil lamp, another 9.5 per cent are using kerosene lamp and there are 4.8 per cent in the category of others. In the case of beneficiaries of BPL category, about 28.7 per cent are having electricity as source of light, 39.6 per cent are using oil lamp, 25.3 per cent are using kerosene lamp and there are 6.4 per cent in the category of others. It is revealed that majority beneficiaries in APL category are having electricity as source of light where as it is oil lamp in the case of BPL beneficiaries.

7.1.14 Classification on the Basis of Source of Water

The beneficiaries are classified on the basis of source of water as given in table 7. 15.

Table 7.15 Classification on The Basis of Source of Water

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Open Well	170	19.7	7	20.0	43	41.0	134	16.9	177	19.7
Bore Well	80	9.2	5	14.3	31	29.5	54	6.8	85	9.4
Public Tap	267	30.9	10	28.6	5	4.8	272	34.2	277	30.8
Tankers	79	9.1	4	11.4	5	4.8	78	9.8	83	9.2
Rivers	110	12.7	4	11.4	0	0.0	114	14.3	114	12.7
Canals	119	13.8	4	11.4	0	0.0	123	15.5	123	13.7
Water Connection	40	4.6	1	2.9	21	20.0	20	2.5	41	4.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.15 it is clear that among the beneficiaries of Ernakulam district, about 19.7 per cent are having open wells as source of water, 9.2 per cent are having bore wells, 4.6 per cent are having water connections, 9.1 per cent are having water from tankers, 12.7 per cent are having water from rivers 13.8 per cent are having water from canals, and the remaining 30.9 per cent having public taps as source of water. In the case of beneficiaries of Wayanad district, about 20 per cent are having open wells as source of water, 14.3 per cent are having bore wells, 2.9 per cent are having water connections, 11.4 per cent each are having water from tankers, rivers and canals, and the remaining 28.6 per cent having public taps as source of water. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having public tap as source of water. Among the beneficiaries of APL category, about 41 per cent are having open wells as source of water, 29.5 per cent are having bore wells, 20 per cent are having water connections, 4.8 per cent are having water from tankers, none are having water from rivers and canals, and the remaining 4.8

per cent having public taps as source of water. In the case of beneficiaries of BPL category, about 16.9 per cent are having open wells as source of water, 6.8 per cent are having bore wells, 2.5 per cent are having water connections, 9.8 per cent are having water from tankers, 14.3 per cent are having water from rivers 15.5 per cent are having water from canals, and the remaining 34.2 per cent having public taps as source of water. It is revealed that majority beneficiaries in APL category are having open wells as source of water, whereas majority beneficiaries in BPL category are having public taps as source of water.

7.1.15 Classification on the Basis of Water Treatment

Hygienic condition of the household is a contributory factor for the healthy lives of the people. Similarly, precautions taken with respect to the hygiene and health often prevent ill health. Drinking treated water is one of the several measures to prevent sickness. The beneficiaries are classified on the basis of water treatment as given in table 7. 16.

Table 7.16 Classification on the Basis of Water Treatment

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	247	28.6	17	48.6	68	64.8	196	24.7	264	29.3
No	618	71.4	18	51.4	37	35.2	599	75.3	636	70.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 7.16 shows that there are about 28.6 per cent beneficiaries who used treated water and 71.4 per cent beneficiaries who used non-treated water in Ernakulam district. There are about 48.6 per cent beneficiaries who used treated water and 51.4 per cent beneficiaries who used non-treated water in Wayanad district. This point to the fact that the majority beneficiaries both in Ernakulam and Wayanad districts are not making water treatment and it is revealed that

Wayanad beneficiaries are more aware about the health factor compared to Ernakulam beneficiaries. There are about 64.8 per cent beneficiaries who used treated water and 35.2 per cent beneficiaries who used non-treated water in APL category. There are only 24.7 per cent beneficiaries who used treated water and 75.3 per cent beneficiaries who used non-treated water in BPL category. This point to the fact that the majority APL beneficiaries are making water treatment and only minority of BPL beneficiaries are making water treatment. It is revealed that APL beneficiaries are more aware about the health factor compared to BPL beneficiaries.

7.1.16 Classification on the Basis of Type of Water Treatment

The beneficiaries are classified on the basis of type of water treatment as given in table 7. 17.

Table 7.17 Classification on The Basis of Type of Water Treatment

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Boiling	112	12.9	15	42.9	26	24.8	101	12.7	127	14.1
Filtering	58	6.7	1	2.9	11	10.5	48	6.0	59	6.6
Cloth Filtering	43	5.0	1	2.9	6	5.7	38	4.8	44	4.9
Any Disinfectant	20	2.3	0	0.0	20	19.0	0	0.0	20	2.2
Others	14	1.6	0	0.0	5	4.8	9	1.1	14	1.6
Not treating	618	71.4	18	51.4	37	35.2	599	75.3	636	70.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.17 it is clear that among the beneficiaries of Ernakulam district, about 12.9 per cent are resorting to boiling as type of water treatment, 6.7 per cent are resorting to filtering, 5 per cent are resorting to cloth filtering, 2.3 per cent are using disinfectant as type of water treatment, and there are 1.6 per cent in the category of others. In the case of beneficiaries of Wayanad district, about 42.9 per cent are resorting to boiling as type of water treatment,

2.9 per cent are resorting to filtering, another 2.9 per cent are resorting to cloth filtering, nobody is using disinfectant as type of water treatment, and there are none in the category of others. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are resorting to boiling as the major type of water treatment. Among the beneficiaries of APL category, about 24.8 per cent are resorting to boiling as type of water treatment, 10.5 per cent are resorting to filtering, 5.7 per cent are resorting to cloth filtering, 19 per cent are using disinfectant as type of water treatment, and the remaining 4.8 per cent in the category of others. In the case of beneficiaries of BPL category, about 12.7 per cent are resorting to boiling as type of water treatment, 6 per cent are resorting to filtering, 4.8 per cent are resorting to cloth filtering, nobody is using disinfectant as type of water treatment, and the remaining 1.1 per cent in the category of others. It is revealed that majority beneficiaries both in APL and BPL category are resorting to boiling as the major type of water treatment.

7.1.17 Classification on the Basis of Source of Outside General Information

The beneficiaries are classified on the basis of source of outside general information as given in table 7. 18.

Table 7.18 Classification on the Basis of Source of Outside General Information

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Newspapers	206	23.8	17	48.6	36	34.3	187	23.5	223	24.8
Radio	211	24.4	8	22.9	30	28.6	189	23.8	219	24.3
Television	162	18.7	0	0.0	30	28.6	132	16.6	162	18.0
Magazines	111	12.8	3	8.6	6	5.7	108	13.6	114	12.7
Government Officials	56	6.5	3	8.6	1	1.0	58	7.3	59	6.6
Public Leaders	50	5.8	3	8.6	1	1.0	52	6.5	53	5.9
Neighbours / Friends	69	8.0	1	2.9	1	1.0	69	8.7	70	7.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 7.18 it is clear that among the beneficiaries of Ernakulam district, about 23.8 per cent are depending on news papers for outside general information, another 24.4 per cent are depending on radio, 18.7 per cent are depending on television, 12.8 per cent on magazines, 6.5 per cent on government officials, 5.8 per cent on public leaders and 8 per cent are depending on neighbours/friends for outside general information. In the case of beneficiaries of Wayanad district, about 48.6 per cent are depending on news papers for outside general information, another 22.9 per cent are depending on radio, 0 per cent are depending on television, 8.6 per cent on magazines, 8.6 per cent on government officials, 8.6 per cent on public leaders and 8 per cent are depending on neighbours/friends for outside general information. It is revealed that majority beneficiaries in Ernakulam district are depending on radio as the major source of outside general information and majority beneficiaries in Wayanad district are depending on newspapers as the major source of outside general information. Among the beneficiaries of APL category, about 34.3 per cent are depending on news papers for outside general information, another 28.6 per cent are depending on radio, 28.6 per cent are depending on television, 5.7 per cent on magazines, 1 per cent on government officials, 1 per cent on public leaders and 1 per cent are depending on neighbours/friends for outside general information. In the case of beneficiaries of BPL category, about 23.5 per cent are depending on news papers for outside general information, another 23.8 per cent are depending on radio, 16.6 per cent are depending on television, 13.6 per cent on magazines, 7.3 per cent on government officials, 6.5 per cent on public leaders and 8.7 per cent are depending on neighbours/friends for outside general information. It is revealed that majority beneficiaries in APL category are depending on newspaper as the major source of outside general

information and majority beneficiaries in BPL category are depending on radio as the major source of outside general information.

7.1.18 Classification on the Basis of State of Health

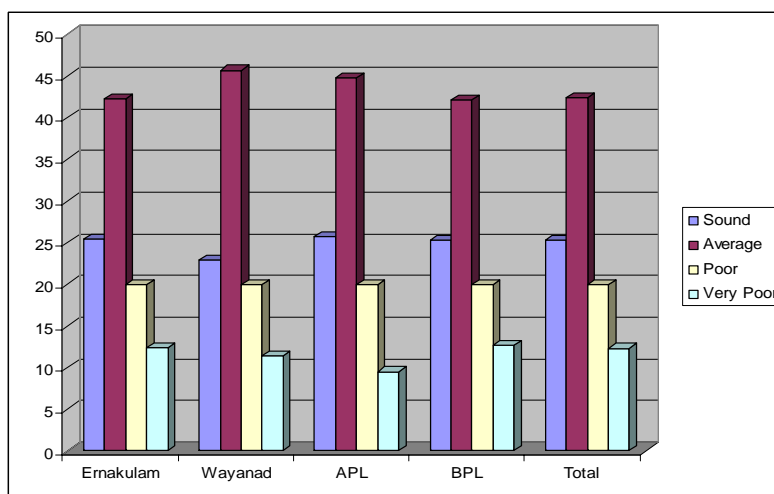
The beneficiaries are classified on the basis of state of health as given in table 7. 19.

Table 7.19 Classification on The Basis of State of Health

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Sound	220	25.4	8	22.9	27	25.7	201	25.3	228	25.3
Average	366	42.3	16	45.7	47	44.8	335	42.1	382	42.4
Poor	172	19.9	7	20.0	21	20.0	158	19.9	179	19.9
Very Poor	107	12.4	4	11.4	10	9.5	101	12.7	111	12.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 7.4 Classification on the Basis of State of Health



From the table 7.19 it is clear that among the beneficiaries of Ernakulam district, about 25.4 per cent are having sound health, 42.3 per cent are having average health, 19.9 per cent are having poor health, and 12.4 per cent are having very poor health. In the case of beneficiaries of Wayanad district, about

22.9 per cent are having sound health, 45.7 per cent are having average health, 20 per cent are having poor health, and 11.4 per cent are having very poor health. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having average health and there is no significant difference between Ernakulam and Wayanad beneficiaries with regard to the state of health. Among the beneficiaries of APL category, about 25.7 per cent are having sound health, 44.8 per cent are having average health, 20 per cent are having poor health, and 9.5 per cent are having very poor health. In the case of beneficiaries of BPL category, about 25.3 per cent are having sound health, 42.1 per cent are having average health, 19.9 per cent are having poor health, and 12.7 per cent are having very poor health. It is revealed that majority beneficiaries both in APL and BPL category are having average health and there is no significant difference between APL and BPL beneficiaries with regard to the state of health.

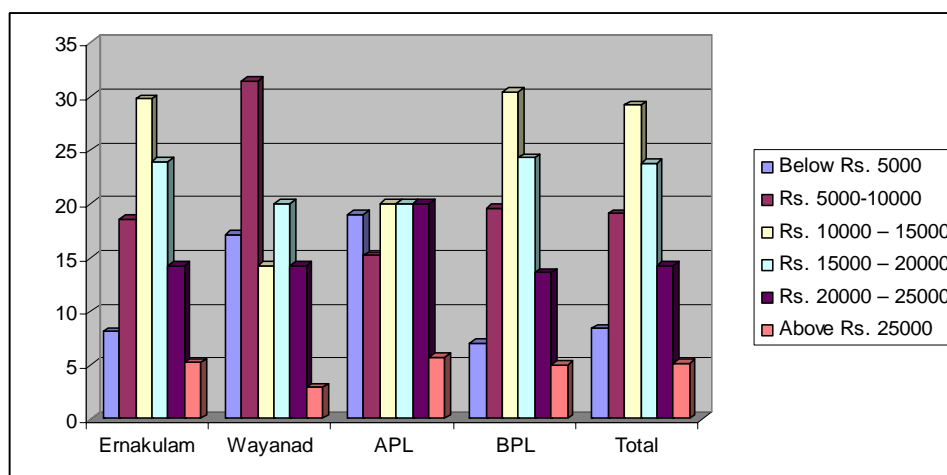
7.1.19 Classification on the Basis of Household Average Annual Expenditure on Medical Care

The beneficiaries are classified on the basis of household average annual expenditure on medical care as given in table 7. 20.

Table 7.20 Classification on The Basis of Household Average Annual Expenditure on Medical Care

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Below Rs. 5000	70	8.1	6	17.1	20	19.0	56	7.0	76	8.4
Rs. 5000-10000	161	18.6	11	31.4	16	15.2	156	19.6	172	19.1
Rs. 10000—15000	258	29.8	5	14.3	21	20.0	242	30.4	263	29.2
Rs. 15000—20000	207	23.9	7	20.0	21	20.0	193	24.3	214	23.8
Rs. 20000—25000	124	14.3	5	14.3	21	20.0	108	13.6	129	14.3
Above Rs. 25000	45	5.2	1	2.9	6	5.7	40	5.0	46	5.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 7.5 Classification on the Basis of Household Average Annual Expenditure on Medical Care

From the table 7.20 it is clear that among the beneficiaries of Ernakulam district, about 8.1 per cent are having household average annual expenditure on medical care less than Rs.5000, 18.6 per cent having expenditure in between Rs.5000-10000, 29.8 per cent having expenditure in between Rs.10000-15000, 23.9 per cent having expenditure in between Rs.15000-20000, 14.3 per cent having expenditure in between Rs.20000-25000, and 5.2 per cent having expenditure more than 25000. Among the beneficiaries of Wayanad district, about 17.1 per cent are having household average annual expenditure on medical care less than Rs.5000, 31.4 per cent having expenditure in between Rs.5000-10000, 14.3 per cent having expenditure in between Rs.10000-15000, 20 per cent having expenditure in between Rs.15000-20000, 14.3 per cent having expenditure in between Rs.20000-25000, and 2.9 per cent having expenditure more than 25000. Among the beneficiaries of APL category, about 19 per cent are having household average annual expenditure on medical care less than Rs.5000, 15.2 per cent having expenditure in between Rs.5000-10000, 20 per cent having expenditure in between Rs.10000-15000, 20 per cent having

expenditure in between Rs.15000-20000, 20 per cent having expenditure in between Rs.20000-25000, and 5.7 per cent having expenditure more than 25000. Among the beneficiaries of BPL category, about 7 per cent are having household average annual expenditure on medical care less than Rs.5000, 19.6 per cent having expenditure in between Rs.5000-10000, 30.4 per cent having expenditure in between Rs.10000-15000, 24.3 per cent having expenditure in between Rs.15000-20000, 13.6 per cent having expenditure in between Rs.20000-25000, and 5 per cent having expenditure more than 25000.

7.1.20 Classification on the Basis of Percentage of House Hold Average Annual Expenditure on Medical Care to Total Household Expenditure

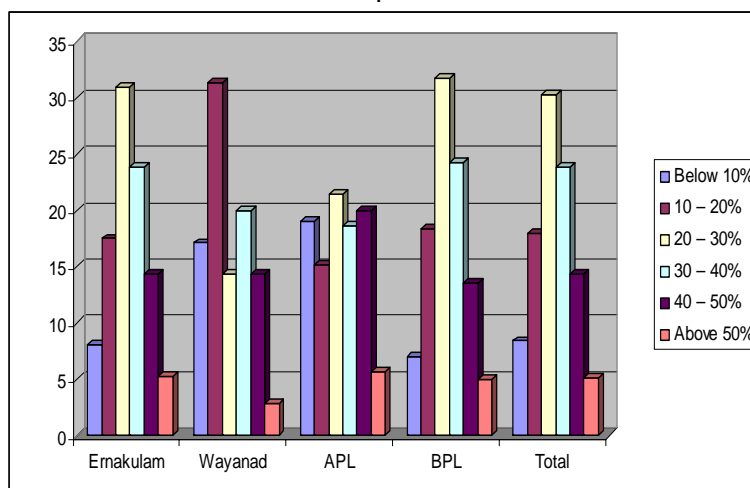
The beneficiaries are classified on the basis of house hold average annual expenditure on medical care as a percentage to total household expenditure as given in table 7. 21.

Table 7. 21 Classification On The Basis Of Percentage of House Hold Average Annual Expenditure on Medical Care to Total Household Expenditure

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Below 10 per cent	70	8.1	6	17.1	20	19.0	56	7.0	76	8.4
10 – 20 per cent	151	17.5	11	31.4	16	15.2	146	18.4	162	18.0
20 – 30 per cent	268	31.0	5	14.3	23	21.4	252	31.7	273	30.3
30 – 40 per cent	207	23.9	7	20.0	19	18.7	193	24.3	214	23.8
40 – 50 per cent	124	14.3	5	14.3	21	20.0	108	13.6	129	14.3
Above 50 per cent	45	5.2	1	2.9	6	5.7	40	5.0	46	5.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 7.6 Classification on the Basis of Percentage of House Hold Average Annual Expenditure on Medical Care to Total Household Expenditure



From the table 7.21 it is clear that among the beneficiaries of Ernakulam district, about 8.1 per cent are having house hold average annual expenditure on medical care as a percentage to total household expenditure less than 10 per cent, 17.5 per cent are having in between 10-20 per cent, 31 per cent are having in between 20-30 per cent, 23.9 per cent are having in between 30-40 per cent, 14.3 per cent are having in between 40-50 per cent and 5.2 per cent are having more than 50 per cent. In the case of beneficiaries of Wayanad district, about 17.1 per cent are having house hold average annual expenditure on medical care as a percentage to total household expenditure less than 10 per cent, 31.4 per cent are having in between 10-20 per cent, 14.3 per cent are having in between 20-30 per cent, 20 per cent are having in between 30-40 per cent, 14.3 per cent are having in between 40-50 per cent and 2.9 per cent are having more than 50 per cent. It is revealed that majority beneficiaries in Ernakulam district are having house hold average annual expenditure on medical care as a percentage to total household expenditure in between 20-30 per cent, whereas majority beneficiaries in Wayanad district are having house hold average annual

expenditure on medical care as a percentage to total household expenditure in between 10-20 per cent, and there is significant difference between Ernakulam and Wayanad beneficiaries with regard to this point. Among the beneficiaries of APL category, about 19 per cent are having house hold average annual expenditure on medical care as a percentage to total household expenditure less than 10 per cent, 15.2 per cent are having in between 10-20 per cent, 21.4 per cent are having in between 20-30 per cent, 18.7 per cent are having in between 30-40 per cent, 20 per cent are having in between 40-50 per cent and 5.7 per cent are having more than 50 per cent. In the case of beneficiaries of BPL category, about 7 per cent are having house hold average annual expenditure on medical care as a percentage to total household expenditure less than 10 per cent, 18.4 per cent are having in between 10-20 per cent, 31.7 per cent are having in between 20-30 per cent, 24.3 per cent are having in between 30-40 per cent, 13.6 per cent are having in between 40-50 per cent and 5 per cent are having more than 50 per cent. It is revealed that majority beneficiaries both in APL and BPL category are having house hold average annual expenditure on medical care as a percentage to total household expenditure in between 20-30 per cent and there is no significant difference between APL and BPL beneficiaries with regard to this point.

Thus the socio-economic profile of the beneficiaries revealed the following:

- Majority of the beneficiaries (53.1 per cent) were males. Females on the other constituted 46.9 per cent.
- There are only 1.3 per cent beneficiaries below the age of 20 years. 8.6 per cent beneficiaries in the category of 20-30 years, 17 per cent in the category of 30-40 years, 32.8 per cent in the category of 40-50 years.

Majority of the beneficiaries (40.3 per cent) fall in the category of above 50 years.

- The educational profile portrayed a low status, as 30.4 per cent of the beneficiaries had only below S.S.L.C. level, 48.2 per cent were having S.S.L.C. as their educational qualification, 16 per cent under graduates, 3.6 per cent graduates, 1.2 per cent post graduates and only 0.6 per cent professionals.
- The occupation profile also portrayed a low status, as only 2.3 per cent of the beneficiaries were government employees, followed by 0.6 per cent professionals, 27.6 self employed and 31.6 per cent private employees respectively. Majority of the beneficiaries (38 per cent) fall in the category of unemployed.
- Majority (39.8 per cent) of the beneficiaries under study were having a family size of 2-4 members. Those with 4-6 members followed with 36.6 per cent beneficiaries and there are 16.6 per cent beneficiaries with 6-8 members. Beneficiaries with more than 8 family members were the least with 7.1 per cent.
- Regarding the religion of the beneficiaries under study, Christian families figured quite prominently with 38.4 per cent. Hindus and Muslims succeeded with 28.4 per cent and 30.4 per cent respectively. There are 2.8 per cent beneficiaries in the category of others.
- Regarding social group, OBC formed the major group with 42.8 per cent. General followed next with 33.2 per cent. Scheduled caste and Scheduled tribe beneficiaries were found to be comparatively lower with 16.8 per cent and 7.2 per cent respectively.
- Regarding monthly income, 89.6 per cent beneficiaries belong to the category of less than Rs.1000/, 1.8 per cent between Rs.1000-2000, 2.9

- per cent between Rs.2000-3000, another 2.9 per cent between Rs.3000-4000, 1.8 per cent between Rs.4000-5000, and there are only 1.1 per cent beneficiaries who are having monthly income more than Rs. 5000/
- There are only 10 per cent beneficiaries who owned houses, 49.3 per cent living in parent's houses, 13.6 in relative's houses, 22.4 per cent in rented houses and there are 4.6 per cent belonging to the category of others.
 - Type of roof of the house varied from 'terrace to 'tarpaulin sheet'. Majority of the houses (47.7 per cent) belonged to tile category. Terrace was reported by 5.9 per cent, 17.3 per cent thatched, 14.8 per cent asbestos, 9.9 per cent tarpaulin and 4.4 per cent others. The figures showed that a good number of the respondents under study were living in houses of dilapidated condition, depicting their miserable situation.
 - Pit was the common type of latrines found among the beneficiaries under study. 53.2 per cent of the beneficiaries reported about it. 26.4 per cent reported the absence of latrines. 17.3 per cent reported septic tank/flush system and there are 3 per cent in the category of others. Here again, the picture is not much encouraging, portraying a dismal scenario of the beneficiaries with the absence of basic amenities.
 - About 20.8 per cent stated the absence of a drainage system in their households. Open drainage system which is almost equivalent to the absence of a drainage was reported by 54.2 per cent. 11.8 per cent had covered, 10.2 per cent had underground and there are 3 per cent in the category of others. Thus a total of 75 per cent of the beneficiaries under study were deprived of a proper drainage system.
 - Most (36.1 per cent) of the beneficiaries had only oil lamp, as the source of light. Electricity and kerosene lamp followed next with 34.2 per cent

and 23.4 per cent respectively. 6.2 per cent beneficiaries in the category of others.

- Most (30.8 per cent) of the beneficiaries had only public taps, as the source of drinking water. Open wells, rivers and canals followed next with 19.7 per cent, 12.7 per cent and 12.7 per cent respectively. 9.4 per cent reported bore wells, 9.2 per cent tankers and 4.6 per cent reported water connections as the sources of drinking water.
- Only 29.3 per cent of the households reported to have treated their water before drinking.
- Major mode of treatment of water was boiling as 14.1 per cent reported about it. The other modes of treatment included: using disinfectant, filtering and cloth filtering.
- Most (24.8 per cent) of the beneficiaries had news paper, as the source of outside general information. Radio and T.V. followed next with 24.3 per cent, and 18 per cent respectively. 12.7 per cent reported magazines, 6.6 per cent government officials, 5.9 per cent public leaders and 7.8 per cent reported neighbours/friends as the sources of outside general information.
- Regarding state of health, majority (42.4 per cent) reported average health, 25.3 per cent reported sound health, poor health reported by 19.9 per cent and 12.3 per cent reported very poor health.
- About 8.4 per cent of the beneficiaries reported household average annual expenditure on medical care below Rs.5000/, 19.1 per cent in between Rs. 5000-10000, 29.2 per cent in between Rs. 10000-15000, 23.8 per cent in between Rs. 15000-20000, 14.3 per cent in between Rs. 20000-25000 and 5.1 per cent reported it above Rs. 25000/.

- About 8.4 per cent of the beneficiaries reported percentage of household average annual expenditure on medical care to total expenditure below 10 per cent, 18 per cent in between 10-20 per cent, 30.3 per cent in between 20-30 per cent, 23.8 per cent in between 30-40 per cent, 14.3 per cent in between 40-50 per cent and 5 per cent reported it above 50 per cent.

The socio-economic profile of the sample beneficiaries thus illustrated that majority of the beneficiaries under RSBY-CHIS were of a very low status in terms of education, occupation, income, ownership of house, its structure, type of latrines, type of drainage and the source of drinking water and light. The details in this regard re-emphasize the low economic status and poor condition of the beneficiaries. Moreover, it is also revealed that majority of the beneficiaries had only average health and they are spending a good percentage of their income on medical care and it throws light on the inevitability of a well defined health insurance scheme like RSBY-CHIS.



Chapter 8

**Awareness of the Beneficiaries on
the Features of RSBY-CHIS**



- 8.1 Suggested awareness activity that may be undertaken by network hospitals
 - 8.2 Health Camps that may be organized by network hospitals
 - 8.3 On-site OPD Camps that may be organized by network hospitals
 - 8.4 Details About Awareness Level of the Beneficiaries about RSBY-CHIS
 - 8.5 Mann-Whitney U Test
-

The success of RSBY-CHIS largely depends on the local understanding of the dimensions of the scheme and determinants of access to health services. Over time, increased awareness should raise the utilization rates observed. The understanding of different features of RSBY-CHIS is very important for enrolment as well as hospitalization by use of smart cards. There is an urgent need to make the beneficiaries accountable for the program. Though the macro-level awareness about availability of RSBY-CHIS is very high, additional efforts are needed to be put in by the insurers to enhance the level of awareness about the features of the scheme amongst the beneficiaries. The intrinsic benefits of the scheme to households, like affordability and accessibility to health facilities, are obvious, but issues of awareness and understanding of the program remain. This was the rationale for prescribing a role for intermediaries whose main role would be to make it easier for RSBY-CHIS beneficiaries to avail of services. Insurers are mandated to work with such intermediaries, but here there is a conflict of interest since success should lead to higher claims ratios and lower insurance company profits.

Awareness activities about availability of free treatment in hospitals under RSBY-CHIS and health camps are the main vehicles for sensitizing the beneficiaries of RSBY-CHIS of latent ailments and consequences thereof if such ailments remain unattended for prolonged period. All Network Hospitals need to conduct regular free health camps. Common ailments can be attended to during such camps only and those serious in nature are to be referred for admission in hospital.

8.1 Suggested awareness activity that may be undertaken by network hospitals

1. Pamphlet Distribution
2. Public announcements
3. Playing of Audio-Visual media (Cassettes, Audio CDs and DVDs)
4. Scroll in local cable networks
5. News/Advertisements in local dailies
6. Display of posters
7. Display of banners
8. Self Help Group meetings
9. Village or Panchayat meetings
10. Exhibits on hygiene, general health, prevention of communicable diseases etc.
11. Exhibits on early detection and prevention of chronic diseases

8.2 Health Camps that may be organized by network hospitals

1. Health camps may be organized at a frequency of at least once a month
2. It should be organized in areas of high concentration of RSBY cardholders
3. Typically a health camp may involve
 - a. Routine pathological diagnosis
 - b. Consultation for ailments
 - c. Dispensing medicines there for
 - d. Portable medical equipment can be used for effectiveness
4. Camp coordinator to ensure that the schedule is informed to all beneficiaries including people's representatives.
5. The following documentation have to be done during the camp:
 - a. Each patient has to be given an outpatient-cum-prescription card.
 - b. Patients who require hospitalization should be given Referral card with the details of date for reporting to the hospital, place of appointment, name of consultant and mobile number of hospital coordinator or RSBY Helpdesk coordinator.
 - c. Details of all outpatients and referred patients to be recorded by camp coordinators
6. The patients referred from the camps shall be followed up to report to the network hospital by the RSBY helpdesk coordinator for the specific hospital.
7. Arrangement should be made to provide shade for waiting patients by erecting shamianas

8. Providing pedestal fans during summers
9. Seating arrangement for waiting patients
10. Drinking water for patients
11. Toilet facility for patients
12. Screening enclosures for patients

8.3 On-site OPD Camps that may be organized by network hospitals

For ailments which are serious in nature and may require use of non-portable equipment for diagnostic purposes, hospitals may organize OPD camps in hospitals. Typically it is expected that the diseases which are common in the area of a hospital's outreach and occupational ailments are better diagnosed at such camps. Those requiring hospitalization, may be so advised on the spot.

As the government of Kerala looks to support and expand healthcare provided through the RSBY-CHIS, it is important to understand the levels of awareness that exist about the program. The CHIAK has well defined objectives to achieve while formulating RSBY-CHIS. How far these objectives are materialized by way of awareness is analyzed in this chapter. To measure awareness levels of the beneficiaries a section was developed in the research instrument.

8.4 Details about Awareness Level of the Beneficiaries about RSBY-CHIS

All the tables and figures in this chapter are derived from the sample survey.

8.4.1 General Awareness

8.4.1.1 Amount of Coverage in CHIS

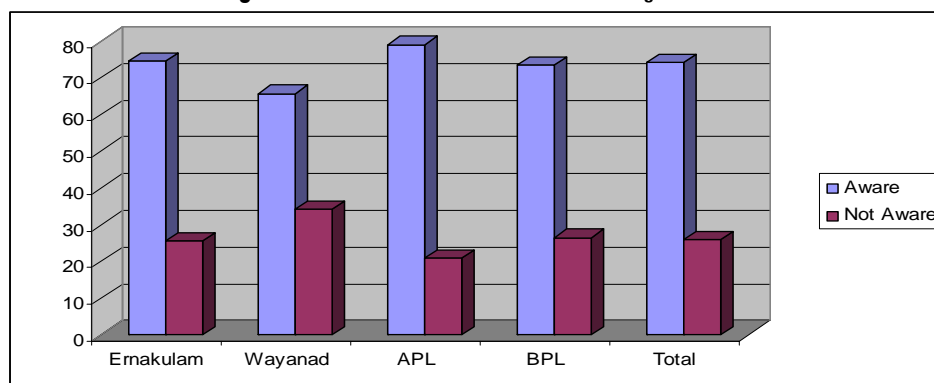
RSBY-CHIS is a comprehensive, insurance-backed healthcare scheme which provides for coverage of hospitalization expenses incurred by the smartcard holders. It provides hospitalization coverage for up to Rs. 30,000/- for a family of five on a floater basis. The card can be used multiple times till the insurance coverage is exhausted. The table 8.1 illustrates awareness of beneficiaries on amount of coverage in CHIS.

Table 8.1 Awareness on Amount of Coverage in CHIS

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	644	74.5	23	65.7	83	79.0	584	73.5	667	74.1
Not Aware	221	25.5	12	34.3	22	21.0	211	26.5	233	25.9
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.1 Awareness on Amount of Coverage in CHIS



The table 8.1 shows that there are about 74.5 per cent beneficiaries who have awareness and only 25.5 per cent who have no awareness on amount of coverage in CHIS in Ernakulam district. There are about 65.7 per cent beneficiaries who have awareness and only 34.3 per cent who have no awareness on amount of coverage in CHIS in Wayanad district. This point to

the fact that the awareness on amount of coverage in CHIS is relatively higher in Ernakulam beneficiaries compared to Wayanad beneficiaries. There are about 79 per cent beneficiaries who have awareness and only 21 per cent who have no awareness on amount of coverage in CHIS in APL category. There are about 73.5 per cent beneficiaries who have awareness and only 26.5 per cent who have no awareness on amount of coverage in CHIS in BPL category. This point to the fact that the awareness on amount of coverage in CHIS is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on amount of coverage in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.2.

Table 8.2 Chi-square Analysis on Awareness on Amount of Coverage in CHIS

Awareness	Combined		Total	Chi-square	Df	p - value
	APL	BPL				
Aware	83	584	667	1.510	1	0.219
Not Aware	22	211	233			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p - value
	Ernakulam	Wayanad				
Aware	644	23	667	1.338	1	0.247
Not Aware	221	12	233			
Total	865	35	900			

Awareness	Ernakulam		Total	Chi-square	df	p - value
	APL	BPL				
Aware	80	564	644	1.830	1	0.176
Not Aware	20	201	221			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p - value
	APL	BPL				
Aware	3	20	23	0.085	1	0.999
Not Aware	2	10	12			
Total	5	30	35			

Awareness	APL		Total	Chi-square	df	p-value
	Ernakulam	Wayanad				
Aware	80	3	83	1.150	1	0.581
Not Aware	20	2	22			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p-value
	Ernakulam	Wayanad				
Aware	564	20	584	0.738	1	0.390
Not Aware	201	10	211			
Total	765	30	795			

Source: Primary data

The table 8.2 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.219, whereas it is 0.247 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P-value is 0.176 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.999 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P-value is 0.581 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.390 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.1.2 Knowledge about CHIS-PLUS

CHIS-PLUS is an additional treatment benefit of Rs. 70,000/- over and above the RSBY benefits to all the RSBY-CHIS card holders except APL card holders for treatment of Cancer, heart and kidney related diseases. The table 8.3 illustrates awareness of beneficiaries on CHIS-PLUS.

Table 8.3 Knowledge about CHIS-PLUS

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	432	49.9	20	57.1	57	54.3	395	49.7	452	50.2
Not Aware	433	50.1	15	42.9	48	45.7	400	50.3	448	49.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.3 shows that there are about 49.9 per cent beneficiaries who have awareness and 50.1 per cent who have no awareness on CHIS-PLUS in Ernakulam district. There are about 57.1 per cent beneficiaries who have awareness and 42.9 per cent who have no awareness on CHIS-PLUS in Wayanad district. This point to the fact that the awareness on CHIS-PLUS is relatively higher in Wayanad beneficiaries compared to Ernakulam beneficiaries. There are about 54.3 per cent beneficiaries who have awareness and 45.7 per cent who have no awareness on CHIS-PLUS in APL category. There are about 49.7 per cent beneficiaries who have awareness and 50.3 per cent who have no awareness on CHIS-PLUS in BPL category. This point to the fact that the awareness on CHIS-PLUS is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on CHIS-PLUS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.4.

Table 8.4 Chi-square Analysis on Awareness on CHIS-PLUS

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	55	377	432	1.157	1	0.282
Not Aware	45	388	433			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	2	18	20	0.700	1	0.631
Not Aware	3	12	15			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	55	2	57	0.432	1	0.658
Not Aware	45	3	48			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	377	18	395	1.327	1	0.249
Not Aware	388	12	400			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	57	395	452	0.785	1	0.376
Not Aware	48	400	448			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	432	20	452	0.698	1	0.404
Not Aware	433	15	448			
Total	865	35	900			

Source: Primary data

The table 8.4 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.376, whereas it is 0.404 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.282 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.631 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.658 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.249 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.1.3 Amount of Coverage in CHIS-PLUS

The table 8.5 illustrates awareness of beneficiaries on amount of coverage in CHIS-PLUS.

Table 8.5 Awareness on Amount of Coverage in CHIS-PLUS

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	140	16.2	6	17.1	15	14.3	131	16.5	146	16.2
Not Aware	725	83.8	29	82.9	90	85.7	664	83.5	754	83.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.5 shows that there are about 16.2 per cent beneficiaries who have awareness and 83.8 per cent who have no awareness on amount of coverage in CHIS-PLUS in Ernakulam district. There are about 17.1 per cent beneficiaries who have awareness and 82.9 per cent who have no awareness on amount of coverage in CHIS-PLUS in Wayanad district. This point to the fact that the awareness on amount of coverage in CHIS-PLUS is more or less the same in both Ernakulam and Wayanad beneficiaries and it is very low in both Ernakulam and Wayanad beneficiaries. There are about 14.3 per cent beneficiaries who have awareness and 85.7 per cent who have no awareness on amount of coverage in CHIS-PLUS in APL category. There are about 16.5 per cent beneficiaries who have awareness and 83.5 per cent who have no awareness on amount of coverage in CHIS-PLUS in BPL category. This point to the fact that the awareness on amount of coverage in CHIS-PLUS is more or less the same in both APL and BPL categories and it is very low in both APL and BPL beneficiaries. CHIS-PLUS is introduced only recently and this may be the reason for its low level of awareness.

Whether these differences in awareness level on amount of coverage in CHIS-PLUS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.6

Table 8.6 Chi-square Analysis on Awareness on Amount of Coverage in CHIS-PLUS

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	15	125	140	0.117	1	0.732
Not Aware	85	640	725			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	0	6	6	1.207	1	0.561
Not Aware	5	24	29			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	15	0	15	0.875	1	0.603
Not Aware	85	5	90			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	125	6	131	0.281	1	0.596
Not Aware	640	24	664			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	15	131	146	0.328	1	0.567
Not Aware	90	664	754			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	140	6	146	0.023	1	0.880
Not Aware	725	29	754			
Total	865	35	900			

Source: Primary data

The table 8.6 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.567, whereas it is 0.880 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.732 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.561 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.603 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.596 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.1.4 Awareness on Empanelled Hospitals in CHIS

There are hospitals empanelled by the concerned insurance company in consultation with the State Government to provide cashless treatment to RSBY-CHIS beneficiaries. The beneficiaries can get hospitalized in any of these

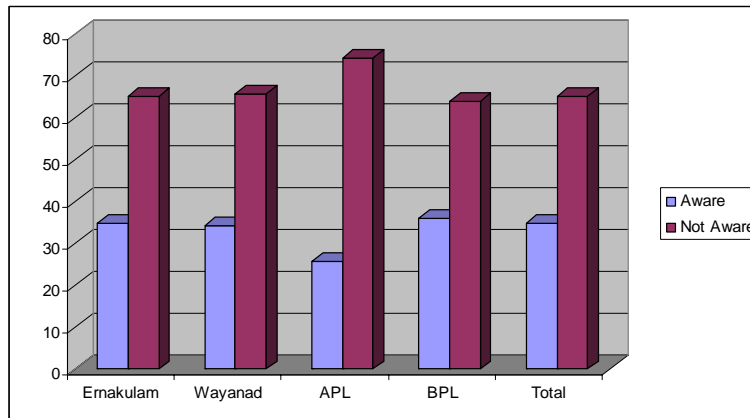
network hospitals under the scheme. The table 8.7 illustrates awareness of beneficiaries on empanelled hospitals in CHIS.

Table 8.7 Awareness on Empanelled Hospitals in CHIS

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	301	34.8	12	34.3	27	25.7	286	36.0	313	34.8
Not Aware	564	65.2	23	65.7	78	74.3	509	64.0	587	65.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.2 Awareness on Empanelled Hospitals in CHIS



The table 8.7 shows that there are about 34.8 per cent beneficiaries who have awareness and 65.2 per cent who have no awareness on empanelled hospitals in CHIS in Ernakulam district. There are about 34.3 per cent beneficiaries who have awareness and 65.7 per cent who have no awareness on empanelled hospitals in CHIS in Wayanad district. This point to the fact that the awareness on empanelled hospitals in CHIS is more or less the same in both Ernakulam and Wayanad categories and it is relatively poor in both Ernakulam and Wayanad beneficiaries. There are about 25.7 per cent beneficiaries who have awareness and 74.3 per cent who have no awareness on empanelled hospitals in CHIS in APL category. There are about 36 per cent beneficiaries

who have awareness and 64 per cent who have no awareness on empanelled hospitals in CHIS in BPL category. This point to the fact that the awareness on empanelled hospitals in CHIS is relatively higher in BPL beneficiaries compared to APL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.8.

Table 8.8 Chi-square Analysis on Awareness on Empanelled Hospitals in CHIS

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	25	276	301	4.784	1	0.029
Not Aware	75	489	564			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	2	10	12	0.085	1	0.999
Not Aware	3	20	23			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	25	2	27	0.561	1	0.601
Not Aware	75	3	78			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p - value
	Ernakulam	Wayanad				
Aware	276	10	286	0.094	1	0.759
Not Aware	489	20	509			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p - value
	APL	BPL				
Aware	27	286	313	4.305	1	0.038
Not Aware	78	509	587			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p - value
	Ernakulam	Wayanad				
Aware	301	12	313	0.004	1	0.950
Not Aware	564	23	587			
Total	865	35	900			

Source: Primary data

The table 8.8 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.038 and so the difference in awareness level on empanelled hospitals is significant in between APL and BPL beneficiaries, whereas it is 0.950 in between Ernakulam and Wayanad beneficiaries and so not significant. P- value is 0.029 in between the APL and BPL beneficiaries of Ernakulam district and so the difference in awareness level on empanelled hospitals is significant in between APL and BPL beneficiaries of Ernakulam district, whereas it is 0.999 in between the APL and BPL beneficiaries of Wayanad district, and so not significant. P- value is 0.601 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.759 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.1.5 Awareness on Empanelled Hospitals in CHIS-PLUS

CHIS-PLUS is implemented by CHIAK with the assistance of participating hospitals utilizing software developed by KELTRON. A RSBY-CHIS card holder who suffers from any of the three fatal diseases will have to contact any of the participating hospitals for availing treatment facility. The table 8.9 illustrates awareness of beneficiaries on empanelled hospitals in CHIS-PLUS.

Table 8.9 Awareness on Empanelled Hospitals in CHIS-PLUS

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	320	37.0	8	22.9	30	28.6	298	37.5	328	36.4
Not Aware	545	63.0	27	77.1	75	71.4	497	62.5	572	63.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.9 shows that there are about 37 per cent beneficiaries who have awareness and 63 per cent who have no awareness on empanelled hospitals in CHIS-PLUS in Ernakulam District. There are about 22.9 per cent beneficiaries who have awareness and 77.1 per cent who have no awareness on empanelled hospitals in CHIS-PLUS in Wayanad District. This point to the fact that the awareness on empanelled hospitals in CHIS-PLUS is relatively higher in Ernakulam beneficiaries compared to Wayanad beneficiaries. There are about 28.6 per cent beneficiaries who have awareness and 71.4 per cent who have no awareness on empanelled hospitals in CHIS-PLUS in APL category. There are about 37.5 per cent beneficiaries who have awareness and 62.5 per cent who have no awareness on empanelled hospitals in CHIS-PLUS in BPL category. This point to the fact that the awareness on empanelled hospitals in CHIS-PLUS is relatively higher in BPL beneficiaries compared to APL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.10.

Table 8.10 Chi-square Analysis on Awareness on Empanelled Hospitals in CHIS-PLUS

Awareness	Ernakulam		Total	Chi-square	Df	p - value
	APL	BPL				
Aware	30	290	320	2.373	1	0.123
Not Aware	70	475	545			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p - value
	APL	BPL				
Aware	0	8	8	1.728	1	0.315
Not Aware	5	22	27			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p - value
	Ernakulam	Wayanad				
Aware	30	0	30	2.100	1	0.318
Not Aware	70	5	75			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p - value
	Ernakulam	Wayanad				
Aware	290	8	298	1.557	1	0.212
Not Aware	475	22	497			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p - value
	APL	BPL				
Aware	30	298	328	3.181	1	0.074
Not Aware	75	497	572			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p - value
	Ernakulam	Wayanad				
Aware	320	8	328	2.903	1	0.088
Not Aware	545	27	572			
Total	865	35	900			

Source: Primary data

The table 8.10 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.074, whereas it is 0.088 in between Ernakulam

and Wayanad beneficiaries and so both of them not significant. P- value is 0.123 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.315 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.318 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.212 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.2 Awareness on Procedures during Admission as an In Patient

8.4.2.1 Awareness on Giving Smartcard at the RSBY-CHIS Counter during Admission

The first step for availing hospitalization under the scheme is to give the smart card at the RSBY-CHIS help desk. The table 8.11 illustrates awareness of beneficiaries on giving smart card at the RSBY-CHIS counter during admission.

Table 8.11 Awareness on Giving Smartcard at the RSBY-CHIS Counter during Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	407	47.1	18	51.4	49	46.7	376	47.3	425	47.2
Not Aware	458	52.9	17	48.6	56	53.3	419	52.7	475	52.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.11 shows that there are about 47.1 per cent beneficiaries who have awareness and 52.9 per cent who have no awareness on giving smart card at the RSBY-CHIS counter during admission in Ernakulam district. There are about 51.4 per cent beneficiaries who have awareness and 48.6 per cent who have no awareness on giving smart card at the RSBY-CHIS counter during admission in Wayanad district. This point to the fact that the awareness on

giving smart card at the RSBY-CHIS counter during admission is more or less the same in both Ernakulam and Wayanad beneficiaries and it is relatively high in both Ernakulam and Wayanad beneficiaries. There are about 46.7 per cent beneficiaries who have awareness and 53.3 per cent who have no awareness on giving smart card at the RSBY-CHIS counter during admission in APL category. There are about 47.3 per cent beneficiaries who have awareness and 52.7 per cent who have no awareness on giving smart card at the RSBY-CHIS counter during admission in BPL category. This points to the fact that the awareness on giving smart card at the RSBY-CHIS counter during admission is more or less the same in both APL and BPL categories and it is relatively high in both APL and BPL beneficiaries.

Whether these differences in awareness level on giving smart card at the RSBY-CHIS counter during admission among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.12

Table 8.12 Chi-square Analysis on Awareness on Giving Smartcard at the RSBY-CHIS Counter During Admission

Awareness	Ernakulam		Total	Chi-square	df	p – value
	APL	BPL				
Aware	45	362	407	0.191	1	0.662
Not Aware	55	403	458			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p – value
	APL	BPL				
Aware	4	14	18	1.906	1	0.338
Not Aware	1	16	17			
Total	5	30	35			

Awareness	APL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	45	4	49	2.344	1	0.182
Not Aware	55	1	56			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p - value
	Ernakulam	Wayanad				
Aware	362	14	376	0.005	1	0.944
Not Aware	403	16	419			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	df	p – value
	APL	BPL				
Aware	49	376	425	0.015	1	0.903
Not Aware	56	419	475			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	407	18	425	0.259	1	0.611
Not Aware	458	17	475			
Total	865	35	900			

Source: Primary data

The table 8.12 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.903, whereas it is 0.611 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.662 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.338 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.182 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.944 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.2.2 Awareness on Knowing the Available Balance in the Card during Admission

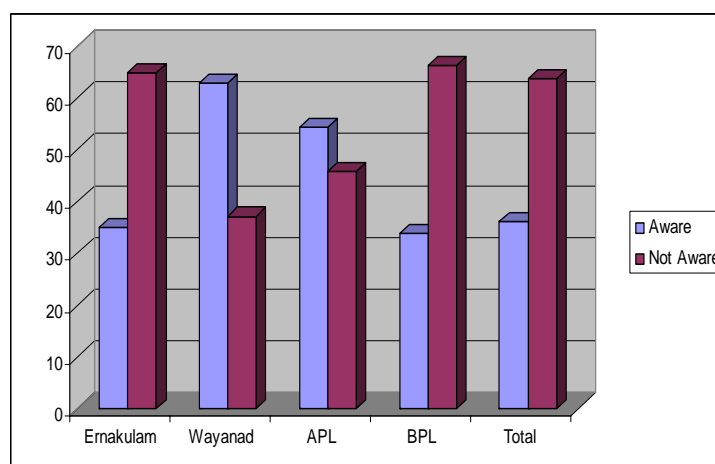
RSBY-CHIS provide that no payment is to be made by an insured person for treatment taken in a network-hospital up to the limit of sum insured. For treatments in excess of the limit of sum insured and also for treatments excluded under the scheme, the insured person shall have to bear the expenses. Thus knowing the available balance is very essential before starting the treatment. The table 8.13 illustrates awareness of beneficiaries on knowing the balance in the card during admission.

Table 8.13 Awareness on Knowing the Available Balance in the Card during Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	304	35.1	22	62.9	57	54.3	269	33.8	326	36.2
Not Aware	561	64.9	13	37.1	48	45.7	526	66.2	574	63.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.3 Awareness on Knowing the Available Balance in the Card during Admission



The table 8.13 shows that there are about 35.1 per cent beneficiaries who have awareness and 64.9 per cent who have no awareness on knowing the available balance in the card during admission in Ernakulam district. There are

about 62.9 per cent beneficiaries who have awareness and 37.1 per cent who have no awareness on giving smart card at the RSBY-CHIS counter during admission in Wayanad district. This points to the fact that the awareness on knowing the available balance in the card during admission is relatively higher in Wayanad beneficiaries compared to Ernakulam beneficiaries. There are about 54.3 per cent beneficiaries who have awareness and 45.7 per cent who have no awareness on knowing the available balance in the card during admission in APL category. There are about 33.8 per cent beneficiaries who have awareness and 66.2 per cent who have no awareness on giving smart card at the RSBY-CHIS counter during admission in BPL category. This points to the fact that the awareness on knowing the available balance in the card during admission is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.14.

Table 8.14 Chi-square Analysis on Awareness on Knowing the Available Balance in the Card During Admission

Awareness	Ernakulam		Total	Chi-square	df	p – value
	APL	BPL				
Aware	55	249	304	19.557	1	0.000
Not Aware	45	516	561			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p – value
	APL	BPL				
Aware	2	20	22	1.305	1	0.337
Not Aware	3	10	13			
Total	5	30	35			

Awareness of the Beneficiaries on the Features of RSBY-CHIS

Awareness	APL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	55	2	57	0.432	1	0.658
Not Aware	45	3	48			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	249	20	269	15.010	1	0.000
Not Aware	516	10	526			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	df	p – value
	APL	BPL				
Aware	57	269	326	16.785	1	0.000
Not Aware	48	526	574			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	304	22	326	11.183	1	0.001
Not Aware	561	13	574			
Total	865	35	900			

Source: Primary data

The table 8.14 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.000, whereas it is 0.001 in between Ernakulam and Wayanad beneficiaries and so both of them significant. P- value is 0.000 in between the APL and BPL beneficiaries of Ernakulam district and it is significant, whereas it is 0.337 in between the APL and BPL beneficiaries of Wayanad district, and so it is not significant. P- value is 0.658 in between the Ernakulam APL and Wayanad APL beneficiaries and so not significant, whereas it is 0.000 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so it is significant.

8.4.2.3 Awareness on Finger Print Verification during Admission

Smart Card enables identification of beneficiary through photograph and fingerprints, besides other information about a patient. The same can be read at the hospital using the card reader and a computer. The table 8.15 illustrates awareness of beneficiaries on finger print verification during admission.

Table 8.15 Awareness on Finger Print Verification during Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	463	53.5	10	28.6	47	44.8	426	53.6	473	52.6
Not Aware	402	46.5	25	71.4	58	55.2	369	46.4	427	47.4
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.15 shows that there are about 53.5 per cent beneficiaries who have awareness and 46.5 per cent who have no awareness on finger print verification during admission in Ernakulam district. There are only 28.6 per cent beneficiaries who have awareness and 71.4 per cent who have no awareness on finger print verification during admission in Wayanad district. This point to the fact that the awareness on finger print verification during admission is relatively higher in Ernakulam beneficiaries compared to Wayanad beneficiaries. There are about 44.8 per cent beneficiaries who have awareness and 55.2 per cent who have no awareness on finger print verification during admission in APL category. There are about 53.6 per cent beneficiaries who have awareness and 46.4 per cent who have no awareness on finger print verification during admission in BPL category. This point to the fact that the awareness on finger print verification during admission is relatively higher in BPL beneficiaries compared to APL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.16.

Table 8.16 Chi-square Analysis on Awareness on Finger Print Verification during Admission

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	45	418	463	3.304	1	0.069
Not Aware	55	347	402			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	2	8	10	0.373	1	0.610
Not Aware	3	22	25			
Total	5	30	35			

Awareness	APL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	45	2	47	0.048	1	0.999
Not Aware	55	3	58			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	418	8	426	9.083	1	0.003
Not Aware	347	22	369			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	df	p – value
	APL	BPL				
Aware	47	426	473	2.896	1	0.089
Not Aware	58	369	427			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	463	10	473	8.401	1	0.004
Not Aware	402	25	427			
Total	865	35	900			

Source: Primary data

The table 8.16 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.089 and so not significant, whereas it is 0.004 in between Ernakulam and Wayanad beneficiaries and so it is significant. P- value is 0.069 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.610 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.999 in between the Ernakulam APL and Wayanad APL beneficiaries and so not significant, whereas it is 0.003 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so it is significant.

8.4.2.4 Awareness on Free Medicines and Tests Even From Outside

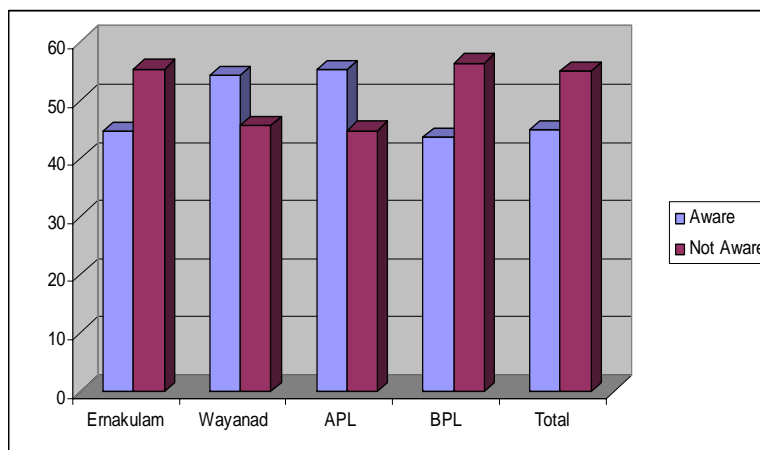
The beneficiary doesn't have to make any payment to anybody for medicines and tests even if it is obtained from outside as these are covered in the package rates, the payment of which is made by the insurance company to the hospital. The table 8.17 illustrates awareness of beneficiaries on free medicines and tests even from outside.

Table 8.17 Awareness on Free Medicines and Tests Even From Outside

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	386	44.6	19	54.3	58	55.2	347	43.6	405	45.0
Not Aware	479	55.4	16	45.7	47	44.8	448	56.4	495	55.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.4 Awareness on Free Medicines and Tests Even From Outside



The table 8.17 shows that there are about 44.6 per cent beneficiaries who were aware off and 55.4 per cent who were not aware off about free medicines and tests even from outside Ernakulam district. There are about 54.3 per cent beneficiaries who have awareness and 45.7 per cent who have no awareness on free medicines and tests even from outside in Wayanad district. This point to the fact that the awareness on free medicines and tests even from outside is relatively higher in Wayanad beneficiaries compared to Ernakulam beneficiaries. There are about 55.2 per cent beneficiaries who have awareness and 44.8 per cent who have no awareness on free medicines and tests even from outside in APL category. There are about 43.6 per cent beneficiaries who have awareness and 56.4 per cent who have no awareness on free medicines and tests even from outside in BPL category. This point to the fact that the awareness on free medicines and tests even from outside is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.18.

Table 8.18 Chi-square Analysis on Awareness on Free Medicines and Tests Even From Outside

Awareness	Ernakulam		Total	Chi-square	df	p – value
	APL	BPL				
Aware	55	331	386	4.926	1	0.026
Not Aware	45	434	479			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p – value
	APL	BPL				
Aware	3	16	19	0.077	1	0.999
Not Aware	2	14	16			
Total	5	30	35			

Awareness	APL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	55	3	58	0.048	1	0.999
Not Aware	45	2	47			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	331	16	347	1.189	1	0.276
Not Aware	434	14	448			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	df	p – value
	APL	BPL				
Aware	58	347	405	5.034	1	0.025
Not Aware	47	448	495			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	386	19	405	1.269	1	0.260
Not Aware	479	16	495			
Total	865	35	900			

Source: Primary data

The table 8.18 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.025 and so it is significant, whereas it is 0.260 in between Ernakulam and Wayanad beneficiaries and so not significant.

P- value is 0.026 in between the APL and BPL beneficiaries of Ernakulam district and so it is significant, whereas it is 0.999 in between the APL and BPL beneficiaries of Wayanad district, and so not significant. P- value is 0.999 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.276 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.2.5 Awareness on Free Food to the Patient

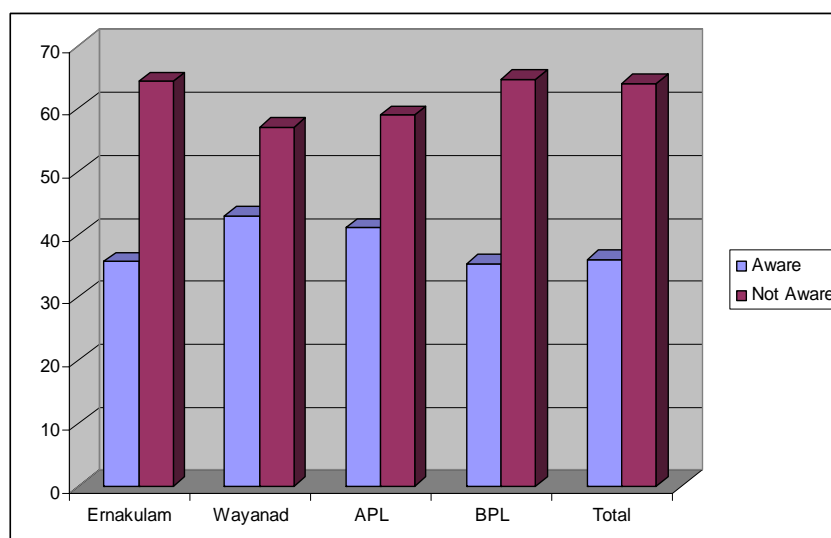
The package of health services under RSBY-CHIS covers free food during hospitalization. This is given only to the patient. The table 8.19 illustrates awareness of beneficiaries on free food to the patient.

Table 8.19 Awareness on Free Food to the Patient

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	309	35.7	15	42.9	43	41.0	281	35.3	324	36.0
Not Aware	556	64.3	20	57.1	62	59.0	514	64.7	576	64.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.5 Awareness on Free Food to the Patient



The table 8.19 shows that there are only 35.7 per cent beneficiaries who have awareness and 64.3 per cent who have no awareness on free food to the patient in Ernakulam district. There are about 42.9 per cent beneficiaries who have awareness and 57.1 per cent who have no awareness on free food to the patient in Wayanad district. This point to the fact that the awareness on free food to the patient is relatively higher in Wayanad beneficiaries compared to Ernakulam beneficiaries. There are about 41 per cent beneficiaries who have awareness and 59 per cent who have no awareness on free food to the patient in APL category. There are only 35.3 per cent beneficiaries who have awareness and 64.7 per cent who have no awareness on free food to the patient in BPL category. This point to the fact that the awareness on free food to the patient is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.20.

Table 8.20 Chi-square Analysis on Awareness on Free Food to the Patient

Awareness	Ernakulam		Total	Chi-square	Df	p - value
	APL	BPL				
Aware	40	269	309	0.901	1	0.343
Not Aware	60	496	556			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p - value
	APL	BPL				
Aware	3	12	15	0.700	1	0.631
Not Aware	2	18	20			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p - value
	Ernakulam	Wayanad				
Aware	40	3	43	0.788	1	0.646
Not Aware	60	2	62			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	269	12	281	0.296	1	0.587
Not Aware	496	18	514			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	43	281	324	1.265	1	0.261
Not Aware	62	514	576			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	309	15	324	0.743	1	0.389
Not Aware	556	20	576			
Total	865	35	900			

Source: Primary data

The table 8.20 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.261, whereas it is 0.389 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.343 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.631 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.646 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.587 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.3 Awareness on Procedures during Discharge

8.4.3.1 Awareness on Receiving Discharge Summary

The table 8.21 illustrates awareness of beneficiaries on receiving discharge summary.

Table 8.21 Awareness on Receiving Discharge Summary

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	320	37.0	8	22.9	30	28.6	298	37.5	328	36.4
Not Aware	545	63.0	27	77.1	75	71.4	497	62.5	572	63.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.21 shows that there are only 37 per cent beneficiaries who have awareness and 63 per cent who have no awareness on receiving discharge summary in Ernakulam district. There are only 22.9 per cent beneficiaries who have awareness and 77.1 per cent who have no awareness on receiving discharge summary in Wayanad district. This point to the fact that the awareness on receiving discharge summary is relatively higher in Ernakulam beneficiaries compared to Wayanad beneficiaries. There are only 28.6 per cent beneficiaries who have awareness and 71.4 per cent who have no awareness on receiving discharge summary in APL category. There are about 37.5 per cent beneficiaries who have awareness and 62.5 per cent who have no awareness on receiving discharge summary in BPL category. This point to the fact that the awareness on receiving discharge summary is relatively higher in BPL beneficiaries compared to APL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.22.

Table 8.22 Chi-square Analysis on Awareness on Receiving Discharge Summary

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	30	290	320	2.373	1	0.123
Not Aware	70	475	545			
Total	100	765	865			

Awareness of the Beneficiaries on the Features of RSBY-CHIS

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	0	8	8	1.728	1	0.315
Not Aware	5	22	27			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	30	0	30	2.100	1	0.318
Not Aware	70	5	75			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	290	8	298	1.557	1	0.212
Not Aware	475	22	497			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	30	298	328	3.181	1	0.074
Not Aware	75	497	572			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	320	8	328	2.903	1	0.088
Not Aware	545	27	572			
Total	865	35	900			

Source: Primary data

The table 8.22 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.074, whereas it is 0.088 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.123 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.315 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.318 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.212 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.3.2 Awareness on Fingerprint Verification during Discharge

The table 8.23 illustrates awareness of beneficiaries on fingerprint verification during discharge.

Table 8.23 Awareness on Fingerprint Verification during Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	407	47.1	18	51.4	49	46.7	376	47.3	425	47.2
Not Aware	458	52.9	17	48.6	56	53.3	419	52.7	475	52.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.23 shows that there are about 47.1 per cent beneficiaries who have awareness and 52.9 per cent who have no awareness on fingerprint verification during discharge in Ernakulam district. There are only 51.4 per cent beneficiaries who have awareness and 48.6 per cent who have no awareness on fingerprint verification during discharge in Wayanad district. This point to the fact that the awareness on fingerprint verification during discharge is more or less the same in both Ernakulam and Wayanad categories. There are about 46.7 per cent beneficiaries who have awareness and 53.3 per cent who have no awareness on fingerprint verification during discharge in APL category. There are about 47.3 per cent beneficiaries who have awareness and 52.7 per cent who have no awareness on fingerprint verification during discharge in BPL category. This point to the fact that the awareness on fingerprint verification during discharge is more or less the same in both APL and BPL categories.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.24.

Table 8.24 Chi-square Analysis on Awareness on Fingerprint Verification during Discharge

Awareness	Ernakulam		Total	Chi-square	df	p – value
	APL	BPL				
Aware	45	362	407	0.191	1	0.662
Not Aware	55	403	458			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p – value
	APL	BPL				
Aware	4	14	18	1.906	1	0.338
Not Aware	1	16	17			
Total	5	30	35			

Awareness	APL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	45	4	49	2.344	1	0.182
Not Aware	55	1	56			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	362	14	376	0.005	1	0.944
Not Aware	403	16	419			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	df	p – value
	APL	BPL				
Aware	49	376	425	0.015	1	0.903
Not Aware	56	419	475			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	407	18	425	0.259	1	0.730
Not Aware	458	17	475			
Total	865	35	900			

Source: Primary data

The table 8.24 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.903, whereas it is 0.730 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.662 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.338 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.182 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.944 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.3.3 Awareness on Receiving the Smartcard Back during Discharge

The table 8.25 illustrates awareness of beneficiaries on receiving the smartcard back during discharge.

Table 8.25 Awareness on Receiving the Smartcard Back during Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	304	35.1	22	62.9	57	54.3	269	33.8	326	36.2
Not Aware	561	64.9	13	37.1	48	45.7	526	66.2	574	63.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.25 shows that there are only 35.1 per cent beneficiaries who have awareness and 64.9 per cent who have no awareness on receiving the smartcard back during discharge in Ernakulam district. There are about 62.9 per cent beneficiaries who have awareness and 37.1 per cent who have no awareness on receiving the smartcard back during discharge in Wayanad district. This point to the fact that the awareness on receiving the smartcard back during discharge is relatively higher in Wayanad beneficiaries compared to Ernakulam beneficiaries. There are about 54.3 per cent beneficiaries who have awareness and 45.7 per cent who have no awareness on receiving the

smartcard back during discharge in APL category. There are only 33.8 per cent beneficiaries who have awareness and 66.2 per cent who have no awareness on receiving the smartcard back during discharge in BPL category. This point to the fact that the awareness on receiving the smartcard back during discharge is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.26.

Table 8.26 Chi-square Analysis on Awareness on Receiving the Smartcard Back during Discharge

Awareness	Ernakulam		Total	Chi-square	df	p – value
	APL	BPL				
Aware	55	249	304	19.557	1	0.000
Not Aware	45	516	561			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	df	p – value
	APL	BPL				
Aware	2	20	22	1.305	1	0.337
Not Aware	3	10	13			
Total	5	30	35			

Awareness	APL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	55	2	57	0.432	1	0.658
Not Aware	45	3	48			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	249	20	269	15.010	1	0.000
Not Aware	516	10	526			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	df	p – value
	APL	BPL				
Aware	57	269	326	16.789	1	0.000
Not Aware	48	526	574			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	df	p – value
	Ernakulam	Wayanad				
Aware	304	22	326	11.183	1	0.001
Not Aware	561	13	574			
Total	865	35	900			

Source: Primary data

The table 8.26 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.000, whereas it is 0.001 in between Ernakulam and Wayanad beneficiaries and so both of them significant. P- value is 0.000 in between the APL and BPL beneficiaries of Ernakulam district and so it is significant, whereas it is 0.337 in between the APL and BPL beneficiaries of Wayanad district, and so not significant. P- value is 0.658 in between the Ernakulam APL and Wayanad APL beneficiaries and so not significant, whereas it is 0.000 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so it is significant.

8.4.3.4 Awareness on Receiving Information on Money Left In the Smartcard during Discharge

The table 8.27 illustrates awareness of beneficiaries on receiving information on money left in the smartcard during discharge.

Table 8.27 Awareness on Receiving Information on Money Left in the Smartcard during Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	463	53.5	10	28.6	47	44.8	426	53.6	473	52.6
Not Aware	402	46.5	25	71.4	58	55.2	369	46.4	427	47.4
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 8.27 shows that there are about 53.5 per cent beneficiaries who have awareness and 46.5 per cent who have no awareness on receiving information on money left in the smartcard during discharge in Ernakulam district. There are only 28.6 per cent beneficiaries who have awareness and 71.4 per cent who have no awareness on receiving information on money left in the smart card during discharge in Wayanad district. This point to the fact that the awareness on receiving information on money left in the smart card during discharge is relatively higher in Ernakulam beneficiaries compared to Wayanad beneficiaries. There are about 44.8 per cent beneficiaries who have awareness and 55.2 per cent who have no awareness on receiving information on money left in the smartcard during discharge in APL category. There are only 53.6 per cent beneficiaries who have awareness and 46.4 per cent who have no awareness on receiving information on money left in the smart card during discharge in BPL category. This point to the fact that the awareness on receiving information on money left in the smart card during discharge is relatively higher in BPL beneficiaries compared to APL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.28.

Table 8.28 Chi-square Analysis on Awareness on Receiving Information on Money Left in the Smartcard during Discharge

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	45	418	463	3.304	1	0.069
Not Aware	55	347	402			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	2	8	10	0.373	1	0.610
Not Aware	3	22	25			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	45	2	47	0.048	1	0.999
Not Aware	55	3	58			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	418	8	426	9.083	1	0.003
Not Aware	347	22	369			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	47	426	473	2.896	1	0.089
Not Aware	58	369	427			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	463	10	473	8.401	1	0.004
Not Aware	402	25	427			
Total	865	35	900			

Source: Primary data

The table 8.28 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.089 and so not significant, whereas it is 0.004 in between Ernakulam and Wayanad beneficiaries and so it is significant. P- value is 0.069 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.610 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.999 in between the Ernakulam APL and Wayanad APL beneficiaries and so not significant, whereas it is 0.003 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so it is significant.

8.4.3.5 Awareness on Coverage of 5 Days Post Hospitalization Expenses

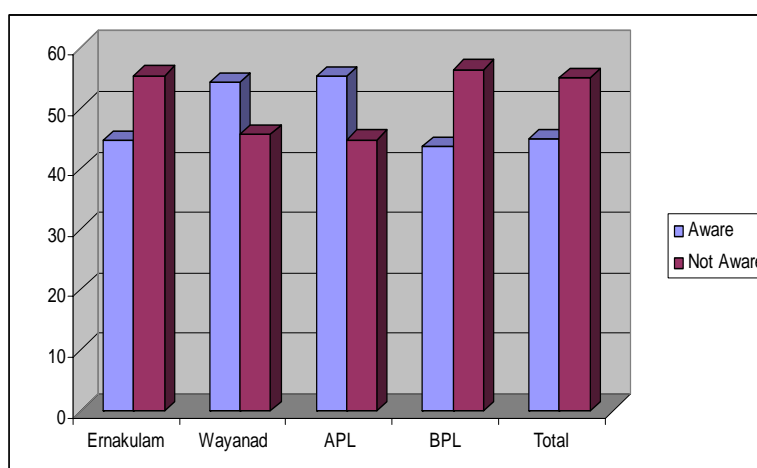
RSBY-CHIS is only proper and effective insurance scheme in India which covers medical expenses for pre-hospitalization, hospitalization and post-hospitalization medical care. The scheme covers medicine and treatment expenses up to one day prior to hospitalization and five days after discharge from hospital towards post hospitalization expenses. The pre and post-hospitalization expenses are included in the approved health care package of the scheme. During hospitalization, the card is blocked for minimum period of 3 days in advance under specific package and an amount @ Rs. 500/- per day is deducted from insurance coverage in the card. The deduction for admission in ICU is Rs. 1000/- per day. The table 8.29 illustrates awareness of beneficiaries on coverage of 5 days post hospitalization expenses.

Table 8.29 Awareness on Coverage of 5 Days Post Hospitalization Expenses

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	386	44.6	19	54.3	58	55.2	347	43.6	405	45.0
Not Aware	479	55.4	16	45.7	47	44.8	448	56.4	495	55.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.6 Awareness on Coverage of 5 Days Post Hospitalization Expenses



The table 8.29 shows that there are about 44.6 per cent beneficiaries who have awareness and 55.4 per cent who have no awareness on coverage of 5 days post hospitalization expenses in Ernakulam district. There are about 54.3 per cent beneficiaries who have awareness and 45.7 per cent who have no awareness on coverage of 5 days post hospitalization expenses in Wayanad district. These points to the fact that the awareness on coverage of 5 days post hospitalization expenses is relatively higher in Wayanad beneficiaries compared to Ernakulam beneficiaries. There are about 55.2 per cent beneficiaries who have awareness and 44.8 per cent who have no awareness on coverage of 5 days post hospitalization expenses in APL category. There are about 43.6 per cent beneficiaries who have awareness and 56.4 per cent who have no awareness on coverage of 5 days post hospitalization expenses in BPL category. This points to the fact that the awareness on coverage of 5 days post hospitalization expenses is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.30.

Table 8.30 Chi-square Analysis on Awareness on Coverage of 5 Days Post Hospitalization Expenses

Awareness	Ernakulam		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	55	331	386	4.926	1	0.026
Not Aware	45	434	479			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	3	16	19	0.077	1	0.999
Not Aware	2	14	16			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	55	3	58	0.048	1	0.999
Not Aware	45	2	47			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	331	16	347	1.189	1	0.276
Not Aware	434	14	448			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	58	347	405	5.034	1	0.025
Not Aware	47	448	495			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	386	19	405	1.269	1	0.260
Not Aware	479	16	495			
Total	865	35	900			

Source: Primary data

The table 8.30 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.025 and so it is significant, whereas it is 0.260 in between Ernakulam and Wayanad beneficiaries and so not significant. P- value is 0.026 in between the APL and BPL beneficiaries of Ernakulam district and so it is significant, whereas it is 0.999 in between the APL and BPL beneficiaries of Wayanad district, and so not significant. P- value is 0.999 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.276 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.4.3.6 Awareness on Traveling Allowance of Rs.100/.

The scheme allocates a sum of Rs. 1000/- per annum towards transportation expenses for hospitalization for five members of a family. The

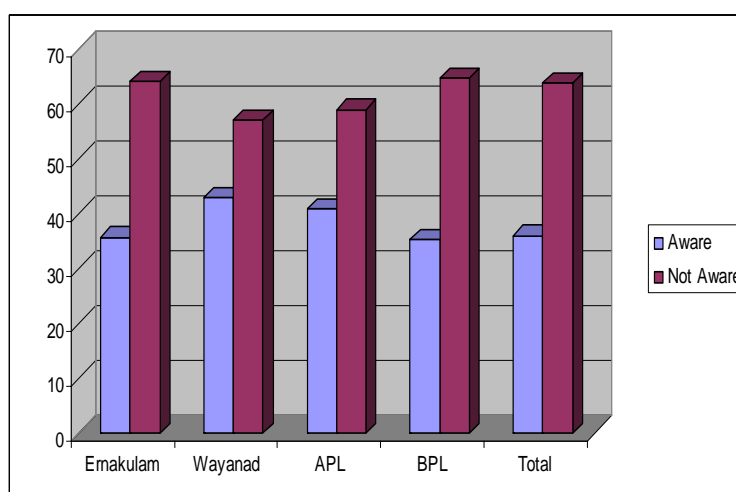
beneficiaries availing hospitalization are entitled to claim transportation expenses at the time of discharge from the hospital @ Rs. 100/- per visit up to a maximum of 10 visits. The table 8.31 illustrates awareness of beneficiaries on Traveling allowance of Rs.100/.

Table 8.31 Awareness On Traveling Allowance Of Rs.100/.

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Aware	309	35.7	15	42.9	43	41.0	281	35.3	324	36.0
Not Aware	556	64.3	20	57.1	62	59.0	514	64.7	576	64.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 8.7 Awareness on Traveling Allowance Of Rs.100/.



The table 8.31 shows that there are only 35.7 per cent beneficiaries who have awareness and 64.3 per cent who have no awareness on traveling allowance of Rs.100/ in Ernakulam district. There are 42.9 per cent beneficiaries who have awareness and 57.1 per cent who have no awareness on traveling allowance of Rs.100/ in Wayanad district. This points to the fact that the awareness on Traveling allowance of Rs.100/ is relatively higher in

Wayanad beneficiaries compared to Ernakulam beneficiaries. There are 41 per cent beneficiaries who have awareness and 59 per cent who have no awareness on traveling allowance of Rs.100/ in APL category. There are only 35.3 per cent beneficiaries who have awareness and 64.7 per cent who have no awareness on traveling allowance of Rs.100/ in BPL category. This point to the fact that the awareness on Traveling allowance of Rs.100/ is relatively higher in APL beneficiaries compared to BPL beneficiaries.

Whether these differences in awareness level on empanelled hospitals in CHIS among different categories are significant or not, is statistically examined with the help of Chi-square test. The result is given in table 8.32.

Table 8.32 Chi-square Analysis on Awareness on Traveling Allowance of Rs.100/.

Awareness	Ernakulam		Total	Chi-square	df	p – value
	APL	BPL				
Aware	40	269	309	0.901	1	0.343
Not Aware	60	496	556			
Total	100	765	865			

Awareness	Wayanad		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	3	12	15	0.700	1	0.631
Not Aware	2	18	20			
Total	5	30	35			

Awareness	APL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	40	3	43	0.788	1	0.646
Not Aware	60	2	62			
Total	100	5	105			

Awareness	BPL		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	269	12	281	0.296	1	0.587
Not Aware	496	18	514			
Total	765	30	795			

Awareness	Combined		Total	Chi-square	Df	p – value
	APL	BPL				
Aware	43	281	324	1.265	1	0.261
Not Aware	62	514	576			
Total	105	795	900			

Awareness	Combined		Total	Chi-square	Df	p – value
	Ernakulam	Wayanad				
Aware	309	15	324	0.743	1	0.473
Not Aware	556	20	576			
Total	865	35	900			

Source: Primary data

The table 8.32 revealed that p-value for Chi-square analysis in between APL and BPL beneficiaries is 0.261, whereas it is 0.473 in between Ernakulam and Wayanad beneficiaries and so both of them not significant. P- value is 0.343 in between the APL and BPL beneficiaries of Ernakulam district, whereas it is 0.631 in between the APL and BPL beneficiaries of Wayanad district, and so both of them not significant. P- value is 0.646 in between the Ernakulam APL and Wayanad APL beneficiaries, whereas it is 0.587 in between Ernakulam BPL and Wayanad BPL beneficiaries, and so both of them not significant.

8.5 Mann-Whitney U Test

For having an overall understanding of the level of awareness on various features of the scheme among different categories of beneficiaries, Mann-whitney U test has been applied, the result of which is given in tables 8.33, 8.34, 8.35, 8.36, 8.37, and 8.38.

Table 8.33 Mann-Whitney U Test on Ernakulam Beneficiaries

	Category	Mean	SD	Z - value	p – value
General Awareness	APL	2.05	1.290	-0.597	0.550
	BPL	2.13	1.310		
Awareness on Procedures during Admission as an Inpatient	APL	2.40	1.206	-1.749	0.080
	BPL	2.13	1.089		
Awareness on Procedures during Discharge	APL	2.70	1.193	-1.824	0.068
	BPL	2.51	1.112		
Total Awareness	APL	7.15	2.757	-1.853	0.064
	BPL	6.77	2.512		

Source: Primary data

P- value for Mann-Whitney U test, done on Ernakulam APL and Ernakulam BPL beneficiaries on general awareness, is 0.550. For awareness on procedures during admission as an inpatient, it is 0.080 and for awareness on procedures during discharge, it is 0.068. For total awareness on Ernakulam APL and Ernakulam BPL beneficiaries, p-value is 0.064. Thus none of the differences in awareness level on the features of the scheme, in between Ernakulam APL and Ernakulam BPL beneficiaries is significant.

Table 8.34 Mann-Whitney U Test on Wayanad Beneficiaries

Category		Mean	SD	Z - value	p - value
General Awareness	APL	1.40	0.894	0.258	0.299
	BPL	2.07	1.202		
Awareness on Procedures during Admission as an Inpatient	APL	2.80	1.095	0.126	0.185
	BPL	2.33	0.884		
Awareness on Procedures during Discharge	APL	2.80	1.095	0.383	0.448
	BPL	2.60	0.894		
Total Awareness	APL	7.00	3.000	0.847	0.873
	BPL	7.00	2.133		

Source: Primary data

P- value for Mann-Whitney U test, done on Wayanad APL and Wayanad BPL beneficiaries on general awareness, is 0.299. For awareness on procedures during admission as an inpatient, it is 0.185 and for awareness on procedures during discharge, it is 0.448. For total awareness on Ernakulam APL and Ernakulam BPL beneficiaries, p-value is 0.873. Thus none of the differences in awareness level on the features of the scheme, in between Wayanad APL and Wayanad BPL beneficiaries is significant.

Table 8.35 Mann-Whitney U Test on APL Beneficiaries

	Category	Mean	SD	Z - value	p - value
General Awareness	Ernakulam	2.05	1.290	-0.790	0.430
	Wayanad	1.40	0.894		
Awareness on Procedures during Admission as an Inpatient	Ernakulam	2.40	1.206	-0.854	0.393
	Wayanad	2.80	1.095		
Awareness on Procedures during Discharge	Ernakulam	2.70	1.193	-0.197	0.843
	Wayanad	2.80	1.095		
Total Awareness	Ernakulam	7.15	2.757	-0.228	0.820
	Wayanad	7.00	3.000		

Source: Primary data

P- value for Mann-Whitney U test, done on Ernakulam APL and Wayanad APL beneficiaries on general awareness, is 0.430. For awareness on procedures during admission as an inpatient, it is 0.393 and for awareness on procedures during discharge, it is 0.843. For total awareness on Ernakulam APL and Ernakulam BPL beneficiaries, p-value is 0.820. Thus none of the differences in awareness level on the features of the scheme, in between Ernakulam APL and Wayanad APL beneficiaries is significant.

Table 8.36 Mann-Whitney U Test on BPL Beneficiaries

	Category	Mean	SD	Z - value	p – value
General Awareness	Ernakulam	2.13	1.310	-0.112	0.911
	Wayanad	2.07	1.202		
Awareness on Procedures during Admission as an Inpatient	Ernakulam	2.13	1.089	-0.777	0.437
	Wayanad	2.33	0.884		
Awareness on Procedures during Discharge	Ernakulam	2.51	1.112	-0.358	0.721
	Wayanad	2.60	0.894		
Total Awareness	Ernakulam	6.77	2.512	-0.499	0.618
	Wayanad	7.00	2.133		

Source: Primary data

P- value for Mann-Whitney U test, done on Ernakulam BPL and Wayanad BPL beneficiaries on general awareness, is 0.911. For awareness on procedures during admission as an inpatient, it is 0.437 and for awareness on procedures during discharge, it is 0.721. For total awareness on Ernakulam APL and Ernakulam BPL beneficiaries, p-value is 0.618. Thus none of the differences in awareness level on the features of the scheme, in between Ernakulam BPL and Wayanad BPL beneficiaries is significant.

Table 8.37 Mann-Whitney U Test on Ernakulam and Wayanad Beneficiaries - combined

	Category	Mean	SD	Z - value	p – value
General Awareness	Ernakulam	2.12	1.307	-0.435	0.664
	Wayanad	1.97	1.175		
Awareness on Procedures during Admission as an Inpatient	Ernakulam	2.16	1.106	-1.137	0.256
	Wayanad	2.40	0.914		
Awareness on Procedures during Discharge	Ernakulam	2.53	1.123	-0.455	0.649
	Wayanad	2.63	0.910		
Total Awareness	Ernakulam	6.82	2.543	-0.508	0.611
	Wayanad	7.00	2.223		

Source: Primary data

P- value for Mann-Whitney U test, done on Ernakulam and Wayanad beneficiaries on general awareness, is 0.664. For awareness on procedures during admission as an inpatient, it is 0.256 and for awareness on procedures during discharge, it is 0.649. For total awareness on Ernakulam APL and Ernakulam BPL beneficiaries, p-value is 0.611. Thus none of the differences in awareness level on the features of the scheme, in between Ernakulam and Wayanad beneficiaries is significant.

Hypothesis H₁

There is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.

P- value for Mann-Whitney U test done on Ernakulam and Wayanad beneficiaries on total awareness is 0.611, indicating that the Hypothesis can be accepted. It is concluded that there is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.

Table 8.38 Mann-Whitney U Test on APL and BPL Beneficiaries - combined

	Category	Mean	SD	Z - value	p - value
General Awareness	APL	2.02	1.278	-0.805	0.421
	BPL	2.13	1.305		
Awareness on Procedures during Admission as an Inpatient	APL	2.42	1.199	-1.951	0.051
	BPL	2.14	1.082		
Awareness on Procedures during Discharge	APL	2.70	1.184	-1.938	0.053
	BPL	2.51	1.105		
Total Awareness	APL	7.14	2.754	-1.867	0.062
	BPL	6.78	2.498		

Source: Primary data

P- value for Mann-Whitney U test, done on APL and BPL beneficiaries on general awareness, is 0.421. For awareness on procedures during admission as an inpatient, it is 0.051 and for awareness on procedures during discharge, it

is 0.053. For total awareness on APL and BPL beneficiaries, p-value is 0.062. Thus none of the differences in awareness level on the features of the scheme, in between APL and BPL is significant.

Hypothesis H₂

There is no significant difference between BPL and APL beneficiaries as far as the level of awareness on the feature of the scheme is concerned.

P- value for Mann-Whitney U test done on BPL and APL beneficiaries on total awareness is 0.062, indicating that the Hypothesis can be accepted. It is concluded that there is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.

Thus, an analysis on the awareness of the beneficiaries regarding various features of the scheme, revealed the following:

General awareness:

- About 74.1 per cent of the beneficiaries were aware off about the amount of coverage in CHIS.
- About 50.2 per cent of the beneficiaries were aware off about CHIS-PLUS.
- Only 16.2 per cent of the beneficiaries were aware off about amount of coverage in CHIS-PLUS.
- Only 34.8 per cent of the beneficiaries were aware off about empanelled hospitals in CHIS. Chi-square analysis revealed that the difference in awareness on empanelled hospitals in CHIS in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in

awareness on empanelled hospitals in CHIS in between total APL and total BPL beneficiaries is also significant.

- Only 36.4 per cent of the beneficiaries were aware off about empanelled hospitals in CHIS-PLUS.

Awareness on procedures during admission as an inpatient:

- About 47.2 per cent of the beneficiaries were aware off about giving smart card at the RSBY-CHIS counter during admission.
- Only 36.2 per cent of the beneficiaries were aware off about knowing the available balance in the card during admission. Chi-square analysis revealed that the difference in awareness on knowing the available balance in the card during admission in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on knowing the available balance in the card during admission is also significant in between Ernakulam BPL and Wayanad BPL beneficiaries, in between total Ernakulam and total Wayanad beneficiaries and in between total APL and total BPL beneficiaries.
- About 52.6 per cent of the beneficiaries were aware off about finger print verification during admission. Chi-square analysis revealed that the difference in awareness on finger print verification during admission in between Ernakulam BPL and Wayanad BPL beneficiaries is significant. This difference in awareness on finger print verification during admission is also significant in between total Ernakulam and total Wayanad beneficiaries.
- About 45 per cent of the beneficiaries were aware off about free medicines and tests even from outside. Chi-square analysis revealed that

the difference in awareness on free medicines and tests even from outside in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on finger print verification during admission is also significant in between total APL and total BPL beneficiaries.

- Only 36 per cent of the beneficiaries were aware off about free food to the patient during hospitalization.

Awareness on procedures during discharge:

- Only 36.4 per cent of the beneficiaries were aware off about receiving discharge summary.
- About 47.2 per cent of the beneficiaries were aware off about finger print verification during discharge.
- Only 36.2 per cent of the beneficiaries were aware off about receiving smart card back during discharge. Chi-square analysis revealed that the difference in awareness on receiving smart card back during discharge in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on receiving smart card back during discharge is also significant in between Ernakulam BPL and Wayanad BPL beneficiaries, in between total Ernakulam and total Wayanad beneficiaries and in between total APL and total BPL beneficiaries.
- About 52.6 per cent of the beneficiaries were aware off about receiving information on money left in the smart card during discharge. Chi-square analysis revealed that the difference in awareness on receiving information on money left in the smart card during discharge in between

Ernakulam BPL and Wayanad BPL beneficiaries is significant. This difference in awareness on receiving information on money left in the smart card during discharge is also significant in between total Ernakulam and total Wayanad beneficiaries.

- About 45 per cent of the beneficiaries were aware off about coverage of 5 days post hospitalization expenses. Chi-square analysis revealed that the difference in awareness on coverage of 5 days post hospitalization expenses in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on coverage of 5 days post hospitalization expenses is also significant in between total APL and total BPL beneficiaries.
- Only 36 per cent of the beneficiaries were aware off about traveling allowance of Rs.100/.

For having an overall understanding of awareness level of the beneficiaries, Mann-Whitney U test has been performed on the above 3 groups of features of the scheme. The result shows that:

- In between Ernakulam APL and Ernakulam BPL beneficiaries, the difference in general awareness is not significant, awareness on procedures during admission as an inpatient is not significant and awareness on procedures during discharge is also not significant. The difference in total awareness in between Ernakulam APL and Ernakulam BPL beneficiaries is also not significant.
- In between Wayanad APL and Wayanad BPL beneficiaries, the difference in general awareness is not significant, awareness on procedures during admission as an inpatient is not significant and

awareness on procedures during discharge is also not significant. The difference in total awareness in between Wayanad APL and Wayanad BPL beneficiaries is also not significant.

- In between Ernakulam APL and Wayanad APL beneficiaries, the difference in general awareness is not significant, awareness on procedures during admission as an inpatient is not significant and awareness on procedures during discharge is also not significant. The difference in total awareness in between Ernakulam APL and Wayanad APL beneficiaries is also not significant.
- In between Ernakulam BPL and Wayanad BPL beneficiaries, the difference in general awareness is not significant, awareness on procedures during admission as an inpatient is not significant and awareness on procedures during discharge is also not significant. The difference in total awareness in between Ernakulam BPL and Wayanad BPL beneficiaries is also not significant.
- In between total Ernakulam and total Wayanad beneficiaries, the difference in general awareness is not significant, awareness on procedures during admission as an inpatient is not significant and awareness on procedures during discharge is also not significant. The difference in total awareness in between total Ernakulam and total Wayanad beneficiaries is also not significant.
- In between total APL and total BPL beneficiaries, the difference in general awareness is not significant, awareness on procedures during admission as an inpatient is not significant and awareness on procedures during discharge is also not significant. The difference in

total awareness in between total APL and total BPL beneficiaries is also not significant.

The above analysis revealed that the awareness level of the scheme related details among the beneficiaries was found to be very low. Even the staff at RSBY-CHIS help desk of the hospitals are not well educated about the scheme for which they failed to meet the queries raised by the patients. One can fairly estimate that the response of a predominantly rural and poor population to a technology-driven initiative like RSBY-CHIS would be very poor, if its features and benefits are not adequately explained. Knowledge about different features of RSBY-CHIS creates greater involvement among the beneficiaries. Thus there is a wide gap between project strategy and implementation level. The capacity building interventions have been drastically missing. Thus, it is recommended that concerned authorities should organize frequent awareness programs for the same. Notwithstanding the possibility that these responses regarding the awareness level of the beneficiaries are that of a sampled population and may not be fully representative of overall situation, the situation needs to be addressed urgently.

.....**END**.....

Chapter 9

Details About and Economics of RSBY-CHIS and Non RSBY-CHIS Hospitalization



- 9.1 Details About And Economics Of Non RSBY-CHIS Hospitalisation
 - 9.2 Details About RSBY-CHIS Hospitalization
 - 9.3 Average Expenditure For Hospitalization
 - 9.4 Repeated Measures Analysis
-

RSBY-CHIS provides for an annual medical insurance cover for a maximum amount of Rs.30000/- to a family of five members. The treatment can be availed of from the empanelled hospitals based on the package rates fixed. The CHIAK has the well defined objective of providing financial security to the beneficiaries from hospitalization related expenses, to achieve, while formulating RSBY-CHIS. How far this objective is materialized by way of hospitalization under the scheme is analysed in this chapter. It probes into the details of the experiences during hospitalization and the expenditures incurred to the patients due to both non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization.

9.1 Details About and Economics of Non RSBY-CHIS Hospitalisation

The details of last hospitalization case of either the beneficiary himself or his/her family member, which was not covered by RSBY-CHIS were assessed using the variables medical services received, receipt of treatment before hospitalization and its source, continuation of treatment after discharge and its source and the expenditure incurred for such non RSBY-CHIS treatment. Out of the 900 beneficiaries, only 709 had undergone non-RSBY

hospitalization. The rest of them either not subjected to hospitalization nor the difficulty to recall the details prevented them from admitting it. All the tables and figures in this chapter are derived from the sample survey.

9.1.1 Details of Medical Services Received During non RSBY-CHIS hospitalization

The details of medical services received during non RSBY-CHIS hospitalization is given in table 9.1.

Table 9.1 Details of Medical Services Received During Non RSBY-CHIS Hospitalization

Surgery	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Not Received	580	67.1	17	48.6	53	50.5	544	68.4	597	66.3
Received Free	33	3.8	2	5.7	5	4.8	30	3.8	35	3.9
Partially Free	25	2.9	3	8.6	6	5.7	22	2.8	28	3.1
On Payment	44	5.1	5	14.3	16	15.2	33	4.2	49	5.4
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Medicine	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Not Received	0	0.0	14	40.0	0	0.0	14	1.8	14	1.6
Received Free	258	29.8	5	14.3	23	21.9	240	30.2	263	29.2
Partially Free	268	31.0	3	8.6	31	29.5	240	30.2	271	30.1
On Payment	156	18.0	5	14.3	26	24.8	135	17.0	161	17.9
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
X-ray/ ECG/EEG/ Scan	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Not Received	512	59.2	17	48.6	53	50.5	476	59.9	529	58.8
Received Free	73	8.4	3	8.6	6	5.7	70	8.8	76	8.4
Partially Free	63	7.3	4	11.4	5	4.8	62	7.8	67	7.4
On Payment	34	3.9	3	8.6	16	15.2	21	2.6	37	4.1
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Other diagnostic tests	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Not Received	622	71.9	18	51.4	64	61.0	576	72.5	640	71.1
Received Free	23	2.7	2	5.7	5	4.8	20	2.5	25	2.8
Partially Free	23	2.7	7	20.0	5	4.8	18	2.3	23	2.6
On Payment	14	1.6	0	0.0	6	5.7	15	1.9	21	2.3
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Out of the 865 Ernakulam beneficiaries, only 682 had undergone non RSBY-CHIS hospitalization. The seek with respect to the medical services received by them through the non-RSBY hospitalization portrayed that while cent percent were prescribed medicines for their sicknesses, the number of patients who had to undergo either surgery, X-ray/ECG/Scan or other diagnostic tests were comparatively lower. Out of the 682, only 102, 170, 60 of them went through the above medical treatments respectively. 33 out of 102, 258 out of 682, 73 out of 170, and 23 out of 60 beneficiaries each reported about the free receipt of surgery, medicines, X-ray/ECG/Scan or other diagnostic tests respectively. Nevertheless, a few had to pay a partial amount. The number of patients in this regard was 25, 268, 63, and 23. However, there are some patients who had to pay the full amount for such investigations. The number of patients in this regard was 44, 156, 34, and 14.

Out of the 35 Wayanad beneficiaries, only 27 had undergone non RSBY-CHIS hospitalization. The seek with respect to the medical services received by them through the non-RSBY hospitalization portrayed that while 13 were prescribed medicines for their sicknesses, the number of patients who had to undergo either surgery, X-ray/ECG/Scan or other diagnostic tests were comparatively lower. Out of the 27, only 10, 10, and 9 of them went through the above medical treatments respectively. 2 out of 10, 5 out of 13, 3 out of 10, and 2 out of 9 beneficiaries each reported about the free receipt of surgery, medicines, X-ray/ECG/Scan or other diagnostic tests respectively. Nevertheless, a few had to pay a partial amount. The number of patients in this regard was 3, 3, 4, and 7. However, there are some patients who had to pay the full amount for such investigations. The number of patients in this regard was 5, 5, 3, and 0.

Out of the 105 APL beneficiaries, only 80 had undergone non RSBY-CHIS hospitalization. The seek with respect to the medical services received by them through the non-RSBY hospitalization portrayed that while cent percent were prescribed medicines for their sicknesses, the number of patients who had to undergo either surgery, X-ray/ECG/Scan or other diagnostic tests were comparatively lower. Out of the 80, only 27, 27 and 16 of them went through the above medical treatments respectively. 5 out of 27, 23 out of 80, 6 out of 27, and 5 out of 16 beneficiaries each reported about the free receipt of surgery, medicines, X-ray/ECG/Scan or other diagnostic tests respectively. Nevertheless, a few had to pay a partial amount. The number of patients in this regard was 6, 31, 5, and 5. However, the number of patients who had to pay the full amount for such investigations was comparatively higher. The number of patients in this regard was 16, 26, 16, and 6.

Out of the 795 BPL beneficiaries, only 629 had undergone non RSBY-CHIS hospitalization. The seek with respect to the medical services received by them through the non-RSBY hospitalization portrayed that while 615 were prescribed medicines for their sicknesses, the number of patients who had to undergo either surgery, X-ray/ECG/Scan or other diagnostic tests were comparatively lower. Out of the 629, only 85, 153 and 53 of them went through the above medical treatments respectively. 30 out of 85, 240 out of 615, 70 out of 153, and 20 out of 53 beneficiaries each reported about the free receipt of surgery, medicines, X-ray/ECG/Scan or other diagnostic tests respectively. Nevertheless, a few had to pay a partial amount. The number of patients in this regard was 22, 240, 62, and 18. However, there are some patients who had to pay the full amount for such investigations. The number of patients in this regard was 33, 135, 21, and 15.

9.1.2 Treatment Received before Hospitalization

The details of treatment received before non RSBY-CHIS hospitalization is given in table 9.2.

Table 9.2 Treatment Received Before Hospitalization

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	251	29.0	23	65.7	41	39.0	233	29.3	274	30.4
No	431	49.8	4	11.4	39	37.1	396	49.8	435	48.3
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 9.2 shows that out of 682 hospitalized beneficiaries in Ernakulam, there are 251 who have availed treatment before hospitalization and 431 who have not availed treatment before hospitalization. Out of 27 hospitalized beneficiaries in Wayanad, there are 23 beneficiaries who have availed treatment before hospitalization and 4 beneficiaries who have not availed treatment before hospitalization. Out of 80 hospitalized beneficiaries in APL category, there are 41 beneficiaries who have availed treatment before hospitalization and 39 who have not availed treatment before hospitalization. There are 233 beneficiaries who have availed treatment before hospitalization and 396 who have not availed treatment before hospitalization out of 629 hospitalized beneficiaries in BPL category.

9.1.3 Source of Treatment Received Before Hospitalization

The source of treatment received before non RSBY-CHIS hospitalization is given in table 9.3.

Table 9.3 Source of Treatment Received Before Hospitalization

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Public Hospital	45	5.2	7	20.0	6	5.7	46	5.8	52	5.8
Public Dispensary	107	12.4	2	5.7	20	19.0	89	11.2	109	12.1
Private Hospital	70	8.1	8	22.9	5	4.8	73	9.2	78	8.7
Private Doctor	29	3.4	6	17.1	10	9.5	25	3.1	35	3.9
Not subjected to pre-hospitalization treatment	614	71.0	12	34.3	64	61.0	562	70.7	626	69.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 9.3 shows that there are 45, 107, 70 and 29 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in Ernakulam. There are 7, 2, 8 and 6 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in Wayanad. There are 6, 20, 5 and 10 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in APL category. There are 46, 89, 73 and 25 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in BPL category.

9.1.4 Treatment Received After Hospitalization

The details of treatment received after non RSBY-CHIS hospitalization is given in table 9.4.

Table 9.4 Treatment Received After Hospitalization

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	341	39.4	13	37.1	40	38.1	314	39.5	354	39.3
No	341	39.4	14	40.0	40	38.1	315	39.6	355	39.4
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 9.4 shows that out of 682 hospitalized beneficiaries in Ernakulam, there are 341 who have availed treatment after hospitalization and 341 who have not availed treatment after hospitalization. Out of 27 hospitalized beneficiaries in Wayanad, there are 13 beneficiaries who have availed treatment after hospitalization and 14 beneficiaries who have not availed treatment after hospitalization. Out of 80 hospitalized beneficiaries in APL category, there are 40 beneficiaries who have availed treatment after hospitalization and 40 who have not availed treatment after hospitalization. There are 314 beneficiaries who have availed treatment before hospitalization and 315 who have not availed treatment before hospitalization out of 629 hospitalized beneficiaries in BPL category.

9.1.5 Source of Treatment Received After Hospitalization

The source of treatment received after non RSBY-CHIS hospitalization is given in table 9.5.

Table 9.5 Source of Treatment Received After Hospitalization

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Public Hospital	67	7.7	2	5.7	20	19.0	49	6.2	69	7.7
Public Dispensary	77	8.9	6	17.1	10	9.5	73	9.2	83	9.2
Private Hospital	102	11.8	2	5.7	7	6.7	97	12.2	104	11.6
Private Doctor	95	11.0	3	8.6	3	2.9	95	11.9	98	10.9
Not subjected to post hospitalization treatment	524	60.6	22	62.9	65	61.9	481	60.5	546	60.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

The table 9.5 shows that there are 67, 77, 102 and 95 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in Ernakulam. There are 2, 6, 2 and 3 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in Wayanad. There are 20, 10, 7 and 3 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in APL category. There are 49, 73, 97 and 95 beneficiaries who have taken pre hospitalization treatment from public hospital, public dispensary, private hospital and private doctor respectively in BPL category.

9.1.6 Expenditures during Non RSBY-CHIS Hospitalization

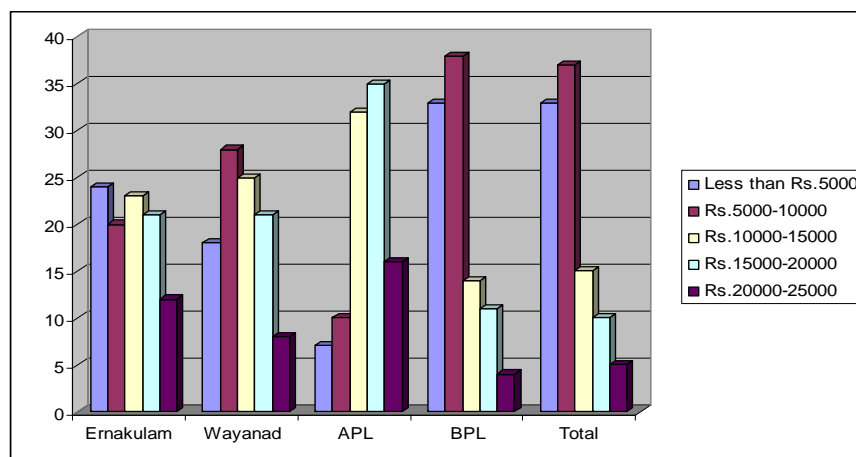
Financial accessibility and affordability is a major factor in the event of hospitalisation and illness. The expenditures incurred during non RSBY-CHIS hospitalization is given in table 9.6.

Table 9.6 Expenditures during Non RSBY-CHIS Hospitalization

	Ernakulam	Wayanad	APL	BPL	Total
Less than Rs.5000	164(24)	5(18)	6(7)	208(33)	234(33)
Rs.5000-10000	136(20)	8(28)	8(10)	239(38)	262(37)
Rs.10000-15000	157(23)	7(25)	25(32)	88(14)	106(15)
Rs.15000-20000	143(21)	5(21)	28(35)	69(11)	71(10)
Rs.20000-25000	82(12)	2(8)	13(16)	25(4)	36(5)
Total	682(100)	27(100)	80(100)	629(100)	709(100)

(Figure in brackets are percentage to total)

Source: Primary data

Figure 9.1 Expenditures during Non RSBY-CHIS Hospitalization

The expenses of the non-RSBY hospitalized persons varied between thousands of rupees. The expenses included in this regard were: Doctors'/surgeons' fee, medicines, diagnostic tests, bed charges, attendant charges, physiotherapy, personal medical appliances, blood, oxygen cylinder, etc. The variation reported in this regard extended from Rs.1000/- to Rs.25000/-. Of the 682 beneficiaries in Ernakulam, who received treatment in this regard, about 24 per cent of the beneficiaries reported an expenditure less than Rs.5000, about 20 per cent reported an expenditure in between Rs.5000-10000, about 23 per cent reported an expenditure in between Rs.10000- 15000, about 21 per cent reported an expenditure in between Rs.15000- 20000 and 12 per cent reported an expenditure in between Rs.20000-25000. Of the 27 beneficiaries in Wayanad, who received treatment in this regard, about 18 per cent of the beneficiaries reported an expenditure less than Rs.5000, about 28 per cent reported an expenditure in between Rs.5000-10000, about 25 per cent reported an expenditure in between Rs.10000- 15000, about 21 per cent reported an expenditure in between Rs.15000- 20000 and 8 per cent reported an expenditure in between Rs.20000-25000. Of the 80 beneficiaries in APL category, who

received treatment in this regard, about 7 per cent of the beneficiaries reported an expenditure less than Rs.5000, about 10 per cent reported an expenditure in between Rs.5000-10000, about 32 per cent reported an expenditure in between Rs.10000- 15000, about 35 per cent reported an expenditure in between Rs.15000- 20000 and 16 per cent reported an expenditure in between Rs.20000-25000. Of the 629 beneficiaries in BPL category, who received treatment in this regard, about 33 per cent of the beneficiaries reported an expenditure less than Rs.5000, about 38 per cent reported an expenditure in between Rs.5000-10000, about 14 per cent reported an expenditure in between Rs.10000- 15000, about 11 per cent reported an expenditure in between Rs.15000- 20000 and 4 per cent reported an expenditure in between Rs.20000-25000. It should be noted here that the expenditures incurred under each head were mentioned with an approximation which differed according to the recalling capacity of the beneficiaries. Many were not even aware about the expenditures and hence, their responses in this regard seemed to be a guess work.

9.1.7 Source of Finance for the Above Expenditure

The source of finance for the above expenditure is given in table 9.7.

Table 9.7 Source of Finance for the Above Expenditure

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Household Income / Savings	137	15.8	8	22.9	27	25.7	118	14.8	145	16.1
Borrowings	292	33.8	9	25.7	28	26.7	273	34.3	301	33.4
Contributions from Friends & Relatives	118	13.6	6	17.1	15	14.3	109	13.7	124	13.8
Other Sources	135	15.6	4	11.4	10	9.5	129	16.2	139	15.4
Not hospitalized	183	21.2	8	22.9	25	23.8	166	20.9	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.7 it is clear that among the beneficiaries of Ernakulam district, about 15.8 per cent have met the expenditure for non RSBY hospitalization from household income/savings, 33.8 per cent from borrowings,

13.6 per cent out of contributions from friends and relatives and 15.6 per cent have to sell their ornaments or physical assets to meet the expenditure. In the case of beneficiaries of Wayanad district, about 22.9 per cent have met the expenditure for non RSBY hospitalization from household income/savings, 25.7 per cent from borrowings, 17.1 per cent out of contributions from friends and relatives and 11.4 per cent have to sell their ornaments or physical assets to meet the expenditure. It is revealed that majority beneficiaries in both Ernakulam and Wayanad districts had to borrow money from others to meet the expenditure. Among the beneficiaries of APL category, about 25.7 per cent have met the expenditure for non RSBY hospitalization from household income/savings, 26.7 per cent from borrowings, 14.3 per cent out of contributions from friends and relatives and 9.5 per cent have to sell their ornaments or physical assets to meet the expenditure. In the case of beneficiaries of BPL category, about 14.8 per cent have met the expenditure for non RSBY hospitalization from household income/savings, 34.3 per cent from borrowings, 13.7 per cent out of contributions from friends and relatives and 16.2 per cent have to sell their ornaments or physical assets to meet the expenditure. It is revealed that majority beneficiaries both in APL and BPL category had to borrow money from others to meet the expenditure. It throws light into the ground reality that irrespective of economic category, generally an incidence of hospitalization in Kerala leads to borrowing by the households.

9.1.8 Source of Reimbursement (If Any)

The illness in poor homes has drastic economic consequences. The poor people have to utilize their savings or borrow from neighbourhood or sell assets to meet the health expenses of ailing family members. Such expenses push them into deeper poverty trap and long term debt. If there are any

reimbursement of this expense, it would be a great blessing to the poor. The source of reimbursement if any, for the above expenditure is given in table 9.8.

Table 9.8 Source of Reimbursement (If Any)

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Government Employer	5	0.6	1	2.9	6	5.7	0	0.0	6	0.7
Private Employer	35	4.0	3	8.6	6	5.7	32	4.0	38	4.2
Medical Insurance Companies	15	1.7	2	5.7	5	4.8	12	1.5	17	1.9
Other Agencies	15	1.7	2	5.7	5	4.8	12	1.5	17	1.9
No reimbursement	795	91.9	27	77.1	83	79.0	739	93.0	822	91.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.8 it is clear that among the 70 beneficiaries of Ernakulam district, who have got reimbursement, 5 have got it from government employer, 35 from private employer, 15 from insurance agencies and 15 from other agencies. In the case of 8 beneficiaries of Wayanad district, who have got reimbursement, 1 has got it from government employer, 3 from private employer, 2 from insurance agencies and 2 from other agencies. Among the 22 beneficiaries of APL category who have got reimbursement, 6 have got it from government employer, 6 from private employer, 5 from insurance agencies and 5 from other agencies. In the case of 56 beneficiaries of BPL category who have got reimbursement, none have got it from government employer, 32 from private employer, 12 from insurance agencies and 12 from other agencies.

9.2 Details about RSBY-CHIS Hospitalization

The details of RSBY-CHIS hospitalization were assessed using the variables: nature of treatment, reason for choosing a particular hospital for treatment, details about transportation, details on inpatient experience, details

on discharge, present health status of the patient and the expenditure incurred for such RSBY-CHIS hospitalization.

9.2.1 General Details

9.2.1.1 Number of Hospitalization Cases in the Last One Year

To have an idea about the morbidity level of the beneficiaries, it is essential to know the number of hospitalization cases in their family during the last one year. The table 9.9 reveals the same.

Table 9.9 Number of Hospitalization Cases in the Last One Year

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Once	482	55.7	24	68.6	84	80.0	422	53.1	506	56.2
Twice	215	24.9	3	8.6	6	5.7	212	26.7	218	24.2
Thrice	95	11.0	4	11.4	10	9.5	89	11.2	99	11.0
More than Thrice	73	8.4	4	11.4	5	4.8	72	9.1	77	8.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.9 it is clear that among the beneficiaries of Ernakulam district, about 55.7 per cent are having one hospitalization case in their family, 24.9 per cent are having two hospitalization cases, 11 per cent are having three hospitalization cases and there are 8.4 per cent in the category of more than three times. In the case of beneficiaries of Wayanad district, about 68.6 per cent are having one hospitalization case in their family, 8.6 per cent are having two hospitalization cases, 11.4 per cent are having three hospitalization cases and there are 11.4 per cent in the category of more than three times. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having one hospitalization case in their family and there are 44.3 per cent of beneficiaries in Ernakulam district who are having two or more hospitalization cases whereas it is only 31.4 per cent in the case of Wayanad district. So there

is significant difference in the morbidity level of Ernakulam and Wayanad districts. Among the beneficiaries of APL category, about 80 per cent are having one hospitalization case in their family, 5.7 per cent are having two hospitalization cases, 9.5 per cent are having three hospitalization cases and there are 4.8 per cent in the category of more than three times. In the case of beneficiaries of BPL category, about 53.1 per cent are having one hospitalization case in their family, 26.7 per cent are having two hospitalization cases, 11.2 per cent are having three hospitalization cases and there are 9.1 per cent in the category of more than three times. It is revealed that majority beneficiaries both in APL and BPL category are having one hospitalization case in their family and there are 47 per cent of beneficiaries in BPL category who are having two or more hospitalization cases whereas it is only 20 per cent in the case of APL category. So there is significant difference in the morbidity level of APL and BPL categories.

9.2.1.2 Number of Family Members Hospitalized in the Last One Year

The table 9.10 reveals the number of family members hospitalized in the last one year.

Table 9.10 Number of Family Members Hospitalized In the Last One Year

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
One	482	55.7	24	68.6	84	80.0	422	53.1	506	56.2
Two	270	31.2	3	8.6	11	10.5	262	33.0	273	30.3
Three	104	12.0	4	11.4	10	9.5	98	12.3	108	12.0
More than 3	9	1.0	4	11.4	0	0.0	13	1.6	13	1.4
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.10 it is clear that among the beneficiaries of Ernakulam district, about 55.7 per cent are having one family member hospitalized, 31.2 per cent are having two members hospitalized, 12 per cent are having three family member hospitalized, and there are 1 per cent in the category of more than three members. Among the beneficiaries of Wayanad district, about 68.6 per cent are having one family member hospitalized, 8.6 per cent are having two members hospitalized, 11.4 per cent are having three family member hospitalized, and there are 11.4 per cent in the category of more than three members. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having one member hospitalized in their family and there are 44.2 per cent of beneficiaries in Ernakulam district who are having two or more members hospitalized whereas it is only 31.4 per cent in the case of Wayanad district. Among the beneficiaries of APL category, about 80 per cent are having one family member hospitalized, 10.5 per cent are having two members hospitalized, 9.5 per cent are having three family member hospitalized, and there are none in the category of more than three members. Among the beneficiaries of BPL category, about 53.1 per cent are having one family member hospitalized, 33 per cent are having two members hospitalized, 12.3 per cent are having three family member hospitalized, and there are 1.6 per cent in the category of more than three members. It is revealed that majority beneficiaries both in APL and BPL category are having one member hospitalized in their family and there are 46.9 per cent of beneficiaries in BPL category who are having two or more members hospitalized whereas it is only 20 per cent in the case of APL category.

9.2.1.3 Nature of Treatment in the Last Hospitalization Case

RSBY-CHIS provide that no payment is to be made by an insured person for treatment taken in a network-hospital up to the limit of sum insured. All medical bills are settled between a hospital and the insurance company based on the package rates. There are mainly 3 packages available under the scheme, i.e. Surgical, Non Surgical and ICU admissions. For non surgical

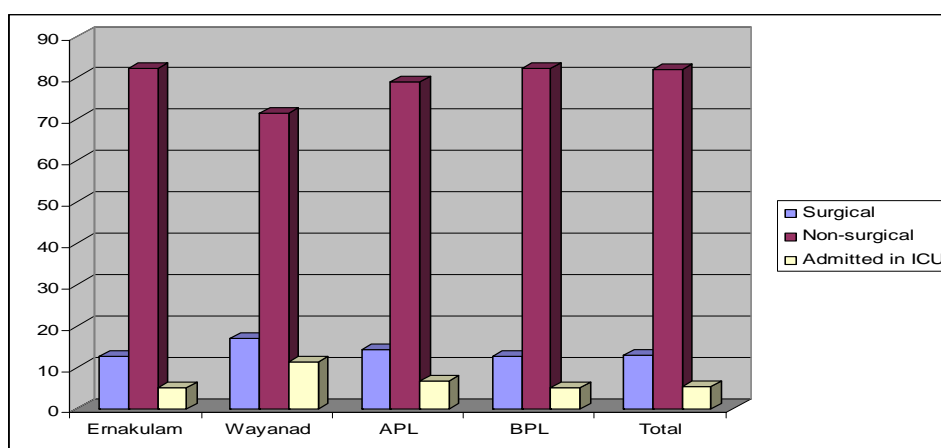
interventions the rate is Rs.500/ - per day, whereas for ICU admissions, it is R.1000/-per day. But for surgical interventions different rates are specified in the package in accordance with th type surgery. The package rates are given in appendix B. So it is essential to know the nature of treatment. The table 9.11 reveals the nature of treatment in the last hospitalization case.

Table 9.11 Nature of Treatment in the Last Hospitalization Case

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Surgical	110	12.7	6	17.1	15	14.3	101	12.7	116	12.9
Non-surgical	711	82.2	25	71.4	83	79.0	653	82.1	736	81.8
Admitted in ICU	44	5.1	4	11.4	7	6.7	41	5.2	48	5.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Table 9.2 Nature of Treatment in the Last Hospitalization Case



From the table 9.11 it is clear that among the beneficiaries of Ernakulam district, about 12.7 per cent are having surgical treatment, 82.2 per cent are having non surgical treatment, and 5.1 per cent are admitted in ICU. Among the beneficiaries of Wayanad district, about 17.1 per cent are having surgical treatment, 71.4 per cent are having non surgical treatment, and 11.4 per cent are admitted in ICU. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having non surgical treatment and there are no

significant differences with regard to the nature of treatment in between Ernakulam and Wayanad districts. Among the beneficiaries of APL category, about 14.3 per cent are having surgical treatment, 79 per cent are having non surgical treatment, and 6.7 per cent are admitted in ICU. Among the beneficiaries of BPL category, about 12.7 per cent are having surgical treatment, 82.1 per cent are having non surgical treatment, and 5.2 per cent are admitted in ICU. It is revealed that majority beneficiaries both in APL and BPL category are having non surgical treatment and there are no significant differences with regard to the nature of treatment in between APL and BPL categories.

9.2.1.4 Nature of Surgery

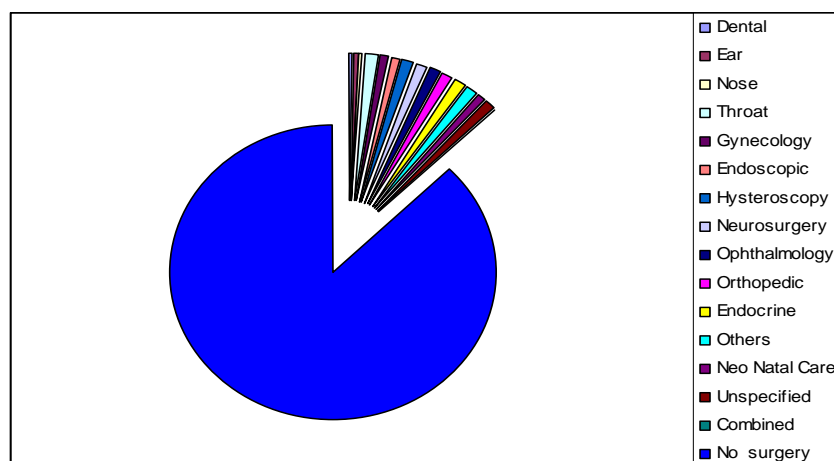
The table 9.12 reveals the nature of surgery.

Table 9.12 Nature of surgery

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Dental	0	0.0	2	5.7	0	0.0	2	0.3	2	0.2
Ear	5	0.6	0	0.0	5	4.8	0	0.0	5	0.6
Nose	0	0.0	2	5.7	0	0.0	2	0.3	2	0.2
Throat	14	1.6	0	0.0	5	4.8	9	1.1	14	1.6
Gynecology	5	0.6	0	0.0	5	4.8	0	0.0	5	0.6
Endoscopic	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Hysteroscopy	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Neurosurgery	9	1.0	0	0.0	0	0.0	9	1.1	9	1.0
Ophthalmology	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Orthopedic	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Endocrine	9	1.0	0	0.0	0	0.0	9	1.1	9	1.0
Others	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Neo Natal Care	9	1.0	0	0.0	0	0.0	9	1.1	9	1.0
Unspecified	9	1.0	0	0.0	0	0.0	9	1.1	9	1.0
Combined	0	0.0	2	5.7	0	0.0	2	0.3	2	0.2
No surgery	755	87.3	29	82.9	90	85.7	694	87.3	784	87.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.3 Nature Of surgery



From the table 9.12 it is clear that among the beneficiaries of Ernakulam district, the highest number of surgery was in throat, whereas in the case of Wayanad beneficiaries, the highest number of surgery was in the category of unspecified, dental and nose. Among the beneficiaries of APL category, the highest number of surgery was in gynecology, ear and thorat, whereas in the case of BPL beneficiaries, the highest number of surgery was in the category of Endoscopic, Hysteroscopy, orthopedic and others.

9.2.1.5 Reason for Choosing a Particular Hospital for Treatment

Physical accessibility is a major factor in the event of hospitalization and illness. RSBY-CHIS benefits are available only in empanelled hospitals under the scheme. An analysis of the factors which made the beneficiaries to choose a particular hospital for treatment is very essential in order to find out the physical accessibility of health care facilities under the scheme. For this, the beneficiaries were asked to rank 6 factors in the order of their preferences. Then, weights were given to each reason of their choice in the reverse order, ie. for the first choice 6 weights, 2nd choice 5, 3rd choice 4, 4th choice 3, 5th choice 2 and 6th choice 1. There after weighted averages were calculated. The number

of beneficiaries in each choice were multiplied with their respective rank and this total weighted score is divided by total number. The figure got is average weighted score. Reason with highest AWS is given the first rank and so on. Separate analysis of this AWS for Ernakulam, Wayanad, APL and BPL beneficiaries are shown in table 9.13.

Table 9.13 Ranking of Reasons for Choosing a Particular Hospital for Treatment

Factors	Ernakulam		Wayanad		APL		BPL		Total	
	AWS	RANK	AWS	RANK	AWS	RANK	AWS	RANK	AWS	RANK
Near to the home	4.4	2	4.6	2	2.2	5	4.7	2	4.8	2
Reputation of the hospital is good	2.2	5	1.1	6	4.3	2	1.0	6	1.2	6
Suggested by the relative/friends	1.2	6	2.1	5	1.2	6	2.2	5	2.0	5
Referred by doctors	3.8	4	3.7	4	3.8	4	4.2	3	4.1	3
Always go to This hospital	4.1	3	4.0	3	4.1	3	3.5	4	3.6	4
There is no other RSBY-CHIS empanelled hospitals Nearby	5.3	1	5.5	1	5.4	1	5.4	1	5.3	1

Source: Primary data

From the table 9.13 it is clear that among the 6 factors, first rank goes to the factor that ‘there is no other RSBY-CHIS empanelled hospitals nearby’ in all categories of beneficiaries. Thus it is revealed that majority beneficiaries have chosen a particular hospital, as they have no other choice under the scheme. This is throwing light to the unavoidable necessity that there should be more empanelled hospitals under the scheme.

9.2.2 Details about Transportation

RSBY-CHIS entails transportation allowance of Rs.100/- per journey upto a maximum of Rs. 1000/- per year. The empanelled hospitals are directed to provide the amount to the patients at the time of their discharge. Accordingly, an enquiry was also carried out to understand details about the transportation of the patients. The variables considered in this regard were:

distance to the hospital, mode of travel, details on accompaniment and cost of travel and its reimbursement.

9.2.2.1 Distance of the Hospital from Beneficiaries' House

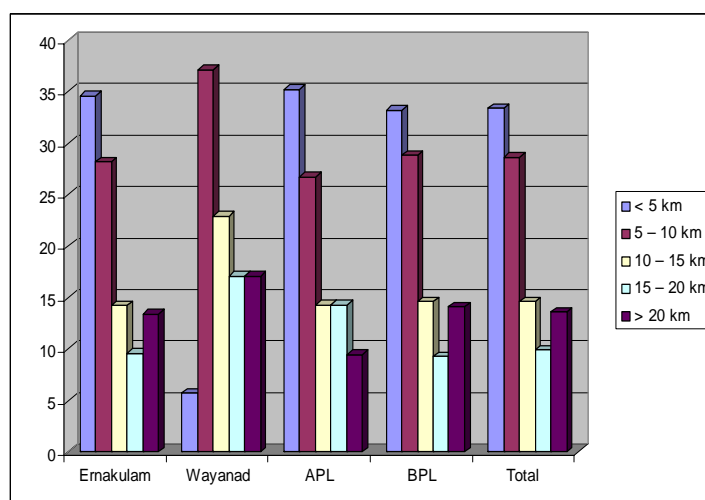
To have an idea about the beneficiaries' accessibility to health care facilities, it is essential to know the distance of the hospital from the beneficiaries' house. The table 9.14 reveals the same.

Table 9.14 Distance of the Hospital from Beneficiaries' House

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
< 5 km	299	34.6	2	5.7	37	35.2	264	33.2	301	33.4
5 – 10 km	244	28.2	13	37.1	28	26.7	229	28.8	257	28.6
10 – 15 km	123	14.2	8	22.9	15	14.3	116	14.6	131	14.6
15 – 20 km	83	9.6	6	17.1	15	14.3	74	9.3	89	9.9
> 20 km	116	13.4	6	17.1	10	9.5	112	14.1	122	13.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.4 Distance of the Hospital from Beneficiaries' House



From the table 9.14 it is clear that among the beneficiaries of Ernakulam district, about 34.6 per cent are having distance to hospital less than 5 km, 28.2 per cent are having distance to hospital in between 5-10 km, 14.2 per cent are

having distance to hospital in between 10-15 km, 9.6 per cent are having distance to hospital in between 15-20 km, and 13.4 per cent are having distance to hospital more than 20 km. In the case of beneficiaries of Wayanad district, about 5.7 per cent are having distance to hospital less than 5 km, 37.1 per cent are having distance to hospital in between 5-10 km, 22.9 per cent are having distance to hospital in between 10-15 km, 17.1 per cent are having distance to hospital in between 15-20 km, and 17.1 per cent are having distance to hospital more than 20 km. It is revealed that majority beneficiaries in Ernakulam district are having distance to hospital less than 5km whereas beneficiaries in Wayanad district are having distance to hospital in between 5-10 km. Among the beneficiaries of APL category, about 35.2 per cent are having distance to hospital less than 5 km, 26.7 per cent are having distance to hospital in between 5-10 km, 14.3 per cent are having distance to hospital in between 10-15 km, 14.3 per cent are having distance to hospital in between 15-20 km, and 9.5 per cent are having distance to hospital more than 20 km. In the case of beneficiaries of BPL category, about 33.2 per cent are having distance to hospital less than 5 km, 28.8 per cent are having distance to hospital in between 5-10 km, 14.6 per cent are having distance to hospital in between 10-15 km, 9.3 per cent are having distance to hospital in between 15-20 km, and 14.1 per cent are having distance to hospital more than 20 km. It is revealed that majority beneficiaries both in APL and BPL category are having distance to hospital less than 5 km and there are no significant differences with regard to distance to hospital from beneficiaries' house in between APL and BPL categories.

9.2.2.2 Mode of Transportation to the Hospital

The beneficiaries are classified on the basis of their mode of transportation to the hospital as given in table 9.15.

Table 9.15 Mode of Transportation to the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Bus	221	25.5	9	25.7	21	20.0	209	26.3	230	25.6
Car	145	16.8	4	11.4	32	30.5	117	14.7	149	16.6
Rickshaw	281	32.5	14	40.0	37	35.2	258	32.5	295	32.8
Two Wheeler	122	14.1	4	11.4	5	4.8	121	15.2	126	14.0
Others	96	11.1	4	11.4	10	9.5	90	11.3	100	11.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.15 it is clear that among the beneficiaries of Ernakulam district, about 25.5 per cent are traveling by bus to reach the hospital, 16.8 per cent by car, 32.5 per cent by rickshaw, 14.1 per cent by two wheeler, and 11.1 per cent are using other modes of transportation. In the case of beneficiaries of Wayanad district, about 25.7 per cent are traveling by bus to reach the hospital, 11.4 per cent by car, 40 per cent by rickshaw, 11.4 per cent by two wheeler, and 11.4 per cent are using other modes of transportation. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are using rickshaw as the mode of transportation and there are no significant differences with regard to mode of transportation in between Ernakulam and Wayanad districts. Among the beneficiaries of APL category, about 20 per cent are traveling by bus to reach the hospital, 30.5 per cent by car, 35.2 per cent by rickshaw, 4.8 per cent by two wheeler, and 9.5 per cent are using other modes of transportation. In the case of beneficiaries of BPL category, about 26.3 per cent are traveling by bus to reach the hospital, 14.7 per cent by car, 32.5 per cent by rickshaw, 15.2 per cent by two wheeler, and 11.3 per cent are using other modes of transportation. It is revealed that majority beneficiaries both in APL and BPL category are using rickshaw as the mode of transportation and

there are no significant differences with regard to mode of transportation in between APL and BPL categories.

9.2.2.3 Family Members Accompanying To the Hospital

The beneficiaries are classified on the basis of family members accompanying to the hospital as given in table 9.16.

Table 9.16 Family Members Accompanying to the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	793	91.7	30	85.7	89	84.8	734	92.3	823	91.4
No	72	8.3	5	14.3	16	15.2	61	7.7	77	8.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.16 it is clear that among the beneficiaries of Ernakulam district, about 91.7 per cent are followed by family members whereas 8.3 per cent are not followed by. Among the beneficiaries of Wayanad district, about 85.7 per cent are followed by family members whereas 14.3 per cent are not followed by. Likewise, among the APL beneficiaries, about 84.8 per cent are followed by family members whereas 5.2 per cent are not followed by. Among the BPL beneficiaries, about 92.3 per cent are followed by family members whereas 7.7 per cent are not followed by.

9.2.2.4 Number of Family Members Accompanying to the Hospital

The beneficiaries are classified on the basis of number of family members accompanying to the hospital as given in table 9.17.

Table 9.17 Number of Family Members Accompanying To the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
One	707	81.7	8	22.9	75	71.4	640	80.5	715	79.4
Two	42	4.9	15	42.9	8	7.6	49	6.2	57	6.3
Three	24	2.8	5	14.3	6	5.7	23	2.9	29	3.2
Four	20	2.3	2	5.7	0	0.0	22	2.8	22	2.4
Not followed by	72	8.3	5	14.3	16	15.2	61	7.7	77	8.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.17 it is clear that among the beneficiaries of Ernakulam district, about 81.7 per cent beneficiaries are accompanied by one family member, 4.9 per cent are accompanied by two, 2.8 per cent by three, 2.3 per cent by four and 8.3 per cent are not accompanied by. In the case of beneficiaries of Wayanad district, about 22.9 per cent beneficiaries are accompanied by one family member, 42.9 per cent are accompanied by two, 14.3 per cent by three, 5.7 per cent by four and 14.3 per cent are not accompanied by. It is revealed that majority beneficiaries in Ernakulam district are followed by one family member whereas in Wayanad district it is two family members. Among the beneficiaries of APL category, about 71.4 per cent beneficiaries are accompanied by one family member, 7.6 per cent are accompanied by two, 5.7 per cent by three, 0 per cent by four and 15.2 per cent are not accompanied by. In the case of beneficiaries of BPL category, about 80.5 per cent beneficiaries are accompanied by one family member, 6.2 per cent are accompanied by two, 2.9 per cent by three, 2.8 per cent by four and 7.7 per cent are not accompanied by. It is revealed that majority beneficiaries both in APL and BPL category are accompanied by one family member to the hospital.

9.2.2.5 Cost of Transportation to Reach the Hospital

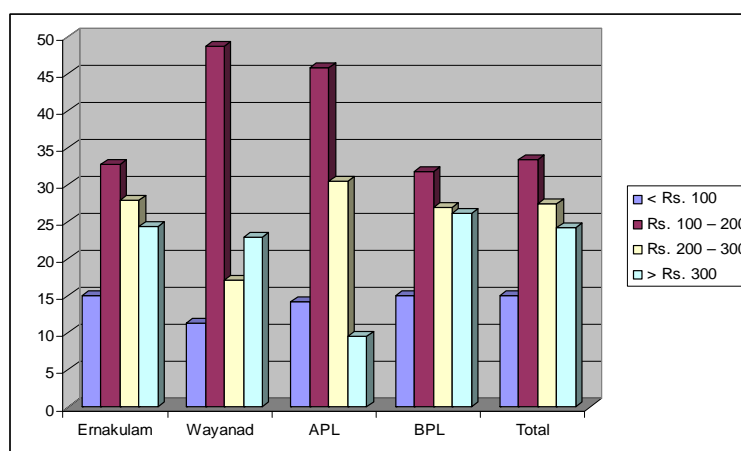
There is traveling allowance of Rs.100 per each episode of hospitalization subject to a maximum of 10 times in an year. So it is essential to know whether this amount of Rs.100 is sufficient to meet their cost of transportation and it is shown in table 9.18.

Table 9.18 Cost of Transportation to Reach the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
< Rs. 100	131	15.1	4	11.4	15	14.3	120	15.1	135	15.0
Rs. 100 – 200	283	32.7	17	48.6	48	45.7	252	31.7	300	33.3
Rs. 200 – 300	241	27.9	6	17.1	32	30.5	215	27.0	247	27.4
> Rs. 300	210	24.3	8	22.9	10	9.5	208	26.2	218	24.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.5 Cost of Transportation to Reach the Hospital



From the table 9.18 it is clear that among the beneficiaries of Ernakulam district, about 15.1 per cent beneficiaries have incurred less than Rs.100 by way of transportation cost, 32.7 per cent in between Rs.100-200, 27.9 per cent in between Rs.200-300, and 24.3 per cent incurred more than Rs.300 by way of transportation. In the case of beneficiaries of Wayanad

district, about 11.4 per cent beneficiaries have incurred less than Rs.100 by way of transportation cost, 48.6 per cent in between Rs.100-200, 17.1 per cent in between Rs.200-300, and 22.9 per cent incurred more than Rs.300 by way of transportation. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are having transportation cost in between Rs.100-200 and there are 84.9 per cent of beneficiaries in Ernakulam who have incurred more than Rs.100 for transportation and there are 88.6 per cent beneficiaries who have incurred more than Rs.100 in the case of Wayanad district. Among the beneficiaries of APL category, about 14.3 per cent beneficiaries have incurred less than Rs.100 by way of transportation cost, 45.7 per cent in between Rs.100-200, 30.5 per cent in between Rs.200-300, and 9.5 per cent incurred more than Rs.300 by way of transportation. Among the BPL beneficiaries, about 15.1 per cent beneficiaries have incurred less than Rs.100 by way of transportation cost, 31.7 per cent in between Rs.100-200, 27 per cent in between Rs.200-300, and 26.2 per cent incurred more than Rs.300 by way of transportation. It is revealed that majority beneficiaries both in APL and BPL category are having transportation cost in between Rs.100-200 and there are 85.7 per cent of beneficiaries in APL category who have incurred more than Rs.100 for transportation and there are 84.9 per cent beneficiaries who have incurred more than Rs.100 in the case of BPL category. So transportation allowance of Rs.100 is not sufficient to meet the cost of transportation of the beneficiaries of all categories.

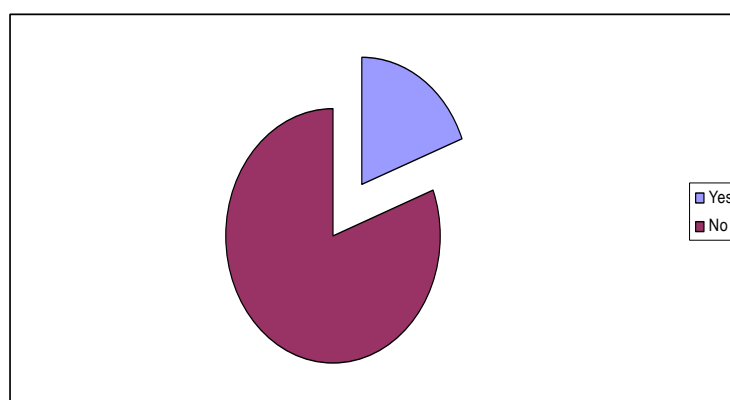
9.2.2.6 Reimbursement of the Cost of Transportation

There is a provision for travelling allowance of Rs.100 in the scheme. So it is essential to know whether it is actually given to the beneficiaries. Response to such a question reveals the following as shown in table 9.19.

Table 9.19 Reimbursement of the Cost of Transportation

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	164	19.0	10	28.6	22	21.0	152	19.2	174	19.3
No	701	81.0	25	71.4	83	79.0	643	80.9	726	80.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.6 Reimbursement of the Cost of Transportation

From the table 9.19 it is clear that among the beneficiaries of Ernakulam district, only 19 per cent have got traveling allowance of Rs.100, and 81 per cent have not received any traveling allowance. In the case of beneficiaries of Wayanad district, only 28.6 per cent have got traveling allowance of Rs.100, and 71.4 per cent have not received any traveling allowance. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts are not provided with traveling allowance which constitutes a feature of the scheme. Among the beneficiaries of APL category, only 21 per cent have got traveling allowance of Rs.100, and 79 per cent have not received any traveling allowance. In the case of beneficiaries of BPL category, only 19.2 per cent have got traveling allowance of Rs.100, and 80.9 per cent have not received any traveling allowance. It is revealed that majority beneficiaries both in APL and

BPL category are not provided with traveling allowance which constitutes a feature of the scheme.

9.2.2.7 How much of Traveling Cost Being Reimbursed?

The beneficiaries who have positively responded to the question of whether or not they have received travelling allowance were enquired about the amount of traveling allowance. Response to such a question reveals the following as shown in table 9.20.

Table 9.20 How much of Traveling Cost Being Reimbursed

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Less than 100	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Exactly 100	164	100.0	10	100.0	22	100.0	152	100.0	174	100.0
More than 100	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	164	100.0	10	100.0	22	100.0	152	100.0	174	100.0

Source: Primary data

From the table 9.20 it is clear that among the beneficiaries of both Ernakulam and Wayanad districts, 100 per cent of those who have got traveling allowance of Rs.100, responded that have received exactly Rs.100 as traveling allowance. Among the beneficiaries of both APL and BPL category also, 100 per cent of those who have got traveling allowance of Rs.100, responded that have received exactly Rs.100 as traveling allowance.

9.2.2.8 Reason for Not Providing Traveling Allowance

The beneficiaries who have negatively responded to the question of whether or not they have received travelling allowance were enquired about what was the reason cited by the hospital authorities for not providing travelling allowance. Response to such a question reveals the following as shown in table 9.21.

Table 9.21 Reason for Not Providing Travelling Allowance

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hospital Refused	173	20.0	7	20.0	31	29.5	149	18.7	180	20.0
Did not know there was such a Provision	141	16.3	4	11.4	20	19.0	125	15.7	145	16.1
Hospital said they will give this later	293	33.9	14	40.0	27	25.7	280	35.2	307	34.1
Patient did not ask for it	172	19.9	7	20.0	16	15.2	163	20.5	179	19.9
Others	86	9.9	3	8.6	11	10.5	78	9.8	89	9.9
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.21 it is clear that among the beneficiaries of Ernakulam district, about 20 per cent beneficiaries have cited the reason for not providing traveling allowance as refusal of the hospital, 33.9 per cent have cited that hospital said they will give this later, 19.9 per cent have cited that they did not ask for it and there are 16.3 per cent and 9.9 per cent respectively in the categories of did not know there was such a provision and others. In the case of beneficiaries of Wayanad district, about 20 per cent beneficiaries have cited the reason for not providing traveling allowance as refusal of the hospital, 11.4 per cent cited that they did not know there was such a provision, 40 per cent have cited that hospital said they will give this later, 20 per cent have cited that they did not ask for it and there is 8.6 per cent beneficiaries in the category of others. It is revealed that majority beneficiaries both in Ernakulam and Wayanad districts have cited the reason that hospital said they will give this later and there is no significant difference with regard to this point in between Ernakulam and Wayanad districts. Among the beneficiaries of APL category, about 29.5 per cent beneficiaries have cited the reason for not providing traveling allowance as refusal of the hospital, 19 per cent cited that they did not know

there was such a provision, 25.7 per cent have cited that hospital said they will give this later, 15.2 per cent have cited that they did not ask for it and there are 10.5 per cent in the categories of others. In the case of beneficiaries of BPL category, about 18.7 per cent beneficiaries have cited the reason for not providing traveling allowance as refusal of the hospital, 15.7 per cent cited that they did not know there was such a provision, 35.2 per cent have cited that hospital said they will give this later, 20.5 per cent have cited that they did not ask for it and there is 9.8 per cent beneficiaries in the category of others. It is revealed that majority beneficiaries in APL category cited the reason as refusal of the hospital, whereas majority beneficiaries in BPL category have cited the reason that hospital said they will give this later.

9.2.3 Details about Inpatient Experience

The satisfaction level of the beneficiaries greatly depends on the experience at the hospitals. This section details the patients' experience at the hospitals during the admission time. Probably, the promptness, delicacy and the gentleness of the hospital machinery during the time of admission contribute a great deal in forming their perception /opinion about the hospital and the services. Being a cashless service in the case of RSBY-CHIS, it could happen that the hospital staff could deal in an indifferent or lukewarm manner to the patients. Hence, an in-depth enquiry was carried out to understand the patients' experience at the time of admission using the variables: presence of RSBY-CHIS help desk, availability of equipments, time taken to attend, finger print verification, advance information about the cost involved, information on money left in the card, sufficiency of money, mode of admission, dealing of staff at helpdesk, availability of bed, condition at the time of admission, availability of wheel chair, duration taken for attending the patient by

nurse/doctor after admission, diagnostic tests outside, purchase of medicines and food at hospitals.

9.2.3.1 Presence of RSBY-CHIS Help Desk at the Hospital

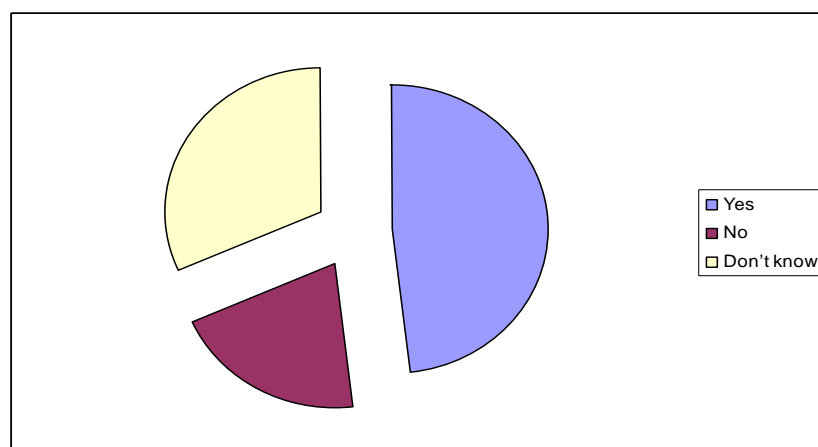
In the instructions given to the empanelled hospitals it is compulsory to set up a RSBY-CHIS help desk. So it is essential to know whether there is the presence of a help desk at the hospital to facilitate the beneficiaries to seek treatment under the scheme. The table 9.22 reveals the same.

Table 9.22 Presence of RSBY-CHIS Help Desk at the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	422	48.8	10	28.6	37	35.2	395	49.7	432	48.0
No	179	20.7	4	11.4	27	25.7	156	19.6	183	20.3
Don't know	264	30.5	21	60.0	41	39.0	244	30.7	285	31.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.7 Presence of RSBY-CHIS Help Desk at the Hospital



From the table 9.22 it is clear that among the beneficiaries of Ernakulam district, there are about 48.8 per cent beneficiaries who have stated that there is a help desk, 20.7 per cent stated that there is no help desk and 30.5 per cent responded that they did not know about it. Among the beneficiaries of Wayanad

district, there are about 28.6 per cent beneficiaries who have stated that there is a help desk, 11.4 per cent stated that there is no help desk and 60 per cent responded that they did not know about it. Among the beneficiaries of APL category, there are about 35.2 per cent beneficiaries who have stated that there is a help desk, 25.7 per cent stated that there is no help desk and 39 per cent responded that they did not know about it. Among the beneficiaries of BPL category, there are about 49.7 per cent beneficiaries who have stated that there is a help desk, 19.6 per cent stated that there is no help desk and 30.7 per cent responded that they did not know about it.

9.2.3.2 Is It A Separate Help Desk?

The RSBY-CHIS help desk should be in a visible manner at the hospital to facilitate the beneficiaries to seek treatment under the scheme. So it is essential to know whether the help desk is a separate one or part of the other desks like reception. The table 9.23 reveals the same.

Table 9.23 Is It A Separate Help Desk?

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	220	25.4	8	22.9	22	21.0	206	25.9	228	25.3
No	70	8.1	2	5.7	5	4.8	67	8.4	72	8.0
DNK	132	15.3	0	0.0	10	9.5	122	15.3	132	14.7
Total	422	48.8	10	28.6	37	35.2	395	49.7	432	48.0

Source: Primary data

From the table 9.23 it is clear that among the beneficiaries of Ernakulam district, out of 422 beneficiaries who have stated that there was a help desk, 220 stated that it was a separate help desk, 70 stated that there was no separate help desk and 132 responded that they did not know about it. Among the beneficiaries of Wayanad district, out of 10 beneficiaries who have stated that there was a help desk, 8 stated that it was a separate help desk, 2 stated that

there was no separate help desk. Among the beneficiaries of APL category, out of 37 beneficiaries who have stated that there was a help desk, 22 stated that it was a separate help desk, 5 stated that there was no separate help desk and 10 responded that they did not know about it. Among the beneficiaries of BPL category, out of 395 beneficiaries who have stated that there was a help desk, 206 stated that it was a separate help desk, 67 stated that there was no separate help desk and 122 responded that they did not know about it. It is revealed that majority beneficiaries positively responded and so majority of the empanelled hospitals have complied to the instruction given to them.

9.2.3.3 Finding out the RSBY-CHIS Help Desk at the Hospital

Easy accessibility to the help desk is possible only if the same has a structure in a prominent place of the hospital. The table 9.24 reveals the response of the beneficiaries regarding their finding out of the help desk at the hospital.

Table 9.24 Finding out the RSBY-CHIS Help Desk at the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Visible sign boards	121	14.0	4	11.5	17	16.2	108	13.6	125	13.9
By asking hospital staff	189	21.9	4	11.4	10	9.5	183	23.0	193	21.4
Found by themselves without any assistance	112	12.9	2	5.7	10	9.5	104	13.1	114	12.7
Total	422	48.8	10	28.6	37	35.2	395	49.7	432	48.0

Source: Primary data

From the table 9.24 it is clear that among the beneficiaries of Ernakulam district, there are 121 beneficiaries who have stated that there is visible sign boards, 189 stated that they asked hospital staff and 112 responded that they found it by themselves without any assistance. Among the beneficiaries of Wayanad district, there are 4 beneficiaries who have stated that there is visible

sign boards, 4 stated that they asked hospital staff and 2 responded that they found it by themselves without any assistance. Among the beneficiaries of APL category, there are 17 beneficiaries who have stated that there is visible sign boards, 10 stated that they asked hospital staff and 10 responded that they found it by themselves without any assistance. Among the beneficiaries of BPL category, there are 108 beneficiaries who have stated that there is visible sign boards, 183 stated that they asked hospital staff and 104 responded that they found it by themselves without any assistance.

9.2.3.4 Availability of the Equipments

Each of the RSBY help desk was to be equipped with certain hardware components like computer, finger print scanner, camera, smart card readers, smartcard printers, telephone and internet connection. So it is essential to know whether there are such facilities in the hospital to facilitate the beneficiaries to seek treatment under the scheme. The table 9.25 reveals the same.

Table 9.25 Availability of the Equipments

Fingerprint scanner	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	540	62.4	25	71.4	73	69.5	492	61.9	565	62.8
No	109	12.6	5	14.3	6	5.7	108	13.6	114	12.7
DNK	216	25.0	5	14.3	26	24.8	195	24.5	221	24.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Smart card reader	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	540	62.4	25	71.4	73	69.5	492	61.9	565	62.8
No	109	12.6	5	14.3	6	5.7	108	13.6	114	12.7
DNK	216	25.0	5	14.3	26	24.8	195	24.5	221	24.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Computer	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	803	92.8	31	88.6	100	95.2	734	92.3	834	92.7
No	34	3.9	2	5.7	5	4.8	31	3.9	36	4.0
DNK	28	3.2	2	5.7	0	0.0	30	3.8	30	3.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Printer	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	540	62.4	25	71.4	73	69.5	492	61.9	565	62.8
No	109	12.6	5	14.3	6	5.7	108	13.6	114	12.7
DNK	216	25.0	5	14.3	26	24.8	195	24.5	221	24.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.25 it is clear that majority of the beneficiaries of all categories confirmed about the availability of fingerprint scanner, smart card reader and printer. Regarding computer, there is near cent percent positive response among all categories of beneficiaries. It may be as a result of the familiarity of the beneficiaries with computer, which cannot be expected in the case of other equipments.

9.2.3.5 Waiting Period Before Attended By the Staff

The table 9.26 reveals the response of the beneficiaries regarding waiting period before attended by the staff.

Table 9.26 Waiting Period Before Attended By the Staff

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
<5 Minutes	90	10.4	3	8.6	16	15.2	77	9.7	93	10.3
5 – 15 Minutes	257	29.7	10	28.6	25	23.8	242	30.4	267	29.7
15 - 30 Minutes	308	35.6	16	45.7	24	22.9	300	37.7	324	36.0
30 - 60 Minutes	114	13.2	2	5.7	20	19.0	96	12.1	116	12.9
> 60 Minutes	96	11.1	4	11.4	20	19.0	80	10.1	100	11.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.26 it is clear that among the beneficiaries of Ernakulam district, there are about 10.4 per cent beneficiaries who had to wait less than 5 minutes before attended by the staff, 29.7 per cent beneficiaries who had to wait between 5-15 minutes, 35.6 per cent beneficiaries who had to wait between 15-30 minutes, 13.2 per cent beneficiaries who had to wait between 30-60 minutes, and there are 11.1 per cent beneficiaries who had to wait more than 60 minutes before attended by the staff. Among the beneficiaries of Wayanad district, there are about 8.6 per cent beneficiaries who had to wait less than 5 minutes before attended by the staff, 28.6 per cent beneficiaries who had to wait between 5-15 minutes, 45.7 per cent beneficiaries who had to wait

between 15-30 minutes, 5.7 per cent beneficiaries who had to wait between 30-60 minutes, and there are 11.4 per cent beneficiaries who had to wait more than 60 minutes before attended by the staff. It is revealed that majority beneficiaries both in APL and BPL category had to wait between 15-30 minutes before attended by the staff and there is no significant difference with regard to this point in between Ernakulam and Wayanad beneficiaries. Among the beneficiaries of APL category, there are about 15.2 per cent beneficiaries who had to wait less than 5 minutes before attended by the staff, 23.8 per cent beneficiaries who had to wait between 5-15 minutes, 22.9 per cent beneficiaries who had to wait between 15-30 minutes, 19 per cent beneficiaries who had to wait between 30-60 minutes, and there are 19 per cent beneficiaries who had to wait more than 60 minutes before attended by the staff. Among the beneficiaries of BPL category, there are about 9.7 per cent beneficiaries who had to wait less than 5 minutes before attended by the staff, 30.4 per cent beneficiaries who had to wait between 5-15 minutes, 37.7 per cent beneficiaries who had to wait between 15-30 minutes, 12.1 per cent beneficiaries who had to wait between 30-60 minutes, and there are 10.1 per cent beneficiaries who had to wait more than 60 minutes before attended by the staff. It is revealed that majority beneficiaries in APL category had to wait between 5-15 minutes whereas BPL majority had to wait between 15-30 minutes before attended by the staff.

9.2.3.6 Finger Print Verification during Admission

One of the pre-requisites for availing the cashless benefits of the RSBY-CHIS insurance at the hospital is to verify the finger print of either the patient or his/her family member listed on the card. The table 9.27 reveals the response

of the beneficiaries towards the question whether finger print verification was done through a finger print scanner during admission.

Table 9.27 Finger Print Verification during Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	649	75.0	30	85.7	79	75.2	600	75.5	679	75.4
No	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Don't know	216	25.0	5	14.3	26	24.8	195	24.5	221	24.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.27 it is clear that among the beneficiaries of Ernakulam district, there are about 75 per cent beneficiaries who have stated that finger print verification was done through a finger print scanner, 0 per cent stated that there was no finger print verification and 25 per cent responded that they did not know about it. Among the beneficiaries of Wayanad district, there are about 85.7 per cent beneficiaries who have stated that finger print verification was done through a finger print scanner, 0 per cent stated that there was no finger print verification and 14.3 per cent responded that they did not know about it. Among the beneficiaries of APL category, there are about 75.2 per cent beneficiaries who have stated that finger print verification was done through a finger print scanner, 0 per cent stated that there was no finger print verification and 24.8 per cent responded that they did not know about it. Among the beneficiaries of BPL category, there are about 75.5 per cent beneficiaries who have stated that finger print verification was done through a finger print scanner, 0 per cent stated that there was no finger print verification and 24.5 per cent responded that they did not know about it. It is revealed that majority beneficiaries of all categories positively responded and so majority of the empanelled hospitals have complied to the instruction given to them.

9.2.3.7 Whose Finger Print Was Used For Verification and Registration?

The table 9.28 reveals the response of the beneficiaries towards the question Whose finger print was used for verification and registration?

Table 9.28 Whose Finger Print Was Used For Verification And Registration?

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Patient	86	13.2	5	16.6	11	13.9	80	13.3	91	13.4
Family member	563	86.8	25	83.4	68	86.1	520	86.7	588	86.6
Total	649	100.0	30	100.0	79	100.0	600	100.0	679	100.0

Source: Primary data

From the table 9.28 it is clear that among the beneficiaries of Ernakulam district, there are about 13.2 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 86.8 per cent stated that family members' finger print verification was done. Among the beneficiaries of Wayanad district, there are about 16.6 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 83.4 per cent stated that family members' finger print verification was done. Among the beneficiaries of APL category, there are about 13.9 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 86.1 per cent stated that family members' finger print verification was done. Among the beneficiaries of BPL category, there are about 13.3 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 86.7 per cent stated that family members' finger print verification was done.

9.2.3.8 Reason for Not Taking Patients' Finger Print Verification

The table 9.29 reveals the reasons for not taking patients' finger print verification.

Table 9.29 Reason for Not Taking Patients' Finger Print Verification

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Patient was in bad condition	673	77.8	27	77.1	83	79.0	617	77.6	700	77.8
Patient's thumb is injured	44	5.1	0	0.0	5	4.8	39	4.9	44	4.9
Suggested by the hospital	52	6.0	2	5.7	5	4.8	49	6.2	54	6.0
Others	10	1.2	1	2.9	1	1.0	10	1.3	11	1.2
Patient's fingerprint	86	9.9	5	14.3	11	10.5	80	10.1	91	10.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.29 it is clear that among the beneficiaries of Ernakulam district, there are about 77.8 per cent beneficiaries who have stated that patient was not in a condition to give finger print verification, 5.1 per cent stated that patients' thumb was injured, 6 per cent stated that it was suggested by the hospital and there was 1.2 per cent in the category of others. Among the beneficiaries of Wayanad district, there are about 77.1 per cent beneficiaries who have stated that patient was not in a condition to give finger print verification, 0 per cent stated that patients' thumb was injured, 5.7 per cent stated that it was suggested by the hospital and there was 2.9 per cent in the category of others. Among the beneficiaries of APL category, there are about 79 per cent beneficiaries who have stated that patient was not in a condition to give finger print verification, 4.8 per cent stated that patients' thumb was injured, 4.8 per cent stated that it was suggested by the hospital and there was 1 per cent in the category of others. Among the beneficiaries of BPL category, there are about 77.6 per cent beneficiaries who have stated that patient was not in a condition to give finger print verification, 4.9 per cent stated that patients' thumb was injured, 6.2 per cent stated that it was suggested by the hospital and

there was 1.3 per cent in the category of others. It is revealed that majority beneficiaries of all categories stated that the reason for not taking patients' finger print verification is the poor condition of the patient.

9.2.3.9 Which Family Member Provided the Finger Print Verification?

The table 9.30 reveals the response for the question which family member provided the finger print verification?

Table 9.30 Which Family Member Provided The Finger Print Verification?

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Husband	45	7.9	3	12.0	11	16.1	39	7.5	50	8.5
Wife	173	30.7	4	16.0	12	17.6	105	20.1	105	17.8
Son	54	9.5	5	20.0	12	17.6	117	22.5	124	21.0
Daughter	119	21.1	6	24.0	15	22.0	110	21.1	125	21.2
Mother	130	23.0	3	12.0	13	19.1	116	22.3	136	23.1
Father	42	7.4	4	16.0	5	7.3	33	6.3	48	8.1
Total	563	100.0	25	100.0	68	100.0	520	100.0	588	100.0

Source: Primary data

From the table 9.30 it is clear that among the beneficiaries of Ernakulam district, there are about 7.9 per cent beneficiaries who have stated that husband's finger print verification was taken, 30.7 per cent stated that wife's, 9.5 per cent stated that son's, 21.1 per cent stated that daughter's, 23 per cent stated that mother's, 7.4 per cent stated that father's, and there was none in the category of others. Among the beneficiaries of Wayanad district, there are about 12 per cent beneficiaries who have stated that husband's finger print verification, was taken, 16 per cent stated that wife's, 20 per cent stated that son's, 24 per cent stated that daughter's, 12 per cent stated that mother's, 16 per cent stated that father's, and there was none in the category of others. Among

the beneficiaries of APL category, there are about 16.1 per cent beneficiaries who have stated that husband's finger print verification, was taken, 17.6 per cent stated that wife's, 17.6 per cent stated that son's, 22 per cent stated that daughter's, 19.1 per cent stated that mother's, 7.3 per cent stated that father's, and there was none in the category of others. Among the beneficiaries of BPL category, there are about 7.5 per cent beneficiaries who have stated that husband's finger print verification, was taken, 20.1 per cent stated that wife's, 22.5 per cent stated that son's, 21.1 per cent stated that daughter's, 22.3 per cent stated that mother's, 6.3 per cent stated that father's, and there was none in the category of others.

9.2.3.10 Giving Necessary Information to the Beneficiaries

Often the ignorance of the patient regarding their right to information on various provisions of the scheme might have been a contributory factor for not asking the RSBY-CHIS personnel of the hospital about the cost involved for the treatment. It was also observed that neither the hospital personnel nor the RSBY-CHIS personnel were keen to provide information about the same to the patient as they feared the misuse of the scheme by the patients. As per the scheme, the concerned hospital should impart to the beneficiaries necessary information regarding the scheme. So it is essential to know whether there are such information provided by the hospital to facilitate the beneficiaries to seek treatment under the scheme. The table 9.31 reveals the same.

Table 9.31 Giving Necessary Information to the Beneficiaries

Cost of treatment	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	622	71.9	20	57.1	67	63.8	575	72.3	642	71.3
No	243	28.1	15	42.9	38	36.2	220	27.7	258	28.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Money left in the smartcard	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	622	71.9	20	57.1	67	63.8	575	72.3	642	71.3
No	243	28.1	15	42.9	38	36.2	220	27.7	258	28.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Sufficiency of money for the treatment	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	622	71.9	20	57.1	67	63.8	575	72.3	642	71.3
No	243	28.1	15	42.9	38	36.2	220	27.7	258	28.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
Need to pay if balance is not sufficient	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	622	71.9	20	57.1	67	63.8	575	72.3	642	71.3
No	243	28.1	15	42.9	38	36.2	220	27.7	258	28.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.31 it is clear that majority of the beneficiaries of all categories were informed about the cost of the treatment, money left in the smartcard, sufficiency of money in the card for the treatment and if the balance is not sufficient, would have to pay the difference.

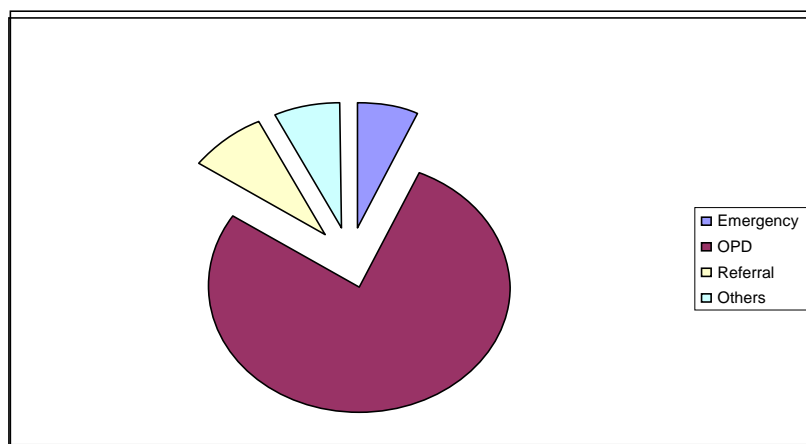
9.2.3.11 Nature of Admission

The table 9.32 reveals the nature of admission.

Table 9.32 Nature of Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Emergency	58	6.7	2	5.7	10	9.5	50	6.3	60	6.7
OPD	672	77.7	28	80.0	84	80.0	616	77.5	700	77.8
Referral	72	8.3	2	5.7	5	4.8	69	8.7	74	8.2
Others	63	7.3	3	8.6	6	5.7	60	7.5	66	7.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.8 Nature of Admission

From the table 9.32 it is clear that among the beneficiaries of Ernakulam district, there are about 6.7 per cent beneficiaries who have been admitted due to emergency, 77.7 per cent admitted through OPD, 8.3 per cent admitted through referral and there are 7.3 per cent in the category of others. Among the beneficiaries of Wayanad district, there are about 5.7 per cent beneficiaries who have been admitted due to emergency, 80 per cent admitted through OPD, 5.7 per cent admitted through referral and there are 8.6 per cent in the category of others. Among the beneficiaries of APL category, there are about 9.5 per cent beneficiaries who have been admitted due to emergency, 80 per cent admitted through OPD, 4.8 per cent admitted through referral and there are 5.7 per cent in the category of others. Among the beneficiaries of BPL category, there are about 6.3 per cent beneficiaries who have been admitted due to emergency, 77.5 per cent admitted through OPD, 8.7 per cent admitted through referral and there are 7.5 per cent in the category of others. It is revealed that majority beneficiaries have been admitted through OPD.

9.2.3.12 Availability of Bed on Admission

Availability of bed at the time of admission was a concern for most of the patients. It is all the more intense in the case of persons who come under the insurance scheme as it is generally perceived that the hospitals provide first priority to those who pay the amount directly. The table 9.33 reveals the availability of bed on admission.

Table 9.33 Availability of Bed on Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	392	45.3	15	42.9	76	72.4	331	41.6	407	45.2
Patient was asked to wait for a few hours	348	40.2	17	48.6	8	7.6	357	44.9	365	40.6
Patient asked to come back on another day	67	7.7	2	5.7	10	9.5	59	7.4	69	7.7
Others	58	6.7	1	2.9	11	10.5	48	6.0	59	6.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.33 it is clear that among the beneficiaries of Ernakulam district, there are about 45.3 per cent beneficiaries who have got bed as soon as the patient was advised admission, 40.2 per cent beneficiaries were asked to wait for a few hours, 7.7 per cent was asked to come back on another day and there are 6.7 per cent in the category of others. Among the beneficiaries of Wayanad district, there are about 42.9 per cent beneficiaries who have got bed as soon as the patient was advised admission, 48.6 per cent beneficiaries were asked to wait for a few hours, 5.7 per cent was asked to come back on another day and there are 2.9 per cent in the category of others. Among the beneficiaries of APL category, about there are 72.4 per cent beneficiaries who have got bed as soon as the patient was advised admission, 7.6 per cent beneficiaries were

asked to wait for a few hours, 9.5 per cent was asked to come back on another day and there are 10.5 per cent in the category of others. Among the beneficiaries of BPL category, there are about 41.6 per cent beneficiaries who have got bed as soon as the patient was advised admission, 44.9 per cent beneficiaries were asked to wait for a few hours, 7.4 per cent was asked to come back on another day and there are 6 per cent in the category of others. It is revealed that majority beneficiaries have got bed as soon as the patient was advised admission.

9.2.3.13 Condition of the Patient at the Time of Admission

The table 9.34 reveals the condition of the patient on the time of admission.

Table 9.34 Condition of the Patient at the Time of Admission

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Able to Walk by Own	392	45.3	15	42.9	76	72.4	331	41.6	407	45.2
Able to Walk by Support	348	40.2	17	48.6	8	7.6	357	44.9	365	40.6
Needed Stretcher / Wheelchair	125	14.5	3	8.6	21	20.0	107	13.5	128	14.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.34 it is clear that among the beneficiaries of Ernakulam district, there are about 45.3 per cent patients were able to walk by own during admission, 40.2 per cent patients were able to walk by support during admission and 14.5 per cent patients needed stretcher/wheel chair during admission. Among the beneficiaries of Wayanad district, there are about 42.9 per cent patients were able to walk by own during admission, 48.6 per cent patients were able to walk by support during admission and 8.6 per cent patients

needed stretcher/wheel chair during admission. Among the beneficiaries of APL category, there are about 72.4 per cent patients were able to walk by own during admission, 7.6 per cent patients were able to walk by support during admission and 20 per cent patients needed stretcher/wheel chair during admission. Among the beneficiaries of BPL category, there are about 41.6 per cent patients were able to walk by own during admission, 44.9 per cent patients were able to walk by support during admission and 13.5 per cent patients needed stretcher/wheel chair during admission.

9.2.3.14 Availability of Stretcher/Wheel Chair

The table 9.35 reveals the availability of stretcher/wheel chair on admission.

Table 9.35 Availability of Stretcher/Wheel Chair

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	105	12.1	2	5.7	20	19.0	87	10.9	107	11.9
No	20	2.3	1	2.9	1	1.0	20	2.5	21	2.3
Not needed	740	85.5	32	91.4	84	80.0	688	86.5	772	85.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.35 it is clear that among the 125 beneficiaries of Ernakulam district who needed stretcher/wheelchair, there are 105 who had got it and 20 patients had not got it. Among the 3 beneficiaries of Wayanad district, there are 2 who had got it and 1 patient had not got it. Among the 21 beneficiaries of APL category, there are 20 who had got it and 1 patient had not got it. Among the 107 beneficiaries of BPL category, there are 87 who had got it and 20 patients had not got it. It is revealed that majority beneficiaries received wheel chair/stretcher on request.

9.2.3.15 Who Pushed the Wheel Chair/Stretcher?

The table 9.36 reveals the response for the question who pushed the wheel chair/stretcher?

Table 9.36 Who Pushed The Wheel Chair/Stretcher?

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hospital Staff	85	9.8	2	5.7	20	19.0	67	8.4	87	9.7
Relatives	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Others	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Not used stretcher/ wheelchair	760	87.9	33	94.3	85	81.0	708	89.1	793	88.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.36 it is clear that among the beneficiaries of Ernakulam district, there are 85 patients who have stated that the wheel chair/stretcher was pushed by the hospital staff, 10 patients who have stated that the wheel chair/stretcher was pushed by their relatives and there are 10 in the category of others. Among the beneficiaries of Wayanad district, there are 2 patients who have stated that the wheel chair/stretcher was pushed by the hospital staff. Among the beneficiaries of APL category, there are 20 patients who have stated that the wheel chair/stretcher was pushed by the hospital staff. Among the beneficiaries of BPL, there are 67 patients who have stated that the wheel chair/stretcher was pushed by the hospital staff, 10 patients who have stated that the wheel chair/stretcher was pushed by their relatives and there are 10 in the category of others. Lack of required facilities and human resources in the hospital might have been the reasons for the negated answers in this regard.

9.2.3.16 Waiting Period Before Attended and Checked By the Nursing Staff

The table 9.37 reveals the response of the beneficiaries regarding waiting period before attended and checked by the nursing staff.

Table 9.37 Waiting Period Before Attended and Checked By the Nursing Staff

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
<15 Minutes	352	40.7	16	45.7	45	42.9	323	40.6	368	40.9
15 – 30 Minutes	315	36.4	10	28.6	34	32.4	291	36.6	325	36.1
30 – 60 Minutes	101	11.7	4	11.4	15	14.3	90	11.3	105	11.7
> 60 Minutes	97	11.2	5	14.3	11	10.5	91	11.4	102	11.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.37 it is clear that among the beneficiaries of Ernakulam district, there are about 40.7 per cent beneficiaries who had to wait less than 15 minutes before attended by the nursing staff, 36.4 per cent beneficiaries who had to wait between 15-30 minutes, 11.7 per cent beneficiaries who had to wait between 30-60 minutes, and there are 11.2 per cent beneficiaries who had to wait more than 60 minutes before attended by the nursing staff. Among the beneficiaries of Wayanad district, there are about 45.7 per cent beneficiaries who had to wait less than 15 minutes before attended by the nursing staff, 28.6 per cent beneficiaries who had to wait between 15-30 minutes, 11.4 per cent beneficiaries who had to wait between 30-60 minutes, and there are 14.3 per cent beneficiaries who had to wait more than 60 minutes before attended by the nursing staff. Among the beneficiaries of APL category, there are about 42.9 per cent beneficiaries who had to wait less than 15 minutes before attended by the nursing staff, 32.4 per cent beneficiaries who had to wait between 15-30 minutes, 14.3 per cent beneficiaries who had to wait between 30-60 minutes, and there are 10.5 per cent beneficiaries who had to wait more than 60 minutes before attended by the nursing staff. Among the beneficiaries of BPL category, there are about 40.6 per cent beneficiaries who had to wait less than 15 minutes before attended by the nursing staff, 36.6 per cent beneficiaries who had to wait between 15-30 minutes, 11.3 per cent beneficiaries who had to wait between

30-60 minutes, and there are 11.4 per cent beneficiaries who had to wait more than 60 minutes before attended by the nursing staff. It is revealed that majority beneficiaries in all categories had to wait less than 15 minutes before attended by the staff.

9.2.3.17 Waiting Period Before Attended and Checked By the Doctor

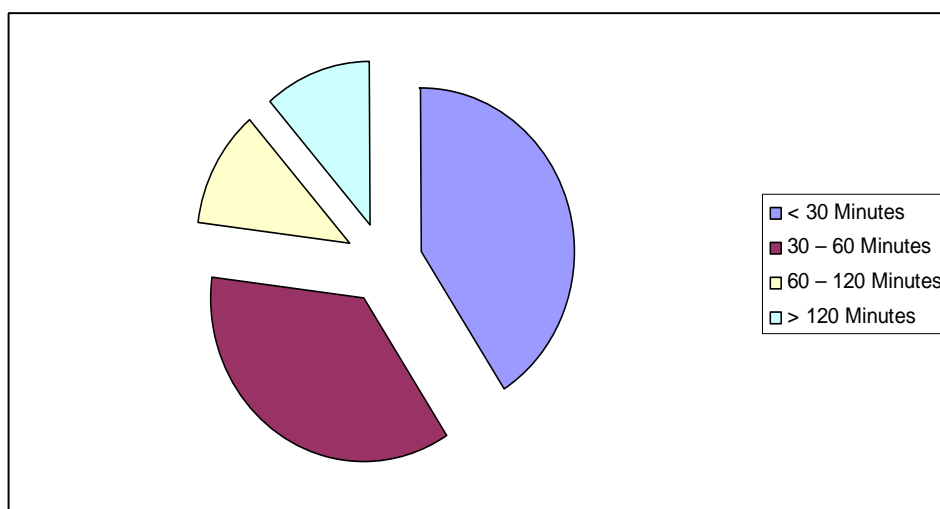
The table 9.38 reveals the response of the beneficiaries regarding waiting period before attended and checked by the doctor.

Table 9.38 Waiting Period Before Attended and Checked By the Doctor

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
< 30 Minutes	352	40.7	16	45.7	45	42.9	323	40.6	368	40.9
30 – 60 Minutes	315	36.4	10	28.6	34	32.4	291	36.6	325	36.1
60 – 120 Minutes	101	11.7	4	11.4	15	14.3	90	11.3	105	11.7
> 120 Minutes	97	11.2	5	14.3	11	10.5	91	11.4	102	11.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.9 Waiting Period Before Attended and Checked by the Doctor



From the table 9.38 it is clear that among the beneficiaries of Ernakulam district, there are about 40.7 per cent beneficiaries who had to wait less than 30

minutes before attended by the doctor, 36.4 per cent beneficiaries who had to wait between 30-60 minutes, 11.7 per cent beneficiaries who had to wait between 60-120 minutes, and there are 11.2 per cent beneficiaries who had to wait more than 120 minutes before attended by the doctor. Among the beneficiaries of Wayanad district, there are about 45.7 per cent beneficiaries who had to wait less than 30 minutes before attended by the doctor, 28.6 per cent beneficiaries who had to wait between 30-60 minutes, 11.4 per cent beneficiaries who had to wait between 60-120 minutes, and there are 14.3 per cent beneficiaries who had to wait more than 120 minutes before attended by the doctor. Among the beneficiaries of APL category, there are about 42.9 per cent beneficiaries who had to wait less than 30 minutes before attended by the doctor, 32.4 per cent beneficiaries who had to wait between 30-60 minutes, 14.3 per cent beneficiaries who had to wait between 60-120 minutes, and there are 10.5 per cent beneficiaries who had to wait more than 120 minutes before attended by the doctor. Among the beneficiaries of BPL category, there are about 40.6 per cent beneficiaries who had to wait less than 30 minutes before attended by the doctor, 36.6 per cent beneficiaries who had to wait between 30-60 minutes, 11.3 per cent beneficiaries who had to wait between 60-120 minutes, and there are 11.4 per cent beneficiaries who had to wait more than 120 minutes before attended by the doctor. It is revealed that majority beneficiaries in all categories had to wait less than 30 minutes before attended by the doctor. It is observed by the researcher that majority of the non RSBY-CHIS patients are also waiting for less than 30 minutes before attended by the doctor. It can be assumed that there is no discrimination in between RSBY-CHIS and non RSBY-CHIS patients.

9.2.3.18 Test or Medicine from Outside

The table 9.39 reveals the response of the beneficiaries regarding whether they have been asked to get any diagnostic test or medicine from outside or not.

Table 9.39 Test or Medicine from Outside

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	144	16.6	7	20.0	21	20.0	130	16.4	151	16.8
No	721	83.4	28	80.0	84	80.0	665	83.6	749	83.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.39 it is clear that among the beneficiaries of Ernakulam district, there are about 16.6 per cent beneficiaries who have been asked to get diagnostic test or medicine from outside and 83.4 per cent beneficiaries who have not been asked for the same. Among the beneficiaries of Wayanad district, there are about 20 per cent beneficiaries who have been asked to get diagnostic test or medicine from outside and 80 per cent beneficiaries who have not been asked for the same. Among the beneficiaries of APL category, there are about 20 per cent beneficiaries who have been asked to get diagnostic test or medicine from outside and 80 per cent beneficiaries who have not been asked for the same. Among the beneficiaries of BPL category, there are about 16.4 per cent beneficiaries who have been asked to get diagnostic test or medicine from outside and 83.6 per cent beneficiaries who have not been asked for the same.

9.2.3.19 Paying for Test or Medicine Obtained From Outside

The package of health services under RSBY-CHIS covers even test or medicine obtained from outside. A section of empanelled hospitals violate the norms and do not provide free test or medicine obtained from outside during

hospitalization. The table 9.40 reveals the response of the beneficiaries regarding whether they have been asked to pay by themselves for any such tests or medicines obtained from outside or not.

Table 9.40 Paying For Test Or Medicine Obtained From Outside

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	91	10.5	5	14.3	16	15.2	80	10.1	96	10.7
No	53	6.1	2	5.7	5	4.8	50	6.3	55	6.1
No test or medicine from outside	721	83.4	28	80.0	84	80.0	665	83.6	749	83.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.40 it is clear that among the 144 beneficiaries of Ernakulam district who had been prescribed test or medicine from outside, there are 91 beneficiaries who have been asked to pay for diagnostic test or medicine obtained from outside and 53 beneficiaries who have not been asked for the same. Among the 7 beneficiaries of Wayanad district, there are 5 beneficiaries who have been asked to pay for diagnostic test or medicine from outside and 2 beneficiaries who have not been asked for the same. Among the 21 beneficiaries of APL category, there are 16 beneficiaries who have been asked to pay for diagnostic test or medicine obtained from outside and 5 beneficiaries who have not been asked for the same. Among the 130 beneficiaries of BPL category, there are 80 beneficiaries who have been asked to pay for diagnostic test or medicine from outside and 50 beneficiaries who have not been asked for the same.

9.2.3.20 Reason for Asking For the Payment of Test or Medicine Obtained From Outside

The table 9.41 reveals the response of the beneficiaries regarding whether they have been asked to pay by themselves for any such tests or medicines obtained from outside or not.

Table 9.41 Reason for Asking For the Payment of Test or Medicine Obtained From Outside

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hospital staff said it was not a part of the RSBY package	24	2.8	1	2.9	6	5.7	19	2.4	25	2.8
Did not asked	19	2.2	2	5.7	5	4.8	21	2.6	26	2.9
Hospital paid cash to the patient later	24	2.8	2	5.7	0	0.0	21	2.6	21	2.3
Hospital did not have sufficient fund	24	2.8	0	0.0	5	4.8	19	2.4	24	2.7
Not paid	774	89.5	30	85.7	89	84.8	715	89.9	804	89.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.41 it is clear that among the 91 beneficiaries of Ernakulam district who had been asked to pay for test or medicine obtained from outside, there are 24 beneficiaries who have stated the reason that hospital staff said it was not a part of the RSBY package, 19 stated that they did not asked, 24 stated that hospital paid cash to the patient later and 24 stated that hospital did not have sufficient fund. Among the 5 beneficiaries Wayanad district, there 1 beneficiary who have stated the reason that hospital staff said it was not a part of the RSBY package, 2 stated that they did not asked, 2 stated that hospital paid cash to the patient later and none stated that hospital did not have sufficient fund. Among the 16 beneficiaries of APL category, there are 6 beneficiaries who have stated the reason that hospital staff said it was not a part of the RSBY package, 5 stated that they did not asked, none stated that hospital paid cash to the patient later and 5 stated that hospital did not have sufficient

fund. Among the 80 beneficiaries of BPL category, there are 19 beneficiaries who have stated the reason that hospital staff said it was not a part of the RSBY package, 21 stated that they did not asked, 21 stated that hospital paid cash to the patient later and 19 stated that hospital did not have sufficient fund. It is revealed that majority beneficiaries stated the reason that hospital did not have sufficient facility.

9.2.3.21 Food to the Patient

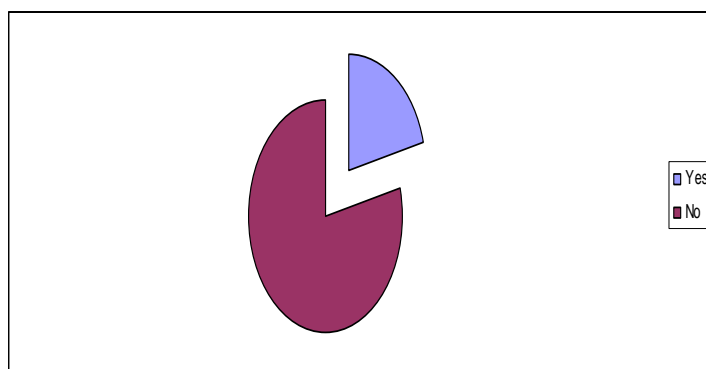
The package of health services under RSBY covers free food during hospitalization. A section of empanelled hospitals violate the norm and do not provide free food to the patients during hospitalization. In some cases, the patients prefer to avail home food instead of hospital food. The table 9.42 reveals the response of the beneficiaries regarding whether they have been provided with food or not.

Table 9.42 Food to the Patient

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	182	21.0	9	25.7	21	20.0	170	21.4	191	21.2
No	683	79.0	26	74.3	84	80.0	625	78.6	709	78.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.10 Food to the Patient



From the table 9.42 it is clear that among the beneficiaries of Ernakulam district, there are about 21 per cent beneficiaries who have been provided with food and 79 per cent beneficiaries who have not been provided with food. Among the beneficiaries of Wayanad district, there are about 25.7 per cent beneficiaries who have been provided with food and 74.3 per cent beneficiaries who have not been provided with food among the beneficiaries of APL category, there are about 20 per cent beneficiaries who have been provided with food and 80 per cent beneficiaries who have not been provided with food. Among the beneficiaries of BPL category, there are about 21.4 per cent beneficiaries who have been provided with food and 78.6 per cent beneficiaries who have not been provided with food.

9.2.3.22 Reason for Not Providing Food

The table 9.43 reveals the response of the beneficiaries regarding the reason for not providing food to the patients.

Table 9.43 Reason for Not Providing Food

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Hospital staff said it was not a part of the RSBY package	170	19.7	7	20.0	18	17.1	159	20.0	177	19.7
Did not asked	172	19.9	5	14.3	21	20.0	156	19.6	177	19.7
Hospital paid cash to the patient to buy food	77	8.9	2	5.7	20	19.0	59	7.4	79	8.8
Hospital staff said they have no sufficient fund	264	30.5	12	34.3	25	23.8	251	31.6	276	30.7
Received food	182	21.0	9	25.7	21	20.0	170	21.4	191	21.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.43 it is clear that among the 683 beneficiaries of Ernakulam district who had not received food, there are 170 beneficiaries who

have stated the reason that hospital staff said it was not a part of the RSBY package, 172 stated that hospital did not have food serving facility, 77 stated that hospital paid cash to the patient to buy food and 264 stated that hospital did not have sufficient fund. Among the 26 beneficiaries of Wayanad district, there are 7 beneficiaries who have stated the reason that hospital staff said it was not a part of the RSBY package, 5 stated that hospital did not have food serving facility, 2 stated that hospital paid cash to the patient to buy food and 12 stated that hospital did not have sufficient fund. Among the 84 beneficiaries of APL category, there are 18 beneficiaries who have stated the reason that hospital staff said it was not a part of the RSBY package, 21 stated that hospital did not have food serving facility, 20 stated that hospital paid cash to the patient to buy food and 25 stated that hospital did not have sufficient fund. Among the 625 beneficiaries of BPL category, there are 159 beneficiaries who have stated the reason that hospital staff said it was not a part of the RSBY package, 156 stated that hospital did not have food serving facility, 59 stated that hospital paid cash to the patient to buy food and 251 stated that hospital did not have sufficient fund. It is revealed that majority beneficiaries of all categories stated the reason that hospital did not have sufficient fund.

9.2.3.23 Quality of Food

The table 9.44 reveals the response of the beneficiaries regarding the quality of food.

Table 9.44 Quality of Food

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very Good	28	3.2	0	0.0	0	0.0	28	3.5	28	3.1
Good	33	3.8	0	0.0	5	4.8	28	3.5	33	3.7
Average	86	9.9	7	20.0	11	10.5	82	10.3	93	10.3
Bad	15	1.7	2	5.7	5	4.8	12	1.5	17	1.9
Very Bad	20	2.3	0	0.0	0	0.0	20	2.5	20	2.2
Not received food	683	79.0	26	74.3	84	80.0	625	78.6	709	78.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Out of the total 182 Ernakulam beneficiaries who have received food, 28 beneficiaries have stated that the food was very good, 33 beneficiaries were in the category of good, 86 beneficiaries were in the category of average, 15 beneficiaries in the category of bad and in the category of very bad, there was 20 beneficiaries. Out of the total 9 BPL beneficiaries, 7 beneficiaries have stated that the food was average and 2 beneficiaries in the category of bad. Out of the total 21 APL beneficiaries, 5 beneficiaries were in the category of good, 11 beneficiaries were in the category of average and 5 in the category of very bad. Out of the total 170 BPL beneficiaries, 28 beneficiaries have stated that the food was very good, 28 beneficiaries were in the category of good, 82 beneficiaries were in the category of average, 12 beneficiaries in the category of bad and in the category of very bad, there was 20 beneficiaries. Thus we can imply that majority beneficiaries in all categories were having average satisfaction about the quality of food and only a minority i.e. around 40 were of the opinion that the food was very bad.

9.2.4 Details on Discharge

The experience on discharge was elicited using the following variables: finger print verification, receiving the smart card back on discharge, prescription of test or medicine, duration of hospitalization, health status of the patient on discharge etc.

9.2.4.1 Finger Print Verification on Discharge

The table 9.45 reveals the response of the beneficiaries towards the question whether finger print verification was done through a finger print scanner on discharge.

Table 9.45 Finger Print Verification on Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
No	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.45 it is clear that among the beneficiaries of all categories, cent percent beneficiaries have stated that finger print verification was done through a finger print scanner on discharge from the hospital.

9.2.4.2 Whose Finger Print Was Taken On Discharge?

The table 9.46 reveals the response of the beneficiaries towards the question Whose finger print was taken on discharge?

Table 9.46 Whose Finger Print Was Taken On Discharge?

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Patient	86	9.9	5	14.3	11	10.5	80	10.1	91	10.1
Family Member	779	90.1	30	85.7	94	89.5	715	89.9	809	89.9
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.46 it is clear that among the beneficiaries of Ernakulam district, there are about 9.9 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner and 90.1 per cent stated that family members' finger print verification was done. Among the beneficiaries of Wayanad district, there are about 14.3 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 85.7 per cent stated that family members' finger print verification was done. Among the beneficiaries of APL category, there are about 10.5 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 89.5 per cent stated

that family members' finger print verification was done. Among the beneficiaries of BPL category, there are about 10.1 per cent beneficiaries who have stated that patients' finger print verification was done through a finger print scanner, and 89.9 per cent stated that family members' finger print verification was done.

9.2.4.3 Receiving the Smart Card Back on the Day of Discharge

Smart card is a pre-requisite for the cashless treatment at hospitals under the RSBY-CHIS. Accordingly, each one is required to collect back the card at the time of discharge. The card entails the patients' identity and details about the money for treatment. Considering the inevitability of the card for availing treatment, the beneficiaries were asked if they had received back the card on the day of discharge. The table 9.47 reveals the response of the beneficiaries towards an enquiry about receiving the smart card back on the day of discharge.

Table 9.47 Receiving the Smart Card Back On the Day of Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	822	95.0	33	94.3	100	95.2	755	95.0	855	95.0
No	43	5.0	2	5.7	5	4.8	40	5.0	45	5.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.47 it is clear that among the beneficiaries of Ernakulam district, there are about 95 per cent beneficiaries who have admitted that they have received their smart card on the same day of discharge, but 5 per cent stated that they have not received the card on the day of discharge. Among the beneficiaries of Wayanad district, there are about 94.3 per cent beneficiaries who have admitted that they have received their smart card on the same day of discharge, but 5.7 per cent stated that they have not received the card on the day of discharge. Among the beneficiaries of APL category, there are about 95.2 per

cent beneficiaries who have admitted that they have received their smart card on the same day of discharge, but 4.8 per cent stated that they have not received the card on the day of discharge. Among the beneficiaries of BPL category, there are about 95 per cent beneficiaries who have admitted that they have received their smart card on the same day of discharge, but 5 per cent stated that they have not received the card on the day of discharge. Thus only a minority of the beneficiaries were denied with their smart card on the day of discharge.

9.2.4.4 Waiting Period before Receiving the Smart Card Back

The table 9.48 reveals the response of those beneficiaries who have not received the smart card on discharge, regarding waiting period before receiving it.

Table 9.48 Waiting Period Before receiving the smart card back

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
< 5 Days	43	5.0	2	5.7	5	4.8	40	5.0	45	5.0
Received card on discharge	822	95.0	33	94.3	100	95.2	755	95.0	855	95.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.48 it is clear that the beneficiaries of all categories who had not received the smart card on the day of discharge, had to wait less than 5 days before receiving the card back and there are none in other categories.

9.2.4.5 Reason for Holding Back the Smart Card on Discharge

The table 9.49 reveals the reason for holding back the smart card by the hospital authorities on discharge.

Table 9.49 Reason for Holding Back the Smart Card On Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Staff wanted money for returning the card	9	1.0	0	0.0	0	0.0	9	1.1	9	1.0
Staff wanted to keep the card till insurance claims were settled	14	1.6	2	5.7	5	4.8	11	1.4	16	1.8
Staff said the card will stay deposited at the hospital	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Did not asked	10	1.2	0	0.0	0	0.0	10	1.3	10	1.1
Received card on discharge	822	95.0	33	94.3	100	95.2	755	95.0	855	95.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.49 it is clear that among the 43 beneficiaries of Ernakulam district who had not received card on discharge, 9 beneficiaries stated that staff wanted money for returning the card back on discharge, 14 stated that staff wanted to keep the card till insurance claims were settled, 10 stated that the staff wanted to deposit it always at the hospital and there are 10 beneficiaries in the category of others. Among the 2 beneficiaries of Wayanad district, both of them stated that staff wanted to keep the card till insurance claims were settled and there are none in other categories. Among the 5 beneficiaries of APL category, all of them stated that staff wanted to keep the card till insurance claims were settled and there are none in other categories. Among the 40 beneficiaries of BPL category, 9 beneficiaries stated that staff wanted money for returning the card back on discharge, 11 stated that staff wanted to keep the card till insurance claims were settled, 10 stated that the staff wanted to deposit it always at the hospital and there are 10 beneficiaries in the category of others. It is revealed that

majority beneficiaries of all categories stated the reason that staff wanted to keep the card till insurance claims were settled.

9.2.4.6 Prescription of Medicine on Discharge

Pre and post hospitalization expenses up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital shall be part of the package rates under the scheme. The table 9.50 reveals the response of the beneficiaries towards an enquiry about prescribing medicine on discharge.

Table 9.50 Prescribing Medicine on Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0
No	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.50 it is clear that all the beneficiaries of all categories have been prescribed medicine on discharge.

9.2.4.7 Prescription of Medicine on Discharge- Number of Days

The table 9.51 reveals the response of the beneficiaries towards the question: for how many days the medicines needed to be taken after discharge?

Table 9.51 Prescription of Medicine on Discharge- Number of Days

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
One day	53	6.1	1	2.9	16	15.2	38	4.8	54	6.0
Two days	42	4.9	1	2.9	6	5.7	37	4.7	43	4.8
Three days	51	5.9	2	5.7	5	4.8	48	6.0	53	5.9
Four days	212	24.5	6	17.1	50	47.6	168	21.1	218	24.2
Five days	232	26.8	12	34.3	15	14.3	229	28.8	244	27.1
More than 5 days	275	31.8	13	37.1	13	12.4	275	34.6	288	32.0
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.51 it is clear that among the beneficiaries of Ernakulam district, there are about 6.1 per cent in the category of one day, 4.9 per cent in the category of two days, 5.9 per cent in the category of three days, 24.5 per cent in the category of four days, 26.8 per cent in the category of five days and 31.8 per cent stated that they have been prescribed medicine for more than five days. Among the beneficiaries of Wayanad district, there are about 2.9 per cent in the category of one day, 2.9 per cent in the category of two days, 5.7 per cent in the category of three days, 17.1 per cent in the category of four days, 34.3 per cent in the category of five days and 37.1 per cent stated that they have been prescribed medicine for more than five days. Among the beneficiaries of APL category, there are about 15.2 per cent in the category of one day, 5.7 per cent in the category of two days, 4.8 per cent beneficiaries in the category of three days, 47.6 per cent in the category of four days, 14.3 per cent in the category of five days and 12.4 per cent stated that they have been prescribed medicine for more than five days. Among the beneficiaries of BPL category, there are about 4.8 per cent in the category of one day, 4.7 per cent beneficiaries in the category of two days, 6 per cent beneficiaries in the category of three days, 21.1 per cent in the category of four days, 28.8 per cent in the category of five days and 34.6 per cent stated that they have been prescribed medicine for more than five days. It is revealed that majority beneficiaries in APL category have been prescribed medicine for four days whereas majority beneficiaries in all other categories have been prescribed medicine for more than five days.

9.2.4.8 Provision of Free of Cost Medicine by the Hospital

Pre and post hospitalization expenses up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital shall be free under

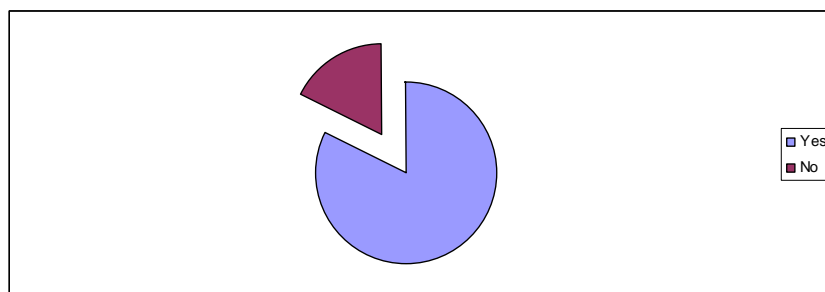
the scheme. The table 9.52 reveals the data regarding provision of free of cost medicine by the hospital.

Table 9.52 Provision of Free of Cost Medicine by the Hospital on Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	711	82.2	28	80.0	84	80.0	655	82.4	739	82.1
No	154	17.8	7	20.0	21	20.0	140	17.6	161	17.9
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.11 Provision of Free of Cost Medicine by the Hospital on Discharge



From the table 9.52 it is clear that among the beneficiaries of Ernakulam district, there are about 82.2 per cent beneficiaries who have admitted that they have received free medicine on discharge and 17.8 per cent stated that they have not received free medicine on discharge. Among the beneficiaries of Wayanad district, there are about 80 per cent beneficiaries who have admitted that they have received free medicine on discharge and 20 per cent stated that they have not received free medicine on discharge. Among the beneficiaries of APL category, there are about 80 per cent beneficiaries who have admitted that they have received free medicine on discharge and 20 per cent stated that they have not received free medicine on discharge. Among the beneficiaries of BPL category, there are about 82.4 per cent beneficiaries who have admitted that they have received free medicine on discharge and 17.6 per cent stated that they have not received free medicine on discharge. It is revealed that one important

feature of the scheme, i.e. post hospitalization expenses up to 5 days from the date of discharge from the hospital, is received by around 80 per cent of the beneficiaries in all categories.

9.2.4.9 Reason for Not Providing Free Medicine on Discharge

The table 9.53 reveals the reason for not providing free medicine on discharge.

Table 9.53 Reason for Not Providing Free Medicine on Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Did not Asked	44	5.1	2	5.7	5	4.8	41	5.2	46	5.1
No Reason Provided	48	5.5	2	5.7	10	9.5	40	5.0	50	5.6
It is not Part of RSBY	52	6.0	2	5.7	5	4.8	49	6.2	54	6.0
Others	10	1.2	1	2.9	1	1.0	10	1.3	11	1.2
Received free medicine	711	82.2	28	80.0	84	80.0	655	82.4	739	82.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.53 it is clear that among the 154 beneficiaries of Ernakulam district who had not received free medicine on discharge, 44 beneficiaries stated that they did not asked the reason for not providing free medicine on discharge, 48 stated that no reason provided by the staff, 52 stated that hospital staff said that free medicine on discharge is not part of RSBY and there is 10 in the category of others. Among the 7 beneficiaries of Wayanad district, 2 beneficiaries stated that they did not asked the reason for not providing free medicine on discharge, 2 stated that no reason provided by the staff, 2 stated that hospital staff said that free medicine on discharge is not part of RSBY and there is 1 in the category of others. Among the 21 beneficiaries of APL category, 5 beneficiaries stated that they did not asked the reason for not

providing free medicine on discharge, 10 stated that no reason provided by the staff, 5 stated that hospital staff said that free medicine on discharge is not part of RSBY and there is 1 in the category of others. Among the 140 beneficiaries of BPL category, 41 beneficiaries stated that they did not asked the reason for not providing free medicine on discharge, 40 stated that no reason provided by the staff, 49 stated that hospital staff said that free medicine on discharge is not part of RSBY and there is 10 in the category of others. It is revealed that majority beneficiaries in APL category stated that no reason provided by the staff whereas majority beneficiaries in all other categories stated that hospital staff said that free medicine on discharge is not part of RSBY-CHIS.

9.2.4.10 Prescription of Diagnostic Test on Discharge

Post hospitalization expenses up to 5 days from the date of discharge from the hospital shall be part of the package rates under the scheme and so the beneficiaries have a right to avail free diagnostic tests prescribed within 5 days, if any. The table 9.54 reveals the response of the beneficiaries towards an enquiry about prescribing any diagnostic test on discharge.

Table 9.54 Prescribing Diagnostic Test on Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	105	12.1	5	14.3	11	10.5	99	12.5	110	12.2
No	760	87.9	30	85.7	94	89.5	696	87.5	790	87.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.54 it is clear that among the beneficiaries of Ernakulam district, there are about 12.1 per cent beneficiaries who have admitted that they have been prescribed test on discharge and 87.9 per cent stated that they have not been prescribed any medicine on discharge. Among the beneficiaries of Wayanad district, there are about 14.3 per cent beneficiaries who have admitted

that they have been prescribed medicine on discharge and 85.7 per cent stated that they have not been prescribed any medicine on discharge. Among the beneficiaries of APL category, there are about 10.5 per cent beneficiaries who have admitted that they have been prescribed test on discharge and 89.5 per cent stated that they have not been prescribed any medicine on discharge. Among the beneficiaries of BPL category, there are about 12.5 per cent beneficiaries who have admitted that they have been prescribed medicine on discharge and 87.5 per cent stated that they have not been prescribed any medicine on discharge.

9.2.4.11 Prescription Of diagnostic Test on Discharge- Within How Many Days?

The table 9.55 reveals the response of the beneficiaries towards the question: within how many days the tests needed to be taken after discharge?

Table 9.55 Prescription of Medicine on Discharge- Within How Many Days?

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
One day	9	1.0	0	0.0	0	0.0	9	1.1	9	1.0
Two days	19	2.2	0	0.0	0	0.0	19	2.4	19	2.1
Three days	20	2.3	0	0.0	0	0.0	20	2.5	20	2.2
Four days	19	2.2	2	5.7	0	0.0	21	2.6	21	2.3
Five days	38	4.4	3	8.6	11	10.5	30	3.8	41	4.6
Not prescribed test	760	87.9	30	85.7	94	89.5	696	87.5	790	87.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.55 it is clear that among the 105 beneficiaries of Ernakulam district who have been prescribed test, there are 9 in the category of one day, 19 in the category of two days, 20 in the category of three days, 19 in the category of four days, and 38 stated that they have been prescribed test

which has to be taken within five days. Among the 5 beneficiaries of Wayanad district, there are none in the categories of one, two and three days, 2 in the category of four days, and 3 in the category of five days. Among the 11 beneficiaries of APL category, all of them belong to the category of five days. Among the 99 beneficiaries of BPL category, there are 9 in the category of one day, 19 in the category of two days, 20 in the category of three days, 21 in the category of four days, and 30 in the category of five days. It is revealed that all the beneficiaries who have been prescribed test on discharge need to be taken it within five days.

9.2.4.12 Provision of Free Of Cost Test by the Hospital

Pre and post hospitalization expenses up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital shall be part of the package rates under the scheme. The table 9.56 reveals the data regarding provision of free of cost test by the hospital.

Table 9.56 Provision of Free Of Cost Test by the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	38	4.4	3	8.6	1	1.0	40	5.0	41	4.6
No	67	7.7	2	5.7	10	9.5	59	7.4	69	7.7
Not prescribed test	760	87.9	30	85.7	94	89.5	696	87.5	790	87.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.56 it is clear that among the 105 beneficiaries of APL category who have been prescribed test on discharge, there are 38 beneficiaries who have admitted that they have received free test on discharge and 67 stated that they have not received free test on discharge. Among the 5 beneficiaries of Wayanad district, there are 3 beneficiaries who have admitted that they have received free test on discharge and 2 stated that they have not received free test

on discharge. Among the 11 beneficiaries of APL category, there is 1 beneficiary who have admitted that he has received free test on discharge and 10 stated that they have not received free test on discharge. Among the 99 beneficiaries of BPL category, there are 40 beneficiaries who have admitted that they have received free test on discharge and 59 stated that they have not received free test on discharge. It is revealed that one important feature of the scheme, i.e. post hospitalization expenses up to 5 days from the date of discharge from the hospital, is not received by majority of the beneficiaries of all categories who have been prescribed test on discharge.

9.2.4.13 Reason for Not Providing Free Test on Discharge

The table 9.57 reveals the reasons for not providing free test on discharge.

Table 9.57 Reason for Not Providing Free Test on Discharge

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Did not Asked	15	1.7	2	5.7	5	4.8	12	1.5	17	1.9
No Reason Provided	24	2.8	0	0.0	5	4.8	19	2.4	24	2.7
It is not Part of RSBY	28	3.2	0	0.0	0	0.0	28	3.5	28	3.1
Either free test received or not prescribed test	798	92.3	33	94.3	95	90.5	736	92.6	831	92.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.57 it is clear that among the 67 beneficiaries of APL category who have not received free test, 15 beneficiaries stated that they did not asked the reason for not providing free test on discharge, 24 stated that no reason provided by the staff, 28 stated that hospital staff said that free test on discharge is not part of RSBY and there is none in the category of others.

Among the 2 beneficiaries of Wayanad district, both of them stated that they did not asked the reason for not providing free test on discharge. Among the 10 beneficiaries of APL category, 5 beneficiaries stated that they did not asked the reason for not providing free test on discharge, and 5 stated that no reason provided by the staff. Among the 59 beneficiaries of BPL category, 12 beneficiaries stated that they did not asked the reason for not providing free test on discharge, 19 stated that no reason provided by the staff, and 28 stated that hospital staff said that free test on discharge is not part of RSBY.

9.2.4.14 Present Health Status of the Patient

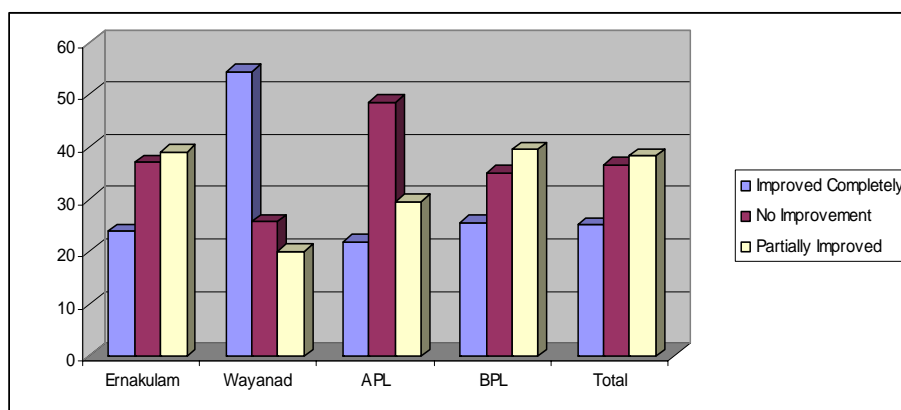
The table 9.58 reveals the present health status of the patient.

Table 9.58 Present Health Status of the Patient

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Improved Completely	207	23.9	19	54.3	23	21.9	203	25.5	226	25.1
No Improvement	320	37.0	9	25.7	51	48.6	278	35.0	329	36.6
Partially Improved	338	39.1	7	20.0	31	29.5	314	39.5	345	38.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 9.12 Present Health Status of the Patient



From the table 9.58 it is clear that among the beneficiaries of Ernakulam district, about 23.9 per cent beneficiaries stated that their condition has improved completely, 39.1 per cent stated that partially improved, 37 per cent stated that no improvement in their condition and there is none in the category of died. Among the beneficiaries of Wayanad district, about 54.3 per cent beneficiaries stated that their condition has improved completely, 20 per cent stated that partially improved, 25.7 per cent stated that no improvement in their condition and there is none in the category of died. Among the beneficiaries of APL category, about 21.9 per cent beneficiaries stated that their condition has improved completely, 29.5 per cent stated that partially improved, 48.6 per cent stated that no improvement in their condition and there is none in the category of died. Among the beneficiaries of BPL category, about 25.5 per cent beneficiaries stated that their condition has improved completely, 39.5 per cent stated that partially improved, 35 per cent stated that no improvement in their condition and there is none in the category of died.

9.2.4.15 Duration of Hospitalization

The table 9.59 reveals the duration of hospitalization.

Table 9.59 Duration of Hospitalization

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
< 5 Days	351	40.6	9	25.7	38	36.2	322	40.5	360	40.0
5 - 10 Days	357	41.3	19	54.3	51	48.6	325	40.9	376	41.8
10 - 15 Days	85	9.8	5	14.3	11	10.5	79	9.9	90	10.0
> 15 Days	72	8.3	2	5.7	5	4.8	69	8.7	74	8.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

From the table 9.59 it is clear that among the beneficiaries of Ernakulam district, about 40.6 per cent beneficiaries have stated that they have been admitted in the hospital for less than 5 days, 41.3 per cent stated that they have been admitted for in between 5-10 days, 9.8 per cent stated that they have been

admitted for in between 10-15 days and there is 8.3 per cent in the category of more than 15 days. Among the beneficiaries of Wayanad district, about 25.7 per cent beneficiaries have stated that they have been admitted in the hospital for less than 5 days, 54.3 per cent stated that they have been admitted for in between 5-10 days, 14.3 per cent stated that they have been admitted for in between 10-15 days and there is 5.7 per cent in the category of more than 15 days. Among the beneficiaries of APL category, about 36.2 per cent beneficiaries have stated that they have been admitted in the hospital for less than 5 days, 48.6 per cent stated that they have been admitted for in between 5-10 days, 10.5 per cent stated that they have been admitted for in between 10-15 days and there is 4.8 per cent in the category of more than 15 days. Among the beneficiaries of BPL category, about 40.5 per cent beneficiaries have stated that they have been admitted in the hospital for less than 5 days, 40.9 per cent stated that they have been admitted for in between 5-10 days, 9.9 per cent stated that they have been admitted for in between 10-15 days and there is 8.7 per cent in the category of more than 15 days.

9.2.4.16 Expenditures during RSBY-CHIS Hospitalization

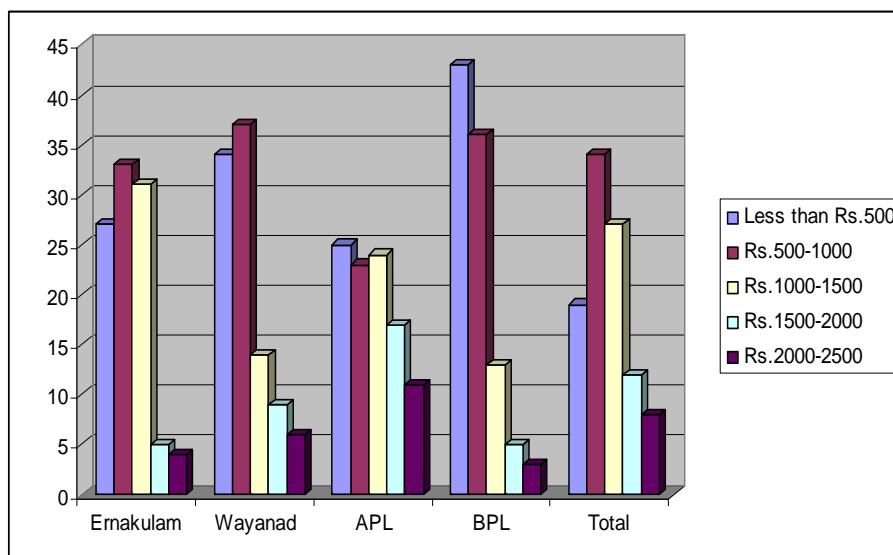
The expenditures incurred during non RSBY-CHIS hospitalization is given in table 9.60.

Table 9.60 Expenditures during RSBY-CHIS Hospitalization

	Ernakulam	Wayanad	APL	BPL	Total
Less than Rs.500	234(27)	12(34)	26(25)	338(43)	171(19)
Rs.500-1000	286(33)	13(37)	24(23)	285(36)	306(34)
Rs.1000-1500	270(31)	5(14)	25(24)	108(13)	243(27)
Rs.1500-2000	43(5)	3(9)	18(17)	39(5)	108(12)
Rs.2000-2500	32(4)	2(6)	12(11)	25(3)	72(8)
Total	865(100)	35(100)	105(100)	795(100)	900(100)

(Figure in brackets are percentage to total)

Source: Primary data

Figure 9.13 Expenditures during RSBY-CHIS Hospitalization

The expenses of the RSBY-CHIS hospitalized persons varied between thousands of rupees. The expenses included in this regard were: Doctors'/surgeons' fee, medicines, diagnostic tests, bed charges, attendant charges, physiotherapy, personal medical appliances, blood, oxygen cylinder, etc. The variation reported in this regard extended from Rs.200/- to Rs.2500/-. Of the 865 beneficiaries in Ernakulam, who received treatment in this regard, about 27 per cent of the beneficiaries reported an expenditure less than Rs.500, 33 per cent reported an expenditure in between Rs.500-1000, 31 per cent reported an expenditure in between Rs.1000-1500, 5 per cent reported an expenditure in between Rs.1500-2000 and 4 per cent reported an expenditure in between Rs.2000-2500. Of the 35 beneficiaries in Wayanad, who received treatment in this regard, about 34 per cent of the beneficiaries reported an expenditure less than Rs.500, 37 per cent reported an expenditure in between Rs.500-1000, 14 per cent reported an expenditure in between Rs.1000-1500, 9

per cent reported an expenditure in between Rs.1500-2000 and 6 per cent reported an expenditure in between Rs.2000-2500. Of the 105 beneficiaries in APL category, who received treatment in this regard, about 25 per cent of the beneficiaries reported an expenditure less than Rs.500, 23 per cent reported an expenditure in between Rs.500-1000, 24 per cent reported an expenditure in between Rs.1000-1500, 17 per cent reported an expenditure in between Rs.1500-2000 and 11 per cent reported an expenditure in between Rs.2000-2500. Of the 795 beneficiaries in BPL category, who received treatment in this regard, about 43 per cent of the beneficiaries reported an expenditure less than Rs.500, 36 per cent reported an expenditure in between Rs.500-1000, 13 per cent reported an expenditure in between Rs.1000-1500, 5 per cent reported an expenditure in between Rs.1500-2000 and 3 per cent reported an expenditure in between Rs.2000-2500. It should be noted here that the expenditures incurred under each head were mentioned with an approximation which differed according to the recalling capacity of the beneficiaries. Many were not even aware about the expenditures and hence, their responses in this regard seemed to be a guess work.

Financial accessibility and affordability is a major factor in the event of hospitalization and illness. Around 50 per cent of beneficiaries have incurred less than Rs. 1000/- whereas the rest of the beneficiaries have incurred Rs. 1000-Rs.2500. Regarding expenditures for non RSBY-CHIS hospitalization, 33 per cent of the beneficiaries incurred less than Rs. 5000/, 37 per cent in between Rs.5000-10000, 15 per cent in between Rs.10000-15000, 10 per cent in between Rs.15000-20000, and 5 per cent in between Rs.20000-25000. It is evident that the intervention of RSBY-CHIS has prevented significant section

of poor households from catastrophic spending and distress financing relating to hospitalization and treatment.

9.3 Average Expenditure for Hospitalization

The details of average expenditure for hospitalization, both for Non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization are given in table 9.61 and 9.62.

Table 9.61 Average Expenditure for Hospitalization- Economic Category

Category	Average expenditure for hospitalization	APL	BPL	Total
Ernakulam	Average expenditure for non RSBY-CHIS hospitalization	5543	3362	3602
	Average expenditure for RSBY-CHIS hospitalization	594.5	565.3	568.7
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4948.5	2796.7	3033.3
Wayanad	Average expenditure for non RSBY-CHIS hospitalization	4500	3718	3863
	Average expenditure for RSBY-CHIS hospitalization	428.0	616.7	589.7
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4072	3101.3	3273.3
Combined	Average expenditure for non RSBY-CHIS hospitalization	5478	3375	3612
	Average expenditure for RSBY-CHIS hospitalization	586.6	567.3	569.5
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4891.4	2807.7	3042.5

Source: Primary data

The table 9.61 shows that in the case of APL beneficiaries, there is a reduction in hospitalization expenditure, on an average, by an amount of Rs. 4891.4/. In the case of BPL beneficiaries, there is a reduction in hospitalization expenditure, on an average, by an amount of Rs. 2807.7/. It is concluded that the scheme helped both APL and BPL beneficiaries to mitigate their hospitalization expenditure, and it is comparatively higher in the case of APL beneficiaries.

Table 9.62 Average Expenditure for Hospitalization – District Category

Category	Average expenditure for hospitalization	Ernakulam	Wayanad	Total
APL	Average expenditure for non RSBY-CHIS hospitalization	5543	4500	5478
	Average expenditure for RSBY-CHIS hospitalization	594.5	428.0	586.6
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4948.5	4072	4891.4
BPL	Average expenditure for non RSBY-CHIS hospitalization	3362	3718	3375
	Average expenditure for RSBY-CHIS hospitalization	565.3	616.7	567.3
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	2796.7	3101.3	2807.7
Combined	Average expenditure for non RSBY-CHIS hospitalization	3602	3863	3612
	Average expenditure for RSBY-CHIS hospitalization	568.7	589.7	569.5
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	3033.3	3273.3	3042.5

Source: Primary data

The table 9.62 shows that in the case of Ernakulam beneficiaries, there is a reduction in hospitalization expenditure, on an average, by an amount of Rs. 3033.3/-. In the case of Wayanad beneficiaries, there is a reduction in hospitalization expenditure, on an average, by an amount of Rs. 3273.3/-. It is concluded that the scheme helped both Ernakulam and Wayanad beneficiaries to mitigate their hospitalization expenditure, and it is comparatively higher in the case of Wayanad beneficiaries.

9.4 Repeated Measures Analysis

The main objective of this study is to evaluate the effectiveness of RSBY-CHIS with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses. This is done by applying Repeated Measures Analysis. The effectiveness of the scheme depends on the fact that whether the scheme has helped the beneficiaries to mitigate their hospitalization expenditure or not. For this, expenditure for non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization incurred by the sample

beneficiaries are compared and by applying the test the following results are obtained.

Table 9.63 Effectiveness of the Scheme

		F - value	p - value
Ernakulam	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	1461.876	0.000
	Difference in effectiveness in between Ernakulam APL and BPL beneficiaries	39.485	0.000
Wayanad	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	164.125	0.000
	Difference in effectiveness in between Wayanad APL and BPL beneficiaries	0.037	0.849
Combined	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	1583.702	0.000
	Difference in effectiveness in between total APL and BPL beneficiaries	36.171	0.000
APL	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	202.478	0.000
	Difference in effectiveness in between Ernakulam APL and Wayanad APL beneficiaries	2.874	0.094
BPL	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	325.131	0.000
	Difference in effectiveness in between Ernakulam BPL and Wayanad BPL beneficiaries	1.115	0.291
Combined	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	433.044	0.000
	Difference in effectiveness in between total Ernakulam and Wayanad beneficiaries	0.409	0.523

Source: Primary data

From the table 9.63 it is revealed that the scheme is effective in terms of reduction in hospitalization expenditure of the beneficiaries. It is effective in the case of all categories of beneficiaries, as the p- value is 0.000 in the case of all categories of beneficiaries. An analysis is also performed to find out whether this effectiveness is significantly different in between different categories of beneficiaries. The concerned p- value indicates that the difference is significant in between Ernakulam APL and BPL beneficiaries and also in between total APL and BPL beneficiaries.

Hypothesis H₃

There is no significant difference in the effectiveness of the scheme in between Ernakulam and Wayanad beneficiaries.

By applying Repeated Measures Analysis, p-value for difference in effectiveness in between Ernakulam and Wayanad beneficiaries is found to be 0.523, indicating that the Hypothesis can be accepted. It can be concluded that there is no significant difference in the effectiveness of the scheme in between Ernakulam and Wayanad beneficiaries.

Hypothesis H₄

There is no significant difference in the effectiveness of the scheme in between BPL and APL beneficiaries.

By applying Repeated Measures Analysis, p-value for difference in effectiveness in between BPL and APL beneficiaries is found to be 0.000, indicating that the Hypothesis cannot be accepted. It can be concluded that there is significant difference in the effectiveness of the scheme in between APL and BPL beneficiaries.

Thus an analysis on the details and economics of both non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization revealed the following:

Non RSBY-CHIS Hospitalization: Out of 900 beneficiaries, 709 beneficiaries recalled the details of either theirs or their family member's non RSBY-CHIS hospitalization.

- Regarding details of medical services, 112 beneficiaries subjected to surgery, out of which, 32 beneficiaries obtained it free, 28 beneficiaries partly free and 49 beneficiaries received it on payment. Out of 695

beneficiaries who received medicine, 263 beneficiaries received it free, 271 beneficiaries received it partly free, and 161 beneficiaries received it on payment. Out of 180 beneficiaries who had been subjected to X ray/ ECG/EEG/scan, 76 beneficiaries received it free, 67 beneficiaries received it partly free, and 37 beneficiaries received it on payment. Out of 69 beneficiaries who had been subjected to other diagnostic tests, 25 beneficiaries received it free, 23 beneficiaries received it partly free, and 21 beneficiaries received it on payment.

- 274 beneficiaries received treatment before hospitalization, 435 beneficiaries not received treatment before hospitalization.
- Out of 274 beneficiaries who received treatment before hospitalization, 52 beneficiaries obtained it from public hospitals, 109 from public dispensaries, 78 from private hospitals and 35 from private doctors.
- 354 beneficiaries received treatment after hospitalization, 355 beneficiaries not received treatment after hospitalization.
- Out of 354 beneficiaries who received treatment after hospitalization, 69 beneficiaries obtained it from public hospitals, 83 from public dispensaries, 104 from private hospitals and 98 from private doctors.
- Regarding expenditures for non RSBY-CHIS hospitalization, 33 per cent of the beneficiaries incurred less than Rs. 5000/, 37 per cent in between Rs.5000-10000, 15 per cent in between Rs.10000-15000, 10 per cent in between Rs.15000-20000, and 5 per cent in between Rs.20000-25000.

- Regarding source of finance for the above expenditure, 145 beneficiaries had it from household income/savings, 301 beneficiaries had it from borrowings, 124 beneficiaries had it from the contributions of friends/relatives and 139 beneficiaries had it from other sources.
- Out of 709 beneficiaries, only 78 beneficiaries had got reimbursement for the above expenditure. 6 beneficiaries got it from government employer, 38 from private employer, 17 from health insurance companies and 17 got it from other agencies.

RSBY-CHIS Hospitalization:

- Out of 900 beneficiaries, 56.2 per cent beneficiaries had only one hospitalization case, 24.2 per cent had two hospitalization cases, 11 per cent had three hospitalization cases and 8.6 per cent had more than three hospitalization cases in the last one year.
- About 56.2 per cent beneficiaries had only one family member hospitalized, 30.3 per cent had two family members hospitalized, 12 per cent had three family members hospitalized, three hospitalization cases and 1.4 per cent had more than three family members hospitalized in the last one year.
- About 12.9 per cent beneficiaries had undergone surgical treatment, 81.8 per cent beneficiaries non surgical treatment and 5.3 per cent beneficiaries admitted in ICU.
- Out of 116 beneficiaries who had undergone surgery, 2 beneficiaries dental, 5 ear, 2 nose, 14 throat, 5 gynaecology, 10 endoscopic, 10 hysteroscopy, 9 neuro surgery, 10 ophthalmology, 10 orthopedic, 9 endocrine, 9 neonatal care, 9 unspecified, 2 combined and 10 others.

- With regard to the reason for choosing a particular hospital for treatment, the beneficiaries had given first rank to the factor ‘there is no other RSBY-CHIS empanelled hospitals nearby’. Second rank goes to the factor ‘hospital is near to the home’, third rank goes to the factor ‘referred by doctors’, fourth rank to the factor ‘always go to this hospital’ fifth rank to ‘suggested by friends and relatives’ and last rank goes to ‘reputation of the hospital is good’. Thus it is revealed that the beneficiaries are forced to go to a particular hospital, as there is no other alternative.
- About 33.4 per cent beneficiaries had to travel less than 5 km to the hospital, 28.6 per cent beneficiaries had to travel in between 5-10 km, 14.6 per cent beneficiaries had to travel in between 10-15 km, 9.9 per cent beneficiaries had to travel in between 15-20 km, and 13.6 per cent had to travel more than 20 km to reach the hospital. This finding also necessitates the empanelment more hospitals under the network of the scheme.
- About 25.6 per cent of the beneficiaries reached the hospital by way of bus, 16.6 per cent by car, 32.8 per cent by rickshaw, 14 per cent by two-wheeler and 11.1 per cent by other modes of transportation.
- About 91.4 per cent of the beneficiaries accompanied by their family members to the hospital, whereas 8.6 per cent beneficiaries not accompanied by their family members.
- About 79.4 per cent of the beneficiaries followed by one family member, 6.3 per cent by two family members, 3.2 per cent by three family members and 2.4 per cent followed by four family members to the hospital.

- About 15 per cent of the beneficiaries had incurred less than Rs.100/ by way of cost of transportation, 33.3 per cent in between Rs.100-200, 27.4 per cent in between Rs.200-300, 24.2 per cent incurred more than Rs.300/. Thus it is revealed that around 85 per cent of the beneficiaries had incurred more than Rs.100 by way of transportation cost, and hence the traveling allowance of Rs.100 is not sufficient to meet the transportation cost of the majority beneficiaries.
- Even though there is a provision of traveling allowance of Rs.100/ in the scheme, only 19.3 per cent of the beneficiaries received it, whereas 80.7 per cent beneficiaries denied with it. This indicates the poor implementation of the scheme and many benefits of the scheme are not given to the beneficiaries.
- All the beneficiaries, who had received traveling allowance, were provided exactly with Rs.100/.
- Among the beneficiaries who were not provided with traveling allowance, 20 per cent cited the reason for not giving T.A.as ‘hospital refused’, 16.1 per cent stated that ‘did not know there was such a provision’, 34 per cent stated that ‘hospital said they will give this later’, 19.9 per cent ‘did not ask for it’ and there are 9.9 per cent in the category of ‘others’.
- About 48 per cent of the beneficiaries stated that there was the presence of RSBY-CHIS help desk at the hospital, whereas 20.3 per cent responded negatively and there are 31.7 per cent beneficiaries who don’t know about it.

- 228 beneficiaries stated that the RSBY-CHIS help desk at the hospital was a separate one, whereas 72 responded negatively and there are 132 beneficiaries who don't know about it.
- 125 beneficiaries stated that there was visible sign boards to find out the help desk, 193 beneficiaries found it by asking the hospital staff and 114 beneficiaries found it by themselves without any assistance.
- With regard to the availability of finger print scanner, 62.8 per cent beneficiaries responded positively, 12.7 per cent negatively and 24.6 per cent beneficiaries don't know about it. In the case of smart card reader, 62.8 per cent beneficiaries responded positively, 12.7 per cent negatively and 24.6 per cent beneficiaries don't know about it. With regard to the availability of computer, 92.7 per cent beneficiaries responded positively, 4 per cent negatively and 3.3 per cent beneficiaries don't know about it. In the case of printer, 62.8 per cent beneficiaries responded positively, 12.7 per cent negatively and 24.6 per cent beneficiaries don't know about it.
- About 10.3 per cent beneficiaries had to wait less than 5 minutes before attended by the staff, 29.7 per cent in between 5-15 minutes, 36 per cent in between 15-30 minutes, 12.9 per cent in between 30-60 minutes and 11.1 per cent had to wait more than 60 minutes before attended by the staff.
- With regard to finger print verification during admission, 75.4 per cent beneficiaries responded positively, 0 per cent negatively and 24.6 per cent beneficiaries don't know about it.

- Out of 679 beneficiaries patient's finger print verification was done in the case of 13.4 per cent, whereas family members' finger print verification was done in the case of 86.6 per cent.
- With regard to the reason for not taking patient's finger print verification, 77.8 per cent stated that patient was in a bad condition, 4.9 per cent stated that patient's thumb was injured, 6 per cent stated that it was suggested by the hospital and there are 1.2 per cent beneficiaries in the category of others.
- With regard to the question which family member provided finger print verification, 8.5 per cent stated that husbands', 17.8 per cent wife's', 21 per cent sons', 21.2 per cent daughters', 23.1 per cent mothers' and 8.1 per cent by fathers' finger print verification.
- A seek with respect to imparting necessary information to the beneficiaries revealed the following: with regard to cost of treatment, 71.3 per cent were informed about it, 28.7 per cent not informed about it. The same was the situation with other information like money left in the smart card reader, sufficiency of money for the treatment and the fact that the beneficiaries need to pay the difference, if the balance is not sufficient. Thus around 25 per cent of the beneficiaries were not informed about the basic realities of the scheme.
- Regarding nature of admission, 6.7 per cent beneficiaries admitted through emergency, 77.8 per cent through OPD, 8.2 per cent through referral, 7.3 per cent beneficiaries through 'others'.

- About 45.2 per cent of the beneficiaries received bed immediately on admission, 40.6 per cent were asked to wait for a few hours, 7.7 per cent were asked to come back on another day, and there are 6.6 per cent beneficiaries in the category of others.
- About 45.2 per cent of the beneficiaries were able to walk by own during admission, 40.6 per cent able to walk only by support and 14.2 per cent beneficiaries needed stretcher/wheel chair.
- Out 128 beneficiaries who needed stretcher/wheel chair, 107 availed it, and 21 not availed it.
- Out of 107 beneficiaries who availed stretcher/wheel chair, in the case of 87 beneficiaries, hospital staff pushed it, 10 beneficiaries by relatives and 10 beneficiaries by others.
- About 40.9 per cent beneficiaries had to wait less than 15 minutes before attended and checked by the nursing staff, 36.1 per cent in between 15-30 minutes, 11.7 per cent in between 30-60 minutes, and 11.3 per cent had to wait more than 60 minutes before attended and checked by the nursing staff.
- About 40.9 per cent beneficiaries had to wait less than 30 minutes before attended and checked by the doctor, 36.1 per cent in between 30-60 minutes, 11.7 per cent in between 60-120 minutes, and 11.3 per cent had to wait more than 120 minutes before attended and checked by the doctor. It is observed by the researcher that majority of the non RSBY-CHIS patients are also waiting for less than 30 minutes before attended by the doctor. It can be assumed that there is no discrimination in between RSBY-CHIS and non RSBY-CHIS patients.

- About 16.8 per cent of the beneficiaries were asked to obtain test or medicine from outside and 83.2 per cent beneficiaries were not asked to.
- Out of 151 beneficiaries who were asked to obtain test or medicine from outside, 96 were asked to pay for the same from their own pockets whereas 55 were not asked to. Thus, even if the scheme envisages free test or medicine even from outside, it was not given to the beneficiaries.
- A seek with respect to the reason for not giving free test or medicine even from outside revealed the following: out of 96 beneficiaries who have been asked to pay, 25 beneficiaries were stated the reason that 'hospital staff said it was not a part of RSBY-CHIS package', 26 beneficiaries did not asked the reason, 21 beneficiaries stated that 'hospital paid cash to the patient later' and 24 beneficiaries stated the reason that 'the hospital did not have sufficient fund'.
- Even though there is a provision of free food to the patient in the scheme, only 21.2 per cent of the beneficiaries received it, whereas 78.2 per cent beneficiaries denied with it. This indicates the poor implementation of the scheme and many benefits of the scheme are not given to the beneficiaries.
- A seek with respect to the reason for not giving free food revealed the following: out of 709 beneficiaries who have been denied with free food, 177 beneficiaries were stated the reason that 'hospital staff said it was not a part of RSBY-CHIS package', 177 beneficiaries did not asked the reason, 79 beneficiaries stated that 'hospital paid cash to the patient to buy food' and 276 beneficiaries stated the reason that 'the hospital did not have sufficient fund'.

- With regard to the quality of food, out of 191 beneficiaries who have been provided with free food, 28 beneficiaries stated that food was very good, 33 beneficiaries stated it as good, 93 stated it as average, 17 rated it as bad, and 20 beneficiaries rated the quality of food as very bad.
- Cent percent beneficiaries responded positively to the question whether finger print verification on discharge was done or not.
- Patient's finger print was taken in the case of 10.1 per cent beneficiaries, whereas family members' finger print was taken in the case of 89.9 per cent beneficiaries.
- About 95 per cent beneficiaries received the smart card on the same day of discharge, whereas 5 per cent not received it on the day of discharge.
- All the 45 beneficiaries who had not received the smart card on the day of discharge received it within 5 days.
- A seek with respect to the reason for not providing the smart card on the day of discharge, revealed the following: out of 45 beneficiaries, 9 beneficiaries were stated the reason that 'staff wanted money for returning the card', 16 beneficiaries stated that 'staff wanted to keep the card till the insurance claims were settled', 10 beneficiaries stated that 'staff said the card will stay deposited at the hospital' and 10 beneficiaries stated the reason that 'they did not asked'.
- Cent percent beneficiaries responded positively to the question whether they have been prescribed medicine on discharge or not.

- There was 6 per cent beneficiaries who had been prescribed medicine for one day, 4.8 per cent beneficiaries for two days, 5.9 per cent beneficiaries for three days, 24.2 per cent beneficiaries for four days, 27.1 per cent beneficiaries for five days and 32 per cent beneficiaries had been prescribed medicine for more than five days.
- About 82.1 per cent of the beneficiaries had been provided with free medicine on discharge, whereas 17.9 per cent of the beneficiaries were not provided with free medicine. Thus it is revealed that around 20 per cent of the beneficiaries were not provided with one important benefit under the scheme, i.e. post hospitalization expenses for 5 days.
- A seek with respect to the reason for not providing free medicine for 5 days on discharge, revealed the following: out of 161 beneficiaries, 50 beneficiaries stated that ‘no reason provided by the hospital’, 54 beneficiaries stated the reason that ‘hospital staff said it was not a part of RSBY-CHIS package’, 46 beneficiaries stated the reason that ‘they did not asked’ and there are 11 beneficiaries in the category of ‘others’.
- About 12.2 per cent beneficiaries responded positively to the question whether they have been prescribed diagnostic test on discharge and 87.8 per cent beneficiaries responded negatively for the same.
- Out of 110 beneficiaries who had been prescribed diagnostic test on discharge, 9 beneficiaries had to do it within one day, 19 beneficiaries had to do it within two days, 20 beneficiaries had to do it within three days, 21 beneficiaries had to do it within four days, and 41 beneficiaries had to do it within five days.

- Out of 110 beneficiaries who had been prescribed diagnostic test on discharge, 41 beneficiaries had been provided with free of cost test on discharge, whereas 69 beneficiaries were not provided with free of cost test on discharge. Thus it is revealed that around 50 per cent of the beneficiaries were not provided with one important benefit under the scheme, i.e. post hospitalization expenses for 5 days.
- A seek with respect to the reason for not providing free of cost test within 5 days after discharge, revealed the following: out of 69 beneficiaries, 24 beneficiaries stated that ‘no reason provided by the hospital’, 28 beneficiaries stated the reason that ‘hospital staff said it was not a part of RSBY-CHIS package’, and 17 beneficiaries stated the reason that ‘they did not asked’.
- Regarding the present health status of the patients, 25.1 per cent beneficiaries responded that they had been improved completely, 36.6 per cent beneficiaries responded that there had not been any improvement in their condition and 38.3 per cent beneficiaries stated that there had been only partial improvement.
- With regard to duration of hospitalization, 40 per cent beneficiaries had been hospitalized for less than 5 days, 41.8 per cent hospitalized for 5-10 days, 10 per cent hospitalized for 10-15 days and 8.2 per cent hospitalized for more than 15 days.

- Regarding expenditures for RSBY-CHIS hospitalization, 19 per cent of the beneficiaries had incurred only less than Rs. 500/, 34 per cent in between Rs.500-1000, 27 per cent in between Rs.1000-1500, 12 per cent in between Rs.1500-2000, and 8 per cent in between Rs.2000-2500. Thus it is revealed that compared to non RSBY-CHIS hospitalization, there is only less expenditures incurred by the beneficiaries for their RSBY-CHIS hospitalization.
- To evaluate the effectiveness of RSBY-CHIS with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses, Repeated Measure Analysis has been applied. The result showed that the scheme is effective in terms of reduction in hospitalization expenditure of the beneficiaries. It is effective in the case of all categories of beneficiaries, as the p- value is 0.000 in the case of all categories of beneficiaries. An analysis is also performed to find out whether this effectiveness is significantly different in between different categories of beneficiaries. The concerned p- value indicates that the difference is significant in between Ernakulam APL and BPL beneficiaries and also in between total APL and BPL beneficiaries.

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Chapter **10**

**Satisfaction on the Experience Under
RSBY-CHIS Hospitalization**



- 10.1 Answering Patient Related Queries by the Hospital
 - 10.2 Satisfaction About the Behaviour of the Staff at the RSBY-CHIS Help Desk
 - 10.3 Satisfaction About the Treatment Provided at the Hospital
 - 10.4 Option of Beneficiaries if Scheme Had Not Been There
 - 10.5 Recommending Friends and Relatives for Treatment Under the Scheme
 - 10.6 Reason for Not Recommending the Scheme
 - 10.7 Satisfaction With RSBY-CHIS
 - 10.8 Reason for Dissatisfaction
 - 10.9 Suggestions for the Betterment of the System
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The success of any scheme depends on the utilization of the same and the satisfaction of the customers. Hence, the study has made an attempt to understand the experience of the people with the RSBY- CHIS along with an assessment of their satisfaction with the utilization of the scheme. Beneficiary satisfaction is an ambiguous and abstract concept and the actual manifestation of the state of satisfaction varies from person to person. The state of satisfaction depends on a number of both psychological and physical variables. The level of satisfaction also varies depending on other options the customer may have and other services against which the beneficiary compares the scheme or the program.

The study has made an attempt to elicit the opinion of the beneficiaries on the delivery of various services through RSBY-CHIS using the variables: answering to the patient related queries by the hospital, satisfaction about the

behaviour of the staff at the RSBY-CHIS help desk, Satisfaction about treatment at the hospital, option of beneficiaries if scheme had not been there, recommending friends and relatives for treatment under the scheme, satisfaction with RSBY-CHIS and suggestions for the betterment of the system.

10.1 Answering Patient Related Queries by the Hospital

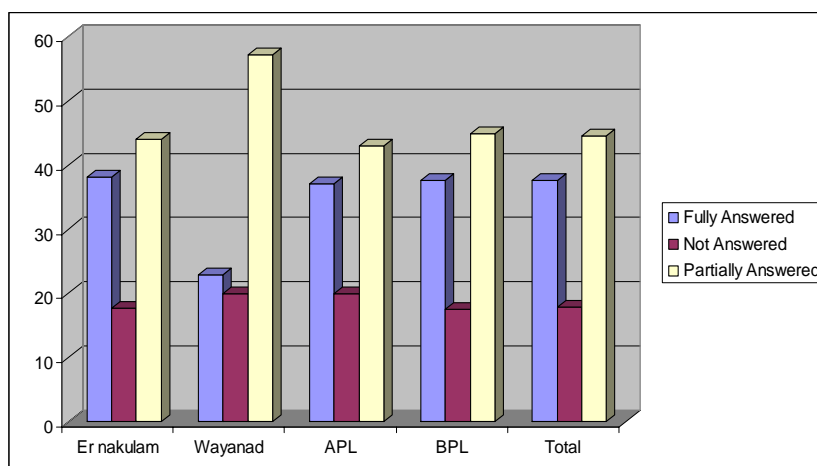
The hospitals are the prime concerns that address the queries of the beneficiaries related to every aspect of the scheme. Subsequently, the beneficiaries were asked whether they received the required information on each of their queries. The table 10.1 and figure 10.1 reveals the responses of the beneficiaries regarding this question.

Table 10.1 Answering Patient Related Queries by the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Fully Answered	330	38.2	8	22.9	39	37.1	299	37.6	338	37.6
Not Answered	154	17.8	7	20.0	21	20.0	140	17.6	161	17.9
Partially Answered	381	44.0	20	57.1	45	42.9	356	44.8	401	44.6
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.1 Answering Patient Related Queries by the Hospital



From table 10.1 and figure 10.1 it is clear that among the beneficiaries of Ernakulam district, about 38.2 per cent beneficiaries have stated that their patient related queries were fully answered by the hospital, about 17.8 per cent stated that their queries were not answered by the hospital, and about 44 per cent stated that their queries have been answered only partially. Among the beneficiaries of Wayanad district, about 22.9 per cent beneficiaries have stated that their patient related queries were fully answered by the hospital, about 20 per cent stated that their queries were not answered by the hospital, and about 57.1 per cent stated that their queries have been answered only partially. Among the beneficiaries of APL category, about 37.1 per cent beneficiaries have stated that their patient related queries were fully answered by the hospital, about 20 per cent stated that their queries were not answered by the hospital, and about 42.9 per cent stated that their queries have been answered only partially. Among the beneficiaries of BPL category, about 37.6 per cent beneficiaries have stated that their patient related queries were fully answered by the hospital, about 17.6 per cent stated that their queries were not answered by the hospital, and about 44.8 per cent stated that their queries have been answered only partially. It is revealed that majority beneficiaries in all categories have been stated that their patient related queries have been only partially answered. Even the staff at RSBY-CHIS help desk of the hospitals are not well educated about the scheme for which they fail to meet the queries raised by the patients.

10.2 Satisfaction about the Behaviour of the Staff at the RSBY-CHIS Help Desk

The RSBY-CHIS staff has a great role to play in assisting the poor families to utilize the scheme. The behaviour of the staff at help desk counts

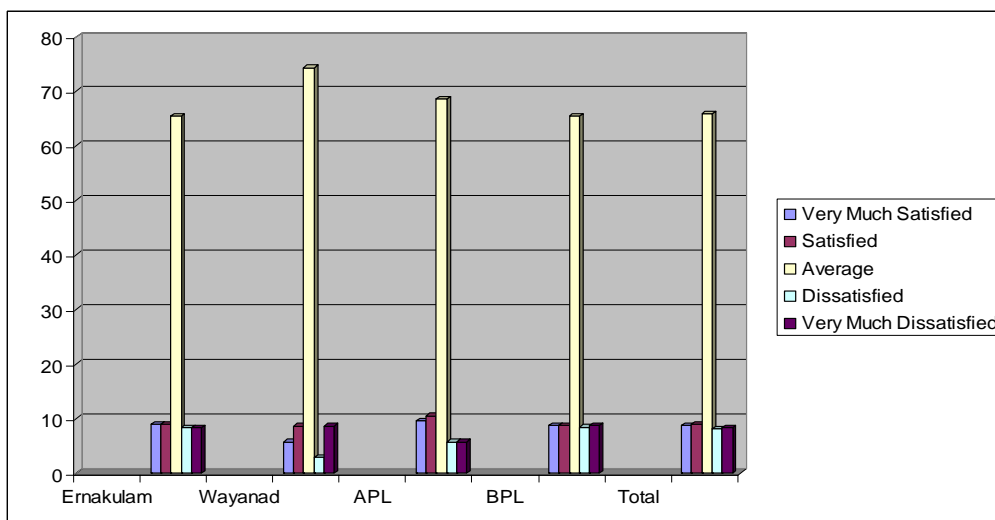
much in encouraging poor patients to prefer hospitalization. Prompt and timely assistance to them could encourage and facilitate easy utilization. Hence, the beneficiaries of the scheme were asked to opine about the dealings of the RSBY-CHIS personnel at the hospitals. The satisfaction level of the beneficiaries about the behaviour of the staff at RSBY-CHIS help desk as revealed from this survey is given in table 10.2 and figure 10.2.

Table 10.2 Satisfaction about the Behaviour of the Staff at the RSBY-CHIS Help Desk

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very Much Satisfied	77	8.9	2	5.7	10	9.5	69	8.7	79	8.8
Satisfied	77	8.9	3	8.6	11	10.5	69	8.7	80	8.9
Average	567	65.5	26	74.3	72	68.6	521	65.5	593	65.9
Dissatisfied	72	8.3	1	2.9	6	5.7	67	8.4	73	8.1
Very Much Dissatisfied	72	8.3	3	8.6	6	5.7	69	8.7	75	8.3
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.2 Satisfaction about The Behaviour of the Staff At The RSBY-CHIS Help Desk



Among the beneficiaries of Ernakulam district about 8.9 per cent beneficiaries were very much satisfied with the staff, about 8.9 per cent

beneficiaries were in the category of satisfied, about 65.5 per cent beneficiaries were having average satisfaction, about 8.3 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.3 per cent beneficiaries. Among the beneficiaries of Wayanad district, about 5.7 per cent beneficiaries were very much satisfied with the staff, about 8.6 per cent beneficiaries were in the category of satisfied, about 74.3 per cent beneficiaries were having average satisfaction, about 2.9 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.6 per cent beneficiaries. Among the APL beneficiaries about 9.5 per cent beneficiaries were very much satisfied with the staff, about 10.5 per cent beneficiaries were in the category of satisfied, about 68.6 per cent beneficiaries were having average satisfaction, about 5.7 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 5.7 per cent beneficiaries. Among the BPL beneficiaries, about 8.7 per cent beneficiaries were very much satisfied with the staff, about 8.7 per cent beneficiaries were in the category of satisfied, about 65.5 per cent beneficiaries were having average satisfaction, about 8.4 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.7 per cent beneficiaries. Thus one can imply that majority beneficiaries of all categories were having average satisfaction with the staff at help desk.

10.3 Satisfaction about the Treatment Provided At the Hospital

Patient's satisfaction and perception on quality of services is very important determinant of health service utilization. So it is essential to understand the extent to which the people were happy with the treatment they received using the RSBY-CHIS. It is to be noted here that the cashless services

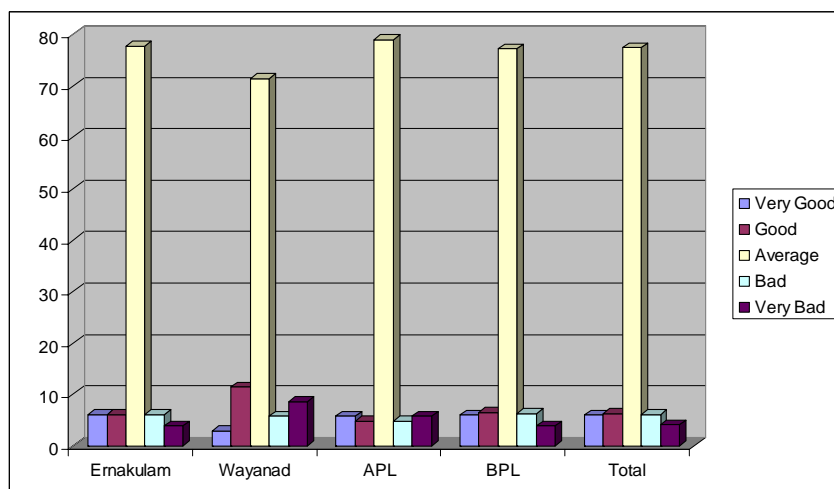
from the hospitals were received by the beneficiaries only from the empanelled hospitals and the number of empanelled hospitals that had all the specialist services was only a few. Hence, the query assumes much importance. The satisfaction rating of the beneficiaries about the treatment provided at the hospital as revealed from this survey is given in table 10.3 and figure 10.3.

Table 10.3 Satisfaction about the Treatment Provided At the Hospital

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very Good	53	6.1	1	2.9	6	5.7	48	6.0	54	6.0
Good	53	6.1	4	11.4	5	4.8	52	6.5	57	6.3
Average	672	77.7	25	71.4	83	79.0	614	77.2	697	77.4
Bad	53	6.1	2	5.7	5	4.8	50	6.3	55	6.1
Very Bad	34	3.9	3	8.6	6	5.7	31	3.9	37	4.1
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.3 Satisfaction about the Treatment Provided At the Hospital



Out of the total 865 Ernakulam beneficiaries, about 6.1 per cent beneficiaries have stated very good satisfaction with the treatment at the hospital, another 6.1 per cent beneficiaries were in the category of good satisfaction, about 77.7 per cent beneficiaries were having average satisfaction,

about 6.1 per cent beneficiaries in the category of poor satisfaction and in the category of very poor satisfaction, there was about 3.9 per cent beneficiaries. Out of the total 35 Wayanad beneficiaries, about 2.9 per cent beneficiaries have stated very good satisfaction with the treatment at the hospital, about 11.4 per cent beneficiaries were in the category of good satisfaction, about 71.4 per cent beneficiaries were having average satisfaction, about 5.7 per cent beneficiaries in the category of poor satisfaction and in the category of very poor satisfaction, there was about 8.6 per cent beneficiaries. Out of the total 105 APL beneficiaries, about 5.7 per cent beneficiaries have stated very good satisfaction with the treatment at the hospital, about 4.8 per cent beneficiaries were in the category of good satisfaction, about 79 per cent beneficiaries were having average satisfaction, about 4.8 per cent beneficiaries in the category of poor satisfaction and in the category of very poor satisfaction, there was about 5.7 per cent beneficiaries. Out of the total 795 BPL beneficiaries, about 6 per cent beneficiaries have stated very good satisfaction with the treatment at the hospital, about 6.5 per cent beneficiaries were in the category of good satisfaction, about 77.2 per cent beneficiaries were having average satisfaction, about 6.3 per cent beneficiaries in the category of poor satisfaction and in the category of very poor satisfaction, there was about 3.9 per cent beneficiaries. Thus we can imply that majority beneficiaries in all categories were having average satisfaction with the treatment at the hospital and only a minority i.e. around about 10 per cent was dissatisfied.

10.4. Option of Beneficiaries If Scheme Had Not Been There

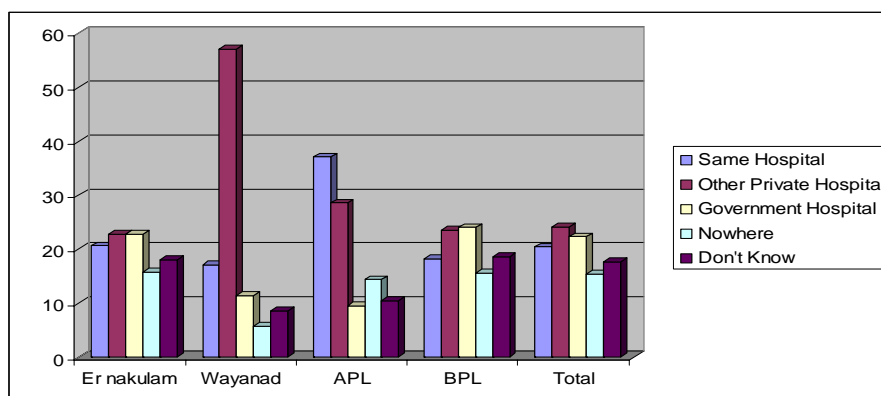
There was a question to the effect that what would have been done by the beneficiaries if the scheme had not been there. Table 10.4 and figure 10.4 reveals the response of the beneficiaries towards this question.

Table 10.4 Option of Beneficiaries If Scheme Had Not Been There

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Same Hospital	178	20.6	6	17.1	39	37.1	145	18.2	184	20.4
Other Private Hospital	197	22.8	20	57.1	30	28.6	187	23.5	217	24.1
Government Hospital	197	22.8	4	11.4	10	9.5	191	24.0	201	22.3
Nowhere	137	15.8	2	5.7	15	14.3	124	15.6	139	15.4
Don't Know	156	18.0	3	8.6	11	10.5	148	18.6	159	17.7
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.4 Option of Beneficiaries if Scheme Had Not Been There



From table 10.4 and figure 10.4 it is clear that among the beneficiaries of Ernakulam district, there are about 20.6 per cent beneficiaries who have stated that they would have gone to the same hospital if the scheme had not been there, about 22.8 per cent beneficiaries stated that they would have gone to any other private hospital, about 22.8 per cent beneficiaries stated that they would have gone to the government hospital and 15.8 per cent beneficiaries stated that they would go nowhere, and about 18 per cent stated that they don't know. Among the beneficiaries of Wayanad district, there are about 17.1 per cent beneficiaries who have stated that they would have gone to the same hospital if the scheme had not been there, about 57.1 per cent beneficiaries

stated that they would have gone to any other private hospital, about 11.4 per cent beneficiaries stated that they would have gone to the government hospital and about 5.7 per cent beneficiaries stated that they would go nowhere, and about 8.6 per cent stated that they don't know. Among the beneficiaries of APL category, there are about 37.1 per cent beneficiaries who have stated that they would have gone to the same hospital if the scheme had not been there, about 28.6 per cent beneficiaries stated that they would have gone to any other private hospital, about 9.5 per cent beneficiaries stated that they would have gone to the government hospital and about 14.3 per cent beneficiaries stated that they would go nowhere, and about 10.5 per cent stated that they don't know. Among the beneficiaries of BPL category, there are about 18.2 per cent beneficiaries who have stated that they would have gone to the same hospital if the scheme had not been there, about 23.5 per cent beneficiaries stated that they would have gone to any other private hospital, about 24 per cent beneficiaries stated that they would have gone to the government hospital and about 15.6 per cent beneficiaries stated that they would go nowhere, and about 28.6 per cent stated that they don't know. It is revealed that majority beneficiaries in general have stated that they would have gone to other private hospital if the scheme had not been there where as majority beneficiaries in BPL category have stated that they would have gone to government hospital if the scheme had not been there. The study signifies that Government and Public Hospitals are more dependable for poor people compared to private hospitals.

10.5. Recommending Friends and Relatives for Treatment under the Scheme

Satisfaction with the quality of services received through a scheme would normally enforce the beneficiaries to enroll others into the scheme

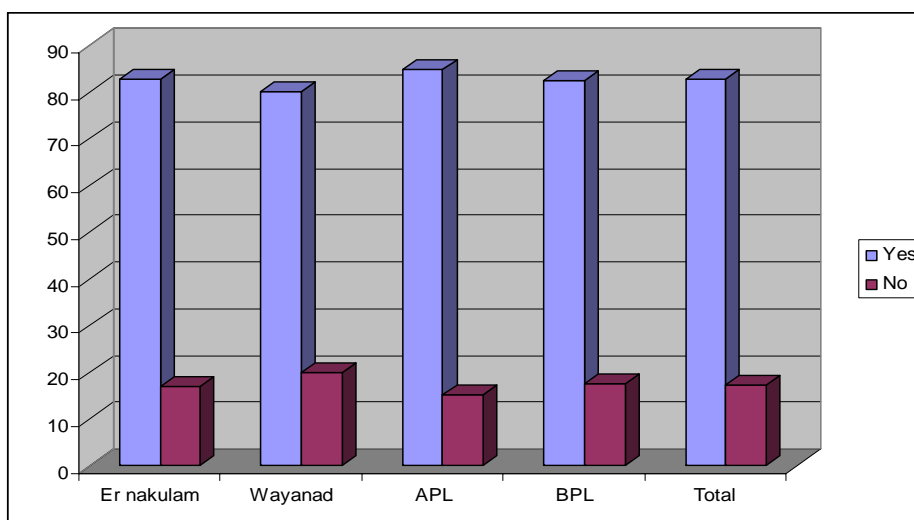
facilitating them to receive the same benefits as they receive. So if there is effective utilization of the scheme by the beneficiaries, one natural outcome would be recommending their relatives and friends to take treatment under the scheme. Accordingly, the beneficiaries were asked whether they would recommend others especially their relatives and friends to join the scheme. Table 10.5 and figure 10.5 reveals the response of the beneficiaries towards this question.

Table 10.5 Recommending Friends and Relatives for Treatment under the Scheme

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	717	82.9	28	80.0	89	84.8	656	82.5	745	82.8
No	148	17.1	7	20.0	16	15.2	139	17.5	155	17.2
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.5 Recommending Friends and Relatives for Treatment under the Scheme



From table 10.5 and figure 10.5 it is clear that among the beneficiaries of Ernakulam district, there are about 82.9 per cent beneficiaries who have admitted that they will recommend their relatives and friends to take treatment under the scheme and about 17.1 per cent stated that they will not recommend.

Among the beneficiaries of Wayanad district, there are about 80 per cent beneficiaries who have stated that they will recommend their relatives and friends and about 20 per cent stated that they will not recommend. Among the beneficiaries of APL category, there are about 84.8 per cent beneficiaries who have admitted that they will recommend their relatives and friends to take treatment under the scheme *and* about 15.2 per cent stated that they will not recommend. Among the beneficiaries of BPL category, there are about 82.5 per cent beneficiaries who have stated that they will recommend their relatives and friends and about 17.5 per cent stated that they will not recommend. It is revealed that majority beneficiaries of all categories stated that they will recommend their relatives and friends to take treatment under the scheme which points to the fact that the scheme is helpful to the beneficiaries.

10.6. Reason for Not Recommending the Scheme

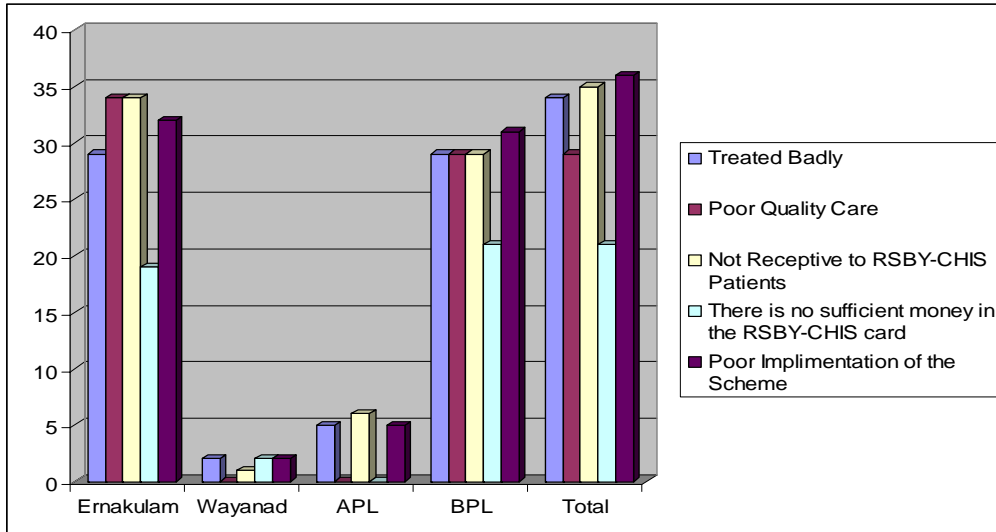
Table 10.6 and figure 10.6 reveals the reasons given by the beneficiaries for not recommending the scheme.

Table 10.6 Reason for Not Recommending the Scheme

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Treated Badly	29	3.4	2	5.7	5	4.8	29	3.6	34	3.8
Poor Quality Care	34	3.9	0	0.0	0	0.0	29	3.6	29	3.2
Not Receptive to RSBY-CHIS Patients	34	3.9	1	2.9	6	5.7	29	3.6	35	3.9
There is no sufficient money in the RSBY-CHIS card	19	2.2	2	5.7	0	0.0	21	2.8	21	2.3
Poor Implimentation of the Scheme	32	3.7	2	5.7	5	4.8	31	3.9	36	4.0
Will recommend the scheme	717	82.9	28	80.0	89	84.8	656	82.5	745	82.8
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.6 Reason For Not Recommending The Scheme



From table 10.6 and figure 10.6 it is clear that among the 148 beneficiaries of Ernakulam district who had stated they would not recommend the scheme, there are 29 beneficiaries who have stated that they had been treated badly, 34 beneficiaries stated that the treatment under the scheme was poor in quality, 34 beneficiaries stated that the hospitals are not receptive to RSBY-CHIS patients, 19 beneficiaries stated that there is no sufficient money in RSBY-CHIS card and 32 beneficiaries stated that the implementation of the scheme is very poor. Among the 7 beneficiaries of Wayanad district, there are 2 beneficiaries who have stated that they had been treated badly, none of the beneficiaries stated that the treatment under the scheme was poor in quality, 1 beneficiary stated that the hospitals are not receptive to RSBY-CHIS patients, 2 beneficiaries stated that there is no sufficient money in RSBY-CHIS card and 2 beneficiaries stated that the implementation of the scheme is very poor. Among the 16 beneficiaries of APL category, there are 5 beneficiaries who have stated that they had been treated badly, none of the beneficiaries stated that the

treatment under the scheme was poor in quality, 6 beneficiaries stated that the hospitals are not receptive to RSBY-CHIS patients, none of the beneficiaries stated that there is no sufficient money in RSBY-CHIS card and 5 beneficiaries stated that the implementation of the scheme is very poor. Among the 139 beneficiaries of BPL category, there are 29 beneficiaries who have stated that they had been treated badly, 29 beneficiaries stated that the treatment under the scheme was poor in quality, 29 beneficiaries stated that the hospitals are not receptive to RSBY-CHIS patients, 21 beneficiaries stated that there is no sufficient money in RSBY-CHIS card and 31 beneficiaries stated that the implementation of the scheme is very poor. It is revealed that majority beneficiaries in general stated that poor implementation of the scheme is the reason for not recommending their relatives and friends to take treatment under the scheme.

10.7 Satisfaction with RSBY-CHIS

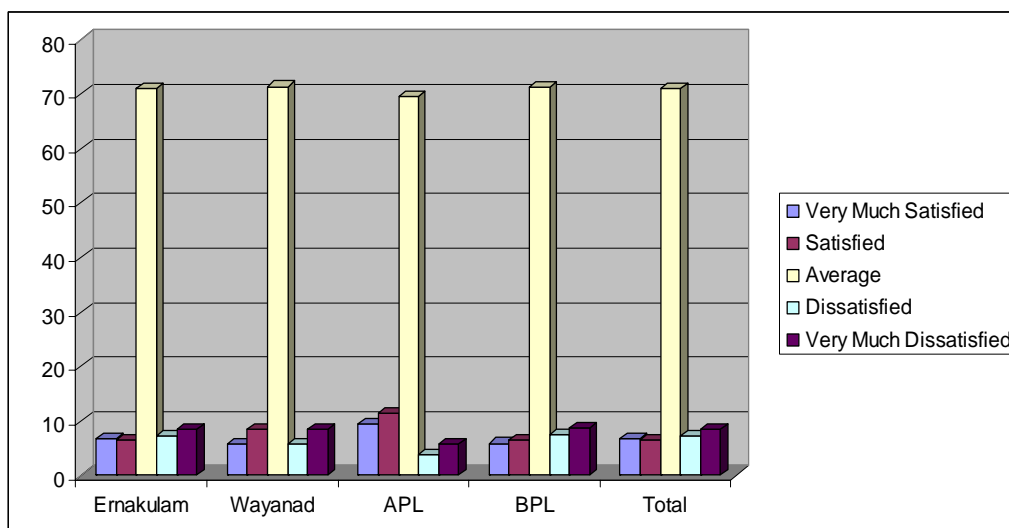
The satisfaction rating of the beneficiaries about the present health insurance scheme as revealed from this survey is given in table 10.7 and figure 10.7.

Table 10.7 Satisfaction with RSBY-CHIS

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Very Much Satisfied	60	6.7	2	5.7	10	9.5	47	5.9	60	6.7
Satisfied	54	6.5	3	8.6	12	11.4	51	6.4	58	6.5
Average	615	71.1	25	71.4	73	69.5	567	71.3	640	71.1
Dissatisfied	63	7.3	2	5.7	4	3.8	60	7.5	66	7.3
Very Much Dissatisfied	73	8.4	3	8.6	6	5.7	70	8.8	76	8.4
Total	865	100.0	35	100.0	105	100.0	795	100.0	900	100.0

Source: Primary data

Figure 10.7 Satisfaction With RSBY-CHIS



Out of the total 865 Ernakulam beneficiaries, about 6.7 per cent beneficiaries have stated that they are very much satisfied with the present insurance scheme, about 6.5 per cent beneficiaries were in the category of satisfied, about 71.1 per cent beneficiaries were having average satisfaction, about 7.3 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.4 per cent beneficiaries. Out of the total 35 Wayanad beneficiaries, about 5.7 per cent beneficiaries have stated that they are very much satisfied with the present insurance scheme, about 8.6 per cent beneficiaries were in the category of satisfied, about 71.4 per cent beneficiaries were having average satisfaction, about 5.7 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.6 per cent beneficiaries. Out of the total 105 APL beneficiaries, about 9.5 per cent beneficiaries have stated that they are very much satisfied with the present insurance scheme, about 11.4 per cent

beneficiaries were in the category of satisfied, about 69.5 per cent beneficiaries were having average satisfaction, about 3.8 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 5.7 per cent beneficiaries. Out of the total 795 BPL beneficiaries, about 5.9 per cent beneficiaries have stated that they are very much satisfied with the present insurance scheme, about 6.4 per cent beneficiaries were in the category of satisfied, about 71.3 per cent beneficiaries were having average satisfaction, about 7.5 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.8 per cent beneficiaries. Thus we can imply that majority beneficiaries of all categories were having average satisfaction with the scheme and only a minority i.e. around about 15 per cent were dissatisfied.

10.8 Reason for Dissatisfaction

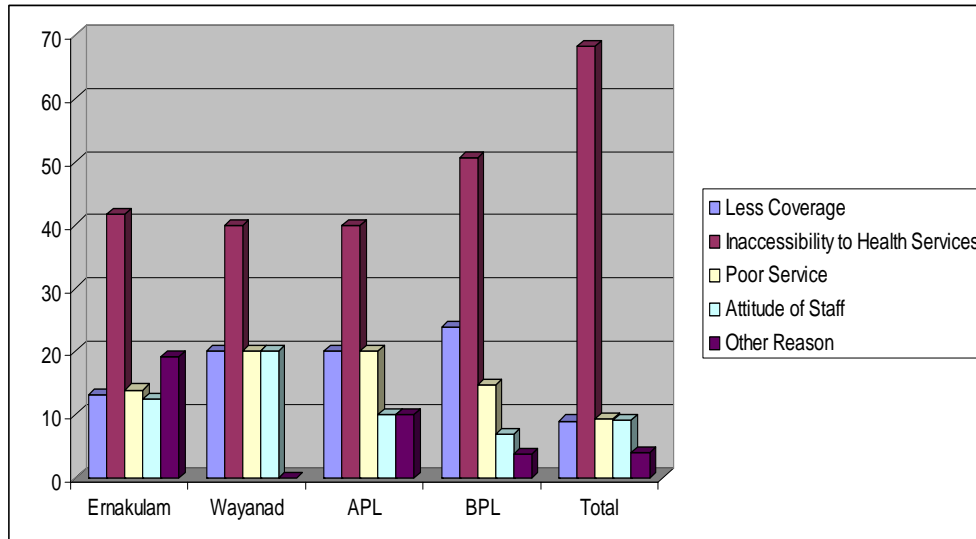
Table 10.8 and figure 10.8 reveals the reasons given by the beneficiaries for dissatisfaction under the scheme.

Table 10.8 Reason for Dissatisfaction

	Ernakulam		Wayanad		APL		BPL		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Less Coverage	18	13.2	1	20.0	2	20.0	31	23.8	19	9.0
Inaccessibility to Health Services	56	41.7	2	40.0	4	40.0	66	50.7	58	68.3
Poor Service	19	13.9	1	20.0	2	20.0	19	14.6	20	9.4
Attitude of Staff	17	12.5	1	20.0	1	10.0	9	6.9	18	9.2
Other Reason	26	19.1	0	0.0	1	10.0	5	3.8	26	4.0
Total	136	100.0	5	100.0	10	100.0	130	100.0	141	100.0

Source: Primary data

Figure 10.8 Reason For Dissatisfaction



From table 10.8 and figure 10.8 it is clear that among the beneficiaries of Ernakulam district, there are about 13.2 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 41.7 per cent beneficiaries stated the reason as inaccessibility to health services, about 13.9 per cent beneficiaries stated that there was poor service, about 12.5 per cent beneficiaries stated attitude of staff as the reason for dissatisfaction and there are about 19.1 per cent beneficiaries in the category of any other reason. Among the beneficiaries of Wayanad district, there are about 20 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 40 per cent beneficiaries stated the reason as inaccessibility to health services, about 20 per cent beneficiaries stated that there was poor service, about 20 per cent beneficiaries stated attitude of staff as the reason for dissatisfaction and there are about 20 per cent beneficiaries in the category of any other reason. Among the beneficiaries of APL category, there are about 20 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 40 per cent

beneficiaries stated the reason as inaccessibility to health services, about 20 per cent beneficiaries stated that there was poor service, about 10 per cent beneficiaries stated attitude of staff as the reason for dissatisfaction and there are about 10 per cent beneficiaries in the category of any other reason. Among the beneficiaries of BPL category, there are about 23.8 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 50.7 per cent beneficiaries stated the reason as inaccessibility to health services, about 14.6 per cent beneficiaries stated that there was poor service, about 6.9 per cent beneficiaries stated attitude of staff as the reason for dissatisfaction and there are about 3.8 per cent beneficiaries in the category of any other reason. It is revealed that majority beneficiaries of all categories have stated that inaccessibility to health services as the reason for dissatisfaction, which throws light on the urgent necessity of including more hospitals under the network of the scheme.

10.9 Suggestions for the Betterment of the System

An analysis of the suggestions made by the beneficiaries for improving the system is very essential in order to find out the necessary modifications needed in the system. For this, the beneficiaries were asked to rank 5 factors in the order of their preferences. Then, weights were given to each factor of their choice in the reverse order, i.e. for the first choice 5 weights, 2nd choice 4, 3rd choice 3, 4th choice 2 and 5th choice 1. Thereafter weighted averages were calculated. The number of beneficiaries in each choice was multiplied with their respective rank and this total weighted score is divided by total number. The figure got is average weighted score. Factor with highest AWS is given the first rank and so on. Separate analysis of this AWS for all categories of beneficiaries is shown in table 10.9.

Table 10.9 Suggestions for the Betterment of the System

Factors	Ernakulam		Wayanad		APL		BPL		Total	
	AWS	RANK	AWS	RANK	AWS	RANK	AWS	RANK	AWS	RANK
Reduction in premium	1.3	5	4.4	1	4.5	1	1.2	5	1.2	5
Empanelment of more hospitals	4.6	1	4.2	2	4.4	2	4.4	1	4.5	1
Increasing the sum assured	4.1	2	3.1	3	3.0	3	4.3	2	4.2	2
Including more family members	3.2	3	2.1	4	2.0	4	3.2	3	3.8	3
Attitude of staff	1.8	4	1.2	5	1.1	5	1.9	4	1.3	4

Source: Primary Data

From table 10.9 it is clear that while the Wayanad and APL beneficiaries are giving first rank to reduction in premium, the Ernakulam and BPL beneficiaries are giving first rank to empanelment of more hospitals. Empanelment of more hospitals is given only second rank by the Wayanad and APL beneficiaries, whereas the Ernakulam and BPL beneficiaries are giving second rank to increasing the sum assured. Increasing the sum assured is given only third rank by the Wayanad and APL beneficiaries, whereas the Ernakulam and BPL beneficiaries are giving third rank to including more family members. Including more family members is given only fourth rank by the Wayanad and APL beneficiaries, whereas the Ernakulam and BPL beneficiaries are giving fourth rank to attitude of staff. Attitude of staff is given only fifth rank by the Wayanad and APL beneficiaries, whereas the Ernakulam and BPL beneficiaries are giving fifth rank to reduction in premium.

Thus, an analysis on the satisfaction of the beneficiaries revealed the following:

- It is revealed that about 37.6 per cent beneficiaries have stated that their patient related queries were fully answered by the hospital, about 17.9 per cent stated that their queries were not answered by the hospital, and

about 44.6 per cent stated that their queries have been answered only partially. Thus a great majority of beneficiaries in all categories have been stated that their patient related queries have been only partially answered.

- It is revealed that about 8.8 per cent beneficiaries have stated very much satisfied with the behaviour of the staff at the RSBY-CHIS help desk, about 8.9 per cent beneficiaries were in the category of satisfied, about 65.9 per cent beneficiaries were having average satisfaction, about 8.1 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.3 per cent beneficiaries. Thus a great majority of the beneficiaries in all categories were having average satisfaction with the behaviour of the staff at the RSBY-CHIS help desk, i.e. around 15 per cent were dissatisfied.
- It is revealed that about 6 per cent beneficiaries have stated very good satisfaction with the treatment at the hospital, about 6.3 per cent beneficiaries were in the category of good satisfaction, about 77.4 per cent beneficiaries were having average satisfaction, about 6.1 per cent beneficiaries in the category of poor satisfaction and in the category of very poor satisfaction, there was about 4.1 per cent beneficiaries. Thus a great majority of the beneficiaries in all categories were having average satisfaction with the treatment at the hospital and only a minority i.e. around 10 per cent was dissatisfied.
- It is revealed that there are about 20.4 per cent beneficiaries who have stated that they would have gone to the same hospital if the scheme had not been there, about 24.1 per cent beneficiaries stated that they would have gone to any other private hospital, about 22.3 per cent beneficiaries

stated that they would have gone to the government hospital and about 15.4 per cent beneficiaries stated that they would go nowhere, and about 28.6 per cent stated that they don't know. Majority beneficiaries in general have stated that they would have gone to any other private hospital if the scheme had not been there where as majority beneficiaries in BPL category have stated that they would have gone to government hospital if the scheme had not been there. The study signifies that Government and Public Hospitals are more dependable for poor people compared to private hospitals.

- It is revealed that there are about 82.8 per cent beneficiaries who have stated that they will recommend their relatives and friends and about 17.2 per cent stated that they will not recommend. Thus majority beneficiaries have stated that they will recommend their relatives and friends to take treatment under the scheme which points to the fact that the scheme is helpful to the beneficiaries.
- Among the 155 beneficiaries who have stated that they will not recommend the scheme to their friends and relatives, there are 34 beneficiaries who have stated the reason for it that they had been treated badly, 29 beneficiaries stated that the treatment under the scheme was poor in quality, 35 beneficiaries stated that the hospitals are not receptive to RSBY-CHIS patients, 21 beneficiaries stated that there is no sufficient money in RSBY-CHIS card and 36 beneficiaries stated that the implementation of the scheme is very poor. It is revealed that majority beneficiaries in general stated that poor implementation of the scheme is the reason for not recommending their relatives and friends to take treatment under the scheme.

- It is revealed that about 6.7 per cent beneficiaries have stated that they are very much satisfied with the present insurance scheme, about 6.5 per cent beneficiaries were in the category of satisfied, about 71.1 per cent beneficiaries were having average satisfaction, about 7.3 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.4 per cent beneficiaries. Thus it can be implied that majority beneficiaries were having average satisfaction with the scheme and only a minority i.e. around 15 per cent was dissatisfied.
- There are about 9 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 68.3 per cent beneficiaries stated the reason as inaccessibility to health services, about 9.4 per cent beneficiaries stated that there was poor service, about 9.2 per cent beneficiaries stated attitude of staff as the reason for dissatisfaction and there are about 4 per cent beneficiaries in the category of any other reason. It is revealed that majority beneficiaries have stated that inaccessibility to health services as the reason for dissatisfaction, which throws light on the urgent necessity of including more hospitals under the network of the scheme.
- An analysis of the suggestions made by the beneficiaries for improving the system revealed that empanelment of more hospitals is the most preferred improvement by majority of the beneficiaries and this factor was given first rank, followed by 'increasing the sum assured' which was given second rank. Third rank goes to the factor that 'including more family members' and fourth rank to the factor 'attitude of staff'. Least preferred suggestion is 'reduction in premium'. This may be due

to the nominal amount of Rs.30/ only paid by the BPL beneficiaries for obtaining the smart card.

It is thus clear from the above responses that a great majority of the beneficiaries under study were having average satisfaction with the services provided through the RSBY-CHIS. It is suggested that more hospitals should be empanelled and that the list should include more hospitals which have maximum number of facilities and should be spread across the length and breadth of the area, facilitating its utilization by maximum number of people.

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Chapter 11

Findings and Suggestions



- 11.1 Findings
 - 11.2 Suggestions
 - 11.3 Conclusion
 - 11.4 Scope For Further Research
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The study named “Rashtriya Swasthya Bhima Yojana-Comprehensive Health Insurance Scheme (RSBY-CHIS) In Kerala : A Study On The Effectiveness And Utilization Of The Scheme With Special Reference To Ernakulam And Wayanad Districts” aimed to find out the extent to which the beneficiaries in Kerala make use of the benefits provided by a social health insurance scheme like RSBY-CHIS. It made an attempt to understand the effectiveness of RSBY-CHIS in Kerala, with special reference to Ernakulam and Wayanad districts, as these two districts are having the highest and lowest utilization of the scheme respectively. The research is carried out with the following specific objectives.

1. To study the socio-economic profile of the beneficiaries of the scheme.
2. To study the awareness level of the beneficiaries regarding the features of the scheme.
3. To evaluate the effectiveness of the scheme with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses.

4. To study the satisfaction level of the beneficiaries in the utilization of the scheme.
5. To suggest suitable measures to make the scheme more effective and useful to the beneficiaries.

To elicit information on each of the afore-mentioned objectives, data were collected from four categories of beneficiaries i.e. APL and BPL beneficiaries and Ernakulam and Wayanad beneficiaries. Accordingly, 105 APL (100 from Ernakulam and 5 from Wayanad) and 795 BPL (765 from Ernakulam and 30 from Wayanad) beneficiaries came under the purview of the study. This chapter presents the findings derived from the data gathered from the various categories of beneficiaries and the subsequent suggestions for making the scheme more effective and useful to the beneficiaries.

11.1 Findings

11.1.1 Socio-Economic Profile:

The socio-economic profile of the sample beneficiaries illustrated that majority of the beneficiaries under RSBY-CHIS were of a very low status in terms of education, occupation, income, ownership of house, its structure, type of latrines, type of drainage and the source of drinking water and light. The study found that:

- Majority of the of the beneficiaries (about 53.1 per cent) were males. Females on the other constituted about 46.9 per cent.
- There are only 1.3 per cent of the beneficiaries coming below the age of 20 years. about 8.6 per cent beneficiaries in the category of 20-30 years, about 17 per cent in the category of 30-40 years, about 32.8 per cent in

the category of 40-50 years. Majority of the beneficiaries (about 40.3 per cent) fall in the category of above 50 years.

- The educational profile portrayed a low status, as 30.4 per cent of the beneficiaries had only below S.S.L.C., about 48.2 per cent were having S.S.L.C. as their educational qualification, about 16 per cent under graduates, about 3.6 per cent graduates, about 1.2 per cent post graduates and only 0.6 per cent professionals.
- The occupation profile also portrayed a low status, as only 2.3 per cent of the beneficiaries were government employees, followed by 0.6 per cent professionals, about 27.6 self employed and about 31.6 per cent private employees. Majority of the beneficiaries (about 38 per cent) fall in the category of unemployed.
- Majority (about 39.8 per cent) of the beneficiaries under study were having a family size of 2-4 members. Those with 4-6 members followed with 36.6 per cent beneficiaries and there are about 16.6 per cent beneficiaries with 6-8 members. Beneficiaries with more than 8 family members were the least with 7.1 per cent.
- Regarding the religion of the beneficiaries under study, Christian families figured quite prominently with 38.4 per cent. Hindus and Muslims succeeded with 28.4 per cent and 30.4 per cent respectively. There are about 2.8 per cent beneficiaries in the category of others.
- Regarding social group, OBC formed the major group with 42.8 per cent. General followed next with 33.2 per cent. Scheduled caste and Scheduled tribe beneficiaries were found to be comparatively lower with 16.8 per cent and 7.2 per cent respectively.

- Regarding monthly income, about 89.6 per cent beneficiaries belong to the category of less than Rs.1000/, about 1.8 per cent between Rs.1000-2000, about 2.9 per cent between Rs.2000-3000, another 2.9 per cent between Rs.3000-4000, about 1.8 per cent between Rs.4000-5000, and there are only 1.1 per cent beneficiaries who are having monthly income more than Rs. 5000/
- There are only 10 per cent beneficiaries who owned house, about 49.3 per cent living in parent's house, about 13.6 in relative's house, about 22.4 per cent in rented house and there are about 4.6 per cent belonging to the category of other.
- Type of roof of the house varied from 'terrace to 'tarpaulin sheet'. Majority of the houses (about 47.7 per cent) belonged to tile category. Terrace was reported by about 5.9 per cent, about 17.3 per cent thatched, about 14.8 per cent asbestos, about 9.9 per cent tarpaulin and about 4.4 per cent others. The figures showed that a good number of the respondents under study were living in houses of dilapidated condition, depicting their miserable situation.
- Pit was the common type of latrine found among the beneficiaries under study. About 53.2 per cent of the beneficiaries reported about it. About 26.4 per cent reported the absence of latrines. About 17.3 per cent reported septic tank/flush system and there are about 3 per cent in the category of others. Here again, the picture is not much encouraging, portraying a dismal scenario of the beneficiaries with the absence of basic amenities.

- About 20.8 per cent stated the absence of a drainage system in their households. Open drainage system which is almost equivalent to the absence of a drainage was reported by about 54.2 per cent. about 11.8 per cent had covered, about 10.2 per cent had underground and there are about 3 per cent in the category of others. Thus a total of about 75 per cent of the beneficiaries under study were deprived of a proper drainage system.
- Most (about 36.1 per cent) of the beneficiaries had only oil lamp, as the source of light. Electricity and kerosene lamp followed next with 34.2 per cent and 23.4 per cent respectively. About 6.2 per cent beneficiaries in the category of others.
- Most (about 30.8 per cent) of the beneficiaries had only public tap, as the source of drinking water. Open well, rivers and canals followed next with 19.7 per cent, 12.7 per cent and 12.7 per cent respectively. About 9.4 per cent reported bore well, about 9.2 per cent tankers and about 4.6 per cent reported water connection as the sources of drinking water.
- Only 29.3 per cent of the households reported to have treated their water before drinking.
- Major mode of treatment of water was boiling as 14.1 per cent reported about it. The other modes of treatment included: using disinfectant, filtering and cloth filtering.
- Most (about 24.8 per cent) of the beneficiaries had news paper, as the source of outside general information. Radio and T.V. followed next with 24.3 per cent, and about 18 per cent respectively. About 12.7 per cent reported magazines, about 6.6 per cent government officials, about

5.9 per cent public leaders and about 7.8 per cent reported neighbours/friends as the sources of outside general information.

- Regarding state of health, majority (about 42.4 per cent) reported average health, about 25.3 per cent reported sound health, poor health reported by 19.9 per cent and about 12.3 per cent reported very poor health.
- About 8.4 per cent of the beneficiaries reported household average annual expenditure on medical care below Rs.5000/, about 19.1 per cent in between Rs. 5000-10000, about 29.2 per cent in between Rs. 10000-15000, about 23.8 per cent in between Rs. 15000-20000, about 14.3 per cent in between Rs. 20000-25000 and about 5.1 per cent reported it above Rs. 25000/.
- About 8.4 per cent of the beneficiaries reported percentage of household average annual expenditure on medical care to total expenditure below 10 per cent, about 18 per cent in between 10-20 per cent, about 30.3 per cent in between 20-30 per cent, about 23.8 per cent in between 30-40 per cent, about 14.3 per cent in between 40-50 per cent and about 5 per cent reported it above 50 per cent.

11.1.2 Awareness:

The awareness level of the scheme related details among the beneficiaries was found low. There is a wide gap between project strategy and implementation level. An analysis on the awareness of the beneficiaries regarding various features of the scheme, revealed the following:

General awareness:

- About 74.1 per cent of the beneficiaries were aware off about the amount of coverage in CHIS.
- About 50.2 per cent of the beneficiaries were aware off about CHIS-PLUS.
- Only 16.2 per cent of the beneficiaries were aware off about amount of coverage in CHIS-PLUS.
- Only 34.8 per cent of the beneficiaries were aware off about empanelled hospitals in CHIS.
- Only 36.4 per cent of the beneficiaries were aware off about empanelled hospitals in CHIS-PLUS.

Awareness on procedures during admission as an inpatient:

- About 47.2 per cent of the beneficiaries were aware off about giving smart card at the RSBY-CHIS counter during admission.
- Only 36.2 per cent of the beneficiaries were aware off about knowing the available balance in the card during admission.
- About 52.6 per cent of the beneficiaries were aware off about finger print verification during admission.
- About 45 per cent of the beneficiaries were aware off about free medicines and tests even from outside.
- Only 36 per cent of the beneficiaries were aware off about free food to the patient during hospitalization.

Awareness on procedures during discharge:

- Only 36.4 per cent of the beneficiaries were aware off about receiving discharge summary.
- About 47.2 per cent of the beneficiaries were aware off about finger print verification during discharge.
- Only 36.2 per cent of the beneficiaries were aware off about receiving smart card back during discharge.
- About 52.6 per cent of the beneficiaries were aware off about receiving information on money left in the smart card during discharge.
- About 45 per cent of the beneficiaries were aware off about coverage of 5 days post hospitalization expenses.
- Only 36 per cent of the beneficiaries were aware off about traveling allowance of Rs.100/.
- Chi-square analysis revealed that the difference in awareness on empanelled hospitals in CHIS in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on empanelled hospitals in CHIS in between total APL and total BPL beneficiaries is also significant.
- Chi-square analysis revealed that the difference in awareness on knowing the available balance in the card during admission in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on knowing the available balance in the card durng admission is also significant in between Ernakulam BPL and Wayanad BPL beneficiaries, in between total Ernakulam and total

Wayanad beneficiaries and in between total APL and total BPL beneficiaries.

- Chi-square analysis revealed that the difference in awareness on finger print verification during admission in between Ernakulam BPL and Wayanad BPL beneficiaries is significant. This difference in awareness on finger print verification during admission is also significant in between total Ernakulam and total Wayanad beneficiaries.
- Chi-square analysis revealed that the difference in awareness on free medicines and tests even from outside in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on finger print verification during admission is also significant in between total APL and total BPL beneficiaries.
- Chi-square analysis revealed that the difference in awareness on receiving smart card back during discharge in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on receiving smart card back during discharge is also significant in between Ernakulam BPL and Wayanad BPL beneficiaries, in between total Ernakulam and total Wayanad beneficiaries and in between total APL and total BPL beneficiaries.
- Chi-square analysis revealed that the difference in awareness on receiving information on money left in the smart card during discharge in between Ernakulam BPL and Wayanad BPL beneficiaries is significant. This difference in awareness on receiving information on money left in the smart card during discharge is also significant in between total Ernakulam and total Wayanad beneficiaries.

- Chi-square analysis revealed that the difference in awareness on coverage of 5 days post hospitalization expenses in between Ernakulam APL and Ernakulam BPL beneficiaries is significant. This difference in awareness on coverage of 5 days post hospitalization expenses is also significant in between total APL and total BPL beneficiaries.
- For having an overall understanding of awareness level of the beneficiaries, Mann-Whitney U test has been performed on the above 3 groups of features of the scheme. The result showed that there is no significant difference in the awareness level among different categories of beneficiaries.

11.1.3 Effectiveness and Utilization of RSBY-CHIS

An analysis on the details and economics of both non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization revealed the following:

Non RSBY-CHIS Hospitalization: Out of 900 beneficiaries, 709 beneficiaries recalled the details of either theirs or their family member's non RSBY-CHIS hospitalization.

- Regarding expenditures for non RSBY-CHIS hospitalization, about 33 per cent of the beneficiaries incurred less than Rs. 5000/, about 37 per cent in between Rs.5000-10000, about 15 per cent in between Rs.10000-15000, about 10 per cent in between Rs.15000-20000, and about 5 per cent in between Rs.20000-25000.
- Regarding source of finance for the above expenditure, 145 beneficiaries had it from household income/savings, 301 beneficiaries had it from borrowings, 124 beneficiaries had it from the contributions of friends/relatives and 139 beneficiaries had it from other sources.

- Out of 709 beneficiaries, only 78 beneficiaries had got reimbursement for the above expenditure. 6 beneficiaries got it from government employer, 38 from private employer, 17 from health insurance companies and 17 got it from other agencies.

RSBY-CHIS Hospitalization:

- About 12.9 per cent beneficiaries had undergone surgical treatment, about 81.8 per cent beneficiaries non surgical treatment and about 5.3 per cent beneficiaries admitted in ICU.
- Out of 116 beneficiaries who had undergone surgery, 2 beneficiaries dental, 5 ear, 2 nose, 14 throat, 5 gynaecology, 10 endoscopic, 10 hysteroscopy, 9 neuro surgery, 10 ophthalmology, 10 orthopedic, 9 endocrine, 9 neonatal care, 9 unspecified, 2 combined and 10 others.
- With regard to the reason for choosing a particular hospital for treatment, the beneficiaries had given first rank to the factor ‘there is no other RSBY-CHIS empanelled hospitals nearby’. Second rank goes to the factor ‘hospital is near to the home’, third rank goes to the factor ‘referred by doctors’, fourth rank to the factor ‘always go to this hospital’ fifth rank to ‘suggested by friends and relatives’ and last rank goes to ‘reputation of the hospital is good’. Thus it is revealed that the beneficiaries are forced to go to a particular hospital, as there is no other alternative.
- About 33.4 per cent beneficiaries had to travel less than 5 km to the hospital, about 28.6 per cent beneficiaries had to travel in between 5-10 km, about 14.6 per cent beneficiaries had to travel in between 10-15 km, about 9.9 per cent beneficiaries had to travel in between 15-20 km, and about 13.6 per cent had to travel more than 20 km to reach the hospital.

This finding also necessitates the empanelment more hospitals under the network of the scheme.

- About 15 per cent of the beneficiaries had incurred less than Rs.100/ by way of cost of transportation, about 33.3 per cent in between Rs.100-200, about 27.4 per cent in between Rs.200-300, about 24.2 per cent incurred more than Rs.300/. Thus it is revealed that around 85 per cent of the beneficiaries had incurred more than Rs.100 by way of transportation cost, and hence the traveling allowance of Rs.100 is not sufficient to meet the transportation cost of the majority beneficiaries.
- Even though there is a provision of traveling allowance of Rs.100/ in the scheme, only 19.3 per cent of the beneficiaries received it, whereas about 80.7 per cent beneficiaries denied with it. This indicates the poor implementation of the scheme and many benefits of the scheme are not given to the beneficiaries.
- Among the beneficiaries who were not provided with traveling allowance, about 20 per cent cited the reason for not giving traveling allowance as 'hospital refused', about 16.1 per cent stated that 'did not know there was such a provision', about 34 per cent stated that 'hospital said they will give this later', about 19.9 per cent 'did not ask for it' and there are about 9.9 per cent in the category of 'others'.
- About 10.3 per cent beneficiaries had to wait less than 5 minutes before attended by the staff, about 29.7 per cent in between 5-15 minutes, about 36 per cent in between 15-30 minutes, about 12.9 per cent in between 30-60 minutes and about 11.1 per cent had to wait more than 60 minutes before attended by the staff.

- A seek with respect to imparting necessary information to the beneficiaries revealed the following: with regard to cost of treatment, about 71.3 per cent were informed about it, about 28.7 per cent not informed about it. The same was the situation with other information like money left in the smart card reader, sufficiency of money for the treatment and the fact that the beneficiaries need to pay the difference, if the balance is not sufficient. Thus around 25 per cent of the beneficiaries were not informed about the basic realities of the scheme.
- Regarding nature of admission, about 6.7 per cent beneficiaries admitted through emergency, about 77.8 per cent through OPD, about 8.2 per cent through referral, and about 7.3 per cent beneficiaries through 'others'.
- About 45.2 per cent of the beneficiaries received bed immediately on admission, about 40.6 per cent were asked to wait for a few hours, about 7.7 per cent were asked to come back on another day, and there are about 6.6 per cent beneficiaries in the category of others.
- About 45.2 per cent of the beneficiaries were able to walk by own during admission, about 40.6 per cent able to walk only by support and about 14.2 per cent beneficiaries needed stretcher/wheel chair.
- Out 128 beneficiaries who needed stretcher/wheel chair, 107 availed it, and 21 not availed it.
- Out of 107 beneficiaries who availed stretcher/wheel chair, in the case of 87 beneficiaries, hospital staff pushed it, 10 beneficiaries by relatives and 10 beneficiaries by others.

- About 40.9 per cent beneficiaries had to wait less than 15 minutes before attended and checked by the nursing staff, about 36.1 per cent in between 15-30 minutes, about 11.7 per cent in between 30-60 minutes, and 11.3 per cent had to wait more than 60 minutes before attended and checked by the nursing staff.
- About 40.9 per cent beneficiaries had to wait less than 30 minutes before attended and checked by the doctor, about 36.1 per cent in between 30-60 minutes, about 11.7 per cent in between 60-120 minutes, and about 11.3 per cent had to wait more than 120 minutes before attended and checked by the doctor. It is observed by the researcher that majority of the non RSBY-CHIS patients are also waiting for less than 30 minutes before attended by the doctor. It can be assumed that there is no discrimination in between RSBY-CHIS and non RSBY-CHIS patients.
- About 16.8 per cent of the beneficiaries were asked to obtain test or medicine from outside and about 83.2 per cent beneficiaries were not asked to.
- Out of 151 beneficiaries who were asked to obtain test or medicine from outside, 96 were asked to pay for the same from their own pockets whereas 55 were not asked to. Thus, even if the scheme envisages free test or medicine even from outside, it was not given to the beneficiaries.

- A seek with respect to the reason for not giving free test or medicine even from outside revealed the following: out of 96 beneficiaries who have been asked to pay, 25 beneficiaries were stated the reason that 'hospital staff said it was not a part of RSBY-CHIS package', 26 beneficiaries did not asked the reason, 21 beneficiaries stated that 'hospital paid cash to the patient later' and 24 beneficiaries stated the reason that 'the hospital did not have sufficient fund'.
- Even though there is a provision of free food to the patient in the scheme, only 21.2 per cent of the beneficiaries received it, whereas about 78.2 per cent beneficiaries denied with it. This indicates the poor implementation of the scheme and many benefits of the scheme are not given to the beneficiaries.
- A seek with respect to the reason for not giving free food revealed the following: out of 709 beneficiaries who have been denied with free food, 177 beneficiaries were stated the reason that 'hospital staff said it was not a part of RSBY-CHIS package', 177 beneficiaries did not asked the reason, 79 beneficiaries stated that 'hospital paid cash to the patient to buy food' and 276 beneficiaries stated the reason that 'the hospital did not have sufficient fund'.
- With regard to the quality of food, out of 191 beneficiaries who have been provided with free food, 28 beneficiaries stated that food was very good, 33 beneficiaries stated it as good, 93 stated it as average, 17 rated it as bad, and 20 beneficiaries rated the quality of food as very bad.
- About 95 per cent beneficiaries received the smart card on the same day of discharge, whereas about 5 per cent not received it on the day of discharge.

- All the 45 beneficiaries who had not received the smart card on the day of discharge, received it within 5 days.
- A seek with respect to the reason for not providing the smart card on the day of discharge, revealed the following: out of 45 beneficiaries, 9 beneficiaries were stated the reason that 'staff wanted money for returning the card', 16 beneficiaries stated that 'staff wanted to keep the card till the insurance claims were settled', 10 beneficiaries stated that 'staff said the card will stay deposited at the hospital' and 10 beneficiaries stated the reason that 'they did not asked'.
- About 82.1 per cent of the beneficiaries had been provided with free medicine on discharge, whereas about 17.9 per cent of the beneficiaries were not provided with free medicine. Thus it is revealed that around 20 per cent of the beneficiaries were not provided with one important benefit under the scheme, i.e. post hospitalization expenses for 5 days.
- A seek with respect to the reason for not providing free medicine for 5 days on discharge, revealed the following: out of 161 beneficiaries, 50 beneficiaries stated that 'no reason provided by the hospital', 54 beneficiaries stated the reason that 'hospital staff said it was not a part of RSBY-CHIS package', 46 beneficiaries stated the reason that 'they did not asked' and there are 11 beneficiaries in the category of 'others'.
- Out of 110 beneficiaries who had been prescribed diagnostic test on discharge, 41 beneficiaries had been provided with free of cost test on discharge, whereas 69 beneficiaries were not provided with free of cost test on discharge. Thus it is revealed that around 50 per cent of the beneficiaries were not provided with one important benefit under the scheme, i.e. post hospitalization expenses for 5 days.

- A seek with respect to the reason for not providing free of cost test within 5 days after discharge, revealed the following: out of 69 beneficiaries, 24 beneficiaries stated that ‘no reason provided by the hospital’, 28 beneficiaries stated the reason that ‘hospital staff said it was not a part of RSBY-CHIS package’, and 17 beneficiaries stated the reason that ‘they did not asked’.
- Regarding the present health status of the patients, about 25.1 per cent beneficiaries responded that they had been improved completely, about 36.6 per cent beneficiaries responded that there had not been any improvement in their condition and about 38.3 per cent beneficiaries stated that there had been only partial improvement.
- With regard to duration of hospitalization, about 40 per cent beneficiaries had been hospitalized for less than 5 days, about 41.8 per cent hospitalized for 5-10 days, about 10 per cent hospitalized for 10-15 days and about 8.2 per cent hospitalized for more than 15 days.
- Regarding expenditures for RSBY-CHIS hospitalization, about 19 per cent of the beneficiaries had incurred only less than Rs. 500/, about 34 per cent in between Rs.500-1000, about 27 per cent in between Rs.1000-1500, about 12 per cent in between Rs.1500-2000, and about 8 per cent in between Rs.2000-2500. Thus it is revealed that compared to non RSBY-CHIS hospitalization, there is only less expenditures incurred by the beneficiaries for their RSBY-CHIS hospitalization.

- To evaluate the effectiveness of RSBY-CHIS with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses, Repeated Measure Analysis has been applied. The result showed that the scheme is effective in terms of reduction in hospitalization expenditure of the beneficiaries. It is effective in the case of all categories of beneficiaries, as the p- value is 0.000 in the case of all categories of beneficiaries. An analysis is also performed to find out whether this effectiveness is significantly different in between different categories of beneficiaries. The concerned p- value indicates that the difference is significant in between Ernakulam APL and BPL beneficiaries and also in between total Ernakulam and Wayanad beneficiaries.

11.1.4 Satisfaction on the Experience under RSBY-CHIS Hospitalization

A great majority of the beneficiaries under study were having average satisfaction with the services provided through RSBY-CHIS. An analysis on the satisfaction of the beneficiaries revealed the following:

- It is revealed that about 37.6 per cent beneficiaries have stated that their patient related queries were fully answered by the hospital, about 17.9 per cent stated that their queries were not answered by the hospital, and about 44.6 per cent stated that their queries have been answered only partially. Thus a great majority of beneficiaries in all categories have been stated that their patient related queries have been only partially answered.
- It is revealed that about 8.8 per cent beneficiaries have stated very much satisfied with the behaviour of the staff at the RSBY-CHIS help desk, about 8.9 per cent beneficiaries were in the category of satisfied, about

65.9 per cent beneficiaries were having average satisfaction, about 8.1 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.3 per cent beneficiaries. Thus a great majority of the beneficiaries in all categories were having average satisfaction with the behaviour of the staff at the RSBY-CHIS help desk, i.e. around 15 per cent were dissatisfied.

- It is revealed that about 6 per cent beneficiaries have stated very good satisfaction with the treatment at the hospital, about 6.3 per cent beneficiaries were in the category of good satisfaction, about 77.4 per cent beneficiaries were having average satisfaction, about 6.1 per cent beneficiaries in the category of poor satisfaction and in the category of very poor satisfaction, there was about 4.1 per cent beneficiaries. Thus a great majority of the beneficiaries in all categories were having average satisfaction with the treatment at the hospital and only a minority i.e. around 10 per cent were dissatisfied.
- It is revealed that there are about 20.4 per cent beneficiaries who have stated that they would have gone to the same hospital if the scheme had not been there, about 24.1 per cent beneficiaries stated that they would have gone to any other private hospital, about 22.3 per cent beneficiaries stated that they would have gone to the government hospital and about 15.4 per cent beneficiaries stated that they would go nowhere, and about 28.6 per cent stated that they don't know. Majority beneficiaries in general have stated that they would have gone to any other private hospital if the scheme had not been there where as majority beneficiaries in BPL category have stated that they would have gone to government hospital if the scheme had not been there. The study signifies that

Government and Public Hospitals are more dependable for poor people compared to private hospitals.

- It is revealed that there are about 82.8 per cent beneficiaries who have stated that they will recommend their relatives and friends and about 17.2 per cent stated that they will not recommend. Thus majority beneficiaries have stated that they will recommend their relatives and friends to take treatment under the scheme which points to the fact that the scheme is helpful to the beneficiaries.
- Among the 155 beneficiaries who have stated that they will not recommend the scheme to their friends and relatives, there are 34 beneficiaries who have stated the reason for it that they had been treated badly, 29 beneficiaries stated that the treatment under the scheme was poor in quality, 35 beneficiaries stated that the hospitals are not receptive to RSBY-CHIS patients, 21 beneficiaries stated that there is no sufficient money in RSBY-CHIS card and 36 beneficiaries stated that the implementation of the scheme is very poor. It is revealed that majority beneficiaries in general stated that poor implementation of the scheme is the reason for not recommending their relatives and friends to take treatment under the scheme.
- It is revealed that about 6.7 per cent beneficiaries have stated that they are very much satisfied with the present insurance scheme, about 6.5 per cent beneficiaries were in the category of satisfied, about 71.1 per cent beneficiaries were having average satisfaction, about 7.3 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.4 per cent beneficiaries. Thus it can be implied that majority beneficiaries were having average satisfaction

with the scheme and only a minority i.e. around 15 per cent were dissatisfied.

- There are about 9 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 68.3 per cent beneficiaries stated the reason as inaccessibility to health services, about 9.4 per cent beneficiaries stated that there was poor service, about 9.2 per cent beneficiaries stated attitude of staff as the reason for dissatisfaction and there are about 4 per cent beneficiaries in the category of any other reason. It is revealed that majority beneficiaries have stated that inaccessibility to health services as the reason for dissatisfaction, which throws light on the urgent necessity of including more hospitals under the network of the scheme.
- An analysis of the suggestions made by the beneficiaries for improving the system revealed that empanelment of more hospitals is the most preferred improvement by majority of the beneficiaries and this factor was given first rank, followed by 'increasing the sum assured' which was given second rank. Third rank goes to the factor that 'including more family members' and fourth rank to the factor 'attitude of staff'. Least preferred suggestion is 'reduction in premium'. This may be due to the nominal amount of Rs.30/ only paid by the BPL beneficiaries for obtaining the smart card.

11.2 Suggestions

Based on the above findings, the following suggestions are made for making the scheme more effective and useful for the beneficiaries:

- The APL beneficiaries need to pay a premium of Rs.1274/ at present, to enroll under the scheme. But the study found out that majority of the sample beneficiaries, including the APL beneficiaries, under RSBY-CHIS were of a very low status in terms of education, occupation, income, ownership of house, its structure, type of latrines, type of drainage and the source of drinking water and light. Moreover, the APL beneficiaries have given first rank to the factor 'reduction in premium' as their suggestion for the betterment of the system. So it is suggested that this high premium may be reduced to help the APL beneficiaries.
- The awareness level of the scheme related details among the RSBY-CHIS beneficiaries was found low. Often they are of the belief that it is a free service provided by the hospitals. The hospital staff stated that the beneficiaries are not availing the services due to lack of knowledge or information as they do not know how to approach and take the benefit. Thus, it is recommended that the concerned authority should organize frequent awareness programs for the same and ensure wide publicity about the RSBY-CHIS and its provisions among the general public.
- A seek with respect to imparting necessary information to the beneficiaries revealed that around 25 per cent of the beneficiaries were not informed about the basic realities of the scheme like cost of treatment, money left in the smart card, sufficiency of money for the treatment and the fact that the beneficiaries need to pay the difference, if the balance is not sufficient. Even the hospital staff has only insufficient information and instructions regarding the processes and the roles they

have to perform under the scheme. Accordingly, many of the information such as information about the money left in the card, cost involved in treatment etc. which they are supposed to hand over to the patients, are not provided by most. Thus, it is recommended that the concerned authority should organize seminars/classes for the hospital authorities about the various elements of the scheme and the roles they are expected to perform with respect to the scheme.

- There are ambiguities in the guidelines regarding the provision of food and traveling allowance. Many of the hospitals are not providing food and traveling allowance to the patients and they stated either the reason that they had no sufficient fund or the reason that they have no such instructions. From the study it is revealed that even though there is a provision of traveling allowance of Rs.100/ in the scheme, only 19.3 per cent of the beneficiaries received it, whereas about 80.7 per cent beneficiaries denied with it. Likewise, even though there is a provision of free food to the patient in the scheme, only 21.2 per cent of the beneficiaries received it, whereas about 78.2 per cent beneficiaries denied with it. This indicates the poor implementation of the scheme and many benefits of the scheme are not given to the beneficiaries. It is observed that the government hospital provide food and transportation allowance to smart card holders which are missing in case of empanelled private hospitals. So it is essential to ensure strict monitoring by the government/CHIAK on the implementation of the scheme by the hospitals.

- From the study it is revealed that out of 151 beneficiaries who were asked to obtain test or medicine from outside, 96 were asked to pay for the same from their own pockets whereas 55 were not asked to. Thus, even if the scheme envisages free test or medicine even from outside, it was not given to majority of the beneficiaries. So it is essential to ensure strict monitoring by the government/CHIAK on the implementation of the scheme by the hospitals.
- It is revealed from the study that around 50 per cent of the beneficiaries were not provided with one important benefit under the scheme, i.e. post hospitalization expenses for 5 days. Around 20 per cent of the beneficiaries were not provided with free medicine on discharge. Likewise, out of 110 beneficiaries who had been prescribed diagnostic test on discharge, 69 beneficiaries were not provided with free of cost test on discharge. So it is essential to ensure strict monitoring by the government/CHIAK on the implementation of the scheme by the hospitals.
- From the study it is revealed that around 85 per cent of the beneficiaries had incurred more than Rs.100 by way of transportation cost, and hence the traveling allowance of Rs.100 is not sufficient to meet the transportation cost of the majority beneficiaries. So it is essential to increase the traveling allowance of Rs.100/- to at least Rs.300/-, as the majority beneficiaries under the study incurred a cost of around Rs.300/- by way of transportation.
- There are only 6 empanelled hospitals, i.e. 5 public and 1 private hospital in Wayanad and only 22 empanelled hospitals, i.e. 10 public

and 12 private hospitals in Ernakulam district. So it is suggested that more hospitals should be empanelled and should include hospitals which have maximum number of facilities and should be spread across the length and breadth of the area facilitating its utilization by maximum number of people. It is believed that people are more likely to use hospitals within a 10 km radius of habitation. This may explain higher usage in the more urbanized district headquarters where there are more hospitals. Hence proximity matters, as does having an adequate number of empanelled hospitals. Thus lesser number of empanelled hospitals which at times prevents the utilization of the scheme by families that do not have the empanelled hospitals nearby. Likewise, involvement of reputed healthcare facilities appears to be very low in the scheme. The only private hospital in Wayanad is an eye hospital. Efforts need to be made to have many more empanelled hospitals under the scheme.

- Another observation is that there is a strong need for OPD coverage as expressed by the beneficiaries. Health insurance scheme for the poor should take care of not just the inpatient or hospital care, as designed in the proposed scheme, but also of the outpatient care. Thus it is suggested that outpatient department coverage may be added as a benefit under the scheme.
- Timely reimbursement to hospitals emerges as the major expectation from the hospitals as it resulted in denial of treatment to beneficiaries in a few cases. The authorities of private hospitals complain that their claims are kept pending for years together. The private hospitals feel encouraged by timely settlement of their claims and timely redressal of their complaints by authorities. Delay in settlement of claims creates

ripple off effects in terms of rejection of card holders for hospitalization, increase in out of pocket expenses by smart card holders and sometimes it ends up in the coming out of the concerned private hospital from the network of empanelled hospitals. The mandatory provision for settlement of claims within 21 days is not strictly followed by TPAs. The insurance companies ignore the conditions accepted in MoU for examination and settlement of claims. A good number of reputed private hospitals have provided hospitalization services to needy RSBY-CHIS beneficiaries on priority basis overlooking stringent procedural formalities. These hospitals have been deprived off a portion of their claims reimbursed by Insurance Companies. A significant section of their claims have been rejected, although they have provided high quality health service to poor RSBY-CHIS beneficiaries. (e.g. Leo Hospital in Wayanad and many other private hospitals empanelled earlier under the scheme). Thus it is suggested that timely settlement of claims both to government and empanelled private hospitals would add robust strength to the program.

- There is a need for setting up monitoring mechanism for progress and also addressing grievances at the operational level. The weakness in grievance redressal mechanism should be eliminated by timely redressal of grievances. The strengthening of the redressal will ensure enhanced hospitalization as well as penetration of the scheme in remote areas of the state.

11.3 Conclusion

The study named “Rashtriya Swasthya Bhima Yojana-Comprehensive Health Insurance Scheme (RSBY-CHIS) In Kerala: A Study On The

Effectiveness And Utilization Of The Scheme With Special Reference To Ernakulam And Wayanad Districts” has been conducted with objectives as given in the first chapter of the thesis. The methodology has also been stated in the first chapter. Data collected is presented and analyzed in chapters 7, 8, 9 and 10. The findings emerging from the study and the suggestions based on the findings, to make the scheme more effective and useful, were elaborated in the previous part of this chapter. Accordingly, the conclusion derived from the study is presented below:

The first objective was to study the socio-economic profile of the beneficiaries of the scheme. It has been found that the socio-economic profile of the sample beneficiaries under RSBY-CHIS were of a very low status in terms of education, occupation, income, ownership of house, its structure, type of latrines, type of drainage and the source of drinking water and light. The details in this regard re-emphasize the low economic status and poor condition of the beneficiaries. Moreover, it is also revealed that majority of the beneficiaries had only average health and they are spending a good percentage of their income on medical care and it throws light on the inevitability of a well defined health insurance scheme like RSBY-CHIS.

- The second objective was to study the awareness level of the beneficiaries regarding the features of the scheme. It has been found that the awareness level of the scheme related details among the beneficiaries was found very low. Even the staff at RSBY-CHIS help desk of the hospitals is not well educated about the scheme for which they fail to meet the queries raised by the patients. One can fairly estimate that the response of a predominantly rural and poor population to a technology-driven initiative like RSBY-CHIS will be very poor, if

its features and benefits are not adequately explained. Knowledge about different features of RSBY-CHIS creates greater involvement among the beneficiaries. Thus there is a wide gap between project strategy and implementation level. The capacity building interventions have been drastically missing. Thus, it is recommended that concerned authorities should organize frequent awareness programs for the same. Notwithstanding the possibility that these responses regarding the awareness level of the beneficiaries are that of a sampled population and may not be fully representative of overall situation, the situation needs to be addressed urgently.

- The third objective was to evaluate the effectiveness of the scheme with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses. The effectiveness of the scheme depends on the fact that whether the scheme has helped the beneficiaries to mitigate their hospitalization expenditure or not. For this, expenditure for non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization incurred by the sample beneficiaries are compared. Regarding expenditures for non RSBY-CHIS hospitalization, about 33 per cent of the beneficiaries incurred less than Rs. 5000/, about 37 per cent in between Rs.5000-10000, about 15 per cent in between Rs.10000-15000, about 10 per cent in between Rs.15000-20000, and about 5 per cent in between Rs.20000-25000. But for RSBY-CHIS hospitalization, around 50 per cent of beneficiaries have incurred only Rs. 1000/- or less, and the rest of the beneficiaries have incurred in between Rs. 1000-Rs.2500. It is evident that the intervention of RSBY-CHIS has prevented significant section of poor households from catastrophic

spending and distress financing relating to hospitalization and treatment. For statistically verifying it, Repeated Measures Analysis has been applied. The result showed that the scheme is effective in terms of reduction in hospitalization expenditure of the beneficiaries. It is effective in the case of all categories of beneficiaries, as the p- value is 0.000 in the case of all categories of beneficiaries. An analysis is also performed to find out whether this effectiveness is significantly different in between different categories of beneficiaries. The concerned p- value indicates that the difference is significant in between Ernakulam APL and BPL beneficiaries and also in between total APL and BPL beneficiaries.

- The fourth objective was to study the satisfaction level of the beneficiaries in the utilization of the scheme. It has been revealed that about 6.7 per cent beneficiaries are very much satisfied with the present insurance scheme, about 6.5 per cent beneficiaries were in the category of satisfied, about 71.1 per cent beneficiaries were having average satisfaction, about 7.3 per cent beneficiaries in the category of dissatisfied and in the category of very much dissatisfied, there was about 8.4 per cent beneficiaries. Thus it can be implied that majority beneficiaries were having average satisfaction with the scheme and only a minority i.e. around 15 per cent were dissatisfied. Among this 15 per cent dissatisfied beneficiaries, there are about 9 per cent beneficiaries who had given less coverage as the reason for dissatisfaction, about 68.3 per cent beneficiaries stated the reason as inaccessibility to health services, about 9.4 per cent beneficiaries stated that there was poor service, about 9.2 per cent beneficiaries stated

attitude of staff as the reason for dissatisfaction and there are about 4 per cent beneficiaries in the category of any other reason. It is revealed that majority beneficiaries have stated that inaccessibility to health services as the reason for dissatisfaction, which throws light on the urgent necessity of including more hospitals under the network of the scheme.

- The fifth objective was to suggest suitable measures to make the scheme more effective and useful to the beneficiaries. These suggestions are given in the previous part of this chapter. Among these, the main suggestions are reducing the high premium for the APL beneficiaries, empanelling more hospitals, increasing the awareness level of the beneficiaries, rectifying the ambiguities in the implementation of the scheme, including OPD coverage, timely reimbursement to hospitals and establishing a good monitoring mechanism and effective grievance redressal of the beneficiaries.

It is thus clear from this study that majority of the beneficiaries were having average satisfaction with the services provided through the RSBY-CHIS. If the scheme could achieve such average satisfaction level at its infancy stage, it is sure that necessary changes and modifications will accelerate its utilization by the beneficiaries. The scheme hence, is a boon and no doubt it would enhance the health status of the beneficiaries. It has really assisted them to reduce their hospitalization expenses and utilize better hospital facilities. But such a scheme, which strengthens demand side, makes sense only when the supply of health care is reasonably well developed. Where this is not so, the scheme is meaningless. The supply of health care in the rural and remote areas of our state is far from satisfactory. Although public health care centers are pervasive, these centers have degraded overtime due to lack of funds,

accountability and so forth. Thus any attempt at introducing health insurance for the poor must also be accompanied by revival of health care facilities. Even though RSBY-CHIS has a positive role in reducing the hospitalization expenditure among the beneficiaries, low awareness level, limited number of private empanelled hospitals, poor implementation of the scheme, absence of effective monitoring mechanism and redressal of grievances, timely reimbursement to hospitals, ambiguities in the benefits of the scheme, etc., are some of the pertinent issues still persisting as constraints in achieving the desired objectives of RSBY-CHIS. The program designers and policy planners may take effective steps to address the issues concerned, while making future plans in implementing the RSBY-CHIS more effectively or in improved forms.

11.4 Scope for Further Research

Future research can be extended in a number of ways and some of the possibilities are enumerated below:

There are rising claim ratios in RSBY-CHIS during the successive years and incurring huge losses to the insurance company. Data shows that there is about 132 crores of rupees losses incurred by United India Insurance Company Ltd. till now. Rising claim ratios in RSBY-CHIS will push future premiums higher, hence increasing the cost to the government and putting the scheme in jeopardy. It is therefore vital that we understand the factors that influence enrolments and utilization. Thrust may be given on this aspect while doing further research on RSBY-CHIS.

The study revealed that some hospitals in the network were found lacking in certain facilities requiring the patients to seek such facilities from out-of-the-network hospitals and thereby incur non-reimbursable costs. So

further research can be conducted to evaluate whether the facilities available in the network hospitals are sufficient to meet the health requirements of the beneficiaries.

The present study basically a representative study as it was limited to two districts only, i.e. Ernakulam and Wayanad districts in Kerala. Effectiveness of RSBY-CHIS in mitigating the hospitalization expenditure, at macro level has to be studied so as to formulate policies and programs in that perspective.

The study revealed that the beneficiaries enrolled under the scheme are not provided with the full benefits as envisaged in the scheme. Many of the beneficiaries are not provided with free food, free test or medicine even from outside, pre and post hospitalization expenses etc. There is a wide gap between project strategy and implementation level. So in depth studies can be conducted about the implementation of the scheme.

It is also advisable that a comparative study can be conducted between successful Private Health Insurance Schemes and RSBY-CHIS. A study of this kind shall not only help bring out qualitative & quantitative findings but will also help incorporate the best practices in RSBY-CHIS.

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Interview Schedule for RSBY-CHIS Beneficiaries

Sub: “RASHTRIYA SWASTHYA BHIMA YOJANA-COMPREHENSIVE HEALTH INSURANCE SCHEME (RSBY-CHIS) IN KERALA: A STUDY ON THE EFFECTIVENESS AND UTILIZATION OF THE SCHEME WITH SPECIAL REFERENCE TO ERNAKULAM AND WAYANAD DISTRICTS”

Instructions: Probable answers for most of the questions given against each with codes 1-9. Appropriate code representing the answer to be recorded in the space provided at right side.

SECTION A - PROFILE OF THE BENEFICIARY

1. Name of the district: Ernakulam - 1 Wayanad - 2
2. Number of the smart card:
3. Name of the beneficiary:
4. Place of residence:
5. Age: Below 20 - 1 20-30 - 2 30-40 - 3 40-50 - 4 Above 50 - 5
6. Gender: Male - 1 Female - 2
7. Qualification: Below S.S.L.C.- 1 S.S.L.C. - 2 Under graduate - 3
 Graduate - 4 Post Graduate - 5 Professional - 6
8. Occupation:

Government employee - 1	Private employee - 2
Self employed - 3	Professional - 4 Unemployed - 5
9. Religion: Hinduism - 1 Christianity - 2 Islam - 3 Others - 9
10. Social group: SC - 1 ST.- 2 OBC - 3 General - 4

11. Number of family members:

2-4 -1 4-6 - 2 6-8 - 3 More than 8 - 4

12. House hold monthly income:

Up to 1000 - 1 1000- 2000 - 2 2000-3000 - 3

3000-4000 - 4 4000- 5000 - 5 Above 5000 - 6

13. Economic category: APL - 1 BPL - 2

Housing pattern and physical amenities

14. Is the house you presently living in:

Own -1 Parents -2 Relatives -3 Rented -4 Others -9

15. Type of roof of the house:

Terrace -1 Tile -2 Thatched house -3 Asbestos sheet -4

Tarpaulin sheet -5 Others -9

16. Type of latrine:

Septic tank/Flush system -1 Pit -2 No latrine -3 Others -9

17. Type of drainage:

Open -1 Covered -2 Underground -3 No drainage -4 Others -9

18. Source of light in the house:

Electricity -1 Oil lamp - 2 Kerosene lamp -3 Others -9

19. Major source of drinking water:

Open well -1 Bore well -2 Public tap -3

Tankers -4 Rivers -5 Canals -6 Water connection -7

20. Is water treated before drinking? :

Yes -1 No -2

21. If yes, type of water treatment:

Boiling -1 Filtering -2 Clothe filtering -3

Any disinfectant -4 Others -9

22. Main source of outside general information:

Newspapers -1 Radio -2 Television -3 Magazines -4
 Government officials -5 Public leaders -6 Neighbours/ Friends -7

23. Your state of health:

Sound health -1 Average health -2
 Poor health -3 Very poor health -4 Others-9

24. House hold average annual expenditure on medical care:

Less than Rs.5000 -1 Rs. 5000-10000 -2 Rs.10000-15000 -3
 Rs.15000-20000 -4 Rs. 20000-25000 -5 Above Rs.25000 -6

25. House hold average annual expenditure on medical care as a percentage to total household expenditure :

Less than 10% -1 10-20% -2 20-30% -3
 30-40% -4 40-50% -5 Above 50% -6

**SECTION B - DETAILS ABOUT AWARENESS LEVEL OF THE BENEFICIARY ABOUT
RSBY-CHIS**

26. General Awareness

SL. NO.	Information On	Awareness (CODE-1)	No Awareness (Code-2)
1	The amount of coverage in CHIS		
2	Knowledge about CHIS-PLUS		
3	The amount of coverage in CHIS-PLUS		
4	Empanelled hospitals in CHIS		
5	Empanelled hospitals in CHIS-PLUS		

27. Awareness on Procedures during Admission as an Inpatient

Sl. No.	Information On	Awareness (Code-1)	No Awareness (Code-2)
1	Giving smartcard at the RSBY-CHIS counter during admission		
2	Knowing the balance in the card		
3	Finger print verification		
4	Free medicines and tests even from outside		
5	Free food to the patient		

28. Awareness on Procedures during Discharge

Sl. No.	Information On	Awareness (Code-1)	No Awareness (Code-2)
1	Receiving discharge summary		
2	Fingerprint verification		
3	Receiving the smartcard back		
4	Information on money left in the smartcard		
5	Coverage of 5 day post hospitalization expenses		
6	Traveling allowance of Rs.100/.		

SECTION C – DETAILS ABOUT NON-RSBY-CHIS HOSPITALISATION

(IF ANY)

Details of last hospitalization case which was not covered by RSBY-CHIS

29. Details of medical services received during hospitalization

Medical services	Not received (Code-1)	Received free (Code-2)	Partly free (Code-3)	On payment (Code-4)
Surgery				
Medicine				
X-ray/ECG/EEG/Scan				
Other diagnostic tests				

30. Whether treatment availed before hospitalization:

Yes -1

No -2

35. Major source of finance for the above expenditure

Source	Amount (In Rupees)
Household income/savings(code-1)	
Borrowings (code-2)	
Contributions from friends and relatives(code-3)	
Other sources (incl. sale of ornaments and other physical assets, draught animals, etc.)(code-9)	
Total	

36. Amount of reimbursement (Rs) (if any)

Source	Amount (In Rupees)
Employer	Government (code-1)
	Private (code-2)
Medical insurance companies (code-3)	
Other agencies (code-9)	
Total	

SECTION D - DETAILS ABOUT RSBY-CHIS HOSPITALIZATION**Details of last hospitalization case in past 365 days which was covered by RSBY-CHIS**

37. No. of hospitalization cases in your family in the last one year:

Once -1 Twice -2 Thrice -3 More than thrice

38. No. of family members hospitalized in the last one year:

1 -1 2 -2 3 -3 More than 3 -4

39. What was the nature of treatment in the last hospitalization case for which hospitalization was sought?

Surgical -1 Non surgical -2 Admitted in ICU -3

40. If surgical, what was the surgery?

- | | | | | | |
|---|--------|-------------------|------------------|--------------|--------------------------|
| Dental -1 | Ear -2 | Nose -3 | Throat -4 | General -5 | |
| Gynaecology -6 | | Endoscopic -7 | Hysteroscopic -8 | | <input type="checkbox"/> |
| Neurosurgery -9 | | Ophthalmology -10 | Orthopaedic -11 | | |
| Paediatric -12 | | Endocrine -13 | Urology -14 | Oncology -15 | |
| Other commonly used procedures -16 Neo natal care -17 | | | | | |
| Combined -18 | | Unspecified -19 | | | |

(Please refer package code at the end of the document)

41. Why this particular hospital was chosen for treatment? :

(Rank them in the order of preference)

- | | |
|---|--------------------------|
| Near to the home -1 | <input type="checkbox"/> |
| Reputation of the hospital is good -2 | <input type="checkbox"/> |
| Suggested by the relative/ friends -3 | <input type="checkbox"/> |
| Referred by doctors -4 | <input type="checkbox"/> |
| Always go to this hospital -5 | <input type="checkbox"/> |
| There is no other RSBY empanelled hospitals nearby -6 | <input type="checkbox"/> |

Details about transportation

42. How far is the hospital from your house (Approximately)?

- | | | | |
|-------------------|--------------------|-------------|--------------------------|
| Less than 5 km -1 | 5-10 km -2 | 10-15 km -3 | <input type="checkbox"/> |
| 15-20 km -4 | More than 20 km -5 | | |

43. How did the patient go to the hospital ?

- | | | | | | |
|--------|--------|-------------|----------------|-----------|--------------------------|
| Bus -1 | Car -2 | Rickshaw -3 | Two wheeler -4 | Others -9 | <input type="checkbox"/> |
|--------|--------|-------------|----------------|-----------|--------------------------|

44. Did any family member accompany patient to the hospital ?

- | | | |
|--------|-------|--------------------------|
| Yes -1 | No -2 | <input type="checkbox"/> |
|--------|-------|--------------------------|

45. If yes, how many family members accompany patient to the hospital?

- | | | | | | |
|--------|--------|----------|---------|-------------------|--------------------------|
| One -1 | Two -2 | Three -3 | Four -4 | More than four -5 | <input type="checkbox"/> |
|--------|--------|----------|---------|-------------------|--------------------------|

46. What was the cost of transportation to reach the hospital?

Less than 100 -1 100- 200 -2 200- 300 -3 More than 300 -4

47. Did the hospital reimburse the cost of transportation?

Yes -1 No -2

48. If yes, how much was the reimbursement ?

Less than 100 -1 Exactly 100 -2 More than 100 -3

49. If no, why ?

Hospital refused -1 Did not know there was such a provision -2

Hospital said they will give this later -3 Patient did not ask for it -4

Others -9

Inpatient experience

50. Was there a RSBY-CHIS help desk at the hospital?

Yes -1 No -2 Do not know -3

51. Was it a separate desk for RSBY-CHIS or part of the other desk like reception?

Yes -1 No -2 Do not know -3

52. Were following equipments available at the help desk?

Equipments	Yes (code-1)	No (code-2)	Don't know (code-3)
Finger print scanner			
Smart card reader			
Computer			
Printer			

53. How did the beneficiary find out about the RSBY help desk?

Visible sign boards-1 By asking hospital staff-2

No signboard but found by themselves without any assistance-3

54. How long did the patient has to wait before he/she was attended by the staff?

- Less than 5 minutes -1 Between 5 to15 minute -2
- Between 15 to 30 minutes -3 Between 30 to 60 minutes -4
- More than 60 minutes -5

55. Was fingerprint verification done through a fingerprint scanner?

- Yes -1 No -2 Don't know -3

56. Whose finger print was used for verification and registration?

- Patient -1 Family member listed on smart card -2

57. If family member, Why patient's fingerprint was not verified?

- Patient was not in a condition to give fingerprint -1
- Patient's thumb is injured -2 Suggested by the hospital -3 Others -9

58. Which family member provided the fingerprint verification?

- Husband -1 Wife -2 Son -3 Daughter -4
- Mother -5 Father -6 Others -9

59. Was the beneficiary informed about the following in advance?

Item	Yes (code-1)	No(code-2)
Cost of the treatment		
Money left in the smart card		
Sufficiency of money in the card for the treatment		
If not sufficient, would have to pay the difference		

60. How was the admission advised through?

- Emergency-1 OPD -2 Referral-3 Others -9

61. Are you satisfied about the behaviour of the staff at the RSBY-CHIS help-desk?

- Very much satisfied -1 Satisfied-2 Average -3
- Dissatisfied-4 Very much dissatisfied -5

62. Was the bed made available as soon as the patient was advised admission?

- Yes-1 Patient was asked to wait for a few hours -2
- Patient asked to come back on another day -3 Others -9

63. What was the condition of the patient at the time of admission?
- Able to Walk by own -1 Able to walk by support -2
Needed stretcher/ wheelchair -3
64. Was a wheelchair/ stretcher available?
- Yes -1 No -2
65. If yes, Who pushed the wheelchair / stretcher?
- Hospital staff -1 Relatives -2 Others -9
66. After admission how long did the nursing staff take to come and check the patient?
- Less than 15 minutes -1 Between 15 to 30 minute -2
Between 30 to 60 minutes -3 More than 60 minutes -4 Others -9
67. After how long did the Doctor on duty come and check the patient?
- Less than 30 minutes -1 Between 30 to 60 minute -2
Between 60 to 120 minutes -3 More than 120 minutes -4 Others -9
68. Was the patient asked to get any diagnostic test or medicine from outside?
- Yes -1 No -2
69. Were the beneficiary asked to pay by themselves for any such tests or medicines obtained from outside?
- Yes -1 No -2
70. If yes, why?
- Hospital staff said it was not a part of the RSBY package -1
Hospital did not have sufficient facility -2
Hospital paid cash to the patient later -3
Hospital did not have sufficient fund -4
71. Was the patient provided with food during stay at the hospital?
- Yes -1 No -2

72. If no, why?

Hospital staff said it was not a part of the RSBY package - 1

Hospital did not have food serving facility - 2

Hospital paid cash to the patient to buy food - 3

Hospital staff said they have no sufficient fund - 4

73. What was the quality of food?

Very Good -1 Good -2 Average -3 Bad -4 Very Bad -5

74. Expenditure for treatment during Stay at Hospital (Rs.)

Item of expenditure		Amount (from own pocket)(In Rupees)
Doctor's/ surgeon's fee	Hospital staff	
	Other specialists	
Medicines	From hospital	
	From outside	
Diagnostic tests		
Bed charges		
Attendant charges		
Physiotherapy		
Personal medical appliances		
Others	Blood, oxygen cylinder etc.	
	Services (ambulance etc.)	
Total		

Details on discharge

75. Was the fingerprint verification done at the time of discharge?

Yes -1 No -2

76. If no, then why fingerprint verification was not done at the time of discharge?

Hospital did not ask for it -1 Hospital said it is not necessary -2

Hospital said they did not know about this -3

Machine was not working -4 Don't know -5 Others -9

77. Whose fingerprint was taken?

Patient -1 Family member -2

78. Did you get the card back on the day of discharge?
Yes -1 No -2
79. If no, after how many days you got it back?
Less than 5 days -1 5-10 days -2 10-15 days -3 More than 15 days 4
80. What was the reason for holding back the card?
Staff wanted money for returning the card -1
Staff wanted to keep the card till insurance claims were settled -2
Staff said the card will stay deposited at the hospital -3 Others -9
81. Was the patient prescribed any medicines after the discharge?
Yes -1 No -2
82. If yes, for how many days the medicines needed to be taken after discharge?
1 -1 2 -2 3 -3 4 -4 5 -5 More than 5 -6
83. Were these medicines provided by the hospital?
Yes -1 No -2
84. If not, was any reason cited by the hospital for not providing the medicines?
Did not asked -1 No reason provided -2
It is not part of RSBY -3 Others -9
85. Was the patient prescribed any tests after discharge?
Yes -1 No -2
86. Within how many days of discharge those tests were supposed to be done?
1 -1 2 -2 3 -3 4 -4 5 -5 More than 5 -5
87. Were facilities for those tests organized by the hospital free of cost?
Yes -1 No -2
88. Was any reason cited by the hospital for not providing the facility of free test?
Did not asked -1 No reason provided -2
It is not part of RSBY -3 Others -9

89. What is the present health status of patient?

Has improved completely -1 Has died -2
No improvement -3 Partially improved -4

90. For how many days patient was admitted?

Less than 5 days -1 5-10 days -2
10-15 days -3 More than 15 days -4

Patient Satisfaction

91. Were all your patient related queries answered during your visit to hospital for treatment under RSBY-CHIS?

Fully answered -1 Not answered -2 Partially answered -3

92. How would you rate your satisfaction about the treatment provided at the hospital?

Very good -1 Good -2 Average -3 Poor -4 Very poor -5

93. Where would you have gone if scheme had not been there?

To the same hospital -1 To any other private hospital -2
To government hospital -3 Nowhere -4 Don't know -5 Others -9

94. Will you recommend your relatives/friends to take treatment under the scheme?

Yes -1 No -2

95. If no, Why?

Treated badly -1 Poor quality care -2 Not receptive to RSBY-CHIS patients -3
There is no sufficient money in the RSBY-CHIS card -4
Poor implementation of the scheme -5

96. Are you satisfied with your present insurance scheme?

Very much satisfied -1 Satisfied -2 Average -3
Dissatisfied -4 Very much Dissatisfied-5

97. If you are dissatisfied, state the reason.

- Less coverage -1 Inaccessibility to health services -2
Poor service -3 Attitude of staff -4 Any other reason -5

98. Do you think the present system of health insurance need a betterment in the following aspects? (Rank them in the order of preference)

1. Reduction in premium 2. Empanelment of more hospitals
3. Increasing the sum assured 4. Including more family members
5 Attitude of staff

99. What are the patient's suggestions for improving the scheme?

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.....
.....

Thank You

.....*DGR*.....

Medical/Surgical Package Rates fixed for the year 2010-11

PROVISIONAL / SUGGESTED LIST FOR MEDICAL AND SURGICAL INTERVENTIONS / PROCEDURES IN GENERAL WARD FOR WHICH PACKAGE RATES MAY BE FIXED

These package rates will include bed charges (General ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray, Scan, MRI Scan and Any other modern diagnostic methods, Food to patient etc. Expenses incurred for diagnostic test and medicines upto 1 day before the admission of the patient and cost of diagnostic test and medicine upto 5 days of the discharge from the hospital for the same ailment/surgery will also be the part of package. The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre-hospitalisation) to his discharge from hospital and 5 days after discharge, and any complication while in hospital, making the transaction truly cashless to the patient. Transportation charge of Rs.100 at the time of discharge (subject to a limit of Rs.1000 per annum) will be extra.

Medical (Non-surgical) hospitalisation procedures means Bacterial meningitis, Bronchitis- Bacterial/Viral, Chicken pox, Dengue fever, Diphtheria, Dysentery, Epilepsy, Filariasis, Food poisoning, Hepatitis, Malaria, Measles, Meningitis, Plague, Pneumonia, Septicemia, Tuberculosis (Extra pulmonary, pulmonary etc), Tetanus, Typhoid, Viral fever, Urinary tract infection, Lower respiratory tract infection and other such procedures requiring hospitalisation etc.

<p>(i). NON-SURGICAL(Medical) TREATMENT IN GENERAL WARD</p> <p>These package rates will include bed charges (General ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Medicines and Drugs, X-Ray, Scan, MRI Scan and Any other modern diagnostic methods, Food to patient etc. Expenses incurred for diagnostic test and medicines upto 1 day before the admission of the patient and cost of diagnostic test and medicine upto 5 days of the discharge from the hospital for the same ailment / surgery will also be the part of package. The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre-hospitalisation) to his discharge from</p>	<p>Maximum upto Rs. 500/- per day</p>
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<p>hospital and 5 days after discharge, food to patient and any complication while in hospital, making the transaction truly cashless to the patient. Transportation charge of Rs.100 at the time of discharge (subject to a limit of Rs.1000 per annum) will be extra.</p>	
<p>(ii) IF ADMITTED IN ICU: This includes bed charges (general ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Medicines and Drugs, X-Ray, Scan and Diagnostic Tests, food to patient etc. during stay in I.C.U.</p>	<p>Maximum upto Rs. 1000/- per day</p>
<p>(iii) SURGICAL PROCEDURES IN GENERAL WARD (NOT SPECIFIED IN PACKAGE IV): This includes bed charges (General ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray, Scan, MRI Scan and Any other modern diagnostic methods, Food to patient etc. Expenses incurred for diagnostic test and medicines upto 1 day before the admission of the patient and cost of diagnostic test and medicine upto 5 days of the discharge from the hospital for the same ailment/surgery will also be the part of package. The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre hospitalisation) to his discharge from hospital and 5 days after discharge, food to patient and any complication while in hospital, making the transaction truly cashless to the patient. Transportation charge of Rs.100 at the time of discharge (subject to a limit of Rs.1000 per annum) will be extra.</p>	<p>To be negotiated with Insurer before carrying out the procedure</p>
<p>(iv) SURGICAL PROCEDURES IN GENERAL WARD (SPECIFIED IN PACKAGE IV): This includes bed charges (General ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees etc, Anesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances etc, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray, Scan, MRI Scan and Any other modern diagnostic methods, etc, Food to patient etc. Expenses incurred for diagnostic test and medicines upto 1 day before the admission of the patient and cost of diagnostic test and medicine upto 5 days of the discharge from the hospital for the same ailment/surgery will also be the part of package.</p>	<p>Refer IV below.</p>

<p>The package should cover the entire cost of treatment of the patient from date of reporting (1 day Pre-hospitalisation) to his discharge from hospital and 5 days after discharge, food to patient and any complication while in hospital, making the transaction truly cashless to the patient. Transportation charge of Rs.100 at the time of discharge (subject to a limit of Rs.1000 per annum) will be extra.</p>	
<p>(V) Maternity benefit Package: These package will include Bed charges (General Ward), Nursing and Boarding charges, Surgeons, Anesthetists, Medical Practitioner and Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges and Cost of Surgical Appliances etc, Medicines and Drugs, X-Ray, Scan, MRI Scan and Any other modern diagnostic methods, etc, Food to patient etc. Expenses incurred for diagnostic test and medicines up to 1 day before the admission of the patient and cost of diagnostic test and medicine up to 5 days of the discharge from the hospital for the same ailment/surgery and food to patient will also be the part of package. The new-born child shall also be given treatment as per the provisions given under para 5 (f) of the tender document. The package should cover the entire cost of treatment of the patients from date of reporting to his discharge from hospital and 5 days after discharge and any complication while in hospital, making the transaction truly cashless to the patient. Transportation charge of Rs.100 at the time of discharge (subject to a limit of Rs.1000 per annum) will be extra.</p>	<p>Normal Delivery Rs. 2500/-</p> <p>Caesarian Section/ Complicated Rs.4500/-</p>

IPD & DAY CARE PROCEDURES				
			COST	DAYS
DENTAL				D-DayCare
1	1	Fistulectomy	8000	1
2	2	Fixation of fracture of jaw	10000	2
3	3	Sequestrectomy	10000	1
4	4	Tumour excision	5000	2
5	5	Extraction of tooth including LA	100	D
6	6	Complicated extraction of tooth including LA	200	D
7	7	Flap operation per tooth	150	D
8	8	Gingivectomy per tooth	150	D
9	9	Cyst under LA (Small)	200	D
10	10	Cyst under LA (Large)	300	D

Annexure 2

11	11	Apisectomy including LA	450	D
12	12	Fracture wiring including LA	600	D
13	13	Infra oral x-ray	50	D
		EAR		
14	1	Aural polypectomy	10000	1
15	2	Decompression sac	9000	2
16	3	Fenestration	7000	2
17	4	Labyrinthectomy	7000	2
18	5	Mastoidectomy cortcol module radical	7000	3
19	6	Mastoidectomy with tympanoplasty	9000	2
20	7	Mastoidectomy	6000	2
21	8	Mastoidectomy With Myringoplasty	9000	2
22	9	Myringoplasty	6000	2
23	10	Myringoplasty with ossiculoplasty	9000	2
24	11	Myringotomy - Bilateral	4500	2
25	12	Myringotomy - Unilateral	2500	2
26	13	Myringotomy with grommet - One ear	2500	2
27	14	Myringotomy with grommet - Both ear	4000	2
28	15	Ossiculoplasty	6000	2
29	16	Partial amputation pinna	1 000	1
30	17	Preauricular sinus	6000	2
31	18	Stapedectomy	6500	2
32	19	Vidian neurectomy - Micro	7000	3
33	20	Tympanoplasty	7000	5
		NOSE		
34	1	Ant. Ethmoidal artery ligation	12000	3
35	2	Antrostomy - Bilateral	6000	3
36	3	Antrostomy - Unilateral	4000	3
37	4	Caldwell - luc - Bilateral	6000	2
38	5	Caldwell - luc- Unilateral	4500	2
39	6	Cryosurgery	7000	2
40	7	Rhinorrhoea - repair	5000	1
41	8	Endoscopic Dacryocystorhinostomy (DCR)	9000	1
42	9	Endoscopic septoplasty	8500	1
43	10	Ethmoidectomy - External	5000	2
44	11	Fracture reduction nose with septal correction	6500	1
45	12	Fracture setting maxilla	8500	1
46	13	Fracture setting nasal bone	4000	1
47	14	Functional endoscopic sinus (FESS)	6000	1
48	15	Intra nasal ethmoidectomy	7000	2
49	16	Rhinotomy - Lateral	8500	2
50	17	Nasal polypectomy - Bilateral	5000	1
51	18	Nasal polypectomy - Unilateral	3000	1

Medical Surgical Package Rates fixed for the year 2010-11

52	19	Turbinectomy Partial - Bilateral	7000	3
53	20	Turbinectomy Partial - Unilateral	4500	3
54	21	Radical fronto ethmo sphenodectomy	15000	5
55	22	Rhinoplasty	12000	3
56	23	Septoplasty	5500	2
57	24	Sinus antroscopy	3000	1
58	25	Submucos resection	4000	1
59	26	Trans antral ethmoidectomy	6000	2
60	27	Youngs operation	5500	2
		THROAT		
61	1	Adeno tonsillectomy	6000	1
62	2	Adenoidectomy	4000	1
63	3	Arytenoidectomy	15000	2
64	4	Choanal atresia	10000	2
65	5	Retro pharyngeal abscess - Drainage	4 000	1
66	6	Pharyngeal diverticulum's - Excision	12 000	2
67	7	Laryngectomy	12 000	2
68	8	Maxilla - Excision	10 000	1
69	9	Oro antral fistula	10000	2
70	10	Parapharyngeal - Explorationy	10000	2
71	11	Parapharyngeal -Tumour excision	15000	3
72	12	Parapharyngeal abscess - Drainage	15000	2
73	13	Pharyngo plasty	12000	2
74	14	Release of tongue tie	3000	1
75	15	Retropharyngeal abscess drainage	7000	1
76	16	Styloidectomy - Both side	10000	3
77	17	Styloidectomy - One side	8000	3
78	18	Superficial parotidectomy	10000	3
79	19	Thyroglossal cyst - Excision	8000	2
80	20	Thyroglossal fistula - Excision	8000	3
81	21	Tonsillectomy - Bilateral	7000	1
82	22	Tonsillectomy - Unilateral	5500	1
83	23	Total parotidectomy	15000	2
84	24	Uvulophanyngo plasty	10000	2
		EYE		
85	25	Syringing of lachrymal sac for one eye	50	D
86	26	Chalazion operation both eyes	300	D
87	27	Foreign body removal	150	D
88	28	Refraction / Fundoscopy	50	D
89	29	A - scan	150	D
90	30	Tomography	350	D
91	31	Syringing and probing	450	D
92	32	Cateract with 10 L	6300	D

GENERAL				
93	1	Abdomino perineal resection	10 000	3
94	2	Addventitious Burse - Excission	7000	3
95	3	Anterior resection for CA	10 000	5
96	4	Appendicectomy	6 000	2
97	5	Appendicular abscess - Drainage	7 000	2
98	6	Arteriovenous (AV) Malformation of Soft Tissue Tumour - Excision	7000	3
99	7	Axcillary Lymphnode - Excission	2500	1
100	8	Bakers cyst - Excision	5000	3
101	9	Bilateral inguinal block dissection	13 000	3
102	10	Bleeding ulcer - Gastrectomy & vagotomy	17 000	5
103	11	Bleeding ulcer - Partial gastrectomy	15 000	5
104	12	Block dissection cervical nodes	9 000	3
105	13	Branchial fistula	13000	3
106	14	Breast - Excission	7000	3
107	15	Breast Lump - Left - Excission	5000	2
108	16	Breast Lump - Right - Excission	5000	2
109	17	Breast Mass - Excission	5000	2
110	18	Bronchial cyst	5 000	3
111	19	Bursa - Excission	7000	3
112	20	Bypass - Inoprablaca of pancreas	13 000	5
113	21	Caecopexy	13 000	3
114	22	Carbuncle back	3 500	1
115	23	Cavernostomy	13 000	5
116	24	Cervial Lymphnodes - Excission	2500	2
117	25	Cholecystostomy	10 000	5
118	26	Cholecystectomy & exploration	12 000	3
119	27	Colocystoplasty	15 000	5
120	28	Colostomy	10 000	5
121	29	Commando operation	15 000	5
122	30	Corn - Large - Excission	500	D
123	31	Cyst over Scrotum - Excission	4000	1
124	32	Cystic Mass - Excission	2000	1
125	33	Dermoid Cyst - Small - Excission	1000	D
126	34	Dermoid Cyst - Large - Excission	2500	D
127	35	Distal Pancreatectomy with Pancreatico Jejunostomy	17000	7
128	36	Diverticulectomy	15 000	3
129	37	Dorsal Slit and Reduction of Paraphimosis	1000	D
130	38	Drainage of ischio rectal abscess	4 000	1
131	39	Drainage of large abscess	2 000	D
132	40	Drainage of peripherally gastric abscess	8 000	3
133	41	Drainage of psoas abscess	3 000	1
134	42	Drainage of subdiaphragmatic abscess	8 000	3

Medical Surgical Package Rates fixed for the year 2010-11

135	43	Drainage pericardial effusion	11 000	7
136	44	Duodenal diverticulum	15 000	5
137	45	Duodenal jejunostomy	15 000	5
138	46	Duodenectomy	20000	7
139	47	Dupcryptren's	13000	7
140	48	Duplication of intestine	17 000	10
141	49	Epidymal Cyst	5500	2
142	50	Epidedectomy	8 000	3
143	51	Epididymal Swelling -Excission	5500	2
144	52	Epidymal Cyst	3000	1
145	53	Evacuation of Scrotal Hematoma	5000	2
146	54	Excision benign tumor -Small intestine	15 000	5
147	55	Excision bronchial sinus	4 000	D
148	56	Excision of liver abscess	13 000	3
149	57	Excision filarial scrotum	7 000	3
150	58	Excision mammary fistula	5 500	2
151	59	Excision meckel's diverticulum	10 000	3
152	60	Excision pilonidal sinus	5 500	1
153	61	Excision small intestinal fistulla	12 000	5
154	62	Excision submandibular gland	10000	5
155	63	Excission of Small Growth from Tongue	1500	D
156	64	Excission of Large Growth from Tongue	5000	3
157	65	Excission of Swelling in Right Cervial Region	4000	1
158	66	Excission of Small Swelling in Hand	1500	D
159	67	Excission of Large Swelling in Hand	2500	D
160	68	Excission under Neurofibroma	7000	3
161	69	Excission of siniuds and curetage	7000	2
162	70	Facial decompression	15000	5
163	71	Fibro Lipoma of Right Sided Spermatic with Lord Excission	2500	1
164	72	Fibroadenoma - Bilateral	5000	2
165	73	Fibrodenna - Unilateral	2500	1
166	74	Fibroma - Excission	4000	1
167	75	Fissurectomy	7 000	2
168	76	Fissurectomy with Eversion of Sac - Bilateral	7000	2
169	77	Fissurectomy and Haemorrhoidectomy	9000	2
170	78	Fissurectomy with Sphincterotomy	9000	2
171	79	Fistula Repair	5000	2
172	80	Fistulectomy	7 500	2
173	81	Foreign Body Removal in Deep Region	5000	1
174	82	Fulguration	5000	1
175	83	Fundoplication	9000	3
176	84	G J Vagotomy	10000	5
177	85	Vagotomy	7000	3
178	86	Ganglion - large - Excission	3000	1
179	87	Ganglion (Dorsum of Both Wrist) - Excission	4000	1

Annexure 2

180	88	Ganglion - Small - Excision	600	D
181	89	Gastro jejunal ulcer	10 000	5
182	90	Gastro jejuno colic fistula	10 000	5
183	91	Gastrojejunosotomy	10 000	5
184	92	Gastrotomy	12 000	7
185	93	Graham's operation	10 000	5
186	94	Granuloma - Excision	4000	1
187	95	Growth - Excision	1200	D
188	96	Haemangioma - Excision	7000	3
189	97	Haemorrhage of small intestine	10 000	3
190	98	Hemi glossectomy	10 000	3
191	99	Hemi mandibulectomy	10 000	3
192	100	Hemicolectomy	12 000	5
193	101	Hemithyroplasty	12000	3
194	102	Hepatic resection (lobectomy)	15 000	7
195	103	Hernia Epigastric	7 000	3
196	104	Hernia Incisional	7 000	3
197	105	Hernia repair & release of obstruction	7000	3
198	106	Hernia - Umbilical	7 000	3
199	107	Hernia - Ventral - lipectomy/incisional	7 000	3
200	108	Hernia - Femoral	7 000	3
201	109	Hernioplasty	7 000	3
202	110	Herniorraphy and Hydrocelectomy Sac Excision	7000	3
203	111	Hernia - Hiatus	7 000	3
204	112	Hydatid cyst of liver	10 000	3
205	113	Hydrocele Sac of Both Sides - Excision	5000	2
206	114	Hydrocelectomy - Excision	4000	2
207	115	Hydrocelectomy+Hernioplasty - Excision	7000	3
208	116	Hydrocele - Excision - Unilateral	3000	2
209	117	Hydrocele - Excision - Bilateral	5500	2
210	118	Ileio signoidostomy	13 000	5
211	119	Infected Bunion Foot - Excision	4000	1
212	120	Inguinal node (bulk dissection) axial	7 000	2
213	121	Intestinal perforation	9 000	6
214	122	Intestinal Obstruction	9 000	6
215	123	Intussusception	10 000	7
216	124	Jejunostomy	10 000	6
217	125	Closure of Perforation	7000	5
218	126	Cysto reductive surgery	7000	3
219	127	Gastric Perforation	10000	6
220	128	Intestinal Perforation (Resection Anastomosis)	9000	5
221	129	Appendicular Perforation	7000	5
222	130	Burst Abdomen Obstruction	11000	7
223	131	Closure of Hollow Viscus Perforation	9000	5
224	132	Laryngectomy & pharyngeal diverticulum	10000	3

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225	133	Pharyngeal diverticulum	6500	2
226	134	Laryngectomy with block dissection	12000	3
227	135	Laryngo fissure	10000	3
228	136	Laryngopharangeotomy	12 000	3
229	137	Ileostomy	10 000	7
230	138	Lipoma	2 000	D
231	139	Loop colostomy sigmoid	12 000	5
232	140	Lords procedure (haemorrhoids)	5 000	2
233	141	Lumpectomy - Excission	4000	1
234	142	Mastectomy	9 000	2
235	143	Mesenteric cyst - Excision	9 000	3
236	144	Mesenteric caval anastomosis	10 000	5
237	145	Micro-laryngoscopic surgery	10000	3
238	146	Oesophagoscopy for foreign body removal	6000	D
239	147	Oesophagectomy	8 500	5
240	148	Oesophagus portal hypertension	12 000	5
241	149	Pelvic abscess - Open drainage	8 000	5
242	150	Orchidectomy	5 500	1
243	151	Orchidectomy + Herniorrhaphy	7000	2
244	152	Orchidopexy	6 000	5
245	153	Orchidopexy with Circumssion	6500	5
246	154	Orchidopexy With Eversion of Sac	7000	5
247	155	Orchidopexy with Herniotomy	8500	5
248	156	Orchitis	6000	2
249	157	Pancreaticoduodenectomy	11 000	6
250	158	Papilloma Rectum - Excission	3500	2
251	159	Parapharyngeal Tumor - Excission	5000	2
252	160	Phyiomatous Growth in the Scalp - Excission	2500	1
253	161	Porto caval anastomosis	12 000	5
254	162	Pyloroplasty	11 000	5
255	163	Radical mastectomy	9 000	2
256	164	Radical Neck Dissection - Excission	15000	6
257	165	Hernia - Spigelion	7 000	3
258	166	Rectal dilation	3 000	1
259	167	Prolapse of Rectal Mass - Excission	5500	2
260	168	Rectal polyp	3 000	1
261	169	Rectopexy	10 000	3
262	170	Repair of common bile duct	10 000	3
263	171	Resection anastomosis (Large Intestine)	15 000	8
264	172	Resection anastomosis (Small Intestine)	15 000	8
265	173	Retroperitoneal Tumor - Excission	9000	5
266	174	Sebaceous Cyst Infected - Excission	1200	D
267	175	Salivary Gland - Excission	7000	3
268	176	Sebaceous Cyst - Excission	1200	D
269	177	Segmental resection of breast	10 000	2
270	178	Scrotal Swelling (Multiple) - Excission	5500	2

Annexure 2

271	179	Sigmoid diverticulum	15 000	7
272	180	Simple closure - Peptic perforation	11 000	6
273	181	Sinus - Excission	5000	1
274	182	Soft Tissue Tumor - Excission	4000	1
275	183	Spindle Cell Tumor - Excission	7000	3
276	184	Splenectomy	23 000	10
277	185	Submandibular Lymphs - Excission	4500	2
278	186	Submandibular Mass Excission + Reconstruction	15000	5
279	187	Submandibular salivary gland -Removal	9 500	5
280	188	Superficial parodectomy	12 500	5
281	189	Sweeling in Rt and Lt Foot - Excission	2400	1
282	190	Sweling Over Scapullar Region	4000	1
283	191	Terminal colostomy	12 000	5
284	192	Thyroplasty	11000	5
285	193	Coloectomy - Total	15 000	6
286	194	Cystectomy - Total	10 000	6
287	195	Glossectomy - Total	15 000	7
288	196	Pharyngectomy & reconstruction - Total	13 000	6
289	197	Tracheal stenosis (End to end anastamosis)	15000	6
290	198	Tracheoplasty	15000	6
291	199	Tranverse colostomy	10 000	5
292	200	Umbilical Sinus - Excission	5000	2
293	201	Vagotomy & drainage	12 000	5
294	202	Vagotomy & pyloroplasty	15 000	6
295	203	Varicose Veins - Excission and Ligation	7000	3
296	204	Vasco vasostomy	11 000	3
297	205	Volvlous of large bowel	12 000	4
298	206	Warren's shunt	15 000	6
		GYNAECOLOGY		
299	1	Abdomonal open for stress incision	9000	5
300	2	Bartholin abscess I & D	1500	D
301	3	Bartholin cyst removal	1500	D
302	4	Cervical ppolypctomy	3000	1
303	5	Cyst labial	1000	D
304	6	Cyst vaginal enucleation	1500	D
305	7	Ovarian cystectomy	3000	1
306	8	Cystocele - Anterior repair	7000	2
307	9	D&C (Dilatation & curretage)	2500	D
308	10	Electro cauterisation cryo surgery	2500	D
309	11	Fractional curretage	2500	D
310	12	Gilliams operation	6000	2
311	13	Haemato colpo/excision - Vaginal septum	3000	D
312	14	Hymenectomy & repair of hymen	5000	D
313	15	Hysterectomy - abdominal	10000	5

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314	16	Hysterectomy - Vaginal	10000	5
315	17	Hysterectomy - Wertheims operation	10000	5
316	18	Hysterotomy -Tumors removal	10000	5
317	19	Myomectomy - Abdominal	10000	5
318	20	Ovarectomy	7000	3
319	21	Perineal tear repair	1500	D
320	22	Prolapse uterus -L forts	9000	4
321	23	Prolapse uterus - Manchester	9000	4
322	24	Retro vaginal fistula repair	7000	3
323	25	Salpingoophrectomy	5000	2
324	26	Tuboplasty	5000	2
325	27	Vaginal tear repair	2500	D
326	28	Vulvectomy	4000	1
327	29	Vulvectomy - Radical	3500	1
328	30	Vulval tumors removal	5000	2
		ENDOSCOPIC PROCEDURES		
329	1	Ablation of endometriotic spot	5000	D
330	2	Adenolysis	7000	D
331	3	Appendectomy	11 000	1
332	4	Cholecystectomy	10 000	1
333	5	Cholecystectomy and Drainage of Lever abscess	14200	1
334	6	Cholecystectomy with Excision of TO Mass	15000	1
335	7	Cyst aspiration	1000	D
336	8	Endometria to endometria anastomosis	7000	1
337	9	Fimbriolysis	5000	1
338	10	Hemicolectomy	10 000	1
339	11	Hysterectomy with bilateral salpingo operectomy	7000	1
340	12	Incisional hernia - Repair	7 000	1
341	13	Inguinal hernia - Bilateral	10 000	2
342	14	Inguinal hernia - Unilateral	7 000	2
343	15	Intestinal resection	10 000	3
344	16	Myomectomy	7000	1
345	17	Oophrectomy	5000	1
346	18	Ovarian cystectomy	3000	D
347	19	Perotomies	9000	5
348	20	Salpingo ophrectomy	7000	1
349	21	Salpingostomy	6000	1
350	22	Uterine septum	5000	D
351	23	Varicocele - Bilateral	11 000	1
352	24	Varicocele - Unilateral	9 000	1
353	25	Repair of ureterocele - Endoscopy	13 000	3

HYSTEROSCOPIC				
354	1	Ablation of endometrium	7 000	D
355	2	Hysteroscopic tubal cannulation	7 500	D
356	3	Polypectomy	7 000	D
357	4	Uterine synechia - Cutting	5 000	D
NEUROSURGERY				
358	1	Anneurysm	17 000	10
359	2	Anterior encephalocele	23 000	10
360	3	Burr hole	15 000	8
361	4	Carotid endartrectomy	15 000	10
362	5	Carpal tunnel release	11 000	5
363	6	Cervical ribs - Bilateral	13 000	7
364	7	Cervical ribs - Unilateral	10 000	5
365	8	Cranio ventricular	14 000	9
366	9	Cranioplasty	10 000	7
367	10	Craniostenosis	15 000	7
368	11	Cerebrospinal fluid (CSF) rhinorrohea	10 000	3
369	12	Duroplasty	9 000	5
370	13	Haematoma (Child irritable subdural)	15 000	10
371	14	Haematoma - Brain (hypertensive)	15 000	9
372	15	Haematoma - Brain (head injuries)	15 000	9
373	16	Laminectomy with fusion	13 000	6
374	17	Local neurectomy	11 000	6
375	18	Lumbar disc	10 000	5
376	19	Meningocele - Anterior	20 000	10
377	20	Meningocele - Lumbar	15 000	8
378	21	Meningococle - Occipital	20 000	10
379	22	Microdiscectomy - Cervical	15 000	10
380	23	Microdiscectomy - Lumbar	15 000	10
381	24	Neurolysis	15 000	8
382	25	Peripheral nerve surgery	12 000	7
383	26	Posterior fossa - Decompression	15 000	8
384	27	Repair & Transposition Nerve	6500	3
385	28	Brachial Plexus - Repair	15000	7
386	29	Spina Bifida - Large - Repair	22000	10
387	30	Spina Bifida - Small - Repair	18000	10
388	31	Shunt	12 000	7
389	32	Skull traction	8 000	5
390	33	Spine - Anterior decompression	18 000	8
391	34	Spine - Canal stenosis	14 000	6
392	35	Spine - Decompression & fusion	17 000	6
393	36	Spine - Disc cervical/lumbar	15 000	6
394	37	Spine - Extradural tumour	14 000	7
395	38	Spine - Intradural tumour	14 000	7

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396	39	Spine - Intramedullar tumours	15 000	7
397	40	Subdural aspiration	8 000	3
398	41	Temporal rhizotomy	12 000	5
399	42	Trans sphenoidal	15 000	6
400	43	Tumours - Supratentorial	18 000	7
401	44	Tumours meninges - Gocussa	18 000	7
402	45	Tumours meninges - Posterior	18 000	7
403	46	Vagotomy with Gastrojejunostomy	15000	6
404	47	Vagotomy with Pyeloplasty	15000	6
405	48	Vagotomy: Highly Selective	12000	5
406	49	Vagotomy - Selective	12000	5
407	50	Ventricular puncture	8 000	3
		OPHTHALMOLOGY		
408	1	Abscess drainage of lid	500	D
409	2	Anterior chamber reconstruction	7 000	3
410	3	Buckle removal	7 500	2
411	4	Canaliculo dacrocystro rhinostomy	4 000	1
412	5	Capsulotomy	2 000	1
413	6	Cataract - Bilateral	5 000	D
414	7	Cataract - Unilateral	3 500	D
415	8	Corneal grafting	4 000	D
416	9	Cryoretinopexy - Closed	5 000	1
417	10	Cryoretinopexy - Open	6 000	1
418	11	Cyclocryotherapy	3 500	D
419	12	Cyst	1 000	D
420	13	Dacrocystectomy With Pterygium - Excission	6500	D
421	14	Dacrocystro rhinostomy	5 000	D
422	15	Dacryocystectomy	5 000	D
423	16	Endoscopic optic nerve decompression	8000	D
424	17	Endoscopic optic orbital decompression	8000	D
425	18	Enucleation	2 000	1
426	19	Enucleation with implant	3 500	1
427	20	Excentration	3 500	D
428	21	Extropion correction	3 000	D
429	22	Glaucoma surgery (trabeculectomy)	7 000	2
430	23	Intraocular foreign body removal	3 000	D
431	24	Keratoplasty	6 000	1
432	25	Lensectomy	2 500	D
433	26	Limbal dermoid removal	2 500	D
434	27	Membranectomy	6 000	D
435	28	Perforating corneo - Scleral injury	5 000	2
436	29	Pterygium (Day care)	1 000	D
437	30	Ptosis	2 000	D
438	31	Radical keratotomy	5 000	1
439	32	IRIS prolapse - Repair	5 000	2

Annexure 2

440	33	Retinal detachment surgery	10 000	2
441	34	Small tumour of lid - Excision	500	D
442	35	Socket reconstruction	6 000	3
443	36	Trabeculectomy - Right	5000	D
444	37	Tridectomy	1800	D
445	39	Tumours of IRIS	4 000	2
446	40	Vitrectomy	4 500	2
447	41	Vitrectomy + Retinal Detachment	20000	3
		ORTHOPAEDIC		
448	1	Acromion reconstruction	20 000	10
449	2	Accessory bone - Excision	12 000	3
450	3	Amputation - Upper Fore Arm	15000	5
451	4	Amputaion - Index Fingure	1000	1
452	5	Amputation - Forearm	18000	5
453	6	Amputation - Wrist Axcillary Node Disection	12000	4
454	7	Amputation - 2nd and 3rd Toe	2000	1
455	8	Amputation - 2nd Toe	1000	1
456	9	Amputation - 3rd and 4th Toes	2000	1
457	10	Amputation - 4th and 5th Toes	2000	1
458	11	Amputation - Ankle	12000	5
459	12	Amputation - Arm	18000	6
460	13	Amputation - Digits	3500	1
461	14	Amputation - Fifth Toe	1000	1
462	15	Amputation - Foot	18000	5
463	16	Amputation - Forefoot	15000	5
464	17	Amputation - Great Toe	1000	1
465	18	Amputation - Wrist	12000	5
466	19	Amputation - Leg	20000	7
467	20	Amputation - part of Toe and Fixation of K Wire	12000	5
468	21	Amputation - Thigh	18000	7
469	22	Anterior & posterior spine fixation	25 000	6
470	23	Arthroplasty - Excission	8000	3
471	24	Arthorotomy	15 000	7
472	25	Arthrodesis ankle triple	16 000	7
473	26	Arthroplasty (joints) - Excision	13 000	3
474	27	Arthroplasty of Femurhead - Excission	18000	7
475	28	Bimalleolar fracture fixation	12 000	6
476	29	Bone Tumour and Reconstruction -Major - Excission	13000	6
477	30	Bone Tumour and Reconstruction - Minor - Excission	10000	4
478	31	Calcaneal Spur - Excission of Both	9000	3
479	32	Clavicle surgery	15 000	5
480	33	Close fixation - hand bones	7 000	3

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481	34	Close fixation - foot bones	6 500	2
482	35	Close Reduction - Small joints	3500	1
483	36	Closed interlock nailing+Bone Grafting	12000	2
484	37	Closed Interlocking Intermedullary	12000	2
485	38	Closed Interlocking Tibia + Orif of Fracture Fixation	12000	3
486	39	Closed Reduction and Internal Fixation	12000	3
487	40	Closed reduction and internal fixation with K wire	12000	3
488	41	Closed reduction and Percutaneous screw Fixation	8000	3
489	42	Closed Reduction and Percutaneous Pinning	8000	3
490	43	Closed Reduction and Pertenopus Nailing	8000	3
491	44	Closed reduction and Proceed to Posterior Stabilization	16000	5
492	45	Debridement & closure - Major	5 000	3
493	46	Debridement & closure - Minor	3 000	1
494	47	Decompression and Spinal Fixation	16000	5
495	48	Decompression and Stabilization with Steffiplat	16000	6
496	49	Decompression L5 S1 Fusion with Posterior Stabalization	16000	6
497	50	Decompression of Carpal Tunnel Syndrome	4500	2
498	51	Decompression Posteier D12+L1	12000	5
499	52	Decompression Stabilization and Laminectomy	16000	5
500	53	Dislocation - Elbow	1 000	D
501	54	Dislocation - Shoulder	1 000	D
502	55	Dislocation- Hip	1 000	1
503	56	Dislocation - Knee	1 000	1
504	57	Drinage of abscess cold	1 000	D
505	58	Dupuytren contracture	12000	6
506	59	Epiphysial stimulation	10 000	3
507	60	Exostosis - Small bones -Excission	5500	2
508	61	Exostosis - Femur - Excission	15000	7
509	62	Exostosis - Humerus - Excission	15000	7
510	63	Exostosis - Radius - Excission	12000	6
511	64	Exostosis - Ulna - Excission	12000	6
512	65	Exostosis - Tibia- Excission	12000	6
513	66	Exostosis - Fibula - Excission	12000	6
514	67	Exostosis - Patella - Excission	12000	6
515	68	Exploration and Ulnar Repair	9500	5
516	69	External fixation - Long bone	13 000	4
517	70	External fixation - Small bone	11 500	2
518	71	External fixation - Pelvis	15 000	5
519	72	Fasciotomy	12 000	2

Annexure 2

520	73	Fixater with joint arthrolysis	18 000	9
521	74	Fracture - Acetabulam	18 000	9
522	75	Fracture - Femoral neck - MUA & Internal Fixation	18000	7
523	76	Fracture - Femoral Neck open reduction & Nailing	15000	7
524	77	Fracture - Fibula Internal Fixation	15000	7
525	78	Fracture - Hip Internal Fixation	15000	7
526	79	Fracture - Humerous Internal Fixation	13000	2
527	80	Fracture - Olecranon of ulna	9 500	2
528	81	Fracture - Radius Internal Fixation	9 500	2
529	82	Fracture - TIBIA Internal Fixation	10500	4
530	83	Fracture - Fibula Internal Fixation	10500	4
531	84	Fracture - Ulna Internal Fixation	9500	4
532	85	Fractured Fragment Excission	5000	2
533	86	Girdle stone arthroplasty	15 000	7
534	87	Harrington instrumentation	15 000	5
535	88	Head radius - Excision	15 000	3
536	89	High tibial osteotomy	12 000	5
537	90	Hip region surgery	18 000	7
538	91	Hip Spica	4 000	D
539	92	Internal fixation lateral epicondyle	9 000	4
540	93	Internal fixation of other small bone	7 000	3
541	94	Joint reconstruction	22 000	10
542	95	Laminectomy	18 000	9
543	96	Leg lengthening	15 000	8
544	97	Llizarov fixation	15 000	6
545	98	Multiple tendon repair	12 500	5
546	99	Nerve repair surgery	14 000	6
547	100	Nerve transplant/release	13 500	5
548	101	Neurolysis	18 000	7
549	102	Open reduction internal fixation (2 small bone)	12 000	5
550	103	Open reduction internal fixation (large bone)	16 000	6
551	104	Open reduction of CDH	17 000	7
552	105	Open reduction of small joint	5 000	1
553	106	Open reduction with phemister grafting	10 000	3
554	107	Osteotomy -small bone	18 000	6
555	108	Osteotomy -long bone	21 000	8
556	109	Patellectomy	15 000	7
557	110	Pelvic fracture fixation	17 000	8
558	111	Pelvic osteotomy	22 000	10
559	112	Percutaneous fixation of fracture	10 000	6
560	113	Prepatellar Bursa and repair of MCL of Knee	15500	7
561	114	Reconstruction of ACL/PCL	19 000	7
562	115	Retrocalcanal Bursa - Excission	8000	4
563	116	Sequestrectomy of long bones	18 000	7

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564	117	Shoulder jacket	5 000	D
565	118	Sinus Over Sacrum Excission	7500	2
566	119	Skin grafting	5 000	1
567	120	Spinal fusion	22 000	10
568	121	Synovectomy	18 000	7
569	122	Synovial cyst - Excission	5000	1
570	123	Tendo achyllis tenotomy	5 000	1
571	124	Tendon grafting	18 000	3
572	125	Tendon nerve surgery of foot	2 000	1
573	126	Tendon release	2 500	1
574	127	Tenolysis	8 000	2
575	128	Tenotomy	8 000	2
576	129	Tension band wiring patella	12 500	5
577	130	Trigger thumb	2 500	D
578	131	Wound Debridment	1000	D
579	132	Application of P.O.P costs for upper and lower limbs	750	D
580	133	Application of functional cast brace	1000	D
581	134	Application of skin tractions	700	D
582	135	Application of skeletal tractions	1300	D
583	136	Bandage and straping for fractures	350	D
584	137	Aspiration and intra articular injections	400	D
585	138	Application of P.O.P spices and jackets	2100	D
586	139	Close reduction of fractures of limp and P.O.P	1700	D
587	140	Reduction of compound fractures	1700	D
		PAEDIATRIC		
588	1	Abdomino perioneal (exomphalos)	13 000	5
589	2	Anal dilatation	5 000	3
590	3	Anal transposition for ectopic anus	17 000	7
591	4	Chordee correction	10 000	5
592	5	Closure colostomy	10 000	7
593	6	Coloctomy	12000	5
594	7	Colon transplant	12 000	3
595	8	Cystolithotomy	6 000	3
596	9	Esophageal atresia (fistula)	7 000	3
597	10	Gastrostomy	12000	5
598	11	Hernia - Diaphragmatic	7 000	3
599	12	Hernia - Epigastric	7 000	3
600	13	Hernia - Umbilical	7 000	3
601	14	Hernia-inguinal - Bilateral	10 000	3
602	15	Hernia-inguinal -Unilateral	7 000	3
603	16	Mackel's diverticulectomy	7 000	3
604	17	Meniscectomy	6 000	3
605	18	Nephrolithotomy	10 000	3

606	19	Orchidopexy - Bilateral	3000	2
607	20	Orchidopexy - Unilateral)	2 000	2
608	21	Pyelolithotomy	10 000	5
609	22	Pyeloplasty	10 000	5
610	23	Pyloric stenosis (Ramsted OP)	8 000	3
611	24	Rectal polyp	3 000	2
612	25	Resection & anastomosis of intestine	17 000	7
613	26	Supra pubic drainage - Open	4 000	2
614	27	Torsion testis	10 000	5
615	28	Tracheo esophageal fistula	15 000	5
616	29	Ureterotomy	10 000	5
617	30	Urethroplasty	15 000	5
618	31	Vesicostomy	12000	5
		ENDOCRINE		
619	1	Adenoma Parathyroid - Excision	15 000	3
620	2	Adrenal Gland Tumour - Excision	9000	5
621	3	Axillary Lymphnodes - Excision	13000	3
622	4	Parotid Tumour - Excision	9000	3
623	5	Post Fossa	12000	5
624	6	Sphincterotomy	13000	5
625	7	Thyroid adenoma resection enucleation	12 000	5
626	8	Thyroidectomy - Hemi	9000	3
627	9	Thyroidectomy - Partial	10 000	3
628	10	Thyroidectomy - Total	16000	5
629	11	Total thyroidectomy & block dissection	17 000	5
630	12	Total Thyroidectomy + Reconstruction	12000	5
631	13	Trendelenburg Ligament and Stripping	9000	3
		UROLOGY		
632	1	Bladder calculi-removal	7000	1
633	2	Bladder tumour (fulguration)	2 000	1
634	3	Correction of extrophy of bladder	1 500	1
635	4	Cystolithotomy	6 000	2
636	5	Cysto gastrostomy	10 000	3
637	6	Cysto jejunostomy	10 000	3
638	7	Dormia extraction of calculus	5 000	1
639	8	Drainage of perinephric abscess	4 000	1
640	9	Drainage of psoas abscess	2 500	1
641	10	Excision of urethral carbuncle	5 000	1
642	11	Exploration of epididymus (unsuccessful vasco vasectomy)	6 000	2
643	12	Hydrocele - Bilateral	5 000	2
644	13	Hydrocele - Unilateral	2 500	2

Medical Surgical Package Rates fixed for the year 2010-11

645	14	Internal urethrotomy	7 000	3
646	15	Litholapexy	5 000	2
647	16	Lithotripsy	7500	1
648	17	Meatoplasty	2 000	1
649	18	Meatotomy	1 500	1
650	19	Neoblastoma	10 000	3
651	20	Nephrectomy	10 000	3
652	21	Nephrectomy (Renal tumour)	10 000	3
653	22	Nephro uretrectomy	10 000	3
654	23	Nephrolithotomy	15 000	3
655	24	Nephropexy	9 000	2
656	25	Nephrostomy	7 000	2
657	26	Nephrourethrotomy	11 000	3
658	27	Open resection of bladder neck	5 000	2
659	28	Operation for cyst of kidney	5 500	3
660	29	Operation for double ureter	9 000	3
661	30	Operation for ectopic ureter	9 000	3
662	31	Operation for injury of bladder	7 000	2
663	32	Partial cystectomy	11 000	3
664	33	Partial nephrectomy	13 000	3
665	34	PCNL (Percutaneous nephro lithotomy) - Biilateral	15 000	3
666	35	PCNL (Percutaneous nephro lithotomy) - Unilateral	11 000	3
667	36	Post urethral valve	4 500	1
668	37	Pyelolithotomy	9 000	2
669	38	Pyeloplasty & similar procedures	10 000	3
670	39	Radical nephrectomy	13 000	3
671	40	Reduction of paraphiornsis	1 000	D
672	41	Reimplanation of Urethra	17000	5
673	42	Reimplantation of Bladder	17000	5
674	43	Reimplantation of Ureter	17000	5
675	44	Repair of uretero vaginal fistula	8 000	2
676	45	Repair of ureterocele - Open	7 000	2
677	46	Retroperitoneal Fibrosis - Renal	15 000	5
678	47	Retropubic prostatectomy	10 000	4
679	48	Speno renal anastomosis	13 000	5
680	49	Sticture Urethra	7500	1
681	50	Suprapubic cystostomy - Open	3 500	1
682	51	Suprapubic drainage - Closed	2 000	1
683	52	Torsion testis	3 500	1
684	53	Trans vesical prostatectomy	9 000	2
685	54	Transurethral fulguration	4 000	1
686	55	TURBT (Transurethral Resection of the Bladder Tumor)	10000	3
687	56	TURP + Circumcision	10000	3
688	57	TURP + Closure of Urinary Fistula	13000	3

Annexure 2

689	58	TURP + Cystolithopexy	12000	3
690	59	TURP + Cystolithotomy	12000	3
691	60	TURP + Cystolithotripsy	12000	3
692	61	TURP + Cystoscopic Removal of Stone	12000	3
693	62	TURP + Nephrectomy	20000	3
694	63	TURP + Orchidectomy	12000	3
695	64	TURP + Suprapubic Cystolithotomy	12000	3
696	65	TURP + TURBT	15000	3
697	66	TURP + URS	14000	3
698	67	TURP + Vesicolithotripsy	12000	3
699	68	TURP + VIU	12000	3
700	69	TURP and Cystolithotripsy	12000	3
701	70	TURP with Hydrocele	12000	3
702	71	TURP With Removal of the Verical Calculi	12000	3
703	72	TURP with Repair of Urethra	12000	3
704	73	TURP with Vesicolithotomy	12000	3
705	74	TURP (Trans-Urethral Resection of Bladder)	9500	3
706	75	TURP+Cystolithopexy	12000	3
707	76	TURP+Urethrolithotomy	15000	3
708	77	TURP+Vesicolithotripsy	12000	3
709	78	Uretero colic anastomosis	8 000	3
710	79	Ureterolithotomy	8 000	3
711	80	Ureteroscopic Calculi - Bilateral	18000	2
712	81	Ureteroscopic Calculi - Unilateral	12000	2
713	82	Ureteroscopic Removal of Lower Ureteric	9000	2
714	83	Ureteroscopic Removal of Ureteric Calculi	7500	2
715	84	Ureteroscopic stone Removal And DJ Stenting	9000	2
716	85	Urethral dilatation	1 500	1
717	86	Urethral injury	4 000	2
718	87	Urethral reconstuction	7 000	3
719	88	Uretric catheterisation - Cystoscopy	1 500	1
720	89	Uretrostomy (cutanie)	5 000	2
721	90	URS + Stone Removal	9000	2
722	91	URS Extraction of Stone Ureter - Bilateral	15000	2
723	92	URS Extraction of Stone Ureter - Unilateral	6000	2
724	93	URS with DJ Stenting With ESWL	15000	2
725	94	URS with Endolitholopexy	9000	2
726	95	URS with Lithotripsy	9000	2
727	96	URS with Lithotripsy with DJ Stenting	10000	2
728	97	URS+Cysto+Lithotomy	9000	2
729	98	V V F Repair	12000	2
730	99	Varicocele	3 500	1
731	100	Vesico uretero reflux - Bilateral	13 000	2
732	101	Vesico uretero reflux - Unilateral	7 000	2
733	102	Vesicolithotomy	7000	2
734	103	VIU (visual internal urethrotomy)	7500	2

Medical Surgical Package Rates fixed for the year 2010-11

735	104	VIU + Cystolithopexy	12000	2
736	105	VIU + TURP	12000	2
737	106	VIU and Meatoplasty	9000	2
738	107	VIU for Stricture Urethra	7500	2
739	108	VIU with Cystoscopy	7500	2
740	109	Y V plasty of bladder neck	9 500	5
		ONCOLOGY		
741	1	Adenoma Excission	10000	7
742	2	Adrenalectomy - Bilateral	19 000	7
743	3	Adrenalectomy - Unilateral	10000	7
744	4	Carcinoma lip - Wedge excision	7 000	5
745	5	Chemotherapy - Per sitting	1 000	D
746	6	Excision cartoid body tumour	13 000	5
747	7	Malignant ovarian	12 000	5
748	8	Operation for neoblastoma	10 000	5
749	9	Partial subtotal gastrectomy ca & ulcer	15 000	7
750	10	Radiotherapy - Per sitting	1 500	D

Note: More common interventions / procedures will be added by the Insurer / State under specific columns. Such rates will be subject to the approval of the Government of Kerala/Chiak.

List of Empanelled Hospitals in Kerala

RSBY/CHIS Empanelled Hospitals 2012-13

Sl.No.	Name of Hospital	Address	District	Sector
1	CHC, Kanyakulangara	Trivandrum	Trivandrum	Govt
2	CHC, Kesavapuram	Kesavapuram	Trivandrum	Govt
3	CHC, Poovar	Tvm	Trivandrum	Govt
4	CHC, Vellarada	Vellarada	Trivandrum	Govt
5	CHC, Vithura	Vithura	Trivandrum	Govt
6	CHC, Vizhinjam	Vizhinjam	Trivandrum	Govt
7	General Hospital	Trivandrum	Trivandrum	Govt
8	Govt. Eye Hospital	Trivandrum	Trivandrum	Govt
9	Govt. Hospital	Parassala	Trivandrum	Govt
10	Govt. Hospital	Attingal	Trivandrum	Govt
11	Govt. Hospital	Peroorkada	Trivandrum	Govt
12	Govt. Hospital	Palode	Trivandrum	Govt
13	Govt.Fort Hospital	Trivandrum	Trivandrum	Govt
14	Medical College	Trivandrum	Trivandrum	Govt
15	SAT Hospital	Trivandrum	Trivandrum	Govt
16	Thaluk Head Quarters	Varkala	Trivandrum	Govt
17	Thaluk Head Quarters	Nedumangad	Trivandrum	Govt
18	Thaluk Head Quarters	Chirayinkeezhu	Trivandrum	Govt
19	Thaluk Head Quarters	Neyyattinkara	Trivandrum	Govt
20	Women & Children	Trivandrum	Trivandrum	Govt
21	A J Hospital	Trivandrum	Trivandrum	Pvt
22	Amardeep Eye Hospital	Peroorkada	Trivandrum	Pvt
23	Anithara Hospital	Poovar	Trivandrum	Pvt
24	Attukal Devi Institute of Medical Sciences	Attukal, Tvm	Trivandrum	Pvt
25	BNV Hospital	Thiruvallam	Trivandrum	Pvt
26	Divyaprabha Eye Hospital	Trivandrum	Trivandrum	Pvt
27	Geetha Hospital	Trivandrum	Trivandrum	Pvt
28	Karette Medical Centre	Karette, Tvm	Trivandrum	Pvt
29	Karunya Hosp. &Diab. Centre	Trivandrum	Trivandrum	Pvt
30	Mariya Nilayam Health Ctr.	Adimalathura	Trivandrum	Pvt
31	S P Multi Speciality Hospital	Trivandrum	Trivandrum	Pvt
32	S R Hospital	Trivandrum	Trivandrum	Pvt
33	S.U.T. Medical College Hosp.	Trivandrum	Trivandrum	Pvt
34	Venad Hospital	Nedumangad	Trivandrum	Pvt
35	Wills Hospital	Vizhinjam, Tvm	Trivandrum	Pvt
36	CHC, Nedumpana	Nedumpana	Kollam	Govt
37	CHC, Nedungolam	Nedungolam	Kollam	Govt
38	CHC, Neendakara	Neendakara	Kollam	Govt
39	CHC, Nilamel	Kollam	Kollam	Govt
40	District Hospital	Kollam	Kollam	Govt
41	Thaluk Head Quarters	Karunagappally	Kollam	Govt
42	Thaluk Head Quarters	Kottarakkara	Kollam	Govt

Annexure 3

Sl.No.	Name of Hospital	Address	District	Sector
43	Thaluk Head Quarters	Sasthamkotta	Kollam	Govt
44	Thaluk Head Quarters	Kadakkal	Kollam	Govt
45	Thaluk Head Quarters	Punalur	Kollam	Govt
46	Victoria Hospital	Kollam	Kollam	Govt
47	Amardeep Eye Hospital	Chinnakkada	Kollam	Pvt
48	Aravind Medical Centre	Kollam	Kollam	Pvt
49	Assisi Attonment Hospital	Kundara	Kollam	Pvt
50	Azeezia Medical College	Kollam	Kollam	Pvt
51	B R Hospital	Kollam	Kollam	Pvt
52	Dr.Viiswanathan Speciality Hospital	Kollam	Kollam	Pvt
53	Little Flower Mission Hospital	Kollam	Kollam	Pvt
54	Mar Theodosius Med. Miss. Hospital	Kollam	Kollam	Pvt
55	Matha Medical Centre	Mathilil	Kollam	Pvt
56	PNNM Memmorial Hospital	Kollam	Kollam	Pvt
57	Robbins Hospital	Chavara	Kollam	Pvt
58	Sankers Eye Hospital	Punalur	Kollam	Pvt
59	SM Hospital	Kadakkal	Kollam	Pvt
60	St.Joseph's Mission Hospital	Kollam	Kollam	Pvt
61	St.Thomas Hospital	Kollam	Kollam	Pvt
62	Star Hospital & Nursing Home	Kollam	Kollam	Pvt
63	St.Joseph Memorial Hospital	Kollam	Kollam	Pvt
64	G.H Alappuzha	Alappuzha	Alappuzha	Govt
65	Medical College	Alappuzha	Alappuzha	Govt
66	THQ, Chenganoor	Alappuzha	Alappuzha	Govt
67	THQ, Cherthala	Alappuzha	Alappuzha	Govt
68	THQ, Harippad	Alappuzha	Alappuzha	Govt
69	THQ, Kayamkulam	Alappuzha	Alappuzha	Govt
70	THQ, Mavelikkara	Alappuzha	Alappuzha	Govt
71	Women & Children Hospital	Alappuzha	Alappuzha	Govt
72	Ahalia Foundation eye Hosp	Alappuzha	Alappuzha	Pvt
73	Century Hospital, CHG NR	Alappuzha	Alappuzha	Pvt
74	Cristos Hospital	Alappuzha	Alappuzha	Pvt
75	Elite Hospital	Alappuzha	Alappuzha	Pvt
76	Hi-Care Medical Centre	Alappuzha	Alappuzha	Pvt
77	Josco Hospital	Alappuzha	Alappuzha	Pvt
78	Maha Jubilee Hospital	Alappuzha	Alappuzha	Pvt
79	Medical Trust Hospital	Alappuzha	Alappuzha	Pvt
80	Moham Hospital	Alappuzha	Alappuzha	Pvt
81	RBM Hospital	Alappuzha	Alappuzha	Pvt
82	Sanjeevani Hospital	Alappuzha	Alappuzha	Pvt
83	St. Sebastian Hospital	Alappuzha	Alappuzha	Pvt
84	St.Michaels Hospital	Alappuzha	Alappuzha	Pvt
85	St.Thomas Hospital, PPM	Alappuzha	Alappuzha	Pvt

List of Empanelled Hospitals in Kerala

Sl.No.	Name of Hospital	Address	District	Sector
86	St.Thomas Mission Hospital	Alappuzha	Alappuzha	Pvt
87	District Hospital	Kottayam	Kottayam	Govt
88	General Hospital	Pala	Kottayam	Govt
89	Medical College	Kottayam	Kottayam	Govt
90	THQ, Changanacherry	Kottayam	Kottayam	Govt
91	THQ, Kanjirappally	Kottayam	Kottayam	Govt
92	THQ, Vaikkam	Kottayam	Kottayam	Govt
93	Assisi Hospital	Kottayam	Kottayam	Pvt
94	Carmel Medical centre	Kottayam	Kottayam	Pvt
95	Chaithanya Hospital	Kottayam	Kottayam	Pvt
96	Co.Op. Hosp., Kaduthuruthy	Kottayam	Kottayam	Pvt
97	Hirange Hospital	Kottayam	Kottayam	Pvt
98	Holy Ghost Mission Hospital	Kottayam	Kottayam	Pvt
99	IHM Hosp. Bharananganam	Kottayam	Kottayam	Pvt
100	CHC, Konni	Pathanamthitta	Pathanamthitta	Govt
101	District Hospital, Kzhery	Kozhancherry	Pathanamthitta	Govt
102	General Hospital	Pathanamthitta	Pathanamthitta	Govt
103	General Hospital	Adoor	Pathanamthitta	Govt
104	Thaluk Head Quarters	Thiruvalla	Pathanamthitta	Govt
105	Thaluk Head Quarters	Mallappally	Pathanamthitta	Govt
106	Thaluk Head Quarters	Ranni	Pathanamthitta	Govt
107	St. Thomas Hospital, Malakara	Pathanamthitta	Pathanamthitta	Pvt
108	CHC, Kothamangalam	Ernakulam	Ernakulam	Govt
109	General Hospital	Ernakulam	Ernakulam	Govt
110	Govt. Maharaja s	Ernakulam	Ernakulam	Govt
111	T.H.Q. Hosp.	Ernakulam	Ernakulam	Govt
112	Taluk Hosp.,Muvattupuzha	Ernakulam	Ernakulam	Govt
113	THQ, Aluva	Ernakulam	Ernakulam	Govt
114	THQ, Fort Kochi	Ernakulam	Ernakulam	Govt
115	THQ, N.Paravoor	Ernakulam	Ernakulam	Govt
116	THQ, Trippunithura	Ernakulam	Ernakulam	Govt
117	W&C Hospital	Ernakulam	Ernakulam	Govt
118	A.P.Varkey Hospital	Ernakulam	Ernakulam	Pvt
119	Aiswarya Hospital	Ernakulam	Ernakulam	Pvt
120	Arogyalayam Hospital	Ernakulam	Ernakulam	Pvt
121	Bharath Rural hospital	Ernakulam	Ernakulam	Pvt
122	Co operative Medical College	Ernakulam	Ernakulam	Pvt
123	Dr. Tonys Super Sp. Hospital	Ernakulam	Ernakulam	Pvt
124	Gautham Hospital	Ernakulam	Ernakulam	Pvt
125	Giridhar Eye Hospital	Ernakulam	Ernakulam	Pvt
126	Jishy Hospital	Ernakulam	Ernakulam	Pvt
127	Little Flower Hospital	Ernakulam	Ernakulam	Pvt
128	MAG J Hospital	Ernakulam	Ernakulam	Pvt

Annexure 3

Sl.No.	Name of Hospital	Address	District	Sector
129	Navabharath Hospital	Ernakulam	Ernakulam	Pvt
130	Nedumchalil Trust Hospital	Ernakulam	Ernakulam	Pvt
131	Sreyas Nursing Home	Ernakulam	Ernakulam	Pvt
132	St.Philominas Hospital	Ernakulam	Ernakulam	Pvt
133	Stella Maris Hospital	Ernakulam	Ernakulam	Pvt
134	Thaqdees Hospitals Ltd.	Ernakulam	Ernakulam	Pvt
135	Vimala Hospital	Ernakulam	Ernakulam	Pvt
136	C A Hospital	Ernakulam	Ernakulam	Pvt
137	CHC, Nedumkandam	IDUKKI	Idukki	Govt
138	Co-operative Hospital, TKMNY	IDUKKI	Idukki	Govt
139	District Hosp., Cheruthoni	IDUKKI	Idukki	Govt
140	PHC, Kattappana	IDUKKI	Idukki	Govt
141	T H Q Peerumeedu	IDUKKI	Idukki	Govt
142	Thaluk Hospital, Adimali	IDUKKI	Idukki	Govt
143	THQ, Thodupuzha	IDUKKI	Idukki	Govt
144	Archana Hospital, Vanapuram	IDUKKI	Idukki	Pvt
145	Devamatha Rajakumari	IDUKKI	Idukki	Pvt
146	Idukki Dist.Co.op.Hospital	IDUKKI	Idukki	Pvt
147	Karuna, Nedumkandam	IDUKKI	Idukki	Pvt
148	Medical Mission Trust Hospital	IDUKKI	Idukki	Pvt
149	Medical Trust, Nedumkandam	IDUKKI	Idukki	Pvt
150	Morning Star, ADIMALY	IDUKKI	Idukki	Pvt
151	Periyar Hospital	IDUKKI	Idukki	Pvt
152	Sahayagiri Hospital	IDUKKI	Idukki	Pvt
153	ST Johns Medical Centre	IDUKKI	Idukki	Pvt
154	St.Marys Hospital	IDUKKI	Idukki	Pvt
155	Chest Hospital	THRISSUR	Thrissur	Govt
156	District Hospital	THRISSUR	Thrissur	Govt
157	Govt.Hospital, Kunnamkulam	THRISSUR	Thrissur	Govt
158	New Medical College	THRISSUR	Thrissur	Govt
159	Taluk Hospital	THRISSUR	Thrissur	Govt
160	Taluk Hospital, Chalakudy	THRISSUR	Thrissur	Govt
161	Taluk Hospital, Chavakkad	THRISSUR	Thrissur	Govt
162	Taluk Hospital, Irinjalakuda	THRISSUR	Thrissur	Govt
163	Taluk Hospital, Vadakancherry	THRISSUR	Thrissur	Govt
164	AL-Iqbal Hospital	THRISSUR	Thrissur	Pvt
165	Assisi Mission Hospital	THRISSUR	Thrissur	Pvt
166	EGM Hospital	THRISSUR	Thrissur	Pvt
167	Gouri Sanker Hospital	THRISSUR	Thrissur	Pvt
168	Guardian M S Hospital	THRISSUR	Thrissur	Pvt
169	I Vision Eye Hospital	THRISSUR	Thrissur	Pvt
170	Irinjalakuda Co.Op. Hospital	THRISSUR	Thrissur	Pvt
171	Lal Memorial Hospital	THRISSUR	Thrissur	Pvt

List of Empanelled Hospitals in Kerala

Sl.No.	Name of Hospital	Address	District	Sector
172	Mar Thimotheus Ch. Hospital	THRISSUR	Thrissur	Pvt
173	Medicare Hospital	THRISSUR	Thrissur	Pvt
174	Peechees Hospital	THRISSUR	Thrissur	Pvt
175	Rajah Charitable Medical Trust	THRISSUR	Thrissur	Pvt
176	Shanthi Hospital	THRISSUR	Thrissur	Pvt
177	T.M. Hospital	THRISSUR	Thrissur	Pvt
178	Trissur Co.Op.Hospital	THRISSUR	Thrissur	Pvt
179	District Hospital, PKD	Palakkad	Palakkad	Govt
180	Taluk Hospital, Pattambi	Palakkad	Palakkad	Govt
181	Taluk Hospital,Chittur	Palakkad	Palakkad	Govt
182	Taluk Hospital,Mannarkad	Palakkad	Palakkad	Govt
183	Taluk Hospital. Alathur	Palakkad	Palakkad	Govt
184	Thaluk Hospital, Ottappalam	Palakkad	Palakkad	Govt
185	Tribal Special Hospital	Palakkad	Palakkad	Govt
186	Assumption Hospital	Palakkad	Palakkad	Pvt
187	ESAF Hospital	Palakkad	Palakkad	Pvt
188	Karuna Madical college	Palakkad	Palakkad	Pvt
189	Palana Institute of M.S	Palakkad	Palakkad	Pvt
190	Seventh Day Advantist Hospital	Palakkad	Palakkad	Pvt
191	Shifa Hospital	Palakkad	Palakkad	Pvt
192	Swami Vivekananda Hospital	Palakkad	Palakkad	Pvt
193	Valluvanad Hospital	Palakkad	Palakkad	Pvt
194	CHC Areekode	Malappuram	Malappuram	Govt
195	CHC Edappal	Malappuram	Malappuram	Govt
196	CHC Edavanna	Malappuram	Malappuram	Govt
197	CHC Kondotty	Malappuram	Malappuram	Govt
198	CHC Malappuram	Malappuram	Malappuram	Govt
199	CHC Melatur	Malappuram	Malappuram	Govt
200	CHC Puratur	Malappuram	Malappuram	Govt
201	CHC Thanur	Malappuram	Malappuram	Govt
202	CHC Wandoor	Malappuram	Malappuram	Govt
203	District Hospital, Manjeri	Malappuram	Malappuram	Govt
204	Taluk Hospital, Nilambur	Malappuram	Malappuram	Govt
205	Taluk Hospital, Perinthalmanna	Malappuram	Malappuram	Govt
206	Taluk Hospital, Ponnai	Malappuram	Malappuram	Govt
207	Taluk Hospital, Thirurangadi	Malappuram	Malappuram	Govt
208	Thaluk Hospital, Tirur	Malappuram	Malappuram	Govt
209	E.K.Nayanar M. Hospital	Malappuram	Malappuram	Pvt
210	Elamkulam Hospital	Malappuram	Malappuram	Pvt
211	Melepurakkal Hospital	Malappuram	Malappuram	Pvt
212	Moonniyoor Nursing Home	Malappuram	Malappuram	Pvt
213	Peoples Hospital	Malappuram	Malappuram	Pvt
214	Prasanthi High Tech	Malappuram	Malappuram	Pvt

Annexure 3

Sl.No.	Name of Hospital	Address	District	Sector
215	Rayhan Eye Hospital	Malappuram	Malappuram	Pvt
216	Safa Hospital	Malappuram	Malappuram	Pvt
217	CHC, Balussery	Calicut	Kozhikkode	Govt
218	CHC, Koduvally	Calicut	Kozhikkode	Govt
219	CHC, Kuttyadi	Calicut	Kozhikkode	Govt
220	CHC, Mukkam	Calicut	Kozhikkode	Govt
221	CHC, Narikuni	Calicut	Kozhikkode	Govt
222	CHC, Perambra	Calicut	Kozhikkode	Govt
223	CHC, Thalakulathur	Calicut	Kozhikkode	Govt
224	CHC, Thamarassery	Calicut	Kozhikkode	Govt
225	General Hospital, Koilandy	Calicut	Kozhikkode	Govt
226	Govt. Beach Hospital	Calicut	Kozhikkode	Govt
227	Govt. Hospital, Nadapuram	Calicut	Kozhikkode	Govt
228	Govt. Hospital, Vadakara	Calicut	Kozhikkode	Govt
229	I.M.C.H,Kozhikkode	Calicut	Kozhikkode	Govt
230	Inst. Of Chest Diseases	Calicut	Kozhikkode	Govt
231	Medical College 32004047	Calicut	Kozhikkode	Govt
232	Medical College,32004020	Calicut	Kozhikkode	Govt
233	W&C Hospital	Calicut	Kozhikkode	Govt
234	Alphonsa Hospital	Calicut	Kozhikkode	Pvt
235	Chavara Hospital	Calicut	Kozhikkode	Pvt
236	EMS memorial Co.Op.Hosp.	Calicut	Kozhikkode	Pvt
237	Holly Cross Hospital	Calicut	Kozhikkode	Pvt
238	Inst. Chest Diseases	Calicut	Kozhikkode	Pvt
239	K.M.C.T. Medical College	Calicut	Kozhikkode	Pvt
240	Lisa Hospital	Calicut	Kozhikkode	Pvt
241	Malabar Diabetics Foundation	Calicut	Kozhikkode	Pvt
242	Malabar Eye hospital	Calicut	Kozhikkode	Pvt
243	Malabar Medical College	Calicut	Kozhikkode	Pvt
244	N C Hospital	Calicut	Kozhikkode	Pvt
245	Smart Hospital & Reserch	Calicut	Kozhikkode	Pvt
246	St. Joseph s Hospital	Calicut	Kozhikkode	Pvt
247	The EMS M.Co.Op.Hospital	Calicut	Kozhikkode	Pvt
248	Vasan Eyecare Hospital	Calicut	Kozhikkode	Pvt
249	Vimala Hospital	Calicut	Kozhikkode	Pvt
250	VIMS Hospital	Calicut	Kozhikkode	Pvt
251	TMH hospital	Calicut	Kozhikkode	Pvt
252	CHC, Meenangadi	Wayanad	Wayand	Govt
253	District Hospital, MNVDY	Wayanad	Wayand	Govt
254	Govt.Hospital, Kalpetta	Wayanad	Wayand	Govt
255	Taluk Hosp., S.Battery	Wayanad	Wayand	Govt
256	THQ, Vythiri	Wayanad	Wayand	Govt
257	Ahalia Eye Hospital	Wayanad	Wayand	Pvt

List of Empanelled Hospitals in Kerala

Sl.No.	Name of Hospital	Address	District	Sector
258	CHC, Iritty	Kannur	Kannur	Govt
259	CHC, Pappinissery	Kannur	Kannur	Govt
260	District Hospital	Kannur	Kannur	Govt
261	General Hospital, THSSRY	Kannur	Kannur	Govt
262	Govt, Taluk Hospital, KUTUPBU	Kannur	Kannur	Govt
263	Govt. Hospital, Payyannur	Kannur	Kannur	Govt
264	Taluk Hospital, Peravoor	Kannur	Kannur	Govt
265	THQ Hospital, Taliparabu	Kannur	Kannur	Govt
266	Comtrust Eye Hospital	Kannur	Kannur	Pvt
267	Kannur Medical College	Kannur	Kannur	Pvt
268	Pariyaram Medical College	Kannur	Kannur	Pvt
269	ST. Martin De Porres Hospital	Kannur	Kannur	Pvt
270	CHC, Badiadukka	Kasargod	Kasaragod	Govt
271	CHC, Neeleshwaram	Kasargod	Kasaragod	Govt
272	CHC, Panathady	Kasargod	Kasaragod	Govt
273	CHC, Thrikkariipoor	Kasargod	Kasaragod	Govt
274	General Hospital	Kasargod	Kasaragod	Govt
275	Government Dist. Hosp. KAGD	Kasargod	Kasaragod	Govt
276	EK Nayanar Mem. Hospital	Kasargod	Kasaragod	Pvt
277	Kamath Medical Centre	Kasargod	Kasaragod	Pvt
278	Malik Deenar Char. Hospital	Kasargod	Kasaragod	Pvt
279	Sachidananda Institute of Med.science	Kasargod	Kasaragod	Pvt
280	Thejaswini Hospital	Kasargod	Kasaragod	Pvt
281	FATHER MULLER HOSPITAL	Manglore	Mangalore	Pvt
282	KS HEGDE HOSPITAL	Manglore	Mangalore	Pvt
283	KVG SULLIA HOSPITAL	Manglore	Mangalore	Pvt
284	WENLOCK HOSPITAL	Manglore	Mangalore	Pvt
285	YENAAPOYA HOSPITAL	Manglore	Mangalore	Pvt
286	KASTURBA MEDICAL COLLEGE	Manglore	Mangalore	Pvt
287	ADARSHA HOSPITAL	Manglore	Mangalore	Pvt