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

Dissertation submitted to Jawaharlal Nehru University
in partial fulfillment of the requirement
for award of the degree of

MASTER OF PHILOSOPHY

JISHA. C J

SCHOOL OF SOCIAL SCIENCES
CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH

JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI
2011

CENTRE OF SOCIAL MEDICINE & COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI - 110 067

25th July 2011

Certificate

This is to certify that the dissertation entitled *"The Comprehensive Health Insurance Scheme (CHIS) in Kerala : An Exploratory Study conducted in Kollam District"* submitted by **Jisha. C.J** in part -fulfillment of the requirements for the degree of **Master of Philosophy** has not been previously submitted for any other degree of this or any other university.

To the best of our knowledge this is an original work.

We recommend that this dissertation should be placed before the examiners for their consideration for the award of the above mentioned degree

Rama V. Baru

Chairperson

Chairperson
Centre of Social Medicine &
Community Health, SSS
Jawaharlal Nehru University
New Delhi-110067

Rama V. Baru

Supervisor

Professor Rama V Baru
Centre of Social Medicine
& Community Health
School of Social Sciences-II
JNU, New Delhi-110067

Tel. : (011) 26704420, 26717676, 26717557 Gram : JAYENU Fax : 91 (011) 26717586, 26704420

Contents

For,

Acchan, Amma and Shaji

Acknowledgement

It has been a very interesting journey for two years now, I decided that I wanted to come to JNU way back in 1998, and yes I did come this far. This journey has brought me to write this - The Dissertation.

I would like to thank and express my gratitude to my supervisor Prof. Dr. Rama V Baru, without whose patience, help, motivation and constant support, this work would have stopped half way.

I would also like to thank Dr. K.R Nayar for his help and suggestions. I take this opportunity to thank other members of the Faculty and the staff at Documentation unit for all their help.

I whole heartedly thank my respondents, Dr. Jagadeeshan at Kerala State Health services, Mrs. Usha V. Girish at United India Insurance and Mrs. Raji at Kottarakara Taluk Hospital for their help and guidance.

My parents and my brother, I owe this to you. The frequent trips to home have been food for thought (quite literally too!) And Shaji, you have been my greatest supporter all these years. I wanted to come to JNU after you showed me around, way back in 1998. Thank you for all the unconditional support, the gadgets and most importantly 24 hour tech support!

I wish to thank my friends, who have seen me through, from sheer crankiness and madness to pure happiness. You need to be thanked for putting up with me; Hari, Smritima, Rohini, Preeti and Sumana-for being a nice room mate!

Thank you, Arathi chechi, Smitha and Kaushik- You guys are the best, in what ever you do!

Jisha. C J

Chapter 1

People have taken care of each other in times of need, financial contracts for pooling risks came into importance only after Industrial Revolution The guilds were organized to further the interests of the members and collectively and it also served as a platform to share risks equally. Initially this was done to collect donations for the sick member of the guild. Over time more formal institutions evolved and they accumulated funds for emergencies and for illness funds.

Tracing the early history of Health insurance programme, the first national Health insurance programme was implemented in Germany in 1893 by Bismarck, the chancellor of Germany. Under this programme the state provides compulsory insurance coverage through contributive deduction at source (salary) for every state employee (Borowitz).[1] The beneficiaries have the option of choosing between private and public service provider. Those who could not pay the premium, the state run scheme would take them in their fold. This model later came to known as the Social Health Insurance. By putting together a social security system, including medical insurance for industrial workers, Bismarck was able to appease the workers.

National Health plans were established in different countries around early 1900's, in England it was established in the year 1911, 1914 in Sweden, and 1930 was the year when it was established in France. All these plans were mainly for the salaried people who would be looked after by the employer or the government. The dependents in most cases were left out from benefits and these schemes were meant only for the salaried classes, meaning that those who held other jobs had to take care of themselves. Around the later 1980's almost every developed country had a health insurance coverage plans for its citizens. The evolution of insurance in USA was much different; it depended on voluntary private initiatives to develop health insurance. During the great depression of 1930's, Blue cross programme where prepaid medical expense benefits could be

[1] *Borowitz, M. and Atun, R. 2006, The unfinished journey from Semashko to Bismarck: Health Reform in Central Asia from 1991 to 2006', Central Asian Survey, 25 (4), pp 419 — 440*

accessed. Under this scheme the patients could enjoy pre paid medical benefits but from a single hospital. The blue shield insurance was against loses due to medical expenses, whereas blue cross was for hospital coverage. Later the Social security Acts of 1965 established the Medicare for the elderly and Medicaid for the indigent.[2]

In India the formal sector employees stand to receive the benefits of the assured social insurance type of benefits, this includes the central government employees as well as the state government employees. The employees have dedicated hospitals where they can seek treatment and also seek referrals to tertiary care hospitals. The employees can claim reimbursements for the treatment sought and also buy medicine suples with their entitlements.

The ESI and maternity benefits act cover only some and selected group of individuals and their families. The Employees State Insurance Act (ESI act) of 1948 is a social insurance scheme covering those employed in the public sector or pubic undertakings and any industry that uses power and employs more than 10 people. It provides four types of benefits namely- medical, sickness, maternity and work injury. It places a limit on the coverage of people based on their income levels. However these income levels are revised in accordance with the market rates. The ESI scheme is tailor made to provide socio economic protection to the worker population and their dependents covered under the scheme. It also carries full benefits for medical care of self and the dependents from the very first day of employment. The ESI operates hospitals for which the employer is supposed to provide an Identification card and is expected to provide medical benefits for those enrolled in it.

The CGHS was introduced in the year 1954 and provides treatment facilities under all systems of medicine, and treatment is available to the currently in service members as well as those who have retired from service. The service of CGHS is available mostly in big towns. Most of the major towns in India are covered under the

[2] Getzer E.T, Health economics- Fundamentals and Flow of funds, John Wiley and sons, Inc; NewYork 1997. Pp91-95

scheme. The central government employees who are the entitled to seek treatment are provided with a unique identification card, which must be used in all transactions.

The ESI and the CGHS are two schemes run by the government for their employees in regular employment and it is quite different from those that are offered by the private and other NGO. The private insurance market has seen a spurt since the opening up of the insurance sector for foreign players in 1999. Since then a number of private and foreign players have launched schemes for individuals and for groups. The insurance market is partially regulated.

Apart from the initiatives by the government there are others by the NGOs which offer community based health insurance for a group of individuals, one of them is the one operating in Nilgiris. The ACCORD ASHWINI scheme was a community based Health insurance scheme, and it covered the tribal population at Gudalur, the premium was collected yearly from the members of the Adivasi Munnetra Sangham, an association that worked fro the welfare of the Adivasis in Nilgiris. As of now the scheme has been taken over by the government and the scheme has been wound up, as the inpatient costs are now looked after by the Tamilnadu government.[3]

The Vimo SEWA scheme of insurance run by the women employed with SEWA.The Self-Employed Women's Association (SEWA) is a registered trade union of 12.56 lakh women workers of the informal economy. It was founded in 1972 by Elaben Bhatt. It is an organization of poor, self-employed women workers. The women earn a living through their own labour or small businesses. VimoSEWA Cooperative offers various insurance packages, which include coverage for death, sickness and loss of assets. The packages have varying levels of premium and corresponding sums insured. VimoSEWA Cooperative Ltd has linked up with various nationalized and private insurance companies for its insurance schemes over the past 16 years and offers its services only to the members of the co operative.

[3] Personal communication with Shyla Nandakumar, ASHWINI Hospital. Gudalur 2 July 2011

Yeshaswini scheme Karnataka, "Yeshasvini Cooperative Farmers Health Care Scheme" was introduced by the State Government to the Co-operative farmers of Karnataka. It was inaugurated on 14th of November 2002 and the scheme was operationalised with effect from 1st June 2003.

The concept of rural health care scheme was initiated by Dr. Devi Prasad Shetty of Narayana Hrudayalaya, Bangalore, and with suitable modifications by Sri A Ramaswamy, then the Principal Secretary to Government of Karnataka, Co-operation Department and band of officers of Co-operation Department with the financial assistance of Government of Karnataka Yeshasvini Health Care Scheme was implemented through network hospitals to provide cost effective quality healthcare facilities to the Co-operative farmers spread across the state of Karnataka.

The Yeshasvini Cooperative Farmers Health Care Trust is registered under the Indian Trust Act 1882. The Hon'ble Chief Minister of Karnataka is the Chief Patron and Minister for Cooperation is Patron. The Government of Karnataka provides matching contribution to the Trust for implementation of the scheme. The scheme provides almost 1600 surgical procedures and for the farmers and his family members. The beneficiary also pays a small premium to enable him to get the services of the hospitals.

Historical Development of Medical care facilities in Kerala

The provision of Health care facilities in Kerala has had an ancient tradition to it. The provision of "*charity was regarded as one of the cardinal duties of the state. One of the main objects of my ambition is to see that good medical aid is placed with in the reach of all classes of my subjects...said the Maharaja of Travancore*" (Aiya 1906)[4].
The state of Kerala has been in the marked out as a state which doles out more than 30 welfare funds, from welfare funds aimed at Coir workers, fishermen, beedi workers, khadi workers, and construction workers. The schemes provide for payment of pension,

[4] Aiya Nagam V, The Travancore State manual, Government Press Trivandrum1906, Vol II P.537

assistance for medical treatment, education of children and the likes (Subrahmanya, 1998)[5].

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

Chapterization

The study is presented in 5 chapters.

Chapter 1 deals with the Inequalities and the policy interventions; it traces the inequalities and the interventions that have been brought about by the concerned authorities to keep a check on them and to correct the inequalities. Chapter 2 deals with rationale, goal and the implementation of the scheme and it traces the transition from RSBY to CHIS in Kerala. Chapter 3 deals with the methodology and the problems that were encountered while collecting data. Chapter 4 presents the data in the form of 8 in depth case studies conducted in 3 different hospitals in Kollam district. Chapter 5 deals with the discussion of results and the major findings of the study.

[5] Subrahmanya R KA "Extension of Social Insurance Schemes in the Formal Sector' in Ginneken V. W (ed) 1998, Social Security for All Indians; Oxford University Press, Delhi. ch 2

Chapter 2

Rising Inequities and Policy Interventions

The country has seen growth and vigor in its economic sector but this has not been the case with human development indicators. The higher rates of mortality for the social and economically vulnerable groups still remain a cause of concern. The differences in the rates of mortality based on factors such as caste, religion and class across the country are a stark remainder of the gaps that divide Indian society (Dreze et al 2009).

The inequalities in access, affordability and the availability of health care are important determinants in the determining the health of the population (Baru et al 2010).[6] The determining factors are in turn affected by other factors like governmental policy, law of the land and the will of the administrators. The increasing levels of inequality and the resultant lack of access to health care has prompted the intervention of the state in a number of ways, in financing and provisioning of services. These include targeted interventions, cash transfers, provisioning of services in poorer districts and mass campaigns[7].

The provisioning, access and the use of medical services have been the focus of attention of researchers, policy makers and civil society organizations. The rising prices of services, has acted as a barrier to access for those who are marginalized. In order to address the needs of the marginalized sections, the government initiated a targeted approach to medical insurance. The programme was designed to reach people who were classified as Below Poverty Line (BPL)

---

[6] *Baru et al (2010) Inequities in Access to Health Sevices in Indic :Caste, Class and religion, economic and Political Weekly ,Vol XLV,No 38, Sepetember 18,pp 49-58*

[7] The Hindu: News / National : Gigantic inequalities in access to healthcare: Amartya Sen. Available at: http://www.thehindu.com/news/national/article2215872.ece?homepage=true [Accessed July 10, 2011].

The idea of Health insurance is considered as an alternative as well as a paradigm shift in health policy. This entailed a shift in the role of the state in financing, provisioning and administrator of services to that of primarily financing and regulation.[8] Within countries, the poorest households seem to suffer the most because of their lack of ability to access and afford the healthcare. They have limited resources to purchase services from the private providers and this leads to seek services from the state funded system, which might be short staffed and not maintained. Policy makers in several countries low to middle income countries are trying to argue for the inclusion of Health insurance as an alternative method to scale up the efforts to improve health outcomes in countries.[9]

Major conferences have been convened at Berlin (2005) and Paris (2007) on Social health insurance in developing countries. Based on the evidences from these seminars, the World Assembly has passed a policy resolution, where by the WHO would advocate Social Health Insurance in low Income countries so that equitable services could be provided to the poor in the low and middle income countries.(WHO 2005)

The effect of health insurance on the use of Health services have been generally demonstrated and accepted as having a positive effect. In a review of studies done on Health insurance and the effects of the 'insured" status, it was seen that there was a positive co-relation between having Health insurance and using more medical care. But this was the case of Developed world; there were hardly any studies on such a co relation for the developing world (Hadley 2003).[10]

Whether health insurance is recommendable strategy to improve healthcare access in low and middle income countries is debated and but very little documentation is available in this regard. This makes the task harder to ascertain whether any efforts in this regard have borne fruit or not. The lack of studies into this aspect has ensured that the

---

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

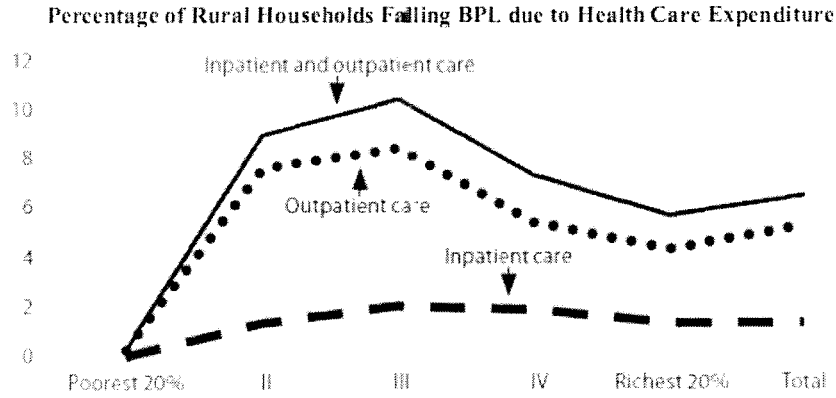
[9] *Ibid.*

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

researchers in these areas have to depend on small and short term effectiveness studies that are carried out for specific purposes as anchor points for any research.

The advocates of health insurance argue that the besides providing a succor from the economic effects of illness, health insurance is also meant to improve access to health care (Nyman 1999). The claims by the pro insurance groups have shown that some sort of insurance coverage helps the patients to seek medical care. The case of ACCORD Ashwini Insurance, where the members of the AMS were covered under the Health Insurance scheme for seeking treatment has been hailed as an example where health insurance can lead to the increased use of medical care. Devadasan et al (2005). According to the authors, the insured people were twice more likely than the uninsured to seek medical attention.

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



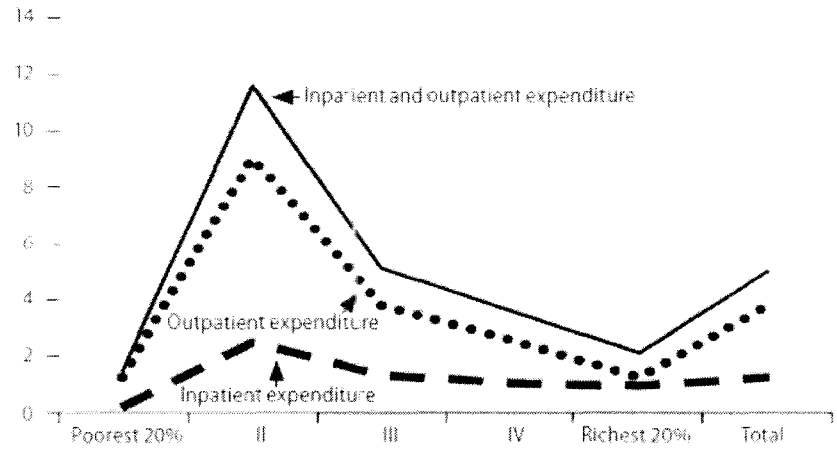
Source- Peter Berman, Rajeev Ahuja, Lavesh Bhandari, The Impoverishing Effect of Healthcare Payments in India: New Methodology and findings, Economic and Political Weekly, April 17,2010 vol xlv no 16,p.67

The above diagram shows the percentage of people who fall below the poverty line after incurring catastrophic Healthcare Expenditure. The deadly combination of out

patient as well as in patient care is responsible for impoverishment of the poorest 20percent of the population. This is a representation of the rural households in India. The vicious cycle of ill health and the resultant lack of income and he consequent debt trap are not the unique features of the rural space, but a feature of the urban areas as well. The provision of government services in these areas is also sparse and poorly manned and maintained.

The following diagram shows the conditions existing in urban households. The spikes in the percentage of people who are pushed into below poverty line status after Healthcare expenditure points to poorest 20 percent of the population.

Percentage of Urban Households Falling BPL due to Health Care Expenditure



Source: Peter Berman, Rajeev Ahuja, Laveesh Bhandari, The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings, Economic & Political Weekly, April 17, 2010 vol xlv no 16, p. 67

In the wake of such stark realities the efforts of the government were directed towards the provisioning of services for the needy as well as those on the margins who cannot afford healthcare on their own. And thus came about the ideas about Universal Coverage, and efforts at bringing in the aspect of providing free treatments at private hospitals considering the availability of such providers even in rural areas. The idea of a PPP, which included an embedded business model to help the insurer, the service

provider as well as the patient evolved.[11] The inherent business model of RSBY made it attractive for the insurers; the provision of 75:25 financing was also attractive for the state governments.

The employees in the formal sector those associated with the organized sector had their own system of safety nets through the CGHS and the ESI for the Central government employees and for state government employees respectively.

Rashtriya Swasthya Bima Yojana

The policy interventions that resulted in the introduction of widely acclaimed RSBY was on the basis of the Electoral declaration of the UPA government which was seeking to come in to power during the 2004 elections. The common minimum programme as it was called set out to develop an insurance scheme which would cater to the informal sector workers and would also provide necessary support for those below the poverty line to access medical care at empanelled hospitals. The National health policy of 2002 had put forth the idea of roping in the private sector to provide services co operating with the government in providing medical services at rates lower than the ones being charged at private hospitals.

This study focuses on the RSBY scheme being implemented in the state of Kerala as CHIS- a comprehensive health insurance scheme; administered by the Nodal agency Comprehensive Health Insurance Agency Kerala (CHIAK).

---

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

Chapter 3

Rashtriya Swasthya Bima Yojana

Rationale, goal and Implementation

Rationale

Health insurance in its narrow sense would mean the act of purchasing health coverage for a person or his/her family in advance by paying a token amount called the premium. The premium might differ according to the ability to pay and also the difference in the scheme that is being considered. The calculation of premium is based on the amount of health coverage opted for, this being the case with most private insurers and also health and life insurance policies meant for individuals.

The financing pattern of healthcare in a country is varied. Broadly there are two options- namely through general taxation or the private individual contributions to health insurance. The selection of the method to finance the healthcare services in a country is dependent upon the choice between equity concerns which can be addressed by taking up pubic provisioning funded by general taxation, or choose private financing of healthcare through private healthcare insurance(Ahuja 2004)[12]

In India, the private out of pocket expenditure forms the bulk of expenditure on health. This is a matter of concern that people, who cannot afford to pay money out of their pocket for treatment at private or public hospitals or their choice, still constitute the majority. The provision of free services at the public institutions has been woefully

---

12 Ahuja, R., 2004. Health insurance for the poor in India. Indian council for research on international economic interactions". Working paper.

inadequate; and does not seem to be sufficient to meet the demands at the primary level. So when the services that have been traditionally offered free have not helped meet the demands, the government developed a model where all the parties involved, namely the insurer, the provider and the beneficiary stand a chance of being at profit. And this has been termed as the in-built business model in health insurance.

In this context health insurance which is financed and run by the state for the poor, who constitute the major part of the population is seen as a way forward. To achieve equilibrium, it is necessary to strike a balance between the efficiency and equity aspects of provision of healthcare. Looking at the society through the insurance perspective; conceptually the society can be considered as having two kinds of people, one who cannot afford to pay only the subsidized premiums for their insurance schemes i.e. the people who cannot afford to pay fully for their treatment; and the second category of people who can afford to pay the whole insurance premiums for a little extra benefit. While the extra benefit is based on their premium paying capacity, it can cover a wide range of disease conditions and hospitalization needs. In cases of the poor, the prioritization of needs is the reason that refrains them from seeking medical help and it also defines to what extent they might seek help and also the ways of coping from disease.

The curious case of the state in India which is not welfarist[13],but still undertakes the function of providing primary healthcare, or rather attempts to; is cornered by the question - why is there a need for insurance if the state can continue providing free services? The answer to it lies in the observation that the poor can also contribute to the premium in small amounts like the small savings account for their own health. Also it has been observed that the beneficiaries like to have a choice between the providers. While a free service would provide no choices, a co payment system has ensured in this case (RSBY) to provide the option of private as well as public providers. By paying a token

---

13 Anon, The state of India's welfare state: Ropey nets | The Economist. Available at: http://www.economist.com/blogs/freeexchange/2011/05/state_indias_welfare_state [Accessed May 20, 2011].

amount towards the card, the beneficiary becomes a consumer of services who has the option of selecting his point of usage of services anywhere in the country; as this card does not tie down the beneficiary in any one area, like in the case of Ration (PDS) shops. Also the transition from being the user to the consumer has ensured that the "consumer" reserves the right to select his provider. Also it has been seen that the health insurance policies can be used to promote desirable behavior in the individuals, like the insurance policy ensures that beneficiary seeks treatment from his hospital of choice at his discretion. The consumer of services also reserves the right to seek treatment for himself and his family at his place of convenience. The smart card can also be split in order to aid the migrant labour who would like to split the amount in his card and take another card so that he can also be a beneficiary of the services even while he is working in some other place than his native place. This functionality helps the individual to ensure that he is also covered in his place of work and also be assured that his/her family left behind also can claim treatment under the scheme.

The recent history of insurance in India

Social health insurance in India has been largely restricted to the organized sector that constitutes only a small proportion of the population. As a result social health insurance accounts for only a small proportion of total health expenditure is funded by the social health insurance, which is much below than that of countries like Korea and Bolivia. It is believed that Social health insurance supports only 2% of the population in India and almost 18% is supported by government budgetary insurance schemes. It is with this background that one has to look into the provision of universal coverage under various schemes put forth by the governments in India.

The existence of several categories of people in the society who can be the beneficiaries of the social insurance and the private or voluntary insurance is very varied. It ranges from the category of people in the Below Poverty Line category, those who are poor but not poor enough to be included under the Below Poverty Line category but those who are borderline cases. And then the distinct classes of the middle class, upper middle class and

the super rich. The beneficiaries for a social insurance scheme could be anyone who falls below the poverty line, but it should also include those who are precariously near the mark and those who can benefit from some state subsidy to help them tide over the needs[14].

Health insurance schemes that were launched to cater to the poor and needy have been very few in number, some of which are the Jan Arogya Bima Yojana launched by The New India Assurance company "*was designed to provide cheap medical insurance to the poorer section of the society, with premium upto Rs.100. The sum insured per person is Rs.5000 in a year.*"[15]

The Universal Health insurance scheme launched by the union government in 2003 provided universal health insurance coverage to people in the age group of 3 months to 65 years, in some states of the country and it was expected to cover all those below the poverty line. This scheme was the precursor to the recent RSBY scheme. As pr the policy documents the scheme provided medical insurance for those covered under the scheme. It carried a coverage of Rs.30,000 per year with riders that the maximum limit for an illness was Rs. 15,000. The coverage is based on the annual premium of 1 rupee per day for an individual, 1.50 per day for a family of 5 including dependent children, and rupee 2 per day for a family of 5 and dependent parents for a year. The benefit of the scheme was limited to cases of hospitalization only and did not include out patient care. The treatment costs are reimbursed to the hospital by the insurance companies according to previously fixed rates.

RSBY: Origin, rollout and implementation

The five year plan for the years 2007-2012 contain the idea for the origin of the Health insurance, the opening lines of which mention the need to protect the poor as there is a need to secure their health in current scenario of rising costs and inequitable

[14] Ibid
[15] *Health Insurance in India: current Scenario, Http://www.searo.who.int/linkfiles/social_health_insurance_an2.pdf. [Accessed 3 May 2011]*

provision of services. The Plan documents also point to the evidence from the 60th round of NSSO stating the cost of hospitalization at public hospitals in rural areas of India being almost Rs.3000 per episode of hospitalization. This soars up to Rs.7000 in case of private institutions. And when the same is considered in the urban areas, it rises to Rs.11,000 at private hospitals and is almost 3 times higher than the rates of public hospitals. In this context the plan document proposes to introduce Comprehensive Healthcare insurance on a risk sharing basis for all and "particularly for the poor"[16]

Under the section on health insurance for the unorganized sector, the plan document mentions the idea and the will to introduce "*...new scheme based on cashless transaction with the objective of improving access to health care and protecting theindividual and hr family from exhorbitant out-of-pocket expenses. Under this scheme,coverage will be given to the beneficiary and her family of five members. Providers will be both public and private.*"

The Common Minimum Programme(CMP) is the document outlining the minimum objectives of the coalition government in power at the centre. The CMP of the UPA I (United progressive Alliance) was set out in the year 2004 during the general elections in India. While it was understood that most of the agenda set out in the CMP was about, promises to meet the growing demand for Healthcare and to start a national health Insurance scheme for the Below Poverty Line families, who might be pushed into the debt trap in case of hospitalization or a prolonged illness. The CMP came up with a new scheme where the workers in the unorganized sector would be covered under the scheme and they would be benefitted in case of emergencies and illnesses.

During the last 5 years the government in power has tried to provide an insurance scheme that would cover the poor comprising mostly of workers belonging to the unorganized sector. The approach was a targeted one covering those who being those who live below the poverty line, earning their livelihood by being employed in the informal sector with no job guarantees or savings to fall back upon during times of distress.

---

16 Eleventh Five year plan document. [Accessed 11June 2011]

The political context of RSBY traces its origin to the first term of the UPA which came up with the Common Minimum Programme. The scheme though announced in the year 2007 by Manmohan Singh, the Prime minister, in 2007, the actual rollout started in the year 2008(Rajasekhar et al. n.d.)[17].

Goals and Features of RSBY

The RSBY (stands for Rashtriya Swasthya Bima Yojana) The National health Insurance Scheme, was introduced in various states in the year 2008 in a phased manner, aiming to cover the entire nation by the year 2012- 2013, it has been initiated by the Central government, launched by the Ministry of Labour to provide Health Insurance for workers belonging to unorganized sector falling below the Below Poverty Line. This scheme was part of the Unorganised Workers Social Security Act of 2008. This scheme was envisioned to include the workers of the unorganized sector and their families. The scheme has an upper limit of Rs.30,000 for a family of five, which can be claimed in a year, in case of illness and which also extends to diseases that are pre existing in nature except certain basic exceptions. Unlike the private insurance companies which run a battery of medical checks before enrolling a member, this scheme does not require any such activity. Under this scheme, a smart card with a chip embedded in it, containing all the relevant data of the family is made. This is called the smart card, contains details about the address and other details of the card holder and his/her spouse and 3 dependent children and including old dependent parents. The card is non transferable and also cannot be used without the bio metric reader recognizing the thumb print of the card holder. The scheme does not place any age limit on the beneficiaries to seek treatment under this scheme. This scheme is extended to all citizens who belong to the Below Poverty Line category; the targeted beneficiaries have to make sure to enroll themselves under the scheme and also to complete the registration procedure by giving their thumb

17 *Rajasekhar, D. et al., IMPLEMENTING HEALTH INSURANCE FOR THE POOR: THE ROLLOUT OF RSBY IN KARNATAKA.*

impression at the time registration. In the current financial year (2010-11) the scheme has been expanded also to include MGNREGA workers as well (Nayar n.d.).

Implementation

Finance and the roll out of the scheme

The financing of the scheme has been divided among the central as well as the state government in the ratio of 75:25, where in the central government provides 75% of the premium amount and the rest of the premium is to be provided by the state government. In the states of Jammu and Kashmir and the north eastern states, the amount of contribution of the central government is 90% and the rest is to be paid by the state government[18]. The state government is also entrusted with the responsibility of collecting the registration amount from the users at the time of enrollment. The contribution of the users varies from Rs.30 for the Below Poverty Line population to the entire premium amount in case of APL families. The reasoning put behind the collection of a nominal fee is to create a sense of value for the card for the beneficiaries, making them aware that they have paid a sum to claim the benefits of a health scheme. The scheme also happens to be the first scheme for the poor where they are required to pay a very nominal fee to "own" their smart card.[19]

The scheme envisages the use of smart card technology to put in place a system that ensures that there is no money transaction required in case of emergency hospitalization. The cashless-ness is to be ensured by the use of smart card to be swiped during a transaction as is every episode of illness is referred to as. The use of Smart card ensures that no body else can claim the benefit meant for that specific family. The use of the card has been restricted to the owner of the card, and his dependents, whose fingerprints may be optionally be registered along with those of the head of the family.

---

18 Official documents: RSBY policy guidelines

19 Rai, Sheila., Rai Niha 2010. Rashtriya Swasthya Bima Yojana(RSBY): Panacea for the Poor. <http://www.napsipag.org/SHEILA%20RAI%20&%20NIHA%20RAI.pdf> [Accessed 5 May 2011].

Enrollment

Targeting of schemes has consistently been noticed as a problem with most government schemes. In order to overcome this problem, the RSBY program asked the State governments to provide the list of BPL beneficiaries in the state and to make this data available to the insurance companies. The insurance company was required to advertise the availability of the scheme at the empanelled hospitals and the enrolment counters to disseminate information about the working of the scheme and the facilities that are available to the patients. During the enrolment procedure, a field key officer (from the local administration) along with a representative of the TPA would be present to oversee the enrollment. Though, in the guidelines it is mentioned that the smart cards must be provided on the same day as the enrollment, it was seen in experience that the procedure took almost a fortnight to a month for the smart cards to be distributed among the beneficiaries. As of February 2011, 60% of Indian districts are covered by RSBY and it covers 22.8million people[20].

An amount of Rs.30,000 is the upper limit for all claims of hospitalization expenses, different procedures are priced differently and are also administered differently. The patient is required to carry the card when seeking treatment, and registration is the point of service. The holder of the card is made to get his thumb read on the biometric reader and briefly mention his illness to the RSBY kiosk operator, the kiosk operator has to later mark the patient as a registered case and allot a package according to the description of the patient's ailment and is later asked to get all the prescriptions marked for being reimbursed or charged from the card. The scheme also has provisions for supply of medicines at the cost of the empanelled hospitals during the period of hospitalization and upto 5 days after discharge from the hospitals. It is the right of the patients to receive equal treatment on par with other categories of patients in empanelled hospitals.

[20] Data accessed from RSBY website.

The hospitals are also bound by their MOU through the TPA to the Government to engage in curative treatment for the patients irrespective of their payment capacity in lieu of their insurance claims.

The scheme makes provision for the patients to seek treatment in private as well as public hospitals, but the involvement of private hospitals. The case of private hospitals to be empanelled is dependent on the interest of their management and their ability to pay certain amount of money towards empanelment fees to the government through the TPA. The process of empanelment of private hospitals involves the Third Party Administration (TPA) engaging in an MOU; agreeing to provide treatment for those holding the RSBY cards and agreeing to conduct medical procedures according to the pre determined package rates. The rates have been decided upon after consultations by the medics and the administrators. The TPA acts as a go between the providing services and the insurer for verifying the transactions and the government.

The RSBY was launched in the year 2008 across the country. All the states were required to form a separate nodal agency that would deal with the implementation, and roll out the scheme. The implementation of the scheme was undertaken with the help of the labour welfare and rehabilitation department, and the concerned nodal agencies that were newly set up. The RSBY took up the role of health insurer for the poor and aimed to provide cashless treatment at different hospitals for different illnesses. The additional positives about the RSBY were that there was no upper age limit for being included in the coverage list and there were no screening or medical tests for pre existing medical conditions. The RSBY also includes maternity services as a part of the package deals. Conditions like the treatment of Sexually transmitted diseases, cosmetic procedures and dental implants are excluded.

The transition from RSBY to CHIS in Kerala

The RSBY scheme was implemented in Kerala on October 2nd 2008. The scheme was to be launched in two districts in Kerala namely, Kollam and Alappuzha in the initial year. The central government had agreed to let the state go ahead and implement the scheme in all the 14 districts in the state during the first year. Two districts were selected by the state government for the initial round of implementation[21]. The State government of Kerala through its Health and Family Welfare Department issued orders on 17.8.2008 with regard to the implementation of RSBY for the unorganized sector workers who were in the Below poverty line (BPL) category and CHIS for the non Below Poverty Line category under the Labour department in government.[22] The coverage of the scheme was extended to all 14 districts of the state, and it was estimated that 11.79 Lakh Below Poverty Line families in Kerala would be covered under the RSBY scheme, in addition to this an estimated 10 Lakh poor from the state's Below Poverty Line list would be included as target population under the scheme. The additional 10 Lakh people included in the RSBY net would have to pay a registration fee of Rs.100 towards their card.[23] This accounted to almost 22 Lakh families in whole state, which made up to one third of the total population of the state. By the financial year 2009-10 the state of Kerala had paid an amount to the tune of 53 crores as premium and by the next year i.e 2010 February, almost 35 crores had been disbursed as treatment expenses and 1, 15,000 beneficiaries had sought treatment and out which 17 crores went to the states coffers while 18 crores was netted by private hospitals as treatment dues from the insurance agencies through RSBY. An additional 10,000 people belonging to the APL category were issued cards against full payment of the premium working out to be more than Rs.500 (Nayar n.d.)[24]

---

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

22 Government of Kerala, G.O(P)No/2008/LBR dated 4.7.2008 Labour and Rehabilitation (J) Department

23 Nair, C.G., 2008. Health Insurance for One Crore People. The Hindu, p.01.

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

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

Under CHIS, existing diseases were also covered and there was an extensive list of rates for different surgical procedures prepared to be followed by the empaneled hospitals. The scheme also offered a personal accident insurance claim in case of an accident to the card holder. The accident insurance coverage is for an amount of Rs. 25,000 per annum.

The CHIS in Kerala has been conceptualized as a cashless insurance scheme, where the beneficiary, the owner of a smart card can seek treatments from empanelled hospitals which include the Community health centres, ESI hospitals, District hospitals and willing private hospitals.

The empanelment of private hospitals is based on several conditions with regard to their capacity of their infrastructure and manpower. The requirements for empanelment of the private providers have to be overseen by the TPA as well as the insurance agency. It is also, required by, the agency CHIAK that insurance agency employ field staff to look into various issues that might come up during the rollout of the scheme. This

includes conducting technical classes for the use of the software as well as the process of manual claim submission in case of software failure.

The cashless system is ensured by the tie-ups forged with medical stores and other diagnostic service providers who provide services to the beneficiaries. The diagnostic service providers can be private players who agree to provide these services at subsidized rates. At the public hospitals these tie- ups would mean subsidized medicines from Medical fair price shops within the vicinity of the hospital. The same provision in private hospitals would mean that the (Hospitals) provide the medicines and the required care during the inpatient care and also provide medicines for the 5 days after discharge.

The health services system would also be required to pitch in with their effort to help and disburse treatment for the beneficiaries under the scheme, it is also expected to provide the services agreed under the MOU with the insurance agency to provide the required amount of care and medication and practice no differentiation with regard to the medical attention provided. The URN (Unique relationship number) that each family is given helps in the record keeping of all he transactions that happen on the card. The URN is unique and it has the components of codes that indicate where the beneficiary is from, his basic details and also the details of his entitlement. The biometric detail helps to prevent the misuse of the card and allows the foolproof identification of the individual.

A new addition to CHIS is the CHIS+ scheme which was launched on February 21st, targeted at the terminally ill; under this scheme the terminally ill would be able to claim treatment costs up to 100,000Rs. This amount would be separate and meant only for the patients suffering from kidney ailments, heart ailments and cancer. This added benefit was introduced during the budget speech in the current year.[25] The scheme has been named as *Hrudayapoorvam*. This scheme is currently available only for one member of the beneficiary below poverty line family in a year. The scheme is run, only in select hospitals mostly at the district hospitals, medical colleges and Regional cancer centres (RCC) in the capital district of Thiruvananthapuram; it includes the medical

[25] CHIS plus Note for the web, retrieved from www.chiak.com on 5th may.

college, and the RCC. This new scheme has been in place since February the 21st in the current financial year and has been effective in all the 14 districts of the state. This scheme is not run with the help of Insurance agency, but is a fully state government funded scheme. Under this scheme the reimbursement for the treatment done will be undertaken directly by the Nodal agency CHIAK to the participating hospital through the software platform developed by Keltron. The scrutiny of claims and their reimbursement is wholly done by the agency and unlike the CHIS scheme no transportation allowance and no incentive is provided to the staff attending to the patients. Also, unlike the CHIS scheme, this scheme is not available for the CHIS APL card holders. This scheme is only intended for the CHIS-Below poverty line population. The only thing common between the CHIS and the CHIS plus is the allocation of only the general ward for treatment purposes and domiciliary purpose.

CHIS

The RSBY and CHIS schemes are 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 agency which administers the scheme. A separate agency the CHIAK was entrusted with the implementation of the scheme. During the first year of implementation 135 hospitals in the public sector and 165 in the private sector, including hospitals in the co-operative sector were part of the scheme. In government sector all the hospitals in the level of CHC's and above were empanelled, all the 5 medical colleges in different districts were also empanelled. The insurer for the first and the second year was United India insurance company

After the first year of implementation, an evaluation was done and it was concluded that the scheme was being successfully implemented and that it was favorable to extend the same scheme for a more wider range of beneficiaries; and thus more families were included in the scheme from the SC/ST families, Fishermen families, agricultural workers, Beedi and Handloom workers, Cashew workers(Pensioners),

anganwadi workers, ASHA workers and helpers, building and construction workers, Headload workers and other unorganized sector workers.

In the initial year of the implementation of the Scheme the state government had expressed its displeasure in letting the scheme work with the private insurers involved in it. The State government then came up with the new scheme where the scheme involved public sector insurers and also included the additional 10 lakh population from the state BPL list. The state also expressed its desire to extend the scheme to the rest of the population by opening up the ceiling on premium payments, and allowing the full payment of premium, which worked out to be Rs.506 plus the charges of Rs.60 for the smart card. Most of the states by then had implemented the basic version of the scheme and had started the trial run in certain districts of the state. The government in Kerala had by then decided to expand the scheme to encompass the whole state and to run the scheme in all the 14 districts of the state.

It was decided that the state government would put out notifications inviting competitive bids for the insurance partner for scheme. During the first year of the scheme the insurer was United India Insurance and has managed to keep the contract for the continuing years as well. Most of the ground work has been entrusted with the TPA (MDIndia) based out of Pune, this institution has field staff working towards the installation, upkeep and the software and electronic interface of the program. The institution also works as a mediator between the Insurer and the service provider, and also helping with the manual claim of insurance claims. Most of the other procedural formalities involved in the working of the scheme are also undertaken by the TPA. The TPA was also chosen after a process of tender. The company also has retained their contract for the past 3 years and has expanded its services offered.

In the past there have been no schemes that have covered the whole population and in some rare cases it misses the target population to a large extent or in some cases entirely. Most the schemes that have been introduced aimed at certain sections of people have rarely generated the amount of interest that RSBY has managed to gather. The

reason for the popularity of the RSBY is the inbuilt business model; that attracts the insurers to come forward and operate such an ambitious scheme at such large scale.

The business model ensures that the burnout ratio i.e. the ratio between the collection of premiums and its disbursement as a form of expenditure from the insurance company is maintained to a low level which maximizes profit and ensures that the insurance agency involved does not incur loses. The burnout ration in the first two years of operation of RSBY has been seen to be around 72.87% in certain districts of north India. The national average stood at 80%. The difference in the burnout ratio indicated the amount of profit that the insurance company had earned in a year. Constant and increased IEC efforts by the governmental agencies have increased the enrolment, and utilization of the scheme in the northern parts of the country which had been seen to lagging in the implementation of the scheme in the first two years.[26]

The use of vernacular press has ensured that the IEC campaigns reach the intended population and that there is the full cooperation of people involved in the programme and also indicating the contact persons in case of ay queries. While the IEC activity is left to the insurance agency, which is entrusted with the job of advertising the scheme in the intended area with the cooperation of the TPAs. It has been seen that the TPA's and the local self government officials work in tandem and designate a person as Field Key Officer (FKO) who work in the local area trying to work the details about the working of the enrollment procedures and also the details about the use of the treatment procedures. The TPAs are also entrusted to work as middlemen trying to process the claims and also trying to work towards the fulfillment of needs of the governing agency. An encouraging trend noticed has been the uptake of treatment services by increasing number of women, while the number of women has increased manifold and outnumbered the number of males using the facilities. The use of healthcare services by women has been an encouraging trend and a positive one at that.

[26] Swarup Anil : RSBY Emerging scenario, Accessed online

The personal experience of the researcher, it was noticed, that the use of healthcare services by women especially in the rural as well as semi urban areas has been a positive change. The increased interest of Non BPL population to ride on the RSBY platform by paying up the whole premium also indicates the level of interest generated by the scheme.

If enrolment and utilization of a scheme are any measures to go by; then surely the RSBY scheme has managed to gather a lot of interest and also a lot of beneficiaries. Most of the beneficiaries also report the ease in the operation of the scheme as a feature that has attracted attention and also the cashless feature as the ones that have motivated them to seek treatment in private as well as public hospitals. Increasing number of workers have mentioned the ease of claims and the seemingly easy methods of uptake of the services at even private hospitals as one feature that has attracted a lot of interest and also savings considering the increasing costs of medical expenses and also the increasing amounts of incidental indebtedness caused by catastrophic medical expenses.
The increase in the medical expenses coupled with the unavailability of services in the rural areas also makes this RSBY scheme a very popular one in the rural areas in most of the states.

In the present scenario, it has been noticed as well as reported in the media that a trend has been noticed wherein the private sector hospitals have been the beneficiaries of the state funded scheme, meant to be PPP model. It has been noticed off late that given a choice people prefer to get themselves treated at private hospitals, citing reasons of hygiene and care received as motivating factors[27].

CHIS in Kollam

The CHIS scheme in Kollam had started in the year 2008 in 24 hospitals, 14 private hospitals and 10 public hospitals. During the very first year of empanelment the

27 Dhoot Vika and ,Kamath Gouri:Private healthcare in rural areas gets RSBY push - Economic Times. Available at: http://articles.economictimes.indiatimes.com/2011-05-12/news/29536172_1_private-hospitals-rsby-empanelled-hospitals [Accessed May 13, 2011].

number of private hospitals has shown an increase and it was reported that the number of private hospitals in smaller towns of Kollam district had empanelled themselves.[28] The only trouble that patients faced in these cases were that they had got to know about these new hospitals very late and by the time the patient load started increasing, the hospital had closed down the scheme. The reasons cited in such cases include the very low rates for most procedures, unmanageable crowd, decline in quality and most widely reported grievance was delayed payment of the due amount by the insurers. Also there have been complaints about irregularities in the scheme and resultant de-empanelment of these hospitals.

The following table shows the implementation of RSBY/CHIS in Kerala during the year 2010-2011 and the estimated number of beneficiaries in the year 2011-2012.

Table 1. Estimated number of beneficiaries during 2011-2012.

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

Adapted from the implementation report 2010-2011, Source CHIAK website

[28] *Personal conversation with PRO at Punalur Taluk Hospital on November 17th 2010.*

During data collection, the researcher had found out that out of the 24 hospitals that were initially empanelled under the scheme, only 17 were currently functioning and out of which 10 public hospitals were still working with the scheme. This was the overall picture during the first phase of data collection during the months of November 2010 to early January 2011. But this picture was set to change in the coming months as a result of the impending assembly elections and the imminent change of guard at the helm. The months of March and April, when the second round of data collection was conducted, the elections had commenced and there was a state of status quo that was being maintained. The election result was announced on the 13th of May and as expected, there was a change in the ruling party; it changed from the Communist party to the Congress led United Democratic Front (UDF). Under the new government the scheme has undergone change already, the scheme has now turned its focus only on the BPL section as new APL cards won't be given out any more. Also, the insurance provider has been given a tender for working with this scheme for the next 3 years, which is against the guidelines provided by the RSBY scheme, which mentions that the extension for than a year would only on the grounds of fool proof working of the scheme and after a yearly valuation has been found to be satisfactory.

The changes that came about as a result of the change in the political leadership in state has led to the scheme losing its comprehensiveness, it was claimed to be the comprehensive health insurance scheme. Along with change in the authority came the decision to narrow down the scheme and to take it forward only as a means of insurance for the population below BPL. The scheme has also done away with the mandatory guideline of not providing monopoly to any insurance provider by agreeing to work with United India insurance being chosen the provider for the next three years. While the new and narrowed scheme is just being rolled out, it needs to be seen whether the targeted approach is beneficial in the long term.

CHIAK – The Nodal Agency

Comprehensive Health Insurance Agency of Kerala - The Nodal Agency is shortly called CHIAK

Comprehensive Health Insurance Agency of Kerala, shortly called CHIAK, is the Nodal Agency constituted for the implementation of the RSBY-CHIS health insurance schemes in Kerala. The CHIAK is a society registered in accordance with the provisions of law under the Travancore Cochin Literary Scientific and Charitable Societies Registration Act, 1955

The Nodal agency was constituted as a separate nodal agency to look after the implementation of the RSBY scheme in Kerala. The agency is headed by an Executive Director and assisted by two Managers and other assisting staff.
The agency is passed the funds for the implementation of the scheme and other working. The empanelment procedure is also looked after the agency which supervises the work of selection of PRO's to be appointed at the different government hospitals and is entrusted with the job of passing the information about the empanelment to the Government as well as the Insurance agencies, who have later entrust the job of conducting the inspection of the hospital to the concerned TPA.

The specific objectives with which the Nodal agency was set up are as under;-

> *"1) To provide health insurance cover to the workers and their families in the unorganized sector under the 'Rashtriya Swasthya Bima 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 programmes meant for social security to workers;

6) To co-ordinate with various Departments and agencies of the Central or State Government, 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 programmes, 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 objects."[29]

[29] Information as provided on the CHIAK website.

Chapter 4- Methodology and Data collection

The concept of Health Insurance and its need are based on the data and studies pointing to the growing inequalities and the need for a supporting structure to protect those who cannot do so by themselves but would get by with some help from others.

The budget speech of the Minister for Finance Mr. Jaswant Singh, in the year 2003, while presenting the budget for the fiscal year mentioned the introduction of an Insurance scheme.

He said- *"For a large majority of our less advantaged citizens, easy access to good health services is just not there. In order to correct this and offer health protection, of some choice, the public sector general insurance companies have been encouraged to design a community-based universal health insurance scheme during 2003-04. Under this scheme, a premium equivalent to Re.1 per day (or Rs.365 per year) for an individual, Rs.1.50 per day for a family of five, and Rs.2 per day for a family of seven, will entitle eligibility to get reimbursement of medical expenses up to Rs.30,000 towards hospitalisation, a cover for death due to accident for Rs.25,000, and compensation due to loss of earning at the rate of Rs.50 per day up to a maximum of 15 days. To make the scheme affordable to BPL families, the Government has decided to contribute Rs.100 per year towards their annual premium... In the first phase, at least an additional 50 lakh BPL families will be covered during 2003-04"*[30].

The statement of the finance minister during his budget presentation was an indication of the need for a scheme to help the poor to access healthcare and that too at affordable rates. The effort of the Union government to introduce a scheme for those who were left out of the traditional scheme of things and those who needed the medical attention were considered the beneficiaries of the scheme. The scheme that was kick started in the year 2003, Universal Health Insurance coverage. The scheme was not as popular as it was expected to be. In the coming years and changed government, the scheme underwent a change, now the scheme was aimed at those who worked in the

[30] Budget speech, Finance minister 2003-2004 Annual Budget presentation, retrieved from Planning commission.org.

informal sector and those who were below the poverty line. It was given a new name and improved technology put in place.

Under the new UPA government I, this scheme was launched as the RSBY where the yearly entitlement was same as the earlier Universal Insurance scheme but there were differences in the way they were administered. This new scheme was proposed to be helping hand to the BPL families to help them access medical care and to prevent indebtedness and increase access to healthcare.

This centrally sponsored scheme administered by the state government could be modified by the state governments before it was implemented in their respective states. The modified RSBY scheme in Kerala was called the CHIS. The state under the rule of Left front government sought to include BPL as well as APL in the scheme and it was widened to include both the categories. Under the new and modified scheme the government partnered with the private and public service providers to provide healthcare services. The choice of provider rested with the patient.

Conceptualization

The RSBY has been conceptualized as a cashless insurance scheme under which the beneficiary stands to seek treatment to the tune of Rs.30,000 a year, for 5 members of his family. The target population for the scheme was those under the BPL and those who were working in the informal sector.

And the equivalent of RSBY in Kerala named as CHIS was conceptualized as a comprehensive scheme to include both APL and BPL population and roping in private as well as private providers in the empanelled list of service providers. Under this scheme the beneficiary is defined as any person who has sought treatment at any of the empanelled hospitals using the smart card.

The scheme was launched all over the country in the year 2008 and in Kerala in the same year. Unlike in other states where the scheme was launched on a pilot basis, in Kerala the scheme was simultaneously started in all districts at the same time. The scheme had completed two years at the time of data collection.

Objectives of the study

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

The specific objectives of the present study were to:

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

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

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

i) Public sector provider – Kottarakara Taluk Hospital.

ii) Private (Not for profit) – Ashtamudi Hospital.

iii) Private (for profit) – S Joseph Memorial Hospital.

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

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

In order to meet the second objective i.e. to study the eligibility, design and implementation of the scheme in Kollam, the researcher interviewed the district nodal officers and the PRO's appointed by the state government, who were working at the different empanelled hospitals in the district. The local nodal officer of the RSBY scheme was also interviewed for details about the scheme and its status in the district.

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

Brief background about the study area

The field area chosen for fieldwork was Kollam, in Kerala. The area was well known for its cashew and coir industries, known as the part of erstwhile Travancore state. This area is noted for the important role it played in the formation of workers movement in the coir industry. However over the last several decades the coir industry has gone into decline for a variety of reasons of infrastructural and other issues. Apart from coir, the other major industry was cashew processing.

Modern Kollam which was earlier known by the name of Quilon has still maintained its lead in the production and processing of cashew which forms the main source of income for the district. The main town known as Chinnakada is a busy trade and marketing area, which also houses many of the administrative offices. The main areas of Kollam district are also dotted by different private as well as by public offices.

Healthcare.

The town has a large number of private as well as public hospitals. While the main district hospital is situated right at the centre of the town, the mother and child

hospital is also situated near the main district hospital. The area is also dominated by caste specific and religion specific cluster of medical service providers.
The oldest among them being the Sanker's hospital, the hospital is situated very close to the city centre and is well known for various specialty departments.

Some other hospitals that are situated in and around the district hospitals have been around for more than 50 years and attract large number of patients. The District hospital has seen expansion and increase in number of patients over the years and this has lead to the vigorous expansion in the infrastructure and the materials. The number of hospitals with modern facilities have seen a constant increase, there have been new medical colleges that have sprung up in non descript villages. One such medical college that was empanelled under the scheme was Travancore medicity, this medical college which is also a teaching college, has separate departments for most streams of medicine and was only in the nascent stage of its growth.

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

The private hospitals ranged from single doctor hospitals to large medical colleges which were empanelled under the scheme, the largest private hospital that was empanelled was the Travancore Medicity, and the smallest being the SM Hospital at Kadakkal. The private hospitals also had certain specific hospitals like the Amardeep Eye hospital and the Sanker's Eye Hospital at Punalur that provided only ophthalmic services. In these hospitals only ophthalmic procedures were allowed and no other services and packages were permitted.

In the district the most utilized hospital in the public sector was the District hospital at Kollam which reported a patient load of 300 people in a day, and understandably the RSBY Kiosk is manned by 4 people round the clock. It was also seen

that the RSBY kiosk at the district hospital was the most crowded and most utilized. In the private sector the Anchal St Joseph's hospital was the largest and most utilized closely followed by the Ashtamudi Hospital at Mevaram.

This study compares 3 different service providers with different ownership models and working setups to compare the service provision, infrastructure involved, and the kind of experiences that the beneficiaries have.

Data collection

The study is exploratory in nature and seeks to look at the scheme from the provider as well as the beneficiary perspective using descriptive methods. The area of study was Kollam District in Kerala. The data collection included visits to all the empanelled hospitals and the interview of all the people involved with the scheme in the hospital, the insurance provider – United India Insurance Company was also approached for getting to know about the scheme and their responses to the reported problems of high claim ratio as reported in the press. The beneficiary perspective was looked at by interviewing patients who had sought treatment at the hospital and by visiting their homes after getting to know their details while they were exiting the hospital. The co-operation of the service provider was ensured by talking to the hospital administration.

The data collection at the private hospitals was ensured by written requests to the administration and the people who were involved in manning the kiosks, the hospital administration staff and the owners; in case of private single owner hospitals.

The source of data for the scheme and its implementation was collected from the official website of the CHIAK, and the articles on the scheme were collected from vernacular press and also from the independent research that has been done on this scheme.

The official documentation was the main source of data while referring to the different package rates and the data relating to empanelment and other technical details.

The news reports about the scheme and the changes in the scheme were collected from local newspapers and it was collected over the time period from August 2010 to April 2011. The inclusion of web content was also done, where the news reports about the same scheme in whole of India was also taken into consideration.

The universe of study was RSBY/CHIS empanelled hospitals in Kollam district, including both the public providers and private service providers. The hospitals empanelled under the scheme ranged from single owner hospitals and nursing homes to private medical colleges.

The method of selecting the 3 different types of hospitals was purposive, keeping in mind their ownership pattern and also the bed strength, which was close to 50, but as there were no public sector hospitals with close to 50 beds offering inpatient services in the district and as most of the CHC s were not offering inpatient services, the Taluk hospital was the next level of hospital that were offering the CHIS services. Thus the selection of 3 hospitals which provided CHIS services included a private for profit hospital (S Joseph Hospital, Neendakara), a Private not for profit hospital (Ashtamudi Hospital, Mevaram) and a public sector provider (Taluk Hospital Kottarakara).

The hospitals were based in Kollam district and are situated in different settings, and attract large number of patients both RSBY and non RSBY patients. While the number of private hospital which continued to work under the scheme as of April 2011 was 10 in number, and there were 10 public hospitals.

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

Data collection was done during the time period from March to April, and the method used was, to conduct in depth interviews with the service providers, and their representatives, and with patients it was in depth interview method.

The data presented in the next chapter is descriptive account in the form of case studies of the 3 different providers and the beneficiaries within these 3 providers. The data collection of data for preparing the case study of beneficiaries was done by interviewing the patient itself and in two cases their bystanders, because the patients were very frail and unable to talk or in distress.

Problems faced during collection of data.

The data collection was centered around the different service providers scattered around the Kollam town, it ranged from single owner nursing homes to Privately owned medical colleges and to District hospitals catering to he whole district. The sheer enormity of travelling for data collection to one of these hospitals was defeated when the hospital refused to allow any interaction. Though the researcher had telephonic conversation with the authorities, while they refused to meet or discuss any further any details about the scheme or the working of the scheme in their hospitals.

There were only a very few private hospitals that empanelled themselves in the Kollam town area, this was because of the fact that the district hospital was a large institution and it catered to most of the needs of the patients in the town area, it also seen that some of the very few that had empanelled themselves during the initial stages had dropped out after a few months. The rates of hospital attrition were growing as the scheme progressed. After the initial few months the ways of the empanelled hospitals changed and the ways of bypassing the scheme came up. The case of Travancore medicity had been kept hush and it was discovered only after some patients had reported the matter to the nearby hospitals about the malpractices that were happening at the hospital.

An attempt was made to meet the administration and seek any report on the working of the scheme, but to much dismay, there was hardly any cooperation from the side of the administration and it was a rather bad experience, as the researcher was driven off and a verbal tiff ensued. It was later that the researcher got to know that the hospital had bee de-empanelled. There was no signage relating to this at the hospital mentioning that the hospital had been removed from the list. Only after the patients got themselves admitted did they know about the de empanelment scenario. The process of seeking a discharge at this point becomes very difficult as the treatment is midway and it would be risky to leave. Several attempts were made to seek permission, but a meeting with the owner cum Managing director of the hospital was a turning point as the person out rightly refused to provide any help whatsoever and asked for confirmation to never return to seek any information on this scheme.

The RSBY scheme places importance condition of the hospital before it is empanelled and according to this, the Hospital must have a fully functional OT, and a post operative ward and the provision for recuperative ward. It was this basic provision that was being prohibited at the different hospitals around the city and it was noticed that at one of the hospitals were found to be violating the norms of operating the OT. The post operative ward was unhygienic and it was seen that the provision of only general ward for the RSBY patients was being violated, as it was slowly made known to the patients that a paid ward would be beneficial for the patients who had just undergone surgery, and it was seen that money for such services was deducted from their card, in addition to the chargeable payments that were expected from the patients by taking up a pay ward. Most of the patients were directed to proceed to the ward without mentioning that their RSBY cards were not valid. Most of the patients had reported that only after they had requested that they came to know of de empanelment.

While the matter with Travancore medicity was that of cover ups and lack of information. The hospital has engaged in malpractices to increase the number of hospitalizations and the claims from the insurance company. The hospital had refused to allow any enquiries from the researcher in this regard and also refused to allow a look at

the old records and any attempts to look at the details of procedures done and other records.

The insistence on clean and functional OT had been tampered with in the case of *STAR hospital Oachira*, where the OT was just another room with bare minimum equipment and separated from the main hospital by a long and narrow corridor which was unkempt and strewn with post surgical waste like cotton swabs and other used surgical material. In the process of engaging the RSBY kiosk operator in a small talk the researcher was taken around the hospital where it was seen that the hospital had seen no immediate cleaning activities and the post operative ward was separated from the normal general ward by a string of green curtains as a partition. The insistence of the kiosk operator to talk in private at the kiosk, which was located at the far end of the narrow corridor, had to seen with caution. The researcher had to resort to seek the company of a person nearby and avoid taking the conversation beyond the open and well lit Reception area.

The experience at Robins Hospital was unpleasant. During the course of the interview the researcher had to walk out, in middle of a conversation; because of inappropriate behavior of the hospital staff. The hospital was situated right beside a busy National Highway, it was also seen that the hospital was functioning in an old house that had been converted in to a hospital and which was very poorly lit and ventilated. The staffs manning the kiosk were all males. The researcher had to resort to a walkout in middle of a conversation because of the inappropriate behavior of the staff and when the researcher tried to report the same to the administration, there seemed to be no doctor on campus and there was hardly any sign any medical intervention in and around the campus. While at the insistence of the researcher, the administration did produce a head nurse, but she feigned ignorance about any male staff working at the kiosk and passed off the matter as being nothing but untrue claims from the unsatisfied patients. While the female patients also reported feeling intimidated and at risk from the kiosk staff, and on further enquiry it was reported that the staff had been working on the hospital without the notice of the "owners of the hospital"

The experience at the St.Joseph's Hospital Anchal was one of non co-operation and resistance in providing any information what so ever with regard to the scheme, and also a verbal diktat that the researcher should not be seen anywhere near the hospital enquiring about the scheme either to the beneficiaries or the functionaries.

The collection at some other hospitals in the private sector were easier considering that they were small hospitals and they had not many specialty departments functioning and it was managed by a single owner. In such cases the hospital owner or their representative made arrangements to meet the patients and also the staff associated with the scheme to be interviewed.

The interview process with beneficiaries in some private hospitals were strictly supervised by the presence of either one or more staff from the hospital and at times the person present during the time of interview would steer the conversation away from the point and make it evident that "such data" was not required for an academic study.

The cooperation of the authorities at the Public hospital was helpful and was not very difficult to convince the need for the study. The authorities at only one hospital, Taluk hospital Karunagapally had demanded an elaborate written request detailing the need for the data and the reason for the study. Only after a written request was processed; that the data collection was made allowed. The authorities also ensured that I carried no recording devices or any other electronic devices.

The following chapter presents the data collected from 3 hospitals and 8 case studies from the 3 hospitals. The data also prides a brief picture of the services present at the hospital and the experience of the beneficiaries and the bystanders, who had sought treatment at the hospitals.

Chapter -5

Case study of implementation of CHIS in 3 types of Institutions.

The primary purpose of Health insurance is to protect people from catastrophic health expenses and it has been seen that large scale enrollment of people into compulsory health insurance programme has been seen as an emerging option for policy makers who are interested in getting increasing number of people under one of these schemes. The umbrella term of insurance can refer to private insurance as well as social insurance as doled out by the government.

The RSBY/CHIS is an ambitious plan to bring all those who are working in unorganized sector, and who cannot claim benefits generally provided for the workers in public sector. The scheme aims to provide treatment at private as well as public hospitals. Under the scheme it is mandatory that all public hospitals from the Community health centre level and above to provide mandatory treatment to people who have registered themselves under the scheme.

In this chapter an attempt has been made to look into the different types of providers who have been roped in to provide services, and the kind of services that are delivered, the profile of the hospital, the services and the manpower, and also the background of the patients who report for care. An attempt has also been made to look into the actual beneficiary experience and their perception about the hospital, the services they received and the changes that they think should be incorporated.

The case study follows 3 hospitals, with different ownership patterns, where one of the hospital is privately owned and run as a for profit entity (SJM Hospital Neendakara), another private hospital which is run on a shareholder basis and is owned by a group of 50 doctors (Ashtamudi Hospital Palathara). This was two types of private institutions which worked in very different ways and also presented very varied patient

profiles and experiences. Another hospital which is taken up for study is the Kottarakara Taluk hospital, a government hospital which functions as the first referral unit.

The comparison between 3 different hospitals were done on the basis of services available, the experience of the beneficiaries for a wide variety of diseases and the men and material that was available with these service providers.
Ideally the comparison should have been between a Community Health centre and other hospitals with similar bed strength but it had to be substituted with a Taluk hospital, as no cases of any inpatient treatment was reported in any of the hospitals barring one, where they "rarely" attended to a delivery case. The Bed strength of other private hospitals being compared in the study is about 45.

The hospitals that were empanelled under the scheme in Kollam district of Kerala were 24 in number according to the official records presented on the CHIAK website, but in reality almost 7 private hospitals had de empanelled themselves for reasons ranging from lack of profits to money diversion and financial irregularities.

The empanelment of private hospitals is done with the help of the TPA, who help in the organizing the MOU to installing the necessary software and also to help in the process of claims for money for procedures conducted. The empanelment of private hospitals is done against the payment of Rs.30, 000 odd rupees, which must be done by drawing a check in favor of the TPA and should be renewed every year. The private hospitals are bound by their MOU to provide services according to the rates agreed on the package list of the RSBY/CHIS.

The private hospitals in the list of empanelled hospitals are required to adhere to certain basic conditions regarding services being offered the general conditionality that it should have a working OT and other necessary measures, and the services of qualifies and practicing doctors. The condition for empanelment of private hospitals is based on inspection of the premises by the TPA as well as the representatives of the insurance

provider. The insurance provider may depute an official who would inspect the premises and report back to a higher authority for appropriate consideration.

During data collection it was noticed that there certain hospitals which clearly flouted the rules and also indulged in malpractices to improve their revenue out of this scheme and to make this profitable for them.

The case studies presented below are an attempt at looking at the kind of services provided in a private(for profit) hospital, private but not for profit hospital, and a government hospital working under the same scheme function in very different ways and the mosaic of experience that the patients have had while seeking treatment at these three providers.

Provider case study-

(a) Private (for profit) Institution

5.1 S. Joseph Memorial Hospital (Neendakara) Kollam.

The SJM HOSPITAL Neendakara is situated on the outskirts of the Kollam town, a 60 bedded hospital. Established in the year 2000 the hospital has been empanelled under the RSBY scheme for the past 2 years. The hospital was established in the year 2000; the hospital first started out with 20 beds and was later upgraded to a full fledged hospital with more beds added and more staff hired over the course of 2 years. The increase in bed strength was marked by increase in the number of doctors as well. It also meant an increase in the infrastructure and machinery in the hospital.

It caters to the population in and around Sakthikulangara area, which is dominated by people associated with fishing and allied activities.

The administration of the hospital is owned by a person who is the doctor at the same hospital. The hospital employs 40 nurses and 11 doctors, who provide their services

as when required on a consultation basis. There are only 3 doctors who are on the rolls as permanent staff of the hospital. It is a private (for profit) hospital run by board of directors. The board of directors includes people who are engaged in business and have contributed money and also donated or helped the hospital to buy equipments. Also included in the board of directors, are those who are doctors and who come and offer their services as consultants.

It is managed as a single owner entity with Dr. Shaji Jose being the authority at the hospital. In the recent past two doctors had donated a fair share of money and joined the hospital as regular doctors, and in return for their investment, they were included in the decision making bodies. Most of the doctors on board were not surprisingly from one religious belief (Syrian Christians). Most of the members of the staff were also from the same religious denomination. It was also noticed that the hospital has decorations chronicling the Life of Christ, which adorned the walls and the reception area, which sought provide a reassuring feeling to the people who came to seek treatment. The administration handled the registration as well as OPD cases and directed the patients to approach different doctors.

The governing board also consisted of the family members of Dr S.Joseph, in whose memoriam the hospital was being run.

Infrastructure and Services

The hospital had separate departments for most of the branches of medicine and also arranged for different doctors as consultants from other hospitals during emergencies and other requirements.

The hospital was expanded in the year 2002 and more departments and inventory added during the expansion, as the ownership rested with a single person, most administrative work was done only during the times when the Doctor was free. In case of emergencies the administrative head also took over the affairs. The hospital was very cleanly maintained and there were 18 workers working in shifts to keep the area clean.

Infrastructure was newly acquired. It was acquired at an estimated cost of more that 9crore Rupees and was being financed by several kind hearted souls in and around the hospital. On further enquiry it was evident that the hospital had garnered resources from different owners of fish processing units in and around the area for funds and had named the different wards in their names as a mark of gratitude. In doing so, the hospital had effectively masked the major source of the money for building such a structure and the amount of money required to buy all the equipments for the hospital.

Background of Patients accessing care

Most of the patients accessing the hospital are from the neighboring areas and also referred those who are referred by nursing homes in and around the Sakthikulangara area. The resident population has developed trust and dependency at the doctors at the Hospital. This is because it is the nearest private hospital which has more than 10 beds with a pediatric department, functional Operating Theatre and other facilities that has ensured a steady clientele. The promoters of the hospital claim that they attract large volume of patients under the RSBY scheme.

The hospital also provides medicines as stipulated by the RSBY norms during the stay at the hospital, and also provides medicines for patients for 5 days after discharge.

The provision that the RSBY patients could only avail the general ward for their stay was enforced very strictly and it was noticed that during a very recent development the Hospital authorities had made a new structure which was concrete structure but covered on all sides by just bare green translucent sheets. There also was a nurse's station attached the new RSBY ward as it was named. There were 18 patients who were admitted at the time of the visit of the researcher. There was hardly any provision for the convenience of the bystanders and others who were accompanying the patients.

A canteen was functional and it provided meals and other refreshments for the patients and their bystanders. Most of the patients shared their bed with their relatives

who were attending on them The RSBY patients were mostly admitted to the general ward and this was partly because of their inability to demand better provision and on the basis for their entitlement. Though the official diktat says that meals should be provided along with the stay at the hospital, the hospitals authorities feigned ignorance of the existence of any such clause and also reported that the hospitals was running on very low margins and could not afford to provide meals and that the had sought permission from the authorities to do so. This meant that the hospital ran a canteen that would provide meals at a price to the patients and was also considered an addition to the costs of operation.

Under the new and revamped hospital, the addition of the RSBY kiosk had added new patients to the hospital and increased the patient load on the hospital. The sudden surge had reportedly brought about a decline in the number of cash patients or bill patients as they were referred to by the administration. The establishment of the RSBY kiosk meant that a small counter was opened, where there was a representative of the hospital and who would engage in transacting with patients and the RSBY online procedures. As the kiosk is situated right near the entrance, but consciously kept away from the main reception area, the staffs at reception area were asked to direct the RSBY patients to the RSBY counter near the pharmacy area, and then they were subsequently admitted and asked to report back to the main hospital building. This supposedly distinction was because of the chaos that was noticed as a result of the large number of people flocking the hospital seeking discounted rates of RSBY and consequently giving a slightly negative picture of the institution to other patients who were bill patients. During the conversation with the manager, he was able to point out with some confidence that the number of BPL patients with RSBY had increased to a large extent and this was seen to be eating into the profits of the hospitals by cutting down other revenue sources and also by inducing losses on account of discounted rates for several procedures.

The reasoning that the hospital authorities provided was that the number of people who had taken up the card were those belonging to the BPL category, and this had led to "such" people crowding the hospital and taking up the beds and leaving the place only

after they were fairly treated. The administrative head also mentioned in the difficulties to control them, as they often retaliated in case of the refusal of satisfactory treatment by the doctors.

During one visit of the researcher, the situation at the hospital had turned little murky and there had been clashes and use of force on the doctors by the bystanders and others who had gathered to witness the situation, and claimed a case of medical negligence.

To this the Chief administrative officer reported- *"These people are like this, no class... you are not fit to be given any treatment rather than stand in long queues at sarkaar hospital"* [31]

There had been number of such instances and according to Mr.Rajan, the chief administrator, it has been noticed that such incidents had slowly made an impact on the stream of patients and a resultant decline in the revenue. The management had expressed its inability to continue the scheme, but a open talk with the workers and others involved in the scheme had shown that there existed a very high regard for the scheme, and it popularity was also a factor in the growth of the hospitals and thus it was decide that the association would continue.

The registration and the signing of the MOU between the hospital and the insurer and the TPA had taken place in early 2009 and it involved the payment of close to Rs.34,000 odd rupees towards empanelment. In the due course the TPA would visit and fix the required hardware and software and also conduct classes to operate the same. In case of any malfunctioning, the TPA and its representatives are expected to look into the issue and solve it. In case of any other queries the field Key officer and the representative are the people who are considered the resource persons.

RSBY implementation in the hospital had been working fine for the past few years and there had been no reported outrages, and there has been no major hurdle that

[31] Visit to the Hospital on 11th November Neendakara, Kollam, Kerala.

was seen in its implementation at the hospital. Most of the paper work and other procedures to be followed with the claims had been done regularly and had reported no problems. Also, periodical inspections done by the insurance agency also had reported no major troubles. In a particular case they had asked the hospital to represent the district in the RSBY met, considering its flawless record of keeping all the records and the transactions updated.

The workings of the scheme, though looking at it from the outsiders point of view looks fair, there are a number of tweaks that have been done to avoid detection and also to avoid or cut down on the costs associated with discounted treatment. In most cases a post operative patient would be given a choice of a paid room instead of the general ward as prescribed in the RSBY guidelines. They would be indicated of the risks and the effects of taking up general ward and linking it with complications or a feeble mention of infection. Most of the time this technique worked and the patient would take up paid room, but still being marked on officials documents as occupying the general ward beds. Thus in this manner the hospitals get their due share from the bed as well as the original rates of hiring a room from the hospital.

Most of the patients reported feeling confined to the hospitals, as they(hospital) took away the cards because otherwise the patients seem to vanish without the cards.
In order to know more about the institution the researcher interviewed couple of people who had been at the hospital as well as some patients who had sought treatment for different ailments and were admitted at the same hospital.

Some of the case studies are presented below.

5.1.1 Case study

Mrs. Chellamma, a 60 year old woman is an unskilled worker, who works at the fish processing units at Sakthikulangara and Ramankulangara area. She has been working as a help to her husband who also engages in small time fishing in the sea and other allied

activities. During the monsoon season when fishing becomes a risky occupation, her husband Ponnan (65) engages in small masonry work and also in fish processing at one of the numerous fish processing units functioning at Sakthikulangara (Kollam).

Ponnan has a history of severe alcohol dependence combined with substance abuse as well. He has taking de-addiction counseling from the nearby church where the pastor has been providing de-addiction counseling services for the past 11 years. Ponnan has been a firm believer in the capacity of the pastor to "cure him" of his addiction to alcohol.

Chellamma was married at the age of 17 and had since then given birth to 7 children of which only 4 have survived, the death of the children were very early in their infancy, 2 of them died of "brain fever" and later one more did due to what Chellamma calls an epileptic fit kind of disease. During the deaths of her children she was living in Kanyakumari, her native place, south of Kollam district in the neighboring state of Tamilnadu. Since the death of her children she had moved to settle down at Kollam in the early years of 1970's. Her husband has had bouts of illnesses ranging from asthma to a slipped disc sustained during the masonry work.

Chellamma's four surviving children are aged above 30 and are engaged in manual labour, fishing and other allied activities and are settled nearby. All of Chellamma's children are married and are enrolled in the RSBY-CHIS scheme separately. Most of her children have been beneficiaries of the scheme on various occasions and are dependent on the scheme for their regular doctor visits in case of disease or ailments. Chellamma got to know about the card and its benefits from her neighbors and also when her husband Ponnan was forced to enroll in the scheme by their children, who stayed a few houses away.

Chellamma and her family had been enrolled at the local Akshaya centre after coming to know about the scheme details from the ads that had started appearing in the vernacular press and also after she was convinced about the need for security in case of

any medical emergency as she and her husband were growing old and also engaged in risky and strenuous jobs which increased their chances of getting sick very often.

Most of the times, Chellamma has to mortgage her gold or her property to pay up for the medical expenses. When her husband had fallen ill, he had slipped a disc during his fall from a tall building. After the fall he had not received proper treatment that resulted in his ill health. He had not sought treatment for many days and when the pain had become unbearable, he resorted to treatment in a small hospital.

Ponnan had to take medication on the prescription of a local Ayurvedic practioner and also on the suggestion of the doctor who had tried "fix" his slipped disc. With no respite to his pain he was taken to the district hospital where he was put on immediate treatment sensing his delicate condition, Chellamma had managed to gather monetary resources to pay up and settle the bills and other expenses. She had to resort to selling two of her jewels to manage the money.

She said- "Gold can be bought later also, but I cannot keep my husband's life on a balance to decide which is more valuable, most of my valuables are his gifts, they cannot be compared to the value of his life".[32]

During that sickness period, Chellamma had pledged her ornaments and sought immediate money, she managed to find enough resources to pay up and get him discharged from the hospital. Expenses on his medication and physiotherapy had forced her to borrow more money from her relatives and her sons. It had made her realize the need to have more savings to tide over illness and the results of loss of remuneration of the earning member of the family and added to his inability to continue with daily activities in daily life and also the inability of her sons to provide for the aged parents, considering that their own livelihood was based upon their daily earnings.

[32] Personal interview with the beneficiary, Neendakara, Kollam. 23rd April.

Taking all this into consideration, she had persuaded Ponnan to take part in the enrollment drive of the RSBY scheme the next year; she had ensured that they enrolled in the second year of the implementation of the programme at Kollam. She too got her thumb impression registered while the registration process was on, she feared exclusivity of the card and decided to take no chances and got herself the Smartcard.

The benefits of the card were explained to her and she was provided with a small leaflet which contained the details about her rights as a Smartcard holder and what all procedures she could get done as part of the insurance policy during the one year that the card is active.

In the recent past Chellamma had developed problems with her reproductive system and had complained of recurring pain and being unable to explain the cause of her trouble and unexplained pains at regular intervals and had recently sought help of a local doctor who had given her some pain relievers, resolving the issue for the time being. She refused to get herself checked fearing huge hospital bills and her inability to pay was worrying her.

She said- "*It took me 11 months to gather courage and try to seek help, it was also because we had just recently got the card and my daughter-in-law pestered me to seek help. I went to robins(Robins Hospital), met the sister(nurse) and was asked to come next week. But I couldn't wait anymore and went to Joseph (S.Joseph hospital).*"[33]

"They took tests, made me visit the lab in town(Kollam city), asked to come 3 days later with results and then was asked to make a visit to the lab to collect the reports and come back to the Hospital."[34]

"Rani(daughter-in-law) collected the results and went to hospital, but sister(nurse) asked her to bring me along for better treatment."

[33] Conversation with Beneficiary.23rd April 2011.Neendakara Kollam
[34] Conversation with Beneficiary 23rd April 2011, Neendakara Kollam.

"I went next day told they told me about an operation, I agreed to anything that would take away my pain. They fixed it for the 20th of April".

The researcher had visited Chellamma one day after her hysterectomy; she was convalescing at her own house as she had been discharged early morning, provided medication for 5 days and had been instructed to meet the doctor after her medication is over.

"I'm already feeling better." Chellamma said.

"I think that they deduced all the 30.000 for such a big operation, I wouldn't have got this done, if we didn't have the smartcard".

Chellamma confessed to be waiting to know how much money is left, as she now wants to use the rest of the money for her husband's treatment of his ailments. Ponnan was also seeking treatment for his ailments and this meant he was about to be admitted in a couple of days time and he was waiting for his wife's recovery, and also wanting to have a feeling of well-being.

Both Chellamma and Ponnan were of the opinion that CHIS was an effective scheme which was helping the poor to seek treatment, and to help them recover from their illness. They opined that the scheme had proved advantageous to them and that they would like to advocate that all people living below the poverty line should opt for the scheme and also that they should make sure that they are benefitted from the scheme. Chellamma vowed to always seek treatment for all her ailments in time to save herself from suffering from any more pain and discomfort.

The beneficiaries had opted for private hospital as it was closer to their place of residence and the felt comfortable about getting them treated at SJM hospital Neendakara (S.Joseph Memorial). Chellamma had been given an option for visiting the district hospital for her operation but she refused and said that doctors at the district hospital are more interested in caesarean operation than hysterectomy operations.

The general perception according the respondent was that the beneficiaries have to claim their due and ask for the services that they require. Chellamma was of the opinion that she had worked really hard during her younger days and refused to heed to anybody and also refused to seek treatment for any of her ailments.

As a grandmother, she made sure that all her daughter-in-laws get the required maternity benefit, and she promptly took them to the district Women and Child hospital for regular check ups and ante natal care. She had recently accompanied her second daughter-in-law for her C-section. Although she has favorable opinion about the scheme she puts forth few suggestions to make it work better and wanted more information dissemination campaigns to happen.

> *She said "Every literate malayali who reads the Newspapers must become a member and seek medical care. Can that happen?? Chellamma had a question for the administrators as well – Why keep the limit at Rs. 30,000, Why not Rs.50,000 ??"*

Chellamma had been a beneficiary since 2009 fiscal year and had been enrolled at the Neendakara Akshaya kiosk and her card is valid for two persons. She is not a recipient of any other social welfare scheme benefits and is also not registered under the matysafed pension scheme. She could not pay the requisite amount of registration fees for joining the state government sponsored pension scheme when it was floated almost 6 years ago. Another factor that has proved problematic for her has been her inability to process her claim for various other pension and benefit schemes that have been offered to her because of the procedural formalities required her to present herself during working hours at the government offices in Kollam town.

5.1.2 Case Study

Lilly Thomas (58) is a housewife and mother of two. She is a resident of Neendakara and her husband Thomas was an employee of the Alind factory which was a public sector undertaking that has been closed down since early 1998. Since then Mr. Thomas has tried his hand at various trades including a brief stint in the Arab emirates. He had to abandon his job at Arab emirates because of his severe diabetes and related complications that had arisen because of his inability to seek expensive treatment in the foreign land and due to his cash strapped condition. He had landed in Kerala after a brief stint of two years at one of the departmental stores in Dubai. He had exhausted most of his savings and earning in his attempt to reach home from the gulf country and hence had been left penniless when he had come back. As a result of his conditions he had to seek immediate care and was hospitalized for nearly two months and had been asked to continue lifelong medication as a result of which he had been dependent on his wife to support him. Meanwhile Mrs. Lilly Thomas had found refuge in working for a school as a helper and earned just enough to manage subsistence.

The school authorities had decided to sponsor the studies of both her children, she also had help from the missionaries working at the school who helped her husband to find work in a small fish processing unit.

Mrs. Lilly had been suffering from unexplained pains and cramps and had been advised to seek medical treatment in order to ease the condition. She had sought help from one of friends at the SJM hospital to fix an appointment and seek a consultation for her pain.

After meeting the doctor at the SJM hospital, she had been advised to undergo thyroid function tests and also other tests to seek an answer to her pains. Mrs. Lilly had been asked to report back with the results after conducting the tests at SJM hospital and she has not been charged anything for the tests. She had been asked to bring her RSBY card and her earlier reports if any when she reports back.

She was asked to meet the doctor with her results and also was asked to meet the consultant who visits Sunday. Mrs. Lilly was very happy when mentioned that all this had been done without any expense from her side. The family of Lilly Thomas was persuaded to finally seek treatment for her ailment once it was understood that treatment under the scheme was free and that they need no pay any money whatsoever to claim the benefits other than the registration amount.

Mrs Lilly was admitted a day before her operation and was explained the procedure and was assured by the nursing as well as by other staff that she will not incur any expenses on account of her treatment. On the assurance of her husband, Mrs. Lilly was admitted and was given medication for a day and was prepared for surgery. Her husband had signed the consent form for her and also stayed back as her bystander for helping her, and for her recovery. During the course of 4 days that she stayed at the hospital, she was required to undergo regular checks and expressed her happiness at the way the doctors looked after her and also the way she was being explained the procedure, its impact and its benefits.

Further discussions with her family revealed that she had been working 16-18 hour shifts some days so that she could make ends meet, and she was also burdened by the treatment expenses of her husband who suffered from complications from diabetes.

Her two children were also not capable of helping her in earning income as they were rather young. But, her children did work during their December vacations, where they helped local stationery shops and decorators in making Christmas trees and Christmas lamps for which they were paid a paltry sum of money. This money was spent towards the Christmas celebration at home and was considered a luxury.
Mrs. Lilly was also considered a good cook, and would often help cook meals and delicacies for small gatherings in her neighbourhood and also as a helper during marriage and other functions in her friends circle.

In midst of her illnesses she would multi-task and also let her children enjoy a secured life with her constant efforts to make them educated. Lilly had taken time off from her work to consult doctors on several occasions and rued about her inability to find a proper care for it. She had tried to seek treatment on different occasions with different doctors and had returned disappointed owing to her inability to pledge any monetary resources and her inability to take days off from her working schedule.
On a rare occasion when she could find some relief she was prescribed some medicines, but later had developed allergic reactions to it and mentioned her inability to further continue her treatment. She had tried physiotherapy sessions for her husband who had become dependent on his wife for his day to day activities. His daily routine was also tuned to the activities of his wife, which mean that he had to dependent on her for his everyday activities.

The missionaries had helped Lilly's husband in getting a job, which helped to manage day to day expenses and also kept him engaged in work and he took time off his daily schedule to attend physiotherapy treatment at the nearby clinic, in the hope of regaining some movement in his legs. In the past few months, the physiotherapy visits had alleviated some pain in his legs and also helped him regain some sense. Most of the times, the family resorted to sharing meals at the mission school, which was a boarding school, and which provided meals for the student inmates, The family used to help the cooks at the boarding in exchange for meals and other essentials.

The day she was admitted, Lilly Thomas was informed about the procedures that would be performed on her and the exact healing time. She was also made to understand the need for such an intervention and the urgency of it.
After the surgery, she was kept under observation for 5 days and was also, shifted from the Operative ICU to the general ward, she was also referred to meet the consultant on a one day during her mandatory 5 day recovery period. During the interview, the patient had reported to the hospital for her regular 2 week check up and reported feeling healthy and also being able to feel strong enough to join work. The patient had reported feeling some discomfort after a week of her operation, which was looked into after she reported

to the hospital and was given an emergency appointment to me the doctor. She had been treated for a gynec problem and also asked to report for her monthly check up to avoid any further complications and had been advised rest and recuperating at her house. But as she was hard pressed for money, she had reportedly taken a break after 2 weeks and joined work.

The school administration gave her an earned leave of one month, so that she could fully recover and join work at a later date. Considering the nature of her work, she feared that she might lose her work and reported feeling uneasy on her extended leave. This had prompted her to seek odd jobs and was reportedly the cause of her pos operation pain, and the resultant admission to the hospital for 2 days. Because this admission was considered as a new illness episode, she was admitted under a new treatment schedule under the RSBY card details and an amount of Rs.500 per day was deducted from her card. She reported being unable to walk or do any work during those two days and was unable to explain the cause for it. During this illness episode her husband had not been able to join her as a bystander and she was left alone with one of her children around for help. After her treatment got over, she vowed to follow the advice of the doctor and rested for nearly 2 weeks before she finally joined work.

The overall experience of the patient in this case has been satisfactory, as she reported feeling secure and healthy after her treatment schedule and also held high opinion of the doctors and staff at SJM hospital for their co-operation and helping mentality. She also reported feeling comforted by the surrounding of the hospital as it had a positive impact on her recuperation. She reported feeling comforted by the presence of religious edicts in and around the hospitals and also the daily prayer schedule. She reported feeling reassured of her health after being advised on activities that she can perform, and those that she cannot. On her arrival at home, she was informed of her husband having met with a freak accident and reported discomfort and his inability to work. She decided to work and started to report for duty right after her mandatory rest period was allocated small odd jobs and was reassured that her pay will not be compromised or cut down for the period of her absence and she was also reassured of her

option of seeking medical treatment in case she needed any with out any delay and it was also indicated to her that she need not worry about the studies of her children.

On being asked about her decision to seek treatment she said- *"I needed treatment, but I could not leave my children and husband to fend for themselves as I wanted to feel better after getting a treatment. My needs could be masked for a long time, but this time it got of my hand. Neither could I work or stay at home."*

She reported feeling better and in a position to provide her 100% in whatever work she engaged in. She also reported her relief in having a RSBY card, which had effectively saved her from pledging her only savings. She reported feeling empowered with the card and also reported being feeling in control of her health and the expenses associated with it. She also reported feeling in control of her ability to tide over the feeling of helplessness that she used to feel during her earlier episodes of illness.

She had taken up this card at the insistence of her neighbor and had been prompted by the new and views that she heard about the card from her neighbors. Her sisters has requested her to enlist herself and asked to report to the hospital with her card, this was after she had reported severe pain and helplessness during one bout of her illness. During the registration she had expressed her desire to seek treatment as soon as possible and was asked to wait at least one month before she could find a hospital and her treatment could start.

When asked about her views on the scheme, she reported feeling secure and also feeling relieved a not having to sell or pawn her belongings to settle her bills. She reported being able to feel at par with others because she was able seek treatment at a private hospital, which she reported would have been only a dream is she did not have a RSBY card with her.

On further enquiry she said that she had some grouses against the system, she said that the one to two month wait to get the cards was very difficult as anyone who wanted

to seek treatment in the intervening months was left without any coverage and which meant that this card should be taken only after deciding to seek treatment after two months.

She also raised an objection to the condition that the biometric reader of most of the hospitals that she had visited had some problem and that they reported not registering her fingerprint and also not being able to register her as a patient. In such event the hospital had asked her o report the next day, she opined that it was impossible for someone in extreme pain to come the next day, only because the "thing" would not register her.

Also, she was of the opinion that the flat rate of Rs.500 for a day at the hospital must be revised as it reduced the balance amount in the card and which might leave her short of money in case she needed another hospitalization. She said that the condition that there were people who needed urgent hospitalization, but could not do so because of the absence of the cards.

Mrs. Lilly Thomas was also aware of the new scheme that was about to be floated, the CHIS PLUS, she expressed her happiness at the scheme and pointed out that there must different levels of entitlement also like in the cases of taxation she said.

On a personal note she said, she personally thanked the government for extending such a scheme to the people below BPL list. She also pointed out that she did not fit into the BPL list if going by the central government standards, and that she would only qualify when taking into account the state BPL list as provided by the state government.

5.1.3 Case study

Pious (42) a daily wage earning male was admitted to the hospital on the 3rd February and had been under treatment for the past one month and had been bedridden most of the time, he suffered from a slipped disc sustained as a result of the fall from an altitude. He had been advised rest and also physiotherapy to alleviate pain, he had been assured that

he would be able to work again but needed some rest and would be able to do so only after considerable sessions of physiotherapy. He had been referred to the SJM hospital from the Travancore medicity hospital, he had been under the impression that it was still an empanelled hospital. He had not noticed the board saying that the particular hospital had been de-empanelled. After having been treated for 5 days and having coughed up a hefty amount he was shunted to the SJM hospital in a friends two wheeler as the hospital refused to le him use the ambulance.

When the researcher had met the patient, he had been just admitted and rued about the problems that he had encountered and his condition and the kind of treatment that was meted out to patients under the scheme in private hospitals, where they were still being treated as second grade citizens and being made to cough up money for even the food that was to be provided to a person who was unable to do his own daily activities.

On further enquiry he reported that there was hardly any signage at the Travancore medicity claiming that it had been de empanelled, this had lead his family to cough up close to 27,000Rs. In short notice ad thus been burdened by the wrong doing of the hospital. This according to the patient was unethical and insensitive attitude on the part of the hospital administration.

At SJM hospital also the hospital authorities had informed him that his treatment depended on the amount that was left on the card as in the very same year his wife has undergone a surgical removal of Uterus and had been treated and billed as RSBY patient, leaving him with very little money on his card and a very slim chance of performing any surgery on him.

The patient had refused to answer any more queries and was visibly agitated at his fate, to which he said -"*why are we treated like our lives have no value? The only difference is that my money is in the card that the government gave me and yours is in your pocket.*"

"My life is valuable to my family and it is upto the doctor to decide whether I survive or live as a dependent hereafter..." [35]

The doctor at SJM hospital also indicated his helpless in the matter and refused to comment citing his inability to foresee things and claimed that some benevolent soul might sponsor his treatment and he shall work towards it.

Provider case study

(b) Private (not for profit) Institution

5.2.1 The Ashtamudi Hospital (Mevaram) Kollam

The Hospital situated at the outskirts of the city, but over the years the city has expanded to include the area in its periphery. The hospital is situated at the town limit area and beyond which the city of Kollam is laid down.

The hospital started its operations in the year 2008. It was launched as a "no frills hospital" (G 2008)[36] and which was advertised as the low cost hospital. The hospital has been operating since 2008 and it was noticed that it catered to the population in a an area which is known to have a concentration of Cashew factories and small industries like aluminum fabrication, and a few motor vehicle wholesale go downs and workshops. The area is predominantly residential barring the few small industries.

The area has been utilized as a corridor for development, as it is planned as a bypass that connects the passengers coming from Trivandrum to avoid entering the city and cut across and move over to the next town. Situated in the area are some private schools and religious institutions. As mentioned before it is predominantly a residential area that is surrounded by other commercial establishments and newer ones are being set up.

---

[35] Conversation with Beneficiary 24th April 2011, Kollam.

[36] G,Rajiv,2008.Doctors open a "no-frill" hospital Indian Express. *http://expressbuzz.com/States/Kerala/doctors%20open%20a%20%E2%80%98no-frill%E2%80%99%20hospital/29746 html.*Availableat: http://expressbuzz.com/States/Kerala/doctors%20open%20a%20%e2%80%98no-frill%e2%80%99%20hospital/29746.html [Accessed June 26, 2011].

The hospital was empanelled under the RSBY scheme in the Month of June 2009 and was empanelled six months after it started it started functioning. During the visit of the researcher, the hospital was being expanded and it was noticed that the hospital had first started functioning in a small building with 20 beds and it was being expanded to include more beds and more amenities and also staff were being hired to run the operations smoothly.

The hospital was being run by a group of 50 doctors, mostly from the 1983 batch graduates from the Alappuzha medical college. The hospital is run on no profit basis and the doctors are mostly consultants who help out the administration in case of need and charge only minimal amounts and do not usually take their consultation charges. Most of the doctors working at the hospital are also privately employed and the doctors are on a rotation basis, also undertaking administrative work at the hospital. The hospital has 28 staff apart from the 50 doctors and equal number of nursing and paramedical staff. Since the inception of the hospital and the start of the scheme there had been 1034 patients and almost 600 and more operations.

The hospital has been noticed to have a steady clientele because it is situated in midst of residential area. Also the hospital has made a name for itself by offering expert services, as the services of the hospital have spread by word of mouth. The hospital also offers subsidized rates for treatment of most patients. The association of RSBY with already low cost of the hospital had added to the number of patients seeking care at the hospital. It was also noticed that separate days had been allocated for different specific treatments and there was a huge uptake of such services on particular days. The hospital also provided services of consultation by eminent doctors on a weekly basis and this was a huge draw among the patients. In the initial months the hospital had cardiology, gynecology, plastic surgery and pediatric speciality doctors who offered their services. Apart from the RSBY health scheme the hospital itself runs a health card scheme where the patients can opt to take a health card for Rs.120 for a family of four to seek unlimited consultations for a year. This scheme is optional and not a prerequisite to seek treatment at the hospital.

The hospital is run by 50 doctors who joined hands in 2008 to start a private limited company named Kerala Academy of Health Sciences and Research. Most of the doctors who have joined the hospital are shareholders of the hospital and are expected to dedicate time and effort to the hospital. The hospital its initial month had the services of 12 steady doctors who would not draw salaries like in the cases of other private hospitals. They would draw only their respective professional fees.

Since its inception the hospital had gained prominence over its claims of low cost and affordability factor among the patients. It was also seen that the hospital provided for hospital fee waiver in cases where the patients were unable to pay for the operation. While the researcher was at the hospital during data collection, it was noticed that in a particular case the patients had come from the one corner of the district hearing about the low rates at the hospital and decided to get operative procedures done as they could not afford to pay even for their medicines that were to be purchased from outside. In this case, the patients had come looking for the service after hearing about tit from their neighbours. The patients had reported their helplessness and informed the hospital authorities about their inability to pay, subsequently the hospital authorities had convened a meeting and tried to asses the situation and to evolve a strategy to be followed in this case. It was decided that the patient be allowed to seek treatment and the concerned doctor had voluntarily offered to waive his professional fees or any other charges and the hospital on its part had arranged for the treatment to start at the earliest.

The Hospital started with bed strength of 30 and had expanded, in the past one year, and now it had stable bed strength of 46 with an additional 12 beds that can be used in case of need. The hospital reports 80% occupancy through out the year and it was noticed that the hospital authorities had taken efforts to see that there is no overcrowding of the wards and also the post operative ward considering the steady stream of patients who reported at the hospital.

The hospital had been advertised a the low cost and no frills hospital which would use advanced medical technology only in case of need and also as being a hospital that also provided trauma care facilities. Most of the patients who reported at hospital had heard of the hospital from the advertisement provided during the empanelment drive and also as a participating member of the RSBY scheme.

At the time of Interview, the hospital was being managed by Dr.Suresh, who had been working with the Indian army, after his successful stints at different places in India, he decide to get back to his hometown and ganged up with his old batch mates to provide medical services at affordable rates and to people who need it. The hospital does not believe in preferring for high end treatment right at the outset, but convenes a meeting of the specialists and then decides upon the nature of treatment to be followed. The administration or the management did not show any specific grouping on religious or caste based cooperation to run the affairs of the hospital. The common thread that kept the share holders together was their association with Alappuzha medical college 1983 batch of MBBS.

Infrastructure and services

The hospital has separate departments for obstetric and gynecological treatments, cardiology department, pediatrics, plastic surgery and a functional operation theater and the services of an ambulance. The facilities also include an ICU and very clean post operative ward.

The hospital has been undertaking construction activity, new blocks and more floors were added to the existing ones and there were more departments that were being added. The hospital administration reported the paucity in funds as being the cause of delay in getting the work done and there was a lack of co-ordination as well, as the doctors were not full time employees but shareholders and they too had to juggle for time from their regular work. In spite of these, the management had put in place a manager cum PRO who dealt with most of the administrative work at the hospital and who would

also look into issues of allotment of doctors and the respective dates for surgery according to the dates on offer by the consultant. The manger is also responsible for the maintenance of staff records and other administrative duties. He is also responsible for the correspondence and the maintenance of RSBY records. The administrator was also responsible for the communication between the TPA (MDIndia) and was know to handle the matters relating to this in a coordinated manner. The work of the manager was aided by the RSBY?CHIS kiosk operator who works on the manual aspect of the working of the card, as he is the person who is entrusted with the job to swipe the card, categorize the disease and select the appropriate package foe each disease. At the hospital this job is done by Mr. Chinmayarth, who has been working since the scheme started in the hospital and it was noticed that he had a good working knowledge of the card, its entitlements, various disease categories, and most importantly he was able to recognize the different categories of diseases. The hospital had a total of 58 beds and of which 46 were stable beds the rest were not very frequently used, but in times like monsoon when there are high incidences of fever and other related ailments, the hospital reports 90% occupancy. According to the Chinmayarth, the occupancy peaked during the last rainy season when the area had reported an outbreak of chikungunya and other types of fevers. The hospital had to turn away patients because of lack of beds and other infrastructure at that time.

Background of patients

The hospital attracted patients from the residential neighborhood as well as others from the closer areas. Most of the patients preferred this hospital because of the proximity of the hospital, and also because of the low costs. The clientele also referred to the ease in seeking treatment as a plus point, and among the patients with whom the researcher had an interaction most of them preferred this hospital because of the nature of treatment that is provided and mentioned about the avoidance of unnecessary tests and scans that were cut out and there were hardly any procedural difficulties encountered during the very first interaction with the staff and the doctors. Most of the doctors who were on duty were found to talk at length to the patients and elicit the necessary responses and also try to arrive at the correct prognosis. The consultation fee for all the

departments was same, they were charged at Rs.20 per visit. The hospital did not charge the RSBY patients any money or any registration fees as was mentioned by other private hospital in and around the area and it was seen that the hospital had displayed big signage announcing its association with the RSBY/CHIS scheme.

A fact that was noticed was that there was another empanelled private medical college nearby but it had been recently taken off the list because of some irregularities. Also, the amount of patients that had been reporting at the hospital saw manifold increase after the other medical college was de- empanelled. It meant that the patient load went up and the usage of services increased manifold, the administration for a short while discussed about continuing the scheme in such conditions. It was also thought that this would bring down the quality of care that was being provided. The practicing doctors at the hospital were adamant on charging no more than Rs.20 for every consultation and were also strict in adherence to the rules of RSBY/CHIS scheme. For the beneficiaries of RSBY/CHIS, consultation was free and treatment was charged on the card.

An attempt has been made to represent the experiences of the beneficiaries of RSBY/CHIS scheme; a few case studies are presented below.

5.2.2 Case study

Harikumar Nanu was 42 years old and was suffering from fever and joint pains. He was diagnosed with Chikungunia and was hospitalized for the past 4 days, and under observation for the past 6 days. Initially he had reported severe body aches and his inability to move his legs and joints as the reason for his hospitalization.

Harikumar was a daily wage labourer and earned around Rs.400 every day by engaging in Agriculture and allied activities, he also worked as a mason in the construction industry, and this was his substitute job, in case he couldn't find agricultural work. As might be expected he does engage in consumption of alcohol. Consumption of alcohol in his view was only "light" and he engaged in "heavy drinking" during "festivals" and "other occasions". Most of his colleagues also engaged in drinking and

that is how he ends getting drunk. He spends close to 150 on his implements as he doesn't own them, but takes them on rent from people who lend their agricultural implements. He has been working since the age of 15[37].

Harikumar is married and father of 2 children, his son is a student and his daughter is toddler. His wife Sarita, is educated and had completed her high school with high grades but her father refused to let her study and got her a job at one of the cashew factories at Ayathil and wanted to get her married off as soon as she was ready. Saritha had married Harikumar 11 years ago and had faced immense trouble in conceiving a child; she had to seek treatment at various hospitals and also tried Ayurvedic medication in her attempts to conceive. After numerous trials and several medications later she finally did conceive and it was after Harikumar had almost exhausted all his resources on infertility treatments and tests. As hers was marriage of her choice, Sarita's parents had refused to speak to her or keep any contact with her. This had forced Harikumar to borrow money and tried to make ends meet. He barely managed to pay the bills and other related activities associated with the infertility treatment. Harikumar also borrowed heavily to build a house, as they were staying at a rented one room accommodation and it was getting difficult to maintain his family. To top it he had to look after the expenses of his expecting wife. This had forced him to sell part of his land to finance his different expenses and it meant that he would have build a house on the left area and that too with no capital to put in. He made a thatched room and that where his wife had brought home the newborn and they started a new life there. It has been 9 years since he started building his new house, which is still being built and with some helping hand of the panchayat and other schemes floated by the government he has managed to make a small livable house.

Since the birth of his first child, he has tried to juggle jobs to fiancé the needs of his growing family and also to save some money. Saritha had joined work 5 months after the birth of her child, but she was constantly faced with health issues and had contemplated leaving her job on number of occasions due to several reasons. She was unable to feed her child, and as a result, the child was malnourished and also falling ill

[37] Interview with respondent

very often. The child had severe breathing troubles and reported feeling short of breath most of the time, for this ailment Saritha had taken her child to the district hospital which was 11 kilometers away and which meant that she would not be able to join work that resulting in loss of pay. This had prompted her to think of leaving her job for the child, she had developed complications after childbirth which were still troubling her.

Harikumar has faced occupational hazards, being affected by leptospirosis, suffering cuts and wounds that have taken from weeks to months to heal. These incidents have made him realize the importance of safe practices and also good healthcare to tide over the illness. During his illness episodes he is forced to seek treatment from private hospitals as he believes that only medicines from private hospitals can cure him, as the medicines provided at Government hospitals are sub standard.

When asked about his preference for private hospitals he said- *"I have never taken medicines from Government hospitals; they keep old stock, fit for cattle."*

"But my wife prefers them for her ailments, she is used to them[38]*"*

On further enquiry it was leant that Harikumar has had various episodes of self treatment behavior, where he would just walk up to the medical store and seek medicines for his ailments without ever meeting a doctor.

Harikumar had got himself registered at the behest of his wife, who was told about this scheme by the supervisor at her work place who told her about the benefits that are included in the card and those that she can claim from private hospitals and those that she can get at public hospitals. Saritha was interested in seeking treatment for her son who suffered from severe breathing trouble throughout the year. It was during this time, that she had learnt about the registration, and she could manage to find some money as it was festival bonus time and she had kept almost 100Rs. Of which she had spent 30 on the registration and the rest towards travelling expenses. The card was received a month later and this was the 3rd time Harikumar and his family was utilizing the card.

[38] Personal interview with Beneficiary. April 11th 2011

This time when he had fallen ill, he sought similar treatment but to his despair, he did not feel the relief and was feeling the symptoms of chikunguniya. He thought of seeking treatment at a local dispensary. But as the dispensary medicines also had no effect on him he sought refuge at Ashtamudi hospital which was a little far away from his residence. He was sure that he could manage to pull through this illness also.

He was given IV drips as soon as he arrived, as he had lot considerable amounts of weight and was unable to walk and complained of severe joint pains and also his inability to eat or drink anything. He was accompanied by his wife and two children at the hospital. They would travel back to their house and return early morning to stay with Harikumar everyday. The family had borrowed money for daily expenses as both the wage earner were unable to work and were forced to stay out of active wage work.

When probed for his choice of hospital, Harikumar said- "*This was the first time, this is closer to home, my family can visit me, it is easier for her (wife) to bring food. It is known to be a good hospital too*".
"*I have heard from my friends and other about it. The fee is also less. Convenience was the main reason*[39]"

On further enquiry he said that he was satisfied with the treatment that was being provided to him, he was also happy about the kind of support that was being given to him while being treated for his condition. He said he was just worried about the amount that might be left on his card, because he had been admitted for the past 8 days. He wanted to "save" in case he or his family might need it during the year. Saritha was happy about the kind of care he was receiving at a private hospital; she reported feeling equal to the rich, seeking treatment at a private hospital.

She said- "*this card has helped my husband to get such(pointing to the ward and the nurses) good treatment and care, I will not be worried to leave him here overnight,*

[39] Personal interview with beneficiary April 11th 2011

unlike in government hospitals where he would have to sleep on the floor, survive on the mercy of the person who occupies the bed above him".
"I'm planning to show my child for his breathing problem, he needs some medicine to solve it[40]*"*

The respondent was asked about his experience and whether he thinks that the scheme is just right. He replied that the scheme was just right for people like him and the ones needing expert care in Kollam can seek treatment at good private hospitals like the one in which he was admitted. *"As there is no medical college in Kollam, we need more good private hospitals and medical colleges to offer RSBY card services"*

It was seen that the respondent was totally impressed by the services provided for the patients at Ashtamudi hospital, his only suggestion was to provide food also, which he says might help ease burden on patients who cannot afford to bring home cooked food everyday or to buy all three times a day from the hospital canteen. His only worry was if he could save up some money in case he needs to use the card for his son. He was planning to talk to the doctor about it and to try and find a way out to and seek help for it.

The overall picture seems a happy and content as the patient had reported feeling relieved and found the hospital services more than satisfactory. While the beneficiary was open to the idea that the limit on the entitlement must be increased, to which he mockingly said- *"It is money, the more the better, why keep a limit?"*

5.2.3 Case study

Sarala (71) is a mother of 3 children and a grandmother of 5 children. She had been a school teacher who had retired from service almost a decade and half ago. She continued to work as a tutor in a private institution and lived alone in her house. She had been living alone for quite some time. She was a beneficiary of the state government pensioner. All her children were well off and working in blue collar jobs, and most of

[40] Personal interview with Beneficiary, April 11th 2011

their spouses were also working women. She was also very actively involved in one of the SHG that worked towards making and marketing hand made paper products in and around the shopping district of Kottiyam. She had very recently suffered a fall from a the stairs and it had resulted in fracturing her leg and also dislocating her knees. As a result of the fall she had been advised total bed rest and she was required to stay away from any walk or any of such activities.

It was during one of these days that her co-workers reminded her about the card that she had got for her self, the RSBY/CHIS card. As a part of empowerment activities the Kudumbasree members had helped in spreading the word about the RSBY/CHIS. It was during this time that they had managed to convince Mrs. Sarala to take a card and they had also helped her to fill out the forms and also in process of getting all the other paper wok done. She had opted for an APL card and had paid the entire amount as premium and got the card in a months time and it was delivered to her house by the Kudumbasree members. She was also made aware of her entitlements and also her rights as a consumer of services and the amount that she could claim as a part of the treatment. She was made aware of the hospitals that she could approach and the procedures that she could get herself treatment for. It was also seen that Mrs. Sarala had preferred the CHIS card to her entitlement at the local ESI hospital, which she said was always crowded and it was very difficult for her to stay so long waiting to meet the doctor and take prescriptions to the nearest medical store and then claim the bills at the end of the month. She mentioned her inability to continue with any such long procedures as it was difficult to do it physically. She also mentioned the long and confusing procedure of trying to get the money refunded and also to try and find the bills and do the paper work associated with the claims.

The beneficiary said she felt comfortable at the hospital as it was closer to her house and also it was known to be a good hospital among those operating the RSBY scheme. It was also known to operate in a hygienic manner as most of her neighbors had reported at least one instance of use of the services of the hospital. The hospital also conducts regular health camps in and around the area, by these activities; it had made a

name for itself. It was also known that the hospitals had in its rolls some senior doctors who had been practicing in and around Kollam town for a very long time and thus were very popular among the masses.

The beneficiary was referred to have a long bone osteotomy, this surgical procedure was supposed to be held as soon as it would take a healing time of at least 60days. And as she was past the age of 55, healing would take time and might even be slow. Keeping this in consideration, the doctors at Ashtamudi requested the relatives of the beneficiary to join them while seeking treatment advice as the process required an invasive operation and also the patient had to be admitted for at least 7 days. During this period, the relatives decided to get the procedure done and also agreed to the deduction of a huge amount for the operation. According to the package rates mentioned in the Manual, operation was to cost Rs.21,000 and the expenses of the room rent would total to about 24,500Rs. The doctors and the concerned staff had sought the opinion as well as the permission of the relatives to go ahead and conduct the procedure.

The beneficiary was admitted two days prior to the operation and was given a briefing about the procedure and the related precautions and also informed her of the future actions that might be needed in case she decided to get any more surgeries done on her.

On the day of the surgery she was successfully operated upon and she was moved to the post operative ICU after the procedure. When the researcher met the beneficiary she was recuperating at the ICU and was being wheeled into the general ward as she had successfully passed her post operative critical period. She was being looked after by her children and had been informed that she could go back to her house in a day or two.

As the beneficiary was unable to speak due to her sedation, it was difficult to get information about her personal experience. As the interviewer could not directly speak to the beneficiary, the details required were collected from her son, who had been staying with her since her accidental fall. She had been advised complete bed rest for the next few weeks and had been provided with medicines for the next few days, but as her pain

would continue for a longer time, she had asked to procure medicines for a period after the stipulated time where the hospital provides for the medicines, she had been instructed to buy medicines from outside.

As her medications were also very costly, the beneficiary's son had expressed his displeasure at not being provided with the course of medication, but he was willing to tide over this aspect for the huge amount that had been covered as a part of the operation. He was of the opinion that *"being from APL family it is not a great matter of concern, but the same case with a person from BPL family would have broke his back, and he would have entered into the debt trap"*

The son was forthcoming in his praise for the scheme and to the reason why they decode to take the benefit of the card. *"My mother was a state government employee, so she could afford such treatment, but as she had his card, we decided to use it. I'm happy that she could fully utilize the card. It is a praiseworthy scheme."*[41]

[41] Beneficiary Interview April 12th 2011

Provider case study -3

(c) Government Hospital

5.3 Kottarakara Taluk Hospital (Kollam)

The Kottarakara Taluk Hospital is the First Referral Unit in and around the area of Kottarakara which is situated 27 kilometers away from Kollam town. The town is mainly surrounded by agricultural land and other petty industries which line the town. Most of the town and its population depend upon Kottarakara town for their business and other administrative needs. While the town does not boast of any major industries, it is mainly agricultural and a laid back town. The town has a number of temples and other religious places. The closest town is Kollam city, which is also the district head quarter.

Although Kottarakara is a though a small town, it has numerous public sector owned cashew factories and also few privately owned ones. They source their raw material from nearby areas and then process and package it as a finished product. The area is also known as a rich source of raw cashew for export purposes. On the healthcare front, the town has numerous private hospitals and single doctor nursing homes. Among them the Taluk Hospital is the biggest government hospital in the town providing services since early 1960's and it has seen expansion in infrastructure, human resources and material. It has constantly evolved to include more specialists on its rolls. Among them the Vijaya hospital was a large private hospital that was empanelled in the RSBY/CHIS scheme, but due to low profitability the owners of the hospital had requested for de empanelment and also sold off the hospital to the Sai trust. They claimed that the trial with RSBY was their last attempt to turn the hospital profitable but it failed, and hence they sold the hospital.

The Taluk hospital

The hospital had been established in the early 1960's and had been a fixture of the town for the past 40 odd years. It had built its reputation as the fever hospital, where the best treatment was available for seasonal fevers and also for different types of communicable diseases. The hospital had developed over the years and had been attracting patients for obstertric and gynecology services. The hospital had in the very recent times seen a change in the administration, and there had been a change in the staff also. This was as a result of the official transfer policy of the government. During the data collection period, the government policy had just come into force, where by there were compulsory transfers in place and this meant that only the some very old and experienced doctors were spared the transfers. The hospital has suffered a decline in the patient stream and this was reported by the Kiosk operator at RSBY/CHIS counter.

The Hospital had been part of the RSBY/CHIS scheme since the very first year of implementation of the scheme. The hospital had demarcated a separate space for the RSBY/CHIS counter, but sadly it was seen that the counter was masked by the main hospital building and it was very difficult to locate the kiosk. The hospital did not have signage to show the kiosk and it was left to the bystanders or the patients themselves to find the kiosk and it was also left to the patients themselves to find the elusive kiosk and to get themselves to register by registering their thumb impression. While the PRO appointed by the government worked at the kiosk, he was also managing the duties of another Taluk hospital at Punalur in Kollam district.

The kiosk operator Mrs.Rajani had been working for the past 5 months and had been appointed recently after the PRO Mr.Arun had to take up additional responsibility of Punalur Taluk hospital. As he was working at both the hospitals he was available at the Kottarakara Hospital 3 days a week and the rest 3 days at the other Punalur Taluk hospital.

Infrastructure and Services

The hospital had been upgraded to a First referral unit in the recent past and it had been provided with funds and resources from a member of Parliament in the local area development scheme as well. Also the fact that the area is represented by one of the prominent leaders of congress for the past several years, it is said that he had ensured that development is not limited to Kollam town but also reaches its peripheries, and it is with this motive that the hospital had been upgraded and several other amenities like the broad gauge railway tracks and also a very well developed bus station catering to the people and which provides services to people to the nearby Tamilnadu as well.

The hospitals had the services of 24 doctors and almost 90 nurses on their rolls. The hospital had a functioning OT and also the services of 2 ambulances and other emergency equipment. The hospital has 200 beds but effective not more than 150 are useable due to various reasons which include the lack of other supporting services and the lack of medical staff. The hospital has had to deal with low intake of staff nurses for the past 7 years and there have been no new appointments for the past 6 years. A number of doctors who report for duty also have decreased since the state law prohibits them from entering into private practice. This rule had forced some of the high performing and sought after doctors to enter into long leaves and start private practice very close to the Government hospital. As it was prohibited by law to engage in private practice, the doctors decided to enter into an agreement with the other staff at the hospital to direct the patients to the private clinics operating nearby. Some of these doctors who were still in Government service were operating in the name of their spouses who were doctors. In one case a dermatologist was working along side his wife who was an Ophthalmologist. But the signage outside the clinic mentions prominently the Government doctor's name.

The infrastructure like in all other cases was minimal but the work on its renovation was being undertaken. As could be the scene in a government hospital, there was overcrowding in wards, the OT had a long queue of patients waiting to be operated upon. The cleaning staff associated with the hospital was making an effort to keep the area clean but in vain, as the water supply was limited and sporadic. The restrooms were being washed once in two days due to lack of water. The wards had little walking space

in between, this was worse for male wards as there more male patients than female patients. The female wards were comparatively well maintained and also the crowding was much lesser, it was noticed that there two people per bed in almost all the wards and this was considered a norm rather than an oddity. The pre operative ward was veiled from the general ward using a curtain and then this also served as the nurse's station. The beds were kept far apart to allow more people to adjust on the floor and take turns to use the bed. The unwritten rule was that the bystanders only get to sit on the sides of the bed and share their meals sitting on the bed. The arrangement of beds ensured that there was sufficient space for the bystanders to sleep.

The hospital did not have a medical store in the premises and most of the medicines that were prescribed had to be bought from the nearby *Neethi* store, which is a medical fair price shop operated by the government, but he stocks of most essential medicines are always low and there are hardly any specific medicines that are available there. Most of the medicines that are not available at the fair price shops are to be purchased by the patient from the private shops in the vicinity of the hospital. The hospital usually directs the patients to find out whether the medicine are available at the N*eethi* store and if they are not then the have to bring back a written note saying that the medicines required are not available, the patient has to then get this chit signed and sealed from the RSBY kiosk. He has to submit the same at the private medical store and get the medicines and then later claim the money from the RSBY counter for the purchase of medicines from the private store.

Apart from these to and fro activities being required to be done almost 3 -4 times on an average, it is also mandatory to bring 5 Photostat copies of the smart card, and the identification document to be presented before the patient get himself/herself registered. The patient also has to stand and wait till his/her chance comes and then has to meet the doctor who would then suggest a hospitalization. After the patient meets the doctor, the patient (if he is able to) or his bystander is asked to come and visit the kiosk to report the exact illness so that the correct package can be selected under the RSBY scheme package details.

The patient is required to surrender the card at the kiosk, the reason for which has been mentioned as the tendency of the patients to leave halfway without checking out from the hospital records and creating multiple logins when the try to use the same card at some other location.

This had prompted the kiosk operator to keep the card in safe custody and also to give them back only after they are ready to leave. The kiosk operator is also entrusted with the job of providing the Travel allowance of Rs.100 for every visit to a maximum amount of Rs.1000 per year. The receipt of this TA has be acknowledged and given in writing to the kiosk owner. The procedure for the receipt of acknowledgement for the TA is different in all the hospitals.

Background of the patients

The hospital is situated in a town that is 30 kms away from Kollam town, and is predominantly an agricultural area. The town is surrounded by plantain and rubber cultivation and serves as a trading area of agricultural produce. The town has numerous small scale industries and the presence of large number of self help groups. Thus, most of the patients seeking care belong to these categories, though there are other large private hospitals nearby and also in the nearest town Punalur for the well heeled patients. Most of the patients who utilized the services of the Taluk hospital also referred to the hospital as one of the oldest ones around, but the development of which was not very robust. The buildings had started falling apart and leaks had developed which endangered the lives of those staying in it. But as the data collection progressed, it was observed that some changes had happened and there was a new effort to get the hospital in better shape.

To present a picture of the services that are provided at the hospital, a few case studies below represent the experience of the beneficiaries.

5.3.1 Case study

Ratnamma (58) is a single woman who lives all by herself. She was a agricultural laborer who also used work as a domestic help at a cashew factory owner's house. She had left her job as a laborer and at the cashew factory because of health problems. She had been a wage laborer since her early teens and had been briefly married. But her husband was a drunkard and a person who migrated for work very often. After the marriage Dineshan went looking for a job and had returned only briefly to stay with her for 2 years, working at odd jobs like working as a mason, helping out at the cashew factory and also as part time cook. During all these years, the couple had tried to start a family, but in vain, Ratnamma was unable to conceive and she blames this as a reason why he never came back after he left one fine day looking for a job. He never returned and since that day Ratnamma had been living alone and worked at the cashew factory to earn a living. She has bought a small piece of land and built a house using her earnings from the cashew factory and also the panchayat fund for destitute women on compassionate grounds. She built a two room structure and had been living in it since early 1990's. She had tried getting one of her relatives to stay with her, her attempts to bring someone to stay with her failed and since then she has been living alone. Her neighbors help her in case of any emergency or need. She works at the cashew factory owner's house as a maid, a job that she took up after her retirement from the manual cashew peeling work at the factory.

She had been appointed to do regular maid duties at the owner's house and was paid 3500Rs as her wages and she was allowed to stay for meals at the owner's house. For the past a month or more she had been bedridden because of her medical condition. She had developed uterine fibroids and had been suffering extreme pain for the past several years, she had sought medical attention once during her entire life for this condition and then the doctor had asked her to get it operated upon. But lack of resources had forced her to take temporary treatment and postponed it to another time, when could manage some more money. As she was employed at the cashew factory she was able to seek treatment any of the ESI hospitals, but as she was alone and she had no bystanders to accompany her, she dropped the idea.

As a literate person, she was very particular about reading vernacular newspapers and that is when she had read about the RSBY/CHIS scheme. She enrolled herself in the second enrollment drive and used her card once, when she had been hospitalized with chikungunia. She had used up close to 3000 during her initial stay. Later when her pains due to the uterine fibroids started giving her trouble, she chose to enquire about the money left in her account and then go forward with her decision to seek treatment for her fibroids.

She selected the month of April because she wanted somebody to stand beside her while she was convalescing after her operation. As it was the month of April and her neighbors children could come and stay with her, she decided to get the operation done. Once she was told that she wanted to get the surgery done, she decided to seek treatment at the govt hospital because it was closer to her house and also was easier for her caretakers to come and visit her. It was her decision to see treatment at the public hospital; this was taken after consulting her friends at the cashew factory and her employers. She got herself an appointment to meet the doctor and when advised for surgery she readily agreed saying that she wanted to get done with it.

When enquired about her decision to seek treatment at the public hospital she replied- "*My employers and most of my friends back at the factory advised me to go to the Taluk hospital, they asked me to meet this particular doctor. She is known as a kind person.*"[42]

The bystander with Ratnamma was a 15 year old Sreedivya; she kept an eye for the needs of Ratnamma and also kept her mother informed in case Ratnamma needed any help.
Most of the times when Ratnamma needed help, she would ask Sreedivya to call her mother. As she had been hospitalized for the past 4 days, she was currently feeling better and planned to get discharged in a day or two.

---

[42] Personal interaction with Beneficiary, April 21st 2011

Her operation, which was to surgically remove her fibroids, she had been charged 12,500 from her card. Ratnamma was happy that she did not have to shell out even a penny, and that she was also spared the cost of taking up a room, as her wounds had healed well enough. She had been allowed to go home as soon as she wanted.

She said- "*I will never again get those terrible pains, I can live peacefully, don't know why it had to happen to me. I will take all precautions as mentioned by the doctor*" [43]

On being asked how she felt getting herself treated at a government hospital, she replied-"*The doctor here was indeed kind and very understanding; she made me understand the procedure in advance and the days of rest that I would need to take.*"

She confessed that she might have start working a soon as possible, because she had been on bed ridden for the past few months and finances were running low. She contemplated joining work in 2 weeks and also trying to get back with new vigor and take up additional work so that she can make up for the lost time.

She looked forward to earn more money so that she could spruce up her house, as she was alone, she wasn't interested in buying any more land or belongings but wanted to earn enough money so that she could live comfortably. She was particularly afraid to buy gold or any other precious things, so she put in her earning in a local revenue generating scheme. She was of the opinion that she would recommend this schme to all those who were hard pressed for money and those who could not make enough money to afford life saving procedures and those that might need hospitalization.

She did not know about CHIS plus scheme, knowing about which she got elated and said- "*Jalaja has cancer, I came to know very late. I will ask her to go and get herself this card*"

She enquired about the card to the nursing assistant who was attending to her. She asked about the formalities. She looked, nodded and said- "*She needs it desperately. Can you please request the doctor saar to please recommend her?*"

"*She has 3 children to look after; they would need all the help. Wont you?? She is also like me, working at factory...*"

---

[43] Personal interaction with Beneficiary, April 21st 2011

The interaction with Ratnamma was insightful in giving a picture about the travails of a single woman; she had no idea if her husband was still alive or had passed away, she no contact with him, she could not establish with "documentary" evidence that she was a single woman, and that she did not know whether she was a widow or a divorcee. Her limbo continues as she could not establish that she was not a dependent or a widow. All this had caused her to stop looking for new security schemes from the government which wanted her to prove her eligibility. She had been living on her own since early 1990's. She does own a ration card, and now the Smart card as she proudly displayed it. She was not hesitant to share her left leaning in political matters and her liking for the welfare measures and the help and solace that it has provided her and many more like her.

Ratnamma wanted just one change, she wanted the paper work involved in this registration *"business"* to be reduced or totally done away with and be replaced by a procedure where there is less of hassles. She also reported that next time she need any medical attention she will use the private providers also.

5.3.2 Case study

Pushpa (37) is a housewife and a mother of two. Her husband Ashokan works as a carpenter, he own his own workshop and employs 5-6 people and up to 11 people during peak season. He was a contract mason who had tried his luck in foreign countries several years ago and found that it was difficult for him to continue working at very low wages.

Ashokan was of the opinion that the "*Arabian states are not good for skilled workers, they require more men who can work*" [44]He made only enough money to send some home and the rest was spent there. He decide to come back after he found that he couldn't save any money, he came back to set up his own workshop and took up work on

[44] Personal interaction with beneficiary on April 23rd, 2011

contract basis and also worked as a sole carpenter when it was required. He undertook contracts and decided if he needed more hands to work.

Pushapam was a housewife and only very rarely engaged in the activities of a SHG that made snacks and packaged them and sold them. She also looked after the financial issues relating to the SHG, she couldn't manage to visit it regularly as she had to look after the needs at the workshop, and she helped her husband in whatever ways she could. Pushpam had just given birth to her baby daughter who was 2 months old. She had been working at the SHG when she got to know of her pregnancy and wanted to save up some money so she tried working a little extra for the money, but as she noticed that her health was deteriorating, so she discontinued and was limited to her house. She also remained more than willing to stay at home.

The purpose for her current visit to the hospital was a persistent problem that she has noticed after her delivery; she had reported some complications during her delivery and had been experiencing recurring pain and discomfort. She wanted to get a check up done and was also in favour of getting a family planning operation done. She also wanted to enquire about the procedure to receive a safe and secure family planning operation. Pushpam had brought along with her sister in law who wanted to know about how and when to use the card, as she herself was expecting a child and wanted to get herself treated at the Taluk hospital. She found the card very beneficial and easy to use. Her sister in law was thus convinced that she could come for her treatment also. She although wanted the delivery to happen at the private clinic. She also enquired if this was valid in a private clinic near her house. She mockingly asked; "*Why can this card be treated like credit or debit card and be usable in every hospital?? There is such a system prevalent in gulf...my husband tells me.*[45]"

The beneficiary had given birth at the same taluk hospital and had faced a lot of hardship as she couldn't find a bed and it was left to the mercy of other expecting mothers or other women who had just delivered to give her some space on the beds. She

[45] Personal interaction with Bystander of the beneficiary, April 23rd,2011

given a shoddy treatment at the hospital and at her request she had got herself discharged and left in a hurry. Pushpam remembers that this might be the reason for her persistent worry. She confessed to not having taken the prescribed medications also, and she had reported that her husband was in no condition to help her as she had been on bed rest and was taking care of her newborn for the past two months.

In such conditions, she had requested the help of her sister in law to travel to the hospital and seek medical advice. This was because her husband couldn't excuse himself from the job that he was at.

The doctor at the hospital had asked her to report back in a week's time after getting all t he tests done and consulting her after the tests. The doctor had hinted at getting the tests done at the Muthoot diagnostics as it was the only one nearby and the hospital by itself had no provisions for this. The service provider was a private one and it had tie- up with the hospital to provide services. The hospital also refused to refer the patients to their own simple X ray unit as they reported it to be not functioning. The Muthoot scan centre was strategically located, and had prominent signage advertising its services, interestingly they also operated an express gold loan centre right next to the diagnostics unit, in case of emergency the needy can always pledge their gold and get money!

The conditions at the hospital had prevented Pushpam from seeking treatment right away, she hesitantly agreed to report back in week's time and also try to get the tests done.

On further enquiry she said- *"Only because I got my delivery done here that I have to face these problems now, had it been a private hospital I would have relaxing at home now. I take the blame for choosing this hospital and the results have made sure that I do not come here ever after"*

"My husband was right, you get treated only at a private hospital, at a government hospital you get looked at...that too if you are lucky enough"

Needless to mention, her experiences with the service provider has been not so great and she reports this might be the last time she ever reports here. She mentioned the lack of services, the lack of manpower and the attitude of the doctors as being the reason for such pathetic condition of a Taluk hospital which caters to a huge population.

She was thinking of taking her card and leaving, but as it was with the kiosk operator, she could not do that. She might have to leave the card and go, which she was not willing to do. At the end she decided to take the card and leave now and to report later. In a fit of rage, she had torn up her reports and wanted to leave as soon as possible as the doctor had not prescribed any medicine what so ever to ease her pain, stating her lactating status. She had walked out of the hospital and was hardly in a position to talk.

The beneficiary had one experience of treatment at the Taluk hospital and said that after her second operation is done she might never ever step into a public hospital. She also refused to recommend any body to use this hospital even in case of an emergency.

5.3.3 Case study

Manikandan(29) a auto rickshaw driver and a father of 2 children had been admitted at the hospital after he complained of severe abdominal pain and was rushed to the hospital past midnight. He was admitted 3 days and had just undergone an appendicectomy and had been on medication for the past 2 days.

He hardly remembers being taken to the operation theater or being operated upon. He only remembers the part where he was had felt very uncomfortable and painful. He had requested one of his friends to come and meet him, and that is when his friend decided to take him to the nearby hospital, which was the Taluk hospital, he was taken in an auto rickshaw and had been in terrible pain. As soon as he was wheeled in the doctor suggested that he should be operated upon early morning. The doctor on duty had given him some injections to ease the pain and the beneficiary had fallen asleep in his state. His wife and other relatives had arrived by early morning and signed the necessary documents and allowed the operation to happen.

The beneficiary's wife Libi(26) had no idea about the conditions of the wards or the post operative ward, she just took the decision to let the operation happen. She had not thought about what would happen after the operation. After the operation was conducted she had to take a difficult decision to beg and let a person on a bed also adjust her husband who had just come out of post operative ward. He was unable to walk or to do any of the primary needs and was now being forced to share a bed with some person who had some other disease. Libi had to take a decision and decide that as soon ash she could find a better place she would leave and she would the beneficiary along so that he can recuperate better. Her sense of helplessness and desperation were mirrored in her talk when she said- "*I have no where else to take him, all that I can do is to wait till he feels better and then take him to some other hospital or nursing home, this would mean that I would have borrow money.*[46]"

During the conversation when she was suggested the names of other empanelled hospitals, she preferred to take him to a private nursing home near her maternal house and was happy to know about the clause that she could also stay back to look after her husband; because here her entry was restricted and she couldn't stay back at hospital to look after her husband as it was not allowed. She had to seek the help of her male relatives and other friends to stay back at night with her husband. All this while, she had been financing her expenses, by borrowing money from her neighbors. This was because she wasn't well versed with the ways of taking out money from the bank. She had promised her neighbors that she will promptly return their money once Manikandan is back.

In this case the beneficiary had no other choice as he was operated upon as a emergency case, he had been given only 20 minutes to react, as soon as he was wheeled in; the duty doctor gave him some injections and moved him to the ward and was kept under observation, the friend who was attending to him was asked to inform his close ones about the operation that had to be performed the following day as a priority and the

[46] Personal interview with bystander and Kin of the beneficiary on 25th April 2011

urgency of the situation. As a precautionary measure the doctor had posted a nurse and given her necessary instructions.

The friend who was accompanying Manikandan was quick to add that a comment that the duty doctor seemed like a true doctor who had saved his friend's life. It was a matter of 7 hours when the other doctors arrived and scheduled a surgery which went well. Manikandan was shifted to the post operative ward and later in the day was shifted out because of lack of beds and was asked to shift to the ward.

The beneficiary had not taken RSBY/CHIS smart card at the time of admission, as it was an emergency. His wife had found the card only later and tried to register herself, when she realized that only her husband could operate it ass he had registered his thumb impression and nobody else in the family had done so. In this case the dependent of the beneficiary had to wait till the head of the family, in this case Manikandan was feeling better to make his thumb read at the RSBY/CHIS kiosk and claim the treatment under the card. This meant that the registration of the patient under the scheme took place more than two days after the operation had happened. This was because the beneficiary was the sole person from his family who had registered his thumb impression, and also the RSBY/CHIS kiosk is closed after 5 in the evening.

At the time of interview the beneficiary had been partly happy at the medical attention that he was given, but at the same time was concerned about the lack of amenities at the hospital. He was bothered by the fact that a post operative ward was so full that people who finished their operation at morning were being shunted to the general ward by evening the very same day.

He said-"*Everybody here survives on their own luck, I'm luck to have stayed 2 days in a general ward and not catch any infection*"

He said that the services of the duty doctor were very commendable. He also mentioned that though the services at the ward were pathetic, he attributed this to the

enormous amount of people who turn up with all sorts of diseases posing huge stress on the doctors and the administrators and all the paramedical staff.

The beneficiary and his wife were planning on seeking a discharge slip from the hospital, were found to have managed vehicle for transport and were advised to come every alternate day for dressing the wound.

On enquiry the beneficiary and his wife reported having mixed feeling s about their stay and operation at the hospital, they liked the services offered under the RSBY/CHIS card, but they disliked the provider; in this case the Taluk hospital Kottarakara. In case of services, they were disappointed at not having received any directions about the procedures involved with the smart card transactions and the resultant problems. Most of the people who were involved in his case, male relatives of Libi and friends of Manikandan reported their helplessness at trying to stay as bystanders, because his wife was not allowed in the male ward.

The experiences from the beneficiaries at the Taluk hospital Kottarakara, range from one being positive to the other end of the spectrum, where a patient had walked out and decide that she needed no more help or care from the providers. The stereotypical image of a public provider is seen to play out. The user experience also throws light on the possibilities of private practice masked within the public service. In the long run it needs to be seen whether the benefits of such a scheme, where the claim money is to be used by the hospital administration for the up gradation of services is utilized or not. Though on policy papers it is the way the money is said to be diverted to, it remains to be seen whether it happen or not.

Chapter 6

Health Insurance – Who Benefits?

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

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

The number of beneficiaries in Kollam and has seen an increase and according to official records as of 19/11/2010, the data for Kollam district shows that the there are almost 19151 APL patients and 184160 BPL patients. The claim settlement for the district of Kerala according to the same record stands at Rs.1088.50 Lakh. The major amount of which went to the private sector which gathered around Rs.778.15 Lakh, followed by the public sector which gathered Rs.310.35Lakh. The numbers presented above depict a picture of preference for the private sector in Kollam district. This trend has been noticed in Thiruvananthapuram, Calicut, Kannur and Kasargod districts.

The study focuses on the study of CHIS in Kollam district, and as has been seen in the data on the implementation working and the roll out of the scheme, it was noticed that there were marked differences in the ways in which the schemes were implemented over Kerala, in certain districts the empanelment of private hospitals was noticed to be way higher than the public hospitals. The case of Kollam was no different, the number of

private hospitals exceeded that of public hospitals. The number being 14 in private hospitals to10 in the public sector.

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

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

The patient or his bystander has to report back after his diagnosis has been done to get the correct package rate to be opted for against the name of the patient and to start his treatment. Under the scheme the patient is to be provided with medication for a day before his admission and as also 5 days after his discharge, this benefit was done away with since most hospitals were starved for cash and were unable to provide food during the period of the stay of the patient. The patient is thus forced to shell out money for food and other petty expenses during the period of hospitalization.. The condition in certain

private hospitals was no different. The patients were asked to report back with certain medicines as it was not available at the hospitals and had to be bought from outside. In case of extremely poor patients the hospital bought these and charged the patients indirectly by keeping them for an extra day citing some other reason, thus deducting the cost of the medicine from the card.

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

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

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

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

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

The public hospitals have been directed to plough back the amounts that they receive as RSBY claims, to help in the upgrading of the services being offered, and infrastructure. From what could be seen at different hospitals, there has been no development at all. Most of the Community health centers had no services to look after more than 5 patients and there were hardly any that offered inpatient services. They "preferred" small ailments.

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

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

The empanelment procedure should take into consideration the services that are available at a particular hospital and the services that it can provide. The provision of services in such hospitals continues to be unmonitored and pose great risk to patients and their safety. In case of another hospital there were no qualified doctors, there had been roped in for the time there was inspection for empanelment and had been ordered. After the empanelment they had been discharged from services.

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

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

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

The preference for a profitable business model is the primary concern of the Insurance provider. Affordable healthcare is what brings the patient into the equation and the profit motive is what brings the service providers into this equation. The permutations and combinations can be numerous, but what can be seen in the present scenario is that the private providers have the last laugh on the matter. The public provider fades into the background while taking in to consideration the number of users who are seeking medical care from the private providers.

Equity Considerations

The analysis about the scheme should include the coverage and also the equity aspects of the scheme. The scheme had been working since 2008, and it has been noticed that the scheme warranted the use of technology and the participation of people to get them registered and use the services. The coverage has notched up, and as per official records, the scheme would cover the total target population by this year and would continue to add more private providers in remote areas to widen the scheme and to extend its reach. The provision of services on par with other patients, for the target population i.e. the BPL, this was the primary aim of the scheme. The aim of the smart card is to

provide equitable services on par with other private services and this is to be ensured by both the private as well as public sector providers alike, who have empanelled themselves.

The smart card marks the user from the non eligible person. In case of Kerala the scheme was a comprehensive one, where the beneficiary could be both the APL population who volunteered to take part and the BPL population who are the target population, in Kollam district which was adjudged the best CHIS implementing district in Kerala[47]. The provision of services has seen a surge since more and more private players empanelled themselves and provision of services in certain hospitals have seen manifold increase in their clientele, also increase in revenue. The case of Ashtamudi hospital is also interesting considering that this particular hospital has been working as a not for profit hospital but still managing to attract patients in large numbers and also expanding with the resources thus received. Most of the resources that have been received in installments in the hospital have been utilized to put up new infrastructure and also to upgrade the facilities that were already available.

Role of TPA

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

The patient, around whom the entire process revolves, is supposed to be the ultimate beneficiary and in this case the patient is expected to get medical facilities of his requirement at his point of preference. The entire process revolves around the beneficiary using his card, starting a registration process, meeting the doctor, getting his diagnosis

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

and starting his treatment. In this study the researcher focused on getting to know the CHIS experience in Kollam district, which was among the first few selected districts in Kerala where the scheme was to be implemented, before the state government decided to implement it in the whole of the state. The district also represents the largest share of CHIS beneficiaries and largest fund out flows as claims from the insurer in the claims segment. The claims also present a very unique picture, the claims by private hospitals out weigh the public ones and the difference is way higher than those in other districts.

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

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

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

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

The change in guard at the helm of affairs has been looked at with caution by the people associated with the CHIS, as the fear that any change in the current setting would affect the working of the scheme as well as their job. As the new scheme had been allocated budget to start its functioning as soon as possible, it remains to be seen whether it is gains popularity like it has in AP, or remains dud. In recent political history, there have been numerous times when the newly formed government has done away with the scheme right after coming in to power. The very recent example from a neighboring state has been the case of Tamil Nadu, where the Jayalalitha Government had done away with existing Kalingar Maruthava Thittam.(2011)[43]

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

The developments on the political front have meant that the scheme might undergo changes according to the whims of the new government. The comprehensiveness has already been compromised with, now the inclusiveness and the coverage has been made optional. From the viewpoint of the current card holders the future is uncertain, being a centrally sponsored scheme it might continue to exist, but, when there are parallel scheme being brought out by the government, the fate of old one hangs in balance. The scheme has been had been running for almost 2 years, and continues to generate headlines for its wide coverage and adaptation in even far off countries[49] is being looked

---

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

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

down upon in one of the states where it has been running successfully ever since its launch.[50]

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

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

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

The access to Healthcare is provided to the target population has increased no doubt, but the sophisticated ways of conning have become more fine tuned. It has also lead to the patients preferring to visit the private providers more than they trust the public sector. If utilization of services is measured then the scheme has been a runaway hit; it

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

has lead to the praise from WB(Anon n.d.).(Anon n.d.)[51], has inspired other countries to replicate the scheme, and has also led to the increase in the number of cases using this while being migrant laborers.

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

.

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

Bibliography

A Critical Assessment of the Existing Health Insurance Models in India : A Research Study Submitted By Public Health Foundation of India 31st January 2011

Ahuja, R. 2004, *Health Insurance for the Poor*, Economic and Political Weekly, July 10, pp 3171-3178

Ahuja, R. and Narang, A. 2005, *Emerging Trends in Health Insurance for Low-Income Groups*, Economic and Political Weekly, September 17, pp 4151-4158

Anon, The state of India's welfare state: Ropey nets | The Economist. Available at:http://www.economist.com/blogs/freeexchange/2011/05/state_indias_welfare_state [Accessed May 20, 2011].

Anon, India's RSBY scheme evokes keen interest overseas - The Economic Times. Available at: http://economictimes.indiatimes.com/personal-finance/insurance/insurance-news/indias-rsby-scheme-evokes-keen-interest-overseas/articleshow/9063738.cms [Accessed July 2, 2011].

Anon, New health insurance in TN to ramp up coverage four-fold. Available at: http://www.business-standard.com/india/news/new-health-insurance-in-tn-to-rampcoverage-four-fold/442344/ [Accessed July 11, 2011].

Anon, 2008. The Hindu□: Opinion / Editorials□: A smart approach to public health. Available at: http://www.hindu.com/2008/11/19/stories/2008111956361000.htm [Accessed May 19, 2011].

Aspalter, C., 2003. *The State and the Making of the Welfare System in India.* Journal of National Development, 3(1), pp.149–79.

Baru, R 2003, *Privatization of Health Services: A South Asian Perspective*', Economic and Political Weekly, 38(42) pp 4433-4437

Baru, R, Financing Health Service: Alternative to Private Insurance', in Prasad, S. and Sathyamala, C. 2006, Securing Health for all, Institute of Human Development, New Delhi

Bhat R and Babu,S 2004. Health Insurance and Third Party Administrators: Issues and Challenges. Published by: Economic and Political Weekly

Berman, Ahuja R, Bhandari L, The Impoverishing Effect of Healthcare Payments in India: New Methodology and findings, Economic and Political Weekly, April 17, 2010 vol xlv no 16, p.67

Borowitz, M. and Atun, R. 2006, The unfinished journey from Semashko to Bismarck: Health Reform in Central Asia from 1991 to 2006', Central Asian Survey, 25 (4), pp 419 — 440

Budget speech, Finance minister 2003-2004 Annual Budget presentation, retrieved from planning commission.org.

Chauhan, C. 2011. 40% of the poorest getting benefit of government schemes: World Bank - Hindustan Times. *http://www.hindustantimes.com/40-of-poorest-getting-benefit-of-govt-schemes-World-Bank/Article1-699129.aspx.* Available at: http://www.hindustantimes.com/40-of-poorest-getting-benefit-of-govt-schemes-World-Bank/Article1-699129.aspx [Accessed May 18, 2011].

Correspondent, S., 2010. 35 Lakh Families to Be Enrolled in Health Scheme. The Hindu, p.04.

Devadasan, N. et. al. 2004, Community Health Insurance in India: An Overview, Economic and Political Weekly July 10, pp 3170-3183

Dhoot Vikas and ,Kamath Gouri:Private healthcare in rural areas gets RSBY push - Economic Times. Available at: http://articles.economictimes.indiatimes.com/2011-05-12/news/29536172_1_private-hospitals-rsby-empanelled-hospitals [Accessed May 13, 2011].

Dror, D. 2006, _Health Insurance for the Poor: Myths and Realities', Economic and Political Weekly, November 4, pp 4541 – 4544 Eleventh Five year plan document. [Accessed 11June 2011]

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

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

Government of Kerala, G.O(P)No.95/2008/LBR dated 4.7.2008 Labour and Rehabilitation (J) Department

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

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

Health Insurance in India: current Scenario, http://www.searo.who.int/linkfiles/social_health_insurance_an2.pdf. [Accessed 3 May 2011]

Isalkar, U., 2011. Activists welcome health scheme for domestic helps - The Times of India. Available at: http://timesofindia.indiatimes.com/city/pune/Activists-welcome-health-scheme-for-domestic-helps/articleshow/8968008.cms [Accessed June 25, 2011].

Khan A UP hospitals misusing RSBY, "treating" men for gynecological diseases: North: India Today. Available at: http://indiatoday.intoday.in/site/Story/110828/104/up-hospitals-misusing-rsby,-treating-men-for-gynaecological-diseases.html [Accessed April 6, 2011].

Khyati S, Fake patients for insurance? Govt hospital under scanner. Available at: http://www.indianexpress.com/news/fake-patients-for-insurance-govt-hospital-under-scanner/780927/ [Accessed April 29, 2011].

KRISHNAKUMAR, R 2008. Healthy scheme. Available at: http://www.hindu.com/fline/fl2522/stories/20081107252203300.htm [Accessed May 19, 2011].

Kurian, N.J., 2010. Financing Healthcare in India. *The Hindu*, p.08.

Mathur V., Ethical questions regarding health insurance in India. Available at: http://www.issuesinmedicalethics.org/191ar23.html [Accessed March 7, 2011].

Maya, C., 2010. Medical College Hospitals bogged down by RSBY. *The Hindu*, p.03.

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

Nair, C.G., 2008. Health Insurance for One Crore People. The Hindu, p.01.

Nair, C.G., 2008. Scheme Poses Major Challenges. The Hindu, p.04.

Official documents: RSBY policy guidelines

Rajasekhar, D. et al.(2010), IMPLEMENTING HEALTH INSURANCE FOR THE POOR: THE ROLLOUT OF RSBY IN KARNATAKA.

Rai, Sheila., Rai Niha 2010. Rashtr ya Swasthya Bima Yojana(RSBY): Panacea for the Poor. <http//:www.napsipag.org/SHEILA%20RAI%20&%20NIHA%20RAI.pdf> [Accessed 5 May 2011].

Rajiv,G, 2008.Doctors open a "no-frill" hospital Indian Express. http://expressbuzz.com/States/Kerala/doctors%20open%20a%20%E2%80%98no-frill%E2%80%99%20hospital/29746.html.Availableat: http://expressbuzz.com/States/Kerala/doctors%20open%20a%20%e2%80%98no-frill%e2%80%99%20hospital/29746.html [Accessed June 26, 2011].

Rajalakshmi T K, Vague promise. Available at: http://www.frontline.in/stories/20110729281509700.htm [Accessed July 12, 2011].

Ramesh, Business Line□: Today's Paper / MONEY & BANKING□: A safety net for poorest of the poor. Available at: http://www.thehindubusinessline.com/todays-paper/tp-money-banking/article991576.ece [Accessed May 5, 2011].

Swarup, A: RSBY Emerging scenario, Accessed online

Savitha.C.Muppala on October 23, 2010, Cabinet Gives the Nod to Health Insurance Scheme for Street Vendors. *http://www.medindia.net/news/Cabinet-Gives-the-Nod-to-Health-Insurance-Scheme-for-Street-Vendors-75709-1.htm.* Available at: http://www.medindia.net/news/Cabinet-Gives-the-Nod-to-Health-Insurance-Scheme-for-Street-Vendors-75709-1.htm [Accessed January 30, 2011].

Sen, A., Soon, your visit to doctor too could be covered by insurance - The Economic Times. Available at: http://economictimes.indiatimes.com/personal-finance/insurance/insurance-news/gvt-scheme-to-cover-to-over-23-mn-if-projects-prove-feasible/articleshow/9264721.cms [Accessed July 18, 2011].

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

Subir K Roy, Subir Roy: A hybrid Indian health-care system. Available at: http://www.business-standard.com/india/news/subir-royhybrid-indian-health-care-system/422161/ [Accessed May 5, 2011].

Swarup, A: RSBY Emerging scenario, Accessed online

Werner S, Devadasan N, Durairaj V and Bart Criel :Community Health Insurance and Universal Coverage: Multiple paths, many rivers to cross World Health Report (2010) Background Paper, No 48

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 and Diagnostic Tests, 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 including Transport Expenses 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, Transport Expenses and any complication while in hospital, making the transaction truly cashless to the patient.

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.

I. NON SURGICAL(Medical) TREATMENT IN GENERAL WARD 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 and Diagnostic Tests, 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 including Transport Expenses 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, Transport Expenses, food to patient and any complication while in hospital, making the transaction truly cashless to the patient.	Maximum upto Rs.___ per day
II. IF ADMITTED IN ICU: This includes bed charges (general ward), Nursing and	Maximum

boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Medicines and Drugs, X-Ray and Diagnostic Tests, food to patient etc. during stay in I.C.U.	upto Rs.___ per day
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 and Diagnostic Tests, 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 including Transport Expenses 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, Transport Expenses, food to patient and any complication while in hospital, making the transaction truly cashless to the patient.	To be negotiated with Insurer before carrying out the procedure
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 and Diagnostic Tests 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 including Transport Expenses 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, Transport Expenses, food to patient and any complication while in hospital, making the transaction truly cashless to the patient.	Refer Appendix I Below

V. **Maternity benefit Package:**	Normal Delivery Rs. 2500/-
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 and Diagnostic Tests 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 transport expenses and food to patient will also be the part of package. The package should cover the entire cost of treatment of the patient 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.	Caesarian Section / Complicated Rs.4500/-

Appendix I

Serial No.	Code No.	ICD 10 Code	RSBY Category	RSBY LOS	Final Rate Proposed
1			**DENTAL**		
1	FP00100001	K05	Fistulectomy	1	10,000
2	FP00100002	S02	Fixation of fracture of jaw	2	10,000
3	FP00100003	K10	Sequestrectomy	1	10,000
4	FP00100004	D16	Tumour excision	2	7,500
2			**EAR**		
5	FP00200001	H74	Aural polypectomy	1	10,000
6	FP00200002	H81	Decompression sac	2	13,500
7	FP00200003	H80	Fenestration	2	7,000
8	FP00200004	H81	Labyrinthectomy	2	10,500
9	FP00200005	H 65	Mastoidectomy	2	6,000
10	FP00200006	H70	Mastoidectomy corticol module radical	3	10,500
11	FP00200007	H 65	Mastoidectomy With Myringoplasty	2	9,000
12	FP00200008	H 65	Mastoidectomy with tympanoplasty	2	9,000
13	FP00200009	H72	Myringoplasty	2	6,000
14	FP00200010	H72	Myringoplasty with Ossiculoplasty	2	9,000
15	FP00200011	H72	Myringotomy - Bilateral	2	4,500
16	FP00200012	H72	Myringotomy - Unilateral	2	2,500
17	FP00200013	H72	Myringotomy with Grommet - One ear	2	5,000
18	FP00200014	H72	Myrinogotomy with Grommet - Both ear	2	6,500
19	FP00200015	H74	Ossiculoplasty	2	7,500

20	FP00200016	C44	Partial amputation - Pinna	1	2,500
21	FP00200017	Q17	Preauricular sinus	2	6,000
22	FP00200018	H80	Stapedectomy	2	8,125
23	FP00200019	H72	Tympanoplasty	5	7,000
24	FP00200020	J30	Vidian neurectomy - Micro	3	7,000
	3	**NOSE**			
25	FP00300001	R04	Ant. Ethmoidal artery ligation	3	12,000
26	FP00300002	J32	Antrostomy – Bilateral	3	6,000
27	FP00300003	J32	Antrostomy – Unilateral	3	4,000
28	FP00300004	J32	Caldwell - luc – Bilateral	2	7,500
29	FP00300005	J32	Caldwell - luc- Unilateral	2	4,500
30	FP00300006	C30	Cryosurgery	2	7,000
31	FP00300007	J00	Rhinorrhoea - Repair	1	5,000
32	FP00300008	H04	Dacryocystorhinostomy (DCR)	1	9,000
33	FP00300009	J32	Septoplasty + FESS	2	5,500
34	FP00300010	J32	Ethmoidectomy - External	2	9,000
35	FP00300011	S02	Fracture reduction nose with septal correction	1	6,500
36	FP00300012	S02	Fracture - setting maxilla	2	8,500
37	FP00300013	S02	Fracture - setting nasal bone	1	4,000
38	FP00300014	J01	Functional Endoscopic Sinus (FESS)	1	9,000
39	FP00300015	J01	Intra Nasal Ethmoidectomy	2	12,250
40	FP00300016	D14	Rhinotomy - Lateral	2	10,625
41	FP00300017	J33	Nasal polypectomy - Bilateral	1	7,500
42	FP00300018	J33	Nasal polypectomy - Unilateral	1	5,250
43	FP00300019	J34	Turbinectomy Partial - Bilateral	3	7,000
44	FP00300020	J34	Turbinectomy Partial - Unilateral	3	4,500
45	FP00300021	C31	Radical fronto ethmo sphenodectomy	5	15,000
46	FP00300022	J34	Rhinoplasty	3	12,000
47	FP00300023	J34	Septoplasty	2	5,500
48	FP00300024	J33	Sinus Antroscopy	1	4,500
49	FP00300025	J34	Submucos resection	1	5,000
50	FP00300026	J01	Trans Antral Ethmoidectomy	2	10,500
51	FP00300027	J31	Youngs operation	2	5,500
	4	**THROAT**			
52	FP00400001	J35	Adeno Tonsillectomy	1	6,000
53	FP00400002	J35	Adenoidectomy	1	4,000
54	FP00400003	C32	Arytenoidectomy	2	15,000
55	FP00400004	Q30	Choanal atresia	2	10,000
56	FP00400005	J03	Tonsillectomy + Myringotomy	3	10,000
57	FP00400006	Q38	Pharyngeal diverticulum's – Excision	2	12,000
58	FP00400007	C32	Laryngectomy	2	15,750
59	FP00400008	C41	Maxilla - Excision	2	10,000

60	FP00400009	K03	Oro Antral fistula		2	10,000
61	FP00400010	J39	Parapharyngeal - Exploration		2	10,000
62	FP00400011	J39	Parapharyngeal Abscess - Drainage		2	15,000
63	FP00400012	D10	Parapharyngeal -Tumour excision		3	26,250
64	FP00400013	Q38	Pharyngoplasty		2	12,000
65	FP00400014	Q38	Release of Tongue tie		1	3,000
66	FP00400015	J39	Retro pharyngeal abscess - Drainage	D		4,000
67	FP00400016	D11	Styloidectomy - Both side		3	10,000
68	FP00400017	D11	Styloidectomy - One side		3	8,000
69	FP00400018	J03	Tonsillectomy + Styloidectomy		2	12,500
70	FP00400019	Q89	Thyroglossal Cyst - Excision		2	10,000
71	FP00400020	Q89	Thyroglossal Fistula - Excision		3	10,000
72	FP00400021	J03	Tonsillectomy - Bilateral		1	7,000
73	FP00400022	J03	Tonsillectomy - Unilateral		1	5,500
74	FP00400023	C07	Total Parotidectomy		2	15,000
75	FP00400024	C05	Uvulophanyngo Plasty		2	12,500
		5	**GENERAL SURGERY**			
76	FP00500001	C20	Abdomino Perineal Resection		3	17,500
77	FP00500002	M70	Adventious Burse - Excision		3	8,750
78	FP00500003	C20	Anterior Resection for CA		5	10,000
79	FP00500004	K35	Appendicectomy		2	6,000
80	FP00500005	K35	Appendicular Abscess - Drainage		2	7,000
81	FP00500006	D18	Arteriovenous (AV) Malformation of Soft Tissue Tumour - Excision		3	17,000
82	FP00500007		Axillary Lymphnode - Excision		1	3,125
83	FP00500008	M71	Bakers Cyst - Excision		3	5,000
84	FP00500009	D36	Bilateral Inguinal block dissection		3	13,000
85	FP00500010	K25	Bleeding Ulcer - Gastrectomy & vagotomy		5	17,000
86	FP00500011	K25	Bleeding Ulcer - Partial gastrectomy		5	15,000
87	FP00500012	C77	Block dissection Cervical Nodes		3	15,750
88	FP00500013	Q18	Branchial Fistula		3	13,000
89	FP00500014	C50	Breast - Excision		3	12,250
90	FP00500015	D25	Breast Lump - Left - Excision		2	5,000
91	FP00500016	D25	Breast Lump - Right - Excision		2	5,000
92	FP00500017	D25	Breast Mass - Excision		2	6,250
93	FP00500018	J98	Bronchial Cyst		3	5,000
94	FP00500019	M06	Bursa - Excision		3	7,000
95	FP00500020		Bypass - Inoprablaca of Pancreas		5	13,000
96	FP00500021	K56	Caecopexy		3	13,000
97	FP00500022	L02	Carbuncle back		1	3,500
98	FP00500023	B44	Cavernostomy		5	13,000
99	FP00500024	C96	Cervial Lymphnodes - Excision		2	2,500
100	FP00500025	K83	Cholecysostomy		5	10,000

101	FP00500026	K80	Cholecystectomy & exploration		3	13,250
102	FP00500027	C67	Colocystoplasty		5	15,000
103	FP00500028	K57	Colostomy		5	12,500
104	FP00500029	C14	Commando Operation		5	15,000
105	FP00500030	L84	Corn - Large - Excision	D		500
106	FP00500031	N49	Cyst over Scrotum - Excision		1	4,000
107	FP00500032	Q61	Cystic Mass - Excision		1	2,000
108	FP00500033	L72	Dermoid Cyst - Large - Excision	D		2,500
109	FP00500034	L72	Dermoid Cyst - Small - Excision	D		1,500
110	FP00500035	K86	Distal Pancreatectomy with Pancreatico Jejunostomy		7	17,000
111	FP00500036	K57	Diverticulectomy		3	15,000
112	FP00500037	N47	Dorsal Slit and Reduction of Paraphimosis	D		1,500
113	FP00500038	K61	Drainage of Ischio Rectal Abscess		1	4,000
114	FP00500039		Drainage of large Abscess	D		2,000
115	FP00500040	K92	Drainage of Peripherally Gastric Abscess		3	8,000
116	FP00500041	L02	Drainage of Psoas Abscess		2	3,750
117	FP00500042	K92	Drainage of Subdiaphramatic Abscess		3	8,000
118	FP00500043	I31	Drainage Pericardial Effusion		7	11,000
119	FP00500044	K57	Duodenal Diverticulum		5	15,000
120	FP00500045	K31	Duodenal Jejunostomy		5	15,000
121	FP00500046	D13	Duodenectomy		7	20,000
122	FP00500047		Dupcrytren's (duputryen's contracture ?]		7	13,000
123	FP00500048	Q43	Duplication of Intestine		8	17,000
124	FP00500049	N43	Hydrocelectomy + Orchidectomy		2	7,000
125	FP00500050	N45	Epidedectomy		3	8,000
126	FP00500051	N45	Epididymal Swelling -Excision		2	5,500
127	FP00500052	N50	Epidymal Cyst	D		3,000
128	FP00500053	N50	Evacuation of Scrotal Hematoma		2	5,000
129	FP00500054	D13	Excision Benign Tumor -Small intestine		5	15,000
130	FP00500055	A15	Excision Bronchial Sinus	D		8,000
131	FP00500056	K75	Excision of liver Abscess		3	13,000
132	FP00500057	N43	Excision Filarial Scrotum		3	8,750
133	FP00500058	N61	Excision Mammary Fistula		2	5,500
134	FP00500059	Q43	Excision Meckel's Diverticulum		3	15,000
135	FP00500060	L05	Excision Pilonidal Sinus		2	8,250
136	FP00500061	K31	Excision Small Intestinal Fistulla		5	12,000
137	FP00500062	K11	Excision Submandibular Gland		5	10,000
138	FP00500063	C01	Excision of Large Growth from Tongue		3	5,000
139	FP00500064	C01	Excision of Small Growth from Tongue	D		1,500
140	FP00500065	L02	Excision of Swelling in Right Cervial Region		1	4,000
141	FP00500066	L02	Excision of Large Swelling in Hand	D		2,500
142	FP00500067	L02	Excision of Small Swelling in Hand	D		1,500

143	FP00500068	D33	Excision of Neurofibroma		3	7,000
144	FP00500069	L05	Exicision of Sinuds and Curetage		2	7,000
145	FP00500070	G51	Facial Decompression		5	15,000
146	FP00500071		Fibro Lipoma of Right Sided Spermatic with Lord Excision		1	2,500
147	FP00500072	D24	Fibroadenoma - Bilateral		2	6,250
148	FP00500073	D24	Fibrodenoma - Unilateral		2	7,000
149	FP00500074		Fibroma - Excision		2	7,000
150	FP00500075	K60	Fissurectomy		2	7,000
151	FP00500076	I84	Fissurectomy and Haemorrhoidectomy		2	11,250
152	FP00500077	K60	Fissurectomy with Eversion of Sac - Bilateral		2	8,750
153	FP00500078	K60	Fissurectomy with Sphincterotomy		2	9,000
154	FP00500079	K60	Fistula Repair		2	5,000
155	FP00500080	K60	Fistulectomy		2	7,500
156	FP00500081		Foreign Body Removal in Deep Region		2	5,000
157	FP00500082		Fulguration		2	5,000
158	FP00500083	K21	Fundoplication		3	15,750
159	FP00500084	K25	G J Vagotomy		5	15,000
160	FP00500085	K25	Vagotomy		3	12,000
161	FP00500086	M67	Ganglion - large - Excision		1	3,000
162	FP00500087	M67	Ganglion (Dorsum of Both Wrist) - Excision		1	4,000
163	FP00500088	M67	Ganglion - Small - Excision	D		1,000
164	FP00500089	K28	Gastro jejunal ulcer		5	10,000
165	FP00500090	K63	Gastro jejuno Colic Fistula		5	12,500
166	FP00500091	C17	Gastrojejunostomy		5	15,000
167	FP00500092	K25	Gastrotomy		7	15,000
168	FP00500093		Graham's Operation		5	12,500
169	FP00500094	A58	Granuloma - Excision		1	4,000
170	FP00500095		Growth - Excision	D		1,800
171	FP00500096	D18	Haemangioma - Excision		3	7,000
172	FP00500097	D13	Haemorrage of Small Intestine		3	15,000
173	FP00500098	C01	Hemi Glossectomy		3	10,000
174	FP00500099	D16	Hemi Mandibulectomy		3	15,000
175	FP00500100	C18	Hemicolectomy		5	16,000
176	FP00500101	J38	Hemithyroplasty		3	12,000
177	FP00500102	C34	Hepatic Resection (lobectomy)		7	15,000
178	FP00500103	K43	Hernia - Epigastric		3	10,000
179	FP00500104	K43	Hernia - Incisional		3	12,250
180	FP00500105	K40	Hernia - Repair & release of obstruction		3	10,000
181	FP00500106	K42	Hernia - Umbilical		3	8,450
182	FP00500107	K43	Hernia - Ventral - Lipectomy/Incisional		3	10,500
183	FP00500108	K41	Hernia - Femoral		3	7,000
184	FP00500109	K40	Hernioplasty		3	7,000

185	FP00500110		Herniorraphy and Hydrocelectomy Sac Excision		3	10,500
186	FP00500111	K44	Hernia - Hiatus		3	12,250
187	FP00500112	B67	Hydatid Cyst of Liver		3	10,000
188	FP00500113		Nodular Cyst	D		3,000
189	FP00500114	N43	Hydrocelectomy - Excision		2	4,000
190	FP00500115		Hydrocelectomy+Hernioplasty - Excision		3	7,000
191	FP00500116	N43	Hydrocele - Excision - Unilateral		2	3,750
192	FP00500117	N43	Hydrocele - Excision - Bilateral		2	5,000
193	FP00500118	C18	Ilieo Sigmoidostomy		5	13,000
194	FP00500119	M20	Infected Bunion Foot - Excision		1	4,000
195	FP00500120		Inguinal Node (bulk dissection) axial		2	10,000
196	FP00500121	K57	Instestinal perforation		6	9,000
197	FP00500122	K56	Intestinal Obstruction		6	9,000
198	FP00500123	K56	Intussusception		7	12,500
199	FP00500124	C16	Jejunostomy		6	10,000
200	FP00500125	K56	Closure of Perforation		5	9,000
201	FP00500126	C67	Cysto Reductive Surgery		3	7,000
202	FP00500127	K63	Gastric Perforation		6	12,500
203	FP00500128	K56	Intestinal Perforation (Resection Anastomosis)		5	11,250
204	FP00500129	K35	Appendicular Perforation		5	10,500
205	FP00500130		Burst Abdomen Obstruction		7	11,000
206	FP00500131	K56	Closure of Hollow Viscus Perforation		5	13,500
207	FP00500132		Laryngectomy & Pharyngeal Diverticulum (Throat)		3	10,000
208	FP00500133	Q42	Anorectoplasty		2	14,000
209	FP00500134	C32	Laryngectomy with Block Dissection (Throat)		3	12,000
210	FP00500135	C32	Laryngo Fissure (Throat)		3	12,500
211	FP00500136	C13	Laryngopharyngectomy (Throat)		3	12,000
212	FP00500137	K51	Ileostomy		7	17,500
213	FP00500138	D17	Lipoma	D		2,000
214	FP00500139	K56	Loop Colostomy Sigmoid		5	12,000
215	FP00500140	I84	Lords Procedure (haemorrhoids)		2	5,000
216	FP00500141	D24	Lumpectomy - Excision		2	7,000
217	FP00500142	C50	Mastectomy		2	9,000
218	FP00500143	K66	Mesenteric Cyst - Excision		3	9,000
219	FP00500144	K76	Mesenteric Caval Anastomosis		5	10,000
220	FP00500145	D14	Microlaryngoscopic Surgery [microlaryngoscopy ?]		3	12,500
221	FP00500146	T18	Oeshophagoscopy for foreign body removal	D		6,000
222	FP00500147	D13	Oesophagectomy		5	14,000
223	FP00500148	I85	Oesophagus Portal Hypertension		5	18,000

224	FP00500149	N73	Pelvic Abscess - Open Drainage		5	8,000
225	FP00500150	C61	Orchidectomy		2	5,500
226	FP00500151	C61	Orchidectomy + Herniorraphy		3	7,000
227	FP00500152	Q53	Orchidopexy		5	6,000
228	FP00500153	Q53	Orchidopexy with Circumsion		5	9,750
229	FP00500154	Q53	Orchidopexy With Eversion of Sac		5	8,750
230	FP00500155		Orchidopexy with Herniotomy		5	14,875
231	FP00500156	N45	Orchititis		2	6,000
232	FP00500157	K86	Pancreatrico Deodeneotomy		6	13,750
233	FP00500158	D12	Papilloma Rectum - Excision		2	3,500
234	FP00500159	I84	Haemorroidectomy+ Fistulectomy		2	7,000
235	FP00500160		Phytomatous Growth in the Scalp - Excision		1	3,125
236	FP00500161	K76	Porto Caval Anastomosis		5	12,000
237	FP00500162	K25	Pyeloroplasty		5	11,000
238	FP00500163	C50	Radical Mastectomy		2	9,000
239	FP00500164	C49	Radical Neck Dissection - Excision		6	18,750
240	FP00500165	K43	Hernia - Spigelian		3	12,250
241	FP00500166	K62	Rectal Dilation		1	4,500
242	FP00500167	K62	Prolapse of Rectal Mass - Excision		2	8,000
243	FP00500168	K62	Rectal polyp		1	3,000
244	FP00500169	K62	Rectopexy		3	10,000
245	FP00500170	K83	Repair of Common Bile Duct		3	12,500
246	FP00500171	C18	Resection Anastomosis (Large Intestine)		8	15,000
247	FP00500172	C17	Resection Anastomosis (Small Intestine)		8	15,000
248	FP00500173	D20	Retroperitoneal Tumor - Excision		5	15,750
249	FP00500174	I84	Haemorroidectomy		2	5,000
250	FP00500175	K11	Salivary Gland - Excision		3	7,000
251	FP00500176	L72	Sebaceous Cyst - Excision	D		1,200
252	FP00500177	N63	Segmental Resection of Breast		2	10,000
253	FP00500178		Scrotal Swelling (Multiple) - Excision		2	5,500
254	FP00500179	K57	Sigmoid Diverticulum		7	15,000
255	FP00500180	K25	Simple closure - Peptic perforation		6	11,000
256	FP00500181	L05	Sinus - Excision		2	5,000
257	FP00500182	D17	Soft Tissue Tumor - Excision		3	4,000
258	FP00500183	C80	Spindle Cell Tumor - Excision		3	7,000
259	FP00500184	D58	Splenectomy		10	23,000
260	FP00500185		Submandibular Lymphs - Excision		2	4,500
261	FP00500186	K11	Submandibular Mass Excision + Reconstruction		5	15,000
262	FP00500187	K11	Submandibular Salivary Gland -Removal		5	9,500
263	FP00500188	D11	Superficial Parodectomy		5	10,000
264	FP00500189	R22	Swelling in Rt and Lt Foot - Excision		1	2,400
265	FP00500190	R22	Swelling Over Scapular Region		1	4,000

266	FP00500191	K57	Terminal Colostomy		5	12,000
267	FP00500192	J38	Thyroplasty		5	11,000
268	FP00500193	C18	Coloectomy - Total		6	15,000
269	FP00500194	C67	Cystectomy - Total		6	10,000
270	FP00500195	C01	Glossectomy – Total (Throat)		7	15,000
271	FP00500196	C33	Pharyngectomy & Reconstruction - Total		6	13,000
272	FP00500197	Q32	Tracheal Stenosis (End to end Anastamosis) (Throat)		6	15,000
273	FP00500198	Q32	Tracheoplasty (Throat)		6	15,000
274	FP00500199	K56	Tranverse Colostomy		5	12,500
275	FP00500200	Q43	Umbilical Sinus - Excision		2	5,000
276	FP00500201	K25	Vagotomy & Drainage		5	15,000
277	FP00500202	K25	Vagotomy & Pyloroplasty		6	15,000
278	FP00500203	I84	Varicose Veins - Excision and Ligation		3	7,000
279	FP00500204		Vasco Vasostomy		3	11,000
280	FP00500205	K56	Volvlous of Large Bowel		4	15,000
281	FP00500206	K76	Warren's Shunt		6	15,000
	6	**GYNAECOLOGY**				
282	FP00600001		Abdomonal open for stress incision		5	11,250
283	FP00600002	N75	Bartholin abscess I & D	D		1,875
284	FP00600003	N75	Bartholin cyst removal	D		1,875
285	FP00600004	N84	Cervical Polypectomy		1	3,000
286	FP00600005	N84	Cyst - Labial	D		1,750
287	FP00600006	D28	Cyst -Vaginal Enucleation	D		1,875
288	FP00600007	N83	Ovarian Cystectomy		1	7,000
289	FP00600008	N81	Cystocele - Anterior repair		2	10,000
290	FP00600009	N96	D&C (Dilatation & curretage)	D		2,500
291	FP00600010		Electro Cauterisation Cryo Surgery	D		2,500
292	FP00600011		Fractional Curretage	D		2,500
293	FP00600012		Gilliams Operation		2	6,000
294	FP00600013		Haemato Colpo/Excision - Vaginal Septum	D		3,000
295	FP00600014	N89	Hymenectomy & Repair of Hymen	D		5,000
296	FP00600015	C53	Hysterectomy - abdominal		5	10,000
297	FP00600016	C53	Hysterectomy - Vaginal		5	10,000
298	FP00600017	C53	Hysterectomy - Wertheims operation		5	12,500
299	FP00600018	D25	Hysterotomy -Tumors removal		5	12,500
300	FP00600019	D25	Myomectomy - Abdominal		5	10,500
301	FP00600020	D27	Ovarectomy/Oophrectomy		3	7,000
302	FP00600021	O70	Perineal Tear Repair	D		1,875
303	FP00600022	N81	Prolapse Uterus -L forts		5	11,250
304	FP00600023	N81	Prolapse Uterus - Manchester		5	11,250
305	FP00600024	N82	Retro Vaginal Fistula -Repair		3	12,250

306	FP00600025	C56	Salpingoophrectomy		3	7,500
307	FP00600026	N97	Tuboplasty		3	8,750
308	FP00600027	O70	Vaginal Tear -Repair	D		3,125
309	FP00600028	D28	Vulvectomy		2	8,000
310	FP00600029	D28	Vulvectomy - Radical		2	7,500
311	FP00600030	D28	Vulval Tumors - Removal		3	5,000
312	FP00600031		Normal Delivery		2	2,500
313	FP00600032		Casearean delivery		3	4,500
	7	**ENDOSCOPIC PROCEDURES**				
314	FP00700001	N80	Ablation of Endometriotic Spot	D		5,000
315	FP00700002		Adhenolysis	D		17,000
316	FP00700003	K35	Appendictomy		2	11,000
317	FP00700004	K80	Cholecystectmy		3	10,000
318	FP00700005	K80	Cholecystectomy and Drainage of Liver abscess		3	14,200
319	FP00700006	K80	Cholecystectomy with Excision of TO Mass		4	15,000
320	FP00700007		Cyst Aspiration	D		1,750
321	FP00700008		Endometria to Endometria Anastomosis		3	7,000
322	FP00700009	N97	Fimbriolysis		2	5,000
323	FP00700010	C18	Hemicolectomy		4	17,000
324	FP00700011	C53	Hysterectomy with bilateral Salpingo Operectomy		3	12,250
325	FP00700012	K43	Incisional Hernia - Repair		2	12,250
326	FP00700013	K40	Inguinal Hernia - Bilateral		2	10,000
327	FP00700014	K40	Inguinal hernia - Unilateral		2	11,000
328	FP00700015	K56	Intestinal resection		3	13,500
329	FP00700016	D25	Myomectomy		2	10,500
330	FP00700017	D27	Oophrectomy		2	7,000
331	FP00700018	N83	Ovarian Cystectomy	D		7,000
332	FP00700019		Perotionities		5	9,000
333	FP00700020	C56	Salpingo Ophrectomy		3	9,000
334	FP00700021	N97	Salpingostomy		2	9,000
335	FP00700022	Q51	Uterine septum	D		7,500
336	FP00700023	I86	Varicocele - Bilateral		1	15,000
337	FP00700024	I86	Varicocele - Unilateral		1	11,000
338	FP00700025	N28	Repair of Ureterocele		3	10,000
	8	**HYSTEROSCOPIC**				
339	FP00800001	N80	Ablation of Endometrium	D		5,000
340	FP00800002	N97	Hysteroscopic Tubal Cannulation	D		7,500
341	FP00800003	N84	Polypectomy	D		7,000
342	FP00800004	N85	Uterine Synechia - Cutting	D		7,500
	9	**NEUROSURGERY**				
343	FP00900001	I67	Anneurysm		10	29,750
344	FP00900002	Q01	Anterior Encephalocele		10	28,750

345	FP00900003	I60	Burr hole	8	18,750
346	FP00900004	I65	Carotid Endarterectomy	10	18,750
347	FP00900005	G56	Carpal Tunnel Release	5	11,000
348	FP00900006	Q76	Cervical Ribs – Bilateral	7	13,000
349	FP00900007	Q76	Cervical Ribs - Unilateral	5	10,000
350	FP00900008		Cranio Ventrical	9	14,000
351	FP00900009		Cranioplasty	7	10,000
352	FP00900010	Q75	Craniostenosis	7	20,000
353	FP00900011	S02	Cerebrospinal Fluid (CSF) Rhinorrohea	3	10,000
354	FP00900012		Duroplasty	5	9,000
355	FP00900013	S06	Haematoma - Brain (head injuries)	9	22,000
356	FP00900014		Haematoma - Brain (hypertensive)	9	22,000
357	FP00900015	S06	Haematoma (Child irritable subdural)	10	22,000
358	FP00900016	M48	Laminectomy with Fusion	6	16,250
359	FP00900017		Local Neurectomy	6	11,000
360	FP00900018	M51	Lumbar Disc	5	10,000
361	FP00900019	Q05	Meningocele - Anterior	10	30,000
362	FP00900020	Q05	Meningocele - Lumbar	8	22,500
363	FP00900021	Q01	Meningococle – Ocipital	10	30,000
364	FP00900022	M50	Microdiscectomy - Cervical	10	15,000
365	FP00900023	M51	Microdiscectomy - Lumber	10	15,000
366	FP00900024	M54	Neurolysis	7	15,000
367	FP00900025		Peripheral Nerve Surgery	7	12,000
368	FP00900026	I82	Posterior Fossa - Decompression	8	18,750
369	FP00900027		Repair & Transposition Nerve	3	6,500
370	FP00900028	S14	Brachial Plexus - Repair	7	18,750
371	FP00900029	Q05	Spina Bifida - Large - Repair	10	22,000
372	FP00900030	Q05	Spina Bifida - Small - Repair	10	18,000
373	FP00900031	G91	Shunt	7	12,000
374	FP00900032	S12	Skull Traction	5	8,000
375	FP00900033		Spine - Anterior Decompression	8	18,000
376	FP00900034	M54	Spine - Canal Stenosis	6	14,000
377	FP00900035	M54	Spine - Decompression & Fusion	6	17,000
378	FP00900036	M54	Spine - Disc Cervical/Lumber	6	15,000
379	FP00900037	C72	Spine - Extradural Tumour	7	14,000
380	FP00900038	C72	Spine - Intradural Tumour	7	14,000
381	FP00900039	C72	Spine - Intramedullar Tumour	7	15,000
382	FP00900040	P10	Subdural aspiration	3	8,000
383	FP00900041	G50	Temporal Rhizotomy	5	12,000
384	FP00900042		Trans Sphenoidal	6	15,000
385	FP00900043	C71	Tumours - Supratentorial	7	22,500
386	FP00900044	D32	Tumours Meninges - Gocussa	7	22,500
387	FP00900045	D32	Tumours Meninges - Posterior	7	22,500

388	FP00900046	K25	Vagotomy - Selective		5	15,000
389	FP00900047	C17	Vagotomy with Gastrojejunostomy		6	15,000
390	FP00900048	K25	Vagotomy with Pyeloroplasty		6	15,000
391	FP00900049	K25	Vagotomy - Highly Selective		5	15,000
392	FP00900050	G00	Ventricular Puncture		3	8,000
	10	**OPHTHALMOLOGY**				
393	FP01000001	H00	Abscess Drainage of Lid	D		500
394	FP01000002	H40	Anterior Chamber Reconstruction		3	7,000
395	FP01000003	H33	Buckle Removal		2	9,375
396	FP01000004	H04	Canaliculo Dacryocysto Rhinostomy		1	7,000
397	FP01000005	H25	Capsulotomy		1	2,000
398	FP01000006	H25	Cataract – Bilateral	D		5,000
399	FP01000007	H25	Cataract – Unilateral	D		3,500
400	FP01000008	H25	Cataract + Pterygium	D		5000
401	FP01000009	H18	Corneal Grafting	D		4,000
402	FP01000010	H33	Cryoretinopexy - Closed		1	5,000
403	FP01000011	H33	Cryoretinopexy - Open		1	6,000
404	FP01000012	H40	Cyclocryotherapy	D		3,500
405	FP01000013	H04	Cyst	D		1,000
406	FP01000014	H04	Dacrocystectomy With Pterygium - Excision	D		6,500
407	FP01000015	H11	Pterigium + Conjunctival Autograft	D		3,500
408	FP01000016	H04	Dacryocystectomy	D		5,000
409	FP01000017	H46	Endoscopic Optic Nerve Decompression	D		8,000
410	FP01000018	E05	Endoscopic Optic Orbital Decompression	D		8,000
411	FP01000019	C69	Enucleation		1	2,000
412	FP01000020	C69	Enuleation with Implant		1	3,500
413	FP01000021	C69	Exentration	D		3,500
414	FP01000022	H02	Ectropion Correction	D		3,000
415	FP01000023	H40	Glaucoma surgery (trabeculectomy)		2	7,000
416	FP01000024	H44	Intraocular Foreign Body Removal	D		3,000
417	FP01000025	H18	Keratoplasty		1	8,000
418	FP01000026	H52	Lensectomy	D		7,500
419	FP01000027	H04	Limbal Dermoid Removal	D		2,500
420	FP01000028	H33	Membranectomy	D		6,000
421	FP01000029	S05	Perforating corneo - Scleral Injury		2	5,000
422	FP01000030	H11	Pterygium (Day care)	D		1,000
423	FP01000031	H02	Ptosis	D		2,000
424	FP01000032	H52	Radial Keratotomy		1	5,000
425	FP01000033	H21	IRIS Prolapse - Repair		2	5,000
426	FP01000034	H33	Retinal Detachment Surgery		2	10,000
427	FP01000035	D31	Small Tumour of Lid - Excision	D		500
428	FP01000036	D31	Socket Reconstruction		3	6,000
429	FP01000037	H40	Trabeculectomy - Right	D		7,500

430	FP01000038	H40	Iridectomy	D		1,800
431	FP01000039	D31	Tumours of IRiS		2	4,000
432	FP01000040	H33	Vitrectomy		2	4,500
433	FP01000041	H33	Vitrectomy + Retinal Detachment		3	20,000
	11	**ORTHOPAEDIC**				
434	FP01100001	S42	Acromion reconstruction		10	20,000
435	FP01100002	Q79	Accessory bone - Excision		3	12,000
436	FP01100003	S48	Ampuation - Upper Fore Arm		5	15,000
437	FP01100004	S68	Amputation - Index Fingure		1	1,000
438	FP01100005	S58	Amputation - Forearm		5	18,000
439	FP01100006		Amputation - Wrist Axillary Node Dissection		4	12,000
440	FP01100007		Amputation - 2nd and 3rd Toe		1	2,000
441	FP01100008		Amputation - 2nd Toe		1	1,000
442	FP01100009		Amputation - 3rd and 4th Toes		1	2,000
443	FP01100010		Amputation - 4th and 5th Toes		1	2,000
444	FP01100011		Amputation - Ankle		5	12,000
445	FP01100012		Amputation - Arm		6	18,000
446	FP01100013	M20	Amputation - Digits		1	3,500
447	FP01100014		Amputation - Fifth Toe		1	1,000
448	FP01100015	S98	Amputation - Foot		5	18,000
449	FP01100016		Amputation - Forefoot		5	15,000
450	FP01100017		Amputation - Great Toe		1	1,000
451	FP01100018	S68	Amputation - Wrist		5	12,000
452	FP01100019	S88	Amputation - Leg		7	20,000
453	FP01100020		Amputation - Part of Toe and Fixation of K Wire		5	12,000
454	FP01100021	S78	Amputation - Thigh		7	18,000
455	FP01100022	M41	Anterior & Posterior Spine Fixation		6	25,000
456	FP01100023		Arthoplasty – Excision		3	8,000
457	FP01100024		Arthorotomy		7	15,000
458	FP01100025	Q66	Arthrodesis Ankle Triple		7	16,000
459	FP01100026		Arthrotomy + Synevectomy		3	15,000
460	FP01100027	Q65	Arthroplasty of Femur head - Excision		7	18,000
461	FP01100028	S82	Bimalleolar Fracture Fixation		6	12,000
462	FP01100029		Bone Tumour and Reconstruction -Major - Excision		6	13,000
463	FP01100030		Bone Tumour and Reconstruction - Minor - Excision		4	10,000
464	FP01100031	M77	Calcaneal Spur - Excision of Both		3	9,000
465	FP01100032	S42	Clavicle Surgery		5	15,000
466	FP01100033	S62	Close Fixation - Hand Bones		3	7,000
467	FP01100034	S92	Close Fixation - Foot Bones		2	6,500
468	FP01100035		Close Reduction - Small Joints		1	3,500

469	FP01100036		Closed Interlock Nailing + Bone Grafting		2	12,000
470	FP01100037		Closed Interlocking Intermedullary		2	12,000
471	FP01100038	S82	Closed Interlocking Tibia + Orif of Fracture Fixation		3	12,000
472	FP01100039		Closed Reduction and Internal Fixation		3	12,000
473	FP01100040		Closed Reduction and Internal Fixation with K wire		3	12,000
474	FP01100041		Closed Reduction and Percutaneous Screw Fixation		3	12,000
475	FP01100042		Closed Reduction and Percuteneous Pinning		3	12,000
476	FP01100043		Closed Reduction and Percutaneous Nailing		3	12,000
477	FP01100044		Closed Reduction and Proceed to Posterior Stabilization		5	16,000
478	FP01100045		Debridement & Closure - Major		3	5,000
479	FP01100046		Debridement & Closure - Minor		1	3,000
480	FP01100047	M48	Decompression and Spinal Fixation		5	20,000
481	FP01100048	M48	Decompression and Stabilization with Steffiplate		6	20,000
482	FP01100049	M43	Decompression L5 S1 Fusion with Posterior Stabilization		6	20,000
483	FP01100050	G56	Decompression of Carpal Tunnel Syndrome		2	4,500
484	FP01100051	M51	Decompression Posteier D12+L1		5	18,000
485	FP01100052	M51	Decompression Stabilization and Laminectomy		5	16,000
486	FP01100053	S53	Dislocation - Elbow	D		1,000
487	FP01100054	S43	Dislocation - Shoulder	D		1,000
488	FP01100055	S73	Dislocation- Hip		1	1,000
489	FP01100056	S83	Dislocation - Knee		1	1,000
490	FP01100057		Drainage of Abscess Cold	D		1,250
491	FP01100058	M72	Dupuytren Contracture		6	12,000
492	FP01100059	M89	Epiphyseal Stimulation		3	10,000
493	FP01100060	M89	Exostosis - Small bones -Excision		2	5,500
494	FP01100061	M89	Exostosis - Femur - Excision		7	15,000
495	FP01100062	M89	Exostosis - Humerus - Excision		7	15,000
496	FP01100063	M89	Exostosis - Radius - Excision		6	12,000
497	FP01100064	M89	Exostosis - Ulna - Excision		6	12,000
498	FP01100065	M89	Exostosis - Tibia- Excision		6	12,000
499	FP01100066	M89	Exostosis - Fibula - Excision		6	12,000
500	FP01100067	M89	Exostosis - Patella - Excision		6	12,000
501	FP01100068		Exploration and Ulnar Repair		5	9,500
502	FP01100069	S72	External fixation - Long bone		4	13,000
503	FP01100070		External fixation - Small bone		2	11,500
504	FP01100071	S32	External fixation - Pelvis		5	15,000
505	FP01100072	M62	Fasciotomy		2	12,000
506	FP01100073		Fixater with Joint Arthrolysis		9	18,000

507	FP01100074	S32	Fracture - Acetabulam		9	18,000
508	FP01100075	S72	Fracture - Femoral neck - MUA & Internal Fixation		7	18,000
509	FP01100076	S72	Fracture - Femoral Neck Open Reduction & Nailing		7	15,000
510	FP01100077	S82	Fracture - Fibula Internal Fixation		7	15,000
511	FP01100078	S72	Fracture - Hip Internal Fixation		7	15,000
512	FP01100079	S42	Fracture - Humerus Internal Fixation		2	13,000
513	FP01100080	S52	Fracture - Olecranon of Ulna		2	9,500
514	FP01100081	S52	Fracture - Radius Internal Fixation		2	9,500
515	FP01100082	S82	Fracture - TIBIA Internal Fixation		4	10,500
516	FP01100083	S82	Fracture - Fibula Internal Fixation		4	10,500
517	FP01100084	S52	Fracture - Ulna Internal Fixation		4	9,500
518	FP01100085		Fractured Fragment Excision		2	7,500
519	FP01100086	M16	Girdle Stone Arthroplasty		7	15,000
520	FP01100087	M41	Harrington Instrumentation		5	15,000
521	FP01100088	S52	Head Radius - Excision		3	15,000
522	FP01100089	M17	High Tibial Osteotomy		5	15,000
523	FP01100090		Hip Region Surgery		7	18,000
524	FP01100091	S72	Hip Spica	D		4,000
525	FP01100092	S42	Internal Fixation Lateral Epicondyle		4	9,000
526	FP01100093		Internal Fixation of other Small Bone		3	7,000
527	FP01100094		Joint Reconstruction		10	22,000
528	FP01100095	M48	Laminectomy		9	18,000
529	FP01100096	M89	Leg Lengthening		8	15,000
530	FP01100097	S72	Llizarov Fixation		6	15,000
531	FP01100098	M66	Multiple Tendon Repair		5	12,500
532	FP01100099		Nerve Repair Surgery		6	14,000
533	FP01100100		Nerve Transplant/Release		5	13,500
534	FP01100101		Neurolysis		7	18,000
535	FP01100102		Open Reduction Internal Fixation (2 Small Bone)		5	12,000
536	FP01100103		Open Reduction Internal Fixation (Large Bone)		6	16,000
537	FP01100104	Q65	Open Reduction of CDH		7	17,000
538	FP01100105		Open Reduction of Small Joint		1	7,500
539	FP01100106		Open Reduction with Phemister Grafting		3	10,000
540	FP01100107		Osteotomy -Small Bone		6	18,000
541	FP01100108		Osteotomy -Long Bone		8	21,000
542	FP01100109	M17	Patellectomy		7	15,000
543	FP01100110	S32	Pelvic Fracture - Fixation		8	17,000
544	FP01100111	M16	Pelvic Osteotomy		10	22,000
545	FP01100112		Percutaneous - Fixation of Fracture		6	10,000
546	FP01100113	M70	Prepatellar Bursa and Repair of MCL of Knee		7	15,500

547	FP01100114	S83	Reconstruction of ACL/PCL		7	19,000
548	FP01100115	M76	Retrocalcaneal Bursa - Excision		4	10,000
549	FP01100116	M86	Sequestrectomy of Long Bones		7	18,000
550	FP01100117	M75	Shoulder Jacket (is it shoulder spica ?	D		5,000
551	FP01100118		Sinus Over Sacrum Excision		2	7,500
552	FP01100119		Skin Grafting		2	7,500
553	FP01100120	M43	Spinal Fusion		10	22,000
554	FP01100121	M05	Synovectomy		7	18,000
555	FP01100122	M71	Synovial Cyst - Excision		1	7,500
556	FP01100123	Q66	Tendo Achilles Tenotomy		1	5,000
557	FP01100124		Tendon Grafting		3	18,000
558	FP01100125	S86	Tendon Nerve Surgery of Foot		1	2,000
559	FP01100126	G56	Tendon Release		1	2,500
560	FP01100127	M67	Tenolysis		2	8,000
561	FP01100128	M67	Tenotomy		2	8,000
562	FP01100129	S82	Tension Band Wiring Patella		5	12,500
563	FP01100130	M65	Trigger Thumb	D		2,500
564	FP01100131		Wound Debridiment	D		1,000
		12	**PAEDIATRIC**			
565	FP01200001	Q79	Abdomino Perioneal (Exomphalos)		5	13,000
566	FP01200002	Q42	Anal Dilatation		3	5,000
567	FP01200003	Q43	Anal Transposition for Ectopic Anus		7	17,000
568	FP01200004	Q54	Chordee Correction		5	10,000
569	FP01200005	Q43	Closure Colostomy		7	12,500
570	FP01200006	Q43	Colectomy		5	12,000
571	FP01200007	Q39	Colon Transplant		3	18,000
572	FP01200008	N21	Cystolithotomy		3	7,500
573	FP01200009	Q39	Esophageal Atresia (Fistula)		3	18,000
574	FP01200010	R62	Gastrostomy		5	15,000
575	FP01200011	Q79	Hernia - Diaphragmatic		3	10,000
576	FP01200012	K43	Hernia - Epigastric		3	7,000
577	FP01200013	K42	Hernia - Umbilical		3	7,000
578	FP01200014	K40	Hernia-Inguinal - Bilateral		3	10,000
579	FP01200015	K40	Hernia-Inguinal -Unilateral		3	7,000
580	FP01200016	Q43	Meckel's Diverticulectomy		3	12,250
581	FP01200017	Q74	Meniscectomy		3	6,000
582	FP01200018	N20	Nephrolithotomy		3	10,000
583	FP01200019	Q53	Orchidopexy - Bilateral		2	7,500
584	FP01200020	Q53	Orchidopexy - Unilateral)		2	5,000
585	FP01200021	N20	Pyelolithotomy		5	10,000
586	FP01200022	Q62	Pyeloplasty		5	15,000
587	FP01200023	Q40	Pyloric Stenosis (Ramsted OP)		3	10,000
588	FP01200024	K62	Rectal Polyp		2	3,750

589	FP01200025		Resection & Anastamosis of Intestine	7	17,000
590	FP01200026	N21	Supra Pubic Drainage - Open	2	4,000
591	FP01200027	N44	Torsion Testis	5	10,000
592	FP01200028	Q39	Tracheo Esophageal Fistula	5	18,750
593	FP01200029	Q62	Ureterotomy	5	10,000
594	FP01200030	N35	Urethroplasty	5	15,000
595	FP01200031	Q62	Vesicostomy	5	12,000
	13	**ENDOCRINE**			
596	FP01300001	D35	Adenoma Parathyroid - Excision	3	15,000
597	FP01300002	D35	Adrenal Gland Tumour - Excision	5	11,250
598	FP01300003	D36	Axillary lymphnode - Excision	3	13,000
599	FP01300004	D11	Parotid Tumour - Excision	3	9,000
600	FP01300005	C25	Pancreatectomy	7	17,000
601	FP01300006	K80	Sphineterotomy (sphincterotomy ?)	5	13,000
602	FP01300007	D34	Thyroid Adenoma Resection Enucleation	5	15,000
603	FP01300008	E05	Thyroidectomy - Hemi	3	9,000
604	FP01300009	E05	Thyroidectomy - Partial	3	10,000
605	FP01300010	C73	Thyroidectomy - Total	5	16,000
606	FP01300011	C73	Total thyroidectomy & block dissection	5	17,000
607	FP01300012	C73	Totol Thyroidectomy + Reconstruction	5	15,000
608	FP01300013		Trendal Burge Ligation and Stripping	3	9,000
	14	**UROLOGY**			
609	FP01400001	N21	Bladder Calculi- Removal	2	7,000
610	FP01400002	C67	Bladder Tumour (Fulgration)	2	2,000
611	FP01400003	Q64	Correction of Extrophy of Bladder	2	1,500
612	FP01400004	N21	Cystilithotomy	2	6,000
613	FP01400005	K86	Cysto Gastrostomy	4	10,000
614	FP01400006	K86	Cysto Jejunostomy	4	10,000
615	FP01400007	N20	Dormia Extraction of Calculus	1	5,000
616	FP01400008	N15	Drainage of Perinepheric Abscess	1	7,500
617	FP01400009	N21	Cystolithopexy	2	7,500
618	FP01400010	N36	Excision of Urethral Carbuncle	1	5,000
619	FP01400011		Exploration of Epididymus (Unsuccesful Vasco vasectomy)	2	7,500
620	FP01400012	Q64	Urachal Cyst	1	4,000
621	FP01400013	Q54	Hydrospadius	2	9,000
622	FP01400014	N35	Internal Urethrotomy	3	7,000
623	FP01400015	N20	Litholapexy	2	7,500
624	FP01400016	N20	Lithotripsy	2	11,000
625	FP01400017	N36	Meatoplasty	1	2,500
626	FP01400018	N36	Meatotomy	1	1,500
627	FP01400019		Neoblastoma	3	10,000
628	FP01400020	Q61	Nephrectomy	4	10,000

629	FP01400021	C64	Nephrectomy (Renal tumour)		4	10,000
630	FP01400022	C64	Nephro Uretrectomy		4	10,000
631	FP01400023	N20	Nephrolithotomy		3	15,000
632	FP01400024	N28	Nephropexy		2	9,000
633	FP01400025	N13	Nephrostomy		2	10,500
634	FP01400026	C64	Nephrourethrotomy (is it Nephrourethrectomy ?)		3	11,000
635	FP01400027	C67	Open Resection of Bladder Neck		2	7,500
636	FP01400028	N28	Operation for Cyst of Kidney		3	9,625
637	FP01400029	N28	Operation for Double Ureter		3	15,750
638	FP01400030	Q62	Fturp		3	12,250
639	FP01400031	S37	Operation for Injury of Bladder		3	12,250
640	FP01400032	C67	Partial Cystectomy		3	16,500
641	FP01400033	C64	Partial Nephrectomy		3	13,000
642	FP01400034	N20	PCNL (Percutaneous nephro lithotomy) - Biilateral		3	18,000
643	FP01400035	N20	PCNL (Percutaneous nephro lithotomy) - Unilateral		3	14,000
644	FP01400036	Q64	Post Urethral Valve		1	9,000
645	FP01400037	N20	Pyelolithotomy		3	13,500
646	FP01400038	N13	Pyeloplasty & Similar Procedures		3	12,500
647	FP01400039	C64	Radical Nephrectomy		3	13,000
648	FP01400040	N47	Reduction of Paraphimosis	D		1,500
649	FP01400041	N36	Reimplanation of Urethra		5	17,000
650	FP01400042	N32	Reimplantation of Bladder		5	17,000
651	FP01400043	N13	Reimplantation of Ureter		5	17,000
652	FP01400044	N82	Repair of Uretero Vaginal Fistula		2	12,000
653	FP01400045	N28	Repair of Ureterocele		3	10,000
654	FP01400046	N13	Retroperitoneal Fibrosis - Renal		5	26,250
655	FP01400047	C61	Retropubic Prostatectomy		4	15,000
656	FP01400048	K76	Spleno Renal Anastomosis		5	13,000
657	FP01400049	N35	Stricture Urethra		1	7,500
658	FP01400050	N40	Suprapubic Cystostomy - Open		2	3,500
659	FP01400051	N40	Suprapubic Drainage - Closed		2	3,500
660	FP01400052	N44	Torsion testis		1	3,500
661	FP01400053	N40	Trans Vesical Prostatectomy		2	15,750
662	FP01400054	N40	Transurethral Fulguration		2	4,000
663	FP01400055	D30	TURBT (Transurethral Resection of the Bladder Tumor)		3	15,000
664	FP01400056	N40	TURP + Circumcision		3	15,000
665	FP01400057	N41	TURP + Closure of Urinary Fistula		3	13,000
666	FP01400058	N40	TURP + Cystolithopexy		3	18,000
667	FP01400059	N40	TURP + Cystolithotomy		3	18,000
668	FP01400060	K60	TURP + Fistulectomy		3	15,000

669	FP01400061	N40	TURP + Cystoscopic Removal of Stone	3	12,000
670	FP01400062	C64	TURP + Nephrectomy	3	25,000
671	FP01400063	C61	TURP + Orchidectomy	3	18,000
672	FP01400064	N40	TURP + Suprapubic Cystolithotomy	3	15,000
673	FP01400065	C61	TURP + TURBT	3	15,000
674	FP01400066	N40	TURP + URS	3	14,000
675	FP01400067	N40	TURP + Vesicolithotripsy	3	15,000
676	FP01400068	N40	TURP + VIU (visual internal urethrotomy)	3	12,000
677	FP01400069	I84	TURP + Haemorrhoidectomy	3	15,000
678	FP01400070	N40	TURP + Hydrocele	3	18,000
679	FP01400071	N40	TURP + Hernioplasty	3	15,000
680	FP01400072	N40	TURP with Repair of Urethra	3	12,000
681	FP01400073		TURP + Herniorraphy	3	17,000
682	FP01400074	N40	TURP (Trans-Urethral Resection of Bladder)Prostate	3	14,250
683	FP01400075	K60	TURP + Fissurectomy	3	15,000
684	FP01400076	N40	TURP + Urethrolithotomy	3	15,000
685	FP01400077	N40	TURP + Urethral dilatation	3	15,000
686	FP01400078	N82	Uretero Colic Anastomosis	3	8,000
687	FP01400079	N20	Ureterolithotomy	3	10,000
688	FP01400080	N20	Ureteroscopic Calculi - Bilateral	2	18,000
689	FP01400081	N20	Ureteroscopic Calculi - Unilateral	2	12,000
690	FP01400082	N35	Ureteroscopy Urethroplasty	3	17,000
691	FP01400083	N20	Ureteroscopy PCNL	3	17,000
692	FP01400084	N20	Ureteroscopic stone Removal And DJ Stenting	3	9,000
693	FP01400085	N35	Urethral Dilatation	1	2,250
694	FP01400086		Urethral Injury	2	10,000
695	FP01400087	N81	Urethral Reconstruction	3	10,000
696	FP01400088	C53	Ureteric Catheterization - Cystoscopy	1	3,000
697	FP01400089	C67	Uretrostomy (Cutanie)	3	10,000
698	FP01400090	N20	URS + Stone Removal	3	9,000
699	FP01400091	N20	URS Extraction of Stone Ureter - Bilateral	3	15,000
700	FP01400092	N20	URS Extraction of Stone Ureter - Unilateral	3	10,500
701	FP01400093	N20	URS with DJ Stenting With ESWL	3	15,000
702	FP01400094		URS with Endolitholopexy	2	9,000
703	FP01400095	N20	URS with Lithotripsy	3	9,000
704	FP01400096	N20	URS with Lithotripsy with DJ Stenting	3	10,000
705	FP01400097	N21	URS+Cysto+Lithotomy	3	9,000
706	FP01400098	N82	V V F Repair	3	15,000
707	FP01400099	Q54	Hypospadias Repair and Orchiopexy	5	16,250
708	FP01400100	N13	Vesico uretero Reflux - Bilateral	3	13,000
709	FP01400101	N13	Vesico Uretero Reflux - Unilateral	3	8,750
710	FP01400102	N21	Vesicolithotomy	3	7,000

711	FP01400103	N35	VIU (Visual Internal Urethrotomy)		3	7,500
712	FP01400104	N21	VIU + Cystolithopexy		3	12,000
713	FP01400105	N43	VIU + Hydrocelectomy		2	15,000
714	FP01400106	N35	VIU and Meatoplasty		2	9,000
715	FP01400107	N35	VIU for Stricture Urethra		2	7,500
716	FP01400108	N35	VIU with Cystoscopy		2	7,500
717	FP01400109	N32	Y V Plasty of Bladder Neck		5	9,500
	15	**ONCOLOGY**				
718	FP01500001		Adenoma Excision		7	10,000
719	FP01500002	C74	Adrenalectomy - Bilateral		7	19,000
720	FP01500003	C74	Adrenalectomy - Unilateral		7	12,500
721	FP01500004	C00	Carcinoma lip - Wedge excision		5	7,000
722	FP01500005	C00-C97	Chemotherapy - Per sitting	D		1,000
723	FP01500006	D44	Excision Carotid Body tumour		5	13,000
724	FP01500007	C56	Malignant ovarian		5	15,000
725	FP01500008		Operation for Neoblastoma		5	10,000
726	FP01500009	C16	Partial Subtotal Gastrectomy & Ulcer		7	15,000
727	FP01500010		Radiotherapy - Per sitting	D		1,500
	18	**MEDICAL (General Ward)**				
728	FP01800001	A15				
729	FP01800002	B15				
730	FP01800003	B16				
731	FP01800004	B17				
732	FP01800005	B18				
733	FP01800006	B19				
734	FP01800007	A09				
735	FP01800008	A08				
736	FP01800009	A04				
737	FP01800010	A05				
738	FP01800011	A90				
739	FP01800012	A91				
740	FP01800013	B50				
741	FP01800014	B51				
742	FP01800015	B52				
743	FP01800016	B53				
744	FP01800017	B54				
745	FP01800018	A01				
746	FP01800019	I10				
747	FP01800020	J45				
748	FP01800021	J12				
749	FP01800022	J13				
750	FP01800023	J14				
751	FP01800024	J15				

752	FP01800025	J16
753	FP01800026	J17*
754	FP01800027	J18
755	FP01800028	O13
756	FP01800029	O14
757	FP01800030	O14
758	FP01800031	A09
759	FP01800032	I60
760	FP01800033	I61
761	FP01800034	I62
762	FP01800035	I63
763	FP01800036	I64
764	FP01800037	J40
765	FP01800038	J41
766	FP01800039	J42
767	FP01800040	J43
768	FP01800041	J44
769	FP01800042	N10
770	FP01800043	N17
771	FP01800044	P58
772	FP01800045	P59
773	FP01800046	I33
774	FP01800047	A87
775	FP01800048	A06
776	FP01800049	E10
777	FP01800050	E11
778	FP01800051	E12
779	FP01800052	E13
780	FP01800053	E14

More common interventions / procedures can be added by the insurer under specific system columns.