THE EXPERIENCE OF UTILISATION OF RASHTRIYA SWASTHYA BIMA YOJNA (RSBY): A QUALITATIVE STUDY IN SITAPUR DISTRICT OF UTTAR PRADESH

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INTRODUCTION

Public health financing is a critical determinant of access to health care. India has seen limited and inequitable financing in the decades since independence and its share of public expenditure on health has been abysmal. As a result, most of the expenses are borne privately through out of pocket (OOP) expenses by individuals and households. About 80 per cent of the total health expenditure and 97 per cent of private expenditure is borne through OOP payments (Baru *et al* 2010). This is highly inequitable as the poor have to face a greater impact of high OOP spending. In recent years, there has been some effort and commitment to increase the share of public spending on health. In 2008-09, public spending as a share of GDP was 1.10 per cent (Balarajan 2011) which was an increase from 0.94 per cent that constituted public spending on health in 2005-05 (Shiva Kumar *et al*, 2011). Although the share of public spending on health has increased, it is still very low compared to OECD countries or even other middle income countries. One of the mechanisms which have contributed to increase in public health financing has been publicly financed health insurance schemes. Health insurance schemes are increasingly being seen as an alternative way of financing health care, although there is still some debate in the policy circles about its potential to be the primary means of financing health care. In the past few years, India has seen a proliferation of social health insurance schemes. While most of these schemes have been launched by the respective state governments (RSBY/CHIS in Kerala, Arogyashree in Andhra Pradesh, Kalaignar in Tamil Nadu and Yeshasvini in Karnataka), the central government has started the Rashtriya Swasthya Bima Yojna (RSBY) since 2008.

RSBY has expanded rapidly in the past three years since its inception. It is meant only for BPL families. In 2011, it had reached about 22 million BPL families. More recent reports show that it has already reached 29 million families as of April 2012 (*Economic Times* April 2012). The RSBY has several features which distinguish it from other central government insurance schemes. It is run in a Public Private Partnership (PPP) model with health care provided by both private as well as public providers. It has been designed along a business model with incentives for all key stakeholders. Inclusion of both public and

private providers is expected to provide choice of provider to the users. It uses biometric technology to provide smart cards to beneficiary families. This is expected to prevent fraud in identification of beneficiaries, carry out paperless transaction and, more importantly, provide cashless treatment to the user. RSBY is being scaled up to include other workers in the informal sector like *beedi* workers, domestic workers and MNREGA workers and pilot studies are being run to test its applicability in providing outpatient care (*The Economic Times* July 2011). Some recent policy documents like the report of the Planning Commission's Steering Committee on Health show that the RSBY model is being considered as a way of financing health care in India. In this context, it becomes extremely important to critically examine the design and implementation of the scheme. Most of the recent studies on RSBY, including evaluation studies by the Ministry of Labour and Employment (MoLE) are either large surveys that enquire into different components of RSBY implementation (Mott Mac Donald 2011a, 2011b; Amicus Advisory Pvt Ltd 2010, 2011; Das and Leino 2011) or they are studies that have used utilisation data to present trends in coverage etc of the scheme (Jain 2011; Sun 2011; Grover and Palacios 2011). There are few studies that have tested whether RSBY is truly able to provide financial risk protection and critique the design of the scheme (Selvaraj 2012). There is also dearth of micro studies on beneficiary experience and experience of providers them selves; therefore there is much scope for understanding and critiquing the way the programme has been conceptualized.

This study is a qualitative study which has used case studies to understand the perception of users of the scheme as well as providers of the scheme in Sitapur district of Uttar Pradesh through case studies. The study uses these findings to enquire whether the RSBY indeed provides choice to the users to choose among health institutions , and in cases where such choice is being exercised, what factors influence this choice. Another question that the study seeks to answer is whether the scheme is truly the cashless scheme that it claims to be. Studies have shown that OOP expenditure includes not just hospitalisation expenses but also indirect costs. (Baru *et al* 2010). Hence this study enquires into indirect costs during hospitalisation as well OOP expenses before and after hopitalisation under RSBY.

RSBY has adopted a business model approach, which is supposed to provide a 'win-win' scenario for all the stakeholders. Inclusion of private providers is seen as one of the strong points in the scheme as it increases choice of providers for the user. Interviews with the providers were meant to enquire into experience of the providers in implementing the scheme. It provided insights into whether RSBY is really providing private providers enough reasons to be part of the scheme.

The first chapter of the dissertation broadly describes the different models of health financing in the world and highlights different issues and inadequacies related to health financing in India. It provides a backdrop to understanding the health insurance schemes at large, and RSBY in particular.

The next chapter specifically looks at the social health insurance scenario in India. It provides an overview of the important social health insurance schemes in the country and goes on to describe in detail the key provisions of the RSBY scheme. This section also reviews recent studies on RSBY and briefly describes the changing policy context in India that has led to the emergence of insurance schemes like RSBY.

The third chapter describes in detail the methodology adopted for the study as well as a description of the area in which the study was done. The fourth and the fifth chapter present the findings that have emerged. While the fourth chapter presents the key findings from the provider's perspective, the fifth chapter presents the findings that have emerged out of interview with the beneficiaries of the scheme.

The final chapter is the discussion chapter which brings together the final analysis and conclusion developed through the findings.

HEALTH CARE FINANCING: TYPOLOGY AND SCENARIO IN INDIA

Health financing is a crucial determinant that affects accessibility and quality of health care in a country. There is however, no single, overarching model or method of financing health care. The type of health care financing mechanism a country adopts is shaped by the larger health care model, which in turn is shaped by a complex set of political, economic and social factors. Traditionally, the Western European welfare regimes and to some extent, other OECD countries have offered examples of the various ways of health financing and organization of the health system. Tax funded single payer mechanism, publicly owned insurance and privately financed insurance are some of the ways in which these countries finance their health care. In the past two to three decades, many developing countries in Asia, Latin America and Africa too have tried different experiments with health care financing. Clearly therefore there are many models and mechanisms of health care financing available. What the best system of financing health care is, is a raging debate today in the post recession economies of Europe and the United States. The neo-liberal regime has responded to this crisis by supporting health care models and financing mechanisms that are 'efficient'. In other words, health care models which reduce the financial responsibility of the state and transfer it to individuals. There is however, very often a tradeoff between efficiency and equity which has led to severe criticism of such models.

In India, the health care system has been undergoing constant change and different experiments are being tried out to finance health care (RSBY, Arogyashree, Yeshasvini). International experience and debates will surely inform changes in health care financing in India. It is therefore important to understand the experiments in health care financing in India with reference to the global context and be able to compare and contrast various health care financing options. Further it is of prime importance to place health financing schemes like the RSBY within the larger context of health financing in the country.

1.1 HEALTH CARE FINANCING UNDER DIFFERENT MODELS OF HEALTH CARE SYSTEMS- AN OVERVIEW OF HEALTH CARE FINANCING IN SOME COUNTRIES

As already pointed, there is no one model of health care financing. Depending on the socio-political, historical and economic contexts, the health care system in a country takes shape. What role the state will play vis-à-vis the private sector, what part of health care will be financed and indeed what will not be financed and who will benefit from it are some of the essential components which differ from country to country depending on the health care model and financing mechanism it has adopted. What form the health care system will take and what health financing model is to be adopted is a decision taken by the state and influenced by a complex set of factors.

Britain's National Health Service (NHS) was a product of several social political and economic factors. The Great Depression had shown the instability of the capitalist system. Economists like Keynes had therefore propagated a more active role for the state. The inter-war period had also shown that existing social policies were inadequate and there was a labour movement which demanded improved health facilities. It was in this context that William Beveridge came up with his plan in 1943 that laid the foundations of the welfare state in the United Kingdom. The final shape of the NHS was a product of negotiations between medical associations (who wanted financial security from the government as well as the freedom to practice privately) and the government, which had to accommodate private interests in the final plan (Doyal 1979). Similarly Germany, the first country to adopt the social insurance model in 1883, resorted to a social insurance model because Chancellor Otto van Bismarck wanted to counter the left leaning labour unions and strengthen the state. Hence, the already existing occupation based sickness funds were retained but there was overall state regulation (Saltman and Dubois 2004).

The above examples only go on to demonstrate that a health system is a product of the socio-political dynamics of the time. Another key factor which influences the shaping of a health system is purely ideological. It is the idea of 'health' itself. How health is viewed is critical in shaping of a health system and in turn health care financing. Green (2007) has distinguished between three different perspectives by which health can be viewed. Health

can be viewed as a *right* just like political freedom or justice. The WHO views enjoyment of highest standards of health as one of the fundamental rights. While each individual cannot experience the same health, each individual should have the same access to services and conditions that ensure enjoyment of good health. Hence, when viewed as a right, the role of the state becomes imperative in ensuring that there is equity in health and access to health care and it plays a dominant role in the provision and regulation of health care. The second view is to regard health as a *consumption good*. In this case, health is seen as an individual prerogative. It is treated like any other material good and the state has a minimal role to play (like setting up quality norms). The third view of health is as an *investment.* In this view, health is important because a healthy workforce is important for high productivity in the economy. Explaining how these different views of health shape the health sector in a country; Green (2007) writes:

> These attitudes can be seen as components of a more complex attitude to health. They demonstrate that governments with different views of health (linked to their ideologies) are likely to view their responsibilities to the health sector differently. New Right governments are likely to see health as an individual responsibility with a minimal State role, whereas socialist governments may see access to health-care as a right with the State thus having a major role to play in promoting this (Green 2007: 10).

It is not just how health is viewed but also how 'health care' is viewed that shapes a health system. At this juncture it is also important to make a distinction between 'private goods' and 'public goods'. Traditionally, economic theory has made a distinction between goods that can be produced and sold privately in the market and goods with characteristics that make them unsuitable for competing in the market and therefore which would face market failure. Private goods are those goods which have excludable benefits. These goods can be priced or rationed in a manner that others can be prevented from enjoying the benefits of the good. The other feature of private goods is that they are rival goods. In other words, consumption of a private good by one consumer automatically means loss for another consumer as the total supply of that good is reduced. These characteristic of private good makes it appropriate to compete in the market, and its price is determined by the market forces. Public goods on the other hand are *non excludable* and *non- rival*. It means that on consumption of a public good by one person, others cannot be excluded from its consumption. Since it is non rival, each individual consumes the same amount of it.

Consumption by one does not reduce the amount available for another individual. Provision in such cases cannot be corrected in a manner to discriminate between consumers. Example of public good could be a street light or a public tap. Another aspect of public goods is the existence of *externalities*. Consumption by one individual is not only beneficial for him or her but also has spill over benefits for other individuals. A frequently quoted example is immunization of the population which leads to herd immunity. These are positive externalities. There could also be negative externalities, wherein the consumption of the good may be positive for the individual but has negative spillover effect for others. An example could be a factory that causes pollution (Rayan and Pearce 1977). The existence of positive externalities has given rise to the concept of something called 'merit good'. A merit good is something that has a positive externality and more importantly it is something that *ought* to be provided for the betterment of society. The concept of 'merit good' was developed by Richard Musgrave on the premise that there are certain goods for which the social benefits exceed the summation of individual benefit (Kurian 2006). According to some authors, a merit good should not depend on the ability or willingness to pay since persons by virtue of being citizens have a right to them (Dasgupta 1993 cit in Kurien 1996). Others claim that in case of merit goods, choice should not be provided to individuals whether to consume it or not because the individual may not have complete information about the beneficial effects of the merit good (Mills and Gilson 1988 cited in Kurien 2006). The example of immunization can be taken here. If instead of a universal immunization programme, individuals are left with a choice, many may not get their children immunized due to the lack of complete information about its benefits. Health care can be given the status of merit good because the resulting good health status is beneficial for the society as a whole. The problem with these goods is what has been termed as the 'free rider problem', other people taking benefit without paying for it or refusing to pay for it.

The reason why it is important to know these concepts is because health provisioning in a country is also defined by the underlying ideology about health care being a 'private good', a 'public good' or a 'merit good'. A larger role for public provisioning of healthcare signifies health care being put in the category of a 'public good' or a 'merit good' which is an entitlement of the 'citizens'. In a more privatized health system, health care is a 'private

good' which is bought and sold in the market for the benefit of 'consumers'. Therefore, a number of factors including social, political, economic as well as how health and health care is viewed shape the health system in a country.

There have been several attempts to differentiate and classify different systems of health care around the world with the purpose of helping easier analysis and comparison. An early classification by Terris (1978), although outdated, throws light on how political organization was used as a defining criterion in the Cold War era. He divided health care system into three types. The first being *Public Assistance,* a system dominant in what he calls pre-capitalist societies of Asia, Africa and Latin America. Of course, much has changed since these typologies were made (three decades back) but these were health care systems where medical care was provided through a public assistance system for the poor that included government hospitals and health centers financed by general taxation and administered by the health department. There could also be special social security schemes for the white collared. The second type of health system was the *Health Insurance* model of capitalist countries (like the U.S, Canada, Denmark, Finland, Iceland, New Zealand, Norway etc). Health was financed by insurance, public or private through compulsory employer and employee contributions, payroll taxes or general taxes. The *National Health Service* model was found predominantly in the then socialist countries. This was based on Nikolai A. Semashko's model advocating a strong unified health administration, entirely state run, providing both preventive and curative services and financed through general taxes. Terris however makes a distinction between the NHS model and the health care system in countries like United Kingdom and Sweden. He calls them *Intermediate Forms*. This is because the general practitioners in these two countries are not salaried physicians working in community centers but have contractual relationship with the government. Such classifications (as were provided by Terris) gave way to the OECD classification of health systems. The OECD classification began to be used more commonly over time (Burau and Blank 2006).

The OECD typology has used institutional arrangements for provisioning of health care and source of funding health care as the criteria for organizing health care systems. An OECD study in 1987 titled *'Financing and Delivering Health Care: A Comparative*

Analysis of OECD Countries' was influential in this respect. It established a health system based on the dichotomy between patient sovereignty one the one hand, and social equity on the other (figure 1.1).

Fig 1.1 : Types of Health care System by Provision and Funding

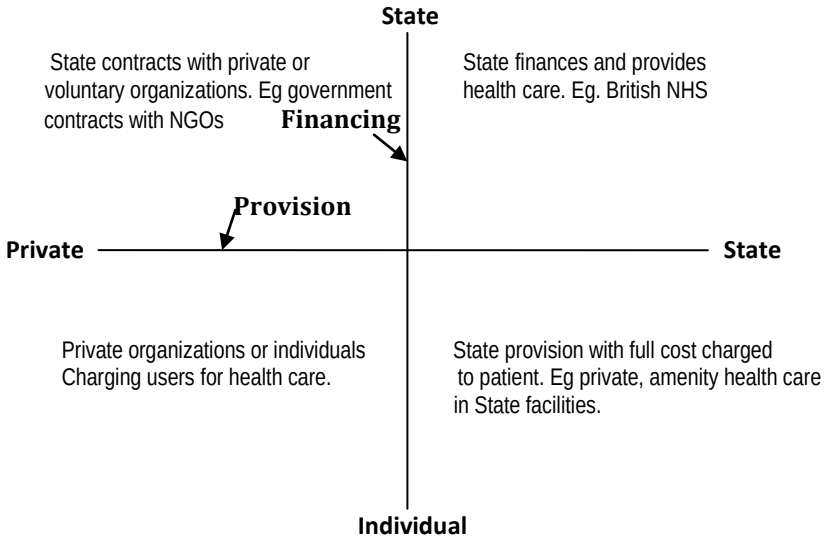
Source: Burau and Blank (2006); Comparing health policy: An assessment of typologies of health systems, Journal of Comparative Policy Analysis: Research and Practice,8:01, *pp 65*

A private insurance system was influenced by the idea of patient sovereignty while the NHS type system was based on the principle of social equity. The former system has institutional arrangement which is characterized by the predominance of incentives while the latter is characterized by control (Burau and Blank 2006). The three main criteria used by the OECD to classify health systems were 'coverage', 'funding' and 'ownership'. Based on these, there are three models of health care (which will be discussed later) (Wendt 2009).

The most commonly used typologies of health care systems base their analysis on two factors – financing and provision of health care, and the involvement of the state vis-à-vis the private sector in these two areas. There can be several combinations of public and private in different aspects of financing and provisioning. Andrew Green's (2007) diagrammatic representation captures this well.

This diagram (Fig.1.2) is important because it captures an important aspect; that public or private financing are in a continuum and not entirely mutually exclusive categories. Different countries have different levels of public and private provision or financing.

Fig 1.2: Combinations of Financing and Provision of Health Care



Source: Green, A (2007): An Introduction to Health Planning for Developing Health Systems (Third Edition), Oxford University Press, New York, p 15

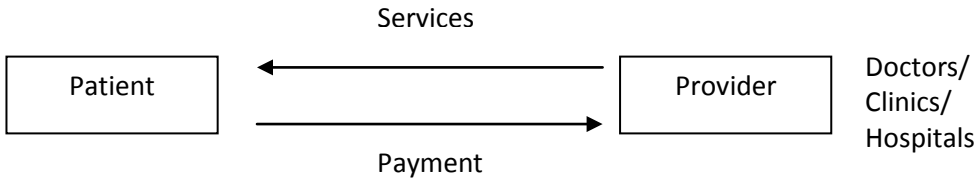
Typically, health can be financed through several sources which include public, private or a combination of both. These are general taxation, employer and employee contributions to mandatory sickness funds or social insurance (government run or regulated autonomous bodies), buying private insurance or direct payment to providers. Similarly provision too could be largely public, largely private or a combination of the two. How providers and hospitals are paid, is a good way to understand the degree of public or private provisioning in a country. There can be government owned salaried physicians, private physician paid by government (through capitation or fee for service mode), private physician paid by public insurance/sickness funds (fee for service), private physician reimbursed by private insurance or private physicians paid out of pocket directly by the patient.

Therefore, based on financing, provisioning and the role of the state in these two, three basic models of health systems are commonly used for the purpose of classification- the National Health Service (or *Beveridge Model*), the Social Health Insurance (*Bismarck Model*) and the private insurance (or *Consumer Sovereignty Model*). These can be called the OECD classification. While these models may apply to OECD countries in large parts of developing countries, the major source of payment is still direct out-of-pocket payment to the providers. Therefore, we can consider OOP to be an existing classification as well.

Community Based Health Insurance (CBHI) has also emerged in recent times as a method of financing. However this section will not focus on the CBHI model since it is limited in its reach.

A diagrammatic representation (adapted from Balasubramaniam 2001) of the commonly used classification of health financing models is provided below.

Fig.1.3 Out of Pocket Expenditure Model

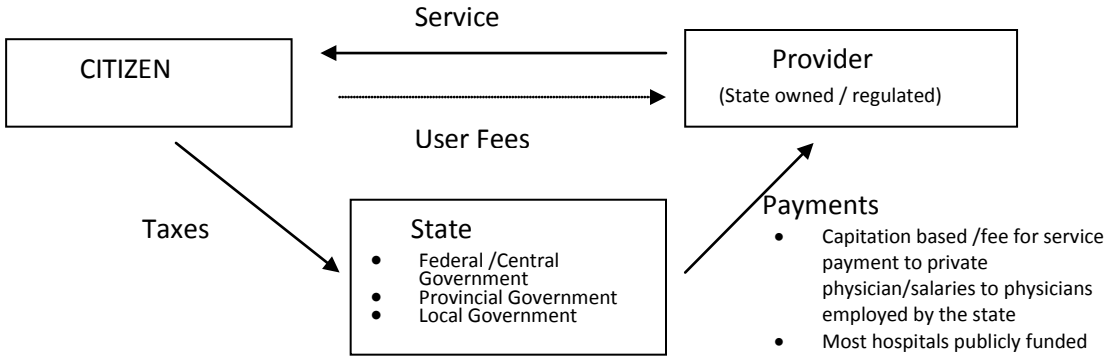


Source: Adapted from Balasubramaniam (2001)

The above model is largely found in developing nations and where providers are largely private and the state either does not have resources to fund health care or state funded health care is not able to reach all segments of the population. The patient makes direct payments to the providers for the services. In the absence of regulation, similar services are charged differently by different providers. This form of system will fall on the bottom left quadrant of Green's diagram. This is the most inequitable form of health financing as the poor have to face an inequitable burden. It is in such systems that catastrophic health expenditure takes place and families are trapped in medical debts.

The National Health Services model is one where health services are largely financed through general taxation. Provision is state owned and free at the point of delivery. In Green's diagram, its place is on the top right quadrant.

Fig. 1.4 National Health Services (Beveridge Model)



Source: Adapted from Balasubramaniam (2001)

United Kingdom's National Health Service (NHS) is the typical example of this model. Almost all the hospitals in the UK are government owned with doctors whose salaries are provided by the government. Outpatient care is largely provided through private general practitioners (GP) who have been contracted by the government. Each area therefore has a GP who gets paid by the NHS, largely on capitation basis. So the services to the patient are free at the point of delivery. Other than the UK, the Nordic countries can be brought under this model (although each country will have some variation from the other in its organization of health services). Canada has a government social health insurance programme –Medicare. But we would describe it as closer to the NHS model because it is funded through general taxes and has a single payer mechanism. Under the Canadian system of health care, all citizens, by law, are eligible to avail free health care. The cardinal feature of this system is that tax revenue by the government is used to provide health care services free at the point of delivery (WHO2005; The Commonwealth Fund 2010).

The specific health services that are to be provided, is decided by the government. In most of these countries, a comprehensive set of services including inpatient, ambulatory and outpatient are provided. Most countries however have introduced some form of user fees as well. Private practice by doctors is extremely limited and caters to a small rich population that has private insurance. Although in these countries (with publicly funded health care), health services are free at the point of delivery, yet there is out of pocket expenditure incurred by patients. This is because most countries have excluded certain services from being fully publicly financed.

Most countries that have a publicly funded system, dental care, physiotherapy, prescription drugs, mental health care and rehabilitation services are either excluded or covered only partly by the government. Private insurance often plays a supplementary role in such cases. Hence, in these countries, the share of private insurance is very limited (see appendix I). (WHO2005; The Commonwealth Fund 2010)

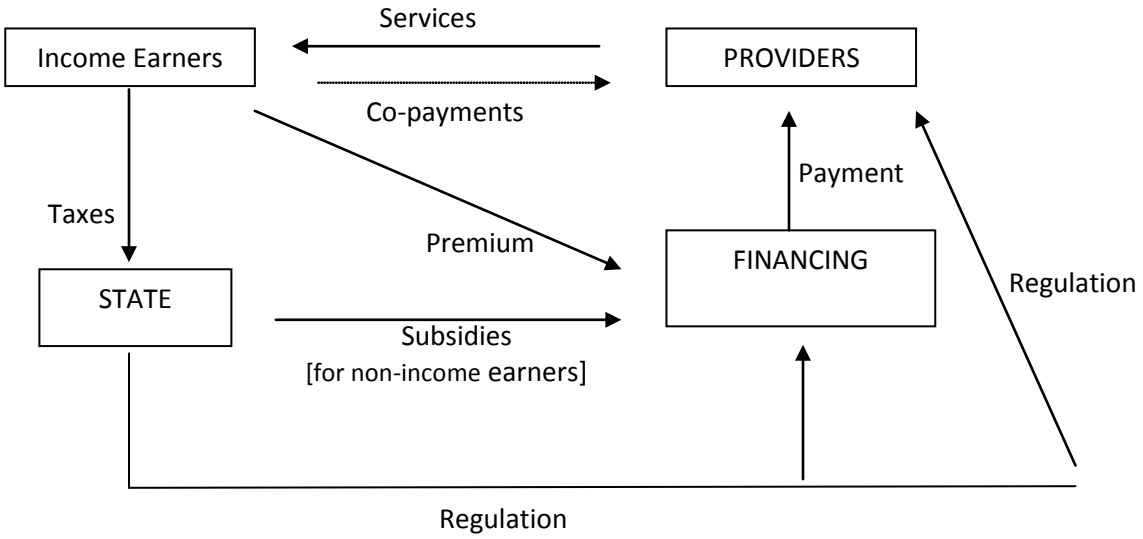
Another feature of the above mentioned health systems is the single payer mechanism. This is a system wherein multiple providers are paid by a single payer- the State. The State therefore has monopsony powers (where one buyer faces many sellers). Since almost all services are purchased by the state and then provided to the citizens, the government has an advantage in negotiating prices while procuring pharmaceuticals or setting rates for different services. This also means that the private sector functions are regulated. In Canada, for example, private providers cannot charge above the agreed-upon fee schedule. The major advantage of a single payer system is that health care costs are regulated. This is in stark contrast to countries like India where multiple providers exist in an unregulated environment and the same service is charged differently by different providers. A general taxation based public health system is considered as the most equitable system since the poor are cross subsidized by the rich through taxes (Hsiao 2010).

But there are also criticisms of this system. To prevent overutilisation, countries have adopted rationing of services. This means that for undergoing medical procedures, there are waiting lines and it may take several weeks to months before patients get the chance to undergo the required medical procedure. These problems have resulted in the rich in these countries to purchase private insurance, so that they can skip long waiting lists and delays in receiving specialist's attention and get direct private medical care. The consequence is an effective undermining of equity in the delivery of services. It creates a dual system, one for the rich who can get private care and one for the others who depend on public care. Many times problems also arise due to underfunding. For a tax financed, public health delivery system to function, adequate funding and manpower are extremely important. In the absence of these, people can be burdened with a poorly functioning public healthcare system that does not cater to their needs (Hsiao 2010). Another criticism in this form of

system is the lack of choice available to the patient to choose a health provider (Enthoven 1989,1991 cited in Chernichovsky, 1995).

In the Social Health Insurance Model, the working population makes contribution to a separate fund which acts as a premium to meet future health costs. In case of ill health, the resources from this fund are used to finance health care.

Fig. 1.5 Social Health Insurance Model (Bismarck Model)



Source: Adapted from Balasubramaniam (2001)

An important requirement for any social health insurance scheme is risk pooling. This is based on the premise that at the population level, distribution of illnesses follows a normal curve. Hence a large risk pool means that the healthy can cross-subsidise the sick. In most countries, the government subsidises premiums for the poor or other non income earners like the aged and children. The most typical example of this model is Germany where it originated. In Germany, there are about 180 competing health insurance funds (called "sickness funds") that are autonomous, not-for-profit, non-governmental bodies regulated by law. The workers have to make compulsory contributions which usually are a per centage of gross wages up to a certain threshold. In addition to the workers, the employers also make contribution to the fund. There have been some changes as of 2009. A uniform contribution rate is set by the government, and although sickness funds continue to collect

contributions, all contributions are centrally pooled by a new central health fund. From this fund the government allocates resources to each sickness fund based on a risk-adjusted capitation formula. (This means that those funds that insure persons with more chronic or difficult to treat ailments will get a larger share from the government) (The Commonwealth Fund, 2010).

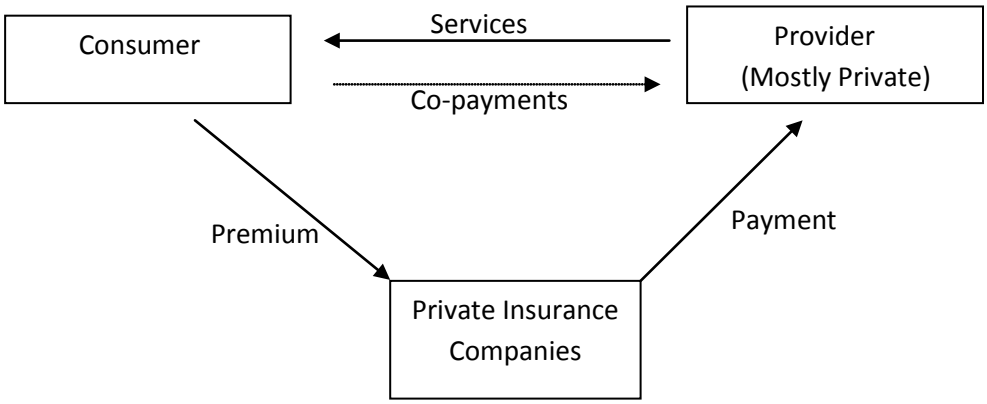
Other countries also have social insurance model but have slight variation from what exists in Germany. In France, for instance, the main source of financing the public health insurance scheme are employer and employee payroll taxes (43 per cent) and a national income tax (contribution to sociale generalisée, 33 per cent). Taxes from various other sources finance the remaining of it. Public health insurance funds are statutory entities with membership based on occupation. In France, there are also not-for-profit, employment-based mutual associations (*mutuelles*).These provide complementary private health insurance and are used to reimburse statutory co-payments and cover 87 per cent to 90 per cent of the population (The Commonwealth Fund 2010). Thus, in France, there is tax based contributory public insurance as well as complementary employment based insurance available. Many more countries have adopted social health insurance to finance their health care but with their own variation to Bismarck's model. For example, while both Germany and France have multi-payer mechanism (different funds reimburse different providers), Taiwan, which introduced National Health Insurance in 1995, has a single payer mechanism which means that a single statutory government body reimburses providers (Cheng 2003). In Netherland, statutory insurance is provided by private insurance companies but these companies are heavily regulated. The insurance companies collect the contribution, the Dutch government then pools and re-distributes these funds among the insurers after risk adjustment (similar to Germany).

The proponents of this model claim several advantages. It helps in mobilizing funds specifically for health and leads to less economic distortion since resources are raised as premiums and contributions by employer and employees. Shifting subsidy from supply side to demand side is expected to be more efficient as is the contracting of private providers (Hsiao 2010). But this model cannot be adopted in countries where the government finds it difficult to raise taxes and a large proportion of the populations are in

the unorganized sector. It is interesting here to note the experience of Taiwan which introduced National Health Insurance (NHI) as late as 1995 to see what implication this form of financing has on access and cost of health care. The utilisation of health care especially outpatient care in Taiwan grew significantly after introduction of universal health insurance. However, for those in the remote areas, insurance per se did not improve access. In 2000, NHI was contributing only 55 per cent of health spending while out of pocket payment was still 32 per cent, mostly due to co-payments and user fees provisions. However overall there was a reduction in out of pocket expenditure from 48 per cent in 1993(Cheng 2003; Lu and Hsiao 2003). Another issue was that doctors were not happy with the package rates and used to find different ways to extract more money; for example over prescription of drugs was common because they could make profit from pharmaceutical companies. Another problem was that there was increase in medical costs leading to more expenditure than revenue (due to political reasons premiums were not revised for seven years). Since then Taiwan has had to adopt several other measures for cost control including increase in co payments (Cheng 2003; Lu and Hsiao 2003). Although this model helps in decreasing out of pocket expenditure yet by itself cannot ensure physical accessibility or quality care. This method of financing also has the risk of cost escalation in the absence of comprehensive regulation.

Another model is the private insurance model. In the private insurance model, people buy insurance cover from private insurance companies which operate in the free market and compete with each other. Services are provided largely by the private sector which is reimbursed by these private insurance companies. There is not much regulation over the insurance sector. This model will fall on the bottom left quadrant of Green's diagram. While financing is largely private, the state subsidises care for the elderly, poor, children and veterans through different government run insurance schemes like Medicare and Medicaid. The advantage with this system is what the OECD document calls 'patient sovereignty' or in other words freedom of choice. Patients are seen as consumers who are able to choose the kind of insurance policy they want and health provider they want to go to.

Fig. 1.6 Private Health Insurance Model (Consumer SovereigntyModel)



Source: Adapted from Balasubramaniam (2001)

Since there are multiple insurers, this system cannot enjoy the benefit of risk pooling and cross subsidization of the poor. Since private insurance companies are primarily interested in profit maximisation, there is cream skimming by insurance companies by rejecting persons with pre-existing illness or by rejecting claims on hospitalisation. Hence this system is neither equitable nor efficient.

A typical example of the Private Insurance Model is the United States of America. Escalating health care cost has become a major concern and a political issue in the US. US provides an important case study as to how health care in free markets escalates costs and yet does not provide equitable access. In 2006, the US was spending sixteen per cent of its Gross Domestic Product (GDP) or $2.1 trillion on health care. This was the highest among the OECD countries. In spite of that, 45 million Americans did not have insurance cover (Marmor *et al* 2009). Countries like Norway, Canada and Germany which are among the top spenders on health were spending only sixty per cent of what US was spending on per capita health care in 2002 (Bodenheimer 2005a). There have been several attempts to analyse reasons for increasing health care costs in the US. One explanation that has been forwarded is that there has been less competition and absence of a truly free market. Since market forces have not been able to function fully, they have not been able to control costs (Enthoven 1993). Its advocates have been coming up with solutions that would control costs within the framework of free markets. Once such solution offered was ‘managed

care' and 'managed competition' through Health Maintenance Organizations (HMOs). HMOs enter into contract with a whole range of providers who agree to provide services based on HMO guidelines and get paid on capitation basis. These service packages are then sold by HMOs to employers who pay HMOs pre payments (just like premiums) for a group of employees. The consumer gets to choose between different HMO plans and chooses the one that provides most value for money. Competition between HMOs is expected to keep control on costs. HMOs lower their cost by negotiating large deals with providers. Since providers would want to be part of HMOs with large number of members, they would lower their fees. The other strategy used by the HMOs was gate keeping and utilisation reviews. What this meant was that HMOs could decide on the number of days a patient can be hospitalised, and whether he/she needs to consult a specialist. Also, the patients would need prior authorization for hospitalisation and for undergoing any expensive medical procedure and HMOs could later deny the payment of services they considered unnecessary (Robinson 2001). The strategy was helpful in reducing costs but only in the short run. Between 1993 and 2000, the years when HMOs saw expansion, the rate of growth in health care spending was 5.7 per cent, much less than 9.7 per cent during 1988-93. But this reduction was short lived. Health care cots grew by 8.3 per cent in 2000, 8.5 per cent in 2001, 9.3 per cent in 2002 and 7.7 per cent in 2003 (Levit *et al* 2001, Bodenheimer 2005a). Neither was there choice nor competition as had been hoped. Patients could only go to doctors who the HMOs had contracted with, faced several barriers in accessing the health care they deemed appropriate and were burdened with additional administrative complexity (Robinson 2001). Health insurance plans and hospitals consolidated so that in all but 14 states, three insurers controlled over 65 per cent of the market giving them market clout to negotiate higher premiums (Bodenheimer 2005a). Another problem with multiple competing insurance companies is the high administrative costs which are eventually shifted to the buyer of these policies. Administration cost was 24 per cent of the total US national expenditure on health care in 1999. Due to multiplicity of insurers, hospitals are faced with increased administrative burden. Private insurance companies must also spend money on advertising which also increases administrative costs (Bodenheimer 2005b). After analysing various reasons for increase in health costs, Bodenheimer and Fernandez (2005) conclude that 'the market

power of physicians, hospitals, and pharmaceutical companies, which has enabled these providers and suppliers to garner high prices for their services and products, and the rapid diffusion of high-cost innovative technologies' have caused increase in health care costs in the US (Bodenheimer and Fernandez 2005).

The models provided above are useful for heuristic reasons. They only provide the larger picture but not the variations within these models. As already demonstrated, different countries have adopted different combinations of public and private to finance health care. Therefore, the above classifications should not be considered rigid. Many recent authors have tried to evolve more nuanced typologies by using criteria other than that have been used by the OECD (Kutzin 2001;Burau & Blank 2006; Wendt 2009). However, above models by and large capture the broader differences and provide us a useful starting point for comparing and contrasting. An understanding of the different systems of health financing is crucial to inform debates about which form of financing is most appropriate and analyzing schemes like Rashtriya Swasthya Bima Yojna.

1.2 HEALTH CARE FINANCING IN INDIA ANDINEQUITIES IN ACCESS TO HELTHCARE

Health care financing in India is highly fragmented and has components of all the models discussed in the previous section. There is a tax financed health care system providing primary to tertiary level of care as well as several publicly managed insurance funds that cater to government employees. Other than these, there is a growing private insurance sector that has become stronger after opening up of the economy and which caters to those employed in the private sector. However, health care in India is financed largely through out-of pocket expenditure. This has serious implications on access to health care and burden of health care costs on individuals and households.

Access to health care is an important prerequisite for enjoying good health. Access to health care in India however is highly inequitable. There is large variation in the kind of health providers -from corporate hospitals charging exorbitant fees accessible to only a handful to the unqualified informal practitioner found in almost every rural area who is

easily accessible to the poor. There is also large variation in health outcomes. Large national surveys like the NFHS as well as other studies have shown (Baru *et al* 2010; Balarajan *et al* 2011) how the poor have to bear an inequitable burden of poor health and have inequitable access to health care. It becomes extremely essential therefore to plan health spending in a manner that counters these inequities. Data however suggests that health spending is still inadequate and Out of Pocket Expenditure (OOP) is still very high.

For India, the total spending on health as per centage of GDP in 2008-09 was estimated to be 4.3 per cent. Out of this, public spending accounts for only 1.10 per cent. (Balarajan *et al* 2011). Although this is an improvement over 0.94 per cent which constituted public spending on health in 2005-06 yet it is far from three per cent that the government committed to spend on health (Shiva Kumar *et al* 2011). The picture becomes clearer when we examine the per capita public spending on health. With Indian Rupee (INR) 268 as the average public health expenditure on health, India has one of the lowest per capita public spending on health even among the SAARC countries (Shiva Kumar *et al* 2011). There is also substantial variation in health spending within states. States like Himachal Pradesh have per capita public health expenditure amounting to INR 630, where as it is only INR 93 for Bihar. Most Southern states that are acknowledged to perform better in health outcomes have higher per capita public expenditure than Northern states (Subramanian *et al* 2011; Shiva Kumar *et al* 2011).

Lower share of the public sector has meant continuing dominance of the private sector. In 2004-05, the private sector accounted for 78 per cent of total health expenditure in the country, making the Indian health sector one of the most privatized health sectors in the world. The share of the private sector noted an increase from 77.4 per cent in 2001-02 to 78 per cent in 2004-05 (Shiva Kumar *et al* 2011). With extremely low levels of public spending, it is not surprising that over the years, the use of private health services has steadily grown at the cost of government health services, both in inpatient and outpatient care. In their analysis of NSSO data from 1986-87 to 2004, Selvaraj and Karan (2009) show that the reported morbidity for short duration ailments has increased by four times between 1986-87 and 2004. This has meant that the utilisation of health services has also increased. But it is the private sector that is catering to this increased demand in the

absence of insufficient investment in the public sector. The same study (Selvaraj and Karan 2009) also shows how the share of the public sector in utilisation of health care- both inpatient and outpatient has seen a decline. NSSO data shows that utilisation of public sector for out-patient care, was 26 per cent in 1986-87 and 21 per cent in 2004-05. There is some increase in utilisation from 1995-96 (19 per cent), but overall there has been a decline in use of public services for outpatient care. A more consistent decline has been seen in the case of inpatient care. From 60.23 per cent utilisation in 1986-87 it has come down to 39.92 per cent, a decline of more than 20 per centage points. The decline has been sharper for urban areas than rural areas, possibly because of the presence of larger number of private hospitals.

Heavy reliance on an unregulated private sector has meant increasing medical costs for those seeking care. The average real expenditure on per hospital admission is estimated to have increased three times in government and private hospitals in both urban and rural areas. The increase in costs has been driven by sharp rise in the prices of drugs. (Shiva Kumar *et al* 2011). Selvaraj and Karan (2009) have estimated on the basis of NSS data that there has been an increase of more than 100 per cent in the per episode hospitalisation cost in the private sector- from less than Rs 1,000 in 1986-87 to approximately Rs 2,000 in 2004 at real prices. While cost of hospitalisation has increased in the public sector as well, it is not in the same proportion. Per episode cost of treatment for outpatient has also increased in this period. In real terms, it has increased from Rs 33 in 1986-87 to Rs 68 in 2004 (Selvaraj and Karan 2009).

Given the large reliance on the private sector for health care, and the absence of insurance cover, much of the cost of health care is borne by households. As per the NFHS only ten per cent of the households are estimated to have at least one member insured in 2005-06. The insurance coverage of the population has increased since then. According to more recent estimates, almost 25 per cent of the population has some form of insurance coverage (PHFI 2011). The relatively low insurance coverage is because the state run insurance schemes cover only government employees and private insurance can be afforded by few. Since the unorganized sector in India which is devoid of any social protection accounts for almost 97 per cent of the workforce, it is not surprising that the insurance cover is limited.

Health care therefore is financed largely by households directly through out of pocket expenditure. Recent studies estimate total OOP expenditure on health to vary from 70 per cent to 80 per cent between 1995-96 and 2000-01. At the household level, OOP expenditure accounts for approximately 5-6 per cent of total household expenditure (Garg and Karan 2009; Baru *et al* 2010). Based on NSS 60th round data, it is estimated that in 2004, the average cost of treatment (including drugs purchased from the market) for inpatient services was INR 3859 in government hospitals and INR 9352 in private hospitals. The cost was higher in urban areas. For outpatient care, the average cost of treatment was INR 242.5 in government sector and INR 309.68 in the private sector. Cost of treatment was higher in urban areas (Selvaraj and Karan 2009). Official documents show that 80 per cent of the total health expenditure and 97 per cent of private expenditure is borne through OOP payments (Baru *et al* 2010).

As in the case of public spending, there is also substantial variation in the OOP spending among states. The more affluent states have a relatively higher proportion of OOP spending than the less affluent states. States like Maharashtra, Punjab and Haryana have OOP at five per cent or above as per centage of the consumption expenditure. Kerala has the largest share of OOP share of seven per cent of the consumption expenditure. On the other hand, poorer states like Orissa, Rajasthan, Bihar and Assam have a lower share of OOP ranging around 2-4 per cent. But there are exceptions too. Uttar Pradesh, although a poor state, has a very high share of OOP at 6.5 per cent which is next to Kerala. On the other hand, high income states like Gujarat and Tamil Nadu have relatively low share of OOP as per centage of consumption expenditure (Garg and Karan 2009).

What is to be noted about OOP estimation is that most of it is based on directs costs like cost of medicines, diagnostic tests, consultation fees and hospitalisation. It does not take into account the travel costs, the loss of wages or informal payments made at the health facility. Inclusion of indirect costs can give a more realistic idea of the financial loss on account of seeking health care. Estimation from the 60th round of NSS shows that direct health expenditure on outpatient care per treated person was nearly 20 per cent of the total household consumption expenditure in rural areas and 13 per cent in urban areas. When indirect costs were added, the proportion went up to 33 per cent in rural areas and 17 per

cent in urban areas. This evidence shows that it is not just hospitalisation that impoverishes households but common ailments may result in greater financial hardship. Not only is burden of health care expenditure high, it is also inequitable with the poorer households spending a higher proportion of their income on health than the poor (Baru *et al* 2010).

Further analysis of out of pocket expenditure shows that drugs constitute the largest component of out of pocket expenditure at around 75 per cent of total OOP expenditure. Expenditure on drugs constitutes up to 60 per cent of total expenditure on in-patient care and 85 per cent of outpatient care. The share is higher for those in rural areas (70 per cent) than in urban areas (60 per cent) and much higher for those in the poorer quintile than the richer quintile (Garg and Karan 2009). From 1996-2006, the cost of listed essential drugs rose by 15 per cent and those that were not listed and not price controlled rose by 137 per cent. While nearly 90 per cent of the drugs were price controlled in the 1970s, only 10 per cent drugs are currently price controlled (Balarajan *et al* 2011). Rising prices of drugs have to be understood in the context of changes in patent laws that were introduced in 2005 to comply with the TRIPS (Trade Related Intellectual Property) agreement.

The impact of high OOP on households is pushing them into further impoverishment. Recent studies have estimated that more than thirty million households are pushed into poverty every year due to high OOP expenses. Garg and Karan (2009) estimated that 32.5 million people (25.5 million in rural and 7 million in urban areas) are pushed below the poverty line as a result of making OOP payments. This by all means is a conservative estimate as it only considers the official poverty line which is widely believed to be very limited. There is no estimate of families already living below the poverty line and who are pushed further into impoverishment. Data from the 52nd Round of NSS (1995-96) shows that over 40 per cent households borrow or sell assets to finance hospitalisation expenditure. It is alarming to see that this proportion increased to 52 per cent by the 60th NSS round in 2004. In 1995-96 more than 45 per cent of households in the bottom two quintiles had to borrow or sell assets to finance hospitalisation expenses, while 32 per cent of those in the richest quintile had to borrow or sell assets (Duggal 2007).

The NSSO data demonstrates as to how high cost of health care and absence of any means to finance health care is crippling households from accessing services. Selvaraj and Karan

(2009) have analysed data from the 42nd (1986-87), 52nd (1995-96) and 60th (2004) rounds of NSS to show that the proportion of persons reporting financial problem as the reason for not seeking care has grown over the past twenty years. In 1986-87, 15 per cent of households in rural areas and ten per cent of households in urban areas could not access treatment because of financial reasons. In 2004 this number grew to 28 per cent in rural areas and 20 per cent in urban areas.

In a context where cost of care is rising and increasing numbers of households are unable to seek care, public financing becomes critical. In the absence of public financing, the poor have to bear an inequitable burden of health costs. Social insurance has emerged as one of the alternative means of financing health care and in the recent past India has seen several experiments in the area of social health insurance. RSBY is one such experiment that has expanded rapidly since its introduction in 2008 and warrants detailed study.

HEALTH INSURANCE IN INDIA: OVERVIEW AND CONTEXT

This chapter describes the major public funded health insurance schemes in India and their outreach. Major components of the RSBY as well as findings from recent studies on RSBY have also been described. The last section of this chapter takes a look at different policy documents to trace the increasing importance of health insurance as a mean of financing. It also presents an understanding of the current policy debate about appropriate means of financing health care in India.

2.1 HEALTH INSURANCE SCHEMES IN INDIA- AN OVERVIEW

Health Insurance is often seen as a viable means of financial risk protection against medical expenses. As discussed in the previous chapter, there are different models of health care financing across the world. Among countries where health insurance is the dominant mechanism, the most efficient and equitable systems are those in which there is pooling of contributions and cross subsidization for the poor by the rich. Health insurance as a sector in India, however, is highly fragmented, with multiple providers, varying benefit packages, and different structures and different population segments being served and hardly any pooling or cross subsidization.

Initial attempts at providing insurance were in the fifties, when the Employees State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) were launched. Both were contributory schemes and only catered to a small section of the formal sector employees. Private and voluntary health insurance was insignificant in its presence until 1986, when the General Insurance Corporation (GIC) of India launched the 'Mediclaim' policy. However, other than GIC there were hardly any credible voluntary health insurance providers at that point. Things started to change in the nineties with the liberalization of the economy. The Government of India set up a committee in 1993 under the chairmanship of RN Malhotra (former Governor of RBI), to propose recommendations for reforms in the insurance sector. The insurance sector of course referred to all forms of insurance including health insurance. In its report in 1994, the committee recommended

the entry of private sector in the insurance industry. The recommendation was that foreign companies be allowed to enter by floating Indian companies, preferably through a joint venture with Indian partners. This also resulted in setting up of an autonomous regulatory body in 2000, the Insurance Regulatory Development Authority (IRDA). It must be remembered here that while the insurance sector was liberalized, it was done from an industry perspective. The impact this would have on health financing, health costs and inequity was not considered (Mahal and Fan 2011). For example, an institution like the IRDA is not in a position to place health needs, financial risk protection or escalation of health costs within its regulatory framework since its mandate is quite different. The IRDA is primarily a regulatory body that lays down guidelines for transparent functioning and growth of the insurance sector. It serves the policy holders'' interest to the extent that it lays down guidelines and offers mechanisms for grievance redressal (IRDA[1]). Today the number of private insurance companies has proliferated but they have limited reach because of high premiums charged and limited benefit packages. Overall private insurance contributes to 5 per cent of the total insured in the country (PHFI 2011).

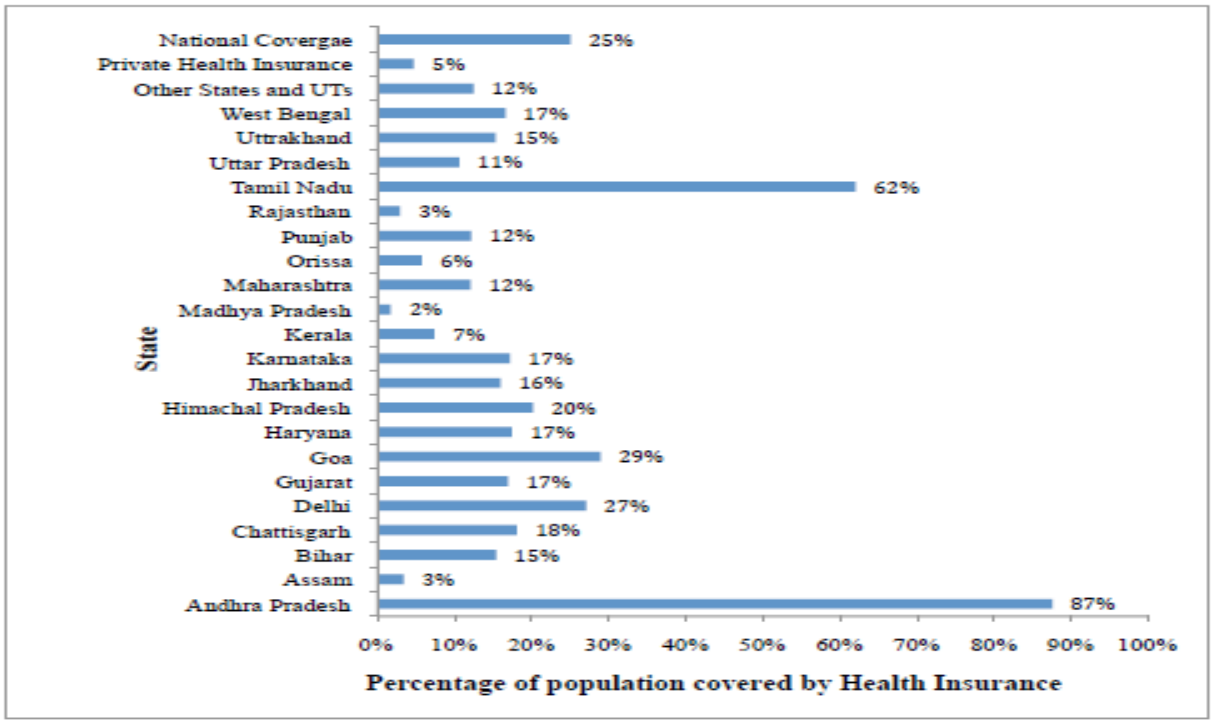
Apart from the two centrally sponsored schemes (CGHS and ESIC) and private insurance, several ministry specific schemes targeting specific sectors (such as ones for weavers, railway employees and defense personnel) and Community Based Health Insurance Schemes (like Vimo SEWA) also exist. However their reach is very limited and therefore they will not be discussed in detail.

There was a significant increase in the extent of insurance coverage in the country since 2007 as a number of government sponsored social insurance schemes were launched, both by states as well as he centre. From about 75 million people covered in 2007, the number has shot up to over 300 million in 2009-10 which means that nearly twenty five per cent of the population has some form of insurance coverage today. Four schemes launched in this period have contributed most significantly to this increased coverage- the Rashtriya Swasthya Bima Yojna (RSBY) by the Ministry of Labour and Employment of the central government, the Rajiv Aarogyasri by the Andhra Pradesh government, Kalaignar's Insurance Scheme for Life Saving Treatment in Tamil Nadu and, Yeshasvini and

[1] www.irda.gov.in/ accessed on 10th February 2012

Vajapayee Arogyasri in Karnataka. If we try to break up the share of the different schemes in insurance coverage, we find that the three big schemes (RSBY, Rajiv Aarogyasri and Kalaignar) in a span of three years have a share of roughly 185 million which is over one-fifth of India's population. Meanwhile, there has also been an increase in the share of the voluntary private health insurance in this period with the coverage rising from 24 million in 2007 to about 55 million in 2010. The numbers covered through the two old programs of social insurance schemes (ESIS and CGHS) also increased from about 50 million in 2007 to roughly around 58.5 million in 2010 (PHFI 2011) .

Fig 2.1: National and Statewise Health Insurance Coverage in 2010



Source : PHFI(2011): A Critical Assessment of the Existing Health Insurance Models in India, pp 25

The figure above gives an overview of the extent of insurance coverage in different states of India. Andhra Pradesh has near universal coverage with about 87 per cent of the population covered. Tamil Nadu is next with about 62 per cent of its population covered. Both these states have started their own insurance schemes. In terms of national coverage, one quarter of the country's population is covered by some insurance scheme.However,

this average is largely driven by the Southern states like Andhra Pradesh and Tamil Nadu. Uttar Pradesh has only eleven per cent of its population covered by any form of insurance. This data however is two years old and it can be expected that the coverage has increased because of the increase in enrolment of RSBY and expansion of insurance in states like Kerala.

The key provisions of some of the important insurance schemes are described below.

2.1.1 Employees State Insurance Scheme (ESIS)

The ESIS was the first attempt in independent India to provide social security to workers. In 1948, the Employees State Insurance Act was promulgated by the parliament. The scheme itself started being implemented in 1952, initially in two centers, and later extended to other parts. However, the eligibility criteria for enrolment limited its reach to a small segment of the organized sector workforce. The act is applicable to non-seasonal factories using power and employing ten or more persons, and non-power using non seasonal factories and establishments employing twenty or more persons (like shops, hotels, restaurants, cinemas, etc). This scheme therefore excludes self-employed workers, and workers working in seasonal industries like plantations and mines. Since workers in the unorganized sector form the overwhelming majority of the workforce in this country, are indeed the most vulnerable and in need for social protection, a scheme like ESIS that excludes them is rather limited in its scope. Further, the scheme caters only to low salaried workers. As per the latest revision, only those workers earning Rs 15,000 per month or less can avail the benefit of ESIS. This wage ceiling is revised periodically based on the Consumer Price Index (CPI) for industrial workers. ESIS is a contributory scheme wherein workers contribute 1.75 per cent of their salary, employers contribute 4.75 per cent of the beneficiary's salary and the state government provides a subsidy equivalent to 12.5 per cent of the expenditure on medical care under ESIS. Since the contributions are taken as a per centage of the salary, they are progressive, as opposed to fixed amount premiums charged in most cases. However, since the high salaried workers are excluded, it becomes a case of poor subsidizing the poor rather than the more equitable option of the rich cross subsidizing the poor, as is the case in universal health insurance schemes globally. ESIS provides a very comprehensive set of services. These include outpatient care,

preventive/wellness care and hospitalization including maternity care. In addition to this, the scheme also provides compensatory cash benefits for loss of wages, disability benefits distinguished by permanent and temporary disability, and a maternity cash program, among other benefits. As per 2009-10 data, there are 55.4 million beneficiaries (14.3 million families) covered by the ESIS which is about eighteen per cent of all those insured in India. However it is not able to fulfill its mandate of providing social security to workers due to its limited reach.

What is significant about ESIS is its structure. The Employees State Insurance Corporation, which is an autonomous agency of the Government of India (under the Ministry of Labour and Employment) is the implementing agency for ESIS. ESI Corporation is also responsible for managing twenty three model hospitals, one in each state. The ESIS has 350 private and 148 self-owned hospitals as part of their network. There are regional directors responsible for administrative matters, premium collection and enrolment of the beneficiaries. The premiums that are collected at the regional level are pooled at the central level under the ESI Corporation. The Corporation then redistributes the funds to the state ESIS at the rate of Rs 1,200 per beneficiary. Another interesting feature about ESIS is that unlike other insurance programmes which largely rely on private hospitals, almost half of the medical services provided under ESIS are in its own network hospitals. Such an elaborate administrative set up also has its drawbacks. The average cost of administration is as high as 16-17 per cent of total expenditure whereas the total expenditure on medical care ranges from 54-60 per cent (PHFI 2011).

2.1.2 Central Government Health Scheme (CGHS)

The Central Government Health Scheme (CGHS) was started in the early fifties (1954). This scheme, however, is even more limited in its coverage than the ESIS. It caters only to the central government employees and their families as well as retired employees. It is both mandatory and contributory and is as progressive as ESIS, since contributions are based on the salary. Along with employees, employers also make contributions. As of 2009-10, it catered to three million beneficiaries across the country. Services provided under this are quite comprehensive and include out-patient, inpatient, AYUSH, maternity as well as

limited preventive and wellness care. CGHS is run by the Ministry of Health and Family Welfare (MoHFW). The Director General is primarily responsible for implementation along with Additional Directors (AD) in twenty five CGHS states who are responsible for the implementation at the state level. Apart from this, there are Chief Medical Officers (CMO) and Medical Officers (MO) at the network health care delivery centres of CGHS who are responsible for their respective centres.

The CGHS however is an extremely expensive scheme when compared to other schemes, including ESIS which provides a similar benefits package. In 2009-10, the CGHS spent nearly Rs 16,000 million while it catered a population of three million. About 17-22 per cent of its total expenditure is on Administration (Salaries and Establishments). Also, it is worth noting that utilization of the scheme is heavily skewed towards the metros, significantly Delhi. Delhi has thirty eight per cent of total cardholders and they consume about fifty seven per cent of the CGHS budget, followed by eight per cent cardholders in Kolkata who consume about four per cent of the overall CGHS budget (PHFI 2011).

2.1.3 Rashtriya Swasthya Bima Yojna

Rahtriya Swathya Bima under the central Ministry of Labour and Employment is currently the largest health insurance scheme (in terms of coverage) in the country. It provides coverage upto Rs 30,000 in a year to BPL households for a specified list of procedures. It mostly caters to secondary level care and both government and private sector hospitals have been empanelled. RSBY will be discussed in detail in the next section.

2.1.4 Yeshasvini Co-operative Farmers Health Care Scheme (Karnataka)

The Yeshasvini scheme was started in Karnataka in the year 2003 by the then state government. This scheme caters to all those who are members of rural co-operative societies as well as their family members. It is a contributory schemeand the ones enroled have to pay Rs 160 every year. 40 per cent of the contribution comes from the government. Although the name suggests that the scheme is limited to farmers, in reality the scheme is

open to all rural co-operative society members, members of Self Help Groups (SHGs) /Sthree Shakti Groups having financial transactions with the Cooperative Society/Banks, members of weavers, beedi workers and Fishermen Cooperative Societies. The scheme is implemented through the Yeshasvini Cooperative Farmers Health Care Trust with the Chief Minister of the state as the chief patron. The governing body represents both civil servants as well as doctors. Treatment can be sought for a list of specified surgical procedures. The list of treatments has been expanded to include medical emergencies like dog bite, snake bite, drowning, accidents during operating agricultural implements, electric shocks, normal delivery, neo natal care and angioplasty procedure, etc. However, it excludes any inpatient treatment that does not require surgery as well as some very expensive procedures like joint replacement surgeries, kidney and heart transplants, chemotherapy as well as cosmetic surgery. The insurance package includes cost of medicines, consumables during hospital stay, cost of Operation Theater, anesthesia, surgeon's fee, professional charge, consultant fee, nursing fee and general ward bed charge among others. (Yeshasvini Co-operative Farmers Health care Scheme[2])

2.1.5 Rajeev Arogyashree Scheme (Andhra Pradesh)

The Rajeev Arogyashree Scheme was introduced in Andhra Pradesh by the state government in 2007. It was one of the few schemes of its kind. It provides cashless treatment for a specified list of surgical procedures to Below Poverty Line (BPL) population in the state in empanelled hospitals upto a limit of Rs 2 lakh. The focus of the scheme is clearly on tertiary care which is deemed to be a catastrophic event and hence impoverishing. The scheme is implemented through the Aarogyasri Health Care Trust which is headed by the Chief Minister of the state and has several civil servants as its members. The scheme has adopted a Public Private Partnership (PPP) model, whereby the trust pays a fixed premium to the insurance agency. The trust has the function of oversight, financial planning & management and monitoring & evaluation. Decisions about the

[2] http://www.yeshasvini.kar.nic.in/ accessed on 10th April, 2012

package of services to be offered, selection of providers of care, price setting, claims processing and payment are done both by the trust and the insurance company in question. An interesting feature of the scheme is the provision of facilitators (by the insurance company) called *Aarogyamithras* at the CHC / Area Hospital / District Hospital and other government hospitals and in the health camps. Their main task is to help the patient though out the process of diagnosis to treatment, be it arranging for consultation with doctors, doing requisite documentation or follow up. It is also his/her task to disseminate information about the scheme. When a patient is diagnosed with a condition requiring surgery, he/she can meet the *Aarogyamithra*, who is a person from the community, and seek help. By way of proof, the beneficiary has to produce their white ration card (meant for BPL) or health card. Treatment can be sought directly at any of the network hospitals in case of an emergency. However there has to be pre-authorisation by the insurance company before any surgery can be undertaken under the scheme.

Benefits provided under the scheme include initial screening, registration and further evaluation, surgery/therapy, 10 days post-discharge medication, free food while in the hospital and transportation charges (equivalent to bus fare from Mandal head quarters to the hospital). The beneficiary can also avail follow-up services (free consultation, tests and medicines) from 11th day of discharge from the hospital for one year for 125 identified surgeries/therapies under follow-up packages. There is provision for hospitals to provide separate outpatient and inpatient ward and reserve at least 25 per cent of beds in each specialty for Aarogyasri patients. Empanelled hospitals are also mandated to conduct a fixed number of health camps (Arogyashree Health care Trust[3]).

As per 2009 data, approximately 20.4 million families and 70 million beneficiaries were covered by the scheme. This constitutes almost 85 per cent of the total population of the state. So even though the scheme had initially started with a limited focus on BPL households, it has been able to expand its coverage to cover most of the population (PHFI 2011).

[3] https://www.aarogyasri.org/ASRI/index.jsp accessed on 10th April, 2012

2.1.6 Chief Minister Kalaignar Insurance Scheme for life saving Treatments (TamilNadu)

The Chief Minister Kalaigner Insurance Scheme was launched in Tamil Nadu by the Dravida Munnetra Kazhagam (DMK) government in 2009. This scheme provided a cover of upto one lakh rupees to families that had an income of below Rs 72,000 per annum. Only tertiary care was covered by this scheme. It functioned in a PPP model, with the government paying full premium for the covered families and a private insurance agency (Star Health) making reimbursement to providers. The implementation structure of this scheme is different from that in Andhra Pradesh and Karnataka. Unlike these states where the responsibility of planning, oversight and monitoring is with a trust, in Tamil Nadu, the scheme is directly implemented by the government through an independent society formed under Tamil Nadu Health System Project (TNHSP). The government plays a regulatory role over the private insurer. For overall implementation of the scheme, the TNHSP has a committee which is headed by the chief secretary and convened by the project director. The insurance company is responsible for enrolment, empanelment of network hospital processing claims and monitoring of the scheme (PHFI 2011).

More recently, a political change in the state has led to drastic changes in this scheme, which was named after the former Chief Minister. The All India Anna Dravida Munnetra Khazagam (AIDMK) government decided to scrap the previous scheme and launched a new scheme in January 2012 called Chief Minister's Comprehensive Health Insurance Scheme. As per newspaper reports, this scheme provides coverage to families upto a maximum amount of Rs 4 lakh for four years as opposed to Rs 1 lakh in the previous scheme. The insurance company in this scheme is a public sector company, United India Insurance Company. This scheme covers newly born infants as well. The package has also been expanded from the previous scheme to include treatment for 1,016 ailments, 113 continuous treatment and 23 diagnostic procedures. Another significant feature of the scheme is the intention to extend the scheme to government hospitals to encourage greater utilization of government run hospitals and to help them raise additional funds through the insurance scheme. Special wards reserved for patients belonging to this scheme are also part of the provision (*The Hindu* 2012; *The Indian Express* 2012).

2.1.7 The Kerala Experience – RSBY/CHIS

Kerala provides an interesting example of how the state government used the RSBY platform to provide universal coverage by introducing some modifications to the scheme. RSBY in Kerala was modified into the Comprehensive Health Insurance Scheme (CHIS). The RSBY/CHIS includes not just BPL households but also Above Poverty Line (APL) households. While the premium for the BPL households is subsidized by the government, the APL households have to pay the full premium (about Rs 500). The state Finance Minister had announced in the 2010-11 budget an additional treatment benefit of Rs. 70,000 (other than the Rs. 30,000 already provided under RSBY) to all the RSBY/CHIS card holders for treatment of cancer, heart and kidney related diseases. The Comprehensive Health Insurance Agency of Kerala (CHIAK) acts as the Nodal Agency and plays a key role in implementing and coordinating the scheme (Arora and Nanda 2010).

Other than these large schemes, some other states like Himachal Pradesh, Orissa and Maharashtra also have their insurance schemes or have modified the RSBY to expand the package.

2.2 THE RASHTRIYA SWASTHAYA BIMA YOJNA (RSBY)

The Rashtriya Swasthya Bima Yojna(RSBY) is a national level insurance scheme for the Below Poverty Line (BPL) families, in which the government subsidises the premium. Although this is not the first scheme that is aimed at providing large scale public insurance, previous efforts have not been as successful as RSBY[4]. It is an insurance scheme that primarily focuses on the Below Poverty Line population in India that has been categorized by the Planning Commission. The scheme, therefore, can potentially reach a population of about 300 million. The scheme has been able to reach around 22.7 million families

[4] The Universal Health Insurance Scheme was announced in 2003. It provided health coverage upto Rs 30,000, life insurance in case of death due to accident upto Rs 25,000 and Rs 50 per day (upto eleven days) as loss of livelihood incase of an illness. It was meant for both BPL and APL families and individuals and the government subsidized only part of the premium for BPL. The scheme had very low take up (0.4 million families) and very low utilization rates (Ahuja and Narang 2005)

(approximately 80 million beneficiaries) in a short span of four years, since its launch in April 2008, which is quite remarkable (PFHI 2011). In fact, in a recent newspaper report, the coverage is claimed to be 28 million families (*Economic Times April* 2012). This in itself is a very large number, especially if we consider the limited coverage that other state funded insurance schemes have been able to achieve in the several decades of their existence. (The government has also announced its intention to extend its coverage to informal sector workers like domestic workers, *beedi* workers and NREGA workers). However, from the point of view of a health financing mechanism that provides universal coverage to all citizens, this scheme is nowhere close.

As per documents on its website, the main objectives of RSBY are to provide financial security to BPL households from hospitalization related expenses, improve access to quality health care, provide beneficiaries the power of choice to select a health care provider and provide a scheme which is transparent and simple to use for the end user. This section will highlight some key features of the scheme including those that differentiate it from the earlier schemes. This section will also present data from the recent studies that have tried to analyse the enrolment and utilization patterns of the scheme.

2.2.1 Key Features of the Scheme

RSBY provides coverage for up to five members of a BPL household including the head of the household, the spouse and three dependents. Each family is provided with a biometric card that stores the fingerprint of all the five members who get enroled. In case of any illness the family can go to any empanelled hospital and seek treatment. The hospital must verify the identity of the beneficiary by taking his/her fingerprint and matching it with that stored in the card. After verifying the identity of the patient, he/she is provided treatment free of cost. This way the scheme aims to provide its beneficiaries *cashless* treatment. The scheme is of course limited only to those conditions which require hospitalization. A list of 780 procedures has been prepared which are covered under RSBY (see Annexure II). Some surgical procedures that do not require hospitalization (like cataract) are also included in the list. Once the treatment is over, the hospital submits its claims to the Insurance Company or the Third Party Administrator (TPA), which in turn reimburses the hospital. Claims are submitted and settled digitally, ensuring minimal paperwork. The

Insurance Company is paid the premium by the government for every family enroled. The scheme is funded by the central and state governments, with the former bearing 75 per cent and the state government bearing 25 per cent of the cost. In Jammu and Kashmir and the North-Eastern States, the centre bears 90 per cent while the state government bears 10 per cent of the cost.

One of the most significant features of the scheme is that pre existing illnesses are covered. Private insurance companies often exclude this to maximize their profit. To facilitate cashless treatment, RSBY package rates (that are reimbursed to the hospitals) include not only doctor's fee, bed charges and food but also expenses incurred for diagnostic tests and medicines up to one day before the admission of the patient as well as up to five days from the day of discharge from the hospital. It provides travel allowance of Rs 100 per hospitalization, up to a maximum of Rs 1000 to the family of the patient.

The scheme is run in a Public Private Partnership (PPP) model with the central government, state government and insurance agencies as actors in functioning of the scheme. What makes RSBY different from other schemes is the formulation of this scheme as a business model, with incentives for key players and the extensive use of technology to administer this scheme (GTZ 2010). The scheme uses biometric technology to provide 'smartcards' to every family that enrols in the scheme. Transaction at the hospital is largely paperless. The enroled family must present the smart card to get free treatment. The claims are also booked by the hospital online. Therefore all data related to treatment and claims are stored digitally.

2.2.2 Process Flow and Key Stakeholders of RSBY

At the centre, the primary responsibility of planning and monitoring is with the **Ministry of Labour and Employmen**t (MoLE), Government of India (GoI). The MoLE has designed the key features of the scheme with technical assistance from the German development agency **GTZ** (Deutsche Gesellschaft für Technische Zusammenarbeit) and the **World Bank**. However the MoLE is not directly responsible for its implementation. Implementation is at the state level for states which want to adopt the scheme. Every state

has to set up an independent **State Nodal Agency** (SNA) which has the primary responsibility of oversight and maintenance of enrolment data. The SNA is also responsible for sending detailed information about the implementation of the programme to the MoLE. The SNA invites tenders by insurance companies. Both public as well as private insurance companies can bid. Separate tenders can be invited for separate districts, from a cluster of districts or the state as a whole. Premium is decided for different districts separately. On acceptance of the tender, the **Insurance Company** enters into a contract with the SNA. It is then the Insurance Company's responsibility to find a **Smart Card Provider** (SCP) who fulfils the specifications laid down in the programme. Insurance Agencies may also appoint a **Third Party Administrator** (TPA), whose job is to monitor the network hospitals and ensure the validity of the claims before reimbursement is made. The TPA and the SCP therefore enter into a contract with the Insurance Company.

Empanelment of **hospitals** is the responsibility of the Insurance Company. The RSBY lays down certain minimum criteria for empanelment of hospitals.

The criteria for empanelling private hospitals and health facilities are:

- At least 10 inpatient medical beds for primary inpatient health care.
- Fully equipped and engaged in providing medical and surgical facilities, including diagnostic facilities, i.e. pathology testing and X-ray, E.C.G. etc for the care and treatment of injured or sick persons as inpatients.
- A fully equipped operating theatre where surgical operations are carried out.
- Fully qualified, round the clock, doctors and nurses
- Basic recordkeeping to furnish details of the insured patient to the insurer or its representative/government/trust as and when required.
- Registration with income tax department.
- Telephone/fax and internet facilities and smart card readers.

(Sethi,2011)

The Insurance Agency enters into a contract with the private hospitals that are empanelled. For empanelment of the public hospitals, the insurance company has to get approval from the state health department to participate and then contact government hospitals.

The private hospitals that are willing to be part of the RSBY network have to bear the cost of setting up required equipment, hardware and software to read the biometric card of the

beneficiary and undertake paperless transaction. It is however the responsibility of the Insurance Company to set up the required equipment for the government hospitals.

Enrolment is done at the village level itself by the SCP or the insurance company. Currently the BPL list as per the BPL survey of 2002 is being used. It is the responsibility of the SNA to provide the BPL list to the insurance agency. The insurance company uses this list to make enrolments. The insurance company should make arrangements to announce beforehand the day and place of enrolment and put up a list of eligible families at a public place. On the day of the enrolment the beneficiary family has to come to the enrolment booth along with family members being enroled. Their fingerprints are taken and the card should be handed over then and there along with a booklet/pamphlet providing information about empanelled hospitals, conditions and other details of the scheme. During enrolment, a government appointed official called the **Field Key Officer** (FKO) who is appointed by the SNA, must be present. It is the FKO's responsibility to oversee that the enrolment being carried out by the insurance company is in compliance with the scheme's provisions. The FKO must also ensure that the correct person (as per the BPL list) is being enroled, by asking for identity proof or asking the *pradhan* to be present to verify the identity of the person. After the smart card is issued, the FKO must validate the card by inserting his/ her smart card and providing his/her fingerprint.

Every district must also have a **District Kiosk** set up by the SNA and staffed and managed by the Insurance Company. The District Kiosk should have all district level data. It is also the place where duplicate cards (splitting of cards) can be generated for families of migrant labourers. The Insurance Company also has to set up a **24 hour helpline** to assist those who want to use the card.

The hospitals can conduct health camps to attract RSBY card holders to utilise the scheme. NGO's can also be involved by the insurance agency for generating awareness about the scheme. RSBY therefore has multiple players who perform different functions for the implementation of the scheme. The table below gives an overview of what role is played by whom.

Fig. 2.2 Different Institutions and their role in Implementation of RSBY

	Central Govt	State Govt.	State Nodal Agency	Insurer/ TPA	NGOs/Other Partners	Providers of Care
Oversight of scheme	X		X			
Setting Up of Nodal Agency		X				
Financing scheme	X	X				
Setting parameters (benefits package, empanelment criteria, BPL criteria, etc.)	X	X				
Hardware specifications (e.g, systems, Smart Card, etc.)	X					
Contract management with Insurer			X			
Accreditation/Empanelment of providers				X		
Collecting Registration Fees				X		
Enrollment			X	X	X	
Financial management/planning	X		X			
Actuarial analysis				X		
Setting rate schedules for services/reimbursement rates	X		X			
Claims processing and payment				X		
Outreach, Marketing to beneficiaries			X	X	X	
Service delivery						X
Developing clinical information system for monitoring/evaluation	X		X			
Monitoring state-level utilization and other patient information	X		X	X		
Monitoring national RSBY information	X					
Customer service				X	X	X
Training	X		X	X		

Source : Swarup and Jain (ND) Rashtriya Swasthya Bima Yojna- A Case Study from India; Accessed from http://www.rsby.gov.in/Documents.aspx?ID=14 accessed on 15th May, 2012

The above table gives a snapshot of the key players involved in the scheme and the role played by them. While the central government is involved in planning and funding the scheme, the actual implementation at the village level takes by private players (insurance companies/TPAs). The state government and the nodal agency that it sets up, help in oversight and devising state specific guidelines. Their actual role in implementation is limited though not entirely absent. They invite bids, manage contract, and appoint FKOs who are present during enrolment. However the larger role at the ground level implementation is left to the private parties.

2.2.3 Enrolment and Utilisation of RSBY- Evidence from Recent Studies

RSBY was started in 2008 in some select districts. As of May 2011, it was operational in 229 districts in 22 states of India. In May 2011, 182 districts had completed one year of

implementation of RSBY while 47 districts had completed two years of implementation. There have been several studies to evaluate different aspects of the scheme, including several working papers and evaluation studies commissioned by the MoLE itself. Most of these studies enquire into enrolment levels, profile of enroling families, awareness levels, hospitalization pattern and user satisfaction (Mott Mac Donald 2011a, 2011b; Amicus Advisory Pvt Ltd 2010, 2011). Few studies have tried to assess the impact on reducing out of pocket expenditure (Amicus Advisory Pvt Ltd 2010, Shahrawat and Rao 2011; Selvaraj 2012).

Enrolment rates in different studies were seen to vary. A recent evaluation study found that the average Conversion Ratio[5] in 229 districts (in 22 states), in May 2011 was 51.2 per cent (Krishnaswamy and Ruchismita 2011). This means that the scheme has been able to reach only about half of the BPL families it targeted. There has been a minor improvement in enrolment over the previous year. An earlier study had found that enrolment ratios in 24 districts in January 2010 were 49.6 per cent (Sun 2010). There are however wide variations in enrolment ratios among states, among districts and indeed at the village level. The conversion ratio in some states like Tripura is as high as 87 per cent, and in Assam it is only 11 per cent (see annexure III). In Uttar Pradesh, conversion ratio was 53 per cent. (Krishnaswamy and Ruchismita 2011). Some districts like Bharuch in Gujrat (66.3 per cent) and Fatehabad (69.7 per cent) and Jind (68.1 per cent) in Haryana, reported relatively high enrolment ratios. Other districts like Gonda (35.3 per cent) in UP, Jalgaon (32.7 per cent) in Maharashtra and Faridabad (32.2 per cent) in Haryana reported very low enrolment (Sun 2010).

One problem during enrolment that has been commonly reported is exclusion of poor and inclusion of non poor due to the deficiencies in the BPL list. The study in Jaunpur district found that about 40 per cent of the respondents reported absence of their names in the BPL list and 31 per cent of non-enrolees had BPL cards (Amicus Advisory Pvt Ltd 2010). It is also well known that the BPL list often includes non poor who are powerful enough to use unfair means or connections to get their names in the BPL list. One study in Karnataka reported that during enrolment, in every village there were some people who were

[5] ratio of number of households enroled to total number of eligible BPL families per district

provoked by inclusion of persons who were generally not perceived as poor. Angry residents approached enrolment officers to question the provision of benefits meant for the poor to the relatively wealthy and the police had to be called in at many places (Rajashekhar *et al* 2011). Another problem with the BPL list is that the current BPL list has data from the BPL survey done almost ten years ago. Using an old list also means exclusion of those who were born after 2002-03.Those who have migrated would still be part of the list and women who have got married into a household after 2002-03 would not have been part of the list.

There is wide variation in utilization rates. But it has been found that hospitalization rates under RSBY are more than the average hospitalization rates in the country. Overall Hospitalisation Ratio of RSBY was found to be 2.4 per cent (of all enroled individuals in all 229 districts). It was higher than what NSS 2004 reported as the hospitalization rates of low income segments at the national level, 1.7 per cent. There were however large variations among states in hospitalization rates. It ranged from 0.1 per cent in Assam to 5.2 per cent in Kerala (in the first year of operation) (Krishnaswamy and Ruchismita 2011).

Almost all the studies found that awareness about the scheme was limited. This was seen in awareness related to different aspects of the scheme like the amount for which cover was provided, hospitals empanelled, provision of travel allowance and provision for free medicines. (Mott Mac Donald 2011a, 2011b; Amicus Advisory Pvt Ltd 2010, 2011; Krishnaswamy and Ruchismita 2011)

Evaluation studies also found that some of the provisions in the scheme like providing smart card on the day of enrolment, providing pamphlet or booklet with list of benefits, claims processing procedure and network hospitals were not followed (Mott Mac Donald 2011a, 2011b; Amicus Advisory Pvt Ltd 2010, 2011; Krishnaswamy and Ruchismita 2011; Rajashekhar *et al* 2011).

2.2.4 Some emerging issues

Some of the studies have also pointed out limitations in the RSBY and indeed other such insurance schemes in providing financial risk protection due to health costs. Shahrawat and Rao (2011) and Selvaraj (2012) point out that much of out of pocket expenditure is caused

due to out patient care. However RSBY and some other the other insurance schemes focus only on inpatient care. Selvaraj (2012) has analysed out of pocket expenses in districts that have implemented RSBY, Arogyashree and Yeshasvini insurance schemes and found that although OOP expenditure has declined marginally from what it was before the introduction of the schemes, the decline is largely contributed by fall in out of pocket expenditure on out patient costs. Indeed there has been increase in cost of hospitalization. Hence the introduction of insurance schemes does not seem to have helped much in providing financial risk protection. Shahrawat and Rao (2011) found in their study that pharmaceuticals contributed to a significant proportion of the OOP expenditure and a decline in pharmaceutical costs rather than inpatient costs have a greater effect in reducing OOP expenditure. They (Shahrawat and Rao 2011) also outline problems with targeting the scheme to the BPL as there are always problems in identifying the poor and problems in the conceptualization of poverty line itself. Narayana (2010) has also pointed out the possibility of increasing cost of premiums for RSBY in the future. Currently in most districts the premium charged by insurance companies is between Rs 500-600. However some districts in Kerala have very high utilization rates, which led insurance companies to increase premiums to over Rs 700 so that they did not run a loss. Narayana estimates that over time, utilization rates are going to go up for many other districts leading the insurance companies to raise premium rates to recover costs. Since the central government has already put down a ceiling on its contribution for premium (per household) at Rs 750, the rest of the cost will have to be borne by the state government. He questions the commitment of state governments to sustain a scheme with escalating costs.

It is worth noting that the RSBY is currently piloting coverage of OPD services in several districts like Puri and Mehsana (*The Economic Times*, July 2011). How successful it will be is yet to be seen.

While one has to appreciate a scheme like RSBY for reaching 28 million families who can potentially benefit from it, it is equally important to take into consideration the limitations which prevent it from being a scheme that provides complete financial risk protection for the poor. Some studies have already mentioned problems like non coverage of outpatient treatment, problems with BPL line estimation and potential for escalating costs. There are

efforts to address some of these issues, as is evident from the efforts being made to include OPD into the ambit of RSBY. The larger and more important question however is where a scheme like RSBY will fit in the health system and to what extent it is able to further the health system's goal of access to universal health care. Selvaraj (2012) has rightly pointed out that RSBY (and other insurance schemes like Arogyashree and Yeshasvini) are narrow in their approach.

> Unfortunately, the provision of health care has been turned into another poverty-reduction programme….The narrow focus of these schemes typically endangers health system and its goal ….. Such insurance programmes lack an overall vision for the health system and its population that it seeks to cover, due to compartmentalisation of care into secondary and tertiary care. Health care is not viewed as a continuum of care, rather seen as a compartmentalised care (Selvaraj 2012: 67).

Since the RSBY (and similar schemes) focus on secondary and tertiary care, and provisioning is largely through the private sector, the public sector is left with primary care. For a health system to achieve its goals, all these have to be integrated in the health system and function in a synchronized manner.

2.3 CONTEXTUALISING GROWTH OF HEALTH INSURANCE AS A HEALTH CARE FINACING MECHANISM IN INDIA

In chapter one, we have already seen that there are different mechanisms of financing health care, followed in different countries globally. It is interesting to enquire, why in the recent past insurance schemes have become so popular, as is evident from the proliferation of insurance policies started by the various state governments as well as the central government funded RSBY. It is also important to note here that insurance based health financing creates, what has been called the 'purchaser–provider split'. The buyer of health care is different from the provider of healthcare. In the context of social health insurance, it means that the health care services will be purchased (financed) by the state and health care will be provided by hospitals which in the case of most schemes in India are largely private hospitals although schemes like RSBY have included government hospitals too in its network. While social health insurance per se does not mean greater privatization of health care, in the current context, the experience of the different schemes being

implemented in India indicates a situation where the public funds finance provisioning in largely private sector hospitals. This will definitely provide an impetus to the private sector in health care and a captive market for these hospitals.

Current policy debates and policy documents indicate a distinct change in the discourse on health financing and provisioning. There has been a shift from public financing and provisioning of health care to a purchaser provider split, an increasing role of health insurance, conversion of patients into consumers and hence the primary place given to 'choice' and the idea that competition in the market can automatically increase quality and reduce costs (as will be seen in the next section). It is not only the Indian health system but health systems across OECD countries, especially those in Europe have seen changes in their health systems and health care policies grounded on these very ideas; ideas which indicate a distinct shift to dominance of neoliberal thinking. It is critical to understand however, that policies often develop in a context and the context for current policy thinking has been taking shape since the past few decades. The first sub section will trace the context within which neo-liberal thinking in health care developed and critique some of its assumptions. A large section has been devoted to this segment in order to help contextualize the changes in health policy over time as well as the current debates on health policy and health financing.

A look at the important policy documents reflect the deliberations about health financing and the increasing importance given to social health insurance. The second sub- section will highlight how policy documents of the Indian government have approached health insurance as a financing mechanism. This will help understand the background in which a scheme like the RSBY came into being.

2.3.1 The Emergence of Neo-liberal thinking in Health Care

After the Second World War, war ravaged Europe had developed an extensive system of welfare states that would provide health care, education and social security to its citizens. Health care systems took different shape in different countries. In the Soviet Union there was a more centralized model of health care, UK and the Nordic countries adopted a tax

based system where as countries like Germany and France adopted the Bismarck model of Social Health Insurance. Across the continent only the US remained a largely privatized health care system. The values which governed health systems in Europe were equity and rights of citizens where as the US gave credence to consumer sovereignty and choice.

But slowly beginning with the eighties, not just Europe but also rest of the world saw a shift in the idea about the role of the state in healthcare. This was evident from policy changes directed at reducing the role of public financing, increased contracting-in of services, privatization of higher levels of care, public private partnerships, making hospitals recover costs through introduction of user fees and co-payments and several other such measures (Koivusalo 2001). There was a shift from the idea that the state should provide health care and that health care was a merit good to the idea that the state should not be burdened with health care costs and that the private sector and individuals should take greater responsibility for health care. This shift signaled the growing dominance of neoliberal thinking. Before tracing the events which assigned a dominant role to neo-liberal thinking in health care, it is important to examine its basic assumptions and tenets.

Neoliberal theory is a theory which holds that an individual's well being is best realized through 'liberating individual entrepreneurial freedoms'. This in turn requires economic and political action directed at an institutional framework that respects strong private property rights, free markets and free trade. The role of the state is to create laws or use other means (if need be use force) to ensure proper functioning of a free market, free trade and right to private property. If there are certain areas where private property rights do not exist (for instance in case of water, land, education, healthcare, public transport) the state must actively create markets. Since private enterprise and entrepreneurial initiative are seen as the key to innovation and wealth creation, the state must ensure individual freedom and create such legal instruments as patents to protect intellectual property. When an individual's entrepreneurial potentials are unleashed, the nation will see increased productivity and wealth creation which will automatically lead to higher living standards for everyone through 'trickle down' of economic benefits. Other than providing institutional framework for establishing free markets, the state's role should be minimal. This is because the state does not have enough information to guess market signals and

powerful interest groups may influence the state. It is for these reasons that de-regulation and privatization become important. Competition is equally important in such a regime. Privatisation combined with deregulation and competition is expected to reduce red tape, improve efficiency, productivity and quality and reduce costs. In a free market system, individuals get to exercise their freedom of choice and are also responsible for their own well being. If an individual is illiterate or poor, it is due to his/ her shortcoming rather than due to structural or systemic problems (like class, gender, ethnicity or caste) (Harvey 2005).

The welfare regimes that developed in much of Europe under the social democrats were clearly based on principles very opposite to what the neoliberals hold by. The most significant difference is the importance of the state in ensuring welfare of its citizens. This was also supported by the Keynesian thinking dominant at that time which had developed after the Great Depression of the thirties. Keynes advocated increased public expenditure so that demand could be maintained and the economic crisis of the thirties was not repeated. But this model was challenged starting with the late sixties and right into the seventies with many countries, coming into the grips of stagflation and deepening of economic crisis due to the OPEC oil embargo of 1973. It was at this point that neoliberal ideas started gaining importance. There were of course a complex interplay of actors, institutions and changes in global politics and trade which were crucial in strengthening of neoliberal doctrine within the policy circles[6]. The real shift globally came with Margaret Thatcher coming to power in the UK in 1979 and Ronald Regan being elected president in the US in 1980 (Harvey 2005). Change was seen in different spheres but also the health sector. Thatcher started the process of introducing 'internal market' within the NHS and a series of 'reforms' primarily aimed at reducing share of public finance of an already underfunded NHS, which had serious negative implications on the comprehensiveness of care, quality of care, population level health planning and geographical distribution of care

[6] David Harvey in his book *A Brief History of Neoliberalism* has described in detail the international events, actors and institutions that championed neoliberal thinking. He also demonstrates the contradictions in what the neoliberal theory states, and how it has been practiced. Neo-liberal logic has been used to legitimize US imperialism and undermine sovereignty of many third world nations. He demonstrates that after the shift towards neoliberal policies, there has been redistribution of income- money has moved from the poorer to the rich and from poorer nations to richer nations. Therefore a strong and powerful interest group has been created that pushes for the continuation of neoliberal thinking for their own benefit.

provided under the NHS (Pollock 2005). Light (2000) has raised the point that there is no empirical basis for what level of expenditure is high. For the US, which spends 16 per cent of its GDP, UK's five per cent will expenditure will be extremely desirable, where as in UK it is seen as burdensome.

The World Bank and the International Monetary Fund also played a crucial role in forwarding the neoliberal agenda through imposing 'conditionalities' and Structural Adjustment Programmes(SAPs) on debt ridden countries (Harvey 2005). In the early nineties, India underwent an economic crisis and had to look at international agencies like IMF and the World Bank for support, which came in return for a series of structural changes in public financing in different sectors including health. The World Bank's controversial World Development Report in 1993 was dedicated to Health Sector Reforms which advocated poor countries to cut down costs in healthcare. The government was to provide selective primary care (which has little business potential) and the more expensive and highly profitable secondary and tertiary care was to be left to the private sector. India too brought about changes in its health system, directed at making health system more cost effective at this period and saw dwindling public financing, increase in contracting of services and imposition of user fees among other measures (Banerji 2001, Sen 2001, Qadeer 2001). The implications for the health system, equity and population health were severe and have been widely documented in different studies (Qadeer ,Sen and Nayar 2001).

The experience of marketisation in other countries has also not been very positive. An analysis of health systems in South Korea, Singapore, Philippines and Chile, all of which adopted market reforms also shows that far from containing cost, competition and increased role of private sector had increased health costs. Another result was the creation of a two tiered health care system with the rich being able to afford higher quality services compared to the poor (Hsiao 1994). It was found that in countries which had introduced private health insurance, these companies were involved in 'cream skimming' and selecting more healthy populations to maximize their profit. A more recent report by Oxfam International (2009) breaks down several myths about the private sector in low income and middle income countries. Far from being more efficient and high in quality,

they are of questionable quality and lead to increase in costs. These studies therefore demonstrate that one would need to critically look at both theoretical assumptions as well as practical experiences of different health systems to understand what indeed is efficient and more importantly if there is a trade off between efficiency and equity.

After much criticism, there has been increase in public funding in primary healthcare through the National Rural Health Mission and there is certainly talk in the policy circles about Universal Health Care (UHC) (something which had been lost after Alma Ata). However, what shape Universal Health Care will eventually take and whether it will reflect the spirit and values of Alma Ata is yet to be seen. Even as UHC sees a come back, much has changed since it was first conceptualized in the Alma Ata conference. The world has taken a neoliberal turn and neoliberal thinking has become strongly entrenched in health care related debates and can be seen cropping up in policy debates diluting the move towards Universal Health Care (see section describing differences between HLEG and Steering Committee).

2.3.2 Tracing Emergence of Health Insurance in Discourse on Health Finance in India- A Reading of Select Policy Documents

Health financing has been a topic of deliberation in policy circles since before independence. There has been a gradual shift from the primary role of the state in financing and provision to a greater role for private sector. This shifting trend can be seen through a study of the major policy documents.

The first policy document to give direction to the Indian government on health policy was the Bhore Committee Report in 1946. This report shows that even before independence, questions of deliberation were quite similar to those being deliberated even today – whether to have a tax based system or an insurance based system, whether it should be free for all or those who can pay should pay, the role of government doctors vis-à-vis private doctors and whether there can be any choice given to the patient as regards the doctor (GoI 1946). The Bhore Committee envisaged a publicly financed health system free at the point of delivery. Is envisaged a health system where none would be denied health care for the

lack of ability to pay for it. In the short term the committee rejected the idea of social health insurance on the grounds that at that time there was limited capacity for people to pay even a small contribution towards health insurance. However it did not entirely close down on the possibility in future.

> Under conditions existing in the country, medical services should be free to all without distinction and the contribution from those who can afford to pay should be through the channel of general and local taxation. It will be for the governments of the future to decide ultimately whether medical service should remain free to all classes of people *or* whether an insurance scheme will be more suitable (GoI 1946: 14)

After independence the government neglected investment in public health. There developed a dual system, an underfinanced three tier government health care system and a proliferation of independent private practitioners (both qualified and unqualified). The ESI and the CGHS were the only large government insurance scheme till the last decade. However the change policy environment came with the introduction of the Health Sector Reforms in the early 1990s. The focus was on reducing the government's role in financing health care (Banerjee 2001; Sen 2001). It is at this time that alternative means of financing, such as social health insurance started being explored as an option.

The National Health Policy (NHP), 2002 clearly brings out this shift in government thinking. It states

> In the context of the very large number of poor in the country, it would be difficult to conceive of an exclusive Government mechanism to provide health services to this category. It has sometimes been felt that a social health insurance scheme, funded by the Government, and with service delivery through the private sector, would be the appropriate solution. The administrative and financial implications of such an initiative are still unknown (GoI 2002: 34).

There is clearly a shift in policy in that health provisioning is no longer seen as the sole responsibility of the government. There is a split made between financing and provisioning where the government limits itself to financing health care, whereas provisioning is by the private sector. Social Health Insurance is seen as a mechanism that would help the government to operationalise this split between financing and provisioning. It further recommends pilot schemes to determine the administrative arrangements

The NHP encourages the involvement of the private sector in all areas of health activity – primary, secondary and tertiary. It also envisions role for private health insurance in the country .

> The Policy also encourages the setting up of private insurance instruments for increasing the scope of the coverage of the secondary and tertiary sector under private health insurance packages (GoI 2002:34)

Another extremely influential policy document was the Report of the National Commission on Macroeconomics and Health in 2005. In its recommendations related to health financing it states:

> Experiment with alternate financing models in a few districts for one year to obtain insights for designing new financing systems that would help contain cost. The shift should be towards the state becoming a financier and purchaser of care, alongside own provisioning to ensure that the patient gets the care as per his choice and also of good quality.
>
> Gradually shift towards a mandatory Universal Health Insurance System for secondary and tertiary care.
>
> (GoI 2005:129)

Here too we see the focus on cost containment and search for alternative financing models. It is of course an alternative to state provisioning and financing. The fact that the report is talking about the state being purchaser and financer implies that provisioning is not necessarily by the state. Other recommendations include shift to mandatory social health insurance in secondary and tertiary care. The emphasis on using insurance to finance secondary and tertiary care implies that while primary care will be provisioned by the state, the private sector will play a role in provisioning of secondary and tertiary care. There are further recommendations about merging state run schemes like ESIS and CGHS and setting up a single corporation for pooling funds. The report however recognizes limited expertise in this area and strongly recommends external experts from 'mature market economies' to assist us in designing an appropriate health insurance scheme. Mature market economies of course have no single form of insurance model. There is the highly privatized US model as well as the social insurance model of European countries like Germany. There is however not much clarity about what kind of insurance model the

report is suggesting. What it does suggest is, containing cost by developing social health insurance to finance secondary and tertiary care.

These policy recommendations found place in the Eleventh Five Year Plan (Planning Commission) for the period of 2007-12. One of the supplementary strategies of NRHM is stated as:

> Effective and viable risk-pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable, and good quality health care (GoI 2008:71).

The Eleventh Five Year Plan goes on to state that there is need to encourage community risk pooling, primarily trough SHGs, implement Community Based Health Insurance (CBHI) in areas where institutional capacity is too weak to organize mandatory nation-wide risk pooling and introduce a new scheme based on cashless transaction for workers in the unorganized sector (possibly RSBY). The Eleventh Plan therefore talks of different insurance schemes for different sections of the population rather than one unified national level scheme to cover the entire population. It however reflects the importance that insurance has started receiving in planning.

More recently the Planning Commission of the Government of India set up a High Level Expert Group on Universal Health Coverage for India under the chairmanship of Dr. Srinath Reddy. The HLEG submitted its report in November 2011. In May 2011, the Planning Commission also set up a Steering Committee on Health for the 12th Five Year Plan with Dr Syeda Hameed as the Chairperson. Dr Srinath Reddy was also a member. Among other things, the Steering Committee was also asked to appoint a special group to deliberate on Health Insurance, Health Care Financing and public health expenditure with inputs of the HLEG and appoint another group to review to review the existing norms for infrastructure/ human resource (keeping inputs of the High Level Expert Group as the basis) in health and critically assess the role of private sector and PPP in Medical Education and health care delivery, suggesting reforms. This shows that the Planning Commission did not accept the recommendations of the HLEG on these areas and therefore wanted another working group to review the recommendations.

The Steering Committee has accepted the definition of Universal Health care (UHC) provided by the HLEG, with one change.[7] While the HLEG definition entitled citizens of the country to UHC, the Steering Committee has included all residents of the country in its ambit. Some of the recommendations from the HLEG and the Steering Committee have been quoted below.

Table : 2.1 Some Key Recommendations of the HLEG and the Steering Committee

Areas of Recommendation	HLEG	Steering Committee
Source of Financing Health care	General taxation complemented by additional mandatory deductions for health care from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary is recommended as principal source of health care financing	Not mentioned clearly. As evident from the definition of UHC State is responsible for financing health care. There is talk of empanelment of private hospitals which suggests a Social Health Insurance model, but it is not clearly mentioned which mechanism will be used to finance it.
User Fees	Free at the point of delivery. The idea of user fees has been rejected due to adverse impact on utilization of health care by the poor.	No mention of user fees
Agency/Organisation for purchasing health care	Recommendation against use of insurance companies or any other independent agents to purchase health care services on behalf of the government Purchases of all health care services under the UHC system should be undertaken either directly by the Central and state governments through their Departments of Health or by quasi-governmental autonomous agencies established for the purpose	The functions of financing, empanelment and regulation of providers should be undertaken by existing or new Government/quasi-Government agencies in the States. No specific mention about who should be purchaser of health care services.
Essential Services Package (ESP)	An Essential Services Package to be provided to citizens which would include primary, secondary and tertiary level care.	Universal and cashless access to an Essential Health Package (providing preventive, promotive, curative and rehabilitative services) including Essential Medicines.
Provisioning of EHP	These different levels of care will be provided at the sub centres, PHCs and District Hospitals.	In order to spur competition and make providers responsive, beneficiary families should be

[7] "Ensuring equitable access for all Indian residents in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants of health delivered to individuals and populations, …(cont.) with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services." (Steering Committee 2012:24).

		provided a choice to opt for a health provider from a panel of public, private and not-for profit providers.

Source: Based on reports of the Steering Committee (2012) and HLEG (2011)

The HLEG has unambiguously rejected the insurance based mechanism for financing health care in the country. The HLEG document states that although schemes like RSBY, where private insurance companies have been able to achieve good enrolment and fraud control, such schemes are not appropriate mechanisms for achieving UHC. This is because

> The use of independent agents fragments the nature of care being provided, and over time, leads to high health care cost inflation and lower levels of wellness. It becomes necessary, therefore, to either explore a completely different approach towards the use of insurance companies and independent agents – more in the "managed care" framework, where they take on explicit population level health outcome responsibilities or invest further in the capacity of the Ministries and Departments of Health to directly provide and purchase services from contracted-in private providers wherever necessary. We favour the latter option (HLEG 2011:13).

The chief reason for rejecting this approach to financing health care is that it fragments health care sector. Since insurance companies will only cover secondary and tertiary level problems and the state is then left with providing preventive and promotive services. Rising costs led the US to adopt the managed care model. It is well known that the managed care model that tries to contain costs has not been very successful in the US to prevent health costs from escalating. The Steering Committee however seems more inclined on an insurance based model as is apparent from its discussion about empanelment of public and private providers. The Steering Committee has also emphasized on choice between public and private provider, and incentivizing health care providers based on health outcomes. It also wants to equip public health care facilities with *'financial and operational autonomy so that they are able to compete with the private and Non Government Organisation (NGO) providers'* (Steering Committee 2012:14). This is reminiscent of the changes that were brought about in the UK NHS where hospitals were converted into autonomous business units that needed to recover costs to sustain themselves and compete with other hospitals. Since health care is largely labour intensive,

this was done through reduction in staff, services and number of beds. Several local hospitals had to close down despite trying measures to cut costs (Pollock 2005).

It is interesting therefore to observe the future developments in health financing that take place. It is clear that there is a split between policy makers about what the right way to finance health care in India should be. There is some agreement on need to provide an essential health services package but there is still ambiguity about how it will be financed and how provisioning will take place. Whether it will be a tax financed model with primary role given to the three tiers of public health care system and contracted in private providers or it will be an insurance based model with empanelled public and private hospitals (as in RSBY) is yet to be seen. Although the Steering Committee has not clearly substantiated the health financing mechanism, it talks of empanelling public and private providers, choice between public and private providers, incentives and autonomy for public providers so that they can compete with private providers. This is very much the model being followed in the RSBY. It therefore becomes critical to examine RSBY as a scheme and critically examine pros and cons of using the RSBY model to finance health care in India.

METHODOLOGY

The current study is placed in a context, where policy makers are divided over the appropriate method of health care financing. While some propose a general tax funded health care, others advocate for an insurance based model. (See section 2.3) The faith in insurance based models has definitely been informed by recent experiments in health insurance in the country which includes RSBY. Hence it becomes important to critically examine schemes like RSBY. Those advocating health insurance as a mechanism of health finance, see it as a viable means of coping with the extremely high levels of Out of Pocket (OOP) expenditure on health. Inadequacy in public financing of health has meant that a large share of health expenditure is borne by households. India has one of the highest levels of OOP expenditure in the world, and with the burden of expenditure being disproportionately high for poorer households, millions of families are pushed into poverty due to medical debts. Introduction of social health insurance like RSBY is seen as the panacea for this problem. The scheme indeed has expanded rapidly to become the largest (in terms of coverage) publicly funded health insurance scheme in a very short time. It is therefore important to study its implications for access to health care and financial risk protection through reduction in OOP expenditure .

The current study therefore aims to understand the experience of utilisation of RSBY from the beneficiaries of the scheme. RSBY has been introduced with the aim of providing cashless hospitalisation to BPL households. Restricting insurance cover to hospitalisation is clearly a limited approach as studies have shown that outpatient treatments is also a leading reason for high OOP expenditure. To what extent OOP expenditure is being addressed by an insurance scheme that only covers hospitalisation is yet to be seen. Further the scheme is limited to BPL households. However studies show that limiting such a scheme to the BPL may not be able to prevent the large scale of impoverishment due to health costs (Sahrawat 2011). Targeting of poor (in this case BPL) is highly exclusionary and sections of the poor who do not make it to the BPL list are left out. The experience of poor outside BPL is unheeded. Micro studies capturing the experience of those who have

utilised RSBY is an area that is still being explored since the scheme is very recent. This study will add to this area of understanding.

Another significant feature of RSBY is the empanelment of both public and private hospitals at the district level, in an insurance scheme of this scale. How service providers perceive this scheme and their experience of implementing the scheme is also a less explored area. This study also tries to capture the experience and perception of such providers who are providing services under RSBY. The scheme has also been lauded for inclusion of both public and private sector providers because it provides choice to the beneficiary, who is from a very poor background, to access the provider he/she wants to. There is need to understand the dynamics of the choice that is exercised in schemes like RSBY.

While a micro study like this is too limited in its scope to address the larger question of whether an insurance scheme like RSBY can indeed be the way to finance health care in India, it will add to the existing debates by providing beneficiary and provider experience of RSBY. Since it is a qualitative study in one block, it cannot be generalised. However it does bring forward important issues from the perspective of both users and providers of the scheme.

3.1 Purpose and Objectives

The purpose of this study is *to understand the experience of utilisation of RSBY by beneficiaries who sought treatment in RSBY empanelled hospitals in Sidhauli block of Sitapur District in Uttar Pradesh (UP)*

The study enquires into utilisation experiences of RSBY beneficiaries who have got treatment under RSBY in two institutions in Sidhauli block of Sitapur District- one public and one private. Sidhauli block has only these two hospitals empanelled under RSBY/

The objectives of the study are as follows:

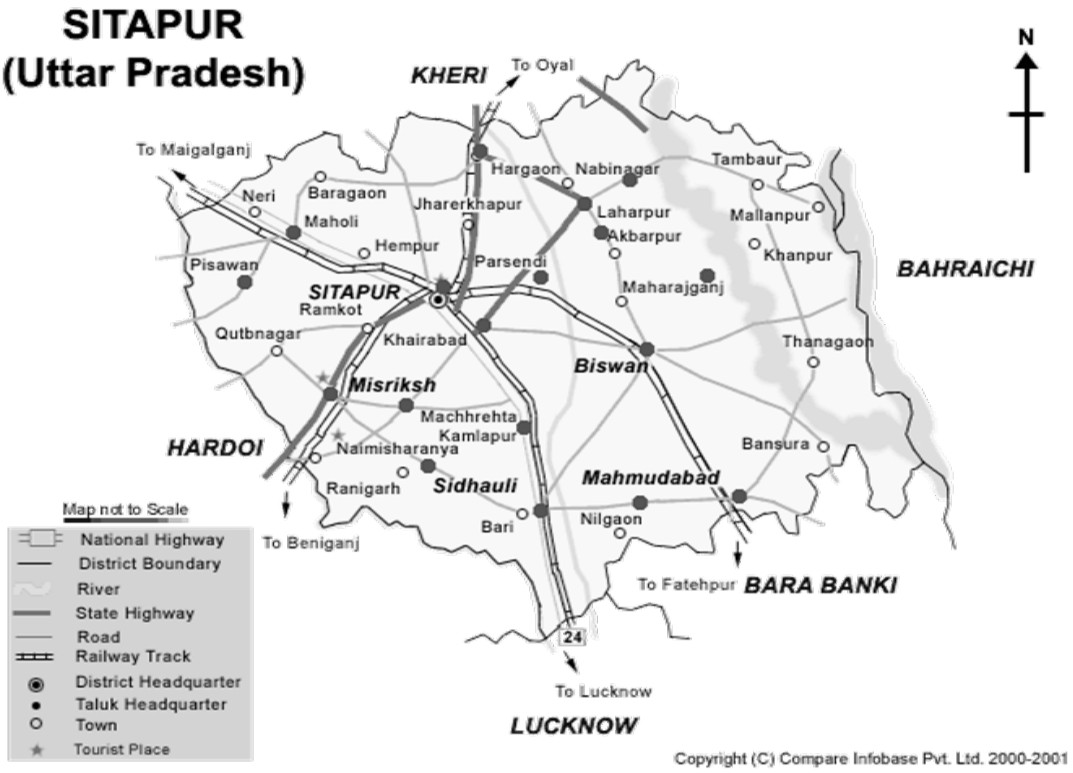
- To study the factors which influenced the beneficiaries to utilise the RSBY scheme
- To study the choice and reasons for choice of service provider by the beneficiaries of RSBY (Public or Private)

- To study if hospitalisation under RSBY is truly cashless or other costs/informal payments are involved
- To study the perception of beneficiaries about the quality of treatment provided to them and the utility of the scheme for them.
- To study the perception of health providers about the scheme in terms of benefits to them and improving accessibility for patients

3.2 Area of Study

The study was conducted in Sitapur district of Uttar Pradesh. Sitapur has 19 blocks. Persons who had used services of institutions in Sidhauli block were interviewed. These include persons from Sidhauli block itself as well as adjoining blocks. Purposive Sampling was used for selection of the area. It was easily physically accessible and the researcher had persons in the district who were willing to assist her with the field work.

Fig: 3.1 Map of Sitapur District, UP



Source: http://www.brandbihar.com/english/up/districts/Sitapur/map%20of%20Sitapur.html

accessed on 4th March 2012

Sitapur is a district in central UP and shares the border with the state capital Lucknow, along with other districts like Hardoi, Kheri, Baharaich and Barabanki (see map). It is spread over an area of 5743 square Km with a total population of more than 36,19,661 (2001 Census)[8]. The district headquarter is about 85 Km from Lucknow. It is well connected from Lucknow via the National Highway 24. Sitapur district has the largest number of BPL families namely 3,58,640.

Sitapur has several well known tertiary and secondary level hospitals. The larger ones among them are the District Hospital and the Government Women's Hospital in Sitapur district headquarter, a 300 bedded missionary run hospital called Bishop Conard Memorial Hospital (popularly BCM Hospital) located in Khairabad (a town 6 Km from the district headquarter). There is also a very old eye hospital called Sitapur Eye Hospital (trust hospital), also located in Khairabad. Apart from these, several private nursing homes and small hospitals have come up in the district. However the block level towns have very few qualified private providers. In these blocks, patients have to depend on public providers or unqualified informal practitioners or they must travel to the district headquarter or the nearest big town. The CHC at Sidhauli is a 30 bedded hospital with four wards. The CHC (Community Health Centre) has an operation theatre and a labour room, 2 incubators as well as pathology testing available. The hospital is also well staffed with a total of 62 members on its payroll. Almost half of these are community level health workers (like ANMs, LHV). There are ten doctors, which includes 5 medical officers and specialist. Other support staff like X-Ray technician, pharmacist, lab technician are also appointed which is not a very common thing in most government hospitals. The CHC therefore is a well equipped and well staffed institution. Since they have a general surgeon and an anaesthetist, they are able to perform some small surgeries as well. User fees is charged for surgeries which ranges from Rs 67 to Rs 400 depending on nature of the surgery [For details of the facility see Appendix IV]

[8] Some websites show population as per 2011 census to be 4,474,446 (http://www.census2011.co.in/census/district/525-sitapur.html) accessed on 12th April,2012

As per data available on the RSBY website[9], 33.71 per cent of BPL families have been enroled in RSBY. A total of 21 hospitals (9 private, 12public) have been empanelled in the district.

Agriculture is the main occupation in the district. The distribution of land holdings shows that both in case of individual as well as joint holdings, an overwhelming majority of cultivators are marginal farmers with less than one hectare of land. 82.5 per cent of individual holdings and 75.1 per cent of joint holdings are marginal holdings.

Table 3.1 Distribution of land holdings and area by agricultural category

Category of Holding (size in Hectare)	Individual Holdings		Joint Holdings	
	Per centage distribution of Holdings	Area in Per cent	Per centage distributinon of Holdings	Area in Per cent
Marginal 0.50-1.0 hec	82.85	52.69	75.1	40.36
Small 1.0-2.0 hec	12	24.22	16.1	27
Semi Medium 2.0-4.0 hec	4.35	17.29	7.02	21.5
Medium 4.0-10.0 hec	0.7	5.33	1.68	9.96
Large 10 hec and above	0.01	0.47	1.15	1.15

Source:Agricultural Census 2004-05, Department of Agricultural Co-operation http://agcensus.dacnet.nic.in accessed on 27th June, 2012

There is also visible inequality in distribution of land. Among individual holdings, 52.69 per cent of the area has 82.85 per cent of the holdings which belong to marginal farmers, whereas 47.31 per cent of the area is distributed among about 17 per cent individual cultivators who are small to large farmers. A similar situation exists in case of joint holdings.

The most commonly grown agricultural food crop is wheat, although paddy is also grown in some areas. Sugarcane is an important cash crop in this area and large tracts of land are under sugarcane cultivation. Productivity of land varies within the district, with one *bigha*

[9] www.rsby.gov.in

of land reportedly producing 1.5 to 3 quintals of grain. Irrigation is available for many farmers through a canal called the Sharda Canal. The relatively affluent also have bore wells in their farms. There are two private sugarcane mills in the district, the Oudh Sugar Mills at Hargaon and the Seksaria Biswan Sugar Factories at Biswan.

Sitapur performs relatively poorly on different social and health indicators compared to other district. The table below tries to highlight this using select indicators and comparing Sitapur's position relative to the district with the highest/best and the district with the lowest/worst indicators

Table 3.2: Position of Sitapur relative to best and worst performing districts in some select indicators

	Sitapur	District with the Best /Highest indicator	District with the Worst/lowest indicator
Per centage of urban population (as per census 2001)	**11.9**	**67.1** Kanpur Nagar	**2.8** Shrawasti
Sex Ratio (as per census 2001)	**862**	**1026** Azamgarh	**841** Badaun,Mathura
Per centage of females literate (as per census 2001)	**35.1**	**72.5** Kanpur Nagar	**18.8** Shrawasti
Per centage of households with toilet facility	**15.8**	**82.5** Ghaziabad	**6.9** Siddharthnagar
Per centage of villages with sub centres	**27.3**	**67.5** Baghpat	**8.7** Azamgarh
Average population covered by sub-centre	**7918**	**4678** Mahoba	**10,695** Kaushambhi
Per centage of villages with Primary Health centres (PHC)	**2.3**	**19.6** Jaunpur	**2.1** Siddharthnagar)*
Average population covered by PHC	**33,385**	**23,370** Banda	**3,18,969** Ghaziabad
Average population covered by CHC	**1,93,519**	**68,733** Chitrakoot	**2,72,141** Sant Ravidas Nagar
Per centage of women who received any ANC	**60.2**	**93.6** Deoria	**34.5** Kanpur Dehat
Per centage of women who had Institutional Delivery	**21.4**	**54.5** Varanasi	**7.0** Bahraich

*Jalaun, Etah, Hathras reported 0 per cent

Source:District Level Household and Facility Survey,2007-08; IIPS Mumbai

As can be seen (Table 3.2), Sitapur is largely rural with only about 12 per cent of the population in urban area. Uttar Pradesh of course has districts like Shrawasti (eastern UP) which have only about 3 per cent urban population. The difference with the most urbanized district of Kanpur Nagar is vast. In terms of sex ratio and per centage of females who are literate, Sitapur is a better than the worst performing districts, but still performs very poorly. There are only 14 other districts out of 70 districts in UP that have per centage of female literates less than that of Sitapur.

Government health facilities are also very limited in the district. Only about 27 per cent of the villages have a sub centre and the average population covered by a sub-centre is almost eight thousand whereas the norm is five thousand. Average population covered by PHC is 33,385 a little more than the norm of 30,000 population and the average population covered by a CHC is 1,93,519 which is more than the expected coverage of 1,20,000 persons. Institutional delivery is extremely low with only about 21 per cent women giving birth in institutions. Coverage of ANC is better than several districts with about 60 per cent women who received any ANC . Sitapur is relatively better than other districts in terms of coverage of government health facility but still there is shortage of health facilities as per the norms laid down in the Indian Public Health Standards.

Sitapur therefore is not very different from other districts of UP and is fairly representative of other districts. The selection of Sidhauli block was done after examining the hospitalisation data of all the hospitals in the district (sampling described in detail below). The study focuses on two empanelled institutions in Sidhauli block. Sidhauli is one of the 19 blocks of Sitapur. It has an advantage over other blocks because it is well connected to both the state capital (Lucknow) and the district headquarter (Sitapur). It is on the National Highway that connects Lucknow to Sitapur. Sidhauli is located about 35 Km from Lucknow. *Sidhauli Block is the only block level town that has a **private** empanelled hospital. All other private hospitals in Sitapur town (district headquarter)* .

3.3 Sampling

The RSBY scheme was started in 2008 in select districts of UP. In Sitapur district it was started in 2010. Every year the card is renewed between a fixed time period. In 2011, cards

were renewed between July and September in Sitapur District. There was also a change in the insurance company working in Sitapur within this short time. While earlier it was ICICI Lombard, currently it is United India Insurance Company. This is the first year that this insurance company is implementing RSBY in Sitapur.

Since the case study aimed to study the utilisation experience of the beneficiaries and enquire if there were any costs incurred during hospitalisation as well as post hopitalisation, it was important to consider a time frame that would not pose difficulty in recall. Also some time should have lapsed since their treatment so that respondents could report any post hospitalisation expenses they had incurred or share any experience they had. It is for this reason that a time frame of four months- July 2011 to October 2011 was selected. (Data was collected between December 2011 and January 2012).

A list of persons who had utilised RSBY between July and October 2011 was obtained with the help of MoLE. This list included a total of 553 beneficiaries from 19 blocks. It would not have been possible to use the entire district level data as a sample frame as the sample then would contain beneficiaries spread across 19 blocks in a large district. A suitable sampling technique therefore had to be used keeping in mind the time and resource constraints. From the district level data of RSBY beneficiaries (for the period of July-October, 2011) certain clear trends were seen which helped in short-listing the block Sidhauli.

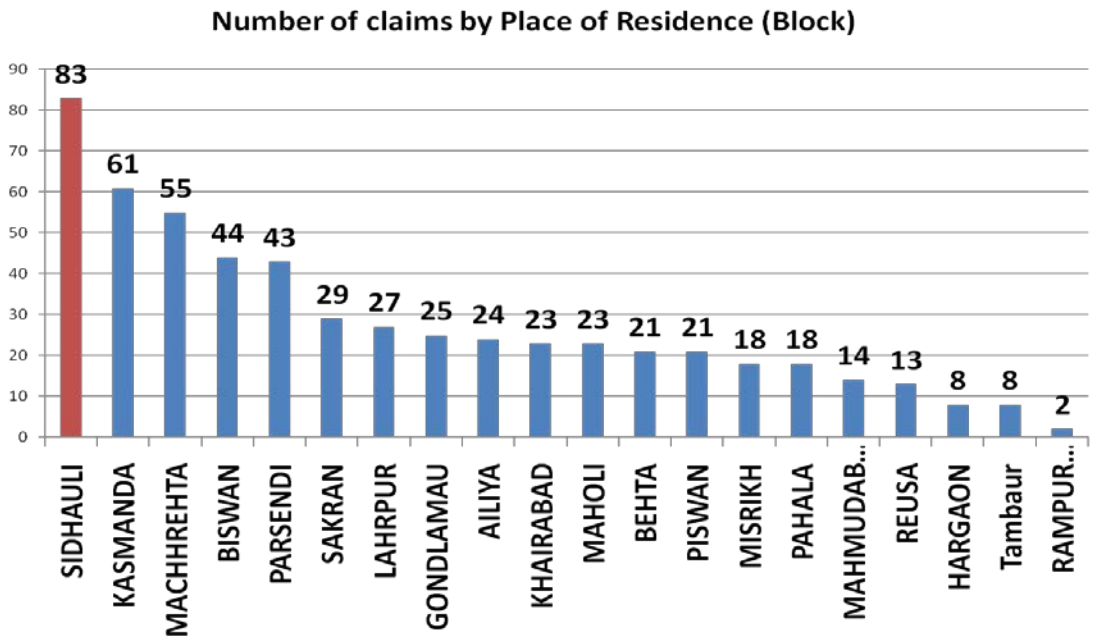
An institution wise analysis showed, that in the given period, KMR Hospital located in Sidhauli Block had the highest number of RSBY cases in the district (190). It had more than double the number of RSBY patients compared to the provider who was in the second spot (Table 3.3).

Table 3.3 : Details of Beneficiaries who utilised RSBY in Sitapur District by Hospital –July-October 2011

Hospital Name[10]	*Number of Claims*
KMR Hospital, Sidhauli	190
SB Hospital,Sitapur	92
RC Hospital , Sitapur	86
PD Hospital, Sitapur	75
RF Hospital, Sitapur	61
DG Hospital, Sitapur	30
SH Hospital ,Sitapur	16
CHC Sidhauli, Sitapur	3
TOTAL	**553**

Source: Utilisation data of RSBY provided by MoLE/GIZ

Fig 3.2: Details of Beneficiaries who utilised RSBY in Sitapur District by place of Residence -July-October 2010



Source: Utilisation data of RSBY provided by MoLE/GIZ

[10] Names of hospitals have been changed to ensure confidentiality

Table 3.4: Sex-wise break up of beneficiaries July-October 2010

Female	**251**
Male	**302**

Source: Utilisation data of RSBY provided by MoLE/GIZ

A block wise analysis showed that out of all the blocks, Sidhauli block had the largest number of utilisation cases (80) in the given period. All these cases except two had been to the above mentioned KMR Hospital. The only other empanelled institution in the block, the CHC had only three cases in this period (all of these were outside from the Sidhauli block).

Therefore the sample was selected from the utilisation cases of the two institutions that had been catering to RSBY beneficiaries in the Sidhauli block- KMR Hospital (private) and CHC Sidhauli (public).

Since CHC Sidhauli had only three cases between July to October, all three were selected. For selecting the sample from the 190 cases of KMR Hospital, systematic sampling was adopted. The list was arranged in chronological order (depending on the date of admission). From that list the first name and then every ninth name was selected. The total sample size therefore is twenty three.

Providers were also interviewed. The Medical Superintendent of the CHC and two doctors in the private hospital were interviewed.

3.4 Tools and Technique of Data Collection

This study uses detailed case studies as a tool for analysis of the problem. Semi structured interviews were used to elicit people's experience of utilisation of RSBY.

In-depth semi structured interviews were used to interview the providers. An Interview guide was prepared to direct the interview and elicit necessary information. Observation during the interview was also helpful in coming up with the findings

Since the study relies on qualitative techniques, important thematic areas were culled out from the case studies by repeatedly studying them. Broad themes and sub themes of the findings were organized in a manner that reflected the broader objectives of the study.

3.5 The Experience of Data Collection

Data collection was an enriching experience and the researcher got support from different quarters. However there were also several challenges that were faced.

The first and foremost task for conducting the study was to obtain a list of beneficiaries, with their accurate address and other details so that a proper sampling plan could be drawn out. This however was difficult as it was not clear which agency had the required information. The researcher started by visiting the State Nodal Agency in Lucknow and meeting the State Nodal Officer. They however had only enrolment data and not the detailed data of beneficiaries who had utilised the scheme. The researcher was asked to visit the insurance agency to obtain the required data. The insurance agency in this case was United India Insurance Company. The data that was provided by them had details of the name, condition for which treatment was sought, date and duration of admission and their card number (URN number). However the most essential detail, the address of the beneficiaries was not present in their database. That list therefore could not have served the purpose.

Next the researcher visited the district headquarter. She visited several empanelled private hospitals and the district hospital. Most of them maintain registers of beneficiaries but often the information is not organized in a manner that is useful. Some of the hospitals refused or tried to postpone sharing their records. Even otherwise it would not have been possible to visit all the 19 empanelled hospitals across the district to obtain the user data.

There is a district Kiosk that acts as a helpdesk for the scheme. But they did not have the data either. Efforts were also made to get in touch with the Third Party Administrator (TPA), who are responsible for processing the claims, but with little success.

Finally the data was obtained through Director General Labour Welfare, Ministry of Labour and Employment (MoLE). With his help, the researcher was directed to the GIZ

(Deutsche Gesselschaft fur Internationale Zusammenarbeit) which is providing technical assistance to the MoLE. The list obtained however did not have the name of the beneficiaries due to confidentiality reasons. The list obtained from the insurance agency came in useful and names of some of the beneficiaries were identified.

The twenty three respondents in the sample were spread across 6 blocks in a radius of about 25 km. The toughest job was to locate all of them. It would have indeed been a herculean task without the support of the Public Distribution System department of Sidhauli Tehseel whose help the researcher had solicited. They helped the researcher not only locate the villages, but also the beneficiaries (sometimes when the address or the names provided were incomplete or incorrect). The address had the name of the Panchayat and not the *majra*[11]. Since one Panchayat had 4-7 *majras* and a total population of close to five thousand, it was difficult to locate some of the beneficiaries. This was especially problematic in the case of women beneficiaries since the names of their husbands were not there. Women are hardly known by their name in these villages and therefore a few villages had to be visited more than once to locate the beneficiary.

However all the beneficiaries in the sample were located and interviews were conducted. In some cases the beneficiary himself/herself was not there or had expired. In such cases interview of the family members was taken.

3.6 Limitations of the Study

The study has several limitations. The first limitation is about reported illness. In most of the cases, respondents were only able to describe the symptom of their illness and were not aware of the actual condition. Efforts were made to enquire into the condition by asking for discharge slips. Prescriptions were asked for and names of medicines were also noted down where possible so that they can give an idea of the condition or problem for which the treatment was sought. Still in some cases it was not possible to find out the exact medical condition for which the treatment was sought or from which the respondents suffered.

[11] A village panchayat may have several hamlets which is called ‘majra’ in local language.

The second limitation was recall of cost of out of pocket expenditure. Respondents were enquired about indirect as well as direct expenses not only of the hospitalisation under RSBY, but also prior to hospitalisation and after hospitalisation. There is no time frame to enquire into the expenditure incurred. Respondents were asked how much they spent on the *condition* for which they sought treatment under RSBY. This is helpful, as the findings show that there were also respondents with chronic conditions who sought treatment under RSBY. A time independent enquiry into medical expenses, gives an idea of the actual financial burden due to certain medical conditions. In some cases the respondents had conditions for many years and hence recall was difficult. Even where it was not a long time back, only approximate figures were provided. The actual OOP expenditure is likely to be much more in some cases. Indirect costs about which enquiry was made, included only food and travel. It was difficult to ascertain the wages lost because some work on their own farms, some do daily wage but only seasonally and therefore calculating the exact loss of wages was difficult.

Another problem was under reporting of income and assets. Even though it was explained at the beginning of the interview that the researcher was a student and the research would be used for academic purposes people under reported their income and assets. For example in Katsariya village, one respondent reported that they had one cow, but later during the interview her daughter said they had seven cows. Similarly in another village, the respondent did not mention that he had a mint oil extraction machine in his farm which the researcher came to know from villagers. This is probably because inclusion in most government schemes and benefits (including RSBY) depends on income and assets. Another reason could have been that in many cases, the researcher was accompanied by the fair price shop dealer (since she had solicited the help of the Public Distribution Department to locate the village and beneficiary). This probably gave the impression that the researcher came from a government department.

Another limitation is that it was not possible for the researcher to re-visit the respondents to fill data gaps if there were any due to lack of connectivity to villages through public transport and resource constraints. To reach most of the villages the researcher had been provided help by the Public Distribution Department or local residents of that area with

whom she had prior acquaintance. Re-visiting those villages, many of which were far and most of which were not connected proper public transport would have required hiring private vehicle to reach them and great deal of additional resources.

3.7 Ethics and Confidentiality

During the data collection the respondents were explained that no names will be disclosed. The confidentiality of the respondents as well as of the providers has been maintained and their names have been changed. It was sometimes difficult to explain that I had not come there for an ‘enquiry’ as was assumed by the villagers, but for a study to understand their experience and problems they faced with the scheme. One villager especially requested that the names of informal providers not be handed over to the authorities since at times of need, such providers were helpful. Villagers as well as the providers who gave interview, were assured that their names will not be disclosed and that this research was for academic purpose.

KEY FINDINGS: PROVIDER PERSPECTIVE

This section presents findings that emerged out of interviews with the two providers[12] in Sidhauli block who have been empanelled under RSBY.

4.1 CASE STUDY- COMMUNITY HEALTH CENTRE, SIDHAULI (public provider)

4.1.1 About Provider

To understand the institution's experience with RSBY, the Medical Superintendent, Dr Singh was interviewed. Dr SK Singh (49 years) belongs to a rural background and comes from a district in Uttar Pradesh called Itawa. He says that his motivation to become a doctor comes from his experience in his village of close relatives dying in the absence of proper medical attention. He completed his MBBS from the King George Medical College (publicly funded institution) in 1985. Thereafter he did his MS in general surgery from Jhansi Medical College. While he was completing his post graduate education, he got an offer to join the state medical services which he accepted. Dr Singh has been in Sidhauli for the last sixteen years. While he joined as a general surgeon in what was then the Primary Health Centre, he was made the Medical Superintendent when the PHC was upgraded to a CHC about three years back

4.1.2 About Facility

The Sidhauli CHC was started as a PHC and was upgraded to a CHC. Today it caters to 500-600 OPD patients in a day and 400-500 IPD patients in a month. Majority of the IPD patients however are there to avail the Janani Suraksha Yojna (JSY) incentive. About 90 per cent patients were reported to be JSY beneficiaries.

It is a well functioning CHC with adequate manpower. The CHC has sufficient manpower to function well. They have medical officers, specialists as well as other staff appointed

[12] Names of providers have been changed for maintaining confidentiality

(not contractual) (See Appendix IV). The infrastructure is also good as many improvements were made after it was converted to a CHC. There are facilities for several pathology tests. However ultrasound is not available and there is no ECG technician although there is ECG machine. Another problem that the CHC faces is erratic power backup. Apart from these problems it is a well equipped hospital.

4.1.3 Experience with RSBY

Enrolment in RSBY Was a Given, Llike Any Other Government Scheme

The CHCs were enroled after the Medical Superintendents had a meeting with the Chief Medical Officer (CMO). The CMO told them about the scheme, and that its objective was to benefit the poor. They were asked to contact the insurance agency to set up the required technology for the implementation of the scheme. The insurance company thereafter had come and set up the smart card reader and installed the required software. There was some apprehension about implementation of the scheme since new technology was being introduced. But RSBY was like any other government scheme that had to be implemented. The decision about having RSBY was already taken by the top level. At the CHC level the only concern was about implementation.

RSBY Has Incentivized Work for Government Hospital Providers

According to the Medical Superintendent the scheme has benefited both the poor as well as the hospital. The money that is paid to the hospital has to be split; with one portion (75 per cent) going to the Rogi Kalyan Samiti (RKS) and another portion (twenty five per cent) going to hospital staff as incentives. This is the amount that comes to the institution after deduction of taxes on the package rate (about four per cent). Out of the twenty five per cent that is provided to the staff as incentives, there is a further break up for the various staff at the hospital that may have provided services to the RSBY patient. (A government order specifies this break-up).

Table 4.1: Break up of RSBY incentive for Government institutions in UP (out of 25 per cent of the amount claimed)

I.	**WARD SIDE**	**10 %**
1	Sister	20 %
2	Staff Nurse	60 %
3	Class IV Employee	20 %
II.	**DIAGNOSTIC WING**	**15 %**
1	X-Ray (Radiology)	35 %
2	Pathology	35 %
3	References (those who refered)	30 %
III.	**SURGERY AND OTHER MEDICAL PROCEDURES**	**50 %**
1	Chief Surgeon/Physician	50 %
2	Anesthetist/ Asst Anesthetist	25 %
3	Nursing Staff	15 %
4	Other Helpers (not included in class IV employee above)	10 %
IV.	**MISCELLANEOUS**	**10 %**
1	Local Administration	10 %
2	Accountant	20 %
3	Record Keeper	20 %
4	Central Administration	5 %
5	Facilitator	40 %
6	Others (on discretion of the MS)	5 %
V.	**SYSTEM IMPROVEMENT**	**15 %**

Source:*Government Order no. 619/5-1-10-5(28)/07 dated 17th June 2010; issued by Prabhat Kumar Sarangi, Secretary, UP Administration*

Given the above break up, in the financial year 2011-12, the RKS would get Rs 71,437 while Rs 23,812 will be distributed as incentives as per the above break up. (the entire amount claimed is yet to be reimbursed)

The provision of incentives was appreciated by the medical superintendent. He admits that being providers at government health facilities is a frustrating process and feels that he has not got much from the department that he has served (for past sixteen years). *" Kabhi*

kabhi lagta hai kya diya vibhag ne".[sometimes I wonder what I have got from the department] Although he admits that he has earned prestige due to his job yet there is dissatisfaction which probably arises out of lack of monetary benefits of the kind that private providers get. He also talks about the difficulties faced in providing good services in a government set up. He recalls how prior to NRHM, even for buying a pen they had to send a requisition to the district for its approval. That had created an environment that was highly de-motivating for the staff. However things changed after NRHM and there was visible change in motivation among staff to improve things. But things have again gone back to what it used to be ever since the NRHM related scam in UP came to light. Now, once again there are delays and a great deal of caution related to financing.

Dr Sing claims that RSBY is like a bonus. Since there is already provision for free treatment for BPL households in government hospitals, the fact that the hospital and staff are being paid for it, is like a bonus. He also implies that it has reduced informal demands for money by the staff because the incentive amount received through is more than what is asked as informal payments. Since the incentive is distributed even among lower cadre staff, he feels that now they do not need to ask patients for informal payments as they are already getting money from RSBY. *"Yeh toh humein bonus mil raha hai, maang ne se zyada humein mil raha hai".[this is a bonus for us, we are getting more than we ask for]* It is for this reason that in some of the cases the lower cadre staff had themselves taken an initiative to get RSBY card holders to get treatment in the hospital

The Private Sector Needs To Be Monitored For the Scheme To Work Properly

There is a great deal of suspicion among the public provider about the private sector providers making undue profit through this scheme. According the Medical Superintendant (MS) there are hearsay reports about some providers and beneficiaries colluding to get money from RSBY package without actually providing the treatment. However none of them were about any specific provider (public or private) that he knew. But it was emphasized several times that the scheme will need to monitor the private providers properly for it to be a success.

The CHC has had visits from the State Nodal Agency for verification in the past. The MS narrates an incident where he had done a renal surgery of a nine year old. The persons who had come for monitoring had raised doubts about the need for that procedure. However at that very hour the patient himself had arrived and therefore they did not have to convince any further. He insists that although the CHC has been honest in claiming reimbursement, he has serious doubts about the private sector providers.

The Conditions Covered Are Limited In the Absence of Outpatient Coverage

One of the major limitations according the MS is that the scheme does not cover outpatient cases which constitute a majority of the cases. Further the scheme has to be linked with medicines to be truly useful. The CHC is able to provide some medicines for five days, but not beyond. This is especially a problem for chronic illnesses like asthma which require regular medication over a long period.

Due To Lack of Awareness Among People, the CHC Is Not Able To Benefit As Much From RSBY As the Private Hospitals

The provider feels that there are fewer RSBY patients coming to the CHC compared to the private hospital because people are not aware that they can get treatment in the CHC through RSBY. To rectify this problem, the ANMs and ASHAs have been given the BPL list. They are expected to identify prospective patients who may need treatment that is covered under RSBY. There have been some cases (like patients requiring cataract surgery) that have been referred by the community level workers. There is however change proposed from this year in the overall administration of the programme. Instead of the Medical Superintendent the Health Education Officer will oversee the implementation of RSBY at the CHC.

It Is a Good Scheme And Beneficial For the Poor

The MS felt that this scheme was beneficial for the poor. However he also claimed that many such schemes were giving rise to corruption as people wanted to get the money without getting treatment. According to him, in the recent past, the government has started providing various benefits to the poor in the villages which has led to people getting used

to freebies. *"Governement her cheez ke kiye paise baatne lagi…"[the government started distributing money for everything]* and therefore people started expecting money out of schemes like RSBY too.

Some Problems Faced During Implementation

In the initial days of the scheme, the main problem was technical. Since the scheme is entirely technology based, technical problems can create major hurdles. The CHC often faced problem related to software or hardware. In 2011 the scheme could not function in the CHC between April to August because the software was not functioning. They had to contact the insurance company several times before they were able they came to rectify the problem. In the meanwhile RSBY cardholders could not be treated under the scheme. Another problem is erratic supply of electricity in the hospital. Despite having a generator, the CHC has to spend many hours without electricity. Electricity supply in Sidhauli is mostly for 8-10 hours at night. At such times using the smartcard technology to register the patient becomes difficult. In one of the cases a patient was registered under RSBY on 12th March, 2011 and the package amount was blocked. However the same evening the computer stopped working and had to be sent for repair. The repaired computer was returned to the CHC only on the 20th . The software could not be uploaded till the 31st of the month. Since the card must be swiped at the end of the procedure too, which could not be done in this case due to technical problems, the amount of Rs 5,500 that was blocked, was not released.

Another problem is delayed payment. While the scheme visualized provision of payment within twenty one days of receiving it from the hospitals, in reality it takes months to settle the claim. Between September 2011 to March 2012, the CHC had a total of 23 claims registered under RSBY for a total amount of Rs 95,250. As of June 1st , six claims, that were claimed between January to March 2001, worth Rs 26,500 was yet to be reimbursed. It is clear that far from being reimbursed within twenty one days, there are extreme delays in reimbursement.

Although the scheme requires a separate helpdesk at the entrance exclusively devoted to RSBY, the CHC is not able to provide that. Currently the clerk has taken on the additional

responsibility of managing data for RSBY. Given that the CHC receives very few cases, it may be difficult to rationalize the appointment of a separate staff for the scheme. Currently the process adopted is that in case of a surgery, the patient is asked if he/she has the RSBY card. If he/she has one then the case is treated under RSBY. The staff at the registration counter are also aware of the scheme and direct patients who come to them with RSBY cards.

Another problem is in term of investigations and diagnostic tests. RSBY is meant to be a cashless scheme and therefore tests are meant to be free of cost. The hospital itself does not have all tests available (including ultrasound) and poor patients are often not able to negotiate with diagnostic test centers outside to provide them with a bill, in the absence of which the cost of tests will not be reimbursed.

There is also some lack of clarity about what account head the travel allowance has to be paid from to the patient . The current Government Order provides for the money to be split between the RKS and the providers.

Suggestions

The main suggestions provided are to link it with outpatient care, include treatment of chronic conditions like asthma and more crucially provide medicines (for longer duration).

4.2 CASE STUDY- KMR HOSPITAL (private provider)

4.2.1 Provider(s) Profile

Dr Ashish Mehta (40 years) is a MD from the Vinnitsa National Medical University, Ukraine, after which he obtained his Diploma in Child Health from a private medical college in Agra . His wife, Dr Richa Mehta (37 years) is an MBBs from Rabindra Nath Tagore Medical College, Udaipur (public), did a Diploma in Maternal and Child Health from IGNOU and a short course in gynaecological laparoscopy from Chhatrapati Sahuji Maharaj Medical University (earlier KGMC), Lucknow. Dr Satish Mehta (72 years), father of Dr. Ashish Mehta, had done his MBBS from KGMC Lucknow.

Dr Satish Mehta after obtaining his medical degree from King George Medical College in Lucknow decided to start his practice in his own village in Sidhauli. He set up his clinic in 1966. He did not work in any government hospital because he wanted to start his independent practice. Dr Ashish Mehta and Dr Richa Mehta started by working in Bishop Conard Memorial Hospital in Khairabad (6 Km from Sitapur). It is a 300 bedded Christian missionary charitable hospital. Dr Ashish Mehta headed the paediatrics department while Dr Richa Mehta worked in the Obstetrics and Gynaecology department. They worked there for about three years and after that started working with Dr Satish Mehta and started a nursing home.

4.2.2 Institution Profile

A Hospital That Enjoys Good Reputation Among Users

KMR Hospital is one of the most well known hospitals in Sidhauli and the adjoining blocks. It is the only private hospital that has been empanelled in a block town. All the remaining private hospitals that have been empanelled under RSBY are located in the district town of Sitapur. KMR Hospital is also the hospital that has the highest number of claims in the district under RSBY. Interviews with beneficiaries of the scheme who sought treatment in KMR Hospital clearly brought out the good reputation that the hospital enjoys among people. People claimed time and again that even if they did not have the benefit of RSBY, they would have still preferred to go to *Satish Doctor's* hospital to get treatment. The institution therefore makes an interesting case study.

The hospital is run as a family enterprise. Dr. Satish Mehta, his son Dr. Ashish Mehta and his daughter -in- law, Dr Richa Mehta currently provide services at the hospital. Dr. Ashish Mehta and Dr. Richa Mehta are primarily responsible for the management of the hospital as well as the implementation of the RSBY.

An Institution Which Has Been Transforming Itself With Each Generation And Its Changing Values

The Mehta family is well known in Sidhauli and have been in the area for many years. Dr. Satish Mehta's father Mr Nirmal Mehta, had migrated with his parents from Rajasthan to Sidhauli when young. He had been active in the freedom struggle in the Sidhauli and was

associated with a local Gandhian leader. Being from a business family, his work had taken him to many parts of the district, to interior villages and he was well known. Today at 91, Mr. Nirmal Mehta serves as the president of Gandhi Memorial Society (a society that had been originally set up by his freedom fighter friend) that runs a post graduate college in Sidhauli . Dr. Satish Mehta acts as the secretary of this society. Mr. Nirmal Mehta had also served a Pradhan of Sidhauli.

The current set up was started as a clinic in 1968 by Dr Satish Mehta. While he primarily catered to outpatient care, there was also a small set up with beds to provide day care if needed. Dr. Satish Mehta's father recalls how his son always wanted to be a doctor. In the initial days when Dr. Mehta started his clinic in the small town of Sidhauli, he was among one of the handful of qualified medical practitioners, not just in the town but in the entire district. In Sidhauli there was just another practitioner apart from Dr. Satish Mehta. There was a government Primary Health Centre that was set up later, but in the absence of a proper functioning government set up, Dr Satish Mehta had been practically the main provider in Sidhauli and the nearby blocks. The fact that Dr Satish Mehta's father practically travelled the entire district for his business and knew a lot of people and that he was respected for his role in the freedom struggle, helped Dr Satish Mehta in the initial days to set up his practice.

After Dr Ashish Mehta and his wife joined his father about eight years ago, the clinic was converted into a nursing home. Around four years back the nursing home was converted into KMR Hospital and about a month back KMR Hospital became a private limited company.

It is interesting to see changing values of the three generations within the same family. The grandfather is rooted in Gandhian tradition and philanthropy through involvement in education society is an expression of long standing values. The father (Dr Satish Mehta) entered the medical profession because he was motivated to and decided to start his work in his village rather than in a city. Although he provides his services at a cost yet he had entered the profession with the motivation to work in his village. Dr Ashish says that for him the medical profession was not much of a choice, it was more a given since his father

was a doctor. Unlike his father who received medical education in a publicly funded medical college, Dr Ashish acquired an expensive medical education from Ukraine. Dr Richa Mehta also a product of publicly funded medical education is today actively involved in setting up a profitable medical business. She says that after her medical education when she had to go to a village in Rajasthan to provide services she was "horrified" by the experience. There was no transport and she had to travel in tractor with other people to reach the destination. It was then that she had decided that she was not going to work in the government health set up. The change from a hospital to a private limited company is a signal of the changing values over generations in the same family.

A Well Equipped Hospital

It can be safely said that it is the most well equipped private hospital outside the district town (which is about 40 Km away). Therefore for people living around a radius of 25-30 Km, they become the only private hospital available. There are four wards - Male Ward (13 beds), Female Ward (7 beds), Post Operative/Semi Private ward (6 beds), Private ward (4 beds). An open space inside the hospital acts as an open ward (6 beds) where patients who have to stay for the day or some hours can stay. The hospital has an operation theatre, a labour room, as well as diagnostic facility available. X-Ray, Ultrasound, as well as a laboratory with computerised testing facility is available. It also has an incubator for newborns as well as a phototherapy equipment for neonates. As Dr Ashish shows me around his hospital, the pride is evident. There is a water cooler and kitchen. Separate toilets for men and women were made but Doctor Ashish laments that there is little use because his patients cannot read which is meant for whom so now they have one toilet which functions as a unisex one. The hospital also has an ambulance. Currently it caters to about 80-100 outdoor patients every day and about 300 indoor patients in a month. (This figure was provided after the assurance that it will not be publicly disclosed, primarily due to tax considerations). The business approach of bringing the best technology and comfort to satisfy customers (in this case patients) and increase sales clearly has its limitations in the health set up in a place like Sidhauli. The doctors inform that though there are three private rooms (at Rs 500 per day) but only three patients in the past eight months have used it. They had also started a semi private ward (at Rs 250 per day). But there were no

takers for it so they have converted it into the post operative ward. For the general wards they do not have separate charge but they charge an additional 40-50 rupees in their medical bills since people in small places will not be in a condition to pay separate bed charges.

Problems Faced in Running the Hospital

Although the hospital is well equipped with some of the more advanced technology available, yet functioning in a semi-urban area has its own drawbacks. One of the biggest problems being faced by them is the non availability of trained staff. Currently the hospital does not have any trained nurses or lab technician, X-Ray assistant or pharmacist. Mostly local graduate or undergraduate youth have been employed to perform these tasks. Dr. Richa Mehta says that she was willing to pay nursing interns upto Rs 10,000 while they get paid only about two thousand in the government set up, but no one came. She says that it is difficult to find people who are willing to stay on in a small place like Sidhauli. Currently there are about twenty five staff members (permanent and temporary) in the hospital. Apart from the three doctors from the Mehta family, there are two BAMS (Ayurveda) resident doctors who are present at night to cater to patients and inform the doctors in case of an emergency. Apart from these the hospital has four ward boys, three sweepers, three security guards , one cook and one person for the laundry.

Another problem with using high end technology in smaller set ups is the erratic supply of electricity. Dr Ashish points at the phototherapy equipment to keep infants warm and says that although they have it they are hardly able to use it because of power cuts.

4.2.3 Enrolment in RSBY

KMR Hospital being the only registered private hospital in the block, was recommended by the CMO to the insurance company. Some years back they had also participated in the *Saubhagyavati* Scheme which was a public private partnership scheme where BPL women could give birth in private hospitals and the government reimbursed around Rs 2000 per delivery (normal). The hospital had gained credibility among government departments after participating in this scheme. Dr Richa feels this was one of the reasons why the CMO had recommended their name to the insurance company.

When asked about their motivation to get empanelled in this scheme, they said that it was more for philanthropic reasons than for any financial gains. The RSBY patients constitute only about ten per cent of their total indoor patients. To comply with RSBY empanelment criteria, they had to employ additional staff. The kitchen was started after empanelling in RSBY. A computer operator and two more staff, one male and one female were appointed.

4.2.4 Experience of Implementing RSBY

Delay in Reimbursement of Claims

The providers claim that they are facing several problems in implementing RSBY. The major problem is the extreme delay in reimbursement of claims. Around 7-8 lakh rupees is yet to be reimbursed. Out of this about Rs 4 lakh is the amount pending from last year since August 2011. This is ironical because the RSBY envisages payment within twenty one days to the provider due to use of paperless high end smart card technology. According to the providers, problems with reimbursement started last year after they had to start dealing with the Third Party Administrator (TPA). New conditions and rules which they had not been informed of earlier were being added to reject claims by showing non compliance to those rules. A few months back the TPA told them that they had not kept two passport size photos and photocopy of the ration card of the beneficiary, a requirement of which they had not been informed earlier and had not needed till then to make claims. (interestingly the scheme itself does not require any proof other than the smart card). This creates a problem for the patient as well because they have to travel back to their village, sometimes long distances, to get the ration card and have to spend additional money to get passport size pictures. Their hospital was also de-empanelled for nearly a month on grounds that they had not maintained a separate OPD register, a condition that they say was mentioned neither in their contract nor communicated to them through any other means. Around 20-25 patients had to be sent back at that time (they also tried to send people to the CHC). When they tried to raise the problem with the TPA representative, he told them that "*bahuto ka 20 lakh baki hai, aap 4-5 lakh ke liye pareshan ho rahe hain*" .*[many are yet to be reimbursed up to 20 lakh rupees, your are fretting for mere 4-5 lakhs].* They feel when ICICI Lombard was the insurance agency, transaction was much

more hassle free. Sometimes they took time to verify a few claims they were not satisfied with but eventually they were reimbursed. Dr. Ashish says that he felt there was a conflict between what the government wanted and what the insurance agency wanted. The government wants more people to get benefit from the scheme and the insurance company wants less people to benefit from it.

Dissatisfaction With Package Rates

There is also dissatisfaction with the package rate itself. In an unregulated environment it is common for providers to set rates of procedures based on their discretion. The amounts therefore paid by RSBY therefore may be much lower than what they are used to charging. The hospital for instance charges around Rs 12,000 for a C-section while RSBY provides Rs 4500 (after deduction of taxes the actual amount is lesser than the specified package rate). The hospital charges Rs 350 for an Ultrasound and Rs 150 for X-Ray. Dr Richa informs that package rates are not able to cover costs. She gives the example of General Ward category which covers mostly day care or less serious problems (non surgical medical problems). Under this category, for one day the hospital is paid Rs 500. But this includes diagnostic tests, food, Rs 100 travel allowance, bed charges, five days medicine and to this one could add the cost of salary paid to RSBY staff. All these costs can be covered only if the patient stays for two to three days (even if not needed). It should be remembered that most of the cases under RSBY in this hospital are under general ward. In addition since the reimbursement is very late, the doctors have to pay from their own pockets to sustain the scheme. She gives another example to illustrate her problem. While the obstetric and gynaecological procedures are dealt by her, they have to invite specialists for other procedures. One of the orthopaedic surgeries has a package rate of Rs 15,000 out which Rs 3000 is paid to the anaesthetist and Rs 8000 is paid to the orthopaedist. (the remaining money, after paying for medicines, food etc is the hospital's). However since the reimbursement takes months they have to pay in advance from their own funds. Dr Richa says "*there is not much benefit in it after so much headache and running around*".

Rejection of Claims

Rejection of claims has also de-motivated the providers. Dr. Richa Mehta says that in the

recent past all her D & C and normal delivery claims have been rejected. She talks of two cases where her claims were rejected on flimsy grounds- both hysterectomy cases. The package provides that for hysterectomy the admission is for zero days. Since rural women are not able to get rest when they return home, on humanitarian grounds she had let a patient stay admitted for eight days. Another patient had been admitted for twenty three hours. Both these claim were rejected. She says that even though the scheme says zero day admission, she had on her own provided them care for longer on humanitarian grounds, but her entire claim had been rejected and she was not paid for performing the procedure. At one point she says:

"We are double minded, (continue) kare ki na kare" [we are in two minds, whether to continue or not]

Attitude Towards Beneficiaries And Perception About the Scheme's Utility (for beneficiaries)

The doctors feel that the scheme has benefited the poor as they are now able to get treatment for conditions that they were unable to get treatment for before, due to lack of money. Dr Richa says that she treated women who had had a uterine prolapsed for eight years but could not get treatment. But at the same time many people who do not have any conditions want treatment because they have the smart card. In my own observation, a gentleman in his late forties or early fifties had come to get treatment for asthma. Dr. Ashish was trying to convince him that it was a chronic condition and he would have to take medicines for life time and getting admitted would not cure him. It was also quite evident that the card holder was not from a BPL household. Since the patient kept persisting, an exasperated Dr. Ashish looked at me and said that it was difficult to explain anything to 'these people' and it was people like them who would say that Dr. Ashish had not spoken to them properly since he had refused to give them treatment. He then told the card holder that he could get admitted if he wanted to, to get temporary relief but he need not get admitted because it was a long term condition. They also got people with letters from local MLAs and leaders to get treatment.

There was an opportunity to share feedback from the beneficiaries of the scheme with the

providers. I was able to tell them of one instance where the beneficiaries had felt that Dr. Ashish had spoken rudely to them. He had responded defensively but through observation there were many small instances where a certain degree of condescending attitude could be seen. As he was showing me around the hospital a young man came and asked if he needed the ultrasound for his ward on the same day, to which the doctor replied in positive. After another ten minutes the same young man came to ask if he could get it after two days, to which Dr. Ashish responded by rebuking him "*yeh koi halwa thodi hai ki aaj nahi to kal kha liya, yahan kisi ki jaan ja rahi hai" [this is not a sweet dish that you can skip it one day and have it on the next, someone's life is at stake here].* Whether this attitude has emerged from medical education and upbringing in a context that was far away from rural realties or a sense of exasperation at not being able to convey 'medical sense' to the ignorant is an interesting question.

KEY FINDINGS: BENEFICIARY PERSPECTIVE

This section provides the findings that emerged out of interview with those persons who themselves or their family members have utilised the RSBY and sought treatment under the scheme.

Table 5.1 Socio-economic Profile of Respondents

Name[13]	Block	Age *(Actual Age)	Sex	Relation To Card Holder	Caste	Education	Land
Champa Kumari	Sidhauli	58	Female	Spouse	Pasi/SC	Non Literate	1 bigha
Ram Pyari	Sidhauli	26 (late thirties)	Female	Spouse	Pasi/SC	Non Literate	2.5 Bigha (provided by govt.
Sultana	Sidhauli	33	Female	Spouse	Muslim/OBC	Non Literate	1 bigha
Samir	Sidhauli	14	Male	Son	Muslim/OBC	8th standard	Father does share cropping, gets produce from 2 bigha
Ramesh	Sidhauli	23	Male	Son	Yadav/OBC	8th standard	2.5 Bigha
Kamlawati	Sidhauli	64	Female	Spouse	Pasi/SC	Non Literate	1 bigha
Nankai	Sidhauli	23 (32 yrs)	Female	Spouse	Pasi/SC	Non Literate	3 bigha
Rani	Kasmanda	30 (7 yrs)	Female	Daughter	Yadav/OBC	School going	18 bigha
Suraj	Kasmanda	16(18)	Male	Son	Pasi/SC	School going High school	10 bigha
Pyarelal	Kasmanda	42	Male	Self	SC/chamar	Non Literate	3 bigha
Jagjeevan	Kasmanda	41	Male	Self	Yadav/OBC	Non Literate	2 bigha

[13] Name of the respondents have been changed.

Ram Charan	Kasmanda	65	Male	Self	Gupta Bhurji/ OBC	8th standard	3 bigha
Ram Ratan	Kasmanda	60	Male	Self	Yadav/OBC	Non Literate	18 bigha
Reeta	Kasmanda	32	Female	Spouse	Varnwal/OBC	Non Literate	3.5 Bigha
Preeti	Kasmanda	40(18 yr)	Female	Daughter	Chamar/SC	Non Literate	6 Bigha
Narendra	Gondlamau	40 (18 yr)	Male	Son	Maurya/OBC	6th standard	5 bigha
Chhote Lal	Gondlamau	55	Male	Self	Chamar/SC	Non Literate	Since father alive, he does not have claim over land
Puja	Gondlamau	35(20 yr)	Female	Sister	General	High School	None (will inherit 1bigha land after father's death
Sunita	Gondlamau	35	Female	Spouse	Pasi/SC	Primary school	30 bigha
Mangal	Biswa	25	Male	Son	Kumhar/OBC	8th standard	4 bigha
Ram Rati	Biswa	45	Female	Spouse	Pasi/SC	Non Literate	2 bigha
Lallan	Machhrehta	50	Male	Self	SC/Pasi	Non Literate	Has 8 bigha but 4 bigha has been given to sharecropper
Ram Kali	Pahala	48(58)	Female	Spouse	Chamar/SC	Non Literate	Landless

Note: approx 5 bigha = 1 acre = 0.4 hectare

****Age in parenthesis '()' is the actual age. It has been written against the age provided in the centralized RSBY data. It shows the discrepancy in beneficiary data which is with the MoLE***

Source: Based on fieldwork December- January, 2012

The table above shows the profile of the respondents who were interviewed. There were eleven male and twelve female respondents and their age ranged from eight to sixty four years. Among the respondents, twelve belonged to Scheduled Caste (SC), ten to Other Backward Caste (OBC) and one to higher caste (General category). The respondents were scattered across six blocks (Kasmanda, Sidhauli, Gondlamau, Pahala and Machhrehta). But almost half of them were from Sidhauli and Kasmanda.

Out of the twenty three respondents, only nine were literate. Out of the twelve female respondents, only two were literate and one was a school going girl. All except one respondent aged over thirty five years were illiterate. Most of the respondents were marginal farmers. With less than 1 hectare (2.5 acres of land).

5.1 CHOICE OF TREATMENT PROVIDERS UNDER RSBY-UNDERSTANDING WHAT CHOICE MEANS FOR USERS

One of the hallmarks of the RSBY is that it has empanelled both public and private providers in its network. What it ostensibly provides is *choice* to the users of the scheme to choose the provider they want get treatment from. One of the objectives of the study was to understand the factors which influence the choice of providers, especially between public and private providers. Beneficiaries of the scheme were therefore asked what induced them to choose a particular provider over another and indeed chose private over public provider or vice versa. It was found that for choice to be exercised there needs to be context which was missing in this case.

Providers Limited In Number and Concentrated In the District Headquarter

There are a total of twenty empanelled hospitals in the district, eleven public and nine private. Out of the nine private hospitals, eight are located in the district headquarter and one is located in Sidhauli. The blocks other than Sidhauli therefore have no private provider empanelled. Sidhauli is also the only block that is well connected as it is located on the national highway and falls almost midway between Lucknow and Sitapur. The other districts which are not so well connected or far from the district headquarter have very limited presence of qualified private providers. The only empanelled providers in these blocks are the Community Health Centres and none of them have reported a single case of RSBY. Given that Sidhauli block has only two providers- one CHC and one private hospital, villages that are close to Sidhauli have only two providers to choose from, not much of a choice.

Information Asymmetry

Another factor which makes choice of provider redundant is information asymmetry. Almost all the respondents who were interviewed did not know at the time of enrolment the institutions where they could seek treatment. Only one respondent, Ramesh said that he had read the pamphlet that provided information about the institutions empanelled in Sitapur district and hence knew where he could get treatment. This is in line with the evaluation studies of RSBY which also show poor information among those enroled in the scheme(ref section 2.2.3). In this regard it is interesting to note the case of Sultana. Sultana is a 33 year old mother of six. Neither she nor her husband is literate and they make their living through daily wage labour. In her last pregnancy, Sultana's water had broken towards the end of her term. Her husband had not thought of using the card because he neither knew that RSBY could be used in case of child birth nor did he know the institutions where he could get treatment. Initially she was taken to the government hospital. There she was told to get an ultrasound test done, which she got from a private provider in Sidhauli and which cost her Rs 350. After seeing the ultrasound report, Sultana was told that it was not yet time for labour and therefore returned home. But for the next two days the amniotic fluid kept leaking. It was then that it was decided to take her to KMR Hospital in Sidhauli to save her from any complication. Sultana was taken to KMR Hospital; the third day after her water broke and was admitted there. She had to pay a registration fee of Rs 50 and bought medicines worth Rs 100. Her husband says that he had gone there prepared to pay five to six thousand rupees as that was what it cost to have a normal delivery in that hospital. Even though it would have put them under debt, they had prioritised saving Sultana's life through treatment in what they considered was a better institution. After admitting Sultana in the hospital, her husband saw a signboard in the hospital with the picture of RSBY smart card. It is then that he enquired about it and found that he could get free treatment under the scheme. Sultana's husband says that he had not known before that he could use the RSBY card there. Sultana therefore had to spend Rs 500 from her pocket even though she could have availed free treatment under the RSBY card in both the institutions she went.

Similar was the case with Narendra. Lack of information about empanelled institutions lead him to consult numerous providers before he went to KMR Hospital. Although

Narendra had the RSBY card he was not aware that he could get treatment there under RSBY. Only after he went to the hospital and saw the RSBY signboard, he enquired about it and was told that he could get treatment there. But by then he had already spent money out of his pocket. He had paid for several tests and even had to borrow money (Rs 480 on ultrasound and Rs 300 on blood test). When he brought his smart card however, he was told that he could not get treatment because the card was used only to treat serious condition requiring hospitalisation. It was only after a lot of pleading with the staff that he was admitted under RSBY General Ward category. Narendra regrets not having full information about empanelled institutions where he could use the RSBY card and says that if he had had the information he would not have wasted his time going to other providers and spend large sums of money. (Narendra had gone to five different providers before coming to this hospital). Since he has had to borrow money from his villagers, he repays it by working for them without wage. As in the case of Sultana, Narendra too, despite having the RSBY card had to incur out of pocket expenditure for treatment. He spent about Rs 800 at KMR hospital, which was an empanelled hospital and about Rs 7000 on different providers before coming to KMR Hospital which could have been saved.

Information asymmetry was also evident from the fact that even after having utilised the scheme most respondents thought that the only institution that was empanelled in Sidhauli was the private hospital (KMR Hospital). Nankai's husband quite confidently says *"sirf private (hospital) mein hota hai ilaaj, sarkari mein nahi"[only private hospitals provide treatment (under RSBY) not government hospitals]*. Some like the family members of Ramrati and Preeti, knew the nearby towns where treatment could be sought but not the institutions where they could seek treatment under RSBY. Information about where treatment could be sought came through by way of other villagers who were relatively more educated. In the case of Samir, it was the informal provider who asked him to go to KMR Hospital and use the smart card. In the case of Ramkali it was the ANM and other villagers who suggested the hospital. In some cases like that of Nankai and Ramrati, their husbands had seen the signboard outside the hospital and enquired. In the case of Puja, her father had seen the smart card being used during an earlier visit to the hospital. None of the respondents were able to tell the name any institution empanelled in the district

headquarters and only those who had actually sought treatment at the CHC knew that the scheme could be used there. In this context where information is extremely limited, there is very little opportunity to exercise choice.

Choice in a Context Where the Public System Does Not Live Up To Expectations

RSBY provides choice to users to choose between public and private providers. However does this choice really exist in a context where the public system is not able to deliver the needs and live up to the expectation of people? It was found that the perception and experience of using health services in the public sector was largely negative. Public sector providers are regarded as insensitive to the needs of patients and corrupt. Another problem stated was lack of availability of several medicines and free tests in public hospitals which leads patients to spend money from out of their pocket. Since medicines and tests contribute to a significant proportion of the cost of medical care, absence of free medicines and tests means that government providers do not have much of an advantage over private providers.

The interview with Champa Kumari provided important insight into perception about the public sector. Champa Kumari is a 58 years old Tuberculosis patient who had never thought of seeking care in the public sector. She lives with her husband and adolescent daughter. They belong to the *Antyodaya* category of poor (poorest of poor) and but for the food grains provided to them through the PDS (Public Distribution System), would find it difficult to survive. It was only after the doctor at the private hospital himself recommended that she get treatment from a public provider, that she went to the CHC. She is now on DOTS treatment. On probing about why Champa Kumari had not thought of using the public sector before, others present there promptly reply "*whahan sunwai kam hoti hai*", implying that in government hospitals people do not pay much attention to their problems. Champa Kumari's husband adds that they have to keep standing in queues and even when the patient is serious, is suffering and in pain, the doctors may ask them to come the next day -

Wahan line lagaiye, who kehte hai wahan chalke baithiye, ab jab (treatment) hogi tab hogi. Mareez wahan tadap raha hai, humara to kaleja dhadak raha hai ki

humara mareez chhatpata raha hai.Wahan doctor kehta hai aaj jaanch likh diya hai kal aana. Kal tak to humara mareez mar jayega to hum kya karenge
[there you stand in a queue. They tell you to go and sit, so there is no certainity when the treatment will begin; and all this while my patient is suffering and in pain and I am anxious. The doctor may just ask you to come the next day while my patient may die the next day]

Sometimes there is a perception that government hospitals do not provide good quality medicines. For instance Reeta says that she prefers the private to government hospital as the medicines provided in government hospitals makes her body hot *"sarkari ki dawa garam kar jati hai"*. This probably implies that she is not satisfied with the medication provided in government hospital, and the perception is that the medicines are not good or have some form of side effects.

Sultana had been to both a public and private provider when the water had broken during her pregnancy. Initially she had been to the government CHC, but had been told that it was not time for labour. Later she went to a private provider because she thought she could get better care over there. She shares her experience and perception of both providers. She says that

"when it is the matter of my life, when I have a problem, if then they (government provider) cannot help me then what is the use (of free treatment). Here (private hospital) if they are taking money, they will be with me (pay more attention)".

At the CHC Sultana was told to get an ultrasound, which she got from a private provider in Sidhauli and which cost her Rs 350. When asked if the government hospital did not have an ultrasound machine, the others present there said that they felt that there must me an arrangement between the government and private providers so that the latter paid them commission in case the former referred them a patient. Sultana's neighbor articulates the negative perception they have of services provided in the CHC. She says that *"There they take admission only when the baby is just about to be delivered, otherwise they tell the woman to go and take a walk. They would not give medicine or do something"*. She says

that in Sultana's case since her water had broken the life of the baby was in danger when they went to the CHC. But she did not receive any attention or care.

Another important perception is that the public facility is insensitive to the poor and responsive to the more powerful. Sultana's husband endorses this view and says that

> *"sarkari haspatal mein yehi hai, jiska pauwa (connections to powerful people) hai jo dadagiri (powerful, being feared by others) hai uska kaam badhiya hota hai aur jo jaan gaye dehat ke hai padhe likhe nahi hai…to andar nahi ghuse de rahi. Hato! Bacho! (shoo away)"*
>
> *[In government hospitals only those who have connections to powerful people or are powerful, get proper treatment. Once they come to know that the person is from the village and illiterate they don't even allow them to enter (the room) and shoo them away.]*

It is interesting to note here how the public facility does not even feature in the minds of people when they talk about health providers. On being asked about their choice of providers, Samir's father says that there were not many qualified providers in the area. He says that there were just two private providers in Sidhauli whom people in the area could visit and one of them was the KMR Hospital- *"Bade doctor do hi hain"*. It us interesting to note that while talking about good health care providers, they did not think of the government CHC.

On asking whether there was any use of a scheme like RSBY, since government hospitals already provided free treatment, Preeti's father says, that the scheme can be used if good medicines are not available in the government hospitals. Similarly Ramrati's husband says that says that sometimes people did not have time (to get treatment in a government hospital) or doctors were not available in the government hospitals, at such times it was useful to have the card. These replies imply that RSBY provides an alternative when users want to avoid non availability of medicines, long waiting time and lack of availability of doctors, all of which are a reality in government hospitals. The alternative in this case is of course the private sector.

In a context where the public system clearly does not function in a manner that fulfills people's needs and expectations, there is very little by way of choice. Choice is possible when both the public sector and private sector have similar resources and facilities and both enjoy similar perception in terms of quality of care. RSBY therefore does not provide choice between public and private providers, but rather an alternative to public providers. The choice, even in a situation when there is less information asymmetry, is between different private providers.

What Choice Means For the Vulnerable

Another aspect that needs to be factored in while talking about 'choice' is the context and social location of those who admittedly have the power to exercise this choice. Currently this scheme is limited to those who are part of the centre's BPL list. It is commonly accepted that the list has many flaws of wrongful inclusion and exclusion, yet it largely covers the poorest in a village. Throughout my data collection and interaction with the respondents, it was reiterated how the users are located in a disadvantaged social context which makes them vulnerable. One of the greatest vulnerabilities is illiteracy. Out of the twenty three respondents, only nine were literate. Even out of these nine, three were school going children and adolescents. Out of twelve female respondents, only two were literate and one was a school going girl. All except one respondent aged over 35 years were illiterate. Out of eleven SC respondents, only one was literate. There were two families in which none of the members, not even children were literate or school going.

Illiterate cannot read a pamphlet, which is how information about private hospitals is disseminated. The perception that the illiterate people from *dehat* had little knowledge about the world around them and could not comprehend things easily, was echoed several times by those who were relatively more educated. This perception has indeed been internalized by people themselves and puts them in a situation where they have little ability to question or negotiate with the provider. One of the respondents, Jagjeevan Prasad was not able to give any details either about the providers he visited or the approximate costs incurred. On probing several times he says he says *"itna hum likhe padhe nahi hain ki yaad ho, humko ek paisa yaad nahi……jab hum padhe likhe nahi hain to kuchh yaad nahi". [I am not so educated that I remember such things.I don't remember a*

paisa…when I am not educated I cant recall a thing] He himself perceives himself incapable of remembering even the name of providers he had visited.

Another instance which brings out the difficulty in disseminating information was seen during the interview with Ram Ratan, a sixty year old gentleman. He had little idea about where he could use the smart card and had eventually got the information after enquiring from several villagers. He had not used the card in the first year of enrolment because he did not know if he could get treatment through the card. Interestingly, while looking at some of the papers, the researcher did come across a pamphlet which had a list of hospitals in the district where they could get treatment. When asked about it, Ram Ratan said that he was illiterate and did not know what was written on it.

Ramkali's husband also articulates the helplessness that the poor, illiterate and aged have to face to utilise a scheme, in the absence of information. Ramkali had recurring muscle spasm and pain in her legs and arms. She visited a number of providers, all of whom were unqualified, informal practitioners. On asking her why she did not go to a qualified practitioner, she replies simply that they just did not have enough money to go to a qualified practitioner. Some of these providers were visited while they had the RSBY card. Ramkali's husband says that the year before, even though they had the card, they did not know where they could get treatment. –

> *"Last year I did not know where what was to be done. 'This year as soon as the card was made, I started finding out where what as to be done… I knew the benefit but did not know where to find the doctor. Some said go here and some said go there. All doctors did not provide treatment under the card… When the last month was left (for the card to expire) then I took the card to Satish's (KMR Hospital) but he said that the date had expired. Now get the card renewed."*

It was after they got information from the ANM and other villagers that they knew they could get treatment in KMR Hospital.

Some of the respondents were just not aware of the condition from which their family member was suffering. Sunita , Puja and Ramkali were not sure what condition they had and whether they were indeed treated for the same condition when they used the RSBY scheme. Ramkali for instance complained that she had muscular pain and therefore went to

the doctor. But her discharge slip and prescriptions show that she was treated for enteric fever (she did have fever too, but her primary complaint was muscular pain). Sunita's husband had spent thousands of rupees in the past three years because his wife complained of increased heart palpitation, shivering of her hands and fainting. However he still did not know what condition his wife had or what kind of treatment was required. In the absence of this basic information the choice of provider is not well informed. Treatment itself is only till there is relief in symptoms until again the symptoms re-emerge and again they look for a provider.

Other Factors Influencing Choice of Provider

There are several other factors that were reported which influenced choice of provider (in the limited context that this choice could be exercised). One of the factors was positive past experience with the provider. This was true in the case of Puja, Preeti, Pyarelal and Ramrati. All of them had previously got treatment at KMR Hospital and were satisfied with their treatment. Hence they claim that even if they did not have the smart card they would have preferred to go that provider.

Others who went to KMR Hospital felt that the private sector hospitals provided better facilities. Puja's father who had got treatment for his daughter at both public and private facilities under the RSBY scheme (first KMR Hospital in Sidhauli and then Balrampur Hospital in Lucknow) says that private hospitals offer greater convenience, better facilities (for staying) and better behavior towards patients. He is also impressed by the latest medical equipment that the KMR hospital boasts. Puja's father says that he would have gone to KMR Hospital even if he did not have the smart card. This is because he had been to the hospital before with his elder daughter and seen their work and was satisfied with their treatment. Ramrati's husband says even if he did not have the smart card and was not enroled under RSBY, he would have gone to KMR Hospital. This decision arises out of his previous experience with the hospital. He recalls that in the past, during illness of other family members, he had had an opportunity to visit the other qualified private practitioners in Sidhauli as well as the district hospital. But his family members had got relief from their problem at KMR Hospital. He says that he had benefitted from the provider (KMR Hosspital) at more than one occasion and had faith in their treatment. On the preference

between public and private providers, he says that it really depends on whose medication suits whom and not about public or private. He gives the example of one qualified private practitioner in Sidhauli who is supposed to be good with problems of children. He also tells about how he had taken his wife to the district hospital because she was complaining of a headache, but they stopped treatment because her condition did not improve. Similar thoughts were echoed by Preeti, who had got treatment from KMR Hospital before and had benefited from the treatment.

Suraj's father gives a pragmatic response to the question of what factors influenced choice of providers. He felt that where one went for treatment really depended on the problem. He gives an example saying that if the problem was serious, it could even take a person to PGI, Lucknow. Suraj's father decided not to get treatment at the private hospital and take his son to the CHC because he was not able to make sense of the diagnosis that was provided by the private hospital.

In the case of Lallan (late) and Samir, the institution was chosen because it was empanelled under RSBY and they were advised to go to that institution by someone they trusted. In the case of Lallan, he had been taken to KMR Hospital with complain of fever and cough. There he had been diagnosed with TB and within a week of being discharged had expired. His wife says that villagers had suggested that he be taken to KMR Hospital since he had the RSBY card. Samir had got a hydrocoelectomy excision done at KMR Hospital and had gone there after the informal provider had suggested to them to use the card and go to KMR Hospital. Samir's father says that they went to the private hospital because they had the RSBY card, otherwise they would have thought of going to the government hospital.
All those who had gone to the CHC had primarily gone there because it was a cheaper option. Hence cost is an important consideration. None of them were aware of the institutions that had been empanelled in their block. Indeed cost considerations mean that for most respondents the first choice of provider is the local informal practitioner. Suraj's father says that they first go to the informal provider (*jholachhap)* since he feels that if a problem can be treated in less money. In his words *"If we can manage treatment within Rs 20-30 why spend Rs 100-200"*. Another villager present there says If one did not have

money, he was bound to go the public hospital. Ramkali who is extremely poor (has *Antyodaya* card meant for poorest of poor), says that she never went to a qualified provider because she never had money. Even if they have some money, they would prefer to go to an informal provider. Another advantage was that they could take their time to repay the informal provider which was not the case with private providers. They went to KMR Hospital because it was an empanelled hospital and villagers had advised them to go there. In the absence of the card, they would not have gone there. Even though cost is an important consideration, it is clear that families can go to any extent if they believe that they can get good treatment, even if at a higher cost. Sultana says that she went to a private hospital, even though it would have cost a lot, because it was a matter of saving her life. Samir's mother says that they would have got good treatment for their son even if it meant selling off their land. Pyarelal, is a Chronic Obstructive Pulmonary Disease patient. He also has a renal condition for which he cannot get surgery, because he has low hemoglobin and is extremely weak. He has already spent large amounts of money on treatment. His wife says that they themselves are willing to spend Rs 30,000, only if there is an assurance that his husband will get cured.

5.2 FINANCIAL RISK PROTECTION THROUGH RSBY-HOW MUCH DOES RSBY SUCCEED

The primary goal of the RSBY is to provide financial risk protection which it does through providing coverage for primarily surgical procedures. The scheme does not exclude pre-existing illnesses and also provides for a nominal travel allowance of Rs 100 to cover indirect expenses to some extent. However some studies have already shown that contrary to popular belief, outpatient care adds to significant financial burden as do indirect costs (Baru *et al*, 2010). The study therefore enquires into OOP expenditure that had to borne by patients on indirect costs. Beneficiaries of the scheme were inquired about treatment seeking, costs incurred prior to using RSBY, costs incurred during hospitalisation under RSBY and post hospitalisation expenses. No specific time frame was kept for providing costs prior to treatment. Respondents were asked to recall how much they had already spent on the treatment of the *condition* for which they had sought treatment under RSBY.

In this study indirect costs include only food and travel as it was easier to remember. Loss of wages was a more complex issue since most of them work in farms or in their homes. Hence it was left out. Some persons have conditions for many years and have visited several providers and were not able to recall details. Figures provided are those reported by the users and are approximate figures.

The table (table 5.2) gives an overview of approximate expenses incurred prior, during and after hospitalisation under RSBY for different patients along with the conditions for which they sought treatment. It also provides information about the treatment that was provided to them.

It clearly shows that a health condition leads to expenses even before and after the event of hospitalisation. Hospitalisation itself, which is covered by RSBY, is not truly cashless for most patients as there are indirect expenses involved that are not entirely covered by the travel allowance provided under RSBY.

It is evident from the table that hospitalisation, which is covered by RSBY, is not truly cashless for most patients as there are indirect expenses involved. The table clearly shows that a health condition leads to expenses even before and after the event of hospitalisation. Several respondents came to the hospital to get treatment for symptoms that had emerged out of chronic conditions. For them the main source of out of pocket expenditure is medicines over a long period of time, and hospitalisation itself cannot provide that. RSBY is limited to cover secondary care hospitalisation events. It does not cover medication for long term chronic condition or conditions requiring outpatient care. Hospitalisation is just an event which has a history as well as future. Free medical attention limited to hospitalisation may help some but largely fails to provide complete financial risk protection.

Respondent Name	Condition/symptoms reported by user for which treatment was sought	Illness Diagnosed/ Treatment Provided (as specified by provider)	Number of Providers visited before RSBY (including qualified and unqualified)	Approximate Amount spent in rupees on treatment *prior* to using RSBY	Approximate amount spent in rupees *during* RSBY treatment (break up where available)*	Approximate amount spent in rupees *after* hospitalisation (till Jan 2012)	Amount booked in rupees under RSBY package
Mangal (Late)	Tuberculosis	Enteric fever	4	40,000###	N.A	Nil	1500
Ramrati	High Fever, body ache	Enteric fever	1	600#	2000 (1st time) (Medicies, Food, Travel) 1000 (2nd time) (Travel and Food)	Nil	1000
Narendra	Swelling in legs and hands	Chronic Hepatitis	5	7000-7500#	1000 (tests and travel) *Travel only=200*	Nil	1000
Chhote Lal	Difficulty in breathing	Fever	1	80-100#	Nil	300	1000
Sunita	Increased heart palpitation, shivering of her hands and fainting	Pain abdomen	4	90,000###	200 (Travel and Food)		1000
Puja	Fever, numbness in leg and hand	Post operation	Nil	Nil	Nil	1700	1000
Ram Ratan	Tuberculosis	Cough and pain in body	2	2000-3000##	N.A	15,000	1000
Preeti	Unknown (mentions Snowphilia)	Enteric fever	8 **##	55,000-60,000**##	400 (Travel)	>1000	1000
Reeta	Pain abdomen	Pain abdomen	3	6000##	100 (Food)	>500	1500

Jagjeevan Prasad	Severe and disabling pain in the stomach, breathlessness and difficulty in movement and active work	Enteric fever	**	>40,000**##	N.A	360	1000
Suraj	Swelling	Abdominal peritalwall abscess/ Abscess Drainage	2	1500#	Nil	300	2000
Ram Charan	Pain in the stomach	Right side Hernia/ Hernioplasty	Nil	Nil	2500-3000 (Food, travel, medicines) *Food & travel only=50*	N.A	7000
Rani	Gluteal abscess	Right Side gluteal abscess/ Drainage of Abscess	Nil	Nil	500-600 (Travel)	450	2000
Lallan (Late)	High fever (was diagnosed as TB positive)	Fever	Nil	Nil	200 (Travel and Food)	Nil	1000
Ramkali	Muscular pain in hands and legs and fever	Fever	6	3000-3500###	300 (Food)	Nil	1000
Pyarelal	Poor function of kidneys and Difficulty in breathing (COPD)	Bonchitis	several**	**	230 (Food)	upto 30,000	1000
Ramesh	Piles and Anal fissure	Piles and Anal fissure/Fissurectomy and Haemorrhoidectomy	1	2500**#	2500 (travel and food)	Nil	11250
Nankai	Pain in the Stomach	Bulky uterus (later hysterec-tomy done)	2	7000-8000###	400 (travel)	> 300	1000
Champa Kumari	Cough, breathlessness and fever (was diagnosed as TB positive)	Pain in chest	3	9250##	600 (travel)	500 -600	1000

Ram Pyari	Hypertension (sleeplessness, restlessness, dizzyness)	Enteric fever	2	200[##]	200 (food)	3300	1000
Samir	Hydrocoel	Hydrocoel/Hydrocel-ectomy excision	2	300-350[#]	Nil	600-700	4000
Kamlawati	High fever , gas formation and pain in the body	Fever	Nil	Nil	30 (travel and food)	Nil	1500
Sultana	Water broke in late pregnancy	Normal Delivery	1	350[#]	50 (medicines/registration)	Nil	2500

NOTE: No specified time frame was given for calculating OOP expenditure.

*Amount after deducting Rs 100 received as Travel Allowance

N.A : respondent not able to recall/data missing

** does not recall as problem exists for past ten years

[#]money spent over past one year

[##]money spent over past two years

[###] money spent over past three years

**[#]money spent over past five years

**[##] money spent over past ten years

Range of Providers Consulted Before Using RSBY

RSBY is a very recent scheme and there is still considerable lack of information about conditions that it covers and health institutions that are empanelled. In case of a health problem therefore, very often people go through a range of providers (including informal providers), end up spending large sums before they find out about the utility of RSBY. There were only five respondents who had straightaway gone to an empanelled institution to seek care (out of these five, two were not aware that the institution was empanelled). While one has to consider that some of the beneficiaries had conditions pre dating the scheme, and therefore it is obvious that they would have gone to other providers, in most cases however, this is the second year that they have the RSBY card. Some of the other providers were visited while they had the card, mostly due to lack of clarity about usefulness and usage of the card. Therefore in majority of the cases, it was found that varying amounts of money have already been spent before seeking treatment under RSBY(See Table 5.2).

Narendra's problem started around the month of June when his legs started swelling. He suffered for about three months, going from one provider to another but without relief and then finally went to KMR Hospital to get treatment. Initially when the problem started, Narendra went to the local informal provider *(provider 1)* in his village, who gave him medicines worth about Rs 80 everyday. Narendra continued this treatment for the next 20-25 days (spending approximately Rs 1500-Rs 2000 on medicines). When his condition did not improve he went to Lucknow Medical College (KGMU) *(provider 2)* for treatment. Far from being free, Narendra ended up paying large amounts of money for his treatment in the government hospital. He says that since he had to buy the medicines from outside, he had to spend a lot of money. About Rs 300 was spent on blood test, Rs 2000 was spent on medicines (for five days) on his first visit and then another Rs 800 was spent on his second visit on medicines for another fifteen days. Since he went to Lucknow twice with another person, the travel cost came to about Rs 400. But he was not satisfied with treatment from there and as he had to travel a large distance for medication, he changed his provider and started going to a private hospital *(provider 3)* in the nearby block town of Misrikh. There he spent about Rs 1500 (out of which Rs 400 was on X-ray and the rest on travel and

medicines). When his condition did not improve there either, he was suggested by an informal provider in his village to visit a qualified practitioner *(provider 4)* in a place called Jargawan. There he spent about Rs 500 and had medicines for about 15 days. But as soon as he stopped his medication, his problem started again. He went to the nearby PHC *(provider 5)* once (spent Rs 20) around which time he was advised to visit KMR Hospital in Sidhauli by his acquaintance. Therefore after having visited a number of providers and with little improvement in his condition, he visited KMR Hospital *(provider 6).* Hence Narendra had already spent between Rs 7000-7500 before he actually reached an empanelled institution. Even after reaching the hospital he ended up spending about Rs 800 (ultrasound and blood test), because he was not aware at that point that he could use the RSBY card in the hospital. At KMR Hospital he was diagnosed and treated for chronic hepatitis.

Similarly Sunita who had symptoms like increased heart palpitation, shivering of her hands and fainting (exact illness not known) went to several providers in the past three years. The first time she complained of this problem, she was taken to the local informal practitioner *(provider 1).* However he told Sunita's husband that he would not be able to manage her condition and that she should be taken to a hospital. They had to spend about Rs 200 on medicines by the informal provider. The very next day her husband took her to SK Hospital *(provider 2),* a private hospital in Lucknow. There she was hospitalized for nine days and the entire hospitalisation cost Rs 20,000. Subsequently she was hospitalized again twice in the same hospital, once for a week which cost them Rs 13,000 and then again for eight days which cost them Rs 20,000. Sunita's husband says that if he includes the indirect expense on food and travel while his wife got treatment in that hospital it would easily be Rs 1,500 to 2,000 every week *(about Rs 5,000).* They also went to a well known government hospital in Lucknow-Lohiya Hospital *(provider 3),* where they got treatment for around four months and the entire treatment cost them about Rs 15,000. Sunita's husband says that although it was a government hospital, they had to get most of the medicines from stores outside. Since medicines were expensive, they had to spend a lot of money even though they got treatment from the government hospital. He says that every time he went he would have to spend Rs 1000 to 1200 on medicines, and the first time he

went there, he had to spend Rs 2000 for only two days worth of medicines. Total cost of travel during the treatment was about Rs 1500. Other than this, Sunita had also been hospitalized in another private hospital in Lucknow *(provider 4)*, where treatment cost about Rs 15,000. It is also important to mention here that they own 30 *bighas* of land which has been given to sharecroppers. So they cannot fall in the BPL category. But the productivity of land is very low in this village because the soil is sandy in nature. Hence they seem to be a family that is not strictly BPL, but also not rich despite owning large amount of land.

On being asked if he feels the scheme has benefited him, Sunita's husband says that it is little use since he still has to borrow money for treatment and literally beg for money from his relatives.

> *Fayeda hum ko kya hua jab hum bheekh mangat ghoomein hain. Dubara le gaye dawa nahi karte hain. Fayeda kya ek do hazar ka jab 30,000 dawai par manauta hai. Jab humka is se us se bheekh mangna pade to fayeda kya 2 hazaar ke liye?*
> *[what is the use when when I have to go about begging for money. When you go (to the hospital) for the second time, they do not provide (free) treatment. What is the use of (treatment worth) one or two thousand rupees when I have get medicines for Rs 30,000. When I have to beg (for money) what is the use of (treatment worth) two thousand rupees]*

Expenses During Hospitalisation Under RSBY

Even though Rs 100 is provided as travel allowance, it was found that indirect costs on travel and food exceed this amount. RSBY in that sense is not truly cashless for most. There were only four persons out of twenty three who either had no expenditure on travel and food or the expenses were covered by the Rs 100 travel allowance that was provided. (see Table 5.2). After deducting Rs 100 travel allowance (for those who got it), seven respondents spent Rs 200 or less on indirect costs, four respondents spent more than Rs 200 and less up to Rs 500 , three respondents spent more than Rs 500 upto Rs 1000 and one respondent reported spending about Rs 2500 on indirect costs.

Post Hospitalisation Costs

The cases clearly show that costs do not end with hospitalisation. Since RSBY primarily provides for surgical procedures, it was found that patients needed to go back several times for dressing or getting stitches cut. This can be seen in the case of Suraj, Samir, Rani and Reeta all of whom had surgeries. Suraj had to got to the CHC every alternate day or so for dressing. Travel expenses for him came to about Rs 300. Samir had got five day's medicine after his hospitalisation free of cost (as provisioned in the scheme). Thereafter he had spend money out of their pocket to get medicines. After the surgery Samir's family spent approximately Rs 600-700 on medicines. After Rani got drainage of her abscess, she had to go every second or third day for dressing to the CHC with her parents. Rani's parents spent about Rs 400 out of their own pocket on travel after the hospitalisation.

It is not only the cases that have had surgery, but also cases where patients suffer from chronic illness that there are continuous expenses after hospitalisation. Ram Pyari suffers from high blood pressure (Hypertension) for the past two years. She was admitted in KMR Hospital under RSBY because she complained of restlessness, dizziness and was not able to sleep for fifteen days. Although she got relief from her immediate problem (sleeplessness, dizziness), her medication related expenses continued thereafter. Ram Pyari says that while she was on medication, she was fine, but her problem retuned once she had finished with her medicines. She therefore went to visit the doctor (KMR Hospital) again. But she was told that they could provide free treatment only if she was admitted and since her condition was not serious they could not admit her. Neither Ram Pyari nor her husband were aware of the fact that the RSBY card is applicable only in case of inpatient care. Since she could not get free medication, she had to spend Rs 250 on medicines and Rs 40 on travel. After this Ram Pyari did not go back to KMR Hospital since she felt that she was not satisfied with their medication and because she could no longer get free treatment there. Next she went to a different private provider in Sidhauli . Here she continued medication for about a month and spent Rs 3000 on medication.

Sunita too continues to spend large sums of money on her medication after the hospitalisation. She is currently under the treatment of the same hospital where she was admitted under RSBY. At the time of interview she had already been under mediation for

the past five weeks. For every two weeks, the cost of medicines is about Rs 800. Since they do not have direct conveyance available to the hospital, they have to hire a vehicle which costs them about Rs 200 every time they visit the hospital. In five weeks therefore Sunita's treatment had cost the family a total of Rs 3000.

5.3 USER EXPERIENCE AND PERCEPTION ABOUT QUALITY OF CARE

The study also aimed to understand the perception of the users about quality of care they received when they sought treatment. The responses show that the perception of quality here includes their experience of staying in the hospital while they were admitted, immediate and regular attention provided by doctors to them at the time of need, providing the kind of medicines they feel is effective, behavior of doctors and staff with the patients and their family and finally the ability of the doctor to treat the ailment or provide relief. Perception about quality is largely about the private provider since twenty out of the twenty three respondents had visited this provider. Although there are only three respondents who had visited the public provider there were other opportunities where people presented their perception about quality of treatment at government hospitals.

Experience and Perception About Quality of Treatment at KMR Hospital

Users of the private hospital had both positive as well as negative experiences to recount. Sultana for example had a positive experience to recount about her treatment at KMR Hospital. Sultana had gone to the hospital during her pregnancy after her water had broken. Sultana and her husband both were very satisfied with their experience in KMR Hospital. Sultana says that she was admitted immediately. Every hour someone came and asked her if she was having any problems. A by stander says that whether one has the RSBY smart card or not, people prefer to go to KMR Hospital as no one can do a better job than them. Another person says that they do things quickly without taking much time. Sultana's husband says that even though they charge money, their work is good.

Narendra also had a positive experience in KMR Hospital. Narendra had swelling in the body especially in his legs. He had been to five different providers (both qualified and unqualified) before he came to KMR Hospital. It was another informal provider who had

recommended him to got to KMR Hospital. Although initially he was not aware of the hospital being empanelled under RSBY, he was eventually able to get treatment under RSBY. He was diagnosed and treated for hepatitis at KMR Hospital. He says that none of the providers were able to provide him relief from his problem. It was only after he got medicines from KMR Hospital that he got relief from his problem. Narendra says that he has not had to consult any other provider since his treatment in KMR Hospital.

Others like Rampyari, Nankai, Preeti, Sunita and Puja said that while they got relief (from their symptoms) while they were under medication, their problem returned again later.

There were others who were not satisfied with the treatment provided at the hospital. Dissatisfaction was expressed by Durga Devi, the wife of late Lallan. Talking about the condition of her late husband Lallan, she says that her husband had had high fever, cold and cough for about over a week. She was advised by some of her villagers to use her smart card and get treatment from Ashish Hopsital. Lallan was admitted there for two days after which he was discharged. He was given medicines for five days (as mandated by the scheme) and then asked to come at the end of five days. But five days into being discharged from the hospital, Lallan died.

Durga Devi expresses her dissatisfaction at the treatment provided at the hospital. She is not convinced with the diagnosis of the problem her husband had. She was told that her husband had TB. She says that she knows what a TB patient looks like, unlike her husband who was very strong and healthy. She stresses this point, saying that he could easily lift heavy weights like sacks full of grain without any problem. She does not therefore believe that her husband had TB (and therefore is probably suspicious of whether or not the right treatment was provided to her husband). She says that although X-Ray and sputum tests had been done for her husband, she was not given the reports. She had asked the doctor for the X-Ray and reports, hoping that she could take those test reports to another doctor to get another opinion on her husband's condition. However she had been told by the doctor there that in their hospital reports were not provided to the patient. Another reason for her dissatisfaction was that her expectation from the provider in terms what she felt was the right way of treatment was also not met by the providers. She complains that the doctors took admission but not even one touched the patient's pulse to see how he was. She says :

"jab paise roz ke do do hazar leo, tab kya nadi pakad kar ke nahi dekh sakat ho mareez fayada hai ki nahi"[when you (the hospital) charge as much as two thousand rupees for a day, should they (doctors) not atleast check his pulse rate to determine if the patient was alright]

Ram Kali, says that although she was satisfied with the medication as it gave her relief, she was unhappy with the behavior and facilities at the hospital. (Interestingly she was admitted and treated for enteric fever according to her discharge slip and not the pain in the leg that she had been describing as the health problem for which she sought treatment.) Her health problem started over two years back. She would have recurring muscle spasm and pain in her legs and arms. Whenever this would start, she would have to give up all household chores and rest. Sometimes she would get medicines from the local informal provider. There was temporary relief while she had the medicines, but the pain would return later. She visited a number of providers, all of whom were unqualified, informal practitioners. Ramkali went to a number of providers and had to spend substantial amounts of money. Some of these providers were visited while they had the RSBY card. It was after they got information from the ANM that they visited KMR Hospital.

Describing her experience in the hospital, Ramkali says that they provide 100-250 grams of food, which is not enough for her. When her husband requested the doctor for more food, he snubbed them and asked how hungry could his patient get that she could not be satisfied with the amount of food provided -*"tumhara mareez kitna khaata hai? Kitna tumhara mareez bhookha rehta hai"* . She says that she was not provided with the X-ray ; when she asked for it she was literally shooed away by the computer operator. Ramkali says that she addressed her (the computer operator) as *'bitiya'* and requested her for the report, but the computer operator *said "bhak chal, chal nikal yahan se…bhag yahan se"* . *[get lost..go away from here]*. She also narrated another instance of bad behavior by the doctor*:*

When they gave us medicines, when I was being discharged, I asked the doctor "doctor sahib aap humko takat ka injection likh deo ,nahin dei deo, koi syrup dei deo, to piye karbe. To humse doctor Ashish bole, kahin ke –abhi tumko gadda

denge" I asked him to give me some syrup that I can drink but he said that abhi tumko gadda denge, le jaana.

[doctor sahib please write me an injection or give me a tonic for strength. So Doctor Ashish tells me- I'll give you gadda (a vegetable), take it]

Experience and Perception About Quality of Treatment at CHC Sidhauli

There were only three users who had gone to the CHC between July and October. This was also because the RSBY software in the CHC was not working between April and August. Some RSBY card holders who visited the hospital during this time could not get treatment under RBY. Out of the three patients one was not satisfied with the treatment. Rani a seven year old had been injected (in her gluteal region) and had developed an abscess. According to doctors in CHC the injected medicine had not been absorbed by the body and hence had turned into an abscess. The injection had been administered by an informal provider when she had fever. Rani's parents took her to the government CHC in Sidhauli for treatment primarily because it was a cheaper option than private providers. There they were told that it would require a minor surgery (drainage of abscess). Although Rani's family had the RSBY card at this point they did not know where they could get treatment under the scheme or the providers from whom they could get treatment. The doctors at the CHC themselves enquired from them if they had an RSBY card and told them that they could get treatment through the card. Despite getting treatment under RSBY, Rani's family had to spend money from out of their own pocket during their treatment at the CHC. They had to buy some of the medicines, spend money on travel as Rani had to be taken for dressing several days after the operation and they were not given the mandatory travel allowance of Rs 100. On asking Rani's mother where she would go if she had to seek treatment again, she says

"I will not go to the government hospital… They don't take good care. Now my daughter was unwell. She got treatment for ten days but still did not get cured.…..10-15 days after the operation there was again swelling in the abscess, she(Rani) could not even sit. We thought what was the use if the problem was not cured. We had spent money already. It could turn into a gangrene."

Therefore fearing that Rani may develop a gangrene they took her to an informal provider and it was his medicines, according to Rani's mother that helped her daughter to get well. She also mentions that the staff in the hospital do not talk properly and scold them.

Ram Charan a 65 year old gentleman had had a hernioplasty done at the CHC. In this case too, it was the doctors who enquired if he had the RSBY card and told him that expenses would be covered through the card. The reason behind choosing the CHC was that he felt there were good doctors there, it was a cheaper option and it was closer to his home compared to Sitapur or Lucknow. About services in the hospital, Ram Charan was satisfied with the treatment and says that there were good facilities – *"badhiya suvidha rahi"*. Although he was treated under RSBY, he was not provided with travel allowance and he had to buy some of the medicines.

Suraj, a 16 year old , got an abscess drained at the CHC under the RSBY scheme. Initially when the problem started, Suraj got treatment from an informal provider for nearly a month. When the problem persisted, Suraj's father decided to take him to KMR Hospital. This decision was supported by the fact that he had the RSBY card. Already about three to four people in his village had got treatment from this hospital under the RSBY scheme. Therefore it was the first choice for him. When he went there, he was told that it was not a serious problem as it there was accumulation of flesh. Nathu says that he was not convinced with the diagnosis and therefore decided to get treatment elsewhere. He himself decided to get an ultrasound done for Suraj from a private provider, took the report and went to the CHC. At this point however he did not know that the CHC also provided treatment under the RSBY scheme. He came to know this when he saw the RSBY signboard there and enquired about it from a senior doctor. Suraj was diagnosed with an internal abscess that needed to be drained surgically. It was a day care procedure and Suraj was released on the same day. He did not have to spend any money on medicines, as the medicines he was provided, lasted for about eight days. However he was not provided the travel allowance of Rs 100 which is mandatory under the scheme. There were also post hospitalisation expenses as he had to come every alternate day or so for dressing. Suraj's father says that he is satisfied with the treatment and the facilities he got in the CHC.

While the researcher was taking the interview, a discussion ensues with the other villagers present there, one of whom says that at government hospitals they only handed a few tablets that lasted for two days, after which they had to buy medicines from outside. To this Nathu disagrees and says

> *This is not the case, what you (others) are saying is not right. I have never got treatment anywhere but in government hospital in my life, not seen medicine from any other place* (implying that they provide good treatment).

5.4 SEEKING TREATMENT UNDER RSBY: WHO BENEFITS

RSBY beneficiaries who had utilised the scheme were asked whether they felt the scheme had indeed benefited them. The response was mixed. RSBY is indeed useful for persons with a certain kinds of problems, mostly pre-existing illnesses where a surgery is required or emergency conditions requiring hospitalisation. But as it can be seen from the list of respondents, out of twenty three cases only four cases required surgery (2 drainage of abscess,1 hernioplasty,1 Fissurectomy and Haemorrhoidectomy) and one was a case of normal delivery. It is to be remembered that RSBY as a scheme, is primarily aiming to provide secondary level care by inclusion of list of (mostly) surgical procedures that require hospitalisation or day care and lead to large out of pocket expenses. There is also one category under the RSBY package namely 'General Ward', which provides for two days of hospitalisation for some chronic conditions as well as infectious diseases that mostly require outpatient treatment but sometimes need hospitalisation. Some of the diseases included in this category are asthma, bronchitis, typhoid, malaria, pneumonia, diabetes, diarrhea and hypertension. The respondents therefore have only five cases of persons with conditions that RSBY as a scheme primarily aims to cater to. The rest fall under 'General Ward', chronic conditions and conditions requiring outpatient care that is not RSBY's primary goal. Perception of whether the scheme was useful was to some extent dependent on the condition for which treatment was sought.

Perception of users with conditions requiring surgery

As already mentioned, there were only four respondents who underwent any form of surgery. Out of these, three were in the public hospital and one was in the private hospital.

The case of Samir demonstrates how the scheme was useful in providing surgical care free of cost in a private hospital. Samir was operated for Hydrocoele under RSBY. His problem had started about a year back but he had not told anyone about it out of embarrassment. Only after the problem had aggravated to a point that he was not able to walk properly, his mother had noticed and asked him about it. It was then that he had shared his problem. He had worked in a box making shop earlier. While shifting some heavy wood he had been hurt by another boy and since then he had the problem. Initially his family took him to a well known qualified private practitioner in Sidhauli. There they got treatment for about two weeks and spent about Rs 200-Rs 250 in the process (including medicines and travel). But since there was not much relief and the medication was expensive they could not continue it. Thereafter they consulted two other informal providers but got little relief. It was then that one of the informal providers himself asked them to use their smart card and get treatment in KMR Hospital. Since they were not sure how and indeed whether the scheme actually worked, Samir's father went to Sidhauli to the hospital to enquire if the card could be used there. After being satisfied that he could indeed get treatment (surgery) for his son through the scheme, he took Samir there. The surgery was done and Samir was admitted at the hospital for two days after which he was discharged. Although they got five days worth of medicines as well as Rs 100 travel allowance, they had to incur post operation expenses. Samir's parents feel that the scheme has benefited. Answering the question about whether the scheme has benefited them, Suraj's father says *"Fayeda hua hai. Humko 2-2.5 hazar lagana padta….sarkar paisa dee, humko yehi fayeda hua" .[It has benefited. We would have had to spend 2 to 2.5 thousand rupees out of our own pocket whereas the government paid for the treatment]*

Suraj had got an abscess drainage done at the CHC. On asking whether he thinks the scheme has benefited them Suraj's father says that it was beneficial as the money that would have been spent out of their pocket is now provided by the government - *There is benefit in that suppose a poor person would have to spend Rs 2000 on operation but that money is being given by the government. That is the benefit what else.*

Sixty five year old Ram Charan, who got a Hernioplasty done at the CHC feels that it is a useful scheme since he did not have to spend any money for treatment, even though he had indirect expenses of about 2500-3000 rupees.

Seven year old Rani'**s** mother is not satisfied because she even after her daughter got her abscess drained, the problem persisted.

The advantage of using RSBY in a government hospital is to the extent of not having to pay the user fees. Ideally any money spent on medicines (for five days after the surgery) and tests have to be reimbursed if the CHC cannot provide it. But these patients reported having to spend money from out of their pocket on medicines. The travel allowance was also not given. Yet they believe that the scheme was useful because it saved them some out of pocket expenditure. The scheme however is beneficial for the provider. In the ordinary course, if the patients did not have the RSBY card, the abscess drainage procedure would have cost them Rs 67 (user fees) and the hernioplasty would have cost R 400. Under RSBY, the CHC is reimbursed Rs 2000 for abscess drainage and Rs 7000 for hernioplasty.

Perception of Users Requiring Emergency Hospitalistion

Some of the patients came to the hospital needing emergency hospitalisation. Ramrati had to be hospitalized twice within a the same month, due to extremely high fever. The first time she had fever, the temperature was so high that she was delirious and reacted violently if any body even touched her, recalls her husband. She was rushed to KMR Hospital is Sidhauli. Although they had the RSBY smart card, it could not be used because the computer operator was not available at night and the system was closed. She was admitted as a private patient and had to spend about Rs 2000 from out of their pocket. Although her condition had improved initially, after a little more than two weeks, Ramrati again came down with high fever and was hospitalized again in KMR Hospital under RSBY. Ramrati's husband's perception about the benefit from the scheme is positive. He felt that it was a good scheme especially for poor people like him *"Hum logon ke liye, garibon ke liye acchi hai (yojna)".[For poor people like us it is a good scheme]*

Sulatana who had a normal delivery in the private hospital after her water had broken, was also happy to be enroled in RSBY. She says that her life was saved and she did not even have to spend money – *"..humari jaan hi bach gayi aur paisa bhi nahi laga"[my life was saved and (I) did not even have to sped a paisa]* Her husband says that in the ordinary course of things, they would have had to pay five to six thousand, but because of being enroled in RSBY, they did not have to spend any money.

There were also cases where people were suffering from chronic conditions but needed emergency care. One such case was that of Chhote Lal. Chhote Lal suffers from a respiratory problem (possibly asthma/bronchitis). He says that the problem started about a year ago. He attributes his respiratory condition it to his regular intake of *ganja*, a habit he says he has quit after his problem started. Initially he would go to the nearby informal practitioner and be given injection costing Rs 20. One the day that he had got hospitalized, he had an asthma attack and had extreme difficulty in breathing properly. One of the persons from his community suggested to him to use his card and get treatment in KMR Hospital. Sidhauli is 26 Km from his village and is the nearest town to get proper medical attention from qualified private practitioners. He was rushed to the hospital where he was immediately admitted. He remained hopitalised for two days after which he was discharged along with medicines and a travel allowance of Rs 100. This was enough to cover the travel cost that he had incurred (about 60 rupees for two persons, two and fro). Chhote lal feels that if it had not been for timely treatment in the hospital he would have died. *"Agar wahan nahi jate to mar jaate".[If I had not gone there, I would have died]* He is also very satisfied with the treatment he got there *"Teen din bharti rahe, khoob aaram mila" [I was admitted for three days. Was greatly comforted]*. Others present there also commend on the good quality of treatment that was provided at the hospital.

Similarly Ram Pyari who suffers from high blood pressure (Hypertension) for the past two years had to be hospitalised. A few months back she started feeling extremely restless, dizzy and even fainted. The biggest trouble for her was sleeplessness. Ram Pyari says that she was not able to sleep for over two weeks which caused her headache, ache in limbs and a general sense of uneasiness and panic. Initially she went to an informal provider and then

to the CHC. But even after medication she did not get relief from her main problem- sleeplessness. It was then that she decided to go to KMR Hospital. Ram Pyari's husband says that they thought of going to KMR Hospital only because they had the RSBY card, otherwise they do not have the money to get treatment there. Ram Pyari's husband says that they have benefited from the scheme as they got treatment worth about Rs 2000. Ram Pyari feels that the scheme was beneficial to the extent that she was able to get relief through treatment there. Her sleeplessness was cured at a time when she had not been able to get sleep for nearly fifteen days.

Although RSBY primarily caters to surgical procedures, the space within the scheme which was able to provide opportunity for these patients to get treatment is helpful. However the usefulness is only to a limited extent as the scheme is useful only if the illness worsens to an extent where one may need hospitalisation. It does not help the patient to manage the condition through treatment and medication. The above two cases of Ram Pyari and Chhote Lal show the limited relevance of the scheme for them.

After her hospitalisation Ram Pyari had returned to the hospital with the hope of free treatment of her condition. She did not know at that point that the scheme was only meant for conditions requiring inpatient care. Since she could not get free medication, she had to spend Rs 250 on medicines and Rs 40 on travel. After this Ram Pyari did not go back to KMR Hospital since she felt that she was not satisfied with their medication and because she could no longer get free treatment there. She went to another private provider in Sidhauli from where she continued medication and spending money out of her pocket. She expresses her dissatisfaction by remarking remarks that only when one is about to die, the scheme can be useful- *"jab marne ki halat ho jaye, tab jao to fayeda hai"[if you are in a near death situation, then it (RSBY) is useful]*

Chhote Lal also went back to the hospital in the hope of free medication and treatment since he did not know at that point that only inpatient cases could be treated under RSBY. On his second visit, he was told that he would have to pay three hundred rupees for the medicines. He requested them to deduct the money from his RSBY card as he did not have the money to pay for medicines. He was then advised by the hospital to go to the

government hospital (CHC) and get medicines since the card did not allow him to get only medicines. Currently therefore he gets medicines from the CHC in Sidhauli.

Perception of Users With Chronic Conditions

Most of the respondents who were treated under RSBY either had chronic conditions that require long term treatment or conditions requiring outpatient care and medication. Most of the respondents who went to the hospital with their card did not know that the scheme was meant for only conditions requiring hospitalisation. The expectation of free treatment with which they went to the institution was therefore not met. Some of the patients therefore were dissatisfied because although they got hospitalized, it did not eventually help their health condition.

Sunita'**s** case demonstrates how large medical costs can be a financial calamity for a household. Her problem started some three years back when she started complaining of increased heart palpitation, shivering of her hands and at certain times would faint. According to her husband there were times when Sunita's condition became so severe that she would not be able to talk or eat for eight to ten days. Since then, they have spent thousands of rupees to treat and been to several providers, but to little avail. Sunita had been to four different providers (1 informal, 1 public and 2 private) before using RSBY. She had been hopitalised four times (all times in private hospital) and spent about Rs 90,000 in her hospitalisation and treatment in the past three years. Her husband informs that their land has already been mortgaged and speaks sadly about not being able to provide his children any education. Sunita's husband says that he enroled in the scheme thinking that if he got treatment through it, it was good, otherwise he would just continue the same as he was. So he was not entirely sure if his wife could get treatment under RSBY. Some of his villagers had told him that he could get treatment in KMR Hospital. One of his relatives in Sidhauli, enquired from KMR Hospital and informed him on phone that the card could be used there. Thereafter he took his wife to the hospital. Subsequently she was hospitalized in the same hospital once more under RSBY.

Sunita's husband recalls that the first time they went to KMR Hospital (provider 5), his wife was admitted for two days under RSBY. But the second time they went there, he was

told that his wife did not have any problem and could not be admitted. *'If there was no problem (illness), why am I spending so much money?'*, he rues. He was told that he could stay for the day, but would have to pay privately for it. When her condition did not improve till night, Sunita was admitted for the night and was therefore charged through RSBY. While she was provided five days medicine the first time his wife was hospitalized, thereafter he has to spend on the medicine and travel himself. He is currently under the treatment of the same hospital for the last five weeks. For every two weeks, the cost of medicines is about Rs 800. Since they do not have direct conveyance available to the hospital, they have to hire a vehicle which costs them about Rs 200 every time they visit the hospital. In the five weeks that she had been under treatment, Sunita's treatment had cost the family a total of Rs 3000.

While large amounts have been spent on the treatment of Sunita, her husband was not able to tell the exact illness that his wife had been diagnosed with. He says none of the doctors actually told him what his wife was suffering from. Even at KMR Hospital, he was merely told that he would have to continue medication, but not what the problem was.

On being asked if he feels the scheme has benefited him, he says that when he has to spend from his own pocket on medicines and literally beg in front of his relatives, he does not see how the scheme has benefited him. He says that when he has to spend large amounts like Rs 30,000 from his pocket, treatment of Rs 2000 in a hospital does not really help him –

> *"Fayeda hum ko kya hua jab hum bheekh mangat ghoomein hain. Dubara le gaye dawa nahi karte hain. Fayeda kya ek do hazar ka jab 30,000 dawai par manauta hai. Jab humka is se us se bheekh mangna pade to fayeda kya 2 hazaar ke liye?"*
> *[what is the use when when I have to go about begging for money. When you go (to the hospital) for the second time, they do not provide (free) treatment. What is the use of (treatment worth) one or two thousand rupees when I have get medicines for Rs 30,000. When I have to beg (for money) what is the use of (treatment worth) two thousand rupees]*

Ram Ratan is a Tuberculosis (TB) patient but currently, he is under treatment from a private provider in Sitapur. He got treatment from a whole range of providers, before settling down to get treatment from the current provider. He had already been to an

informal provider and the PHC. Only when he felt there was little improvement in his condition, he thought of finding out whether the smart card could actually be used and where he could use it. He did not know about empanelled institutions or conditions which could be treated under RSBY. He enquired from his villagers and some people told him that he could get treatment in several hospitals. He chose KMR Hospital because it was closer to his home than other hospitals. He was admitted there for two days after which he was told that he could not get treatment under the scheme for his condition. He is currently getting treatment from a private provider and has to spend large sums of money. When asked whether he thinks RSBY is a beneficial scheme, he claims that the scheme is of little use he did not get any benefit out of it.

Similar is the case of Champa Kumari who is also a TB patient. Champa Kumari is 58 year old lives with her husband and an adolescent daughter. Champa Kumari was suffering from symptoms of TB for the past two years, but only about three months back they came to know that the condition she was suffering from was TB. Earlier private doctors they visited had either not diagnosed or not cared to explain to this couple about the condition Champa Kumari was suffering from. After they had been to several private providers, borrowed and spent substantial amounts of money, they tried seeking advise about what they could do, and whether the card could be any use. They were not sure where they could get treatment from the card. They were advised by the pradhan and educated people in the village to go to KMR Hospital in Sidhauli and make use of the RSBY smart card. However when they went to KMR Hospital, they were refused to be admitted under RSBY (this is probably because RSBY only covers cases that require hospitalisation). Champa Kumari had very high fever and severe cough when she was taken to the hospital. Her husband says that since his wife was in a serious condition, he could not have taken her back even if it meant a lot of expenses to get treatment there. He says that he had gone there expecting free treatment, but when did not get it he could not have just let the patient die, so he had to get treatment even if it meant borrowing money. His relatives who were there told him that they would help him with the money, so he borrowed money from them. He had to spend Rs 700 from his own pocket. Thereafter he came back to his village and told his *pradhan* that he was not able to get treatment under the card and requested him to come to

the hospital and talk to the doctors. On the request of Champa Kumari's husband the pradhan went to the hospital and requested the doctors to admit her under the scheme since she was very poor and could not afford treatment. The doctors then admitted Champa Kumari. She was in the hospital for three days after which the doctors advised them to go to the government hospital. They were told that Champa Kumari had TB and if they got treatment from the government hospital it would be free whereas if they got treatment at their hospital, they would have to spend hundred rupees per day. Since they were poor they would not be able to afford the treatment. Therefore on the advice of doctors from the private hospital, Champa Kumari was taken to CHC Sidhauli for treatment. Currently Champa Kumari is on DOTS treatment and has shown improvement. On being asked whether they thought the scheme was useful, Champa Kumari's husband felt that it was not useful for them because they were not able to get treatment under the scheme for their problem.

> *"Is card se hum kya fayeda bataein. Agar hum ko is se fayeda mil gaya hota, humko kahin jana nahin padata, to hum samajhte is se humara kaam ho gaya hai……is se hum ko koi fayeda nahi mila"[What do I say about benefit from the (RSBY) card. If I had benefited from it (the condition had improved), if I did not have to go anywhere else (to any other doctor), I would have thought it was useful for me…I did not get any benefit from it]*

However when asked if they would think of renewing the card, Champa Kumari's husband says that he would, because at least he got treatment worth some amount through the card, and got admitted in a hospital for three days without having to pay for it. Even if it was a thousand rupees, it was a lot for a poor man like him. He gives the analogy that if a man eats three meals a day, and someone provides him one meal, even that is some benefit. Implying that even if RSBY did not help him with the problem he sought treatment for, at least he got some free treatment.

The same thought, that even though hospitalisation eventually did not help the condition, they got *treatment worth a few thousand rupees* was echoed by several other respondents. Puja's father says that they were charged a thousand rupees from their RSBY card, but

the services provided were worth it . He says that he did not have to pay for X-Ray, blood test, and they were given five days extra medicines as well as a travel allowance. Kamlawati who had been hospitalised because she had very high fever , gas formation and pain in the body, feels that she benefited only as long as she was in the hospital and got medication. Since she cannot get medication any more she again feels sick. Her family however says that they have benefited from the scheme as she was admitted for three days free of cost and they got five days worth medicines and travel allowance. On being asked they have benefited from enroling in the scheme, Nankai**'s** husband says he has benefited since the government paid for the treatment . He feels that he can use the card again if his children or he falls ill and he does not have money to get treatment. About whether the scheme has benefited her, Ramkali says "*the benefit is that we got treatment worth Rs 1000. We got medicines and hundred rupees*." Ram Pyari's husband says that they have benefited from the scheme as they got treatment worth about Rs 2000. On whether they think that RSBY is a beneficial scheme, Preeti's father says that it is beneficial if someone has a health problem and does not have money for treatment.

5.5 RSBY IMPLEMENTATION-SOME GROUND REALITIES

While the study does not aim at finding out the details of whether the scheme is being implemented well, it clearly is an important aspect which affects users and their experience of using the scheme.

One of the most important shortcomings in implementation was lack of proper information dissemination. Other than one respondent, none reported that that they had received a pamphlet with information regarding places where one could seek treatment. The strategy of providing pamphlets itself has to be scrutinized in a context where large number of persons are not literate. As was evident from the case of Ram Ratan, even if people have a pamphlet, it is likely that it will not be read. More ways of providing information about empanelled institutions, about how the smart card is to be used; and conditions which can be treated under this scheme have to be devised. It was also seen that the CHC did not have a display board about RSBY outside the hospital. Such forms of information are crucial as was seen in the case of KMR Hospital where a number of patients went because they saw the signboard about RSBY.

Another discrepancy is the delay in providing smart cards. The scheme envisages provision of smart cards to the user at the time of enrolment. However it was reported (Rani and Preeti) that the card was provided one to two days later.

Another problem is the BPL list itself which forms the basis of selecting the beneficiaries. Currently the central government list is being used which is based on the last BPL survey done about a decade ago. This obviously leaves out persons who may have been married or born after the survey was done. The exclusion of poor families and inclusion of families not falling under the BPL criteria are another problem. For instance in the case of Ram Ratan, who jointly owned 18 *bighas* of land with his brother a well as mint oil extraction equipment, the inclusion in the BPL list was clearly not warranted. The family of Rani, which owned about 18 *bighas* of land and makes an income of about 1-1.5 lakh in a year out of their farm are clearly not a BPL household. This problem has been highlighted in the evaluation studies of the MoLE itself

In the case of the CHC, none of the three respondents who had got treatment there, received travel allowance. Suraj's father says that although he knew about it, he did not ask for it and neither did any one give the travel allowance.

In one of the villages, the villagers spoke about fraud that had taken place during, enrolment the previous year.

> "*Last time (previous year) some people had paid Rs 500 to get the crad made, but later they found out that these were fake cards as codes of other district had been fed in. In two or three places we got to hear that this had taken place. In some places we got to hear that there was physical violence when people came to know this was happening. Those people (card providers) went off but did not refund the money. They had made cards for those who were not in the list."*

In the same village it was also reported that there was a case where a lady had got a tumor surgery done, but later it was found through consultation with other doctors that the surgery was not needed. The negative perception about the scheme was also articulated by

a person *"There is a lot of misuse of the scheme going on . They do surgical procedures that are not required or charge more than Rs 30,000 or provide treatment of one amount but use up more money from the card."* Although he was not able to substantiate all these charges with any examples (other than the one where a woman in their village had got an unwanted tumor operation) and had heard such rumors from others, it shows the general perception about the scheme.

There were a lot of discrepancies reported by the providers as well. The biggest problem reported was delay in reimbursement of claims. It was reported that the reimbursement took as much as six months in some cases, whereas the scheme provides for payment in twenty one days, by the insurance agency. Another problem stated was that the TPA's had asked the hospitals to keep photocopies of BPL ration card and photographs of the beneficiary, both of which are not required by the scheme and defeat the purpose of paperless transaction. It also means extra cost and inconvenience for the users who have to spend money on a passport size picture and sometimes go back to their village to get the ration card.

Another problem being faced by the providers, is having a fulltime staff dedicated to RSBY for twenty four hours. In the CHC the work is managed by the clerk. Since the number of patients coming for RSBY is very low and there is no separate provision for salary of the extra staff, the CHC is not able to provide one. In the private hospital, although there is a computer operator who manages RSBY work, she cannot be available at night. As a result in one of the cases (Ram Rati), when she was brought in to the hospital at night with high fever, there was no one competent enough to use the smart card technology and register the patient. For that night therefore, Ramrati had to pay private hospital charges despite having the smart card.

DISCUSSION and CONCLUSION

Health financing is one of the critical determinants of access to health care in a country. Health Insurance is one of the many ways of health financing available. There can be varying role of the state in financing and provisioning of health care in different types of health systems. Health insurance itself can have varying degrees of state involvement. Germany for instance presents the example of Social Health Insurance where the state plays a significant role. The state is responsible for pooling of funds and regulation of sickness funds. The US presents a model where the state plays a minimal role. It provides insurance for the poor and elderly while all others buy private insurance. The role of the state vis-à-vis the private sector in financing and provisioning of health care is an indicator of the dominant ideological framework within which health is placed. Larger role of the private sector is associated with 'patient sovereignty' where priority is given to choice. It is meant to provide patients the ability to choose between providers as consumers in a free market economy. Larger role of the state in financing and provisioning is located within the framework of equity. It automatically means greater regulation of the private sector and provision of health care as a public good.

In India health financing is highly fragmented. Health care is largely privately financed through OOP expenditure. About 80 per cent of health expenses are met through OOP payments (Baru *et al* 2012). But there is also a tax financed government run three tier health care structure, private insurance as well as some targeted social insurance schemes. High out of pocket expenditure are a consequence of extremely low levels of public expenditure of on health. In 2008-09 India spent only 1.10 per cent of its GDP on health care (Balarajan *et al* 2011) and an average of INR 268 as per capita public spending on health. India has one of the lowest per capita public spending on health even among the SAARC countries (Shiva Kumar *et al* 2011). Low public health spending has also meant that the Indian health sector is one of the most privatized health sectors in the world. In 2004-05, the private sector accounted for 78 per cent of total health expenditure in the country (Shiva Kumar *et al* 2011). Expenditure on health includes not just direct health costs but also indirect health costs. Estimation from the 60th round of NSS shows that

direct health expenditure on outpatient care per treated person was nearly 20 per cent of the total household consumption expenditure in rural areas and 13 per cent in urban areas. When indirect costs were added, the proportion went up to 33 per cent in rural areas and 17 per cent in urban areas. There is also evidence that common ailments and not just hospitalisation adds to financial hardship of households. Not only is burden of health care expenditure high, it is also inequitable with poorer households bearing a greater burden (Baru *et al* 2010). The impact of high OOP on household poverty is also well documented in several studies. Garg and Karan (2009) estimated that 32.5 million people (25.5 million in rural and 7 million in urban areas) are pushed below the poverty line as a result of making OOP payments. In a context where cost of care is rising and increasing number of households are unable to seek care, public financing becomes critical.

In the recent past social health insurance as an alternative means of financing health care and a viable means of providing financial risk protection has gained importance. This is evident from the increase in government financed health insurance schemes in many states like Kerala, Tamil Nadu, Karnataka and Andhra Pradesh and introduction of the nationwide RSBY scheme for the BPL families. Most of these schemes are limited to tertiary level or secondary level hospitalisation.

Recent policy debates on the appropriate means of financing health care in the country are divided over a tax based model and an insurance model. The High Level Expert Group (HLEG) set up by the Planning Commission strongly recommended a tax based model where an essential health package is provided through three tiers of the public health system and contracted-in private providers. Although the HLEG was set up by the Planning Commission, the Planning Commission's reservations about the HLEG's recommendations became clear when it set up the Steering Committee on Health and asked it to review some of the recommendations of the HLEG. The Steering Committee report does not clearly spell out an appropriate model, but it talks of providing an essential health package through empanelling public and private providers and providing financial and functional autonomy to public providers so that they are able to compete with private providers. This is suggestive of a health insurance model, much like RSBY. The Planning Commission's reservation about the HLEG's recommendations of a tax financed system

and some of the recommendations of the Steering Committee have to be read within growing influence of neoliberal thinking in health care. Neoliberal doctrine endorses a minimal role for the state and a larger role of the private sector in a free market economy. Although insurance schemes per se do not mean privatization, the insurance schemes adopted in India cater to high end, high cost, technology driven, secondary and tertiary care, provided by largely private hospitals. This is hugely beneficial for private hospitals as they get a captive market and large amounts of public funds flow into private hospitals instead of strengthening the public health system. The main arguments in favour of such schemes are arguments that are offered by the neoliberal doctrine. These include choice for consumers and increased efficiency, lowering of cost and improvement in quality of health care as a result of competition. There are of course several problems when this framework is applied to health care which is a merit good.

Theoretically, there are already limitations with this model promoting competition among public and private health care providers and choice for users. Some of these limitations have been pointed out by Light (2000). The idea of choice is a product from neo-classical economics, which is based on certain assumptions about the free market that do not hold true in case of health care. Light (2000) has rightly pointed out that economic theory is mediated by social reality devoid of which it does not give a complete picture. The idea that price competition is possible in health care is premised on certain assumptions of neo-classical economics. Some of these assumptions or rather conditions are – existence many buyers and sellers with no one buyer or seller having monopoly, no barriers to entry and exit of sellers so that those who are not efficient will automatically move out ensuring that efficiency and quality by sellers is maintained, full information about services and finally there should be no externalities, so that only the buyers get the benefit out of the product they purchase. However in reality, very often there is dominance of a few providers in the local market and there exist barriers to entry and exit in health care. There is also large information asymmetry about quality of services available. Another distinct factor in the health care sector is that the provider has superior knowledge than 'buyer' which he is able to exploit to his advantage. Patients have a relationship of trust with the doctor, and they would do what the doctor recommends. Knowledge about the actual nature of the medical condition and what the best treatment for it would be is often not available with the patient.

In such a situation customer choice is not practically applicable. Further there are externalities in health. Large scale immunization may lead to herd immunity and public health measures of sanitation and prevention will benefit everyone. However even in a hypothetical scenario, where these all the above conditions exist, the very idea that competition will be able to contain costs, has been challenged by Light (2000) who calls it a theoretical anomaly. In his own words

> Even if all these conditions hold, the long term effect of competition is not to save money but to generate wealth. In the long run, competition rewards those who develop new products, open new markets, and identify or create new 'needs', …..Thus even aside from problems of market failure, using competition to contain costs in health would seem to be a fundamentally shortsighted strategy that in fact sets the stage for health care to experience long-term growth as health-care corporations develop new services and create new markets. (Light 2000: 396)

The US health system is a case in point. With numerous private insurance companies and hospitals functioning in a free market economy, with relatively little government regulation, competition should have been able to reduce costs. But it is the most expensive health care system in the world and different ways of trying to contain costs, like introduction of HMOs has not been very successful. In fact it is the market power of hospitals, physicians and pharmaceutical companies coupled with affinity for high end technology based interventions, that have led to escalating costs (Bodenheimer and Fernandez 2005). Insurance, especially private insurance based models have several other problems associated with them. One problem is cream skimming or selecting healthy population and excluding those who have some illness or more likely to fall sick. Another problem is that those who are insured may be motivated to over-utilise medical services since it will be paid for by the insurer. The problem can also be from the end of the provider who may overprescribe, or prescribe unnecessary tests or expensive medicines as the cost has to be borne by the insurer leading to over-medicalisation.

Even though the problems with an insurance based model are well known, the successful implementation of RSBY (in terms of coverage) has definitely provided a readymade model for insurance based health finance in the country which can be scaled up. It is almost entirely financed by the government, with a larger share of about seventy per cent

coming from the central government and the rest coming from the state government. The RSBY seeks to provide financial risk protection to BPL families through cashless hospitalisation for a specified list of procedures. RSBY has adopted demand side financing which is expected to be more efficient than supply side financing. The scheme has empanelled both public and private providers, therefore its users can choose a provider of their choice. It has tried to tackle some of the problems like cream skimming by making it mandatory for insurance companies to enrol those who have pre-existing conditions. The scheme has been designed as a business model with incentives for key players and is being implemented through a Public Private Partnership (PPP). Competing insurance companies are expected to keep the premiums low and hence keep costs in check. Since the scheme empanels both private as well as public hospitals, it is expected to provide incentives to public hospitals, increase their funds and help in competing with private hospitals.

The findings reiterate that 'choice' through insurance schemes such as RSBY function under strong limitations. Choice has to be understood in a context, devoid of which the idea of choice becomes extremely simplistic. This study shows that in a context where the number of private providers is limited, there is little scope for choice. Resource poor settings, or remote areas will have few private providers since these places provide less scope for a profitable practice. In such places, public providers are often the only qualified health providers. Hence it is difficult to have a scenario where choice between public and private providers can be made available. In Sitapur district, all the private empanelled hospitals are in the district headquarters, except one – KMR Hospital which was in Sidhauli Block. All the other blocks towns have only the CHC empanelled and have not reported a single case of RSBY in the study period. It is quite clear that private hospitals are set up in places that have relatively more resources, better connectivity and amenities. Hence in the district, hospitals are concentrated in the district headquarters and not the relatively far off block towns.

For choice to be exercised there has to be a scenario where there is complete information about what is available to choose from. The beneficiaries however are located within multiple vulnerabilities due to lack of education, poverty, old age and gender. Such information therefore is not easily available with them. The power to choose therefore is

not a given. Choice for such persons, as was seen in the case of the users, is shaped by others who are relatively more informed. Most of the respondents did not know the institutions that had been empanelled, or the conditions that were covered under RSBY. Some were unsure how the smart card could be used and if indeed it could be used. The institution they got treatment in, was chosen because a relative, a villager or someone else had told them that it was a network hospital. In only two cases the respondents reported that they had got a pamphlet with information about the empanelled hospital. But there was one respondent who had a pamphlet, but had no idea what was written on it because he was illiterate. Mere information about empanelled hospitals is not enough to exercise an informed choice. Patients must know what conditions they are afflicted with and the providers who can provide good treatment. But in a situation where many of the patients have little idea about what condition they are afflicted from, patient sovereignty seems a more abstract than real concept.

There is also need to critique the idea that users are able to exercise a choice between public and private providers. None of the users who had availed treatment in the CHC were aware at that time that the CHC was empanelled under RSBY. The larger perception as well as experience of people with the public sector was poor. In a context where the public system clearly does not function in a manner that fulfills people's needs and expectations, there is very little by way of choice. Choice is possible when both the public sector and private sector have similar resources and facilities and both enjoy similar perception in terms of quality of care. RSBY therefore does not provide choice between public and private providers, but rather an alternative to public providers. Even in a situation when there is less information asymmetry, the choice is between different private providers.

The inclusion of private providers is based on the assumption that the business model approach which provides incentives for all players will be able to retain private providers and sustain the scheme in its current form. The interview with the private provider in Sidhauli block however brings out a different reality. The private providers see this scheme as less profitable since the package rates fixed are lower than what they are used to charging. Since final reimbursements are done by TPAs, whose job is to cut costs for the

insurance company, new ways are being devised to reject claims or delay payment. This is something of a disincentive and can affect continuation of private providers in the scheme. Insurance schemes have a tendency to be inflationary and increase cost of care. RSBY has tried to control costs by setting package rates for different procedures. Although this is a micro study, and implications of RSBY on escalating cost of care is difficult to gauge, yet interviews from the private provider indicates that maintaining private providers as existing levels of package rates may be a challenge. As information about the scheme spreads, the utilisation is expected to increase, resulting in decreased profits for the insurance companies. The government will have to increase premiums rates then to sustain the scheme and keep insurance companies interested. The trend of increasing premium rates due to increasing utilisation has been documented in Kerala (Narayana 2010).

The government providers are seeing RSBY as an incentive since a proportion of the RSBY money is divided among the staff. It has also helped in increasing funds of the RKS. But there is a potential problem of moral hazard. A recent newspaper article in *Hindustan Times* highlighted the practice of carrying out unnecessary hysterectomy operations in Chhattisgarh, on women as young as eighteen years of age to claim RSBY package amounts. The article reported that in the last eight months, around 1800 women had undergone hysterectomy for which about two crore rupees had been claimed under RSBY (*Hindustan Times* 2012). This highlights the real danger of moral hazards and the need to further explore and study this area. This study was not able to come up with any conclusive instance to demonstrate moral hazard. This was also because the limitation of the researcher to assess the need and relevance of the medical procedure that respondents underwent, due to lack of medical knowledge and limited information (detailed medical records). However an anecdote narrated by a villager hinted that an unwanted surgery had been carried out by some network hospital.

Since the RSBY package rate includes cost of food, tests, bed charge and consultation, private providers feel that they are not able to recover cost. (The current package rate for ‘general ward’ category is Rs 500 per day.) Since private providers are not able to recover costs in one day of admission, it is possible that they take admission for three days (the maximum that is allowed for ‘general ward’ patients) even though it is unwarranted to

recover costs. In an unregulated health care market, private hospitals often invest money on diagnostic equipment etc and recover costs by setting arbitrary rates. RSBY therefore is not able to provide them enough monetary incentive by setting package rates at levels much lower than what they are used to charging.

One of the primary objectives of RSBY is to ensure financial risk protection for BPL families. Some studies have argued that this scheme has limited scope for financial risk protection since it does not cover out-patient care. Targeting this scheme to BPL also limits is scope and is exclusionary (Shahrawat and Rao 2012). Even though RSBY is focused on hospitalisation, a more recent study shows that real per capita health care expenditure especially on hospitalisation has increased for the poorest households in districts where RSBY and other insurance schemes are being implemented (Selvaraj and Karan 2012).The MoLE's evaluations studies (that are available in public domain) have largely evaded this area of enquiry. Only one study in Jaunpur district (Amicus Advisory 2010) makes an attempt to assess the impact of RSBY on reducing OOP expenditure. It compares the average expenditure on seeking health care by users of RSBY and non users of RSBY and finds that non users have much higher average OOP expenditure than users of RSBY in the district. The current study tries enquires into whether the RSBY is truly cashless, since indirect expenses are also incurred, and whether it is able to provide financial risk protection to families who have used it.

Even though Rs 100 is provided as travel allowance, it is not enough to cover indirect costs. Indirect costs on travel and food (during hospitalisation) ranged between Rs 30 to Rs 2500 making RSBY not entirely a cashless scheme for most. While RSBY is primarily meant for secondary level care and covers procedures requiring surgery, users with all kinds of health problems approach hospitals. The 'General Ward' category in the RSBY package has provided space for such cases to be treated. Actual surgical cases among the respondents interviewed were very few. Hospitalisation included persons whose condition was a result of chronic conditions like hypertension and tuberculosis as well as those who could have got outpatient care like cases of asthma or fever. Financial risk protection has to be evaluated in the context of the illness for which users sought treatment. While the scheme was useful for those who had pre-existing conditions requiring surgery, others

found it less useful. Chronic conditions require long term treatment and the major expenses are on medicines which have to be bought over a long period of time. While hospitalisation may give temporary relief to symptoms emerging out of the condition, it is not able to provide long term treatment for the condition itself. Hopitalisation is an event which has both a history and a future. Merely focusing on hospitalisation therefore does not prevent OOP expenditure. The scheme's scope in providing financial risk protection in its current form, with exclusive focus on secondary level care is very narrow.

There were also several shortcomings in implementation of the scheme. One of the biggest problems was the accuracy of the BPL list itself, which forms the basis of identifying beneficiaries. Several households who do not fulfill the BPL criteria were also found to be part of the list. It is equally possible that poor households have been excluded from the list. There was little awareness about the provisions of the scheme among the users. Here it must be mentioned that apart from the government, the Insurance Company has the responsibility of information dissemination. There is an inherent conflict of interest here. Insurance Companies would want to maximize their profit, and low levels of information among the users would mean low utilisation and higher profits. Majority of the respondents said that they did not receive any pamphlet with information about network hospitals and conditions that were covered. Some of the other provisions like handing over the smart card at the time of enrolment and setting up a separate RSBY counter and appointing staff are not being followed. It is especially difficult in government hospital set up to keep an additional staff when revenue generated by RSBY is not much.

Providing financial risk protection is just one of the objectives of health policy and RSBY is an intervention directed at this objective. But health policy has the larger goal of ensuring health of the population. It is therefore important that health related interventions are aligned to achieve this larger goal and integrated properly in the health system. RSBY is a scheme by the Ministry of Labour and Welfare, with the admirable goal of providing financial risk protection. But it will also have implications on the health system; through strengthening the private sector, by creating a parallel system of incentives in the government hospitals, by moral hazard problems, by directing large amounts of funds entirely for secondary care and other influences that will be clear only with time. It also

raises important public health questions. For example what happens to Tuberculosis patients who visit these hospitals? Do all private hospitals refer them to a government hospital to get the DOTS treatment or does RSBY provide these private hospitals with captive patients who get expensive TB treatment in a private hospital despite having a government run free TB programme. While the government run programme is supposed to track each patient so that he/she does not leave treatment midway and develop a resistant form of TB, one does not know what line of drugs private providers use and what happens when patients discontinue treatment. This question is especially pertinent in Sitapur where both respondents and providers reported that TB was extremely common. One of the respondents in the study who had TB was getting treatment from a private provider (although not the empanelled hospital) and another respondent was referred by the private provider to government hospital (reportedly because she was too poor to afford private medication).

Efforts are on to increase the scope of RSBY by testing the feasibility of including outpatient care in its coverage. It is possible that in future, chronic conditions too will be included as part of the scheme. However it is important to assess where a scheme like RSBY fits into the health system and how it affects the health system. There is need to deliberate whether the need is for a comprehensive 'scheme' to provide financial risk protection from health care costs, or to develop a health 'system' which delivers comprehensive care integrating curative as well as preventive and promotive care. This study shows that RSBY has achieved the aim of providing secondary care to those who had pre-existing condition or required emergency hospitalisation for a short period. Those who received this care in private hospitals have benefitted as the cost of treatment was much lower than what it would have otherwise been. But a large number of respondents in the sample were had conditions other than those requiring surgical care or emergency hospitalisation. While some of them appreciate the idea of free treatment, RSBY is neither able to provide complete financial protection nor long term care for them. What is needed for them is a health 'system' which is responsive, sensitive, accessible and affordable.

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CONTENTS

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Ankita Mukherjee

LIST OF ABBREVIATIONS/ACRONYMS

ANC – Ante Natal Care

ANM – Auxiliary Nurse Midwife

AYUSH – Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy

BPL – Below Poverty Line

CBHI – Community Based Health Insurance

CGHS – Central Government Health Scheme

CHC – Community Health Centre

CMO – Chief Medical Officer

CPI – Consumer Price Index

D &C - Dilation and Curettage

DLC- Differential Leukocyte Count

DOTS - Directly Observed Treatment Short course

ECG- Electro Cardio Gram

ESIS – Employees State Insurance Scheme

ESR - Erythrocyte Sedimentation Rate

FKO – Field Key Officer

GDP –Gross Domestic Product

GoI – Government of India

GTZ - Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)

GIZ- Deutsche Gesselschaft fur Internationale Zusammenarbeit Deutsche Gesselschaft fur Internationale Zusammenarbeit

GIC- General Insurance Corporation of India

HLEG- High Level Expert Group on Universal Health Coverage for India

INR- Indian Rupee

JSY- Janani Suraksha Yojna

IPD – Inpatient Department

IRDA – Insurance Regulatory Authority of India

LHV – Lady Health Visitor

MBBS - Bachelor of Medicine

MoHFW – Ministry of Health and Family Welfare

MoLE – Ministry of Labour and Employment

MO – Medical Officer

NGO – Non Government Organisation

NHS- National Health Service

NREGS –National Rural Employment Guarantee Scheme

NRHM – National Rural Health Mission

NSS – National Sample Survey

OECD- Organisation for Economic Co-operation and Development

OOP- Out of Pocket

OPD – Out Patient Department

OPEC - Organization of the Petroleum Exporting Countries

PDS – Public Distribution System

PHC – Primary Health Care

PHFI – Public Health Foundation of India

PPP – Public Private Partnership

RKS – Rogi Kalyan Samiti

RSBY – Rashtriya Swasthya Bima Yojna

SAARC - South Asian Association for Regional Cooperation

SAP – Structural Adjustment Plans

SCP – Smart Card Providers

SHGs – Self Help Groups

SNA – State Nodal Agency

TLC – Total Leukocyte Count

TPA – Third Party Administrator

TRIPS – Trade Related Intellectual Property Rights Agreement

UHC – Universal Health Care

UK – United Kingdom

UP –Uttar Pradesh

URN- Unique Residency Number

WHO – World Health Organisation

LIST OF TABLES

LIST OF FIGURES

(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.500/- per day
(ii) IF ADMITTED IN ICU: This includes bed charges (general ward), Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Medicines and Drugs, X-Ray and Diagnostic Tests, food to patient etc. during stay in I.C.U.	Maximum upto Rs. 1000/- 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 IV below.
(V) Maternity benefit Package: These package will include Bed charges (General Ward), Nursing and Boarding charges, Surgeons, Anesthetists, Medical Practitioner and Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges and Cost of Surgical Appliances etc, Medicines and Drugs, X-Ray 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 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.	Normal Delivery Rs. 2500/- Caesarian Section / Complicated Rs.4500/-

Serial No.	Code No.	ICD 10 Code	RSBY Category	RSBY LOS	Final Rate
1	1	**DENTAL**			
2	FP00100001	K05	Fistulectomy	1	10,000
3	FP00100002	S02	Fixation of fracture of jaw	2	10,000
4	FP00100003	K10	Sequestrectomy	1	10,000

Package Rates under RSBY for Basic Package

5	FP00100004	D16	Tumour excision	2	7,500
	2	**EAR**			
6	FP00200001	H74	Aural polypectomy	1	10,000
7	FP00200002	H81	Decompression sac	2	13,500
8	FP00200003	H80	Fenestration	2	7,000
9	FP00200004	H81	Labyrinthectomy	2	10,500
10	FP00200005	H 65	Mastoidectomy	2	6,000
11	FP00200006	H70	Mastoidectomy corticol module radical	3	10,500
12	FP00200007	H 65	Mastoidectomy With Myringoplasty	2	9,000
13	FP00200008	H 65	Mastoidectomy with tympanoplasty	2	9,000
14	FP00200009	H72	Myringoplasty	2	6,000
15	FP00200010	H72	Myringoplasty with Ossiculoplasty	2	9,000
16	FP00200011	H72	Myringotomy - Bilateral	2	4,500
17	FP00200012	H72	Myringotomy - Unilateral	2	2,500
18	FP00200013	H72	Myringotomy with Grommet - One ear	2	5,000
19	FP00200014	H72	Myrinogotomy with Grommet - Both ear	2	6,500
20	FP00200015	H74	Ossiculoplasty	2	7,500
21	FP00200016	C44	Partial amputation - Pinna	1	2,500
22	FP00200017	Q17	Preauricular sinus	2	6,000
23	FP00200018	H80	Stapedectomy	2	8,125
24	FP00200019	H72	Tympanoplasty	5	7,000
25	FP00200020	J30	Vidian neurectomy - Micro	3	7,000
	3	**NOSE**			
26	FP00300001	R04	Ant. Ethmoidal artery ligation	3	12,000
27	FP00300002	J32	Antrostomy – Bilateral	3	6,000
28	FP00300003	J32	Antrostomy – Unilateral	3	4,000
29	FP00300004	J32	Caldwell - luc – Bilateral	2	7,500
30	FP00300005	J32	Caldwell - luc- Unilateral	2	4,500
31	FP00300006	C30	Cryosurgery	2	7,000
32	FP00300007	J00	Rhinorrhoea - Repair	1	5,000
33	FP00300008	H04	Dacryocystorhinostomy (DCR)	1	9,000
34	FP00300009	J32	Septoplasty + FESS	2	5,500
35	FP00300010	J32	Ethmoidectomy - External	2	9,000
36	FP00300011	S02	Fracture reduction nose with septal correction	1	6,500
37	FP00300012	S02	Fracture - setting maxilla	2	8,500
38	FP00300013	S02	Fracture - setting nasal bone	1	4,000
39	FP00300014	J01	Functional Endoscopic Sinus (FESS)	1	9,000
40	FP00300015	J01	Intra Nasal Ethmoidectomy	2	12,250
41	FP00300016	D14	Rhinotomy - Lateral	2	10,625

Package Rates under RSBY for Basic Package

42	FP00300017	J33	Nasal polypectomy - Bilateral	1	7,500
43	FP00300018	J33	Nasal polypectomy - Unilateral	1	5,250
44	FP00300019	J34	Turbinectomy Partial - Bilateral	3	7,000
45	FP00300020	J34	Turbinectomy Partial - Unilateral	3	4,500
46	FP00300021	C31	Radical fronto ethmo sphenodectomy	5	15,000
47	FP00300022	J34	Rhinoplasty	3	12,000
48	FP00300023	J34	Septoplasty	2	5,500
49	FP00300024	J33	Sinus Antroscopy	1	4,500
50	FP00300025	J34	Submucos resection	1	5,000
51	FP00300026	J01	Trans Antral Ethmoidectomy	2	10,500
52	FP00300027	J31	Youngs operation	2	5,500
	4	**THROAT**			
53	FP00400001	J35	Adeno Tonsillectomy	1	6,000
54	FP00400002	J35	Adenoidectomy	1	4,000
55	FP00400003	C32	Arytenoidectomy	2	15,000
56	FP00400004	Q30	Choanal atresia	2	10,000
57	FP00400005	J03	Tonsillectomy + Myrinogotomy	3	10,000
58	FP00400006	Q38	Pharyngeal diverticulum's – Excision	2	12,000
59	FP00400007	C32	Laryngectomy	2	15,750
60	FP00400008	C41	Maxilla - Excision	2	10,000
61	FP00400009	K03	Oro Antral fistula	2	10,000
62	FP00400010	J39	Parapharyngeal - Exploration	2	10,000
63	FP00400011	J39	Parapharyngeal Abscess - Drainage	2	15,000
64	FP00400012	D10	Parapharyngeal -Tumour excision	3	26,250
65	FP00400013	Q38	Pharyngoplasty	2	12,000
66	FP00400014	Q38	Release of Tongue tie	1	3,000
67	FP00400015	J39	Retro pharyngeal abscess - Drainage	D	4,000
68	FP00400016	D11	Styloidectomy - Both side	3	10,000
69	FP00400017	D11	Styloidectomy - One side	3	8,000
70	FP00400018	J03	Tonsillectomy + Styloidectomy	2	12,500
71	FP00400019	Q89	Thyroglossal Cyst - Excision	2	10,000
72	FP00400020	Q89	Thyroglossal Fistula - Excision	3	10,000
73	FP00400021	J03	Tonsillectomy - Bilateral	1	7,000
74	FP00400022	J03	Tonsillectomy - Unilateral	1	5,500
75	FP00400023	C07	Total Parotidectomy	2	15,000
76	FP00400024	C05	Uvulophanyngo Plasty	2	12,500
	5	**GENERAL SURGERY**			
77	FP00500001	C20	Abdomino Perineal Resection	3	17,500
78	FP00500002	M70	Adventious Burse - Excision	3	8,750

Package Rates under RSBY for Basic Package

79	FP00500003	C20	Anterior Resection for CA	5	10,000
80	FP00500004	K35	Appendicectomy	2	6,000
81	FP00500005	K35	Appendicular Abscess - Drainage	2	7,000
82	FP00500006	D18	Arteriovenous (AV) Malformation of Soft Tissue Tumour - Excision	3	17,000
83	FP00500007		Axillary Lymphnode - Excision	1	3,125
84	FP00500008	M71	Bakers Cyst - Excision	3	5,000
85	FP00500009	D36	Bilateral Inguinal block dissection	3	13,000
86	FP00500010	K25	Bleeding Ulcer - Gastrectomy & vagotomy	5	17,000
87	FP00500011	K25	Bleeding Ulcer - Partial gastrectomy	5	15,000
88	FP00500012	C77	Block dissection Cervical Nodes	3	15,750
89	FP00500013	Q18	Branchial Fistula	3	13,000
90	FP00500014	C50	Breast - Excision	3	12,250
91	FP00500015	D25	Breast Lump - Left - Excision	2	5,000
92	FP00500016	D25	Breast Lump - Right - Excision	2	5,000
93	FP00500017	D25	Breast Mass - Excision	2	6,250
94	FP00500018	J98	Bronchial Cyst	3	5,000
95	FP00500019	M06	Bursa - Excision	3	7,000
96	FP00500020		Bypass - Inoprablaca of Pancreas	5	13,000
97	FP00500021	K56	Caecopexy	3	13,000
98	FP00500022	L02	Carbuncle back	1	3,500
99	FP00500023	B44	Cavernostomy	5	13,000
100	FP00500024	C96	Cervial Lymphnodes - Excision	2	2,500
101	FP00500025	K83	Cholecysostomy	5	10,000
102	FP00500026	K80	Cholecystectomy & exploration	3	13,250
103	FP00500027	C67	Colocystoplasty	5	15,000
104	FP00500028	K57	Colostomy	5	12,500
105	FP00500029	C14	Commando Operation	5	15,000
106	FP00500030	L84	Corn - Large - Excision	D	500
107	FP00500031	N49	Cyst over Scrotum - Excision	1	4,000
108	FP00500032	Q61	Cystic Mass - Excision	1	2,000
109	FP00500033	L72	Dermoid Cyst - Large - Excision	D	2,500
110	FP00500034	L72	Dermoid Cyst - Small - Excision	D	1,500
111	FP00500035	K86	Distal Pancrcatectomy with Pancreatico Jejunostomy	7	17,000
112	FP00500036	K57	Diverticulectomy	3	15,000
113	FP00500037	N47	Dorsal Slit and Reduction of Paraphimosis	D	1,500
114	FP00500038	K61	Drainage of Ischio Rectal Abscess	1	4,000
115	FP00500039		Drainage of large Abscess	D	2,000
116	FP00500040	K92	Drainage of Peripherally Gastric Abscess	3	8,000

Package Rates under RSBY for Basic Package

117	FP00500041	L02	Drainage of Psoas Abscess	2	3,750
118	FP00500042	K92	Drainage of Subdiaphramatic Abscess	3	8,000
119	FP00500043	I31	Drainage Pericardial Effusion	7	11,000
120	FP00500044	K57	Duodenal Diverticulum	5	15,000
121	FP00500045	K31	Duodenal Jejunostomy	5	15,000
122	FP00500046	D13	Duodenectomy	7	20,000
123	FP00500047		Dupcrytren's (duputryen's contracture)	7	13,000
124	FP00500048	Q43	Duplication of Intestine	8	17,000
125	FP00500049	N43	Hydrocelectomy + Orchidectomy	2	7,000
126	FP00500050	N45	Epidedectomy	3	8,000
127	FP00500051	N45	Epididymal Swelling -Excision	2	5,500
128	FP00500052	N50	Epidymal Cyst	D	3,000
129	FP00500053	N50	Evacuation of Scrotal Hematoma	2	5,000
130	FP00500054	D13	Excision Benign Tumor -Small intestine	5	15,000
131	FP00500055	A15	Excision Bronchial Sinus	D	8,000
132	FP00500056	K75	Excision of liver Abscess	3	13,000
133	FP00500057	N43	Excision Filarial Scrotum	3	8,750
134	FP00500058	N61	Excision Mammary Fistula	2	5,500
135	FP00500059	Q43	Excision Meckel's Diverticulum	3	15,000
136	FP00500060	L05	Excision Pilonidal Sinus	2	8,250
137	FP00500061	K31	Excision Small Intestinal Fistulla	5	12,000
138	FP00500062	K11	Excision Submandibular Gland	5	10,000
139	FP00500063	C01	Excision of Large Growth from Tongue	3	5,000
140	FP00500064	C01	Excision of Small Growth from Tongue	D	1,500
141	FP00500065	L02	Excision of Swelling in Right Cervial Region	1	4,000
142	FP00500066	L02	Excision of Large Swelling in Hand	D	2,500
143	FP00500067	L02	Excision of Small Swelling in Hand	D	1,500
144	FP00500068	D33	Excision of Neurofibroma	3	7,000
145	FP00500069	L05	Exicision of Siniuds and Curetage	2	7,000
146	FP00500070	G51	Facial Decompression	5	15,000
147	FP00500071		Fibro Lipoma of Right Sided Spermatic with Lord Excision	1	2,500
148	FP00500072	D24	Fibroadenoma - Bilateral	2	6,250
149	FP00500073	D24	Fibrodenoma - Unilateral	2	7,000
150	FP00500074		Fibroma - Excision	2	7,000
151	FP00500075	K60	Fissurectomy	2	7,000
152	FP00500076	I84	Fissurectomy and Haemorrhoidectomy	2	11,250
153	FP00500077	K60	Fissurectomy with Eversion of Sac - Bilateral	2	8,750
154	FP00500078	K60	Fissurectomy with Sphincterotomy	2	9,000

Package Rates under RSBY for Basic Package

155	FP00500079	K60	Fistula Repair	2	5,000
156	FP00500080	K60	Fistulectomy	2	7,500
157	FP00500081		Foreign Body Removal in Deep Region	2	5,000
158	FP00500082		Fulguration	2	5,000
159	FP00500083	K21	Fundoplication	3	15,750
160	FP00500084	K25	G J Vagotomy	5	15,000
161	FP00500085	K25	Vagotomy	3	12,000
162	FP00500086	M67	Ganglion - large - Excision	1	3,000
163	FP00500087	M67	Ganglion (Dorsum of Both Wrist) - Excision	1	4,000
164	FP00500088	M67	Ganglion - Small - Excision	D	1,000
165	FP00500089	K28	Gastro jejunal ulcer	5	10,000
166	FP00500090	K63	Gastro jejuno Colic Fistula	5	12,500
167	FP00500091	C17	Gastrojejunostomy	5	15,000
168	FP00500092	K25	Gastrotomy	7	15,000
169	FP00500093		Graham's Operation	5	12,500
170	FP00500094	A58	Granuloma - Excision	1	4,000
171	FP00500095		Growth - Excision	D	1,800
172	FP00500096	D18	Haemangioma - Excision	3	7,000
173	FP00500097	D13	Haemorrage of Small Intestine	3	15,000
174	FP00500098	C01	Hemi Glossectomy	3	10,000
175	FP00500099	D16	Hemi Mandibulectomy	3	15,000
176	FP00500100	C18	Hemicolectomy	5	16,000
177	FP00500101	J38	Hemithyroplasty	3	12,000
178	FP00500102	C34	Hepatic Resection (lobectomy)	7	15,000
179	FP00500103	K43	Hernia - Epigastric	3	10,000
180	FP00500104	K43	Hernia - Incisional	3	12,250
181	FP00500105	K40	Hernia - Repair & release of obstruction	3	10,000
182	FP00500106	K42	Hernia - Umbilical	3	8,450
183	FP00500107	K43	Hernia - Ventral - Lipectomy/Incisional	3	10,500
184	FP00500108	K41	Hernia - Femoral	3	7,000
185	FP00500109	K40	Hernioplasty	3	7,000
186	FP00500110		Herniorraphy and Hydrocelectomy Sac Excision	3	10,500
187	FP00500111	K44	Hernia - Hiatus	3	12,250
188	FP00500112	B67	Hydatid Cyst of Liver	3	10,000
189	FP00500113		Nodular Cyst	D	3,000
190	FP00500114	N43	Hydrocelectomy - Excision	2	4,000
191	FP00500115		Hydrocelectomy+Hernioplasty - Excision	3	7,000
192	FP00500116	N43	Hydrocele - Excision - Unilateral	2	3,750
193	FP00500117	N43	Hydrocele - Excision - Bilateral	2	5,000

Package Rates under RSBY for Basic Package

194	FP00500118	C18	Ilieo Sigmoidostomy	5	13,000
195	FP00500119	M20	Infected Bunion Foot - Excision	1	4,000
196	FP00500120		Inguinal Node (bulk dissection) axial	2	10,000
197	FP00500121	K57	Instestinal perforation	6	9,000
198	FP00500122	K56	Intestinal Obstruction	6	9,000
199	FP00500123	K56	Intussusception	7	12,500
200	FP00500124	C16	Jejunostomy	6	10,000
201	FP00500125	K56	Closure of Perforation	5	9,000
202	FP00500126	C67	Cysto Reductive Surgery	3	7,000
203	FP00500127	K63	Gastric Perforation	6	12,500
204	FP00500128	K56	Intestinal Perforation (Resection Anastomosis)	5	11,250
205	FP00500129	K35	Appendicular Perforation	5	10,500
206	FP00500130		Burst Abdomen Obstruction	7	11,000
207	FP00500131	K56	Closure of Hollow Viscus Perforation	5	13,500
208	FP00500132		Laryngectomy & Pharyngeal Diverticulum (Throat)	3	10,000
209	FP00500133	Q42	Anorectoplasty	2	14,000
210	FP00500134	C32	Laryngectomy with Block Dissection (Throat)	3	12,000
211	FP00500135	C32	Laryngo Fissure (Throat)	3	12,500
212	FP00500136	C13	Laryngopharyngectomy (Throat)	3	12,000
213	FP00500137	K51	Ileostomy	7	17,500
214	FP00500138	D17	Lipoma	D	2,000
215	FP00500139	K56	Loop Colostomy Sigmoid	5	12,000
216	FP00500140	I84	Lords Procedure (haemorrhoids)	2	5,000
217	FP00500141	D24	Lumpectomy - Excision	2	7,000
218	FP00500142	C50	Mastectomy	2	9,000
219	FP00500143	K66	Mesenteric Cyst - Excision	3	9,000
220	FP00500144	K76	Mesenteric Caval Anastomosis	5	10,000
221	FP00500145	D14	Microlaryngoscopic Surgery [microlaryngoscopy ?]	3	12,500
222	FP00500146	T18	Oeshophagoscopy for foreign body removal	D	6,000
223	FP00500147	D13	Oesophagectomy	5	14,000
224	FP00500148	I85	Oesophagus Portal Hypertension	5	18,000
225	FP00500149	N73	Pelvic Abscess - Open Drainage	5	8,000
226	FP00500150	C61	Orchidectomy	2	5,500
227	FP00500151	C61	Orchidectomy + Herniorraphy	3	7,000
228	FP00500152	Q53	Orchidopexy	5	6,000
229	FP00500153	Q53	Orchidopexy with Circumsion	5	9,750
230	FP00500154	Q53	Orchidopexy With Eversion of Sac	5	8,750
231	FP00500155		Orchidopexy with Herniotomy	5	14,875
232	FP00500156	N45	Orchititis	2	6,000

Package Rates under RSBY for Basic Package

233	FP00500157	K86	Pancreatrico Deodeneotomy	6	13,750
234	FP00500158	D12	Papilloma Rectum - Excision	2	3,500
235	FP00500159	I84	Haemorroidectomy+ Fistulectomy	2	7,000
236	FP00500160		Phytomatous Growth in the Scalp - Excision	1	3,125
237	FP00500161	K76	Porto Caval Anastomosis	5	12,000
238	FP00500162	K25	Pyeloroplasty	5	11,000
239	FP00500163	C50	Radical Mastectomy	2	9,000
240	FP00500164	C49	Radical Neck Dissection - Excision	6	18,750
241	FP00500165	K43	Hernia - Spigelian	3	12,250
242	FP00500166	K62	Rectal Dilation	1	4,500
243	FP00500167	K62	Prolapse of Rectal Mass - Excision	2	8,000
244	FP00500168	K62	Rectal polyp	1	3,000
245	FP00500169	K62	Rectopexy	3	10,000
246	FP00500170	K83	Repair of Common Bile Duct	3	12,500
247	FP00500171	C18	Resection Anastomosis (Large Intestine)	8	15,000
248	FP00500172	C17	Resection Anastomosis (Small Intestine)	8	15,000
249	FP00500173	D20	Retroperitoneal Tumor - Excision	5	15,750
250	FP00500174	I84	Haemorroidectomy	2	5,000
251	FP00500175	K11	Salivary Gland - Excision	3	7,000
252	FP00500176	L72	Sebaceous Cyst - Excision	D	1,200
253	FP00500177	N63	Segmental Resection of Breast	2	10,000
254	FP00500178		Scrotal Swelling (Multiple) - Excision	2	5,500
255	FP00500179	K57	Sigmoid Diverticulum	7	15,000
256	FP00500180	K25	Simple closure - Peptic perforation	6	11,000
257	FP00500181	L05	Sinus - Excision	2	5,000
258	FP00500182	D17	Soft Tissue Tumor - Excision	3	4,000
259	FP00500183	C80	Spindle Cell Tumor - Excision	3	7,000
260	FP00500184	D58	Splenectomy	10	23,000
261	FP00500185		Submandibular Lymphs - Excision	2	4,500
262	FP00500186	K11	Submandibular Mass Excision + Reconstruction	5	15,000
263	FP00500187	K11	Submandibular Salivary Gland -Removal	5	9,500
264	FP00500188	D11	Superficial Parodectomy	5	10,000
265	FP00500189	R22	Swelling in Rt and Lt Foot - Excision	1	2,400
266	FP00500190	R22	Swelling Over Scapular Region	1	4,000
267	FP00500191	K57	Terminal Colostomy	5	12,000
268	FP00500192	J38	Thyroplasty	5	11,000
269	FP00500193	C18	Coloectomy - Total	6	15,000
270	FP00500194	C67	Cystectomy - Total	6	10,000
271	FP00500195	C01	Glossectomy – Total (Throat)	7	15,000

Package Rates under RSBY for Basic Package

272	FP00500196	C33	Pharyngectomy & Reconstruction - Total	6	13,000
273	FP00500197	Q32	Tracheal Stenosis (End to end Anastamosis) (Throat)	6	15,000
274	FP00500198	Q32	Tracheoplasty (Throat)	6	15,000
275	FP00500199	K56	Tranverse Colostomy	5	12,500
276	FP00500200	Q43	Umbilical Sinus - Excision	2	5,000
277	FP00500201	K25	Vagotomy & Drainage	5	15,000
278	FP00500202	K25	Vagotomy & Pyloroplasty	6	15,000
279	FP00500203	I84	Varicose Veins - Excision and Ligation	3	7,000
280	FP00500204		Vasco Vasostomy	3	11,000
281	FP00500205	K56	Volvlous of Large Bowel	4	15,000
282	FP00500206	K76	Warren's Shunt	6	15,000
	6	**GYNAECOLOGY**			
283	FP00600001		Abdomonal open for stress incision	5	11,250
284	FP00600002	N75	Bartholin abscess I & D	D	1,875
285	FP00600003	N75	Bartholin cyst removal	D	1,875
286	FP00600004	N84	Cervical Polypectomy	1	3,000
287	FP00600005	N84	Cyst - Labial	D	1,750
288	FP00600006	D28	Cyst -Vaginal Enucleation	D	1,875
289	FP00600007	N83	Ovarian Cystectomy	1	7,000
290	FP00600008	N81	Cystocele - Anterior repair	2	10,000
291	FP00600009	N96	D&C (Dilatation & curretage)	D	2,500
292	FP00600010		Electro Cauterisation Cryo Surgery	D	2,500
293	FP00600011		Fractional Curretage	D	2,500
294	FP00600012		Gilliams Operation	2	6,000
295	FP00600013		Haemato Colpo/Excision - Vaginal Septum	D	3,000
296	FP00600014	N89	Hymenectomy & Repair of Hymen	D	5,000
297	FP00600015	C53	Hysterectomy - abdominal	5	10,000
298	FP00600016	C53	Hysterectomy - Vaginal	5	10,000
299	FP00600017	C53	Hysterectomy - Wertheims operation	5	12,500
300	FP00600018	D25	Hysterotomy -Tumors removal	5	12,500
301	FP00600019	D25	Myomectomy - Abdominal	5	10,500
302	FP00600020	D27	Ovarectomy/Oophrectomy	3	7,000
303	FP00600021	O70	Perineal Tear Repair	D	1,875
304	FP00600022	N81	Prolapse Uterus -L forts	5	11,250
305	FP00600023	N81	Prolapse Uterus - Manchester	5	11,250
306	FP00600024	N82	Retro Vaginal Fistula -Repair	3	12,250
307	FP00600025	C56	Salpingoophrectomy	3	7,500
308	FP00600026	N97	Tuboplasty	3	8,750
309	FP00600027	O70	Vaginal Tear -Repair	D	3,125

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

385	FP00900042		Trans Sphenoidal	6	15,000
386	FP00900043	C71	Tumours - Supratentorial	7	22,500
387	FP00900044	D32	Tumours Meninges - Gocussa	7	22,500
388	FP00900045	D32	Tumours Meninges - Posterior	7	22,500
389	FP00900046	K25	Vagotomy - Selective	5	15,000
390	FP00900047	C17	Vagotomy with Gastrojejunostomy	6	15,000
391	FP00900048	K25	Vagotomy with Pyeloroplasty	6	15,000
392	FP00900049	K25	Vagotomy - Highly Selective	5	15,000
393	FP00900050	G00	Ventricular Puncture	3	8,000
	10	**OPHTHALMOLOGY**			
394	FP01000001	H00	Abscess Drainage of Lid	D	500
395	FP01000002	H40	Anterior Chamber Reconstruction	3	7,000
396	FP01000003	H33	Buckle Removal	2	9,375
397	FP01000004	H04	Canaliculo Dacryocysto Rhinostomy	1	7,000
398	FP01000005	H25	Capsulotomy	1	2,000
399	FP01000006	H25	Cataract – Bilateral	D	5,000
400	FP01000007	H25	Cataract – Unilateral	D	3,500
401	FP01000008	H18	Corneal Grafting	D	4,000
402	FP01000009	H33	Cryoretinopexy - Closed	1	5,000
403	FP01000010	H33	Cryoretinopexy - Open	1	6,000
404	FP01000011	H40	Cyclocryotherapy	D	3,500
405	FP01000012	H04	Cyst	D	1,000
406	FP01000013	H04	Dacrocystectomy With Pterygium - Excision	D	6,500
407	FP01000014	H11	Pterigium + Conjunctival Autograft	D	3,500
408	FP01000015	H04	Dacryocystectomy	D	5,000
409	FP01000016	H46	Endoscopic Optic Nerve Decompression	D	8,000
410	FP01000017	E05	Endoscopic Optic Orbital Decompression	D	8,000
411	FP01000018	C69	Enucleation	1	2,000
412	FP01000019	C69	Enuleation with Implant	1	3,500
413	FP01000020	C69	Exentration	D	3,500
414	FP01000021	H02	Ectropion Correction	D	3,000
415	FP01000022	H40	Glaucoma surgery (trabeculectomy)	2	7,000
416	FP01000023	H44	Intraocular Foreign Body Removal	D	3,000
417	FP01000024	H18	Keratoplasty	1	8,000
418	FP01000025	H52	Lensectomy	D	7,500
419	FP01000026	H04	Limbal Dermoid Removal	D	2,500
420	FP01000027	H33	Membranectomy	D	6,000
421	FP01000028	S05	Perforating corneo - Scleral Injury	2	5,000
422	FP01000029	H11	Pterygium (Day care)	D	1,000

Package Rates under RSBY for Basic Package

423	FP01000030	H02	Ptosis	D	2,000
424	FP01000031	H52	Radial Keratotomy	1	5,000
425	FP01000032	H21	IRIS Prolapse - Repair	2	5,000
426	FP01000033	H33	Retinal Detachment Surgery	2	10,000
427	FP01000034	D31	Small Tumour of Lid - Excision	D	500
428	FP01000035	D31	Socket Reconstruction	3	6,000
429	FP01000036	H40	Trabeculectomy - Right	D	7,500
430	FP01000037	H40	Iridectomy	D	1,800
431	FP01000038	D31	Tumours of IRIS	2	4,000
432	FP01000039	H33	Vitrectomy	2	4,500
433	FP01000040	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

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

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

Package Rates under RSBY for Basic Package

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 Reconstuction	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 Cartoid Body tumour	5	13,000
724	FP01500007	C56	Malignant ovarian	5	15,000
725	FP01500008		Operation for Neoblastoma	5	10,000

Package Rates under RSBY for Basic Package

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	Respiratory tuberculosis, bacteriologically and histologically confirmed		
729	FP01800002	B15	Acute hepatitis A		
730	FP01800003	B16	Acute hepatitis B		
731	FP01800004	B17	Other acute viral hepatitis		
732	FP01800005	B18	Chronic viral hepatitis		
733	FP01800006	B19	Unspecified viral hepatitis		
734	FP01800007	A09	Diarrhoea and gastroenteritis of presumed infectious origin		
735	FP01800008	A08	Viral and other specified intestinal infections		
736	FP01800009	A04	Other bacterial intestinal infections		
737	FP01800010	A05	Other bacterial foodborne intoxications, not elsewhere classified		
738	FP01800011	A90	Dengue fever [classical dengue		
739	FP01800012	A91	Dengue haemorrhagic fever		
740	FP01800013	B50	Plasmodium falciparum malaria		
741	FP01800014	B51	Plasmodium vivax malaria		
742	FP01800015	B52	Plasmodium malariae malaria		
743	FP01800016	B53	Other parasitologically confirmed malaria		
744	FP01800017	B54	Unspecified malaria		
745	FP01800018	A01	Typhoid and paratyphoid fevers		
746	FP01800019	I10	Essential (primary) hypertension		
747	FP01800020	J45	Asthma		
748	FP01800021	J12	Viral pneumonia, not elsewhere classified		
749	FP01800022	J13	Pneumonia due to Streptococcus pneumoniae		
750	FP01800023	J14	Pneumonia due to Haemophilus influenzae		
751	FP01800024	J15	Bacterial pneumonia, not elsewhere classified		
752	FP01800025	J16	Pneumonia due to other infectious organisms, not elsewhere classified		
753	FP01800026	J17*	Pneumonia in diseases classified elsewhere		
754	FP01800027	J18	Pneumonia, organism unspecified		
755	FP01800028	O13	Gestational [pregnancy-induced] hypertension without significant proteinuria		
756	FP01800029	O14	Gestational [pregnancy-induced] hypertension with significant proteinuria		
757	FP01800030	O14	Pneumothorax		
758	FP01800031	A09	Diarrhoea and gastroenteritis of presumed infectious origin		

Package Rates under RSBY for Basic Package

759	FP01800032	I60	Subarachnoid haemorrhage		
760	FP01800033	I61	Intracerebral haemorrhage		
761	FP01800034	I62	Other nontraumatic intracranial haemorrhage		
762	FP01800035	I63	Cerebral infarction		
763	FP01800036	I64	Stroke, not specified as haemorrhage or infarction		
764	FP01800037	J40	Bronchitis, not specified as acute or chronic		
765	FP01800038	J41	Simple and mucopurulent chronic bronchitis		
766	FP01800039	J42	Unspecified chronic bronchitis		
767	FP01800040	J43	Emphysema		
768	FP01800041	J44	Other chronic obstructive pulmonary disease		
769	FP01800042	N10	Acute tubulo-interstitial nephritis		
770	FP01800043	N17	Acute renal failure		
771	FP01800044	P58	Neonatal jaundice due to other excessive haemolysis		
772	FP01800045	P59	Neonatal jaundice from other and unspecified causes		
773	FP01800046	I33	Acute and subacute endocarditis		
774	FP01800047	A87	Viral meningitis		
775	FP01800048	A06	Amoebiasis		
776	FP01800049	E10	Insulin-dependent diabetes mellitus		
777	FP01800050	E11	Non-insulin-dependent diabetes mellitus		
778	FP01800051	E12	Malnutrition-related diabetes mellitus		
779	FP01800052	E13	Other specified diabetes mellitus		
780	FP01800053	E14	Unspecified diabetes mellitus		