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STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESES

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

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REDUCING HEALTH INEQUALITIES: KERALA CMPREHENSIVE HEALTH INSURANCE SCHEME A ROLE MODEL FOR DEVELOPING COUNTRIES

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ABSTRACT

Despite the better outcomes in certain health indicators Kerala is facing the high risk burden of chronic/non-communicable diseases among all Indian states. Recent studies show that the highest prevalence is shifting from the more affluent to the less affluent. However the main financer of health services in India is the individual household and they meet 72% of the total health care costs at the time of illness. The vulnerability of the poor and informal workers increases when they have to pay full for their medical care without any subsidy. Current usage of poverty line as the cut off for eligibility of public subsidies may not be adequate as an episode of hospitalization can bring households above poverty line below it. A large number of people borrow money or sells assets to pay for their treatment. Thus, Health insurance could be a way of overcoming financial handicaps, improving access to quality medical care, reducing inequalities in health and providing financial protection against high medical expenses. Comprehensive Health Insurance is a unique health insurance scheme introduced by Government of Kerala in 2008, expected to increase access to health care and reduce the burden of cost of treatment. The scheme was expected to cover both BPL (Below poverty line) and APL (Above poverty line) families and people who are working in informal sectors. This review paper tries to get some preliminary insights on this unique Health Insurance Scheme successfully practicing in Kerala.

KEYWORDS

Financial protection, Health inequalities, Health insurance, Kerala.

INTRODUCTION

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Universal Declaration of Human Rights (1948), Article 25 (1)

Although the right to social security and health is well establish in international law, most of the governments in developing countries are failed to guarantee this rights to millions of people mainly because of insufficient public health funds. Financing is the most critical of all determinants of a health system. The nature of financing defines the structure, behavior of different stakeholders and quality of outcome. Health financing in India is mainly through different sources: (1) Tax based public sector comprises local, state and central government and autonomous public sector bodies (2) Private sector including the non-for-profit sector organizing and financing directly through insurance (3) Household through out-of pocket payments including user fees paid in public health facilities (4) social or community based insurance and (5) external financing through international grants and loans[1]. How ever the main financier of health services in India is the individual households. They meet about 72% of the total health care costs by paying out of pocket at the time of illness[2]. NSSO 60th Round also indicates that about 60% of hospitalized treatment in rural areas and 42% in urban areas were financed by borrowings and sale of assets. Current usage of poverty line as the cut off for eligibility of public subsidies may not be adequate as an episode of hospitalization. NSSO Repot says that a quarter of hospitalized patients in India have been impoverished because of high medical costs. One of the ways of protecting catastrophic burden of disease is through health insurance, as it protects the households from paying at the time of illness.

Kerala, the South Indian State has a free public health system for the poor for many years. Although the state is well known for its achievements in health, poor and vulnerable populations are often excluded from accessing fair quality health care. High economic costs of health care often preventing to seek health care and highly developed for –profit private health sector deters many who can not have the capacity to pay for quality care. The unique Health Insurance scheme introduced by the government of Kerala is supposed not to replace the free health care but to build upon the existing public health system. This insurance scheme is expected to reduce health inequalities in Kerala and improve access to quality health care to all. This paper attempts to give an overview of the Kerala Comprehensive Health Insurance Scheme which is unique among Indian states.

MATERIALS AND METHODS

This is a review paper comprises published articles in India which are related to community health insurance schemes, RSBY and CHIS. The review process was done through a desk review and online search with more focus on publications on RSBY, Kerala of the past 3 years.

LITERATURE REVIEW

Promoting and protecting Health is essential to human welfare and sustained economic and social development. This was recognized many years ago through Alma –Atta Declaration signatories, WHO noted that Health for all would contribute both to a better quality of life and also to global peace. People also rate health as one of their highest priorities. As a result health becomes a political issue as governments try to meet people's expectations. There are many ways to promote and sustain health. But timely access to health services is a critical issue in many developing countries[3]. This can not be achieved with out a well functioning health financing system. It determines whether people can afford to use health services when they are in need. The World Health Assembly resolution 58.33 from 2005 says everyone should be able to access health services and not be subject to financial hardship in doing so.

Recognizing this, member states of the World Health Organization (WHO) committed in 2005 to develop health financing systems so that all people have access to services and do not suffer financial hard ship paying for them. This goal was defined as universal coverage, sometimes called universal health coverage[4]. For achieving this goal, government faces the following fundamental questions.

- How a health system to be financed?
- How they can protect people from financial consequences of ill health?
- How health system can encourage optimum use of available resources?

- How they can ensure equitable coverage?[5]

The issue of health financing is an essential dimension of Health Systems reform in developing countries. It also occupies a central place in poverty reduction strategies in the implementation of debt initiatives and the pursuit of Millennium Development Goals. Abolishing user fees in health has came back in the agenda of several Sub-Saharan countries(Mali, Niger, Burkina Faso, Kenya etc) to targeted groups of people or interventions. In the emerging countries especially in Asia and Africa, the development of Health Insurance is considered a priority. Meanwhile, government and their development partners are giving importance to considerations of equity in health financing and access to health care[6]. They are more attentive to the role of financing that can play a major role in making health systems more efficient through various mechanisms. Health financing can not be separated from development policies and macroeconomic sector reforms, especially as the lack of resources often coexists with greater difficulties in terms of absorption capacity. The purpose of health financing is to mobilize resources for the health system, to ensure equitable health coverage to all and to set financial incentives for providers and assuring quality health care to all. Many high income countries like United Kingdom relay heavily on taxation or on mandatory social health insurance (Germany, France) for health financing. Low income countries in Asia and Africa are based on out of pocket payments at the point of service and some countries in Sub Saharan Africa mainly depend on international donor support[7]. But most of the countries built their health system based on two or more combination methods.

The choice of different institutional models is mainly based on the, Economic situations, Institutional capacity, external funding and cultural aspects of the country. In the current debate numbers of arguments are put forward by different international agencies to stress the advantages of Health Insurance mainly community based health insurance schemes to promote financing and access of health care in poor countries. Based on these arguments;

- The insurance can increase the availability of resources for health care
- Freeing up of limited public funds to be directed towards the poor people.
- Insurance is a more predictable way of funding than tax based system and this also can encourage private investment in public health system.
- The funds from the claims can retain in the public facilities and can utilize for the expansion of facilities and incentives for the staff.[9]

WHAT IS HEALTH INSURANCE?

Health insurance is a health care financing method. The ILO defines health insurance as "the reduction or elimination of uncertain risk of loss for individual or household by combining a large number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to anyone member". In health insurance scheme people who are in similar risk of a certain event contribute a small amount as premium towards a health insurance fund. This fund is then used to treat people who become ill. The essential components of all health insurance schemes are prepayment and risk pooling[10]. When individuals are healthy they are contributing to the fund and when they become ill the fund can be used for their health care needs. A health insurance program usually has two main functions (1) To increase access to health care (2) To protect households from high medical expenses at the time of illness[11]. The major health insurance schemes practicing in India as well as Kerala are:

1. Social health insurance schemes:

a. ESIS (Employees State Insurance Scheme): started in 1948 under ESI Act, which provides cashless services to workers employed in formal sectors. This scheme is financed by a contribution from central and state governments, employers, employees and managed by ESI Corporation. The corporation has its own dispensaries and hospitals.

b. CGHS (Central Government Health Scheme). Introduced in 1954 and is for central government employees. Employer also contributing a nominal amount according to their scale of pay.

c. UHIS (Universal Health Insurance Scheme): In 2003 ministry of finance introduced a new scheme to all sections of the society. It was implemented through four public sector insurance companies and providing coverage to Rs 30000/ per family and the premium is Rs 365/ per person and Rs 545 /family. People below poverty line are subsidized to Rs 165/ per person and Rs 245/ family. This scheme was the initiative for the development of future RSBY[12].

2. Private Health Insurance Schemes (med claim, Bajaj alliance scheme etc)
3. Community Based Health Insurance Schemes. (More than 30 Schemes in India)

Health Insurance Schemes are considered as a distinctly sub-optimal way of providing health-care to the people. Between the Insurance route on the one hand and the route of providing universal free healthcare through a National Health Service on the other, the latter is infinitely superior. Studies shown that United States, which follows the Insurance route, spends a much larger proportion of the government budget on healthcare compared to the European countries, where social democratic governments, under the influence of the example of the former Soviet Union, had put in place systems of free healthcare. Even though these free healthcare systems have got eroded over time under the impact of neo-liberal policies, they nonetheless have managed to survive and the standard of healthcare in the European countries is far better than that in the US. The reason is simple. Insurance companies, are privately-owned in the US, are extremely niggardly when it comes to settling claims. They employ a team of lawyers to fight claims, which contributes both to high insurance premia (since the costs are higher owing the employment of the team of lawyers) and low settlement ratios (since the lawyers' job is to settle low amount). As the government contributes in varying degrees to insurance premia paid by the poor, there is in effect a transfer from the public exchequer to finance the army of lawyers employed in the Insurance business. A given magnitude of expenditure earmarked for providing healthcare therefore actually ends up providing much less healthcare than under a system of free National Health Service[12].

This is main reason that the Kerala government had always been hesitated to follow the Insurance route. Its Approach Paper in the Eleventh plan was strongly against Health Insurance and in favor of a free healthcare system. It had argued that the best results, if one followed the Insurance route, would be obtained if public insurance companies did the insuring and public medical facilities did the treatment; but in such a case, instead of following the roundabout route of Insurance, it would be better to put an equivalent amount of additional funds simply into the public medical facilities, and provide universal free healthcare for the entire BPL population. Realizing this fact on October 2nd 2007 Prime minister of India announced a new health insurance scheme for households living below poverty line (BPL),defined by the planning commission of India. This scheme was later known as Rashtriya Swashtya Bima Yogana. The first RSBY health insurance card issued in Yamunanagar, Haryana on 28th February 2008. The RSBY is targeted to provide cashless hospitalization to maximum of five households and the ceiling amount is Rs30000/per annum. It covers around 750 specific procedures and hospitalization including preexisting conditions. The government of India financed 75% of the premium and 25% by state governments with a nominal registration fee of Rs30/- for getting smart cards. First insurance policy was activated in april1st 2008.Two years later more than 19 million households had been enrolled resulting the coverage around 60million people. The Central government, however, has insisted on the Insurance route, and since the Kerala Scheme takes the Central Scheme as its base, the Kerala government willy-nilly has to go along the Insurance route in order to get its quota of central funds under the RSBY. It has however reserved the right to choose the Insurance Company for its Scheme. The criterion for choice need not be the mere mechanical one of which company offers the lowest tender. Likewise, it has stipulated that the private hospitals and healthcare facilities where the people can go, in addition to the public system, will be only those private facilities empanelled, which accept a set of prescribed rates as the maximum charges for the various treatments. The RSBY itself stipulates this and prescribes such a set of rates, but, given the wide variations in medical charges that exist across the country, each state taking its own specific conditions and rates for each procedure. RSBY was implemented through National Rural Health Mission (NRHM), has its own directorate in each state.

KERALA SCENRIO

Investment in education and health has been a consistent policy of all successive governments in Kerala[13]. Since 1970s Kerala has been internationally accredited because of its outstanding performance in health indicators. Despite, the better health outcomes on certain health indicators like maternal mortality, infant mortality, life expectancy etc, the much-proclaimed Kerala model of health has been showing a number of disturbing trends. The last 30 years has seen a remarkable transition in Kerala. The state is supposed to be in the stage 111 of the epidemiologic transition. Although mortality is low, the numbers those suffering from chronic/non-communicable diseases in urban and rural are high in Kerala compared to other Indian States. Studies shown that this social transition unfortunately led to the highest prevalence of cardiac disease among all Indian states with a rural prevalence of 7.5% and urban prevalence of 12%.

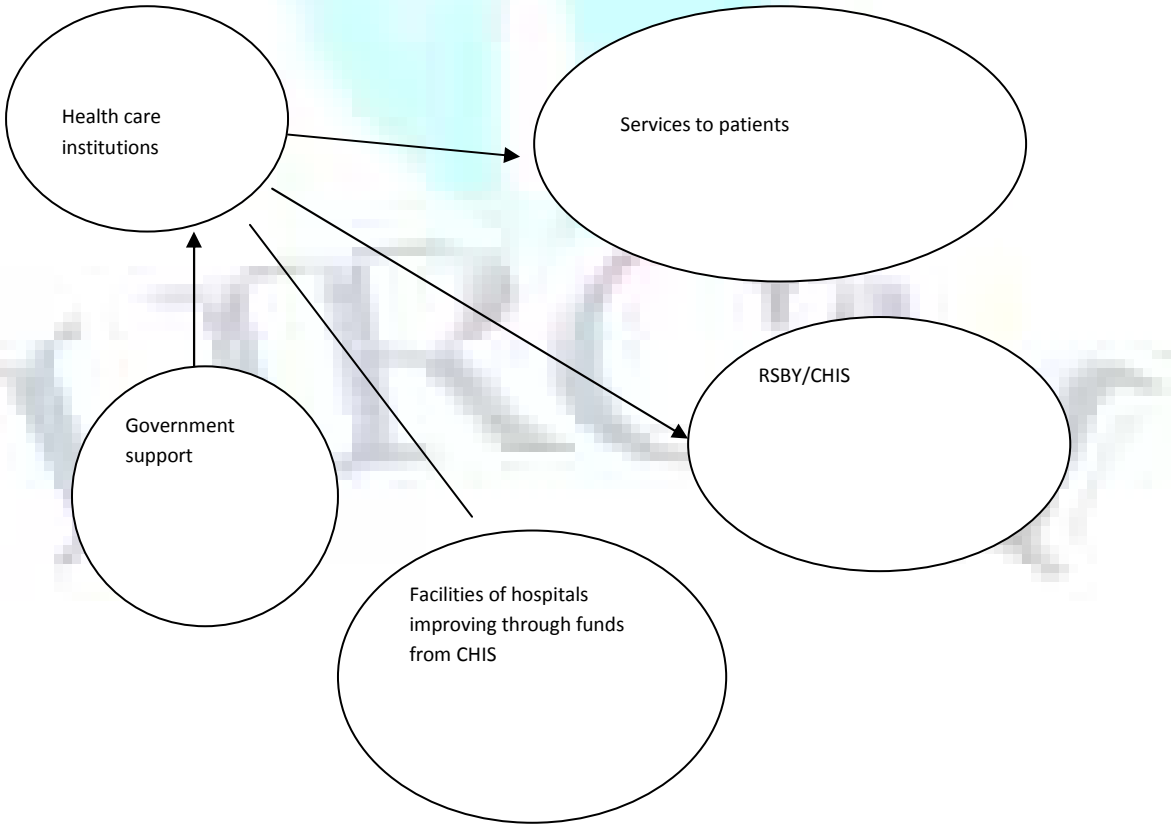
Cardiovascular death is 50% of the total death and by 2020 it is predicted to go up to2/3 of the total deaths in Kerala[14] .Studies shown that the epidemics affect the age group of 25-69, which is very less compared to other developing countries. Cardiological Society Kerala chapter report says in 2008, that 80% of the heart attacks and premature death due to cardiac problems can be prevented by appropriate management and secondary prevention strategies. But the cost of treatment and secondary prevention is so high and majority of people can not afford the high medical expenses. One of the ways to protect this uncertainty and risk of illness is health insurance. Unfortunately only around 11.4% of the population in India is covered under any form of health insurance. Given this scenario Kerala government is thinking of enhancing the protection to households by raising budgetary allocations to health care and also increasing the introduction of new health insurance schemes to the citizens.

Kerala have the best health indicators but have limited number of best public health care institutions. The success of Kerala health indicators is more due to the investment in the social capital especially advancement in educational sector rather than only in the public health care, resulting in a more accountable and integrated primary health care system. Increasingly, the public sector is unable to meet the demands for health care and people have responded to these inadequacies by increasing using the emerging private sector[14]. This has led to the impetus growth of the private medical care set up in the State and the dependence on private health care is quite high even among the lower expenditure classes and rural areas. The unregulated private sector raises household health care expenditures, making health a commodity purchased by 'ability to pay.' Many public facilities remain underutilized especially in the institution at the level of community health centres and below. In the changing scenario, the private sector reigns supremacy in the infrastructure and health manpower development than public sector in the State. The public health centres are currently being utilized mostly for maternal and child health care programmes[15]. In this context, the government of Kerala has taken up the Rashtriya Swasthya Bima Yojana (RSBY) scheme of Central government announced by Prime Minister, along with Comprehensive Health Insurance Scheme for (CHIS) in October 2008. The objective of RSBY/CHIS is to protect below poverty line (BPL) households from major health shocks that involve hospitalization. Specifically, BPL families are entitled to more than 750 in-patient procedures with a cost of up to 30,000 rupees per annum for a nominal registration fee of 30 rupees. The Scheme is jointly implemented by departments of Labour & Rehabilitation, Health & Family Welfare, Rural Development, and Local Self Govt. The Labour Department is the Nodal dept. for implementation of CHIS. A separate agency "Comprehensive Health Insurance Agency of Kerala" (CHIAK) is created for implementation of the scheme. "United India Insurance Company Limited" is the insurance provider for this scheme that will implement all 14 districts. 140 government hospitals and 165 private hospitals have been empanelled towards implementing the scheme. All five government Medical colleges are also included under this scheme[15].

BUILD UPON EXISISTING PUBLIC HEALTH SYSTEM

Kerala at present has a free public health system for the poor. The Insurance Scheme is not supposed to replace free public healthcare provision but to build upon it. This means that those who were earlier accessing the Public System for free healthcare should continue to be eligible for it even after the Insurance Scheme comes into effect, but the Public System should get compensated for an amount up to a maximum of Rs.30, 000 from the Insurance Provider in each such case. In other words, if a patient needs Rs.50, 000 expenses for treatment, then the Public System should provide this treatment. It will be paid back the amount of Rs/30, 000 by the Insurance Provider while the remaining Rs.20000 will have to be met by the public system. This point can be put differently: *the Public System will continue its current practice with regard to charging for its services, which also means that it will not charge any money to the poor; the compensation it will claim from the Insurance Provider will only be against "notional payments", calculated at certain specifically-fixed rates*[16]. If the Public System is to continue with its provision of free treatment to the poor, irrespective of whether, and by how much, it is compensated under the Insurance Scheme, and then it will have to be suitably strengthened. Under the Comprehensive Health Insurance Scheme, private healthcare facilities will be empanelled for treating patients provided they accept the fixed rates. To ensure that the poor get a reasonable amount of healthcare within the Rs.30, 000 insurance limits, these rates have to be kept at a moderate level, and certainly below what the private facilities charge for the facilities at present. E.g. for an abdominal hysterectomy the charge is about Rs 6500/ under CHIS instead of charging Rs 20000/ in private sector. So there will be an excess demand for the public healthcare facilities with the launching of the Insurance Scheme. This has to be met through an improvement in the public health system. The patient has an option to choice private empanelled hospitals also, but the rates are same and are fixed under this scheme. This will be a model for public- private partnerships in health system.

FIGURE 1: RSBY/CHIS MODEL



Source NRHM working paper 2010

The "flow back" of Insurance Premium from the insurance provider to the Public System will be used for improving the quality of health system itself. In addition NRHM itself is providing enough funds for improvement of public health system. For achieving this aim: (i) each Public Healthcare Institution *will be allowed to retain the Insurance premium flow back that it obtains*, at least for the first year, (ii) there must be of incentives for the medical and other staff in each public institution, based on the magnitude of flow back of premium. Since the flow back of insurance payments will take time, and public healthcare institutions in the state cannot wait that long to improve their facilities, they will be allowed to borrow within a limit from co-operative banks under an Escrow Account for undertaking expenditure for such improvement. These loans can be repaid as the insurance payments flow in. Such borrowing in anticipation of flow back will also be necessary for equipping the Public Healthcare Institutions to install the requisite facilities for dealing with "smartcards". The scheme started in August 2008 in Alapuzha district and extended to all 14 districts. Health Insurance Schemes in the country, even under RSBY, have till now been confined to a few districts in particular states. The Kerala Scheme in this respect is a trailblazer, since it covers an entire state, and even within that state a population that greatly exceeds what is currently counted as "poor" by the Planning Commission.

IMPLEMENTATION OF RSBY/CHIS IN KERALA

Initially, the government was doubtful of whether it was necessary to adopt the RSBY as it is or introduce a new one as a comprehensive Health Insurance scheme. Whether it would be a success as it had to compete with the private sector where the facilities were better equipped than the government sector or to involve private providers. However, after one and a half year of implementation, the apprehensions have been proved wrong. The total revenue earned by the empanelled government hospitals stands testimony to this. Since the implementation of RSBY/CHIS scheme till April 2010 the revenue generated by empanelled government hospitals is more that that of the empanelled private hospitals. According to the NRHM report after one year Public health institutions contribute more than 60% of the case load as well as 57% of revenue generated for the public health institutions through the scheme. It stands at almost 25 crores out of Rs. 44 crores collection for year 2009-10 and is projected at 30 corers in 2011-12. The facilities and patient friendly health services have been augmented owing to increased revenue generated through RSBY/CHIS and support from Arogyakeralam. It is highly appreciable to note that the government hospitals are becoming more competent to manage the services. Implementation done through strong Hospital Management Committees the empanelled government hospitals are moving towards a stage of self reliance empowered with the revenue generated through RSBY/CHIS. The staffs in the empanelled hospitals are more motivated because of quality improvements in the hospitals and incentives for the staff. The public health care institutions are now in a position to compete with the private hospitals in terms of providing quality and patient friendly health services. This is apparent in terms of revenue generated by empanelled government hospitals as compared to empanelled private hospitals since the implementation of RSBY/CHIS. In Alapuzha district, Cherthala government hospital is a role model for the implementation of this scheme. First year it self the hospital claimed 1 crore by admitting 2971 cases. As per the Planning Commission estimates there are 11.79 lakhs BPL families in the state, all of whom are being covered under the RSBY. The state Government has estimated another 10 lakhs families eligible to be included in the BPL list. The state Government has decided to extend the benefits of RSBY to additional 10 lakhs poor families also, meeting the entire expenditure from State Government funds. In addition the state Government has decided to extend the same scheme to benefit households Above Poverty Line (APL). But the entire premium should to be borne by the beneficiary and it rate is fixed as Rs 565/ and the coverage will be for five members for a family.

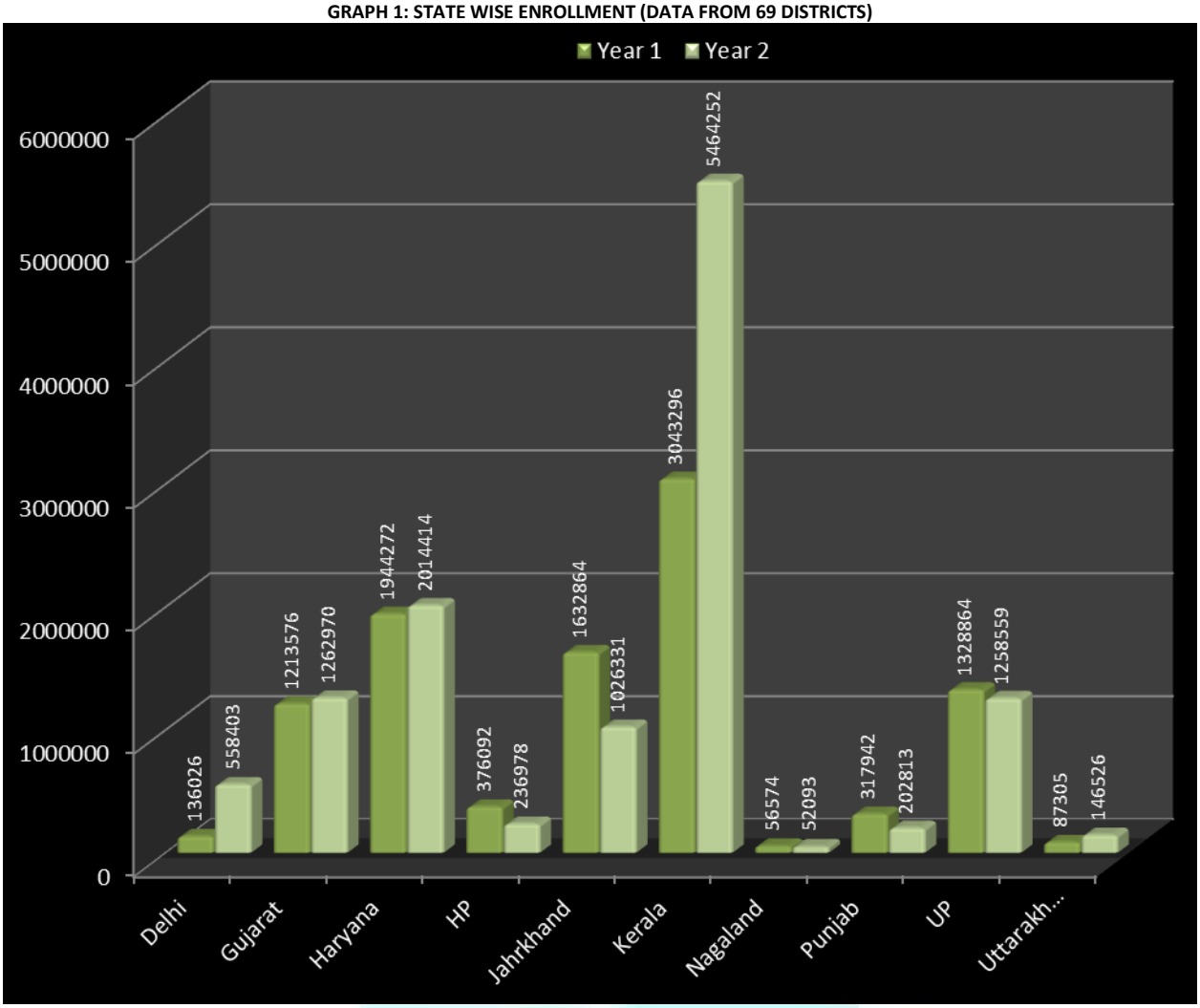
During the 2nd year, the state Government extended the coverage to the following categories also in addition to the BPL families(1) SC/ST Families(2) Fishermen families(3) Ashraya families(4) Agricultural Workers(5) All workers in the Beedi, Handloom, Coir, Khadi, Bamboo, Kattuvalli, Small Plantations, Other unorganized sector(6) Cashew workers and pensioners (7) NREG Workers who had worked at least 15 days(8) Anganvadi Workers/helpers(9) Tailoring workers(10) Asha workers(11) Pensioners of Building and other construction workers welfare board, Head load workers welfare board, Kerala Motor workers welfare board and Kerala Abkari Workers Welfare Board(12) Domestic workers. The state government's target is to bring 35 lakhs of families under the coverage of Health Insurance. The government expects to achieve this target during the year 2011-12.In addition to the coverage of Rs 30,000 available under the Central Scheme, the state government has decided to give additional coverage of Rs 70,000 to the beneficiaries for the treatment of serious disease affecting kidney, heart and for cancer treatment. This Amount in addition to Rs 30000 available under RSBY will be allotted to the respective hospitals directly by CHIAK through non insurance route[18]. Government of India has evaluated that 'Kerala has issued highest number of RSBY smart cards in the Country. The State is also ahead of other States in putting in place procedures and practices which are worthy of appreciation in the implementation of the scheme. As recognition of this achievement Kerala government had given award for outstanding commitment in terms of initiative, innovation and institutional building in RSBY in 2009 and 2010.

TABLE 1: HOSPITAL WISE CLAIMS TILL FEBRUARY 2010

DISTRICT	TYPE	PATIENTS ADMITTED	AMOUNT RECEIVED	AMOUNT PENDING	TOTAL
TRIVANDRUM	GOVT	2775	5742748.00	2807531.50	11485609.50
	PVT	4212	8122916.00	488982.50	16558812.50
	TOTAL	**6987**	**13865664.00**	**3296514.00**	**28044422.00**
KOLLAM	GOVT	1454	2944640.00	2556684.00	5501324.00
	PVT	7799	13072076.00	7671154.00	20743230.00
	TOTAL	**9253**	**16016716.00**	**10227838.00**	**26244554.00**
PATHANAMTHITTA	GOVT	1501	3041693.00	168000.00	6015077.00
	PVT	81	37687.00	313761.00	351448.00
	TOTAL	**1582**	**3079380.00**	**481761.00**	**6366525.00**
ALAPUZHA	GOVT	9135	23200280.00	9263612.50	32463892.50
	PVT	4790	13130715.00	0.00	15934220.00
	TOTAL	**13925**	**36330995.00**	**9263612.50**	**48398112.50**
KOTTAYAM	GOVT	6867	14969485.00	7016643.00	22246128.00
	PVT	1722	3586323.00	0.00	4904785.00
	TOTAL	**8589**	**18555808.00**	**7016643.00**	**27150913.00**
IDUKKI	GOVT	1033	1911202.00	2382401.00	4293603.00
	PVT	0	0.00	0.00	0.00
	TOTAL	**1033**	**1911202.00**	**2382401.00**	**4293603.00**
ERNAKULAM	GOVT	2006	3639159.00	102857.50	5686607.50
	PVT	0	24884857.34	0.00	27645182.84
	TOTAL	**2006**	**28524016.34**	**102857.50**	**33331790.34**
THRISSUR	GOVT	5426	14766486.00	1503035.00	19778488.00
	PVT	5389	16340007.00	9899531.00	26239538.00
	TOTAL	**10815**	**31106493.00**	**11402566.00**	**46018026.00**
PALAKKAD	GOVT	3951	6390913.00	178125.00	8279226.00
	PVT	1339	3393112.00	946401.00	4339513.00
	TOTAL	**5290**	**9784025.00**	**1124526.00**	**12618739.00**
MALAPPURAM	GOVT	792	1149625.00	1997825.50	3147450.50
	PVT	60	12500.00	13000.00	25500.00
	TOTAL	**852**	**1162125.00**	**2010825.50**	**3172950.50**
KOZHIKODE	GOVT	5555	10732426.00	8819706.00	19552132.00
	PVT	2964	5341233.55	805636.05	6146869.60
	TOTAL	**8519**	**16073659.55**	**9625342.05**	**25699001.60**
WAYANAD	GOVT	1362	3065588.00	1792971.00	4858559.00
	PVT	0	0.00	0.00	0.00
	TOTAL	**1362**	**3065588.00**	**1792971.00**	**4858559.00**
KANNUR	GOVT	1441	4042984.50	22500.00	5161669.00
	PVT	1974	6460864.00	0.00	7377748.00
	TOTAL	**3415**	**10503848.50**	**22500.00**	**12539417.00**
KASARGODE	GOVT	3571	4880672.00	9500.00	5093382.00
	PVT	1724	7381145.50	767697.50	8148843.00
	TOTAL	**5295**	**12261817.50**	**777197.50**	**13242225.00**
STATE	**GOVT**	**46869**	**100477901.50**	**38621392.00**	**139099293.50**
	PVT	**32054**	**101763436.39**	**20906163.05**	**122669599.44**
	TOTAL	**78923**	**202241337.89**	**59527555.05**	**261768892.94**

Source: NRHM Kerala working paper 2010

GRAPH 1: STATE WISE ENROLLMENT (DATA FROM 69 DISTRICTS)



Source: NRHM paper RSBY is going.

SPECIAL SCHEME FOR CARDIAC, RENAL AND CANCER (CHIS PLUS) CARE

In February 22nd 2011 Kerala government introduced a new scheme of Comprehensive Health Insurance for all BPL card holders of Kerala, known as "CHIS PLUS". The Home Minister announced in his budget speech for the current year that addition treatment facility up to Rs 70000/ for BPL card holders of RSBY/CHIS for critical care patients of cardiac, cancer and kidney problems. This scheme is implemented through any insurance company like RSBY/CHIS, but fully funded by state government. At the beginning 23 hospitals are empanelled for this scheme where the RSBY/CHIS card holder will get treatment for three fatal diseases of heart, kidney and cancer. Government of Kerala decided to enhance the membership to 35lakhs families and it is assessed that about 0.10% of families will make use of this new scheme. The hospitals will have to provide care for 3500 patients for the year 2010-11 and the expenses will be 24.5 crore. It is expected that CHIS PLUS implementation will prevent premature deaths of people who deserve in poor families[19].In the year 2010, according to the report of NRHM 2500 people were benefited through this scheme.

CONCLUSION

This century has witnessed greater gains in health outcomes then any other times in the history of Kerala. These gains are the results of improvements in income and in health enhancing social policies like housing, clean water, sanitation systems, nutrition and greater gender equality in education. They also result from the awareness of the cause of diseases, its prevention, treatment, financing of health care, introduction of health policies, and expansion of health services, and political commitments all contributes to this success. Improving ways to finance health care and protect populations against the cost of illness has been central to this success story.

There is growing evidence that the level of health care spending in India is currently over 6% of its total GDP and is considerably higher than other developing countries. The evidence also suggests that more than 70% of the total spending on health care is out of pockets expenses. The provision of health care that is adequate in terms of quality and access for the growing demand is always a question in front of all state governments. Particularly, public delivery of health system is poor in quality mainly because of inadequate funding. This highlights the need for alternative financing mechanisms which will reduce the burden of catastrophic payments at the time of illness. Health insurance is one mechanism reducing the burden of financial hardships of citizens when they are sick. In Kerala the prevalence of non-communicable diseases are highest among all Indian states and the cost of treatment and secondary prevention is very high. Unfortunately a very small percentage of people were covered by any form of health insurance in India as well as Kerala and the poor and people who are in informal sectors are more vulnerable**.** In this scenario the Comprehensive Health Insurance Scheme implemented by the government of Kerala for both BPL and APL families (about 35 lakhs of beneficiary families) is appreciable. But getting "smart" cards prepared for a population of this size, distributing the cards on time, empanelling private institutions which are willing to participate in the scheme by accepting the prescribed rates, getting public health facilities to be ready for the implementation for this scheme, settling claims on time ,pose a formidable administrative challenge for the state. Adverse selection and moral hazard are the inherent problems of all health insurance schemes will also affect this scheme. Another important issue is finding poor and most vulnerable groups who are in real need of financial protection at the time of hospitalization. There are many leakages and under coverage for the identification of poor people in planning commission report. So government must take sincere effort to find out the real beneficiaries of this scheme and high political commitment is needed for this effort. Like any other community based insurance schemes the sustainability of this scheme is also questionable.

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