Health Care Financing: The Karnataka's Experience

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The main objective of this paper is to analyse the health care scheme known as Yeshasvini Co-operative Farmers' Health Care Scheme (YCFHCS) introduced in the state of Karnataka, which has evinced a great interest among policy makers in India and abroad, and also as a background, to discuss the importance of health care financing in a developing country like India. The paper is divided into three sections. The first section explains the importance of health care financing, the second section analyses the main features and details of YCFHCS and its relevance in the present context and the third section sums of the analysis.

SECTION I

The recent emphasis on human resource development worldwide has necessitated particularly the developing countries to pay greater attention to health care delivery as health and human resource development are closely related. Health care financing assumes a greater significance in developing countries because of the growing population and the ever-increasing demand for health services. For a country, which has embarked upon economic reforms, investment in human development becomes crucial from the point of view of long run success of economic reforms. Developing countries can achieve far better results with greater emphasis on health care, which is one of the crucial components of human resource development.

With the publication of human development reports since 1990s, countries worldwide are ranked as per human development index (HDI). It is evident from successive human development reports that many developing countries are placed in the bottom of the list with lower ranks as against developed countries, which are found at the top of the list with higher ranks. For instance, as per the HDI

prepared for 177 countries by the UNDP for the year 2002, India's HDI (index 0.595) rank is 127, which is very low even among countries with medium human development (Human Development Report 2004).

Health Care Cost and Poverty: Interrelationship

Health and education play a crucial role in enhancing human capabilities. Of these two, health plays a decisive role because children who enjoy better health are more likely to enroll in schools thus leading to improved literacy levels in the long run. Why health matters is aptly explained in the World Development Report 1993. The report points out that 'Improved health contributes to economic growth in four ways: it reduces production losses caused by workers' illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrollment of children in school and makes them better able to learn and it frees for alternative uses resources that would otherwise have to be spent on treating illness.'

The National Health Policy 2002 aims at raising public expenditure on health from the current level of 0.9 per cent of GDP to 2 per cent of GDP by 2010. It is inevitable for any country, in the recent years, to devote a large part of resources to health care as treating sickness has become costly, more so in a country like India which has a greater incidence of morbidity. Health care financing is of critical importance in India for two reasons. One, health sector is largely dominated by the private sector where nearly four-fifths of health expenditure is out-of-pocket (India Development Report 2004-05, p. 63). Second, the poor and rural people have no easy access to quality health care.

In the absence of provision of free health care services by the government, it is the poor who suffer most because they cannot afford to meet unexpected health related expenses. It is appropriate to refer to what the World Development Report, 1993, states in this connection. The report observes that 'the adverse effects of ill health are greatest for poor people, mainly because they are ill more often, but partly because their income depends exclusively on physical labour and they have no savings to cushion the blow. They may therefore find it impossible to recover from illness with their human and financial capital intact'. Therefore, it is to be noted that, if government fails to provide free health care services to its people,

not only productivity suffers but also the condition of poor would worsen resulting in higher poverty. It is an irony that people in developed countries, who have affordability enjoy better health care facility on accounts higher public expenditure on health than their counterparts in developing countries, who are compelled to spend out of their pocket owing to lower public expenditure. In most high-income countries share of public and private expenditure on health is three-fourth and one-fourth respectively while it is exactly opposite in low-income countries (World Development Indicators, 2003. p. 94). There are four models of health care financing: (1) Direct / out-of-pocket payment by users; (2) Private / Voluntary insurance; (3) Social / compulsory insurance; and (4) General taxation. (Islam, S., 2006, p. 2) Though each model has its own merits and demerits, it is the combination of different models which is needed for a country like India. Several studies have shown that an account of sudden unanticipated huge health expenditure, several families have slipped below the poverty line. This underlines the need for active government intervention in health care financing. In this connection, Yeshasvini health care scheme introduced by the Karnataka government is worthy of detailed analysis.

SECTION II

Karnataka, which is already a global name in information technology, is in the news again for the innovative scheme it has launched in providing health care to farmers. The scheme is known as "Yeshasvini Cooperative Farmers' Health Care Scheme" (YCFHCS). The scheme was formally inaugurated on November 14, 2003 by the then Chief Minister of Karnataka Sri. S.M. Krishna and became operational from June 1, 2003. Yeshasvini scheme has heralded a new chapter in providing quality health care to co-operative farmers. As a result, Karnataka has become a role model for other states. The chief minister of Rajasthan made a special trip to Bangalore in February 2005 to have first hand information about Yeshasvini scheme. Similarly Madhya Pradesh, Himachal Pradesh, Andhra Pradesh and West Bengal have sought details from Karnataka to introduce the scheme in their respective states. It is said that even Bangladesh has shown interest in the scheme (*The Hindu*, Karnataka edition, dated 11-02-2005). The government's claim that the Yeshasvini scheme is first of its kind in the country may probably in the world appear to be justified with two major US bodies, Harvard

and the Rockefeller foundation showing interest in the scheme for replicating it in African countries. It is said that even the World Bank has shown interest in the scheme with a view to exploring possibilities of replicating such a scheme in low-income countries.

Main Features

The scheme was conceptualised by Dr. Devi Shetty, a well-known cardiologist of Bangalore and made implemental by Sri. A. Ramaswamy, Principal Secretary for Co-operation, Government of Karnataka. The scheme is a contributory one, where a farmer who is a member of a cooperative institution can join Yeshasvini scheme by paying a meagre sum of Rs. 120 per year i.e. at the rate of Rs. 10/- every month. The scheme is being managed by the Yeshasvini Cooperative Farmers' Health Care Trust. The Family Health Plan Limited (FHPL) is recognised as the Third Party Administrator as per Insurance Regulatory and Development Authority Act. Following are the special features of the scheme.

— 'Upper age limit to avail the benefits of the scheme is 75 years.
— Suffering from any kind of disease is no bar to avail the benefits of the scheme.
— Farmers have to be a member of co-operative society for at least 6 months to avail the benefits of the scheme.
— Members can avail free surgery costing up to Rs. one lakh and two lakh for multiple surgeries.
— 1600 types of surgeries have been included in the scheme.
— Hospitals which fulfill the parameters fixed by the Yeshasvini Trust only are recognised as Network Hospitals.
— Deputy Commissioner (there is a move now to appoint Chief Executive officer of the Zilla Panchayat in place of Deputy Commissioner) at the district level functioning as Chairman co-ordinates all the activities with the Deputy Registrar of Cooperative Societies of the District functioning as Member Secretary.' (Website, page 3 of 5)

Scheme Details

— 'Scheme provides benefits to co-operative farmers, spouses and two dependents (undivided son and unmarried daughter).
— The co-operative farmer should be a member of the co-operative society for a period of 6 months for joining the scheme.

— Annual contribution of Rs.120 has to be paid for each member of the family. The amount cannot be paid in installments.
— The government of Karnataka, on its part has contributed a sum of Rs. 4.50 crore towards Yeshasvini scheme during the year 2003-04.
— Photo ID card is issued to each beneficiary enrolled under the scheme for easy identification.
— The scheme also offers free outpatient services at network hospitals.
— The network hospitals also offer investigation for the members at a concessional price.
— Over 114 reputed and quality hospitals and nursing homes across the state of Karnataka have been identified for extending cashless treatment to the beneficiaries.' (Website, page 1 of 2)

Procedures for Obtaining Treatment

The beneficiary is required to approach the nearest network hospital with ID card for any surgical benefits under the scheme. The network hospital examines ID card of the beneficiary, forwards the pre-authorisation form to FHPL to know whether the required treatment is covered under the scheme. The FHPL after scrutiny issues pre-authorisation to the network hospital to perform the surgery. The network hospital extends cashless facility to the beneficiary. The network hospital, after performing the surgery, forwards the bill along with the relevant documents to the FHPL for the settlement of the claim. The FHPL scrutinises the bill and presents before the Trust for the sanction of amount.

Role of Family Health Plan Limited (FHPL)

The FHPL is an Insurance Regulatory and Development Authority (IRDA) licensed Third Party Administrator (TPA). The FHPL being the largest TPA in the country is said to be having enough expertise in the field. The FHPL here acts as a coordinator among the insurer, the insured and the health service provider. Basically, the FHPL is meant to:
— 'Arrange effective maintenance and control of the Yeshasvini fund to curb misutilisation.
— Assist the trust in providing cashless surgery to members through a chain network of hospitals across the state.
— Assist in managing Yeshasvini help desks in every hospital.

— Approve pre-authorisations sent by network hospitals.
— Process the claims and arranges payment to the network hospitals.
— Maintain required manpower to monitor, manage and maintain the scheme
— Assist the Trust in issuing ID cards to the beneficiaries of the scheme.
— Manage 24/7 call centre to guide and assist the members.' (Website Page 2 of 2).

Progress Achieved During the Last Three Years

During the first year of the scheme i.e. June 2003 to May 2004, 16.01 lakh farmers got registered and an amount of Rs. 9.60 crore was collected. In turn, the state government contributed Rs. 4.50 crore to the Yeshasvini fund, raising the corpus fund to Rs. 14.56 crore. As on May 31, 2004, 9034 surgeries have been conducted and 36000 members have availed themselves of (valued at Rs. 66 lakh) free OPD facility. Network hospitals numbering 114 have been recognised at city/district levels.

During the second year, i.e. from June 2004 to May 2005, about 20 lakh farmers have enrolled themselves as members and an amount of Rs. 12 crore has been collected as contribution. On the whole, claims numbering 14,963 have been settled involving an amount of Rs 18.02 crore. Besides this, 50171 members have been given free OPD treatment. Further, progress during the third year, i.e. from June 2005 to May 2006 does not appear to be satisfactory for the reason that the total number of farmers who enrolled themselves as members declined to 14.73 lakh. However, the contribution collected was Rs.16.29 crore, probably owing to the doubling of membership fee. Altogether, claims numbering 13,495 have been settled involving an amount of Rs.18.51 crore. Apart from this, 50174 members have been given OPD treatment.

SECTION III

The self-funded Yeshasvini health care scheme has shown good success in the last 3 years. It is interesting to note that the scheme is designed on the basis of the results of the studies which show that on an average only 0.08 per cent of the members covered would require operations (India Today, May 17, 2004, p. 79). It means that the cost of treatment of people suffering from ill-health is borne by

others who do not need any medical help. As a result, managing the scheme will never be a burden to government. Therefore, the scheme is novel and innovative for the simple reason that the community is provided with free health care at no cost to the government. Generally, most health insurance companies do not offer any coverage to the diseases which the insurer was suffering from prior to the buying of policy. Uniqueness of Yeshasvini Scheme is that the member gets coverage even to the diseases which one has been suffering from prior to becoming a member of the Scheme.

The author, out of inquisitiveness, happened to interact with a couple of beneficiaries of the Yeshasvini scheme. All of them have expressed satisfaction about the functioning of the scheme. Time taken for obtaining consent from the FHPL for treatment was one month in three cases and 6 months in one case. One major complaint about the scheme relates to the age limit fixed for women members who are required to undergo operation for uterus-related problems. The trust has permitted operation for uterus-related problems only in case of women of 50+ years. But there are women facing these problems who are in their early and late 40s. Consequently, many women of less than 50 years age suffering from uterus-related problems are denied treatment under Yeshasvini. (Regional Newspaper, *Prajavani*, 19-02-2005) It is often complained that a lot of time is taken to get approval of the FHPL for commencement of treatment by network hospitals. But in order to see that the genuine patient is not made to suffer, the network hospitals, when they are convinced that the treatment is covered under Yeshasvini scheme, have gone ahead with treatment awaiting consent of the FHPL. One major drawback of the Yeshasvini is that it applies only to surgical treatment. In case of treatment for ill-health, which does not require surgical treatment, the patient has to meet the cost himself.

An interesting observation made by the beneficiaries is that in the absence of help under Yeshasvini, they would not have undergone surgery without recourse to borrowings. The general opinion among public is that the scheme is very useful and relevant in the days of rising health care cost. The beneficiaries interviewed categorically stated that the scheme should continue. They made two suggestions. One, whatever charges network hospitals claim for having treated the patient, should be made known to the patient. Second, the scheme should aim at creating greater awareness among poor and marginalised sections of society so that these sections are proportionately benefitted from the scheme.

To sum up, it may be pointed out that there is a very good impression about functioning and usefulness of the Yeshasvini Scheme. Given the kind of awareness among poor and SC/ST people in society, it is likely that the benefits of Yeshasvini accrue largely to relatively better off groups of society. A detailed analysis of the scheme, based on field study is necessary, to find answers to the following questions. (1) Who are the category/class of people being benefitted from the scheme? (2) Has the scheme been able to bridge inequalities in the access and utilisation of health care services in rural areas? (3) Are the poor and marginalised sections of society are completely aware of the benefits under Yeshasvini Scheme?

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