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HEALTH INSURANCE AND SUSTAINABLE DEVELOPMENT: AN EMPERICAL ANALYSIS

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ABSTRACT

Health is an important constituent of sustainable development. It not only enhances human efficiency but also leads to a decline in private and public expenditures on sickness and disease. Health care is the diagnosis, treatment, and prevention of disease, illness, injury and other physical and mental impairments in humans. Health financing is the method of gaining the source of revenue in health services. Health Insurance is a mechanism by which a person protects himself from financial loss caused due to accident or disability. Multiple of health insurance schemes are introduced and implemented by the central and state governments in India in collaboration as well as independent of each other. Since the liberalisation of insurance sector private companies and NGOs also introduced several health insurance programmes. Health insurance sector has made tremendous progress in terms of expenditure and product. Yeshaswini Cooperative Farmers Health Care Scheme (Yeshaswini Health Insurance Scheme) is the most popular and successful programme, initiated by the Karnataka State Government on 1st June 2003, implemented through a network hospitals to provide cashless quality healthcare facilities to the co-operative farmers of Karnataka. The Central Government announced the Ayushman Bharath (National Health Protection Mission) in the 2018-19 budget which is implemented across the country. Karnataka Government subsumed the Yeshaswini scheme with the central scheme of Ayushman Bharat in November 2018. But recently the honourable CM of Karnataka announced the re-launch of Yeshaswini programme independently as earlier. This is high time to discuss the possible impact of merging or continuation of the scheme. The paper discusses impact of most popular health insurance scheme in Karnataka i.e., Yeshaswini health insurance scheme and possible impact of subsuming this scheme with most ambitious programme of the central government i.e., Ayushman Bharat.

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INTRODUCTION

Built on the principle of 'Leaving no one behind' - the '2030 Agenda' of UNDP stresses a holistic approach to achieve sustainable development for all. The new Agenda was adopted in September 2015 by the General Assembly of UNO. It includes 17 Sustainable Development Goals which are also known as Global Goals to end poverty, protect plane and to ensure that all people enjoy peace and prosperity. 'Good Health and Well-being at all ages' – is the third 'Sustainable Development Goal' of UNDP (SDGs). Health is an important constituent of sustainable development. It not only enhances human efficiency but also leads to a decline in private and public expenditures on sickness and disease.

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Improved health of population helps to achieve other goals like reduction in poverty, gender empowerment, universal education and social cohesion. Improved health contributes to economic growth and welfare. Health care is the diagnosis, treatment, and prevention of disease, illness, injury and other physical and mental impairments in humans. Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers. According to the World Health Organization (WHO), a well-functioning health care system requires: (a) A robust financing mechanism, (b) A well-trained and adequately-paid workforce, (c) Reliable information on which to base decisions and policies and (d) Well maintained facilities and logistics to deliver quality medicines and technologies. (WHO, 2010) Health financing is the method of gaining the source of revenue in health services. There are four main methods of financing health services: (i) Financing by public budget, (ii)

Financing by direct payment by patients, (iii) Employer-based and (iv) Health insurance. Health Insurance is a mechanism by which a person protects himself from financial loss caused due to accident or disability. Multiple of health insurance schemes are introduced and implemented by the central and state governments in India in collaboration as well as independent of each other. Since the liberalisation of insurance sector private companies and NGOs also introduced several health insurance programmes. Health insurance sector has made tremendous progress in terms of expenditure and product. Yeshaswini Cooperative Farmers Health Care Scheme (Yeshaswini Health Insurance Scheme) is the most popular and successful programme, initiated by the Karnataka State Government on 1st June 2003, implemented through a network hospitals to provide cashless quality healthcare facilities to the co-operative farmers of Karnataka. The Central Government announced the Ayushman Bharath (National Health Protection Mission) in the 2018-19 budget which will be implemented across the country. Karnataka Government subsumed the Yeshaswini scheme with the central scheme of Ayushman Bharat in November 2018. But recently the honourable CM of Karnataka announced the relaunch of Yeshaswini programme independently as earlier.(Times of India, 2nd February 2019) This is high to discuss the possible impact of merging or continuation of the scheme. In this regard the paper discusses the benefits of Yeshaswini scheme; similarities and differences between Yeshaswini and Ayushman Bharat programmes; and suggests measures. A survey is conducted in Udupi district to analyse the benefits of Yeshaswini Health Insurance Scheme.

Statement of the Problem: Health expenditure is the amount spent by individuals, groups, nations or private and public organizations for total healthcare and/or its various components. Total Health Expenditure (THE) for the year 2014-15 is estimated at Rs. 4,83,259 crore, which accounts for 3.9 percent of GDP. This share is very low when compared with other countries like Australia – 9 percent of GDP, USA – 17.1 percent of GDP, Germany – 11.3 percent of GDP, France – 11.7 percent of GDP, Russia – 6.5 percent of GDP. Government Health Expenditure (GHE) includes all expenses on health incurred by the central, state and local governments. It is estimated at Rs. 1,39,949 crore, which amounts for 29 percent of THE, 1.13 percent GDP and for about 3.94 percent of General Government Expenditure. Of the GHE, the Union Government shares 37 percent and the State Government shares 63 percent. Out-of-Pocket Expenditure (OOPE) is the amount incurred directly by the individuals for seeking healthcare services. The World Health Organisation has recommended that governments must spend at least 5 percent of GDP on health sector. (WHO, World Health Report 2013 – Research for Universal Health Coverage., 2013) However, in India the share of public expenditure on health is only 1.13 percent of GDP and 29 percent of the total health expenditure, 71 percent being the out-of-pocket expenditure. The obligation to pay directly for services at the moment of need prevents millions of people receiving healthcare when they need it. For those who seek treatment, it can result in severe financial hardship, even impoverishment. Over 63 million people are pushed to poverty every year owing to healthcare costs. The only way to reduce reliance on direct payment is for the governments to encourage the risk-pooling prepayment approach. Health Insurance being the risk-pooling mechanism has become an alternative to meet healthcare needs of the people at an affordable cost. World Health Report 2010 opines that if the direct out-of-payment for healthcare is more than 40 percent, it is considered to be a financial catastrophe. NSSO 71st Round Survey data show that in India major source of finance for hospitalisation is income/savings which accounts for 67.8 percent in rural areas and 74.9 percent in urban areas. Next main source of financing hospitalisation is borrowing which accounts for 24.9 percent in rural areas and 18.2 percent in urban areas, contribution from friends/relatives which accounts for 5.4 percent rural areas and 5.0 percent in urban areas. 0.8 percent households in rural and 0.4 percent households in urban areas sell their assets to seek hospitalisation treatment. (NSSO, 2016) In this regard, this is high time to discuss Health Insurance which is specially designed for the protection of low-income people, with affordable insurance products to help them to cope with and recover from common health risk. In this context it is noteworthy that households in which the members are insured are more likely to have access to care and less likely to be burdened by healthcare expenditures than households without insurance. As reported by the Ministry of Health and Family Welfare Current Health Insurance expenditure including that of the government and private is Rs. 32308 crore which accounts for 7.6 percent of Current Health Expenditure. Household payment is the major source of Health Insurance Expenditure. 49.5 percent of the Total Health Insurance Expenditure is sourced from households, 27 percent from the Government, and 23.5 percent from employers. (MoHFW, 2016) Multiple health insurance schemes are introduced by the central and state governments, private companies and NGOs many a time having overlapping target groups and areas, different benefit packages, different objectives, forms and designs.

Objectives of the Study

- To study analyse the financial protection extended by Yeshaswini Health Insurance Scheme.
- To analyse the impact of Yeshaswini Scheme on accessibility and affordability of the people for health care services.
- To study the comparison between Yeshaswini scheme and Ayushman Bharat.
- To suggest measures for the improvement of schemes.

MATERIALS AND METHODS

The study comprises two methodological processes based on the source of data. At first, the study of the secondary sources of information is undertaken. For this purpose reports and documents of various departments and offices of the government and international institutions pertaining to health and health insurance are collected. Apart from this, manuals and handbooks published by the health insurance scheme implementing institutions are collected and studied. Along with this, evaluation and research studies with regard to the schemes undertaken by the experts are examined. The second part of the study consists of field survey to collect primary data. The field survey was undertaken in Udupi district. The area of Udupi district was selected for many reasons. Moreover it ranks first among the districts of Karnataka in health indicator of HDI (1991 and 2001). It also tops in education indicator of HDI (1991 and 2001). It is ranked second and third in HDI 1991 and 2001 respectively. It also tops in the health and education indicators of GDI 1991 and ranks second in the health and education indicators of GDI

Table 1. Enrolment and Benefits under Yeshaswini 2014 to 2016

	Karnataka*		Udupi**	
	2016-17	2015-16	2013-14	2014-15
Members	4342000	412800	78752	87258
Premium (Rs. lakh)	10532.00	8228.00	119.32	174.00
Government Aid (Rs. lakh)	17043.00	10956.00	NA#	NA#
No. of Free OPD Treatment	271776	219444	11717	18852
No. of Surgeries Done	194129	179733	3118	4828
Amount Spent on Surgery (Rs. lakh)	31782.00	28621	148.35	236.80

* Source: website of Yeshaswini Co-operative Farmers Health Car Scheme, **Source: Office of the Deputy Registrar of Cooperative Societies, Udupi, # NA – Not Available

Table 2. Enrolment of Households

No. of Members	Total Members		Enrolled Members	
	No.	%	No.	%
Single	2	1	8	5
Two	5	3	42	28
Three	10	7	28	19
Four and More	133	89	72	48
Total	150	100	150	100

Source: Primary Data

Table 3. Duration of Membership

Duration	Yeshaswini	
	No.	%
More than 5 years	38	25
3-5 years	45	30
2 years	48	32
One year	19	13
Total	150	100

Source: Primary Data

2001 as per Karnataka Human Development report 2005. The district is in a leading position in accomplishing the United Nations Millennium Development Goals in health sector in the state. As per Udupi District Human Development Report – 2014, IMR, MMR, CMR, TFR indicators for Udupi are the lowest in the country. (Udupi Zilla Panchayat and Planning, 2014) Udupi district has three taluks and all the three taluks are selected for the study. Working of the existing health insurance schemes provides a guidelines to achieve improvement in health status in the state. The sample size is 150 and 50 households are selected from the three taluks each randomly.

Analysis

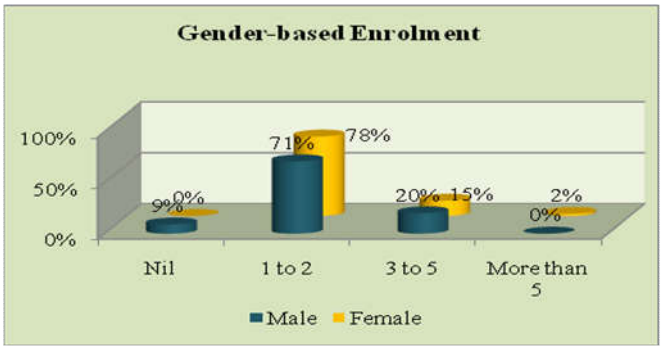
Yeshaswini Cooperative Farmers Health Care Scheme (Yeshaswini HI Scheme) was initiated by the Karnataka State Government on 1st June 2003, implemented through a network hospitals to provide cashless quality healthcare facilities to the co-operative farmers of Karnataka. The Yeshaswini Cooperative Farmers Health Care Trust takes the responsibility of implementing the scheme with financial assistance from the Government of Karnataka. It is a self-funded scheme wherein the enrolled members contribute premiums. All rural co-operative society members, members of Self Help Group/Sthree Shakti Group having financial transaction with the Cooperative Society/Banks, members of Weavers, Beedi Workers and Fisherman Cooperative Societies are eligible to avail the membership under Yeshaswini Health Insurance Scheme. Members can avail free surgery costing up to Rs.1.25 lakh and Rs. 2.00 lakh for multiple surgeries in one year. There are 722 network hospitals both public sector and private sector throughout Karnataka and 25 hospitals in Udupi under the scheme.

Latest data on the enrolment and benefits disbursed under Yeshaswini Health Insurance in Karnataka and Udupi for the year 2014-15 and 2015-16 are tabulated below:

Accessibility to Quality Health Care through Yeshaswini: Accessibility here is assessed in terms of enrolment of the members, duration of membership, gender-wise and age-wise membership.

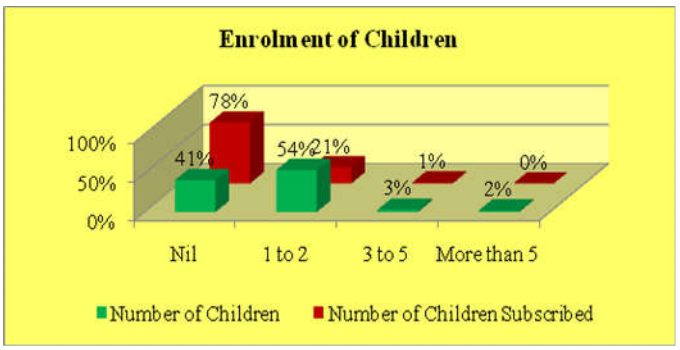
Enrolment: In 10 percent of the families all the members of the family are enrolled under Yeshaswini health insurance scheme. Following table gives the number of members enrolled under the scheme. In 5 percent of the families only a single member is enrolled under the health insurance Yeshaswini. In 28 percent and 19 percent of the families two and three members are enrolled under the scheme respectively. In 48 percent of the families four or more members are enrolled under the health insurance Yeshaswini. 89 percent families have four or more members in the family but only 48 percent families enrolled four or more members into the scheme. This indicates poor access to health insurance scheme in the study area.

Duration of Membership: From the table (3) it is observed that a majority of the Yeshaswini holders i.e., 32 percent have been members for two years. 30 percent of the households have been members for three to five years. 25 percent of the households have been members for more than 5 years and among them 21 percent have been members from the beginning. The remaining 13 percent of the households have been members for the last one year. Though the scheme was introduced decades back sustainability in membership is low.



Source: Primary Data

Figure 1. Gender-based Enrolment under Yeshaswini



Source: Primary Data

Figure 3. Enrolment of Children Under Yeshaswini

Gender-based Enrolment: Enrolment on the basis of gender is discussed as under. The above Figure (1) reveals that in 9 percent of the families male members are not subscribed to health insurance. There is not a family without a female member having subscribed to health insurance. 78 percent of the families have 1 to 2 subscribed female members and 71 percent of the families have the same number of male members subscribed to health insurance. In 15 percent of the families there are 3 to 5 female members subscribed to health insurance whereas in 20 percent of the families there are 3 to 5 male members subscribed to health insurance. In 2 percent of the families there are more than 5 female members subscribed and there is no family with more than 5 subscribed members when Yeshaswini health insurance is taken into consideration. This trend reveals that women have equal access to quality healthcare through Yeshaswini health insurance.

Age-based enrolment: NSS 71st round reports that the aged and children are more vulnerable as they fall sick in highest number. Proportion (number of persons per 1000) of ailing person is highest for the age group of 60 and above (276 in rural and 362 in urban) followed by that among children (103 in rural and 114 in urban). (NSSO, 2016) Enrolment on the basis of age is illustrated as follows:

Enrolment of Aged above 60 years: Primary data reveals that 28 percent of the families have no members above 60 years. 53 percent of the families have no members above 60 years subscribed to health insurance. Majority of the families i.e., 70 percent of them have 1 to 2 members above 60 years whereas only 45 percent of the families have the same number of members above 60 years subscribed to health insurance. In 2 percent of the families there are 3 to 5 members above 60 years and are subscribed to health insurance. The existing trend indicates poor access to quality care for the aged people in case of Yeshaswini health insurance.

Enrolment of Children: It is observed from the figure (3) that there are no children in 41 percent families whereas children are not subscribed to health insurance in 78 percent of the families and the gap shows that in 37 percent of the families, children have poor access to quality healthcare. There are 54 percent of the families having 1 to 2 children but only in 21 percent of the families 1 to 2 children are subscribed to the health insurance. 3 and 2 percent of the families have 3 to 5 children and more than 5 children respectively but no family has enrolled this number of children. Huge gap between the total number of children in the family and the number of children subscribed to health insurance indicates poor access to quality healthcare for children in the case of Yeshaswini health insurance.

Affordability: The amount paid per member, annual premium paid per family, amount one is willing to pay, difficulty in premium payment and its reasons are the factors considered to analyse the affordability.

Amount Paid and Amount Willing to Pay: Yeshaswini is a self-funded scheme. Premium under this plan is Rs. 250 per head per annum for the general category members of rural co-operative societies and for SC/ST members it is Rs. 50 only and remaining amount Rs. 200 is subsidised by the government. Annual contribution per head per annum for the general category members of urban co-operative societies is Rs. 710 and for SC/ST members it is Rs. 110, the remaining amount of Rs. 600 is subsidised by the government (2014-15). Annual contribution towards the Yeshaswini by the surveyed households is given in the following table (4):

Table 4. Annual contribution

Annual Contribution (in Rs.)	Yeshaswini	
	No.	%
0-100	3	2
101-200	-	-
201-300	3	2
301-400	6	4
401-500	32	21
501-1000	45	30
More than 1001	61	41
Total	150	100

Source: Primary data

Table 5. Willingness to Pay

Annual Contribution (in Rs.)	Yeshaswini			
	Member		Family	
	No.	%	No.	%
0-100	65	43	3	2
101-200	51	34	5	3
201-300	28	19	-	-
301-400	-	-	3	2
401-500	6	4	66	44
501-1000	-	-	48	32
> 1001	-	-	25	17
Total	150	100	150	100

Source: Primary Data

Under Yeshaswini 2 percent of the respondents are paying less than Rs. 100 and Rs. 201-300 annually. 4 percent of the respondents are paying Rs. 301-400, 30 percent of the respondents are paying Rs. 501-1000 and majority of the households i.e., 41 percent of the respondents are paying more than Rs. 1000. The difference between the amount which the households are ready to pay and actually pay for health insurance indicates consumers' surplus/deficit. The average amount which the households are ready to pay per head per

Table 6. Respondents' Perception with Regard to Premium Payment

Level of difficulty	Yeshaswini	
	No.	%
Very Difficult	-	-
Difficult	51	34
Neither Difficult nor Easy	78	52
Easy	18	12
Very Easy	3	2
Total	150	100

Source: Primary Data

Table 7. Respondents' Perception about Financial Protection

Respondents' perception	Reduces OOPE		Reduces Borrowing		Reduces Use of Savings		Reduces Asset Sale	
	No.	%	No.	%	No.	%	No.	%
Strongly Agree	69	46	57	38	42	28	60	40
Agree	71	47	83	55	39	26	66	44
Don't know	3	2	3	2	63	42	17	11
Disagree	7	5	7	5	6	4	7	5
Strongly Disagree	-	-	-	-	-	-	-	-
Total	150	100	150	100	150	100	150	100

Source: Primary Data

Table 8. Friedman's Test

Mode of Protection	Mean Rank	Rank	
Reduces OOPE	2.25	1	N=150
Reduces borrowing	2.33	2	Friedman's test Chi square value=103.223
Reduces use of savings	2.44	3	d.f=3
Reduces asset sale	2.98	4	p=0.000< 0.01

Source: Primary Data

year is given in the following Table (5): It is clear in the above Table (5) that a majority i.e., 43 percent of the respondents under Yeshaswini health insurance scheme are willing to contribute Rs. 100 per member per year. 34 percent of the respondents are willing to contribute Rs. 101-200, 19 percent of the respondents are willing to contribute Rs. 201-300 and 4 percent of the respondents are willing to contribute Rs. 401-500 per member per year. Likewise 2 percent of the households are willing to contribute Rs. 100 per family per year. 3 percent of the respondents are willing to contribute annually Rs. 101-200, 2 percent of the respondents are willing to contribute Rs. 301-400 per family. A majority of the respondents i.e., 44 percent are willing to contribute Rs. 401-500, 32 percent of the respondents are willing to pay Rs. 501-1000 and 17 percent of the respondents are willing to contribute more than Rs. 1000 per family per year. A majority of the Yeshaswini holders i.e., 43 percent are willing to pay Rs. 100 per member whereas most of the subscribers are paying Rs. 250 per member per year. It is also found that 76 percent of the households are willing to pay Rs. 400-1000 per family per year and 51 percent of the respondents are paying the same amount. It is also found that 17 percent of the households are willing to pay more than Rs. 1000 per family per year but 41 percent of the households are paying the same amount. It is analysed from the above discussion that the actual premium paid under Yeshaswini is more or less on par with the amount willing to pay per family.

Difficulty in Premium Payment and Reasons: The level of difficulty in the payment of premium is analysed as follows: A majority of the households i.e., 52 percent neither feel it neither difficult nor easy to pay the premium. 34 percent of the households express that the premium payment is difficult, 12 percent say that the payment of premium is easy and the remaining 2 percent of the households say that the premium payment is very easy.

A majority of Yeshaswini members who found it difficult to pay the premium i.e., 48 percent say that absence of instalment is the reason for difficulty. Nearly 33 percent opine that the high rate of the premium and absence of instalment are the reasons for the difficulty. 10 percent of the members find it difficult to pay due to the inconvenient time of payment. 6 percent members opine that inconvenient time of payment and high premiums are the reasons and the rest 5 percent opine that the absence of instalments is the reason for the difficulty.

Financial Protection: NSS 71st Round report shows that the source of hospitalisation expenditure is savings followed by borrowings (NSSO, 2016). The impact of health insurance on financial protection in the study area is analysed under four heads and they are – (i) Impact on out-of-pocket expenditure, (ii) Impact on borrowing for treatment, (iii) Impact on use of savings for treatment and (iv) Impact on asset sale for the sake of treatment. It is clearly revealed from the following table (7), that 46 percent of the respondents strongly agree and 47 percent of the respondents agree that health insurance reduces out-of-pocket expenditure for treatment. It is shown that 38 percent of the households strongly agree that health insurance reduces borrowing for the sake of treatment. Likewise 55 percent of the households agree that health insurance reduces borrowing for the sake of treatment. 40 percent of the respondents strongly agree that health insurance reduces asset sale on account of treatment and 44 percent of the respondents agree with the same. Likewise 28 percent of the households strongly agree and 26 percent of the households agree that health insurance reduces the use of savings for the purpose of treatment. From the above analysis it is inferred that the majority of the households consent that health insurance is useful in reducing financial burden for sake of treatment. Friedman's Test is used to identify the mean ranking for the mode of protection which encourages respondents to subscribe for health insurance schemes.

Table 9. Comparison between Yeshaswini Scheme and Ayushman Bharat

	Yeshaswini Scheme	AB-AK Yojana
Premium	Rs. 300 (rural) Rs. 710 (urban)	Nil
Subsidies	Rs. 200 to SC/ST (rural), Rs. 600 to SC/ST (urban)	Funded 60:40 by centre and state
Benefits	OPD and In-patient Secondary and Tertiary care	Primary care, In-patient Secondary and Tertiary care
Benefit Packages	1600	1354
Coverage amount	Rs. 2 lakh per family per annum	Rs. 5 lakh per family per annum
Target Population	Members of Co-operative Societies and their dependents	All the civilians of Karnataka State

Source: Handbook of Yeshaswini Health Insurance Scheme, Handbook of Ayushman Bharat – Arogya Karnataka Yojana

This test is applied on the data to test whether there is any significant difference in the mean ranking for individual modes of protection. The mean ranking of the factors is tabulated below: The calculated Chi square value is 103.223. The significance value for 3 degrees of freedom is 0.000 which is less than 0.01. Hence it is inferred that there is significant difference in the mean ranking of mode of protection which influences the respondents to subscribe for health insurance products. The lowest mean value is assigned the first rank and the highest mean value with the last rank. From the above table it is conceived that the factor "Reduces OOPE" is ranked first which states that the most influencing mode of protection among all the four modes of protection is the reduction in out-of-pocket expenditure for the sake of health care.

Ayushman Bharat: Ayushman Bharat (National Health Protection Mission) was announced in the 2018-19 budget. It targets 107.4 million 'poor and vulnerable' families identified by the 2011 socio-economic and caste census – at least 500 million individuals, or about 40 percent of the population. It guarantees insurance up to Rs. 5 lakh per family for secondary and tertiary health care. Beneficiaries will pay no premium, and the centre and the state governments will share the premium costs at 60:40 ratio. In April 2018, Karnataka government launched Arogya Karnataka Scheme with an aim to cover all APL and BPL families. The scheme subsumes all the existing health insurance schemes in Karnataka including Yeshaswini scheme. It covers 10 million families and provides an insurance coverage of up to Rs. 1.5 lakh per family per year. The scheme covers 100 per cent hospitalisation expenditure of the BPL households and that of 30 per cent of the APL households. The scheme does not involve any premium. But eventually this scheme is subsumed with Ayushaman Bharat in November 2018 and is named as 'Ayushman Bharat – Arogya Karnataka'(AB-AK Yojana).

Comparison between Yeshaswini Scheme and Ayushman Bharat: As shown in the above Table (9), fundamental difference between Yeshaswini Scheme and Ayushman Bharat is that of premium and benefits. While Yeshaswini is self-funded scheme, but Ayushman Bharat is government sponsored programme. Yeshaswini guarantees the amount worth Rs. 2 lakh per family per annum where as Ayushman Bharat guarantees the benefit of Rs. 5 lakh per family per annum. It is found in the analysis that majority of the respondents feel it difficult to pay the Yeshaswini premium because of high premium and absence of instalment. In this regard the Ayushman Bharat-Arogya Karnataka plan reduces private expenditure on health insurance and hence ensures consumers' surplus as the subscribers are not supposed to any premium. Consumers of Ayushaman Bharat receive greater benefit than the Yeshaswini subscribers as the benefit amount under the plan is more than that of Yeshaswini scheme. Yeshaswini members could avail benefits from any empanelled hospitals for in-patient treatment which is now not possible under Ayushman Bharat – Arogya Karnataka Yojana. Under this plan, members will not be able to opt for treatment in private hospitals at first. Only if the government specified public hospitals do not have that treatment, they can refer the patients to private medical institutions. An exception is there only in case of emergency treatment. A greater reliance on private hospitals for treatment can be observed. Nearly 95 per cent of the surveyed households in the study area prefer private hospitals for treatment due to the inadequate facilities, unavailability of health personnel and medicines in the government hospitals. NSS 71st Round Reports that more than 70 per cent (72 per cent in rural and 79 per cent in urban) of spells of ailment are treated in private sector. Hence under AB-AK Yojana cost-free quality care becomes a dream unless public hospitals are upgraded with quality. Yeshaswini scheme has limited coverage in which only the members of co-operative societies are eligible to enrol under the scheme. But AB-AK Yojana aims universal health coverage covering all the civilians of Karnataka state.

Observations

- Poor access to health insurance scheme in the study area is identified.
- Lower sustainability in membership of health insurance in the study area is observed.
- Gender equality is identified as women have equal access to quality healthcare through Yeshaswini health insurance.
- Poor access to quality care for the aged people and children who are more vulnerable to diseases is observed in case of Yeshaswini health insurance in the study area.
- It is analysed from the survey data that the actual premium paid under Yeshaswini is more or less on par with the amount willing to pay per family in the study area.
- Absence of instalments makes it difficult to pay the premium of health insurance in the study area.
- AB-AK Yojana cost-free quality care becomes a dream due to the inadequate facilities in public hospitals.

Suggestions

- To increase the coverage to the poor, insurance programmes could be linked with the existing poverty alleviation programmes, crop insurance, etc.
- Health insurance programmes can also be linked with the social security programmes like old age pension,

widow pension, etc. which may be useful in deepening the penetration of the programme.

- The government can also make the government sponsored health insurance programmes a mandatory to the BPL people which may enable the poor to go for health insurance.
- Automatic enrolment of BPL into government sponsored health insurance programmes may also ensure poor health care facilities.
- Households who are benefited from the schemes should persuade their relatives and neighbours to go for health insurance. Propagation of the benefits accrued to the members persuades non-members to enrol into the scheme.
- It is also found that, the people in rural and remote areas feel it difficult to take patients to the hospitals for post-surgery visits, dialysis, physiotherapy treatments on regular basis on account of heavy transportation costs. Hence nominal transportation charges can be included in the benefit packages.
- It is also necessary to inform the beneficiary to take cards and necessary particulars at the time of hospitalisation. In-time provision of the documents ensures timely treatment and quick processing and approval.

Conclusion

During the last decade Indian health insurance sector made a tremendous progress. Social Health Insurance schemes cover the employees in the organised sector. Health insurance has a great potential to improve the welfare of the poor and help to fulfil the vision of an inclusive growth. Health Insurance minimises the burden of health expenditure significantly for the poor households and increases their productivity. It is imperative that health insurance scheme ensures high quality of care at an affordable cost. Hence health insurance mechanism bridges the gap between affordability and accessibility of healthcare services.

The middle and low socio-economic groups are a potential market as they are ready to spend a reasonable amount due to huge medical expenses in the absence of health insurance provision. To develop a viable health insurance scheme, it is important to understand consumers' needs and offer a package that is accessible, available, affordable and acceptable to all sections of the society. The gathered inputs and drawn suggestions have greater significance in implementing the different insurance models to ensure the motto of Health for all.

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