Public-Private Partnership Based *Yeshasvini* (Health Care Scheme for Poor) Programme: Answering Towards Comprehensive Health Insurance Coverage in Karnataka-South India?

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Abstract

The *Yeshasvini* (in local language 'success') scheme developed out of an efficient partnership between the government and private partnership in Karnataka state-south India. It is a type of health insurance scheme more known as 'Community funded Healthcare Scheme' with a vision to assure quality healthcare services for the Co-operative members in the state. The scheme was launched in the year 2002. Ever since the launch of the scheme, this unique scheme has become a role model for others to follow in the country. Legally 'Yeshasvini Cooperative Farmers Health Care Trust' was formed and registered under the Indian Trust Act and the Government of Karnataka is giving matching grant to the Trust and a part of the financial resources of the scheme will be obtained from the payment of a small amount every year by the enrolled beneficiaries, for accomplishment of this health care scheme. Yeshasvini Health Care Scheme is being implemented through a network of selected private and public hospitals in the state to provide cost effectual quality healthcare service for the enrolled co-operative members of the state of Karnataka. This paper is based on the available secondary data to show the impact of the programme.

Keywords: Yeshasvini, health, insurance, scheme, hospital

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ความร่วมมือระหว่างภาครัฐกับภาคเอกชนในโครงการ *Yeshasvini* (โครงการบริการสุขภาพสำหรับผู้ยากไร้): คำตอบสำหรับการประกันสุขภาพแบบองค์รวมของรัฐกรณาฏกะ ประเทศอินเดีย

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บทคัดย่อ

Yeshasvini (ภาษาท้องถิ่นแปลว่า ความสำเร็จ) เป็นโครงการที่พัฒนาขึ้นมาจากความร่วมมืออย่างมีประสิทธิภาพระหว่างภาครัฐและภาคเอกชนในรัฐกรณาฏกะ (Karnataka) ซึ่งอยู่ทางตอนใต้ของประเทศอินเดีย เป็นโครงการประกันสุขภาพซึ่งรู้จักกันในอีกชื่อหนึ่งว่า "โครงการกองทุนสุขภาพชุมชน" โดยมีวิสัยทัศน์ในการสร้างหลักประกันคุณภาพการบริการสุขภาพสำหรับสมาชิกของสหกรณ์ในรัฐ โครงการดังกล่าวเริ่มต้นขึ้นในปี พ.ศ. 2545 นับตั้งแต่ก่อตั้งมา ความเป็นเอกลักษณ์ของโครงการกลายมาเป็นต้นแบบให้กับหน่วยงานอื่น ๆ ในประเทศ ในทางกฎหมายแล้ว "สหกรณ์สุขภาพชาวนา Yeshasvini" จัดตั้งขึ้นตามพระราชบัญญัติว่าด้วยทรัสต์ของประเทศอินเดีย รัฐบาลท้องถิ่นแห่งรัฐกรณาฏกะได้ให้เงินทุนสมทบ (matching grant) และส่วนหนึ่งของเงินทุนของโครงการจะได้รับจากผลความสำเร็จของโครงการในแต่ละปี โครงการสุขภาพ Yeshasvini ดำเนินงานผ่านเครือข่ายเอกชนและโรงพยาบาลของรัฐที่ได้รับการคัดเลือกเพื่อให้บริการสุขภาพที่มีคุณภาพและมีต้นทุนที่เหมาะสมสำหรับสมาชิกสหกรณ์ของรัฐกรณาฏกะ บทความนี้ใช้ข้อมูลทุติยภูมิในการศึกษาเพื่อแสดงให้เห็นถึงผลกระทบของโครงการดังกล่าว

Keywords: Yeshasvini สาธารณสุข ประกันสุขภาพ โครงการ โรงพยาบาล

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Background

Any health issue/s creates problems in the income earning capacity of the person who is in below poverty line but that family also traps in debt. India runs the world's one of the largest network of basic medical insurance through rural cooperative system. In today's world, out of pocket expenditure is growing like anything. Today medical technologies are fast spreading and become more costly as poor or marginal sections of the society cannot afford medical cost. Financing health care issue has a long history. Normally relationships between poverty and health insurance have usually focused in many developing countries as these countries will be having poor GDP and lack of required resources. Still many governments have brought community based low cost health insurance for the poor and this has succeeded in many low income nations across the globe (Devadasan et al., 2004). Through community based low cost health insurance schemes, families can be saved from any financial trap and health shocks as well. A well designed such health care programmes may be a highly quality oriented one over the period of time. Instead of completely free, a nominal user pay based insurance programme may create much more impact. Such success stories/programmes may be a model for many other low income countries. Expert felt any govt health insurance programme must be low cost, cash less, comprehensive and must be a provision for the quality health care services. The article demonstrates that community insurance presents a practical replica for providing high-end quality oriented health services in resource-poor scenario stressing on responsibility and effective co-operative management system (Onwujekwe et al., 2009). Majority rural and informal sector workers in India do not have any form of health insurance. In India, ninety-two percent of India's families earn their livelihood mainly from the unorganized sectors only. The poor are predominantly susceptible to the lack of health safety. It is noted that that the poor and margins normally spend 1/4 of their total income on health connected spending only.

Yeshasvini Health Care Scheme

Karnataka-south India has most vital percentage of rural population primarily engaged in agriculture and related activities. State is known for medical tourism. Plenty of hospitals and medical colleges available across the State, However, the bed occupancy rate has been as low as forty-seven percent in the state. It is found that large number of poor rural people is dying, simply because they cannot afford required hospital treatment on time (Devadasan et al., 2004). The main challenge before the government is to provide these sections of the population an easy access to reasonably priced healthcare service in a sustainable and continues mode (Kuruvilla & Liu, 2007). In this background *Yeshasvini (community based health care scheme)* scheme has been a model in the healthcare for the poor in the Karnataka state-south India (Hindu Daily, 2013). Recently Govt. has implemented this programmed even for urban poor co-operative members. These member have to pay little bit more enrollment fee when compare to the rural people.

Structure, Financing and Benefits

This scheme is open to all rural co-operative society members, self help group members, Group having financial transaction with the Cooperative Society/Banks, etc. entire joint/nuclear family members can become the members in a package. As perm this scheme rule the beneficiary should be a member of urban/rural co-operative for at least three months. The members of obsolete and liquidated member will be excluded. It mandated the need for separate Yashaswini card for every family member. A beneficiary could enroll five family members. Each member has to pay certain enrollment fees. Ages of insured are from newborn to seventy-five years. Yeshasvini is basically a cashless scheme, and members are covered for all charges associated with any surgical procedure. This programme is running based on the enrollment fee of the members enrolled and the matching grant by the state government. The premium charged for membership is approximately US$8 per adult per year in rural area and US$16 per individual in urban parts. For marginalized groups small discount will be given. For every member a unique Health Identification enrollment numbers will be given to the main member. The Scheme is administered by the legally registered board called Yeshasvini Trust, which is composed of eleven board members, all from the medical community and the Department of Cooperation Govt. of Karnataka (both public and private officials). This board has/will recognize/d certain well equipped hospitals in the state to implement this scheme in a continues manner.

Any enrolled member can get enlisted medical services in these hospitals for the enlisted health problems. However, in this scheme the Trust has fixed the certain amount for each type of treatment. After the treatment that amount will be credited to the hospital directly by the Trust after getting certain documents. If the treatment cost exceeds the fixed amount, the concerned patient has to pay the remaining amount out of his/her pocket. All enrolled members can get treatment in any one of the four hundred and ninety-six network hospitals (both public and private) conducting eight hundred and twenty-three surgical/medical procedures. The Yeshasvini scheme has paying attention at global level with many international NGOS and replicate it elsewhere, especially in African and other poor countries. Also The World Bank has exposed attention in the performance of this health programme with the intention of giving more realistic solutions to low-cost, high-quality healthcare for the poor countries.

Table 1. Composition of Health Expenditure of Karnataka from 1990-91 to 2009-10

Year	Actual					Composition				
	Medical and Public Health	Family Welfare	Water Supply and Sanitation	Nutrition	Health	Medical and Public Health	Family Welfare	Water Supply and Sanitation	Nutrition	Health
1990-91	24,959	0.0002	6,086	7,684	38,729	64	0.0	16	20	100
1991-92	30,065	0.0002	8,100	8,319	46,484	65	0.0	17	18	100
1992-93	36,732	0.0002	9,577	3,753	50,062	73	0.0	19	7	100
1993-94	40,149	0.0002	11,856	3,573	55,578	72	0.0	21	6	100
1994-95	46,886	0.0002	18,054	4,853	69,793	67	0.0	26	7	100
1995-96	41,880	9,457	22,108	7,469	80,914	52	11.7	27	9	100
1996-97	45,281	8,268	25,525	8,594	87,668	52	9.4	29	10	100
1997-98	58,009	12,797	31,675	16,063	118,544	49	10.8	27	14	100
1998-99	70,375	11,506	43,119	33,574	158,574	44	7.3	27	21	100
1999-00	81,553	16,097	53,402	36,302	187,354	44	8.6	29	19	100
2000-01	83,837	16,696	40,355	33,984	174,872	48	9.5	23	19	100
2001-02	86,524	22,060	37,244	25,999	171,827	50	12.8	22	15	100
2002-03	83,732	16,680	34,042	17,646	152,100	55	11.0	22	12	100
2003-04	81,415	18,155	45,000	28,021	172,591	47	10.5	26	16	100
2004-05	86,673	17,718	52,253	35,993	192,637	45	9.2	27	19	100
2005-06	101,175	13,444	86,815	88,321	289,755	35	4.6	30	30	100
2006-07	117,899	17,062	74,298	92,273	301,532	39	5.7	25	31	100
2007-08	162,593	20,625	115,470	158,070	456,758	36	4.5	25	35	100
2008-09 (RE)	202,174	27,799	138,049	173,211	541,233	37	5.1	26	32	100
2009-10 (BE)	207,642	29,696	144,488	216,232	598,058	35	5.0	24	36	100

Source: Study of State Finances, Reserve Bank of India Reports.

Table 2. The Progress of The Yeshasvini Scheme during the Past Twelve Years Is Detailed Below.

SL NO	Scheme Year	Members Enrolled under the Scheme	Amount Collected (in Lakh)	Amount Released from the Govt.	No. of O.P.D	No. of Surgeries Done	Amount Spent on Surgeries
1	2003-04	160,000	969.00	450.00	35,814	9,047	1,065.35
2	2004-05	2,021,661	1,197.00	357.00	50,174	15,326	1,847.23
3	2005-06	1,473,576	1,634.00	1,100.00	52,892	19,682	2,616.94
4	2006-07	1,853,966	2,156.00	1,985.00	206,977	39,602	3,851.00
5	2007-08	2,318,000	2,775.00	2,500.00	155,572	60,668	5,409.00
6	2008-09	3,047,000	3,610.00	3,000.00	191,109	75,053	6,103.00
7	2009-10	3,069,000	4,136.00	3,000.00	134,534	66,796	5,305.00
8	2010-11	3,047,000	4,168.00	3,000.00	157,480	73,963	5,723.00
9	2011-12	3,070,000	4,508.00	3,000.00	116,690	77,526	6,000.00
10	2012-13	3,036,000	5,888.00	3,500.00	110,842	80,401	7,412.00
11	2013-14	3,751,000	5,272.00	4,500.00	123,205	86,359	8,456.00
12	2014-15	3,872,000	6,940.00	7,100.00	172,442	134,742	15,000.00

Source: Department of Cooperation, Government of Karnataka Various Annual Reports.

Table 3. Distribution by Social Groups of Yeshasvini Users (2011-2013)

Social groups	2011-12		2012-13		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Above poverty line	632	0.7	0	0.0	632	0.4
Below poverty line	1,178	1.4	0	0.0	1,178	0.8
Economical backward class	11,625	13.6	5,227	9.3	16,852	11.9
Minority	828	1.0	0	0	828	0.6
Others/General	69,604	81.3	49,971	88.8	119,575	84.3
Scheduled caste	1,234	1.5	731	1.3	1,974	1.4
Tribes	520	0.6	313	0.6	833	0.6
Total	**85,630**	**100.0**	**56,242**	**100.0**	**141,872**	**100.0**

Sources: Study Report of Centre for Budget and Policy Study, Karnataka (2012)

Table 4. Age-wise Distribution of Gender of Yeshasvini Users (2011-13)

Age	Female		Male		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
0-18 years	3,943	38.9	6,203	61.1	10,146	100
19-36 years	38,350	78.7	10,400	21.3	48,750	100
37-54 years	17,810	49.1	18,464	50.9	36,274	100
55-75 years	15,940	33.7	31,295	66.3	47,235	100
>75 years	3	33.3	6	66.7	9	100
Total	**76,046**	**53.4**	**66,368**	**46.6**	**142,414**	**100**

Sources: Study Report of Centre for Budget and Policy Study, Karnataka (2012)

Table 5. Expenditure per Package in Yeshasvini Scheme (2011-13)

Package	Frequency	Mean Expenditure (in Indian Rupees)	Total Expenditure (in Indian Rupees)	Percentage
CVS (cardio vascular)	18,035.0	23,478.6	423,436,209.0	32.9
END	345.0	9,027.0	3,114,315.0	0.2
ENT	6,743.0	6,419.0	43,288,659.0	3.4
GNL	19,111.0	6,641.4	126,923,462.0	9.9
GST	1,913.0	12,496.9	23,906,566.0	1.9
ME	99.0	1,846.5	182,800.0	0.0
NEURO	2,075.0	19,959.1	41,415,129.0	3.2
NICU	2,042.0	2,714.8	5,543,657.0	0.4
OBG	40,987.0	6,425.8	263,373,469.1	20.5
ONCO	591.0	23,774.9	14,050,947.0	1.1
OPHTHO	43,423.0	4,322.7	187,704,032.4	14.6
ORTHO	6,552.0	10,689.2	70,035,836.5	5.4
PED	1,148.0	8,541.9	9,806,087.0	0.8
THR	88.0	18,342.5	1,614,136.0	0.1
URO (Urology)	7,429.0	8,981.9	66,726,195.8	5.2
VAS	192.0	24,379.2	4,680,800.0	0.4
Total	**150,773.0**	**8,528.1**	**1,285,802,300.8**	**100.0**

Source: Department of Cooperation, Government of Karnataka: Various Annual Reports (2013)

Table 6. Performance of the Surgery Cases and Amount Sanctioned over a Period of Time (2003-04 to 2011-12)

Name of the Districts	Total Surgery Cases (in Numbers)	Percent Share of Cases	Total Amount Sanctioned (In Indian Rupees)	Percent Share of Amount
1. Belgaum	16,683	5.62	167,115,771	6.32
2. Bijapur	11,854	3.99	96,741,892	3.66
3. Bagalkot	15,571	5.25	116,546,579	4.41
4. Dharwad	5,567	1.88	40,460,270	1.53
5. Gadag	6,380	2.15	47,591,860	1.80
6. Haveri	12,930	4.36	93,591,754	3.54
7. UK	5,792	1.95	52,579,700	1.99
8. Raichur	7,104	2.39	67,192,540	2.54
9. Koppal	3,439	1.16	33,361,315	1.26
10. Gulbarga	8,400	2.83	91,668,465	3.47
11. Bidar	4,280	1.44	43,690,390	1.65
12. Bellary	4,123	1.39	51,082,502	1.93
13. Bangalore *(Urban & Rural)*	17,460	5.88	192,050,813	7.27
14. Kolar	14,849	5.00	147,196,796	5.57
15. Tumkur	17,425	5.87	167,671,421	6.34
16. Chitradurga	12,001	4.04	113,658,242	4.30
17. Davangere	19,172	6.46	163,476,512	6.19
18. Shimoga	7,390	2.49	74,167,302	2.81
19. Mysore	11,112	3.74	128,043,570	4.85
20. Chamrajnagar	5,539	1.87	57,669,250	2.18
21. Mandya	34,536	11.64	279,639,153	10.58
22. Hassan	17,536	5.91	147,286,710	5.57
23. Chikmaglur	8,294	2.79	79,330,332	3.00
24. Kodagu	2,600	0.88	31,025,266	1.17
25. D K	5,080	1.71	56,711,070	2.15
26. Udupi	21,670	7.30	103,234,957	3.91
Total	**296,787**	**100.00**	**2,642,784,432**	**100.00**

Source: Department of Cooperation, Government of Karnataka Various Annual Reports (2013)

Discussion

Visibly indicates that total number of members enrolled under the scheme under the Yeshasvini health care scheme in the state from the beginning. From the year 2008-09 onwards the members enrolled under the scheme is gradually increasing. This is mainly because of Cooperative Societies, Self Help Group and Governments progressive policies and their active role in the scheme. The highest number of surgery done in the year 2013-14. Between 2003 to 2005 poor performance can be seen because of less awareness about the scheme (Table 1) This table indicates that different social groups availed the service under Yeshasvini health care scheme in Karnataka state. Economical backward class have obtained highest usage of the scheme scheduled caste and tribes (highly marginalized group in India) have not availed this scheme up to the mark (Table 2). Regarding age group highest number of users comes between nineteen to thirty-six. In case of performance of the surgery cases and few districts have some good result because of presence of good numbers of private hospitals and awareness's. It is found that the current programme has got a vital success and found to have augmented use of health-care services, abridged out-of-pocket spending and has almost reached to the every needy person of the society.

Also it is found that this scheme is giving better health behavior and economic outcomes. In addition this particular programme has special effects across different socio-economic groups in the state. It is also known that this programme has brought down the direct and indirect charge of health-care down but the degree to which this successfully occurs across medical cases as a more pragmatic issue (Mahal, 2002). Supplementary to this, the effects of this particular programme are more marked for the better-off population. Also this community insurance porgramme is providing high-end services for the resource-poor settings through solid responsibility and proper local health care management (Ron, 1999). Because of this scheme today any poor person can get a reasonable good health care treatment even in the private hospitals. Despite having more vital issues it is still not a comprehensive scheme because it covers cost part surgery only. Patients have to bare the other cost of the treatment like diagnostic, lab charge, medicine etc. this is highly imposable for poor income families. This is a big issue here. More problems is that few network hospitals have already started talking to get way out of this scheme because of alleged non-payment of dues by the Trust on time. Trust says releasing matching grant on time from the Govt. is a big issue. It shows private-public partnership will survive only if the interests of all stakeholders are taken into account.

However the other part of this scheme has some questionable substantiation. Low enrolment is usually observed in many districts of the state through this study. We suspect numerous socio-culture and other factors may play a role in explaining low enrolment. Lack of awareness also counts here. More study is required to the explore supply factors and pattern regarding enrolment

and outcome among various social groups. In Some cases elevated enrolment do not associated with the better result. However, a number of evidences found that this scheme has helped in reducing out-of pocket expenditure (Mahal, 2002). Since it is a cashless scheme it is highly helpful in various ways. However, it is also noted that few hospitals are showing discrimination about these insured people while providing various health services treating them just as free beneficiaries. Few big and reputed hospitals also denying services citing unrelated reasons and many rural illiterates and patients' belonging to the lower castes are being treated badly as we found. Moreover there is an obvious confirmation of augmented use of private health services for primary health care among the insured people.

Trivial changes in accessing to quality medical services and the geographically varied effect of this scheme on service utilization points and health seeking and health care behaviour of the insured found very promising. Further, concrete strategies required for reducing claims and managing utilization as much as possible. Impartial effect of this low cost insurance programme and enhanced monetary guard, particularly for the poor and marginalized sections of the society. The role of other public and private insurance agencies as monetary mediators of the widely funded and supported by the Govt. needs additional assessment before moving forward

Conclusion

The major limitation of the study is largely this article is based on the secondary data. Numerous low- and middle-income nations endorse low cost community-based health insurance (CBHI) to get better admittance to health care for the poor and margins. It is largely indicated that the scheme has been proven useful to all sections of society, especially poor people, margins, middle or low income people, laborers, taxi drivers, domestic servants, construction and factory workers to those who are not having regular income. The scheme is meant for middle and lower middle class are the highest beneficiaries till now. However, more awareness among the people is still required because of widespread coverage. Though it provides health security for the poor it is depend on the government subsidy. We suggest that this scheme must be a more quality health care oriented and easily accessible to the poor at the door step. For this we found an effective public-private bond is required. Attempt is needed to comprehend health care culture as a sub culture complex in developing a model of culturally suited health care module progammes especially for the rural people with their different castes and class. There is a dearth need to provide locally setting health education about this scheme. Mass media can play a vital role in this aspect. For become self-sustained one, policy makers must have some other ideas to improve the scheme soon.

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