**Commercialisation of medical care and Public Medical Insurance Schemes in India: Who Benefits?**

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The last two decades have witnessed an expansion of public medical insurance schemes as a means to address the crisis of rising out of pocket expenditures resulting in indebtedness of a large section of the Indian population. Several State governments have initiated targeted public insurance schemes for increasing access and reducing inequities to medical care for the organized sector employees and those below the poverty line. The Central Government Health Scheme and the Employee State Insurnace Scheme are the older public insurance schemes for White Collar and Blue collar workers. During the late 1990s, there was a move to introduce public insurance schemes for the poor, the first of which was implemented in Maharashtra followed by Andhra Pradesh and Karnataka. Building on the design of the State led medical insurance schemes, the Central government introduced the RashtriyaSwasthyaBimaYojana and more recently the Ayushman Bharat. There are a number of public insurance schemes that are currently in operation that include the Central Government Health Scheme, Employees State Insurance Scheme, RashtriyaSwasthyaBimaYojana, Ayushman Bharat and State led schemes that are mostly in Southern and Western States of India. The common feature of the design of all these schemes is that they are a partnership between public financing and mixed provisioning focused on curative services at the secondary and tertiary levels of care. Evidence from the various schemes that are operational suggests that the public insurance schemes have benefitted the ‘for profit’ sector both large and small. It has also led to the proliferation of the middle segment of this sector. The paper will review the evidence to provide an overview of the evolution, design, scope and depth of these various insurance schemes. It proposes to situate the rise and spread of public medical insurance schemes for the poor as a continuum of commercialization of medical care. It argues that the for profit sector has been actively seeking public subsidies in various forms and public insurance schemes will help to increase their patient volume which is essential for ensuring their survival in the market. The paper argues that rampant and unregulated commercialization of health services from the 1980s onwards provided the move towards demand side financing. If we examine the states where the public medical insurance schemes were started they were Western and Southern states where the presence of the for profit sector was large and powerful. The other set of States were the newly formed states of Chattisgarh, Jharkhand and Uttarakhand where the private sector was small but insurance schemes were seen as a way of kick starting the growth of markets. It is argued that the ‘for profit’ sector in medical care depends on patient volumes to maintain their profit margins. Given the large number of players in the market resulted in competition for sourcing patients. The experience of the elite Central Government Health Scheme with the private sector showed that they ensured an assured patient supply. A study of the CGHS and private sector in Hyderabad and Chennai revealed that around 30% of patient supply to corporate hospitals was from those enrolled with the CGHS. This assured supply was important in the context of low coverage of private insurance schemes and rising cost of medical care, which was unaffordable even for the middle classes. A ‘Race to the bottom of the pyramid” was important to tap into around 40 % of the population below the poverty line who could not afford the cost of treatment in a private hospital. Given the poor state of public hospitals a large section of the middle, lower middle and working classes were accessing private hospitals without insurance cover. For the political class, public insurance schemes found a place amongst populist programmes as an assured vote earner. In a sense, the rhetoric of equity was backed by the arithmetic of the market! The evidence shows that public insurance programmes have strengthened the private sector.

The public insurance schemes address the ‘need’ of the private sector and populist politics because the rising cost of medical care and the vulnerabilities it produces has increasingly become a political issue. Medical insurance schemes have a high visibility in political terms that ensure translation into votes. There are multiple consequences of choosing the route of public insurance for the poor. Firstly, it leads to a stratified and fragmented system of public insurance schemes- CGHS and ESI versus the targeted public insurance schemes in terms of entitlements and quality of services. Secondly, there issue of inequity across the different strata among the poor is of concern. Thirdly, the lack of a regulatory structure for the private sector will lead to unnecessary interventions; over charging as a result of supplier induced demand.