Assessing Impact of India's National Health Insurance Scheme (RSBY)

Prasad Bhat[1], Dr. Manoj Kumara N V[2]
[1]*Research student, Department of Management Science, Maharaja Institute of Technology Mysore*
[2]*Associate professor, Department of Management Science, Maharaja Institute of Technology, Mysore*

***Abstract*- Providing quality health care to all is a policy commitment India made by coming a signatory in the Alma Ata declaration. India is working towards providing universal health coverage through its national health policy. However to achieve this goal; it needs to reach out to the poorest and the most vulnerable section of the society, and make available affordable health care to them. RSBY is a step in this direction that insures these families for a minimum sum, to increase their access to health care and protect against catastrophic health expenses. This paper has tried to analyse if the insurance instruments including RSBY have been able to increase health service utilization in the country, especially by the protest quintiles of the population.**

1. INTRODUCTION

In the last five years, there has been a remarkable increase in the health insurance coverage of people in India and roughly around a fourth of the population is now covered under health insurance. This coverage has been possible due to government sponsored health insurance programs like Rajiv Aarogyasri in the state of Andhra Pradesh, Vajpayee Aarogyasri in state of Karnataka, other state based insurance programs in Tamil Nadu, Rajasthan etc. and currently the central government sponsored Rashtriya Swathya Bima Yojna (RSBY) which is a national Health insurance program for the resource poor families.

There are other schemes like Employees State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) which provide extensive coverage and benefits to the insured, however, their population coverage is very limited and only cover formal sector employees. Private health insurance coverage again is very limited both in terms of population and benefits (Ellis, R. P., Alam, M., & Gupta, I., 2000, A Critical Assessment of the Existing Health Insurance Models in India, 2011, Carrin, G., 2002, Forgia, G. L. & Nagpal, S., 2012).

2. LITERATURE REVIEW

- Buvidas- As clearly states that the objectives of managed care is to save and or reduce health care cost by closely monitoring the delivery of health care services.
- Rao, Nundy and Dua-The survey obtained information on the ownership pattern, service provided utilisation levels, human resources appointed, equipment used, prices changed for some services. They found that the ratio of the public –private sector is 60:40 in rural Ares as compared to 10:90 in urban Ares.
- Bhat carried out a survey of 108 private practitioners of allopathic to examine the factors that influence health seeking behaviour and growth of private practice. The survey showed that three factors provided the competitive edge the experience of the treating physician, technology and location, which also acted as barriers to entry.
- Rao sujata- The health system in India consists of a public sector, a private sector and a informal network of providers of care operating which an unregulated environment, with no controls on what services can be provided by whom, in what manner, cost and no standardized protocols to help measure the quality of care.
- Hsio –The health systems have five aspects or knobs that interact with each other and influence its basic nature and direction. Financial, payment systems, organisational, legal and social.
- Archana, studied the claim process of existing health insurance schemes, to identify the barriers in the claim process at the hospital level and the

consumer awareness and satisfaction level in health insurance.

3. OBJECTIVES

The publicly financed health insurance scheme is to provide financial security against Out- of pocket and catastrophic health expenditure to the resource poor households for. Either secondary care of tertiary care services or both.

4. METHODOLOGY

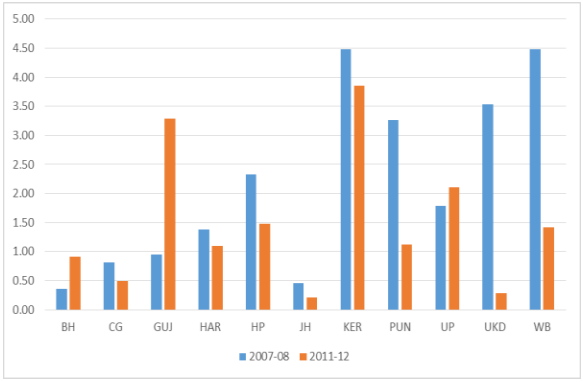
The current paper has used the per capita consumption expenditure data collected in India by the National Sample Survey Organisation (NSSO) for the years 2007-08 and 2011-12. The sample size in the year 2007-08 was 2,42,369 and 2011-12 were2, 03,313 households respectively. In the Consumer Expenditure Survey (CES), the NSSO collects data on household expenditure on wide range of items which includes expenditures on institutional and non-institutional health care along with the expenditure on other household items. The data for the institutional and non-institutional care are collected separately. For institutional care, the recall period is last 365 days and for the non-institutional care the recall period is last 30 days. However, finally the expenditure is presented on monthly per capita basis. The expenditure includes expenditure on drugs and medicines, pathological and diagnostic tests, fees to doctors and nurses, hospital stay and other related health expenditure. These are collected separately for different disease episodes and are added to get the total expenditure under institutional and non-institutional care.

For the purpose of analysis, only those states were selected which have completed 3 to 5 years of RSBY implementation. Hence Bihar, Chhattisgarh, Gujarat, Kerala, Uttar Pradesh, Haryana, Himachal Pradesh, Jharkhand, Punjab, Uttrakhand and West Bengal were included in the analysis. The expenditure data for the year 2007-08 was treated as baseline monthly per capita medical expenditure in the selected states. This has been compared with the monthly per capita medical expenditure data for the year 2011-12 to see whether there was any positive change in the medical expenditure pattern.

5. DATA ANALYSIS AND DISCUSSION

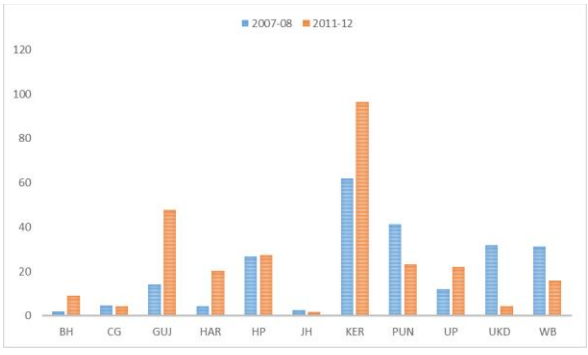
The per capita medical expenditure of 2011-12 was compared with 2007-08 data. There was also a comparison between per capita institutional medical expenses and per-capita non-institutional medical expenses with respect to total per capita expenditure to see their proportionate burden on the total expenditure. Though institutional medical expenses are catastrophic in nature particularly for the resource poor households, even the burden of no institutional medical expenses is very high and carry a risk ofimpoverishing families if the resource poor families do not get any financial

5.1 Percentage of per capita institutional medical expenses to total per capita expenses



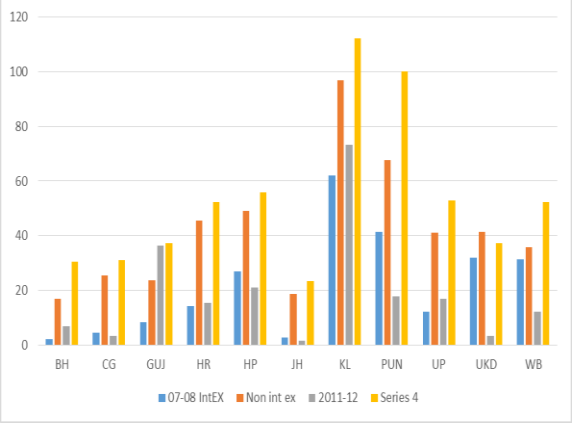
The above graph show a comparison of the percentage of monthly per capita institutional medical expenses to the total monthly per capita expenses between the year 2007-08 and 2011-12.The comparisons shows no substantial increase in the per capita institutional care utilisation despite RSBY being implemented and covering almost all type of hospitalisation cases. Only in case of Gujurat, there was an inncresed utilisation of institutional medical services in the year 2011-12 compared to 2007-08.

5.2 Monthly per capita expenses of institutional medical care for 2007-08 and 2011-12



These show the institutional expenses had increased in the states like Bihar, Gujarat, Haryana, Kerala and Uttar Pradesh during year 2011-2012 in absolute terms as compared to the year 2007-2008, without adjusting for inflation.

5.3 Monthly per capita expenses of institutional and non-institutional medical care for both the reference periods in INR after adjusting for inflation.



The above graph show the monthly capitainstitutional and non-institutional expenses for both the reference periods after adjusting the price 2011-12 for inflation keeping price of the year2007-08 as the base price. This could imply that the benefits of RSBY were yet to reach states where the monthly per capita institutional expenses had either decreased or remained unchanged.

6. CONCLUSION

RSBY scheme holds immense potential of providing a decent coverage of hospitalisation care to the resource poor households, however the above analysis show that even after three to five years of RSBY implementation the benefits were yet to reach the resource poor households in terms of increased utilisation services compared to the baseline year. While the NSSO-CES data analysis shows that the resource poor families have not been substantially benefited through RSBY scheme, yet there is a need for a comprehensively designed population level scientific study of RSBY to assess its real impact and also find out the enabling and disabling factors effecting utilisation of health care under RSBY.

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