



ORIGINAL RESEARCH PAPER

Social Science

PERFORMANCE OF RASHTRIYA SWASTHYA BIMA YOJANA (RSBY) IN INDIA: IMPLICATIONS FOR ITS FUNCTIONAL SUSTAINABILITY

KEY WORDS: RSBY in India, health insurance, performance of RSBY, social security

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ABSTRACT

Medical expenditure on healthcare, particularly the sudden and lump sum hospitalization expenses pose a continuous threat to the poorer families. It is difficult to keep a provision for such expenditure beforehand because of the unpredictability of the amount of expenditures and of the timing of occurrence. The increase in prices of drugs adds on to the medical burden of a family. The hospitalization can also cause severe difficulties to poor patients in the lean period of their earnings as most of them do not have a regular job and work in the informal sectors or as casual workers. This paper analyses the functional viability of the scheme based on the data given in the RSBY website for each state in India. The design is descriptive and the analysis is quantitative. For each state the districts are arranged according to their geographical location, per capita GDP earnings and total population. The performance of the districts is analyzed on different variables like total targeted families, total enrolled families, the number of private and public hospitals enrolled etc. The findings show a wide difference among the different states in India. The inclusion of the private healthcare beneficiaries is significantly correlated. However literacy of the prospective beneficiaries is seen to be an important in making the scheme more inclusive.

INTRODUCTION

Policies on health insurance were dependent on the general national policy of a country and also on the innovation/invention of medical technology. For example in the history of the world, the World War II served as a watershed of policy making and advancement in medical science. The financial protection of citizens against medical menaces was thus different in the period before the Second World War from the period following it. The discovery of penicillin by Alexander Fleming in 1929 and the subsequent commercial manufacture of it in 1940 was a significant step in medical science. Other antibiotics were also discovered that made surgery frequent and successful. The post war period also witnessed gradual expansion of industries followed by increase in employment and earnings. There was also an increase in population ('the baby-boom'). The insurance companies enjoyed better data flows that facilitated better analysis of risks and premiums. There was an improvement in administrative procedures and keeping of records and this facilitated greater coverage. Lastly, the growth of trade unions generated an interest in health safety and the various legislations necessary for it (www.irda.org).

Most of the health insurance policies were introduced in developed countries much earlier than in developing countries due to the obvious advantage of existence of insurance agents, medical infrastructure and the mindset of the citizens and the policy makers to become an active stakeholder in an insurance system. The following section describes the health insurance policy initiatives in some of the developed and developing countries of the world.

To mitigate the burden of hospitalization expenses in India, the government introduced the Rashtriya Swasthya Bima Yojana (RSBY). It is a flagship program of the government. It provides hospitalization coverage to the poor people in India. It is impressive not only in its scale of operation but also in its innovative approach in providing services like use of smart card technology in cashless treatment and initiation of the public-private partnership in delivery of health services. The prospective beneficiaries are provided with Rs 30,000 limit coverage for hospitalization expenses. The pre-existing ailments are covered and there is no age limit. There is a need to pay a nominal sum of Rs.30 annually as premium. The rest of the premium is paid by the central and state governments in the ratio of 75:25. There is a list of empanelled

hospitals including government hospitals and private nursing homes/hospitals that meet the necessary Information Technology (IT) requirements. There is a regular data flow among the government and the service providers regarding utilization of services and settlement of claims

DESIGN AND METHODOLOGY

This paper analyses the functional viability of the scheme based on the data given in the RSBY website for each state in India. The design is descriptive and the analysis is quantitative. For each state the districts are arranged according to their geographical location, per capita GDP earnings and total population. The performance of the districts is analyzed on different variables like total enrolled and targeted families and the total number of public and private hospitals empanelled..

Analysis of RSBY in India

The performance of RSBY in the different states of India is shown in the following table.

State	No. of districts	Total target families	Total enrolled families	Hospitals empanelled		Total hospitals
				Pvt	Pub	
Manipur	6	120237	70925	8	0	8
Meghalaya	10	433657	94194	14	137	151
Mizoram	8	212572	152983	19	79	98
Punjab	22	452979	232352	164	160	324
Uttarakhand	13	718965	285435	67	95	162
Haryana	21	1229850	437850	403	32	435
Himachal Pradesh	12	877763	480588	21	153	174
Tripura	8	771225	492022	2	80	82
Assam	23	2371950	1421104	43	140	183
UP	75	5301377	1464242	887	639	1526
Jharkhand	24	3968109	1714552	279	156	435
Kerala	14	2221283	2021572	177	208	385
Rajasthan	33	3829760	2769097	309	442	751
Odisha	20	4363752	3123600	169	302	471
Chhattisgarh	27	3724030	3442749	542	348	890
Gujarat	24	3724030	3442749	985	451	1436
WB	20	11017179	6110765	723	426	1149
Bihar	38	13939455	6143138	858	124	982
Karnataka	30	11346572	6746836	501	253	754

Table 2 Correlation Matrix I

		No. of districts	Total target families	Total enrolled families	Private Hospitals empanelled	Public Hospitals empanelled	GSDP (in crores)
No. of districts	Pearson Correlation	1	.482*	.350	.703**	.722**	.700**
	Sig. (2-tailed)		.037	.142	.001	.000	.001
Total target families	Pearson Correlation	.482*	1	.942**	.704**	.386	.552*
	Sig. (2-tailed)	.037		.000	.001	.103	.014

Total enrolled families	Pearson Correlation	.350	.942**	1	.682**	.446	.567*
	Sig. (2-tailed)	.142	.000		.001	.056	.011
Private Hospitals empanelled	Pearson Correlation	.703**	.704**	.682**	1	.685**	.835**
	Sig. (2-tailed)	.001	.001	.001		.001	.000
Public Hospitals empanelled	Pearson Correlation	.722**	.386	.446	.685**	1	.809**
	Sig. (2-tailed)	.000	.103	.056	.001		.000
Gross State Domestic Product (in crores)	Pearson Correlation	.700**	.552*	.567*	.835**	.809**	1
	Sig. (2-tailed)	.001	.014	.011	.000	.000	

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

There is a significant correlation between the number of districts of the different states and the number of hospitals empanelled either private or public. There is a significant correlation between the number of private hospitals empanelled and the total target families and the total enrolled families. However there is no significant correlation between the number of public hospitals

empanelled and the total number of target population and the total number of population enrolled. There is no significant correlation between the number of districts and the total enrolled families but there is a significant correlation between the number of targeted families and the number of districts in a state.

Table 3 Demographic profile of the states

Name of the state	Gross State Domestic Product (in crores)	% growth in GDP	% Population in poverty	Literacy Rate	Population	Human Development Index	HDI Rank
Assam	88537	5.87	31.98	72.20	31206	.138	26
Bihar	174734	9.92	33.74	61.80	104099	.158	25
Chhattisgarh	94560	6.26	39.93	70.30	25545	.180	24
Gujarat	427219	7.96	16.63	78.00	60440	.477	10
Haryana	198858	6.49	11.16	75.60	25351	.493	7
Himachal Pradesh	47255	6.24	8.06	82.80	6865	.647	3
Jharkhand	109408	8.91	36.96	66.40	32988	.222	21
Karnataka	314356	5.40	20.91	75.40	61095	.420	12
Kerala	221850	8.24	7.05	94.00	33406	.911	1
Manipur	7625	3.95	36.89	76.90	2856	.199	22
Meghalaya	13465	12.41	11.87	74.40	2967	.246	20
Mizoram	5203	7.23	20.40	91.30	1097	.408	13
Orissa	148226	5.60	32.59	72.90	41974	.261	18
Punjab	173221	5.25	8.26	75.80	27743	.538	6
Rajasthan	244997	4.60	14.71	66.10	68548	.324	16
Tripura	16997	8.70	14.05	87.20	3674	.354	14
UP	465969	5.14	11.26	67.70	199812	.122	28
Uttarakhand	67927	5.65	29.43	78.80	10086	.426	11
WB	374899	8.62	19.98	76.30	91276	.483	8

Source: Census 2011

As regards the GSDP there is a significant correlation between the GSDP of a state and the number of districts, the number of target and enrolled families and the number of public and private hospitals empanelled. The total enrolment of families as against the total targeted has been correlated with the demographic indicators as in Table 4. There is a strong association between the enrolment achieved and the gross state domestic product of a state. There is also an obvious association between the enrolment and the population of any state. There is no association between the literacy level in a state and the total families enrolled. There is a negative significant correlation between the literacy rate and the total target families in a state. This has got implications for proper implementation of the scheme.

An interesting observation exists between the literacy level of a state and the number of empanelled private hospitals. The latter shows a negative significant association. This implies that low levels of literacy may hamper the opportunities for the poor people to get treated in private hospitals and nursing homes. There is however no such association between the literacy rate and the number of empanelled public hospitals. There is also a negative significant association between the literacy rate and the population of a state. So the larger states with a more population need to look into the general literacy of the people so as to give them the opportunities of getting treated in private hospitals. This analysis is particularly useful as there is a significant association between the size of a state and the total target enrolment.

Table 4 Correlation Matrix 5

		Total target families	Total enrolled families	GDSP	Literacy Rate	No. of districts	Private Hospitals empanelled
Total target families	Pearson Correlation	1	.942**	.552*	-.484*	.482*	.704**
	Sig. (2-tailed)		.000	.014	.036	.037	.001
Total enrolled families	Pearson Correlation	.942**	1	.567*	-.378	.350	.682**
	Sig. (2-tailed)	.000		.011	.111	.142	.001
GSDP (in crores)	Pearson Correlation	.552*	.567*	1	-.265	.700**	.835**
	Sig. (2-tailed)	.014	.011		.273	.001	.000
Literacy Rate	Pearson Correlation	-.484*	-.378	-.265	1	-.610**	-.470*
	Sig. (2-tailed)	.036	.111	.273		.006	.042
No. of districts	Pearson Correlation	.482*	.350	.700**	-.610**	1	.703**
	Sig. (2-tailed)	.037	.142	.001	.006		.001
Private Hospitals empanelled	Pearson Correlation	.704**	.682**	.835**	-.470*	.703**	1
	Sig. (2-tailed)	.001	.001	.000	.042	.001	

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

CONCLUSION

The Rashtriya Swasthya Bima Yojana (RSBY) has become an important scheme to provide cashless in patient services to poor people. It has got some new distinctive features that include treatment in private nursing homes and hospitals, the guarantee of hospitalized treatment up to Rs. 30000 for a family of five members and the introduction of smart cards in health care of poor people. Regarding the vastness of the scheme it can be credited with being in operation in almost all the states in India. However being large has its own drawbacks. There is a great difference among the different states in terms of the functioning of the scheme. The scheme leans towards encouraging the collaboration of private health providers as seen from the results of data analysis. The public hospitals being already overcrowded can take this as an encouraging aspect and the patients who are poor and would otherwise never get themselves admitted to a private unit are now having the advantage of getting treated there. However basic literacy of the prospective beneficiaries becomes crucial in the successful viability of the scheme as it includes the rational use of the allotted money, the selection of the health care provider and the use of smart cards. From the analysis it was clear that literacy became a factor of hindrance for the utilization of the private health provision in the districts. It was actually a message for the administrators that more health camps and awareness programmes by mobilising grassroots level village functionaries must be arranged especially for the bigger districts to make the scheme more inclusive and sustainable.

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