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# A Critical Assessment of Indian National Health Insurance Scheme – Rashtriya Swasthya Bima Yojna (RSBY)

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**Abstract:**

*The current paper examines the issues and the impact of India's National Health Insurance Scheme-Rashtriya Swastya Bima Yojna (RSBY) from equity and efficiency perspectives. The paper gives a brief background of India's poverty situation and health care financing. It provides a detailed review of relevant literatures and evaluation papers on RSBY to highlight issues related to its design, coordination between different agencies and issues related to enrolment and utilisation of health care under the program. It also examines NSSO- Consumer Expenditure Survey (CES) of the years 2007-08 and 2009-10 of Government of India to see whether the scheme has really helped to increase the health care utilisation by the resource poor families. The result of NSSO-CES analysis shows no such indication and in fact it shows that per capita medical expenditure has reduced for the lower decile groups in the year 2009-10 compared to the year 2007-08 implying that there has been no increase in health care utilisation. It also shows that expenditure is highly skewed towards higher expenditure decile groups with very high per capita medical expenditure compared to poor decile groups. The per capita medical expenditure were also analysed for different social classes to understand the health care utilisation from the equity perspective. There was a wide variation in the medical expenditure patterns in the different social categories.*

*However, to understand that whether the scheme has really succeeded to provide financial security from out-of-pocket payments and*

*catastrophic health care expenditure, there is a need to do a scientifically designed population level study across the country from equity and efficiency perspectives. This will also enable us to understand the enabling and hindering factors related to RSBY which are affecting to achieve its intended objective of providing financial security to the resource poor families. Since inequities in health care expenditure continue to remain, policy makers need to relook at the scheme to make it more accessible to the poorest and vulnerable sections of the population.*

**Key words**: Health Insurance, RSBY, Equity, Efficiency, out-of-pocket health expenditure, catastrophic health expenditure

## Backdrop of Health Care Finance in India

In a Press Note on Poverty Estimates 2009-10, Planning Commission of India pegged rural poverty at 33.8 percent and urban poverty at 20.9 percent of respective populations. While there is marked difference between rural and urban poverty, the data also shows large interstate variations. States like Sikkim, Tamil Nadu, Delhi, Himachal Pradesh and Kerala fall in one end of the spectrum while Jharkhand, Bihar, Chhattisgarh, Odisha, Uttar Pradesh fall on the other end, with high poverty incidences. Poverty is closely linked to education, income, health and social status of the household. (planningcommission.nic.in/news/press_pov1903.pdf).

Large works of literatures link the incidence of poverty with bad health condition. Wagstaff & Van Doorslaer (2002) found direct relationship between poverty conditions of the country and incidence of catastrophic illnesses due to which families spend their substantial share of income for getting treatment, which are enough to make them impoverish. Though there are various definitions of catastrophic health expenditure, WHO (2005) defines it as health expenditure above 40% of the household's capacity to pay [CTP], which pushes the families into the vicious cycle of poverty. Health expenditures are responsible for more than half of Indian households falling into poverty; the impact of this has been increasingly pushing

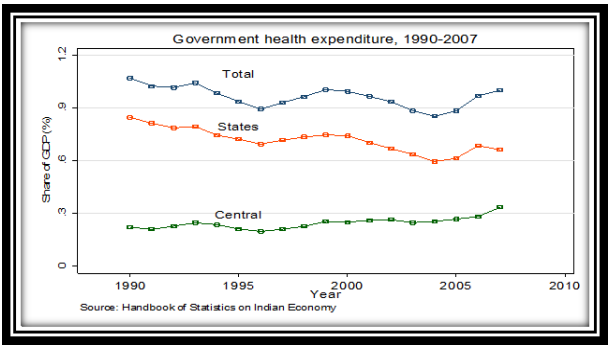
around 39 million Indians into poverty each year (Balarajan et al. 2011). Other studies have also reported that millions of people are being pushed to below the poverty line due to catastrophic health expenditure (Selvaraj & Karan 2009).

Indian health sector faces severe resource crunch, and the government spending on this sector is very limited. India's National Health Accounts for the year 2004-05 shows that out of the total annual health care expenditure in the country which was 4.25% of the country's GDP, the government's share is merely 0.84% of the GDP and private out-of-pocket was 78%.

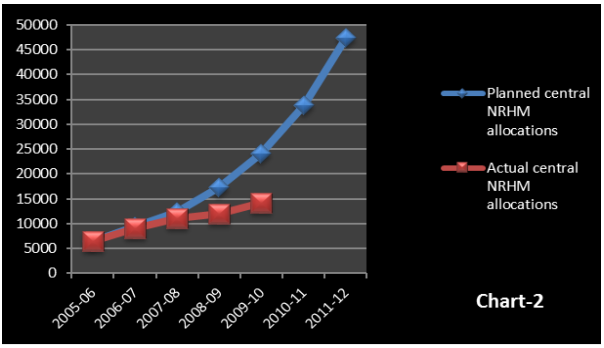
| Country | Health Exp. as % of GDP | Govt. Exp. on Health as % of Total Exp. on Health |
|---|---|---|
| **USA** | 15.2 | 45.1 |
| **Germany** | 10.7 | 76.9 |
| **France** | 11.2 | 79.9 |
| **Canada** | 9.7 | 70.3 |
| **UK** | 8.2 | 87.1 |
| **Brazil** | 7.9 | 44.1 |
| **Mexico** | 6.4 | 45.5 |
| **China** | 4.7 | 38.8 |
| **Malaysia** | 4.2 | 44.8 |
| **Indonesia** | 2.1 | 46.6 |
| **Thailand** | 3.5 | 63.9 |
| **Pakistan** | 2.1 | 17.5 |
| **Sri Lanka** | 4.1 | 46.2 |
| **Nepal** | 5.8 | 28.1 |
| **India** | 5.0 | 19.0 |

Table-1 **Source: National Health Accounts 2004-05**

The share of India's health expenditure as percentage of GDP is much lower than many developing and developed nations. Again, in terms of Government's share of the total health care expenditure of the country, India ranks much below other developing nations like Brazil, China, or even smaller developing countries like Malayasia, Indonesia, Thailand, Sri Lanka or Nepal.




**(Chart-1)** The government finance for the health sector delivery comes from both the Central Government kitty and the respective State Governments' share. A look at the share of Central and State governments' share from 1990 onwards shows that the Central Government share is more or less constant in terms of percentage of GDP and the share of State Governments have reduced drastically, making the total government expenditure in a decreasing trend.

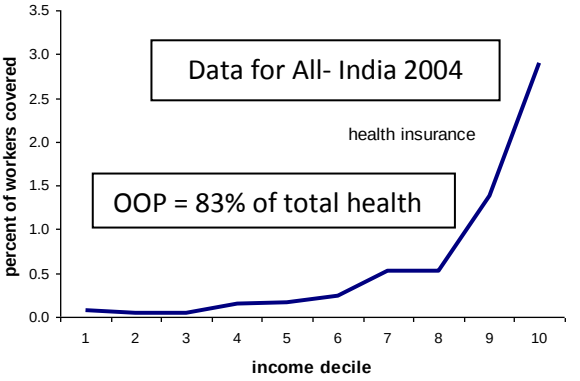



The same trend can also be seen even in the case of one of the flagship health care programs of the government, National Rural Health Mission (NRHM). When NRHM rolled out in 2005-06, a projection of planned central government allocations for NRHM was done from 2005-06 to 2011-12. However, the year wise actual Central Government allocation was as per the plan till 2006-07 and after that it started falling

sharply. Even after the sharp fall in Central allocation, some of the States are not utilizing the allocated fund under the program, which could be due to their low fund absorption capacity.

With such shortfalls in Government spending on health in India, the private out-of-pocket health care expenditure is as high as 78%, which is very regressive in the backdrop of disproportionately large number of resource poor households in the country.

In India, approximately 94 percent of the workforces are working in the unorganized sector constituting one of the largest in the world. People working in unorganized sector can be characterized as belonging to low economic classes, are self-employed, illiterate, migrating and lacking marketable skills. The unorganized sector in India is not covered by any social security scheme like health insurance.




| | OUT OF POCKET (OOP) EXPENSES AND INDEBTEDNESS IN INDIA (Amount in $US) | | |
|---|---|---|---|
| | | ALL INDIA | POOREST |
| 1. | Average OOP Payments made per hospitalization in Govt. facilities | 70 | 54 |
| 2. | Average OOP Payments made per hospitalization in private facilities | 158 | 115 |
| 3. | %age of people indebted due to Out Patient Care | 23 | 21 |
| 4. | %age of people indebted due to In-Patient Care | 52 | 64 |
| | *Table-2 SOURCE: NSSO, GOI* | | |

**(Chart-3)** Low earning capacity coupled with vulnerability makes the people poor and this leads to low demand of health care, which further deteriorates their health condition and this vicious cycle continues. They are less inclined to seek medical care due to scarcity of resources, fear of wage loss etc. Even when they are forced to seek treatment, they end up losing their savings and fall into the debt trap. The expenditure is also distributed regressively; lower economic class people pay a higher proportion of their income towards medical expenses. Studies have shown that this negatively impacts the lower economic classes who either don't seek health care or borrow money from the market to finance their health care (Berman, P. A., 1998).

NSSO 2004 data shows that out of pocket health expenditure is quite high in India for health care and disproportionately high for the poor communities. As per NSSO 2004, OOP health expenditure was 83% of the total health expenditure. Again, because of high out-of-pocket expenditure and low earning capacity and purchasing power, the resource poor communities take huge debt from the market to finance their health expenditure. The data shows that 64% of the poorest are indebted due to in-patient care. Their health insurance coverage is also in a very sorry state with factually no financial security from catastrophic healthcare expenditure. This substantiates the Law of Inverse Care, whereby the people who need the health care the most face the most amounts of difficulties in accessing the health care, and are least likely to get the health needs met (Hart 2000). Also, even after considerable rise in different dimensions of diseases, remaining the hospitalization rate of the country more or less constant at around 2.5% (Selvaraj & Karan 2009) gives an indication that there is something wrong with the health sector in India in its ability to confront the problems. However, health insurance could work as one of the very important measures to protect poor people from the catastrophic health care expenditure.

## Background of Health Insurance Models – Indian Experience

In the past, government has tried to provide health insurance to the resource poor communities through different Central or State schemes. However, these did not achieve the intended objectives due to a number of design and implementation related problems. India has Social Health Insurance (SHI) schemes like Employee State Insurance (ESI) or Central Government Health Scheme (CGHS) but these cover only those people who are employed in the formal sector. Apart from these, there are other state specific schemes like Critical Illness and Personal Accident Scheme in the state of Assam, Sanjivini Scheme in the state of Punjab, Kudumshree in Kerela, Senior Citizen Health Insurance scheme of Indore Municipal Corporation, Rajasthan Swasthya Bima Yojna, Rijiv Ghandhi Arogyashri scheme in Andhra Pradesh, Yeshaswani scheme in Karnataka etc.

The experiences of these schemes are mixed. While some of the schemes have been closed due to high administrative and transaction costs (for getting right information from the patients or service providers like hospitals etc.), some are not able to reach a sizable number of population either due to adverse selection or problems like moral hazard and supplier induced demand. Poorly designed publically finance subsidy plans also lead to market failures due to inadequate price competition, lack of innovation and cases of moral hazard by the health care consumers.

General Insurance Companies (GIC) established by the government in 1973, offers 'Mediclaim' policy through four major government owned GICs. It covers hospitalization expenses, however with numerous exclusions criteria, which make it unviable from the patients' perspective. Moreover, it is not cashless due to which poor people find it difficult to join. It offers reimbursement of expenses; delay in reimbursement is its

major criticism. Also, there are a large number of cases of disallowances reported by the policy holders. They charge very high premium which is unaffordable to the resource poor families. Private Health Insurance, due to its high costs and limited coverage in terms of benefits, is beyond the reach of most of the people working in unorganized sector or vulnerable population.

In 2007, the Central government has launched an insurance scheme called RSBY to provide insurance coverage to the resource poor households for the in-patient health care services (Ellis, Alam, & Gupta 2000, A Critical Assessment of the Existing Health Insurance Models in India, 2011, Selvaraj, & Kara2012, Carrin 2002, Forgia & Nagpal 2012).

## Introduction of Rashtriya Swasthya Bima Yojna (RBSY) – Am Indian National Health Insurance Scheme

The Government of India sponsored RSBY scheme is being operationalised by Ministry of Labour and Employment, and being implemented in collaboration with the State governments and private health care service providers in the public-private-partnership mode. It has been designed taking into account most of the concerns and shortfalls of the previous health insurance schemes. It covers resource poor population, large provider's network, offers package rates for different services, offers cashless benefit, covers pre-existing diseases, no age limit for coverage, provides premium support by the government etc. The scheme covers all Below Poverty Line (BPL) families defined by the Planning Commission of India and now even being extended to larger number of workers from the unorganized sectors. The coverage is Rs. 30,000 per year for a family of five. Key features of this scheme are covering pre-existing diseases, cashless benefit, portability of smart card etc. (www.rsby.gov.in).

## Institutional Arrangement and Management of RSBY

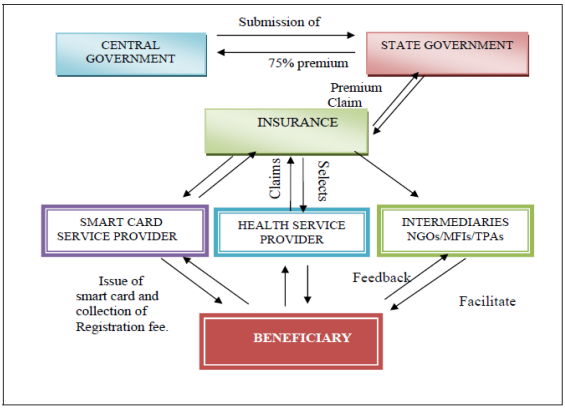



**Chart-4 Source: mohfw.nic.in/NRHM/Presentations/Orrisa.../3rd.../EQ_AS1.pps**

RSBY covers the BPL families who are enlisted in the districts and state. The eligible families need to enroll to get the benefits. On behalf of enrolled families, government pays a premium which is shared between the Central and State Government in the ratio of 75:25. Every beneficiary family pays Rs. 30 for its registration and Rs. 60 for smart card.

The State Government selects insurers through competitive bidding process. The primary reason for contracting insurance companies by the government is to outsource most of the managerial services which are difficult for the government to manage due to manpower constraints.

The selected insurers arrange for the enrollment of eligible families in different locations. These stations are equipped with necessary hardware to take biometric information or fingerprints and photographs and print the smart cards for the families. For these processes they take help of smart card service providers and intermediaries like NGOs/MFIs/TPAs. The smart cards are distributed to families after receiving the fees and their authentication by the concerned government officials known as Field Key Officer (FKO). Details of the scheme are also being provided during

enrollment. The insurers also set up a district kiosk in every district in a location which is easily accessible by the beneficiaries for the services like modifying the existing smart cards, splitting the smart cards, issuing new smart cards etc.
The selected insurers empanel the health care providers both private and public based on certain criteria. The objective behind empanelling private health care providers' along with the public health care providers is to generate competition between them and make the market efficient and complete in terms of provision of depth and breadth of the services. Since patients can visit any of the empanelled hospitals anywhere in the country, this gives them the choice of visiting any health care facility irrespective of whether it is public or private (www.rsby.gov.in).

## Issues Related to Institutional and management Arrangement of RSBY

RSBY is being run by the Ministry of Labour and Employment, Govt of India, at the central level. Ministry of Health and Family Welfare, Govt of India coordinates all the health care programs. And as per the Constitution of India, health is a state subject. Multiplicity of agencies creates problems of coordination. Studies have shown that one of the major problems of delay in rollout of the program at the ground level is due to lack of coordination between these agencies. Again, due to lack of coordination between the insurance companies and the district and state nodal agencies and their functionaries, often the enrolment exercise get cancelled or delayed which is not only a waste of resources but also prevents the eligible poor families from availing the services. Cases have also found that due to non-settlement issues between insurance companies and the medical service providers, some of the private hospitals are not even admitting the RSBY card holders

(Forgia & Nagpal 2012; Rajasekhar, Berg, Ghatak, Manjula & Roy 2011).

## Financing and Provisioning of Health Care under RSBY: Issues related to Equity and Efficiency

Since RSBY is being funded from the general taxes, it is considered to be an efficient health financing mechanism as it has all the important features of prepayment, pooling of risks & resources and cross-subsidisation by the better off communities to the poor. Financing the scheme from general taxation will make the resource flow smooth since taxation amount will be compulsorily paid by the citizens and adverse or cream selection can be avoided. In economic sense, it is considered as progressive because taxes are used to fund for cashless services for the poor. The welfare gains are very high. A few studies have shown that RSBY is doing well in terms of enrollment of intended beneficiaries in some states like Himachal Pradesh, Delhi and Gujarat. Studies have also shown that awareness level of the community about RSBY has increased and now larger populations are availing the benefits of RSBY in these states. However, it needs to be studied whether the benefits of the scheme are actually been received by the intended beneficiaries in terms of reducing their proportionate health expenditure, catastrophic health expenditure and improvement in their health conditions (Evaluation Study of RSBY in Shimla & Kangra districts, Evaluation Of "Rashtriya Swasthya Bima Yojana Scheme" In Chhattisgarh; Krishnaswamy & Ruchismita 2011, Gupta 2010, Dilip 2012).

In such wealth transfer programs for the resource poor communities, it is very important to increase the coverage to improve the social welfare. The primary responsibility of enrolling the intended beneficiaries is with Third Party Administrators (TPA) who are empanelled by the insurance companies. These parties conduct enrolment drives in the field

and also organize awareness programs to attract communities to join the program. Das & Leino (2011) evaluated the impact of Information Education and Communication (IEC) in the enrolment of RSBY in Delhi region and found that IEC had no impact in the enrolment and utilization of the health care services under the scheme. Nandi, S. et al. (2012) in the study done in the state of Chhattisgarh found various issues of discrimination in enrolment.

For instance, far off or remotely situated villages were not being targeted for enrolment in the first stage by the insurance companies because it increased their costs for accessing these villages. Also, in a number of cases, most vulnerable groups like Particularly Vulnerable Tribal Group (PVTG) families, old age people were left out. It was also observed that where the incidence or prevalence of diseases was high, such villages were not targeted by the insurance companies to reduce their claim ratio. The study found that claim ratio was not even 10 percent during one year of its implementation in the state.

Empanelment of a large number of private hospitals as providers, though promoting competition between public and private hospitals, has also given some unscrupulous providers an opportunity to earn money and profit. Due to the problem of supplier induced demand, unnecessary medical services are being provided to the patients over and above the needed services, particularly by the private providers. These providers have also designed strategies to attract patients to sell their services. Moreover, for the costly services, they generally divert the patients to the public hospitals so that they can save the cost of treatment (Forgia & Nagpal 2012; Nandi et al. 2012).

Government has provided package rates for around 1100 in-patient and day care services services which, from an efficiency perspective, is a big improvement over fee-for-service rate and has a potential to create strong incentives for cost containment. However, rates for the services have not been

fixed based on any thorough market study which may create problems like under-pricing of services in some contexts and over-pricing in other contexts. Studies have shown that due to the low package rates, the private empanelled hospitals are not treating complicated cases and patients are being referred to the public hospitals (Forgia & Nagpal 2012; Nandi et al. 2012).

Under RSBY, the proportion of private empanelled hospitals comprise of about 75 percent of the total hospitals empanelled, which is one of the major areas of concern regarding cost of hospitalization. One of the reasons for high proportion of private empanelled hospitals under the scheme is because of limited capacity of public hospitals and administrative difficulties in establishing the formal cashless arrangements. Decision making authority in the case of public hospitals generally lies with the bureaucrats and not with the hospital authority, unlike in private hospitals where most of the operational decisions are taken by the hospitals themselves. This gives the latter an edge in terms of quick decision making on case to case basis compared to public hospitals (Forgia & Nagpal 2012). However, the risk of manipulations for profit maximization is higher in private hospitals even though government has provided pre-specified rates for the prescribed services. Nandi, S., et al, 2012 found that the average value of hospitalization in public hospital was Rs 4,988 while in private hospital it was Rs. 7416 for the RSBY services. The study also found that 58% of the respondents in private sector and 17% in public sector incurred out-of-pocket expenses. Average out-of-pocket expenditure in the private sector was Rs 1078 compared to public sector which was Rs 309 for the RSBY services. Selvaraj & Karan (2009) also found that medical expenditure per episode for out-patient care is Rs. 214 in the government facilities and Rs. 286 in the private facilities. Similarly, for in-patient care the per episode treatment cost in the public facilities is less than Rs. 4,000 compared to more than Rs. 9,000 in the private facilities. However, the costs in the public

hospitals are less compared to the private hospitals which could be because public hospitals are getting two levels of subsidies at both supply side (government grants for the public health care delivery system) and demand side (under RSBY) unlike private hospitals which are getting only demand side subsidy (under RSBY). This leads to unfair competition between public and private hospitals in terms of costs and this could be one of the reasons for the high costs of the latter (Forgia & Nagpal 2012). One needs to study which kinds of services are being provided by these providers and also the quality of services provided by the public and private providers.

However, empanelment of large number of private health facilities gives a strong signal of declining public provisioning of health care. Health is considered to be a public good due to its externality characteristics, issue of equity and problems of information asymmetry in the health care market like adverse selection or cream selection, moral hazard, supplier induced demand etc. This justifies government intervention to provide health care provision rather than involving private providers (Folland, Goodman, & Stano 1997). Due to these market failures in the health sector, it becomes utmost important for the government to play an active role in financing and provisioning of healthcare services for the people (Gertler 1998; Jost 2001; Rice 1992).

Even after 5 to 6 years of implementation of RSBY in the country, the hospitalization rate has increased which shows that it is yet to create an impact on increasing the health care utilization by the resource poor families (Narayana 2011). Narayana (2011) also found huge variations in hospitalization rates between different states. It ranges from 0.39 percent hospitalisation in Punjab to 2.62 percent hospitalisation in Kerela. The study also found the same range of variations in hospitalisation between different districts in all the states. The high variations in hospitalisation rates between the districts within the same states and between the states are also

indicating variations in public and private health infrastructures in different places, issues related to health care finance in different places along with the other underlying factors leading to such variations. These variations in utilisation also lead to variations in the profit margins of insurance companies contracted under RSBY in different places and the places where the hospitalisation rates are low are having high profit margins for the insurance companies which lead to welfare loss (Narayana 2011).

Out-patient services are not covered under RSBY which leaves the financial burden of out-patient care on the shoulders of resource poor people. Approximately 70% of the health care expenses are due to out-patient services. Resource poor people, because of poor living conditions, are susceptible to different diseases which may not require hospitalisation, but which require out-patient care and are expensive. So if such cases are not covered, they may try to avoid treatment due to lack of resources which in the long run may further deteriorate their conditions and the treatment costs would be high (Selvaraj, & Kara 2012; Narayana 2011).

## Analysis of Health Expenditure Pattern from Equity Perspective Using NSSO Data

The National Sample Survey Organisation (NSSO) under Ministry of Statistics and Program Implementation, Government of India collects data on consumer expenditure which also includes medical expenditure both for in-patient and out-patient care. NSSO Consumer Expenditure Survey (CES) data from 2007-08 and 2009-10 has been analysed to understand the impact of health insurance schemes including RSBY on health expenditure, particularly from the equity perspective by looking at the changes in the expenditure pattern between the two periods. The medical expenditures incurred both institutional and non-institutional by different

decile groups for the year 2007-08 and 2009-10 were analysed. The year 2007-08 was chosen as baseline because RSBY was rolled out from April 2007 and the data for this year can be considered as baseline to see the status of insurance coverage and status of health care expenditures for different decile groups, Decile-1 being the poorest groups and decile-10 being the wealthiest groups. Apart from RSBY, there are various state sponsored health insurance programs being run in different states for the last several years. The CES data for the year 2009-10 was used to see whether there was any change in the health expenditure patterns due to RSBY and other state sponsored publically financed health insurance policies.

| India | Table-3: Monthly Per Capita Expenditure (Rs.) for Households in each Decile | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **2007-08** | Decile-1 | Decile-2 | Decile-3 | Decile-4 | Decile-5 | Decile-6 | Decile-7 | Decile-8 | Decile-9 | Decile-10 |
| **Medical Exp.-Institutional (Ind)** | 0.66 | 1.19 | 2.11 | 2.3 | 4.24 | 5.3 | 5.3 | 10 | 19.97 | 84.54 |
| **Medical Exp.-Non Institutional (Ind)** | 8.52 | 12.18 | 15.72 | 19.13 | 22.6 | 27.21 | 31.14 | 40.91 | 54 | 117.77 |
| **Total Non Food Exp.** | 132.89 | 171.34 | 200.25 | 228.34 | 258.85 | 297.14 | 342.21 | 409.32 | 528.72 | 1111.09 |
| **Total Expenses** | 342.36 | 436.18 | 499.98 | 556.62 | 616.77 | 684.53 | 769.24 | 883.62 | 1073.04 | 1861.05 |
| **% of Med. Exp. To Total Non Food Exp.** | 6.91 | 7.80 | 8.90 | 9.39 | 10.37 | 10.94 | 10.65 | 12.44 | 13.99 | 18.21 |
| **% of Med. Exp. To Total Exp.** | 2.68 | 3.07 | 3.57 | 3.85 | 4.35 | 4.75 | 4.74 | 5.76 | 6.89 | 10.87 |

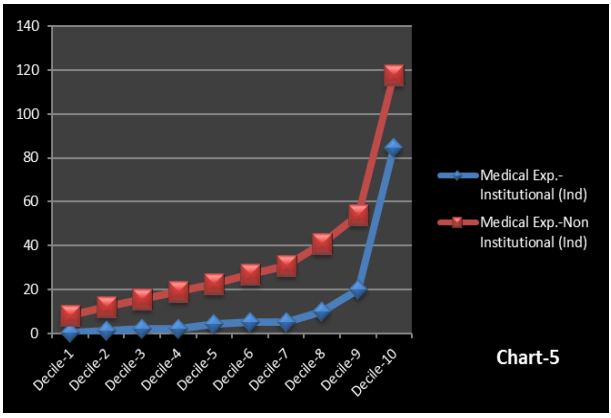
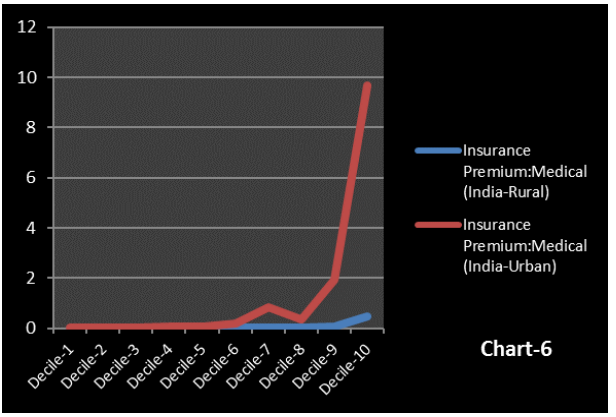


Table-3 and Chart-5 show that the monthly medical expenditure per capita in the lower deciles were very low in proportion to their total non-food expenditure or total monthly expenditure which includes both food and non-food expenditures compared to their better-off counterparts. Also, expenditure on health in the highest deciles were high, both in absolute terms and in proportion to their total non-food expenditure or total expenditure. The data clearly shows that the medical service utilization is highly skewed and raises the question of inequity. The skewed pattern could be a result of affordability or access or both, or due to one segment being financially better protected than the other.

## Financial Risk Protection from Health Care Expenditures: Analysing 2007-8 Data to See the Insurance Coverage for Different Economic Classes:

The current section analyses the monthly per capita medical insurance premium paid by different decile groups or paid on their behalf using 2007-08 consumer expenditure survey. Though the insurance premium paid is not the part of the total consumer expenditure but the analysis will give insight the distribution of health insurance coverage from equity perspective.

| **India (Table-4)** | **Monthly Per Capita Med. Insurance Premium (Rs.) for Households in each Decile** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **2007-08** | Decile-1 | Decile-2 | Decile-3 | Decile-4 | Decile-5 | Decile-6 | Decile-7 | Decile-8 | Decile-9 | Decile-10 |
| **Insurance Premium: Medical (India-Rural)** | 0 | 0.02 | 0 | 0.01 | 0 | 0.04 | 0.03 | 0.02 | 0.05 | 0.48 |
| **Insurance Premium: Medical (India-Urban)** | 0.01 | 0.02 | 0.04 | 0.06 | 0.08 | 0.19 | 0.83 | 0.36 | 1.91 | 9.69 |



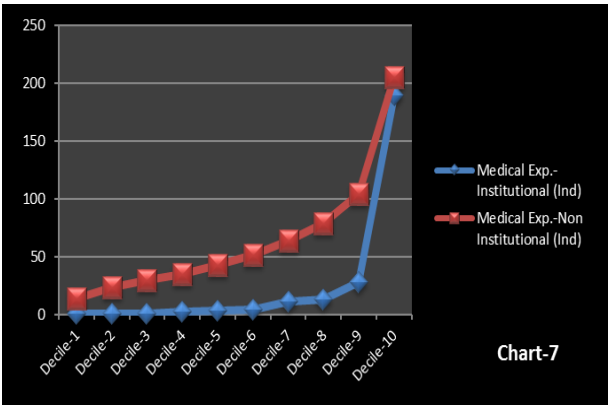

From the Table-4 and Chart-6, it is evident that the health insurance coverage is negligible for the lower deciles. While there could be a number of reasons for their non-enrollment in any health insurance scheme; the result of such non enrollment results in either a catastrophic effect on the financial situation should they fall ill, or they are forced to avoid medical treatment in order to avoid such catastrophic consequences, which however deteriorates their health condition further. From the social cost perspective, there is a substantial cost to the society when persons or families do not have adequate health insurance required to cater to their healthcare needs (Manning W.G. & Ellis, R. P., 2007; Dooley, R. & Judge, W. Q., 2006). However, the upper decile groups are fairly covered under health insurance coverage, thus protecting them against any catastrophic consequences.

Again, urban-rural comparison shows that the former is better covered than the later due to better concentration of services and facilities, but here too, the poorest deciles have very little coverage.

## Analysing 2009- 10 data for Different Economic Classes to See whether there is any Positive Change in the medical Expenditure Pattern Compared to the Year 2007-08

| India | Table-5: Monthly Per Capita Exp. (Rs.) for Households in each Decile in last 30 days | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **2009-10** | Decile -1 | Decile -2 | Decile -3 | Decile -4 | Decile -5 | Decile -6 | Decile -7 | Decile -8 | Decile -9 | Decile -10 |
| **Medical Exp.- Institutional (Ind)** | 0.37 | 0.54 | 0.95 | 1.93 | 3.27 | 3.82 | 10.6 | 12.44 | 28.01 | 189.48 |
| **Medical Exp.-Non Institutional (Ind)** | 13.94 | 23.54 | 29.67 | 35.15 | 42.89 | 51.59 | 63.49 | 78.94 | 103.76 | 204.54 |
| **Total Non Food Exp.** | 195.24 | 295.39 | 379.14 | 471.66 | 590.24 | 723.59 | 905.38 | 1161.48 | 1633.63 | 4230.57 |
| **Total Expenses** | 521.32 | 722.31 | 869.62 | 1027.93 | 1207.69 | 1420.07 | 1687.74 | 2051.45 | 2680.52 | 5673.16 |
| **% of Med. Exp. To Total Non Food Exp.** | 7.33 | 8.15 | 8.08 | 7.86 | 7.82 | 7.66 | 8.18 | 7.87 | 8.07 | 9.31 |
| **% of Med. Exp. To Total Exp.** | 2.74 | 3.33 | 3.52 | 3.61 | 3.82 | 3.90 | 4.39 | 4.45 | 4.92 | 6.95 |

The NSSO CES Report 2009-10 has been analysed to see if there was any change in the pattern of health expenditure in the lower decile groups. The year 2009-10 was chosen, since by then the scheme had been rolled out in most districts of India, and it could be expected that there could be some positive change in their health care expenditure pattern due to insurance coverage.



However, a look at the Table-5 above and Chart-7 shows more or less a similar pattern of utilization as in 2007-08 and more importantly, we can see that there is reduction in the in-patient expenditure in the lower decile group in absolute terms and drastic increase in the out-patient expenditure. The reduction in the in-patient expenditures shows that the impact of RSBY, which covers in-patient services, was still not showing any positive result in the referenced year.

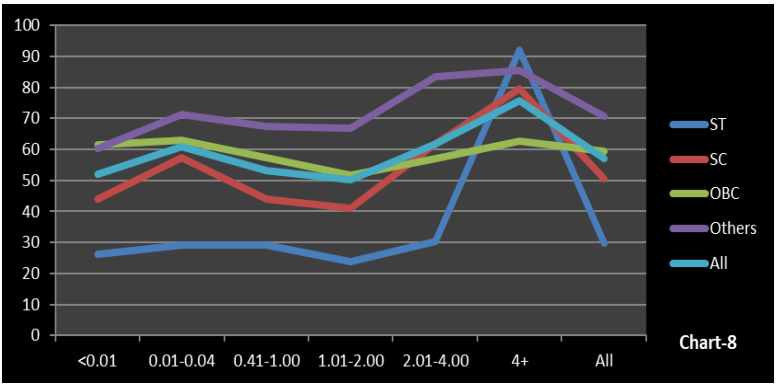
As per the guideline of NSSO, medical expenditure also includes expenditure reimbursed by the insurance companies directly to the households or to the hospitals (under 'cashless' benefit). Hence, one would expect increase in per capita medical expenses of the lower economic decile groups, if they would have received the benefits of such schemes. Remaining the same expenditure pattern implies that the intended beneficiary groups have not received any benefit of reimbursement or cashless in-patient medical care for their medical expenses.

During the same period (i.e. during 2007-08 and 2009-10), if we see the data, there is a sharp increase in the overall household consumer expenditure which might be due to the reasons of inflation or other factors. However, despite this, reduction in the institutional medical expenditure even in the nominal (without adjusting for inflation) terms is surprising and one can conclude that there are still problems of accessibility of institutional care services where financing and insurance play the important role.

The NSSO 2009-10 CES monthly per capita medical expenditure data has been further analysed for different social groups and within each social group, for different land holding sizes which indicate their economic conditions. The purpose is to see if there is any difference in health expenditure pattern between and within the social groups.

**India (2009-10)** **Table-6: Monthly Per Capita Med. Expenses (Rs.) for Households in each group (socio-economic group and land holding size in hectares)**

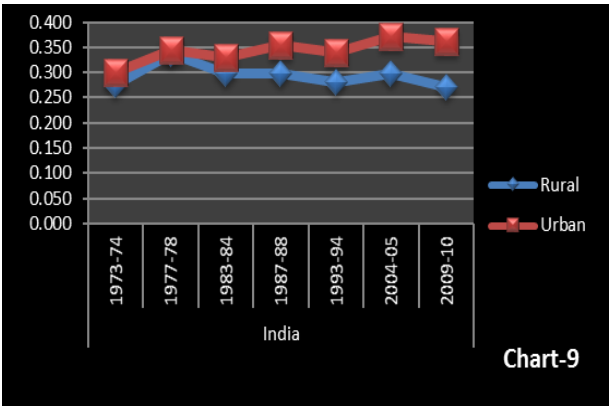
| | <0.01 | 0.01-0.04 | 0.41-1.00 | 1.01-2.00 | 2.01-4.00 | 4+ | All |
|---|---|---|---|---|---|---|---|
| ST | 26.33 | 29.17 | 29.21 | 23.94 | 30.42 | 91.9 | 29.74 |
| SC | 44.01 | 57.19 | 44.11 | 41.06 | 61.67 | 79.51 | 50.42 |
| OBC | 61.47 | 62.94 | 57.25 | 51.84 | 57 | 62.62 | 59.46 |
| Others | 60.19 | 71.19 | 67.35 | 66.75 | 83.41 | 85.5 | 70.55 |
| All | 52.13 | 60.83 | 53.23 | 50.33 | 61.82 | 75.68 | 56.91 |




The monthly expenditure on medical care of Scheduled Tribe (ST) community is the lowest, followed by Scheduled Caste (SC), whose monthly per capita medical expenditure is more than the ST community but still below the average if compared to monthly per capita expenditure of all the groups taken together. The expenditure pattern of Other Backward Classes (OBC) is almost similar to the average. The monthly per capita expenditure of other communities (general category) is highest. Again the rise in monthly per capita medical expenditure appears to be positively correlated by the landholding size, with more expenditure recorded with groups with higher landholdings, underpinning the aspect of inequity in health care finance and health care utilisation.

## Equity in Total Household Expenditure in Rural and Urban India

| Table-7 | Year | Lorenz Ratio | |
|---|---|---|---|
| | | Rural | Urban |
| India | 1973-74 | 0.276 | 0.301 |
| | 1977-78 | 0.339 | 0.345 |
| | 1983-84 | 0.298 | 0.330 |
| | 1987-88 | 0.298 | 0.354 |
| | 1993-94 | 0.282 | 0.339 |
| | 2004-05 | 0.297 | 0.373 |
| | 2009-10 | 0.270 | 0.362 |




The most widely used measure of relative inequality is the Lorenz ratio. If the Lorenz ratio is high, it means that there is high degree of inequality. Table-7 and Chart-9 show that, over the period of last 27 years (from 1973 to 2010), the inequality in the rural areas increased slightly in 1977-78 compared to the previous year but after that it has been on the slightly decreasing trend. On the other hand, the inequality in the urban areas is on the increasing trend. Again, compared to rural India, the Lorenz ratios of the urban areas are always high all through the years which shows that inequality in the urban areas is consistently higher compared to the rural India. The behavior of the Lorenz ratio of household consumption expenditure shows a very high degree of constancy and since medical expenditure is a part of household expenditure; similar trend can be expected for medical expenditure. The previous

analyses of medical expenditure for the year 2007-08 and 2009-10 supports this claim.

## Discussion

RSBY is primarily a welfare maximization program where there is redistribution of wealth from the better off to the economically vulnerable communities. This is demand side financing for the poor because with transfer of wealth and increase in their purchasing power, they can demand for the services. They also have a choice of selecting providers from whom they would like to avail the services, which is an empowering process. This is an unprecedented step which the government has taken to provide social security to the most marginalized population of the country.

However, the above evidences give an extensive overview of the precarious situation of the poor households in relation to their health care financing burden and absence of financial security to meet the health care expenditures. Specific issues underlined were equity, access, effectiveness, affordability and efficiency of the health care finance system. The NSSO-CES analyses for the year 2007-08 and 2009-10 show that RSBY is yet to provide benefits to the resource poor households in terms of increased utilization of health care services particularly for the institutional care. It also shows that there are a number of issues related to design and implementation of the scheme which may hinder it from achieving its intended objective of providing financial security from catastrophic health expenses to those families for whom the program is meant for.

Since RSBY was meant to reduce the catastrophic health expenditures of poor communities, it would be important to conduct a detailed population level study of RSBY to evaluate the implementation of the scheme from equity and from economic efficiency perspectives to see whether the most

vulnerable sections of the societies are being enrolled and the benefits of the scheme have actually been received by the intended beneficiaries in terms of reducing their proportionate health expenditure, catastrophic health expenditure and improvement in their health condition. The economic efficiency perspective will enable to policy makers to see whether the RSBY intervention is cost effective and the equity perspective will enable them to see the distribution of benefits and whether the benefits are reaching to the most marginalized population. It would also be proper to study the optimality of the current publically finance health insurance program to understand whether the program is optimally designed to cater to the needs to the population for whom it is meant for.

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