IMPACT OF PUBLICLY FINANCED HEALTH INSURANCE SCHEME (RASHTRIYA SWASTHYA BIMA YOJNA) FROM EQUITY AND EFFICIENCY PERSPECTIVES

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ABSTRACT

Background: Catastrophic health expenses result in impoverishment of a large number of people every year, a part of it being accounted for by out-of-pocket expenses borne privately by individuals. The impact of the high expenses is worst for the resource poor households who often forego treatment due to affordability barrier. Since India is committed to universalisation of health care, the government had launched a health insurance scheme to provide affordable and quality health service and bring down out-of –pocket and catastrophic health expenditure for the resource poor families.

Research Design: The current study has dealt with publicly financed health insurance, Rashtriya Swathya Bima Yojna (RSBY), which has a potential to achieve universal health insurance in India and particularly reach the vulnerable sections of the society. The study was conducted in two blocks of Ranchi district of Jharkhand with 1643 below poverty line (BPL) households for primary data collection. Both enrolled and non-enrolled households were selected randomly for the study.

Research Questions: The study addressed three research questions:

1. Has RSBY reduced the out-of-pocket health expenditure, incidence of catastrophic health expenditure and incidence of induced impoverishment due to health expenditure of the insured population?
2. Were the benefits of reduction in out-of-pocket, incidence of catastrophic health expenditures and incidence of induced impoverishment due to health expenditure equitably distributed?
3. What were the determining factors for enrolment, hospitalisation, OOPE and CHE?

The study on RSBY was conducted both from equity and efficiency perspectives to assess the impact on care seeking behaviour, out-of pocket expenses, incidences of catastrophic expenses and health expenditure induced impoverishment.

Main Findings: RSBY significantly increased hospitalisation among the enrolled households compared to the non-enrolled households. It also had marginal effect in reducing the burden of out-of-pocket health (OOP) expenditure among the enrolled households compared to non-enrolled households. These are positive outcomes. However, it had also significantly increased the likelihood of health expenditure induced poverty among the enrolled households compared to the non-enrolled households. Also, there was no significant impact on reduction in incidences of catastrophic health expenditure (CHE) among enrolled households. Even while hospitalisation had increased among the enrolled households, the distribution was not equitable. The likelihood of hospitalisation was less among the poorest quintiles compared to the least poor quintile. Redistributive effect has not been seen due to this insurance and there is a significant gap in care seeking, receiving care, CHE and health expense induced poverty between the poorest and least poor quintile.

The study further found that families with better awareness level, from higher expenditure quintile, living in urban areas, those that had experienced hospitalisation care of any family member in the last one year and households with more family-members were more likely to enroll in RSBY.

RSBY enrolled families from higher expenditure quintile received more in-patient (hospitalisation) care. Other determinants were found to be residence in rural areas, proximity to public health providers or informal health providers and experience of serious illness by any member in previous two years. Literacy status of head of household, small family size also had positive impact on likelihood of receiving in-patient care.

Similarly, high out-of-pocket expenditure was seen in cases where there had been hospitalisation in the past one year. High OOP was also incurred by families where there had been any episode of serious illness in past two years. High OOP was seen mainly among families from higher expenditure quintile probably indicating at the inability of resource poor families to afford the medical treatment, assuming the probability of illness is the same for all sections.

Likelihood of health expenditure induced poverty was found to be more among families from poor expenditure quintiles, where head of household was unemployed, large size families and families living in urban areas. It was also found to be more among the households where family members are alcoholic. Similarly, more incidences of catastrophic health expenditure were seen for families that had faced health events like hospitalisation, chronic illness, delivery and particularly C-section delivery. Employment status of head of household, distance from nearest health provider, family size and socio-economic condition of households emerged as other determinants for CHE.

Conclusion: Evidence shows that RSBY, though increased hospitalisation, had failed to achieve its intended objective of providing financial security from health expenditure to the economically weaker sections of the society. The scheme has only made marginal impact on reducing out-of-pocket health expenditure and not made any impact in reducing catastrophic health expenditure or health expenditure induced poverty. Rather, health expenditure induced poverty had increased among the RSBY enrolled families due to increased cases of hospitalization but inadequate financial support. Due to improper targeting, the poorest quintiles were left out both from enrollment as well as availing any benefit of the scheme. Policy makers need to critically evaluate the options of providing healthcare delivery through insurance model versus strengthening the existing public health delivery system from equity and economic efficiency perspective. Even within the insurance model, design, operational and regulatory mechanisms have to be strengthened to ensure equitable distribution of health care.

Key words: Health Insurance, RSBY, Equity, Efficiency, In-patient Care, Out-patient Care, Delivery, out-of-pocket health expenditure, catastrophic health expenditure, health expenditure induced poverty

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