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ANALYSIS OF VIABILITY IN HEALTH DELIVERY: A STUDY OF RASHTRIYA SWASTHYA BIMA YOJANA (RSBY) IN SELECT DISTRICTS OF WEST BENGAL, INDIA

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ABSTRACT

Universal Health Insurance (UHC) has been the aim of many developing countries to provide for all its citizens. 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. This study focuses on the working of the RSBY scheme in four selected districts of West Bengal namely Birbhum, Burdwan, North 24 Parganas, and South 24 Parganas. The viability of the scheme was discussed in terms of the functioning of the scheme. The different factors for determining viability are conversion ratio, a facility for referrals and settlement of claims. The selected districts had different experiences with the selected variables. It was a good learning to know about the viability issues as it gives an important hint about the functioning and the sustainability of the scheme.

KEYWORDS: *RSBY Scheme, Hospitalization Coverage, Viability Issues*

INTRODUCTION

It is a recognized fact that there is an all-out effort by the countries across the globe to promote universal health insurance coverage (UHC) for all its citizens. The initiative was ideologically strengthened by the Millennium Development Goals (MDGs) and the Right to Health criterion in the Rights Based Approach (RBA) to development. In implementing the programmes for universal coverage it was majorly seen that the government of each country had taken an active role in providing funds and in the provision of a health provision network. However, it was a universal truth that most governments irrespective of being in a developed or a less developed country faced the problem of inadequacy or a fluctuation in capital, physical and human resources. There had been efforts from the private and the civil society sector actors to supplement the efforts of the government. But the private sector served mostly the affluent and the civil society organizations supported marginalized communities at a very microscopic level. Thus there was a felt need for an alternative method of healthcare provision. A system of health insurance for the poor across the country could provide the much needed financial support for the treatment of beneficiaries against the burden of medical expenditure. In India, the Rashtriya Swasthya Bima Yojana (RSBY) was introduced for the poor with the vision of universal coverage across the population. It was a unique scheme with a very modern design in its implementation and coverage which tried to solve the hospitalization burden of the poor. Hence, understanding RSBY and its performance were very essential.

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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 the 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 the utilization of services and settlement of claims.

Narayana in 2010, a compared proportion of the eligible families in the BPL category with the fraction of those hospitalized who were covered. The study showed that the proportion of poor families who were enrolled varied across the states, between 39% in Maharashtra to 81% in Kerala. States such UP and Bihar reported poor enrollment. So did hospitalization rates which varied from 3.91 hospitalizations a year per 1,000 persons in Punjab to 26.17 in Kerala. There was a big inequality in the value of hospitalization across states and between districts within the states. The reason cited was the inadequacy of empanelled hospitals as well as the low proportion of private hospitals. Another somewhat different observation but nonetheless significant was the fact there is a need for a greater system of disclosure by a disaggregated value of hospitalization by diseases treated, services provided etc. is required for a meaningful analysis.

Similar studies on the scheme in different places in India report on the level of awareness, accessibility, and utilization of the scheme by the RSBY cardholders. A lot of issues like the feasibility of the scheme, the coordination between the different stakeholders and the uniformity in delivering of services have made their presence felt in the research reports on RSBY (Krishnaswamy and Ruchismita, 2011; Dror and Vellakkal, 2012; Selvaraj and Karan, 2012; Sheshadri, 2013).

RSBY is thus a modest effort to provide protection to the poor against the hazards of hospitalization in returns for a nominal fee. The poor also expect better treatment as they can access the private hospitals and nursing homes. The implementation of the scheme will be successful only when poor patients will enjoy accessibility and a good quality of care from healthcare from the healthcare providers. Such an improved treatment in health outcomes will usually depend on a host of structural, procedural and contextual factors.

The present study attempts to understand the various factors that have led the growth of the health insurance industry in India and focuses particularly on the performance of the RSBY in India. With the Rights Based Approach (RBA) and the consequent Universal Health Coverage (UHC) policies adopted in most countries, India should now try to successfully implement schemes like RSBY which is designed keeping in mind the Right to Health and the gradual inclusion of all into the health protection network. This doctoral study is thus very contextual and justified and can supplement the policy decisions at improving and improvising the scheme in the future.

Again, West Bengal, one of the popular provinces for its unique socio-political history had witnessed very uneven and slow progress in achieving standards in the health sector. Though the Government of West Bengal had taken various policy initiatives to encourage better health care through the Health Sector Strategy (HSS, 2004-2013) and a mention of the need to *''facilitate RSBY and other insurance schemes particularly for the BPL and other unorganized section'' (*Focus Area 1, Plan of Action, 2011-15, Health and Family Welfare Department, Government of West Bengal), there was under-

funding of the schemes and the delivery systems were plagued by vacancies, absenteeism, urban/rich bias in distribution and use of facilities, lack of drugs and other essential support, low motivation of the staff and inefficient management capacity (WB, HSDI, 2005). As RSBY is the only programmer which covers the BPL population in West Bengal, exploring its situation was the need of the hour. From the review of previous studies on RSBY, it was learned that there were sporadic research reports carried out for very few states. There was no study on West Bengal, though the scheme was in operation in the state since 2008. The selected districts (namely Birbhum, Burdwan, North 24 Parganas, and South 24 Parganas), too, had no studies on RSBY at the time of data collection.

Further, from the previous review of literature, it was seen that the challenge was to overcome the problem of pooling of resources to build a common fund and distribute the risks and also to appropriately choose among the different designs for a new scheme and continuously improve the scheme based on evaluative studies on it. The significance of the working of any scheme was seen to be context-specific as it involved a good partnership between the member-beneficiaries, the local service providers and the administration. Thus the importance of a detailed and systematic investigation in different fields and research settings was necessary as the effect of the scheme on the prospective beneficiaries would vary significantly with differences in state-specific infrastructure of the health systems. Innovation and adaptation would vary according to locale-specific client groups, socio-cultural and political systems, the availability of medical infrastructure etc. Thus in-depth research studies on different aspects of the RSBY scheme need to be carried out.

This study focuses on the working of the RSBY scheme in four selected districts of West Bengal namely Birbhum, Burdwan, North 24 Parganas, and South 24 Parganas. All the districts were almost contiguous and they could capture the mobility of the RSBY patients between the districts. During the pilot study, the researcher found that there was inter-district traveling for want of better treatment from the hospitals. The four districts also captured a mix of socio-economic classes in Bengal. Birbhum was a predominantly rural district with the lowest GDP than the other districts. South 24 Parganas was the next highest in the percentage of the rural population and ranked just above Birbhum in GDP earnings. Burdwan had developed into a semi-urban district with moderately better GDP earnings than Birbhum and South 24 Parganas. The remaining district, that is, North 24 Parganas was predominantly an urban area with the highest GDP in West Bengal. The rural-urban criterion was significant in selecting the districts so as to capture the differences in the availability of healthcare services. The selection of districts was also done keeping in mind the completion of at least two phases of the scheme.

The viability of the scheme was discussed in terms of the functioning of the scheme. The different factors for determining viability are as explained as follows:

I. CONVERSION RATIO

The conversion ratio of the scheme was an indication of the ideological basis of reaching out to the target group of the BPL population. In this aspect, North 24 Parganas was the least impressive with only 19.8% of the target group covered. Birbhum managed to target 77% of the BPL population of the district (Table 1).

Table 1: Conversion Ratio

District	Eligible BPL People col.(1)	No. Enrolled col. (2)	Conversion Ratio*,** (col.(2)/col.(1))*100
Birbhum	557486	429091	76.97
Burdwan	972156	678053	69.75
N24Pgns	873041	172838	19.8
S24Pgns	706669	343831	48.66

* For the concept see Krishnaswamy and Ruchismita (2011)

** Researcher's own calculation

(Conversion Ratio

=Ratio of number of individuals enrolled to the number of eligible BPL persons)

II. FACILITY TO RECEIVE REFERRALS

The aspect of viability also tried to understand whether the scheme had inherent built-in strengths to continue the onus of treatment with the given physical infrastructure. As many of the health service providers were small hospitals or nursing homes, they very often lacked the necessary expertise and technological infrastructure to treat the patients or to undergo surgeries. They had to then take recourse to the referral services. Table 2 shows the percentage of visited hospitals/nursing homes that received referral facilities from other health providers. The table shows that Burdwan and North 24 Parganas received the maximum referrals as compared to very low referrals received by Birbhum and South 24 Parganas.

Table 2: Facilities to Receive Referrals

District	No.of Hospitals Who Received Referrals (%)
Birbhum	2%
Burdwan	40%
N24Pgns	51%
S24Pgns	12%

Source: Researcher's fieldwork, 2013.

III. SETTLEMENT OF CLAIMS

The settlement of claims was an important aspect of the viability of any health insurance scheme. In Table 3 it was observed that the percentage of claims settled was impressive across the phases in all the districts. However, there was a slightly decreasing trend in the percentage of settled claims across the different phases. Even then it should also be noticed that since the absolute values were quite big there still were quite large values of claims still to be settled in the later phases. But overall the performance of the hospitals, insurance agents and the concerned government authorities had managed the system of reporting, processing and disbursing of claims efficiently. This held great hope in the future sustainability of the scheme.

Table 3 Pending Claim Details

District	Total Claims of Hospitals in the District (Rs.)	Claims Settled by the Insurance Co. (Rs.)	% of Claims Settled*	Pending Claim
Birbhum Phase I	33150425	32631925	98.44	518500
Phase II	137734337	134205687	97.44	3528650
Phase III	216029721	201269109	93.17	14760612
Phase IV	NA	NA	NA	NA
Burdwan Phase I	77675948	71786433	92.42	5889515
Phase II	124735467	115977242	92.98	8758225
Phase III	232535921	212336621	91.31	20199300
Phase IV	221679637	204758912	93.71	13951575
Phase V	NA	NA	NA	NA
N24Pgns.PhaseI	23937142	21032567	87.87	2904575
Phase II	63358574	62568774	98.75	789800
Phase III	67052400	65407400	97.55	1645000
Phase IV	66131950	61284775	92.67	4847175
S24PgnsPhaseI	83194100	81514900	97.98	1679200
Phase II	23755675	22158225	93.28	1597450

Source: Adapted from http://rsbywb.gov.in/html/claim.php as on 14.04.2014

**Researcher's own calculation*

CONCLUSIONS

There had been a rapid increase in enrolment in the second phase of the working of the scheme. However, the trend in enrolment had slowed down after that in most of the districts. The conversion ratio (ratioof the number of individuals enrolled to the number of eligible BPL persons) was the best in Birbhum which proved that more than 70% of the BPL population in the district have been enrolled as beneficiaries. This ratio was noticeably lower in North 24 Parganas. Krishnaswamy and Ruchismita (2011) found the average conversion ratio* to be 51% in India. In this sample, Birbhum and Burdwan were much above the national average. South 24 Parganas was a close low whereas North 24 Parganas was much below the national average at being only approximately 20%. The bug hospitals received referred cases. These cases were primarily seen in Burdwan and North 24 Parganas. Birbhum had a low 2% of referred cases and South 24 Parganas had 12% of referred cases. All the districts had short-term claims (claims less than a month) pending but Birbhum was the worst with over 2000 claims pending. The only district that had long-term claims (claims more than a month) pending was North 24 Parganas.

RSBY had stood out in terms of its technical edge and transparency in most of the cases. It had done well in terms of targeting and outreaching. The design to increase membership can be made flawless by strengthening the monitoring and supervision of the scheme. The networking with the private health providers, the insurance companies, the government, and the beneficiary needs a good management and governance. The fact that there were very less claims pending put a good beginning to the future responsibility of making the scheme financially viable. The research also put forward the hope for the districts that are laggards in socio-economic parameters. In fact, Birbhum, one of the poorer districts have scored well in terms of accessibility and effectiveness. It can be implied intuitively that the poorer districts can be made as role models as receivers of benefits of a particular scheme. This can give strength to the bonding between the providers and the receivers and guarantee support from the beneficiaries.

The ‘performance indices’ can make clear the progress of different areas on a uniform measurement scale.

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