ISSN 2348-1218 (print)
International Journal of Interdisciplinary Research and Innovations ISSN 2348-1226 (online)
Vol. 6, Issue 4, pp: (225-234), Month: October - December 2018, Available at: www.researchpublish.com

HEALTH INSURANCE FOR THE POOR: AN INTER-COUNTRY ANALYSIS

Dr. Paramita Roy

Associate Professor, Department of Social Work, Visva-Bharati, Sriniketan, Pin: 731236, Birbhum, West Bengal
Contact: 9734581257
Email: proy669@gmail.com, paramita.roy@visva-bharati.ac.in

Abstract: **The financial protection of citizens against medical menaces was thus different in the period before the Second World War from the period following it. Most of the health insurance policies were introduced in developed countries much earlier than in developing countries due to the obvious advantages. The oldest national health insurance was in Germany when Otto von Bismarck passed the historic social legislations of Health Insurance Bill in 1883, Capital Accident Insurance in 1884 and the Old Age Disability Insurance Bill in 1889. After that Germany travelled a long way. Britain formulated the National Insurance Act in 1911 that covered most employed persons and their financial dependents. Most other countries of the world adapted healthcare reforms after the Second World War as they signed the Universal Declaration of Human Rights in 1948. The studies on the health insurance systems in developed countries focusing on the system of universal health insurance coverage in particular, revealed various changes in its form and functioning over time and across regions. There was thus a need to review the health insurance policies in the developing countries as that might have a significant contribution to the design of policies in countries like India. . In Mexico a law was passed in April 2003 to implement the System for Social Protection from Jan 1st 2004. Costa Rica had the first social insurance started in 1941 for urban low-wage workers. In Latin American countries, however, there was a dominant presence of private health insurance. In Vietnam, the new Social Health Insurance regulation came into effect on July 1st, 2005. Another popular health insurance programme run by a developing economy was the PhilHealth programme in the Philippines that covered almost 63% of the population. The system of financing of the UCS in Thailand was new. In China, the New Rural Cooperative Medical Scheme (NRCMS) was launched in the Eleventh Five Year Plan (2006-2010). The case of Indonesia could be highlighted due to its important health insurance program namely, the Jamkesmas. In India, the National Rural Health Mission (NRHM) and the Rashtriya Swasthya Bima Yojana (RSBY) were two significant initiatives under implementation in the rural areas.**

Keywords: **Health Insurance, Comparison of health insurance in countries, RSBY, PhilHealth, UCS.**

1. 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.

2. REVIEW OF HEALTH INSURANCE POLICIES IN DEVELOPED AND DEVELOPING COUNTRIES

The oldest national health insurance was in Germany when Otto von Bismarck passed the historic social legislations of Health Insurance Bill in 1883, Capital Accident Insurance in 1884 and the Old Age Disability Insurance Bill in 1889. After that Germany travelled a long way. In the recent past, health insurance was compulsory for all German long-term residents. The people who earned less than Euro 49,500 were insured with the public statutory health insurance. This covered around 85% of the total population. The health insurance system was operated by many competing sickness funds. Germany had the sickness funds based on professional, political, religious or regional affiliation. They were all non-profit entities entirely focusing on the benefit of its members. Other residents, who earned more, opted for private insurance plans. This mainly included the civil servants and the self employed and covered 10% of the population. The remaining 5% of the population constituted the special groups like the soldiers, etc. Germany had the reputation of spending almost 11% of its GDP on healthcare (Bidgood, 2013).

Britain too was an early starter in providing health insurance to its people. Britain formulated the National Insurance Act in 1911 that covered most employed persons and their financial dependents. In 1948, in the United Kingdom (UK), the National Health Service (NHS) provided healthcare to all legal residents. The healthcare was funded by general taxation. The employers and employees contributed a sum of money based on their salaries. The administration of healthcare rested with the government. In the countries in the United Kingdom healthcare was devolved so that all the countries which were a part of it could have their own independent health care systems. Each NHS of the respective countries including Britain functioned through General Practitioners (GPs) who provided primary healthcare and referrals for further treatment. This system continues even today. The community pharmacies were privately owned but also had contractual bindings with the public health systems.

Most other countries of the world adapted healthcare reforms after the Second World War as they signed the Universal Declaration of Human Rights in 1948. The United States of America (USA) was different. It did not sign Article 25 of the declaration though it had the history of health insurance coverage right from 1850 when the Franklin Health Assurance Company started the insurance for accidents from railways, roadways and steamboats. It allowed the private health providers to have a major share in the health sector. The public sector provided service to specific target groups like the elderly, the disabled, the veterans and the poor. Most of the working citizens received health insurance protection from employers who in turn got tax benefit. The Medicare was an important social health insurance scheme. It provided insurance cover to people above 65 years of age who were totally permanently disabled or had end stage diseases. However its inadequacy was reflected in the fact that most of such beneficiaries also had other supplementary forms of insurance support. The last major change in the USA in the system of healthcare provisioning was the managed care system which was subscription based on pre-funded healthcare with specified terms and conditions that worked on the basis of a contract. Costs were controlled by controlling the demand and supply of healthcare by the citizens. The emphasis was on preventive care and on financial incentives to use care efficiently. The State Children's Health Insurance Program covered the healthcare for the children of the families who earned too much to be protected by Medicaid but too less to afford private insurance. In USA, the number of people without health insurance increased between 2009 and 2010 but the increase was not statistically significant. The rate and number of the uninsured increased for the Asians while the changes for the non-Hispanic Whites and Blacks were not statistically significant (DeNavas-Walt et al, 2011).

Unlike the USA, in Canada, it was the sole responsibility of the government to finance the healthcare of its citizens. The government on the other hand met its own revenue through tax collections. There was no relation between employment and insurance. It was a typical single payer system. Netherlands used the model of compulsory contributions to competing institution funds. These funds could be managed by public organizations, private for profit or private non-profit companies. The healthcare provision did not discriminate the citizens based on any criteria- age, occupation or previous health status. The government set up an equalization pool to spread risks among the different funds. The government also contributed to the pool in the form of subsidy. The Universal healthcare system in France was the best in the world as

proposed by the World Health Organisation (WHO) in 2000. Unlike UK, France did not have a National Health Service. It had a National Insurance. The French system took a pride in the choice it offered its clients. It believed in market based pluralism. Everybody was entitled to insurance. Most of the ambulatory physicians engaged in private practice and the patients enjoyed freedom to choose among them. Nearly all primary care providers were part of the nation's public health insurance system. The fees were tightly controlled and formed the main component in controlling cost. However certain physicians were given the right to charge extra fees from the patients (DiPiero, 2004, Sandier et al, 2004).

The studies on the health insurance systems in developed countries focusing on the system of universal health insurance coverage in particular, revealed various changes in its form and functioning over time and across regions. There was thus a need to review the health insurance policies in the developing countries as that might have a significant contribution to the design of policies in countries like India.

In most of the developing countries the initiation of the system of social protection through health coverage started much later than the developed countries. In Mexico a law was passed in April 2003 to implement the System for Social Protection from Jan 1st 2004. It aimed to cover families not covered by conventional employer based social insurance. The Popular Health Insurance (PHI) was the operational programme of the new system. It was voluntary. Preference was given to the poorer families. The programme was funded both by the federal and the states. The contribution of the federal was 1.5 times the solidarity quota and it increased for the poorer states. The share of the states was the same for all. The share of the families varied progressively with income with a maximum limit of 5% of the disposable income (total spending less spending on the basic needs). Uninsured Mexicans could get access to medical services at the primary and secondary levels gradually expanding to the super-specialty treatment. The families in the lowest two income deciles did not have to contribute to avail the services. In Mexico, the major challenge was financial instability of the government. Thus there was an attempt towards cost-effectiveness in the benefit package. The budgeting was redistributed to suit demand based subsidy.

Costa Rica had the first social insurance started in 1941 for urban low-wage workers. Health insurance had been extended to nearly 90% of the population. The Universal Health Insurance was successful due to certain significant political steps. Primary healthcare and accessibility to emergencies and medicines had been made universal. Ninety-six percent of deliveries were institutional in Costa Rica (Fenk and Knaul, 2007). In Sub-Saharan Africa, there was widespread initiation of community based health insurance schemes. In these schemes premiums were usually moderate but coverage was low and was specific to a particular region and target group. The state, in turn, had the responsibility to try to professionalize the functioning of these schemes as well encourage cooperation between them.

In Latin American countries, however, there was a dominant presence of private health insurance. It would be important to note that this was perhaps a consequence of the massive structural reforms initiated in Latin America in 1990. An obvious ill effect was inequity in the distribution of health insurance benefits as reported in Argentina, Chile and Brazil. Carrin (2002) emphasized that there was a need for a lot of political will to extend universal health coverage to all its citizens. There was also a need for co-financing from all possible partners (employees, employers, enterprises, self-employed workers and communities). Macro-economic stability and equitable growth would reduce poverty and enable more people to contribute.

In Vietnam, the new Social Health Insurance regulation came into effect on July 1st, 2005. The coverage was for all active and retired workers in public sector and the salaried workers in the private sector irrespective of the size of the private units. Moreover very senior citizens (above ninety years), foreign students and the poor were eligible for inclusion for the programmer. The salaried employees paid 2% of their salaries and the employers paid 1% of the salaries to the government as premium. For beneficiaries who were non-salaried a rate of 3% of the national minimum wage was paid by the state. However the country still had to fight the problem of low coverage. This was primarily due to several reasons such as the distances between the hospitals and the homes of the beneficiaries were too much, the conveniences of private services did not suit the poorer citizens, the exclusion of meals and transport services held back many prospective patients and the low level of awareness among the poorer beneficiaries and so on. The goal of universal coverage in Vietnam remained a challenge as a large number of people were in the informal sector. A study by Tran Van Tien in 2011 put forward the issues of larger tax based financing to support the social health insurance programmes in Vietnam. It also emphasized that the government budget to hospitals should be based on performance instead of membership. Monitoring was given an essential importance but only by strict legally empowered authorities. It was proposed that the medical

technologies which formed a part of the packages should be standardized through professionals. Any profit making tendency should be avoided. The primary healthcare and the referral health systems was focused on with more of an improvement than tertiary care as it was thought that they ought to be improved to reduce the disease burden. The capacity of the health insurance agencies was also another issue that was given great significance by the author.

Another popular health insurance programme run by a developing economy was the PhilHealth programme in the Philippines that covered almost 63% of the population. In this programme, the local governments were given the responsibility for identification of the poorest beneficiaries. The local government also shared in the premium paid depending on their class and the years of participation in the scheme. The remainder was contributed by the Central government. The hospital benefits were the same for all the members. The very poor also received Outpatient Consultation and Diagnostic Package (OCDP) in public hospitals for primary consultation. The enrollment of the poor was not mandatory. It depended on the local government. But there were problems of coverage as there was an absence of regulation and the fee-for-service payment mode resulted in excessive financial costs. The social health risk pooling also had scope for a more focused attention (http://www.philhealth.gov.ph/).

Thailand was similar to India as far as the per capita income earned as well as the geographical area was concerned. It thus formed a set example for the Indian planners to learn the problems and strategies in protecting the health security of the country's citizens. In Thailand, the Universal Coverage Scheme (UCS) was planned to provide universal health coverage to all. The National Health Security Act, 2002, in Thailand paved the way for the setting up of a National Health Security Board (NHSB) which was responsible for the registration of the beneficiaries and the service providers, managing the funds and settling the claims as spelt out in the Act. The NHSB had representation from all sectors to reflect inclusiveness. It included health professionals, technical experts, members of the civic bodies and local organizations. The Standards and Quality Control Board was responsible for controlling the quality and was another governing body of the UCS. The regulatory framework introduced the system of capitation for the first time.

The system of financing of the UCS in Thailand was new unlike the previous system where there was allocation of money by the Central Ministry for specific programmes based on the size of the facility, the number of staff and the history of performance. The system was changed to one where the Ministry of Public Health and the network of hospitals were the contractors who could have private clinics and hospitals as their sub-contractors. There was a nominal co-payment from the poor and the non-poor beneficiaries. The capitation rate was adjusted according to the age-composition and the money was deposited in the providers' accounts at the beginning of each year. There were different pay schedules for specialized treatment processes. There were incentives for cases that were treated through early detection particularly of life-style and preventive diseases. There was a need to balance between the behaviour of the providers in containing costs and inclusive treatment. Incentives like quality and variety of cases handled and certain behavioural virtues like in-time payment, hassle free payments etc. were given to the providers. The programme covered both inpatient and outpatient services (Hanvoravongchai, 2013).

China too, like Thailand, was a neighbor of India and had demographic and economic similarities to match. In China, the New Rural Cooperative Medical Scheme (NRCMS) was launched in the Eleventh Five Year Plan (2006-2010). It was managed by the Ministry of Health (MoH) at the central level and the Bureau of Health (BoH) at the local level. The ratio of contribution was 2:2:1 for the central government, the state government and the individuals respectively. Enrollment was on a household basis. The mandated reimbursement rate for inpatient care was 70%. The ceiling on reimbursement was 8% of national annual average income of farmers and no less than Y60, 000. Supplementing the efforts of the NRCMS was the Medical Assistance Program (MA) in China that was initiated in 2003 to pay the premiums for the poor-the remainder of the medical bill not covered under NRCMS. It was managed by the Ministry of Civil Affairs. The central government held the major financial responsibility (Y15 billion). There was fund also from townships, lotteries, donations, etc. The outcome as far as the enrollment rate was concerned had been impressive at 97.5%. Almost 62% of the population was covered by the scheme. There was no coverage for outpatient care. Enrollment to MA was free and voluntary. It targeted the enrolled population under social security network. Local governments were empowered to arrange for various benefit programs as and when the funds permitted. Contributions from lotteries, donations etc. supplemented the government funds for the MA. Though the coverage was full, the beneficiaries were however less in the MA program. The insurance cover also had drastically improved from 29.7% to 95.7% during 2003-11 in China (Liu, 2000; Xu et al, 2003).

The case of Indonesia could be highlighted due to its important health insurance program namely, the Jamkesmas. It was a program financed by the government for the poor and the near-poor. It was started in 2005 and was fully funded by the Central government revenues. It targeted about one-third of the population. This program, however, did not finance the full cost of treatment. The Jamkesmas beneficiaries could access primary care and inpatient care in lower quality beds in secondary and tertiary hospitals without any beneficiary contribution, capping or copayments. The scheme was looked after by the National Task force on Acceleration of Poverty Alleviation (TNP2K) and the various Ministries like Ministry of Finance, the Ministry of Health and the Ministry of National Development Planning. The central government fully financed the scheme and the Ministry of Health looked after the administration. The Ministry of Health received funds annually from the central government based on an annual premium per person times the number of targeted beneficiaries. There were diagnostic related groups who determined the reimbursement coverage.

There was, initially, the capitation system of reimbursement but later the fee-for-service system had been started in its place. To make the providers motivated enough to encourage preventive efforts the autonomy for the service providers was needed. This program used a newly constructed list of target beneficiaries prepared by the national statistical agency Badan Pusat. It used a proxy means test with fourteen indicators. Then each district was assigned a quota of beneficiaries. The districts had the authority to verify the list using their own method of preference. The scheme was totally financed by the government and covered most comprehensive drugs with certain exceptions. There was no copayment or coinsurance.

The inpatient rates were low as compared to the groups other than the poor and the near-poor though the utilization rates improved. The trend is just the reverse for outpatient care utilization. Out-of-pocket expenditure is less than the beneficiaries of other schemes and also than the non-insured on a per capita basis. But on a household basis the out-of-pocket expenditure as a share of total household spending was no less than the non-insured. However the catastrophic expenditure had lessened to some extent for the Jamkesmas beneficiaries. Though the Ministry of Health monitored the data of financial allocation and utilization rates, it did not specifically monitor the outcome targets of the beneficiaries. The supply-side constraints limited utilization and hence concealed the real cost (Thabrany, 2008).

Universal Health Coverage meant that all people got the treatment they needed without fear of falling into poverty. It did not have a ‘one size fits all’ solution. There was no blueprint but it also did not mean ‘anything goes’. Different approaches had been put forward and followed by different countries. The experiences and strategies of each country were different but it remained very clear that the developing countries had started to roll up their sleeves in order to embark on the mission protecting the health of the poor. India had its share of efforts as reflected in National Health Mission and in the latest scheme named Rashtriya Swasthya Bima Yojana (RSBY).

In India, the National Rural Health Mission (NRHM) and the Rashtriya Swasthya Bima Yojana (RSBY) were two significant initiatives under implementation in the rural areas. NRHM has been running for some time whereas RSBY was of comparatively later origin. The first was overseen by the Ministry of Health and Family Welfare (MoHFW) and the latter by Ministry of Labor and Employment. NRHM was an umbrella health sector program which focused on horizontal integration of vertical public health programs. This program emphasized on a renewed importance on health expenditures, the importance of introducing grassroots level workers with performance based incentives and flexibility in flow of finances, formation of ‘Patient Welfare Societies’ at the facility level to give rise to financial flexibility in utilization of funds etc. The introduction of community level health workers on an incentive linked performance contract improved grassroots level awareness, utilization and referrals. NRHM also used information technology to great extent for submission of performance data and financial reports.

The RSBY on the other hand was a demand-side financing program that covers hospitalization expenses with a ceiling. It was cashless and used the smart card technology. At present it covered the people below the poverty line. The reimbursement rate was the same for public and private hospitals. The RSBY supplemented the outpatient benefits of the poor who were not adequately supported by the NRHM. In this respect the RSBY complemented the NRHM. RSBY operated on a cashless and paperless mode. The funds were shared by the central and the state governments in the ratio of 75:25. A token contribution of Rs.30 from the beneficiary was taken for administration and awareness initiatives. After its inception in 2008, the RSBY had increased hospitalization incidence among the poor for the secondary and low cost hospitalizations (Dror and Vellakkal, 2012).

A review of various countries put forward the following points which could be crucial in the journey towards universal health insurance coverage. Firstly, the small and voluntary schemes providing health insurance could be a good trial for

learning the management and functioning of such activities but if universal health insurance had to be implemented across the country then the government had to take up the role of formalizing the schemes and a principle of compulsion, to a certain extent, needed to be established. Secondly, the health insurance benefit package should be gradually adapted to suit the changing demands of the clients. This could vary according to the internal situation of demand and supply of finances and services of each country respectively. Thirdly, merging of funds together with risk equalization schemes was desirable for sustainability and fourthly, self-governance of the individual might be a good alternative to the state and the market which might have a clue as to the importance of community based health insurance schemes in the future. And finally, a fee-for-service scheme could be cost-effective if the costs of the providers could be controlled by technical or political means (Barnighausen and Sauerborn , 2002).

In order to contribute to the learning and practice of health protection of its poor people, there was a need to absorb knowledge from all sources so as to design a programme that would reflect the best of practices. Having taken the inputs from the experiences of the different countries both from the developed and the developing world there was at present an obvious need to browse through the theoretical and empirical studies on the concepts important to implement and evaluate health insurance programmes to understand the pros and cons before adopting any particular scheme. The following section includes such learning from previous studies on health insurance.

3. REVIEW OF STUDIES ON RASHTRIYA SWASTHYA BIMA YOJANA (RSBY), INDIA

Narayana (2010) in his paper found out that the proportion of poor families who enrolled for the scheme varied across states (39% in Maharashtra to 81% in Kerala). U.P. and Bihar were other states with a poor enrolment. Hospitalisation rates also varied from 3.91 hospitalisations per year per thousand people in Punjab to 26.17 in Kerala. Inequity was also found between states and between districts in the value of hospitalisations. Reasons cited were inadequacy of empanelled hospitals and a low prevalence of private hospitals. The author also felt the need for a disaggregated disclosure of value of hospitalisation by diseases treated, services provided etc so that more transparency and accountability could be built into the system.

Regarding the composition of the enrollees, Changqing Sun (2010) did not find any gender bias in RSBY enrolment though he proposed that more studies needed to be done on age specific enrolment take-up rates. He found evidence that some insurers tried to economise on the enrolment by purposively selecting villages. He also did not find any evidence of any 'cream-skimming', like not wanting to enrol older beneficiaries. But Swarup reported that RSBY had higher female hospitalisation ratio in the first year. The satisfaction rate was over 90% during the initial phases but then gradually dropped (Swarup, 2011 in *The Economic Times*).

For Rashtriya Swasthya Bima Yojana (RSBY) one of the primary objectives was to provide quality health care to the beneficiaries. However, the current level of quality of services in the empanelled public and private providers needed much strengthening. To add to this, there was no consistent nationally applicable quality improvement process which had been adopted by these providers. Keeping these things in mind RSBY provided an excellent opportunity for developing a consistent and nationally applicable quality improvement process, both in the public and private sector hospitals which would help RSBY in providing quality and consistent services through its network hospitals (Arora, 2010)

In 2011 there was a survey of 3647 households in Karnataka covering 222 villages in which the data was collected. The findings established the fact that 85% of the households were aware of the fact that such a programme as the RSBY existed and 68% of the beneficiaries were enrolled for the scheme. A significant observation was that around 30% of the enrollees had to pay around Rs.5.20 extra as Rs.2 had to be given to the Anganwadi workers for helping in the process of enrollment and around Rs.100 -200 were paid to correct the wrong names. However the utilization of the scheme was very poor (was only 0.4% after six months of enrollment). The study also reported the inadequacy in the installation and operation of smart card technology and proposed that it needed to be tightened and to correct utilization problems. Some of the hospitals had left the scheme due to the problems in the functioning of the smart cards. The study also found very low coordination between the health and the labour department (Rajasekhar et al, 2011).

Das and Leino (2011) raised two important questions from a different perspective. The first was whether the contracted insurance companies have indulged in 'cream skimming', that is, whether they have selectively enrolled 'healthier' households and secondly whether there was any effect of financial protection and improvement of health on the beneficiaries as consequences of the scheme. The study carried out a pilot information and education campaign (IEC) and

a household survey in six administrative circles of New Delhi in 2008 among randomly selected households from a list of beneficiaries. The objective of the authors was to find the causal effects of the IEC on enrolment and claims from hospitalisations. The four blocks of data were categorised as IEC only, IEC and survey households, survey households only and households that did not fall in any of the three cateogories. The authors used the means-comparison method of analysis. The results were that IEC by itself did not have any effect on enrolment. This was possibly because IEC was carried out much ahead of actual enrolment and also perhaps because IEC removed some of the wrong ideas among the people that it was obligatory and on not enrolling with it would debar them from other benefits like the ration card benefits. Well timed campaigns had marginal increase in enrolment but it was insignificant. However households who experienced the IEC for a longer time and for whom the household survey took place in a longer interval reported the highest enrolment. This confirmed that information repeatedly given but at regular intervals for quite some time had a more significant effect on the listeners. There was also an increase in the net profit of the insurance companies as hospitalisation claims for these marginal households were lower. This increased the profit of the insurance companies. However it was also observed that since RSBY covered pre-existing illnesses, the "sicker" people got enrolled more that the "healthier" people in the beginning.

In a very comprehensive study by Krishnaswamy and Ruchismita (2011), three key performance indicators (KPIs) of RSBY (in the form of three ratios) were analysed across different homogeneous groups. The ratios were Conversion Ratio (Ratio of number of individuals enrolled to number of eligible BPL persons), the Hospitalisation Ratio (Percentage of individual policy holders who claim, ignoring multiple claims per person which is very low) and the Total Expense Ratio (Ratio of sum of claims paid out plus smartcard cost plus service taxes to gross premium collected Rashtriya Swasthya Bima Yojana). These indicators also reflected the profitability of the insurer. Two hundred and twenty nine districts were analysed who were in the first year of operation. The study concluded an important fact that usage drove future uptake. The authors found that the conversion ratio in the second year was higher in districts where the hospitalisation ratio was higher in the first year. This showed that people believed in word-of-mouth from early users of the scheme to take a decision about joining in it. This was against the expected belief that conversion in the first year would be higher due to pent-up-demand of the BPL families who earlier could not afford hospitalisation. Thus it was proved that adoption and diffusion into a new intervention materialised with a time lag. The presence of the government was important because conversion was higher in districts with a more active Gram Panchayat (measured by the number of times gram Panchayats met in a year). Conversion ratio was correlated more to the reach of Third Party Administrators (TPAs) than to the activities of the insurers. The beneficiaries wanted to expect that TPAs with a greater number of districts would enjoy economies of scale, better knowledge of local environment and reuse investment better. The conversion ratio was inversely proportional to the number of BPL families and the size of the districts but uncorrelated with the remoteness of the villages, the overall population of the villages, and the percentage of scheduled tribes in the village or the socio-economic characteristics of the districts.

Dror and Vellakkal (2012) had an important observation on the viability of the RSBY. The overall expected cost of the fully rolled out RSBY was estimated both with BPL estimates and on national average premiums and then the expected cost was compared with the budget allocations made for RSBY. The Tendulkar Committee estimated that approximately 27.8% of BPL households with Rs.530 as the premium needed at least Rs.33.5 billion which was 0.3% of total budget allocation. However the budget allocated only a meager 0.037% in the financial year 2010-11 and this was sufficient to pay only 34% of the enrolled BPL households.

There was also a note of caution for publicly funded health insurance schemes like the RSBY, Rajiv Aarogyasri of Andhra Pradesh and Tamil Nadu Health Insurance schemes in terms of providing financial protection to the beneficiaries (Selvaraj and Karan, 2012). The authors conducted a pre-insurance and post-insurance study involving the period between 2004-5 and 2009-10 together with a case-control approach. Seventy-four districts were selected from Andhra Pradesh, Karnataka and Tamil Nadu. The data source for this study was drawn from the unit level records of the Consumer Expenditure Survey (CES), conducted by the National Sample Survey Office (NSSO), for the respective years. A 365 day recall period was used to know the inpatient, outpatient expenses, total out-of-pocket expenses and drug expenses respectively. Catastrophic expenses were defined as the spending that was reported by any household beyond the threshold exemption limit. The limit was taken as 10% of the total household expenditure. For comparability among intervention and non-intervention, changes in the headcount ratio captured the difference-in-difference effects in time and region effects. The research observed a rise in catastrophic head-count ratio in post-insurance intervention districts, in fact a rise (53%) higher than the non-insurance districts. A quintile analysis showed a higher rise for the poorer groups which was indeed a question of thought.

The authors thus pointed out that the narrow focus of RSBY on secondary and tertiary hospitalisation might be an area of improvement. This was because these schemes aimed at low-frequency high-value hospitalisations which caused impoverishment to the poor. However, this study pointed that out-patient care mattered a lot to the rural consumers. Moreover as experienced by Kerala these schemes could experience gradually increasing premiums by the insurance companies with increasing utilisation. The authors thus emphasised promotive, preventive and primary care before focusing on secondary and tertiary care.

The problems faced in the implementation of the scheme were many. Outdated BPL lists was a reason for lower enrolment in the villages. The proportion of migrant BPL families was also a problem in enrolment. The coordination and management of the enrolment team in conducting the entire enrolment process proved to be a significant factor in the success of the scheme. The insurance firms who were responsible for the enrolment also had their strategic motives in choosing villages with large number of BPL families or 'healthier villagers'. The state government's delay in paying the insurance premium to these insurance companies also was an important factor making the companies lethargic. From the point of view of the software managers who had the responsibility of managing the on-line information system there were the problems of supply of necessary hardware and software and also the capacity building of various officers at different who would be responsible for managing the information system (Qifei We, 2012).

In a study of three selected districts in three states, in India namely, Bihar, Uttarakhand and Karnataka, the GTZ (Dec 2012) emphasised that there should be more evaluative studies to continuously learn and improve the system. There was also a need for incorporating a seamless complaints and grievance system, in order to receive the feedback from the stakeholders and respond to it positively.

Some states, like Chhatisgarh, had tried to extend the RSBY to APL families, but the health care providers, particularly the private hospitals, resisted as they said that this was not feasible. The hospitals demanded that the rates in the packages had to increase. For example for craniotomy- a critical surgery performed on patients suffering from brain lesions or traumatic brain injury, epilepsy and cerebella tremor, the package paid Rs. 28000 whereas the cost was Rs. 1.5 lakh. This provided a thought for the universalisation of RSBY and the futures sustainability of the programme (TOI, March 31, 2013).

A very recent study on RSBY on Karnataka by Sheshadri et al (2013) had brought the issue of social exclusion related to RSBY into focus. It found that the performance of RSBY in rural areas was marginally better than that in the urban areas. Lack of awareness on enrolment, receiving the card on time and finally utilising it was an important reason for this. The importance of reaching out to the beneficiaries was felt in the implementation of the scheme. The authors pointed out that the access to information was perhaps controlled so as to exclude certain prospective beneficiaries from getting valuable information. The political dimension (primarily participation in local politics) and social networking became important factors built into the durability of the scheme. And finally, local administrators (particularly Gram Panchayat members) remained the weak link which had the power and authority to ensure access to its citizens as they understood the vulnerabilities and needs of the beneficiaries.

The authors emphasised on the utility of on-the-spot verification and issuing of smart cards and said that it increased usage as it was more often seen that delayed card issuance missed the target group altogether. Another interesting and significant observation was that there were a large number of villages (about two-thirds) with zero utilisation levels. The reason probably lay with programme implementation than with demand side problems. Primary care utilisation (including sanitation etc.) was inversely related to hospitalisation. Thus encouraging the use of primary facilities could increase the financial stability of the scheme.

In a similar study based on Shimla and Kangra districts of Himachal Pradesh 37% were not aware as to the health card scheme. The pattern of treatment found out that 52% of patients were hospitalized in Gastro, ENT and Accidents cases. In 43% of the hospitals there was an RSBY helpdesk. The time that a patient had to wait was 15-20 minutes on average and this was true for 75% of the patients. Food was also supplied free in the hospitals for 88% of the patients. In general there was a high degree of satisfaction with 94% of the patients reported improved health conditions after surgery and 90% had their queries answered by the doctors (AA Pvt Ltd., www.rsby.org). A comparison with a control group of non-RSBY patients revealed that the beneficiaries of the scheme replied with a more level of satisfaction and also mentioned that they received more attention from the RSBY helpdesk. In a study on Haryana by Westat India Social Sciences, (www.rsby.org) it was found out that the RSBY patients reported that they had to wait for 45 minutes to get admitted to

the hospitals after first check-up. But they akso said that they were informed before about the probable time they needed to wait and they were prepared for it. Most of the patients also reported that the nurses were polite (71%) and that they were made to understand the details of the medications to be followed (64%).

Jaswal stressed upon the importance of simplicity in the servicing of the claims in RSBY which could help the scheme to gain rapid popularity across the country (IRDA Journal, Dec 2010).

Thus with the scheme in full flow and after the first teething problems had been overcome there was now a need for further research. There was a need to develop a quality model to grade the hospitals according to physical infrastructure, equipment, human resources and knowledge resources (Arora, 2010). The review of literature undertaken for this purpose had opened up the avenues for further research.

In brief, the review focused on the health insurance policies in different countries. The studies showed that there were differences in times of initiation of health insurance programmes and in the design of the programmes. Each country introduced different schemes based on the availability of the resources and on the need of the hour. The review realised the felt need of a country to design a scheme which would be specific to the particular socio-economic and cultural requirements of a country. However there was an apprehension of failure as the success of health insurance schemes depended heavily on the preferences of the members. Thus there was a need to learn from similar situations in similar countries. Comparative studies on countries perched on the same socio-economic ladder were projected as an essential requirement in today's research. There were very few studies that ventured into such an endeavour. But as a pre-requirement for that it was necessary to involve in in-depth analyses of health insurance schemes in individual countries based on common parameters. This would lead to futures collaborative studies and strongly stride towards universal health insurance coverage.

There was an understanding on the various concepts related to the evaluation of health insurance programme. There were broadly two dimensions of discussion. The first dealt with the successful implementation of health insurance schemes through various available frameworks and the associated concepts in them. This was followed by various concepts based on the findings in different empirical studies. Aspects of accessibility, utilisation and outcome were highlighted with various sub-categories of indicators. The empirical studies brought out various dimensions related to the actual practice of the scheme. However there were no studies which tried to relate the theoretical frameworks as proposed by authors of different countries to evaluate the performance of health insurance schemes in India. The empirical studies also lacked a theoretical perspective. The second dimension dealt with feeling of the members who had actually received the benefit of the health insurance scheme. The aspect of quality of care was stressed on and discussed by various authors. There were again no studies which related established theoretical concepts to evaluation of health insurance schemes. Since the quality of care given to the patients was very vital for continuance of membership and for the further increase in membership there was a need for studies that focus on quality of care based on existing theoretical framework.

The last section concentrated entirely on the review of studies on RSBY in India. RSBY was the most significant health insurance scheme in India for the poor. As mentioned in the previous paragraphs there was a felt need for serious research studies on RSBY which would have a theoretical backup as it was one of the flagship programmes of the government and citizens expected a viable scheme that would truly reflect the needs of the poor. Moreover there was absolutely no study on West Bengal.

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