Chapter 6
Interrogating the PPP Model in Health-Care Insurance

Rumki Basu

Introduction

Assuring a minimal level of health care to its citizens is an essential constituent of the development process of any nation. Since independence, India has built up a vast health infrastructure and health personnel for primary, secondary and tertiary care in the public, voluntary and private sectors. India is in the midst of an epidemiological and demographic transition with an increasing burden of chronic diseases and decline in mortality and fertility rates. Within the country, there is persistence of extreme inequality and disparity both in terms of access to care as well as health outcomes. Kerala's life expectancy at birth is about 10 years more than that of Madhya Pradesh (MP) and Assam. Infant mortality ratios in MP and Orissa are about five times that of Kerala. Maternal mortality rate in Uttar Pradesh is more than four times that of Tamil Nadu and more than three times that of Haryana. Crude death rates among states also reveal wide variations. Crude death rates in Orissa and MP are about twice the crude death rates in Delhi and Nagaland. This high degree of variation of health indices is itself a reflection of the high variance in the availability of health services in different parts of the country.[1]

Approximately a quarter of India's districts account for 40% of the poor, over half of the malnourished and nearly two thirds of malaria and *kala azar*, leprosy, infant and maternal mortality and other diseases (NCMH 2005). The public health-care system in rural areas in many states and regions is in shambles. Extreme disparities exist in terms of both access to health care and health outcomes. There is lack of convergence with other key areas affecting health, since the system has been unable to mobilise action in areas of safe water, sanitation, hygiene and nutrition – the social determinants of health.[2]

R. Basu (✉)
Department of Political Science, Jamia Millia University,
Jamia Nagar, New Delhi, Delhi, India
e-mail: mailtorumkibasu@gmail.com

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Health spending in the country is estimated to be around 6% of GDP. Out of this, public health expenditure constituted 0.94% (one of the world's lowest), private health expenditure constituted 3.58% and external support 0.11%. Out-of-pocket health expenditure accounts for 72% of the total health expenditure incurred in India. This includes out-of-pocket payments borne by the households for treating illness among any member in the household and also insurance premium contributed by individuals for enrolling themselves or family members in health insurance schemes (Ministry of Health and Family Welfare 2006). Data shows that a majority of expenditure (87.7%) goes towards curative care. Therefore, the importance of public provisioning of quality health care to enable access to affordable and reliable health services cannot be underestimated. It is absolutely imperative for the government to explore new mechanisms for providing universal coverage of population for meeting the cost of hospitalisation, e.g. it could provide public sector-financed universal health insurance for which private and public provider organisations can compete.[3]

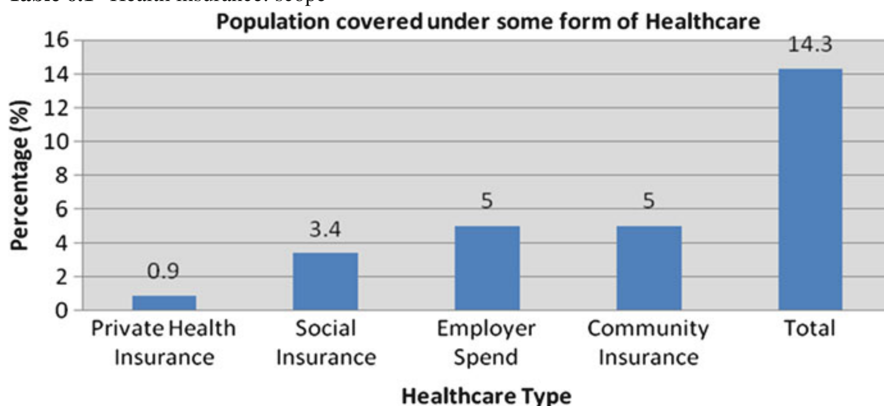
Post-Independence Initiatives

In the years following independence, the government of India prepared to establish a health-care system along the lines of the recommendations of the Bhore Committee in (1946). One of the core principles of the committee was that no citizen should be denied adequate medical care because of inability to pay for it (Banerji 1985). As part of its welfare policy, the government established health infrastructure of reasonably impressive dimensions. Despite high rural/urban and regional biases, there was continuous pressure on the government to redirect policies to meet the needs of the poor and the marginalised (Saxena 2005). However, since the 1990s, as part of the structural adjustment policies, public spending on social sectors such as health was reduced, and a massive restructuring of the health system began to be initiated and health priorities identified on the basis of cost-benefit considerations. The rapid dismantling of the public health system on the one hand, and the expansion of the only-for-profit private health sector on the other, is increasingly placing a high burden on sections of population due to increasing household health expenditures (Chandrasekhar and Ghosh 2006).

Financing of Health Care in India

India is one of the fastest growing economies in the world today which can reap ample benefits from a "demographic dividend" that demographers claim spurs economic growth. India is presently in the intermediate stage of demographic transition characterised by declining fertility and declining mortality, which has resulted in the largest population in the 15–25 age group (about 500 million) and constitutes the

Table 6.1 Health insurance: scope



Source: www.rsby.in

largest share of working age population in the world. As a result, it is pertinent to determine what kind of policies pertaining to employment, health and education should be put in place so that India can benefit by this one time demographic window of opportunity. The need for a concerted targeting of rural India led the government to introduce the National Rural Health Mission (NRHM) as its health flagship scheme in 2005. The objective of this scheme was to carry out necessary structural corrections in the basic health-care delivery system, to improve the availability of and access to quality health care by people, especially the rural poor, women and children (GOI 2005, I). This objective is sought to be attained through strategies aimed at improving household health status through the introduction of female health activists, strengthening a three-tiered public health system, increasing community participation through the involvement of *panchayati* raj institutions and strengthening capacities for data collection to facilitate evidence-based planning, monitoring and supervision.

Despite a government-owned free health-care delivery chain, 64% of the population in India are indebted every year to pay for the medical care they need. Around 85% of the Indian workforce working in the informal sector do not have any kind of insurance and lack access to effective social protection schemes (National Sample Survey Organization 2006). Consequently most Indians have to access private health care that is expensive, unaffordable and even unreliable. In rural areas, the private sector accounts for 58% of all hospitals, beds (29%), doctors (81%) and outpatient cases (77%). Between 1986 and 2004, the average expenditure per hospital admission increased three times in government and private hospitals. The sharp rise in prices of drugs has been the main reason for the growing cost of Medicare, which more than tripled between 1993–1994 and 2006–2007. Loans and sale of assets helped in financing 47 and 31% of hospital admissions in rural and urban areas[4] (Table 6.1).

According to NSSO, nearly 65% of India's poor get into debt and 1% fall below the poverty line each year because of illness despite a government-owned free health-care delivery chain.

Rashtriya Swasthya Bima Yojana (RSBY)

RSBY[5] has been launched by the Ministry of Labour and Employment, government of India, to provide health insurance coverage for below poverty line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalisation. Beneficiaries under RSBY are entitled to hospitalisation coverage up to Rs.30,000/- for most of the diseases that require hospitalisation. Government has even fixed the package rates for the hospitals for a large number of interventions. Pre-existing conditions are covered from day one and there is no age limit. Coverage extends to five members of the family which include the head of a household, spouse and up to three dependents. Beneficiaries need to pay only Rs.30/- as registration fee, while the central and state governments pay the premium to the insurer selected by the state government on the basis of a competitive bidding.

The RSBY scheme is not the first attempt to provide health insurance to low-income workers by the government in India. The scheme, however, differs from the earlier schemes in several important ways.

Who Are the Stakeholders?

The majority of the financing, about 75%, is provided by the government of India (GOI). In the northeastern states and Jammu and Kashmir, GOI's contribution is 90%. GOI also lays down the benefit package and provides detailed information on the electronic data format for BPL families. The central government standardised all implementation documents such as contracts between state governments and insurance companies. Software and hardware were standardised, and the rates for surgical interventions were finalised by the central government.

State Governments

State governments provide 25% of the financing in all states except northeastern states and Jammu and Kashmir where the financial commitment is only 10%. State governments engage in a competitive public bidding process and select a public or private insurance recognised by the Insurance Regulatory Development Authority (IRDA) or enabled by a central legislation. RSBY provides health insurance for the enrolled BPL families from each district up to a maximum number of households based on the definition and the figures provided for each state by the Union Planning Commission. State governments alone are responsible for the accuracy of their BPL

lists. Each state must establish an independent body, the state nodal agency, to implement the scheme in that state through insurance companies. The central government provides the regulatory framework and bulk of the financial support.

Insurance Companies

An electronic list of eligible BPL households is provided to the insurer using a prespecified data format. An enrolment schedule for each village along with dates is prepared by the insurance company with the help of district-level officials. The smart card, along with an information pamphlet describing the scheme and the list of hospitals, is provided on the spot once the beneficiary has paid the 30-rupee fee. This list of enrolled households is maintained centrally and is the basis for financial transfers from the government of India to the state governments. Empanelment of hospitals is done as soon as the insurer gets the contract. The insurer shall empanel enough hospitals in the district (public or private) so that beneficiaries need not travel very far to get the health-care services. Information relating to transactions is sent through a phone line to a district server. This allows the insurer to track claims, transfer funds to hospitals and investigate.

The Health-Care Providers

These hospitals install necessary hardware and software so that smart card transactions can be processed. After rendering the service to the patient, the hospitals need to send an electronic report to the insurer. The insurer, after going through the records information, will make the payment to the hospital within a specified time period which has been agreed between the insurer and the hospital. At present (May 2011) more than 3,200 private hospitals and 1,100 public hospitals across India are RSBY empanelled. RSBY has thus opened up a new market for private sector hospitals whose services were never afforded by BPL families.

The Beneficiaries

The transaction process begins when the member visits the participating hospital. After reaching the hospital, the beneficiary will visit the RSBY help desk where his/her identity will be verified by his/her photograph and fingerprints stored on his/her smart card. If a diagnosis leads to hospitalisation, the beneficiary can get his/her expenses covered up to Rs. 30,000 yearly. Any hospital which is empanelled under RSBY by any insurance company will provide cashless treatment to the beneficiary anywhere in India choosing from 700 inpatient medical procedures. OPD facilities are not covered under this scheme, though OPD consultation is free. However, it is important to remember that the RSBY scheme is in addition to facilities being provided at pre-existing government hospitals in every state.

Incentivizing in RSBY: Why Does It Work?

The government realised that there are three main characteristics of the below poverty line (BPL) families that needed to be taken into consideration in any health-care scheme: the population is poor and therefore cannot pay cash first; is largely illiterate, therefore cannot fill out registration forms; and is largely migrant, therefore would need transportable benefits. Keeping these considerations in mind, the Rashtriya Swasthya Bima Yojana was launched in 2008 and is being implemented by all state governments targeting universal coverage of the entire BPL population in India (approx. 300 million) by 2012–2013.

RSBY is India's first social security scheme that embraces a profit motive and is a good example of public-private partnership in the social sector. The insurer (public or private) is paid premium for each household enrolled for RSBY. Therefore, the insurer has the motivation to enrol as many households as possible from the BPL list. A hospital has the incentive to provide treatment to a large number of beneficiaries as it is paid per beneficiary treated. It can generate revenue from RSBY which helps them improve infrastructure and quality of health care. Insurers, in contrast, monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims. Moreover, the scheme provides for the inclusion of intermediaries such as NGOs which have a greater stake in assisting in the search for BPL households since they are paid for their services. The central government, by paying a maximum sum of Rs.750/- per family per year, allows access to quality health care to its BPL population, thus fulfilling its commitment to one of the important Millennium Development Goals. As of 9 February 2011, RSBY is active in 60% of Indian districts covering 22.8 million households.[6]

RSBY provides the participating BPL household with freedom of choice between public and private hospitals and makes each household member a potential client (with Rs.30,000/- on his card) worth attracting on account of the significant revenues that hospitals stand to earn through the scheme. Today, in less than 3 years of operation, it is being considered as one of the most successful government-funded social protection schemes in India in terms of outreach and sustainability.

RSBY's Expected Outcomes

The following are the expected results of the programme:

- Improved infrastructure and quality of health care in private and public hospitals through RSBY revenues. This will give a needed push to health sector reforms.
- Rs.50 million is being pumped into each district per year, creating business opportunities for both public and private health-care providers.

- The government hospitals are now in a position to compete with the private hospitals in terms of providing patient-friendly health services.
- Total quality management in health care: smart marketing and incentivizing quality through alternate finance model.

Challenges and Problems of RSBY

Only 60% of Indian districts have seen the enrolment of the poor, of which eight states (U.P., Maharashtra, Punjab, Haryana, Chhattisgarh, Gujarat, Bihar and Kerala) account for over 85% of all enrolled districts. The rest of the 20 Indian states and union territories have been slow in enrolment of BPL families in RSBY. Thus, a large geographical area and about 40% of total districts are still outside RSBY coverage. In Kerala, one of the better performers, the variation in enrolment of BPL families is between 60% in Idukki and 100% in Kottayam, as well as 97% in Ernakulam. There is large interdistrict variation in states (Narayana 2010). Overall, just about 50% of the poor in selected districts have been enrolled in RSBY. The exception is Kerala which reported 80% coverage with some districts enrolling almost the entire number of poor households.

The share of private sector hospitals is 95% in Kanpur, 87% in Amritsar and 100% in Karnal – all the high hospitalisation districts. In Kerala, which is the only state with about 45% of the empanelled hospitals in the public sector, the hospitalisation rate does vary with the share of hospitals in the private sector. It is also time for the state governments to understand the way premiums are set. It might be the case that the states are complacent as the central government doles out the bulk of the premium amount. But the situation could rapidly change as more private players get into the scheme and hospitalisation rates go up. A careful analysis of hospitalisation and costs cannot be avoided if premiums have to be kept under control.

Before RSBY, no central-government-funded health sector scheme had been successful at reaching beneficiaries. A further complication was that no IT-enabled government project had been taken up on this scale so far. Thus, RSBY faced major challenges both before and during implementation.

Worries Regarding RSBY

- Rs.30,000 is considered a paltry sum for major surgical interventions in private hospitals. If BPL coverage becomes 100%, premiums may go up.
- Are RSBY patients getting quality health care, and are they satisfied with the service in empanelled hospitals? OPD consultation is free but medication is excluded. Can this be made part of coverage?

Table 6.2 RSBY coverage

Sl. no.	Name of the states	No. of smart cards issued 31.10.2010
1.	Uttar Pradesh	4,992,271
2.	Bihar	3,969,312
3.	West Bengal	2,203,843
4.	Maharashtra	1,545,093
5.	Kerala	1,508,427

Source: www.rsby.in
Note: Enrolments are growing at around one million per month. Target – 300 million BPL families to be covered by 2012
The number of smart cards issued to BPL families under RSBY is the highest in the states above

- What accountability mechanisms should be used to improve the performances of insurers and/or hospitals by state nodal agencies so that the competitive bidding process improves overtime? The lowest bidder is often not the best necessarily in terms of quality assurance.
- How does RSBY coverage impact BPL households in terms of their finances and health-care access in different states?
- Can it meet one of the biggest challenges of Indian public policy in the twenty-first century: i.e. to provide universal access and quality health care to one billion persons?

One of the most urgent and difficult problems in the developing world, more so in India, is how to finance and provide health care for more than a billion persons, a third of them impoverished and belonging to the low-income groups. This is brought out clearly in the World Development Report 2000/2001. In most Asian countries, health care is financed through out-of-pocket payments by individuals. These expenditures jeopardise an equitable health-care system in developing countries. In the absence of financial risk pooling, the poor have to meet the costs of health care from their own pocket resulting in severe indebtedness. The common dilemma facing policymakers is with regard to the need for a government-sponsored health insurance cover despite health services being provided "free" in government hospitals. However, the fact is that the "free" government health services are not meeting the needs of the community. Moreover, 85% of the workforce in India are in the unorganised sector and still do not have the desired social security scheme. In most states, cards are issued on BPL lists made in 2002. According to National Sample Survey Organisation 2004, nearly 65% of India's poor get into debt, and 1% fall below the poverty line each year because of illness. Even today (despite RSBY), only 6% of India's workers in the unorganised sector have a health insurance cover (Table 6.2).

Besides, the ceiling of Rs.30,000 may prove inadequate for major surgeries in private hospitals. The medical college hospitals have to contend with delays in insurance payments. The government hospitals, including the medical college

hospitals, used to have the services of additional doctors and paramedical staff appointed on contract by the National Rural Health Mission. With the mission trying to streamline its funds' utilisation, the hospitals sometimes have been reported to meet the salary expenses from the RSBY funds.

Comprehensive compiling of data on BPL families as a population group has revealed to many state governments remediable deficiencies in their existing BPL data. A few states such as Kerala and Tripura have already revised their BPL data based on their experience with RSBY. This optimisation of BPL data will not only assist further RSBY implementation and operation but will also improve the targeting and outreach of many other social protection schemes.

Health Sector Reforms, Model States and RSBY

India plans to increase its allocation for health to 2% of its GDP in the 12th 5-year plan. It is commonly believed that all states should be responsible for providing their citizens with adequate health care. However, there is considerable debate on whether governments should finance or subsidise health care, while leaving its provision to the private sector, or whether they should provide that care as well.

This public vs. private debate is not quite relevant in poor or developing countries because there is no any good alternative to the public provisioning of health care, especially in rural areas where private providers are few and far between. Appropriately then, India is now going ahead with upgrading and expanding government rural health facilities. Mostly under its 2005 National Rural Health Mission (NRHM) and specially the 2008 RSBY scheme, both public and private health-care providers have been roped in to provide health care in rural areas.

In NRHM, primary health centres (PHCs) and community health centres (CHCs) are being renovated and upgraded, health workers are being reposted and hired to work, volunteers from the community have been selected and trained in almost every village and the availability of essential drugs is improving. Importantly, rural health facilities are receiving substantial funds in the form of untied grants every year, which they can use flexibly, though programme reviews have shown that actual delivery of the NRHM has fallen far short of its targets (the mission is nearing its deadline in 2012). But within this period, the NRHM has managed to get public focus back to the issue of public health. This has put pressure on the state governments to divert resources to the health sector, leading to the review of the public health system and investments. This development has had a positive impact on several health indicators like immunisation, institutional deliveries and antenatal care (Duggal 2006). In most states, outdoor patient visits had increased in rural areas at all levels besides a marked improvement in the service delivery capacity of the public health system. Given the structural constraints and sociocultural disparities in rural India, the fiscal crises of the

states, diversity in administrative ability and political will to administer the structural modifications envisaged under NRHM, even these successes are not insignificant, and the mission will have to be the focus of government attention to revive our public health-care system for the next few years to come.[7]

The Kerala Model and RSBY

The state of Kerala may have the best health indicators and integrated primary health-care system in India but still may not have the best public health-care institutions. Despite better health outcomes, the much proclaimed Kerala model of health has been showing a number of disturbing trends. The paradox is that on the one side Kerala stands as the state with all indicators of better health-care development in terms of infant mortality ratio, maternal mortality ratio, birth rate, death rate, etc. On the other, it outstrips all other Indian states in terms of morbidity especially in chronic/noncommunicable diseases. The public sector is unable to meet the demands for health care, and people have responded to these inadequacies by increasingly using the emerging private sector which now caters to 55–60% of health needs in Kerala. Therefore, it is scarcely surprising that Kerala was the first state to embrace RSBY in all 14 districts of the state and its entire 12 lakh BPL families were covered by the scheme. The government of India in 2009–2010 adjudged and awarded Kerala for outstanding initiative, innovation and institution building in RSBY. The state government decided in 2008 to extend the benefits of RSBY to other APL (above poverty line) families through its own comprehensive health insurance scheme to bring 35 lakh families under the coverage of health insurance. Therefore, despite its excellent publicly funded health-care system, the government of Kerala has realised the importance of RSBY in inducting private providers into the health-care chain. The implementation model of Kerala can also be emulated by others. The major features leading to the success of the model are:

(a) The government has conducted a BPL survey during 2009 to build up a genuinely updated BPL database.
(b) The state nodal agency (in charge of implementation) collects daily reports from all districts declared to evaluate performance.
(c) Has operationalised incentivising schemes for medical staff, *panchayats* and key field officers. The chief minister of Kerala was the leading campaigner of RSBY in the state.

In fact RSBY implementation catalysed health sector reforms in Kerala in the following manner:

- Increased health spending through NRHM
- Increased number of hospitals with Internet facilities
- Renovation of existing hospitals and setting up of specialty hospitals
- Compulsory rural health services introduced from 2007 in Kerala

- Kerala Medical Services Corporation for Drug Distribution and Logistic Management created
- Accreditation for 20 government hospitals and 360 laboratories[8]

Health Sector Reforms and the Tamil Nadu Model

In the context of reforms of health administration in India, the Tamil Nadu model is often cited. It is widely recognised that good public health services is a key to improving health outcomes. Tamil Nadu performs better than all other states in key indicators of maternal and child health care. The child (under five) mortality rate for Tamil Nadu for 2005–2006 is less than half the national average, lower than all the other states except Kerala and Goa. Tamil Nadu is better organised than most Indian states to manage public health threats,[9] and its health department seeks actively to protect public health in urban areas unlike most states.

Tamil Nadu's system can be emulated by others because it has the same overall administrative structure and finances as that of other states with similar cadres of medical and nonmedical staff. The difference is that Tamil Nadu (a) separates the medical officers into public health and medical tracks, (b) requires those in the public health track to secure a public health qualification in addition to their medical degree and (c) orients their work towards managing public health services – while those in the medical track are oriented towards providing hospital care. Tamil Nadu uses a mere 1% of its government medical doctors to be trained as public health managers and incentivises them accordingly. Tamil Nadu's approach is affordable. Its 2004–2005 per capita health expenditure was close to the national average. This suggests that the public expenditures are efficiently used to obtain good performance indicators above. By contrast, Kerala spends 2.8 times more than the national average on private expenditures bringing its total per capita expenditure to 2.5 times the national average (GOI 2006). Conditions would undoubtedly improve if the medical officer-in-charge of a rural health facility was given far greater authority to function and, in return, was held responsible for providing health services of the requisite level to the people. These precedents in the professional management of public health facilities exist in Tamil Nadu. Here, as in other Indian states, government funding is based on inputs – such as the quantity of drugs supplied, the number of staff employed and salaries paid, and the kind of medical equipment provided. But Tamil Nadu has succeeded where others have failed because it implements accountability mechanisms along with strict internal controls and oversight both for the use of these inputs and for the delivery of services of the requisite standard.

Tamil Nadu offers some basic organisational principles whereby public health system can be made more effective within the existing administrative and fiscal resources available to most states in India.

Monica Dasgupta et al. (2010) suggest establishing a public health focal point in the health ministry and revitalising the states' health needs towards a phased progress in four areas: (a) enactment of public health acts to provide the basic legislative

underpinning for public health action, (b) establishment of separate public health directorates with their own budgets and staff, (c) revitalisation of a public health cadre and (d) entrusting the health department in monitoring public health standards.

Health Sector Financing and Health Insurance Schemes in India

Health insurance as a practising concept is relatively new in India except for the employees in the organised sector. In India only 4.9% of the households and 14.3% of the population are covered by some kind of health insurance (NFHS III 2005–2006) of which the urban share accounted for 2.2% and the rural share 0.7%, mandatory health insurance covered 1.4 and 0.4% coverage is shared by other voluntary sources (WHO 2003). Another study reveals that only 9% of the Indian workforce is covered by some form of health insurance through the Central Government Health Scheme (CGHS) and the Employer State Insurance Scheme (ESIS), followed by private and market schemes and employer's contribution schemes. The study surmises that only 10% of health insurance market has been tapped in India so far (Mavalankar and Bhatt 2001).

Health insurance is today recognised as one of the newer solutions to health-care financing. Health insurance includes not only private providers but also the state-sponsored or community-sponsored insurance schemes as well. The community-funded schemes mainly operate for the rural and urban poor. They play a major role in reaching out to the poor because all other schemes are profit-based and meant for the organised sector.

In India, social health insurance schemes like ESIS and CGHS also have restricted coverage and provide poor-quality services in public hospitals and clinics. The other types of schemes available are provided by employers (mining sector, defence, educational institutions, etc.) and also cover nongovernmental organisations. The market-based schemes are not really growing in popularity in urban areas since they exclude a number of deadly diseases in their coverage and there is a steep rise in premium rates. The vast number of rural households and the unorganised sector employees (specially migrant labour) are simply left with no choice but to depend on the free government chain of hospitals, whose services leave much to be desired.

Conclusion

One of the core concerns of the government of India in the health sector identified by the National Commission on Macroeconomics and Health (2005) is promoting equity by reducing household expenditure on total health spending and experimenting with alternate models of health financing. Health insurance is an option that is often talked about in this context. Besides private insurance which is often unaffordable for the

poor and the middle class, there are other forms of health insurance like community health insurance and compulsory national health insurance. Community health insurance usually depends on user charges and community finance. Compulsory national health insurance implies that the government subsidises fully or partly the insurance premium. All forms of insurance are limited to curative health care. This implies that health insurance normally does not address the issues of preventive and promotive health care. Another problem with health insurance is that its success depends on an adequate health infrastructure. In the absence of a significant health infrastructure as a prerequisite, especially in undeveloped regions, even compulsory national health insurance access becomes highly inequitable.

Even if one accepts the recommendation of NCMH regarding alternate models of health-care financing, the principal responsibilities for basic health services and training of personnel will have to be borne by the public exchequer. To address this issue, one can examine the impacts of public health spending on different income/expenditure classes. The midterm appraisal of the 11th plan reports that the poorest quintile of the population received just 10% of the net subsidy from public health expenditure, while the share of the richest quintile was 30%. Further, the study found that the inpatient beds in the primary health centres are significantly underutilised, and the limited utilisation is not particularly pro-poor in the population being served (Eleventh 5 Year Plan Documents, Planning Commission 2007–2012). Yet according to current estimates, 1 lakh beds each year need to be added for the next 20 years at Rs.50,000 crore per year to meet the target of universal health-care access to one billion Indian citizens. This gives an estimate of the challenges ahead for the planners of health policy in India.

The NCMH estimates that if the government is to be the sole provider of the comprehensive package of preventive, promotive and curative services, there will be a fivefold increase in public health expenditures. The commission therefore suggests two major options:

(a) Targeting only the poor for publicly funded comprehensive health care
(b) Considering alternate models of health financing such as contributions, user charges, vouchers and insurance (NCMH 2005) for others

In India, the poor workforce in the unorganised sector, women, children and the very old, are especially vulnerable to health shocks. Since income becomes important in accessing health insurance, the uninsured rate will remain high till there are dramatic changes in the rural economy. The RSBY model will be extremely relevant for developing countries, where by paying a relatively small premium, the government can “set the ball rolling”, and different stakeholders can keep it moving since all have a “stake” in the success of the scheme. The strength of the scheme lies in the fact that it is a social welfare scheme with the profit made by the various stakeholders acting as a catalyst and keeping it sustainable in the long run.

Within 3-plus years of operation, RSBY is being considered as one of the most successful government-funded social insurance schemes in India in a public-private partnership mode and also in terms of outreach and sustainability. It may be considered a precursor to other social protection schemes in the country in future.

Notes

1. In India, in terms of access to medical care, the best five serving states are Kerala, Tamil Nadu, Himachal Pradesh, Gujarat and Haryana.
2. Social determinants of health, broadly stated, are the conditions in which people live and work that affect their opportunities to lead healthy lives. Good medical care is vital, but unless the root social causes that undermine people's health are addressed, the opportunity for well-being will not be achieved.
3. Private expenditure on health in India is about 78% as compared to 14% in the Maldives, 29% in Bhutan, 53% in Sri Lanka, 31% in Thailand and 61% in China.
4. Kounteya Sinha in a Times of India Delhi Report on 8 May 2011.
5. All basic information regarding RSBY has been taken from website www.rsby.in
6. Ibid.
7. Most of the data on NHRM are available at www.mohfw.nic.in/NRHM/PRC-Reports.htm. See also Hussain (2011).
8. See www.rsby.in for the Kerala model of implementation of RSBY.
9. This is amply demonstrated by the state's ability to respond briskly to a major disaster like the tsunami without any outbreak of epidemics and by the state's technical expertise to help control the 1994 plague outbreak in Gujarat.

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