The contribution of India's national health insurance programme (RSBY) to social inclusion in Maharashtra and Uttar Pradesh

Country Briefing

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Key messages

- India's national health insurance programme (RSBY) has reduced out-of-pocket health care costs on *inpatient* treatment and reduced the dependence on debt for beneficiary households.
- A higher proportion of marginalised households (Scheduled Caste and Muslims), however, have incurred out-of-pocket expenditure on inpatient health care treatment, report limited awareness of the RSBY scheme (its benefits and processes), and perceive discriminatory behaviour during their healthcare treatment, than upper caste households.
- Despite assumptions that social health protection schemes like RSBY can contribute to household wellbeing and economic productivity, there is no evidence that RSBY has had a significant impact on these indicators. However, evidence does suggest RSBY can contribute to strengthened social networks and improved perceptions of the central government.
- The findings suggest that greater attention must be given to addressing discrimination based on caste and religion in the design and delivery of RSBY.

Social health protection programmes, such as India's health insurance scheme, RSBY, are increasingly seen as a key component of a social protection approach to reduce poverty and improve health status. Moreover, attention has recently been given to the indirect economic and social benefits of social health protection promoted through principles of solidarity and equity to support economic productivity, empowerment and social outcomes more broadly.[1] This research used a social exclusion lens to analyse the effects of RSBY on socially excluded households in two states in India, Uttar Pradesh and Maharashtra.

The idea of social exclusion is commonly used to discuss the social relations and institutions that 'exclude, discriminate or deprive certain social groups on the basis of a broad range of group identities' (Thorat and Louis, 2003 cited in Skoda et al., 2013: 3). The structure of the caste system and its implications for employment, education and the rules of social and economic exchange are distinctive in India.

Despite witnessing a steady decline in poverty at the national level, India remains a deeply unequal country. Those from lower castes, such as Scheduled Castes and Scheduled Tribes, as well as religious minorities such as Muslims, face exclusion and discrimination in several arenas of public life, leading to disproportionately higher rates of poverty and vulnerability among these groups. Health outcomes for a range of health indicators, for example, are much poorer for socially excluded groups.

Indeed, high health costs and out-of-pocket expenditure (both direct and indirect health-related costs) are a major reason that the poor forego health care. The majority of health expenditure in India is privately financed from household out-of-pocket expenditure and estimates suggest that approximately 39 million Indians were pushed into poverty as a result of out-of-pocket health expenditure in 2004-2005 (Selvaraj and Karan, 2009). Given that socially excluded households are among the poorest, they are highly vulnerable to this increase in poverty. Evidence shows that one hospital stay can cost well over a poor household's annual income (Balarajan et al., 2011; Yip and Mahal, 2008). As such, the longer-term consequences of the burden of health payments for the poor are substantial.

However, it is not just financial barriers which contribute to an under-utilisation of health care and result in poorer health outcomes as well as lower productivity and diminished income. Systemic weaknesses in the health system include insufficient investments, variable quality of care, lack of accountability and social discrimination (Baru et al., 2010). For socially excluded households in particular this results in the experience of discriminatory attitudes, denial of admission and medical treatment, and inadequate/poor quality medical treatment (Sabhrawal, 2011). Such weaknesses have increased inequalities within the health system and in health outcomes.

The roll out of RSBY since 2008 has been designed to overcome some of these challenges, in particular by extending inpatient health care insurance to below-the-poverty-line households. The current number of beneficiaries is almost 37 million households[2] (see Box 1 for programme details).

Box 1: RSBY programme details

The *Rashtriya Swasthya Bima Yojana* (RSBY) health insurance scheme was initiated by India's Ministry of Labour and Employment in 2008. The main objective of the scheme is to provide health insurance to households living below the poverty line with the aim of protecting poor households from major health shocks which push them into poverty and indebtedness. Beneficiary households can access *inpatient* treatment costing up to 30,000 Indian Rupees (approximately $480) per year for five members of the households (e.g. head of the household, spouse and maximum three dependents) by paying Rs 30 (approximately $0.48) as an annual registration fee.

[1] See for instance, http://www.socialhealthprotection.org/

[2] http://www.rsby.gov.in (Accessed April 2014)

Research objectives and methodology

The objective of this study is to examine the effects of RSBY in reducing out-of-pocket health expenses for socially excluded households, and more broadly, to examine the indirect effects of the RSBY scheme on other dimensions of household wellbeing, economic productivity, and community and state-society relations. The research was guided by the social exclusion framework, which emphasises the importance of assessing impacts of interventions on multiple dimensions of poverty and the extent to which they tackle drivers of social exclusion and poverty (Babajanian and Hagen-Zanker, 2012). In assessing the effects of RSBY, the study has generated evidence on the context-related economic, social and institutional factors that mediated its impact.

The study used a mixed methods research approach including a quasi-experimental impact evaluation (propensity score matching), which included a treatment group (RSBY smart card holders: those who have and have not used the smart card) and control group (non RSBY smart card holders). The research was conducted in two districts in two states: Moradabad in Uttar Pradesh and Aurangabad in Maharashtra. The sample size of the quantitative study consisted of 1,500 households in total (1,050 beneficiary households; 450 non-beneficiaries households). Scheduled Caste and Muslim households were purposively chosen because we wanted to select mixed caste villages from the mainstream society. Key informant interviews were carried out in each state with RSBY and government officials, non-governmental organisations (NGOs) and civil society groups. Focus group discussions and in-depth interviews were conducted with beneficiaries and non-beneficiaries in each state to collect detailed information on the direct and indirect effects of the intervention at the household and individual level.

Research findings

Health expenditure and health care experiences

The research findings reveal that RSBY has a positive impact by reducing *inpatient* health expenditure. The quantitative impact analysis shows that the average annual cost of expenditure on inpatient treatment is lower by Rs 3,620 (approximately $60) for treated households and that this difference is statistically significant. Moreover, looking at how health expenditure is financed, we see some small but encouraging differences, indicating that RSBY may be having a positive effect on reducing the burden of debt for beneficiary households. The PSM results show that treated households are less likely to be indebted and less likely to use borrowed money to finance inpatient treatment (although only the former is significant).

However, the PSM impact analysis also shows that total household health expenditure of treated and control households remain similar. One of the reasons for this could be because a high proportion (40%) of RSBY smart cardholders have not used the insurance scheme to pay for inpatient treatment costs. The qualitative analysis indicates that there are a number of reasons for this, including lack of awareness on how to use the smart card or about which hospitals to access, long distances to the hospitals, denial of treatment by empanelled hospitals, or discouragement of beneficiaries to use the smart card by service providers.

The findings also demonstrate that some beneficiary households reported incurring some out-of-pocket expenditure even under the RSBY scheme for inpatient costs. As Table 1 shows, an average of 75% of beneficiary households reported incurring some out-of-pocket health expenditure before hospitalisation. However, a higher percentage of beneficiaries from Scheduled Caste and Muslim households incurred out-of-pocket expenditure in comparison to beneficiaries from upper castes, and the difference is statistically significant. A significantly higher proportion of Scheduled Caste and Muslim survey respondents also reported that they were not aware that they are eligible for transport costs under RSBY. Even those beneficiaries who were aware that they were eligible did not always get their transport cost reimbursed.

Table 1: Out of pocket and transport expenditure of beneficiary households by social groups (Yes %)

Out of pocket and transport expenditure	Scheduled Caste	Muslim	Others	Total
Did you incur any out of pocket expenditure on treatment before you reached an empanelled hospital?* **				
	83.1	77.8	68.0	75.9
Do you know that you are eligible to receive expenditure on transport to reach hospital? ** **				
	65.1	66.7	84.5	72.8
Did you get the transport money refunded after reaching hospital? ** **				
	53.0	56.8	72.2	61.3

*Note: **** Significant at 1%, *** Significant at 5% Source: descriptive statistics*

The majority of RSBY beneficiaries reported positive experiences in using the scheme and in the healthcare provided. For example, only a small proportion (less than 10%) of beneficiary households reported facing challenges enrolling in the scheme. However, differences between social and religious groups are evident in people's experiences of RSBY and in using hospitals covered by the RSBY scheme. Households from marginalised communities, for example, reported facing specific difficulties in enrolling for RSBY, including a lack of information on the date and place of enrolment, with some respondents noting that sometimes announcements are not made in scheduled caste localities. The findings also show that only 62% of Scheduled Caste households and 69% of Muslim households received treatment in their choice of hospitals under the RSBY scheme compared to 86% of upper caste households. Moreover, while overall the majority of beneficiary households perceived that the service provider gave them sufficient attention, a higher proportion of beneficiaries from Scheduled Caste and Muslim households (41% and 30% respectively) felt that the service provider did not give them sufficient attention (in comparison to 13% of beneficiaries from upper castes), and felt they faced discriminatory behaviour during their treatment.

Household wellbeing and livelihoods

The findings from the quantitative impact analysis show that there is no significant impact of RSBY on household wellbeing or livelihoods as measured by a number of indicators on household expenditure, consumption patterns, and income generated from livelihood activities. This is despite the theoretical assumptions which link social health protection to increased household income and improved productivity. Findings from the qualitative data analysis, however, do suggest that in fact, important changes are perceived by some beneficiaries in terms of diversification in diet and economic productivity. Some beneficiaries explained these changes by saying that RSBY had saved them spending money on treatment and that timely treatment through RSBY had helped them return to work sooner after their illness.

However, it is important to note that the beneficiaries reported these changes as small and that low and inconsistent income remains a significant challenge for the poor. For instance, we found only few beneficiaries able to invest a proportion of their income in agricultural activities or return to work sooner after illness. When we looked at whether RSBY had helped to reduce the number of days that people could not work due to illness – and whether, by reducing the financial burden of health expenditure, saved income was redirected to income generating activities – the quantitative results showed no significant impacts.

Community participation and social relations

Looking more broadly at the potential effects of RSBY at the community level, we examined whether RSBY membership had an effect on social relations by looking at the social interactions and networks of beneficiaries and non-beneficiaries. Given the complex social interactions at village level in India, particularly in the context of caste and religious differences and the history of social discrimination and social exclusion, it is perhaps not surprising that a scheme like RSBY would not have any significant effect. As one beneficiary noted:

"*We have been facing discrimination for a long time. How can access to health care through RSBY abolish caste based discrimination against us and provide equality to us?*"

However, the findings do suggest that RSBY beneficiaries' household network support is strengthened, as we found that beneficiaries are slightly more likely to receive support from villagers and neighbours for treatment or other needs.

State-society relations

There is very little difference between beneficiaries and non-beneficiaries in terms of their perceptions of, and interaction with, local government. Beneficiaries are no more likely than non-beneficiaries to raise issues or problems before the local government authority.

Almost all beneficiary households reported that the introduction of RSBY is an indication that the Government of India cares about their socioeconomic situation. Seventy percent of beneficiaries stated that introduction of RSBY has improved their perception of the Government of India. Beneficiaries reported that the fact that all households below the poverty line are entitled to RSBY, the relatively simple enrolment process, and the perceived importance of help with household health care expenses, proved to be important factors explaining these changes in perceptions. As one beneficiary stated:

"*We know central government is running many schemes for the poor. The RSBY scheme is better than some other government schemes as we get the benefits of the scheme without much problem. We do not need to go to government offices many times at block and district level to get the benefits of the scheme; instead, we are registered in the scheme in our own village*".

Policy implications

This research has found that RSBY has had a number of positive effects on poor, excluded households, particularly in terms of reducing inpatient expenditure and reducing dependence on debt, strengthening social networks, and improving perceptions of the central government. Still, a number of important challenges remain, and this research has also shown that a proportion of beneficiaries have still paid OOP for inpatient treatment, that social discrimination in the delivery of healthcare is evident, and there are limited indirect effects on livelihoods and other household wellbeing indicators. These findings suggest that more attention must be paid to addressing discrimination based on caste and religion in the delivery of RSBY. This could include greater commitment to monitor and respond to social discrimination in the delivery of RSBY; provision of locally appropriate awareness raising of the scheme and its benefits, including ensuring that information reaches marginalised localities; investment in training service providers to deliver equitable and non-discriminatory services; and provision of opportunities to strengthen accountability mechanisms and forums for citizen participation to report back on experiences of the scheme.

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This country briefing is part of a wider research project that assessed the effectiveness and relevance of social protection and labour programmes in promoting social inclusion in South Asia. The research was undertaken in collaboration with partner organisations in four countries, examining BRAC's life skills education and livelihoods trainings for young women in Afghanistan, the Chars Livelihoods Programme and the Vulnerable Group Development Programme in Bangladesh, India's National Health Insurance Programme (RSBY) in Maharashtra and Uttar Pradesh and the Child Grant in the Karnali region of Nepal. Reports and briefings for each country and a paper providing cross-country analysis and drawing out lessons of relevance for regional and international policy can be found at: www.odi.org/sp-inclusion.

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