On Publicly-Financed Health Insurance Schemes
Is the Analysis Premature?

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It is a methodological flaw to conclude from data which shows a rise in the incidence of out-of-pocket medical expenses that the Rashtriya Swasthya Bima Yojana is ineffective. A response to Sakthivel Selvaraj, Anup K Karan, "Why Publicly-Financed Health Insurance Schemes Are Ineffective in Providing Financial Risk Protection" (EPW, 17 March 2012).

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The Rashtriya Swasthya Bima Yojana (RSBY) as on March 2012 covers 28 million households in India, which constitutes approximately 11% of the total number of households in the country. The scheme is expected to ultimately provide health insurance protection against hospitalisation to about 130 million people in the country. There is a need to re-examine the manner in which a national scheme of this magnitude has been evaluated by Selvaraj and Karan (EPW, 17 March 2012) and was certified as a failure in terms of providing financial risk protection against catastrophic healthcare expenditure by households in India. The reported analysis which does not go beyond very basic descriptive statistics at the highly aggregated national level, is regrettably replete with methodological flaws.

The authors have compared the National Sample Survey Office's (NSSO) consumer expenditure survey data for 2004-05 (pre-RSBY period) and 2009-10 (post-RSBY period) and found an increase in mean per capita household out-of-pocket (OOP) hospitalisation expenditure and in the prevalence of catastrophic health expenditure due to hospitalisation. The increase in these indicators between these two-time points was directly attributed to the lack of effectiveness of the RSBY in providing financial risk protection to the households. Such crude and un-standardised comparisons are permissible only if the authors can ensure that: (1) a substantial proportion of the households was covered by the RSBY during this inter-survey period, so that the NSSO consumer expenditure survey would have been able to capture the differentials investigated in the paper, and (2) the proportion of households consuming/seeking inpatient care remains unchanged at the time of these two cross-sectional NSSO surveys (a variation in proportion calls for the need to make a standardised comparison of OOP expenditure estimates).

Now let us examine what proportion of households in India was covered by the RSBY in 2009-10. There are two data sources available in the public domain which provide data on the coverage by RSBY for the latter period in which this evaluation was performed. Jain (2011) reports that 22.5 million households had enrolled for RSBY by the end of December 2010, which constitute 9% of households in India. The PHFI (2011) study reports that 80 million beneficiaries were covered under the RSBY, which translates to around 7% of the country's population. So will this RSBY coverage of 7-9% be enough for the NSSO consumer expenditure survey to capture the RSBY's impact on OOP expenditure on hospitalisation in Indian households? The annual hospitalisation rate in India is 25 per 1,000 population (NSSO 2006). Due to this sample size constraint, the authors are in no position to attribute the increase in OOP expenses (Table 2 of their article) and that in the proportion of households facing catastrophic expenses (Table 4 of their article) to the inability of the RSBY to provide financial protection against risk of hospitalisation. Inpatient care is consumed by a small proportion of households in a year and hence the authors will have to wait for the coverage of RSBY to reach at least 30% in order to apply such methodologies. Such high coverage levels are needed for comparison, as programme statistics indicate that one out of eight households among RSBY beneficiaries are reporting hospitalisations during a one-year reference period. Further Dror and Vellakkal (2012) have shown that the coverage of RSBY within the BPL households had touched 28% as on 31 March 2011. The midpoint which the 2009-10 NSSO data refer to is 1 January 2010 and RSBY coverage level here among BPL households is expected to be much less than the 28% estimated as of March 2011.

The second and more serious issue while comparing household-level OOP expenses on hospitalisation between two surveys is the nature of variation in the proportion of households incurring these expenses between the two survey points. Table 1 shows that the proportion of households reporting OOP hospitalisation expenses has increased from 9% in 2004-05 to 13% in 2009-10. Such an increase also limits the crude comparison of OOP expenses and catastrophic spending on hospitalisation reported by the authors. This sharp increase is noted to be very high in the poorest quintile and lowest in the richest quintile. The rich-poor gap in the proportion of households incurring OOP expenses narrowed down during the five-year period. An increase in the proportion of households reporting OOP expenses is more pronounced in the rural than urban areas of the country. This increase in this proportion noted here could be largely due to two reasons: (1) a larger share of households/persons sought medical care in 2009-10 than in 2004-05, due to improvements in access to healthcare and/or (2) a rise in the share of hospitalisation care providers where OOP expenses are unavoidable, due to marginalisation of public hospitals, growth of the private healthcare sector and promotion of public-private partnerships. This issue cannot be settled due to the absence of information on RSBY participation, the household/individual level risk of hospitalisation and the source of healthcare provider in the NSSO survey that has been analysed. However the authors seem to be in a hurry to attribute every increase in burden of hospitalisation expenses to RSBY inefficiency.

Table 1: Percentage of Households Reporting Out-of-Pocket Hospitalisation Expenses by Monthly Per Capita Consumer Expenditure (MPCE) Quintiles

MPCE Quintile	2004-05			2009-10		
	Rural	Urban	Total	Rural	Urban	Total
Poorest	3.6	6.4	4.4	8.6	9.8	8.9
Second poorest	5.2	10.5	6.7	9.1	12.8	10.2
Middle	7.4	9.8	8.1	11.2	15.7	12.6
Second richest	10.7	10.0	10.5	15.4	16.3	15.6
Richest	17.8	12.2	16.3	19.9	15.3	18.5
All	9.0	9.8	9.2	12.8	14.0	13.2
Richest/poorest ratio	4.9	1.9	3.7	2.3	1.6	2.1
Sample households (N)	79,298	45,346	1,24,644	59,097	41,697	1,00,855

Source: Unit records of the NSSO Consumer Expenditure Surveys in 2004-05 and 2009-10.

As is known, the healthcare sector is one of the rapidly growing sectors in India. Apart from medical inflation which is a global phenomenon, the increase in OOP expenses on hospitalisation is mainly triggered by the ever increasing demand for modern medical care which was once physically and financially inaccessible to a vast majority of the population in the country. In the present health system setting, the demand for healthcare will increase in the coming years with an increase in exposure to modern medical care. As a result, the health conditions which were probably undetected in the earlier years due to a lack of access to medical facilities and which the public considers serious and seek medical attention have increased mainly due to expansion of healthcare markets. The authors have adopted a narrow view of attributing every change in OOP expenses on hospitalisation to RSBY ineffectiveness. The changes noted in OOP expenses should be analysed with respect to the broader contextual changes in the health system including the RSBY.

The RSBY covers hospitalisation expenses of households and that was the reason why this rejoinder has been restricted to that part of the analysis in the paper OOP expenses on hospitalisation. The manner in which a flagship programme of the government like RSBY has been evaluated by the authors was unfair not only to RSBY but also to the rich national-level data sets. The authors should have tested the significance as well as confidence interval of differentials observed and should have attempted standardised comparisons before arriving at such strong conclusions. Otherwise the paper will send wrong signals to public health planners (Planning Commission 2012) who are still searching for strategies and models for providing universal access to essential healthcare and medicines in the country.

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