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HEALTH SCHEMES FOR BPL PEOPLES

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Introduction:

Below poverty line is an economic benchmark and poverty threshold used by the government of India to indicate economic disadvantage and to identify individuals and households in need of government assistance and aid. It is determined using various parameters which vary from state to state and within states.. Internationally, an income of less than $1.25 per day per head of purchasing power parity is defined as extreme poverty. By this estimate, about 21.92% percent of Indians are extremely poor. Income-based poverty lines consider the bare minimum incomTo ensure "Health for all" is a huge challenge that confronts the authorities in India, given the country's size and the diversity of its population in socio-economic, regional, and cultural terms. Adequate provision for health financing is essential for strengthening healthcare. In India, expenditure on health is a mere 4 per cent of GDP, of which public spending is 17 per cent and the rest is private. In terms of healthcare, 1.22 billion Indians can be categorized as rural and urban, upper, middle and poor class, or above poverty and below poverty line. The upper or middle class generally residing in urban areas have access to quality healthcare. However, those residing in interior rural areas and living below the poverty line have limited or no access to healthcare. Besides overall lack of health infrastructure, the second most influential factor in healthcare in India is high out of pocket (OOP) health spending (86.4 per cent), and a large population lacking medical insurance coverage.

While the government is committed to providing health for all, adequate financing is critical to ensure it. The government has decided to increase its health spending to increase demand for

healthcare and ensure equity in access to healthcare. To accomplish this in the wake of high out of pocket health spending is a challenging task. This in turn requires alternative security measures for those who cannot pay for healthcare. Coverage by other public1 and private health insurance is limited in India. Hence, to provide universal health coverage in a country like India, where most people are either unemployed, or employed informally in the unorganized sector, is not only challenging but also expensive. These challenges are further intensified due to the disparity in urban and rural health systems. In recent years, the government has recognized the need for effective risk-pooling systems in order to reduce OOP health spending, especially among the poor and those residing in rural areas.

Background of the study:

Rashtriya Bima Swasthya Yojana Scheme was launched in 2008 by the Government of India, with the objective of providing health insurance to the poorest strata of society, i.e. below poverty line (BPL) households. It was introduced in Karnataka in 2009. The primary aim of RSBY is to protect BPL households from catastrophic health expenditure and to promote health-seeking behavior in them. The costs of this scheme are borne in the ratio of 3:1 between the central government and the state. Looking at the structure of RSBY, it is clear that the authorities have identified the target group efficiently and have incorporated within the policy frame the characteristics of the target groups:

(a) poverty, (b) illiteracy, and (c) migration (Swarup, 2011). RSBY provides a cashless, paperless, and portable scheme to beneficiaries.
(b)

In the past Government have tried to provide a health insurance cover to selected beneficiaries either at the State level or National level. However, most of these schemes were not able to achieve their intended objectives. Often there were issues with either the design and/ or implementation of these schemes.
Keeping this background in mind, Government of India decided to design a health insurance scheme which not only avoids the pitfalls of the earlier schemes but goes a step beyond and provides a world class model. A critical review of the existing and earlier health insurance schemes was done with the objective of learning from their good practices as well as seeks lessons from the mistakes. After taking all this into account and also reviewing other successful models of health insurance in the world in similar settings, Rashtriya Swasthya Bima Yojna was designed.

Objectes of the study:

This study is an attempt to investigate various dimensions of RSBY scheme with the help of both secondary data and primary data collected from a field survey. Specific objectives of study are: impact of RSBY

1. To understand the patterns in healthcare access among poor households and analyse the in influencing access to healthcare among the target households.

2. To understand the pattern of healthcare-related expenses among poor households and gauge the impact of RSBY as a measure to reduce the burden of medical expenditure on the target households.

3. To understand the gaps, if any, in information and service delivery by RSBY.

Conclusion:

Below poverty line households are identified as the target beneficiaries of this scheme and the possession of the BPL card (name registered on the BPL list) is the primary criterion of eligibility. Access to healthcare refers to health-seeking behavior and the source of treatment. The objective of this paper is to analyze treatment-seeking behavior among beneficiaries of RSBY, and its impact on increasing access to healthcare Expenditure analysis highlights the spending pattern of the targeted households. The study assesses consumption level, consumption pattern, and medical expenditure of the selected households. Service delivery gaps refer to factors that might limit RSBY's ability to function as a safeguard against catastrophic healthcare expenditure. The rationale of the study is to critically analyse the success and the shortcomings of RSBY; the factors that make it a success, as well as those that are a hindrance. provide basic food requirements; it does not account for other essentials such as health care and education.

Rashtriya Swasthya Bima Yojana or RSBY started rolling from 1st April 2008.
RSBY has been launched by 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 hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most of the diseases that require hospitalization. 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 includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays 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 RSBY scheme, however, differs from these schemes in several important ways.

Recomandtion:

The scepticism was on account of the fact that the scheme was riding on twin non-starters in the context of past national efforts for health insurance and smart cards. But RSBY . Now that it is happening, there are a number of takers. However, when Rashtriya was different. Not only was the conceptual framework Swasthya Bima Yojana (RSBY) was launched, not many believed that it could happen different, the approach to implementation was also at variance with the past efforts.

For a change, RSBY was evolved as a product catering to the requirement of the target group. The characteristics and the requirements of Below Poverty Line (BPL) families were analyzed and the conceptual framework was built on this analyses. The prospective beneficiary (the consumer) was by definition poor. Hence, he could not be expected to raise resource upfront to seek medical assistance and then raise a claim. He was by and large illiterate. Hence, he was in no position to undertake documentation to settle claims. A large number of prospective beneficiaries migrate to other States, primarily in search of employment. Hence, there was a need to provide benefits in the destination States. Through the instrumentality of the smart card, all these problems were taken care of. Thus, the "product" (RSBY) has been designed keeping in mind the "consumer" requirements and evolved after analyses of the "consumer".

The approach usually adopted by Governments in implementing any scheme centres around fixing of periodic targets and monitoring them vigorously. The 'monitoring' model does necessarily entail "acceptance" of the scheme. There is, thus, an absence of "willing participation". The schemes are rolled out because there is a decision to implement such schemes at some level on account of political exigencies, a brainwave, and a genuine concern for the beneficiary group or a combination of these. The key question, therefore, is "Why and how do the States implement the scheme?

Whether it is on account of the pressure from the top (the "stick" approach), as happens in most of the Government schemes which are target oriented and closely monitored.; or whether it is on account of the incentives provided under the scheme (the "carrot" approach), the incentives could be financial or otherwise. The third approach of "ownership" has so far been totally ignored in the Government. Considering the complexity inherent in RSBY and the commitment required to implement it, there was no other option but to adopt the third approach. It is one of the rare schemes of the Government where a sincere attempt has been made to 'market' the scheme rather push it down the throats of State Governments. Willing participation of each of the players is imperative for the scheme to happen. The scheme does not merely entail transfer of funds to the State Governments. The transfer precedes whole lot of activities which culminates in the issue of smart cards by the insurance companies. The release of funds by the

Central Government is 'post-activity' rather than 'pre-activity'. This is at variance with almost all the other Centrally Sponsored Schemes. The scheme attempts to focus on facilitation rather than monitoring. The scheme is testing the persuasive skills of those that are attempting to make it happen. We suggest the following future research based on our analysis:

1. States and districts that have unusually high or low KPIs.
2. The large number of villages with no utilization.
3. The rationale for determining premiums, using third and fourth year data when they become available.
4. Reasons for fraud in enrolment and utilization, especially in high utilization districts.
5. Sample surveys to investigate patient satisfaction, patterns in procedures, claims denials, renewal, usage by migrants, gender bias, and hospital capacity and infrastructure

All in all, the scheme is different. It is different in the context of its conceptual framework, it is different in the manner in which it is actually rolling out and it is likely to be different in the manner in which it will impact the lives of the poorest of the poor in this country. Some such evidence is already visible.