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Fighting or Deepening Exclusions from Health Services?
social health protection program for the poor in India

Opinion Editorial

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India and Universal Health Coverage

The 2012 United Nations General Assembly Resolution on Global Health and Foreign Policy explicitly called for increasing efforts to provide high quality and affordable health services for all, acknowledging the role of good health in fostering international development.[1] This is all the more relevant given the reality of many developing countries where economic and social inequalities create severe health-related imbalances as a consequence.[2] Achieving universal health coverage (UHC), however, is highly dependent on national undertakings in the field of health systems strengthening, such as investing in infrastructure and workforce, establishing efficient health information systems, developing sustainable health financing mechanisms, ensuring access to medicines and health technologies, and assuring leadership and accountability arrangements.[3] India is no exception. Efforts are undertaken towards the achievement of UHC, however, the challenges of the national health system remain significant. In 2010, total government spending on health represented as little as almost 5%, which, what is more, accounted for only one-third of the expenditures on health. Out-of-pocket (OOP) payments for health services continue to constitute a barrier for health care utilization, amounting to 60% of spending for health.[4] In addition, as much as 86% of people residing in rural areas and 82% of those living in urban areas remained not covered by any health insurance, being reliant on their own savings.[5]

Rashthriya Swasthya Bima Yojana Scheme

Faced with the described situation, in 2008, the Government of India launched the Rashtriya Swasthya Bima Yojana (RSBY) health insurance scheme with the objectives of protecting below the poverty line (BPL) households from financial hardships associated with OOP spending and hospital treatment as well as increasing access to hospital services within the poorest population.[6] Next year's tenth anniversary of the scheme

implementation is approaching. This begs the question as to its effectiveness and delivering the intended results. The latest evidence suggests some mixed results. For instance, nation-wide, in terms of the utilization of hospital care services, a mere 12%-13% of BPL households were included in the health insurance system due to RSBY as well as other insurance schemes (including Employees' State Insurance and Central Government Health Scheme).[5] Local and small-scale assessments frequently report contradictory effects.[7] The impact on reducing the level of OOP payments also differs in the literature: from no visible results to the increased burden associated with the continuous process of paying for health services from household resources.[8-10]

RSBY and Exclusionary Processes:

However, when evaluating the scheme effectiveness, another dimension has to be also taken into account besides its official objectives. According to the intention of the initiators, RSBY is a social health protection program deliberately proposed to fight the issue of marginalization of the poor when it comes to the access to health services and hospital treatment. The scheme assessment in the light of bringing a social change and facilitating social cohesion at individual and community level is equally critical. For example, existing evaluations of the scheme point to the fact that many eligible households cannot attend enrolment camps as this involves losing their daily income.[11-13] The high registration fee is often an obstacle as well.[14] In terms of communicating enrolment procedures and provisions, the required information flow between communities and local government authorities is frequently distorted. This is mostly associated with poor political representation and lack of political connections.[11,13,15,17] The latter, moreover, is linked to the experienced misuse of power by local politicians, manifesting itself through corruption practices, among others.[11,15-16] Another factor for constrained scheme awareness and enrolment is literacy of eligible households, often limited as concerning the poor without access to education.[11,15,18] Social and cultural conditions within which the scheme is being implemented, also significantly contribute to its utilization. The status in the social hierarchy, the caste system, is decisive for the participation of individuals in community activities and existing social networks, thereby perpetuating present social exclusion of scheduled castes, scheduled tribes, and other backward classes.[11,13,19]

Towards Greater Social Inclusion in RSBY Management:

The way in which RSBY is managed allows for concluding that it does not contribute to delivering the desired social value associated with its implementation, which is fighting social exclusion and inequalities in access to health services. More inclusive practices vital for the success of the scheme need to be implemented and informed on the basis of research that specifically targets social conditions around which the scheme introduction is being approached. As early as the stage of design, efforts should be made to understand material, social, and health situation of the target population, BPL families, in order to increase the scheme enrolment in the first place. The above examples of exclusionary processes could be used to reverse the situation and suggest more integrating methods of operations. For instance, taking into consideration a difficult financial position of many eligible individuals that, moreover, is also associated with economic migration, more could be done to reach communities in their place of residence and work, with a more efficient handling of enrolment activities and sticking to enrolment timetables, to start with. What is more, greater attention should be paid in order to effectively communicate the scheme assumptions and provisions at a community level. As already emphasized, the target families are frequently not literate enough to benefit from the provided information materials, such as posters, brochures, or pamphlets. In addition, the scheme delivery

has to be facilitated on the basis of existing political interplay between community members and their representatives, acknowledging the specific dynamics. Finally, recognizing factors that are responsible for mobilization of communities, associated with the pursued values and accompanying conduct, should provide a benchmark for revealing mechanisms through with communities and individual members decide to enrol in the scheme. The provided examples represent just a tiny drop in the sea of problems and considerations that should be respected when implementing and further managing the scheme. However, the available qualitative evidence as to the scheme introduction already enables the development of a redefined RSBY implementation strategy.

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