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Performance of Health Sector in India: Focus on Rastriya Swasthya Bima Yojana (RSBY)

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ABSTRACT

The relevance of health sector in the overall socio-economic development of the country, need not be emphasized. Figuring in the top of the priority lists in the Millenium Development Goals (MDG) of the United Nation's charter; India, who has been a signatory to it, is committed to the eradication of poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women. Signed in the year 2000, the progress, unfortunately, has not been an impressive one, despite the fact that the nation has succeeded in addressing the issue of poverty quite effectively, eliminating the gender inequality, to a large extent, in primary and secondary education, achieving the required reversal in the fight against HIV/ AIDS and achieving the target of drinking water facility to name some vital sector, the country has still long way to go. According to the United Nations SDG Index and Dashboards Report 2023, which assesses countries' progress towards the Sustainable Development Goals (SDGs), the SDG Index Rank of the country is 112 out of 166 countries, with an overall index score of 63.5 percent and spill-over score of 99.4 percent! While India has made strong economic growth and has made quite impressive progress in other some sectors of the MDGs (poverty, education), however, it has lagged significantly in the healthcare goals with unacceptably high rates of maternal mortality, infant mortality, and undernutrition.

The health of the population of the country has a matter of

serious national concern. It has been rightly correlated with the overall development of the country. Therefore, a healthy population is a developmental goal by itself though it has also been considered to be a necessary ingredient for achieving the other wider goals of social and economic development. India's health system seems to be, currently, at cross roads with major changes occurring in the field of morbidity and mortality. Some of these changes are considered to be the consequent of demographic transition, which has been accompanied by changes in the age structure of the population; but most of these changes are due to the control of major communicable diseases. It may be noted that there have been significant changes in health conditions and the composition of the health sector independence, and this has brought about simultaneously major transformations in knowledge and technology, as well as in the political and economic environment.

On the flip side of all these developments, it should also be noted that the health care facilities have been in poor condition in rural areas. India has been spending the lowest percentage of its GDP on health in the world. Many health schemes have been started in India to improve health of people since independence. According to the National Health Profile, India has only 0.9 beds per 1000 population and out of which only 30 percent are in rural areas. India has a long way to go in its health care facilities as compared to the world. India has a shortage of hospitals, particularly in rural areas and many existing healthcare facilities lack basic equipment and resources. The ensuing paper focus on the performance of Rastriya Swastha Bima Yojana, the latest scheme that was launched by the government in the year 2008 and covers the Prayagraj district.

Keywords: MDG, SGD, GDP, RSBY, HIV/ AIDS, NMEP.

India, it be stated that is presently experiencing a state of transition in terms of economics, demography and epidemiology which is health. While the last decade has witnessed a remarkable economic growth particularly in terms of gross domestic product (GDP) growth rate), however, this progress has also been accentuated the growing disparities between the rich and the poor. Widening of the gap between the rich and the poor has a dual effect viz. it has a damaging effect on the health and social aspects of the people in the lower segments. While financial inclusion and social security measures are being

implemented by the Government to tide over these economic inequalities; health sector also needs relevant interventions that also adequately addresses the health disparities between and among social and economic classes.

In the last decade, the country has witnessed also unprecedented demographic changes underway that are likely to contribute substantially to enhance the labor force. However, it could benefit the country only if the population becomes healthy. In the current scenario, the country is suffering from the multiple burden of disease — the unfinished agenda of infectious diseases; the challenge of noncommunicable diseases (NCDs) which is closely linked with lifestyle changes; and emergence of new kind of pathogens causing epidemics and pandemics. Further, the health infrastructure is already over-stretched and, therefore, needs to be strengthened to enable it forcefully confront these challenges of the twenty-first century.

However, on the positive side, India has succeeded in overcoming many health indicators like the lowering of mortality and a steady increase in life expectancy since independence. It may be recalled that the Life expectation at birth was estimated at 36.7 years in 1951; by 1981 the figure stood at 54 years, and in the year 2000 it stood at 64.6 years Similarly, the infant mortality rate (IMR) also fell from 146 per 1,000 in 1951, to 70 per 1,000 half a century later, although the decline in infant mortality slowed or stagnated during the decades of 1990s (Visaria, 2004). Similarly, many diseases, such as polio, guinea worm disease, yaws, and tetanus, have been fully eradicated.

Further, the disappointing aspect of these development is that unfortunately, the gains of social interventions have not been equally distributed across regions, and along lines of caste and social status. It could also be seen that the trend of declining mortality in modern India coexists with persistently high levels of ill-health and disability. The recent National Family Health Survey shows that about 46 percent of children under three were underweight, and that only about 44 percent of children were fully immunized (The Hindu, 2007b). India also has been the victim of possessing the highest number of tuberculosis cases, the largest number of people suffering from HIV/AIDS, in the world (Visaria, 2004). At the same time, 'first world' illnesses—hypertension, cardio-vascular disease, cancers—are increasing rapidly (The Hindu, 2007b; Visaria, 2004).

Talking about epidemiological transition, which is, in fact, being largely governed by the social and economic determinants of health and also by some old and some new risk factors such as globalization, unplanned and unregulated urbanization, changing life styles,

environmental causes (e.g., climate change and air pollution), and increasing influence of media and advertising. Further, the rising disparities between the rich and poor and also those living in urban and rural areas has greatly affected their access to health services. For example, the poorest of the poor and the most marginalized sections of the society were not only at a greater risk for communicable and NCDs, but were thoroughly ill equipped to cope with the diseases resulting from these risk factors. If someone in the family got sick, the family was often got trapped in the vicious circle of poverty, partly due to the high cost of health care. The health-care system was often found napping. All these factors have over stretched the health care system to its hilt.

Over the years, particularly after the independence, the healthcare sector has become one of India's largest sectors, both in terms of revenue and employment. Healthcare comprises hospitals, medical devices, clinical trials, outsourcing, telemedicine, medical tourism, health insurance and medical equipment. It may also be noted that the Indian healthcare sector has been growing at a brisk pace due to its strengthening coverage, services, and increasing expenditure by public as well as private players. India's healthcare delivery system is categorized into two major components - public and private. The government, i.e., the public healthcare system, comprises limited secondary and tertiary care institutions in key cities and focuses on providing basic healthcare facilities in the form of Primary Healthcare Centers (PHCs) in rural areas. The private sector provides the majority of secondary, tertiary, and quaternary care institutions with a major concentration being in the metros, tier-I, and tier-II cities.

Relevance of Health Sector

The relevance of health sector in the context of India cannot be over emphasized. Rapid and sustained growth over the last few years has created large employment opportunities. A report by KPMG and FICCI has clearly shown that the healthcare sector has become the fifth largest employer in the year 2015, employing 4.7 million people directly. The NSDC estimates that the health sector will be able to directly employ around 7.5 million people by 2022, adding approximately 2.7 million new jobs between 2017-22 — over 500,000 new jobs per year! Beyond the direct impact on jobs and economic growth, the healthcare sector's employment patterns also have additional multiplier effects and distributional benefits. First, the health sector can boost India's female labour force participation since it employs a large number of women. In fact, the final report of WHO's High-Level Commission on Health Employment and Economic Growth

(2016) specifically highlights the employment potential of the health sector for women.3 Second, the health sector also generates additional jobs and economic activity indirectly i.e., in the non-health sector. The same report by WHO suggests that each dollar spent in the health sector results in an additional USD 0.77 contribution to economic growth as a result of indirect and induced effects.3 These effects include establishing infrastructure and facilities, purchasing equipment as well as building skills through education and training which, in turn, translate into direct manufacturing and services outputs, leading to more jobs.

Healthcare, in recent years, has also become one of the largest sectors of the Indian economy, in terms of both revenue and employment. It has been growing at a CAGR of 22 percent since 2016 and estimated to be employing about 4.7 million people directly. The sector has the potential to generate 2.7 million additional jobs in India between 2017-22, which works out to be over 500,000 new jobs per year. Several factors are cited to have given impetus to the growth of the Indian healthcare sector that includes an aging population, a growing middle class, the rising proportion of lifestyle diseases, an increased emphasis on public-private partnerships as well as accelerated adoption of digital technologies which includes telemedicine. In addition, the heightened interest from investors and increased FDI inflows over the last two decades.

Despite these potentials that this sector offers, it is unfortunate to see that the health care facilities are in poor condition, particularly, in the rural areas. India, over the period of time, has also been spending one of the lowest percentage of its GDP on health in the world. Though many health schemes have been started in India to improve health of people since independence. Still, India has a long way to go in its health care facilities as compared to the world. India has a shortage of hospitals, particularly in rural areas, and many existing healthcare facilities lack basic equipment and resources. According to the National Health Profile estimates, the country has only 0.9 beds per 1000 population and out of which only 30 percent were in the rural areas!

Genisis and Growth of Health Sector

It is quite surprising to see that the rulers of the country were quite sensitive to the health elated issues of the masses and it is erroneous to assume that the structured health policy making and health planning in India was a post-independence phenomenon. In fact, the most comprehensive health policy and plan document ever prepared in India was on the eve of Independence in 1946, before

independence. This was the 'Health Survey and Development Committee Report which is also popularly referred to as the Bhore Committee. It prepared the most comprehensive and a detailed plan of a National Health Service for the country, which would intend to provide a universal coverage to the entire population, free of charges, through a comprehensive state-run salaried health service. However, the health services in India today are as inadequate and underdeveloped as they were during the time of the Bhore Committee, is altogether a different proposition.

Thus, the modern medicine and health care were introduced in India during the colonial period; however, this period also saw the gradual destruction of pre-capitalist modes of production in India. Under pre-capitalist mode of production institutionalized forms of health care delivery, as it is seen today was not existent. The practitioners, who were not formally trained professionals but were the inheritors of a caste-based occupational system, provided health care within one's homes. However, this did not mean that there was no attempt of evolving a formal system. Charaka and Sushruta Samhitas, among other texts, are the living evidence to show that the country also had a system of medicine. Universities like Takshashila, Nalanda and Kashi also provided formal training in Indian medicine (Jaggi, 1979: XIII, 1-3). However, the little evidence that exists also shows that such structured medicine infrastructure existed mostly in towns and particularly around the courts of the rulers; and in the countryside those personnel who operated were called the healers of what in the modern context is understood as 'folk medicine'. With the end of colonial rule in India the population of the country expected a radical transformation of the exploitative social structure that the British rule had nurtured and consolidated. But these expectations were belied, as the new rulers were mere indigenous substitutes of the colonial masters.

Performance During Five Year Plans

It may be recalled that the unfortunately, the country did not any formal health policy even after decades of political independence. However, in 1983 that India adopted a formal or official National Health Policy, though prior to it the health activities of the state were formulated through the Five-Year Plans and the recommendations of various Committees and sub committees. For the Five Year Plans the health sector generally contained those schemes that had targets to be fulfilled. Each plan period had a number of schemes and every subsequent plan added more and dropped a few. In the fifties and sixties, the entire focus of the health sector in India was primarily to manage epidemics. Mass campaigns were started to eradicate the various

diseases. These separate countrywide campaigns with a technocentric approach were launched particularly against malaria, smallpox, tuberculosis, leprosy, filaria, trachoma and cholera. Cadres after cadres of the workers were trained in each of the vertical programmes. The National Malaria Eradication Programme (NMEP) alone required the training of 150,000 workers spread over in 400 units in the prevention and curative aspects of malaria control (Banerji, 1985).

Incidentally, the First Two Five Year Plans laid out the basic structural framework of the public health care delivery system remained unchanged. However, the urban areas continued to get over three-fourth of the medical care resources whereas rural areas received “special attention” only under the Community Development Program (CDP). The history stands testimony to what this special attention meant. However, the CDP was failing even before the beginning of the Second Five Year Plan. The government’s own evaluation reports confessed this failure. The Third Five Year Plan discussed the problems affecting the provision of PHCs, and directed attention to the shortage of health personnel, delays in the construction of PHCs, buildings and staff quarters and inadequate training facilities for the different categories of staff required in the rural areas. (FYP III, 657). The Third Five Year Plan also highlighted inadequacy of health care institutions, doctors and other personnel in rural areas as being the major shortcomings at the end of the second Five Year Plan (Ibid, 652). The Fourth Plan, which was primarily a three-year plan holiday, continued on the same line of third plan and was theoretically based on the socialist pattern of society (FYP IV, 1969: 1-4) however, its policy decisions and plans did not adequately reflect socialism. It was in the Fifth Plan that the government ruefully acknowledged that despite making conspicuous advances in terms of infant mortality rate going down, life expectancy going up, the number of medical institutions, functionaries, beds, health facilities etc., were still inadequate in the rural areas. The Sixth Plan, to a great extent, was influenced by the Alma Ata declaration of ‘Health for All’ by 2000 AD (WHO, 1978) and the ICSSR - ICMR report (1980). The plan confessed that there was a serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which was also being availed mostly by the well to do classes. It was also realized that it is this model which was, primarily, depriving the rural areas and the poor people of the benefits of good health and medical services. The Seventh Five-Year Plan solely focused on providing primary health care and medical services to all with special consideration of vulnerable groups and those who were living in the tribal, hilly and remote rural areas so

as to achieve the Goal of Health for All (HFA) by 2000 A.D. The plan also laid emphasis on the community participation, inter sectoral co-ordination and co-operation. The plan gave priority to the health services in the rural areas, medical education, control of emerging health problems along with the provision of safe drinking water supply and sanitation and integration of Indian system of medicine. However, the plan allocation allocated was only 1.9 percent for health and 1.8 percent for family welfare. The main thrust of Eighth Plan was to strengthen the infrastructure and medical services accessible to tribal, hilly, remote rural areas etc. It could be called to be an extension of the previous plan. Likewise, the Ninth Plan, though was started late political reasons, but maintained the same vision and worked to strengthen the basic infrastructure to provide the primary health services to all those living in the remote and hill areas. The Ninth Plan took forward the recommendations of the eighth plan for setting up of public health system; it also recommended set up of district level a strong detection come response system at the district level for rapid containment of any outbreaks that may occur. besides strengthening the basic infrastructure also focused on growth with social justice and equality. However, it failed to achieve the targeted growth of 6.5 percent. The Tenth Plan besides aiming on reducing the poverty through income and employment generating programmes, also focused on increasing the literacy rate to 75 percent within the plan period. On the health front the thrust of the plan was to improve the health parameters - birth rate, death rate, infant mortality rate and maternal mortality rate and reduce the gap between the State and national averages. The role of health sector in economic development got increasing attention in recent years. It was unanimously accepted that economic growth was not merely a function of incremental capital-output ratio; investment in man was also the priority areas. The eleventh plan, therefore, enhanced allocation for education, imparting skills and health care. All these activities were believed to be promoting the concept of inclusive growth thus became the focal theme of the Eleventh Five-Year Plan. The Plan document presented a well-conceived, comprehensive programme for the sector. Special attention was also focused to promote these activities in the rural areas through the National Rural Health Mission (NRHM). Eleventh Five Year Plan was launched at a time when the country's economy was growing at 7-9 percent per annum, thereby, making India one of the fastest growing economies in the world. Unfortunately, the benefits of the growth and development failed to reach a vast majority of our population. Taking cognizance of this fact, the broad objective of the Eleventh Five Year Plan was to achieve good health for people, especially the poor and the

underprivileged. In order to achieve this, the plan proposed to adopt a comprehensive approach that encompassed individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene and feeding practices. The plan also aimed to facilitate convergence and development of public health systems and services that are responsive to health needs and aspirations of people and subsequently laid emphasis on reducing disparities in health across regions and communities by ensuring access to affordable health care. The Twelfth- Five-Year Plan also focused on promoting faster growth that also promotes inclusion and remains sustainable. Besides this it also aimed to reduce poverty by 10 percent to enable the agriculture sector to grow at 4 percent and the manufacturing at percent. The Twelfth Plan took up the observations made in the eleventh plan that allocation to health sector was weak and that was being reflected on the health outcomes. It, therefore, expressed the necessity of allocating additional resources to health and laid down monitorable targets for parameters relating to Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR), institutionalized delivery, extent of full immunization, etc. It was also observed that in the eleventh plan, the total public expenditure on health in India by Centre and the States had been less than 1.0 per cent of GDP which was needed to be enhanced to 2.0 or 3.0 per cent. The plan also believed that the financial resources were not the only constraint it was the shortage of health professionals at all levels that had become a serious impediment to achieving an expansion in the public provision of health services.

According to the World Health Statistics (2014), this contribution by the public sector to the total expenditure on health by India has been quite low as compared to other developing countries like Brazil (46 percent), China (56 percent), and Indonesia (39 percent). Even when compared with other developed countries, the public spending on healthcare in United Kingdom and United States of America is 83 percent and 48 percent respectively. India also seems to be spending one of the lowest amounts (USD 23) in terms of per capita public health expenditure, in comparison to the other developing countries like Indonesia (USD 38), Sri Lanka (USD 71), and Thailand (USD 177).

According to one estimate about 65 percent of the health expenditure is borne by consumers in India. Household health expenditures are those expenditures that are borne out by the households on health care and includes out of pocket expenditures and prepayments (for example, insurance). Thus, out of pocket expenditure are the payments made directly by individuals at the point of service where the entire cost of the health good or service is not

Table 1: Five Year Plan Allocation to Health Sector
(Rs. in Crores)

Period	Total Plan Innvestment Outlay	Health Sector	Family Welfare	Ayush	Total
First Plan (1951-56)	1960	65.2 (3.3)	0.1 (0.1)	-	65.3 (3.4)
Second Plan (1956-61)	4672.0	140.8 (3.0)	5.0 (0.1)	-	145.8 (3.1)
Third Plan (1961-66)	8576.5	225.9 (2.6)	24.9 (0.3)	-	250.8 (2.9)
Annual Plans (1966-69)	6625.4	140.2 (2.1)	70.4 (1.1)	-	210.6 (3.2)
Fourth Plan (1969-74)	15778.8	335.5 (2.1)	278.0 (1.8)	-	278.0 (1.8)
Fifth Plan (1974-79)	39426.2	760.8 (1.9)	491.8 (1.2)	-	1252.6 (3.1)
Annual Plan (1979 – 80)	12176.5	223.1 (1.8)	118.5 (1.0)	-	341.6 (2.8)
Sixth Plan (1980-85)	109291.7	2025.2 (1.8)	1387.0 (1.3)	-	3412.2 (3.1)
Seventh Plan (1985-90)	218729.6	3688.6 (1.7)	3120.8 (1.4)	-	6809.4 (3.1)
Annual Plan (1990-91)	61518.1	960.9 (1.6)	784.9 (1.3)	-	1745.8 (2.9)
Annual Plan (1991-92)	65855.8	1042.2 (1.6)	856.6 (1.3)	-	1898.8 (2.9)
Eighth Plan (1992-97)	434100.0	7494.2 (1.7)	6500.0 (1.5)	108.0 (0.02)	14102.2 (3.2)
Ninth Plan (1997-02)	859200.0	19818.4 (2.31)	15120.2 (1.76)	266.35 (0.03)	35204.95 (4.09)
Tenth Plan	1484131.3	31020.3	27125.0	775.0	58920.3

Source: National Health Profile, 2005
Planning Commission of India.

Table 2: Public Health Expenditure in Various Other Countries (2015)

Country	Public Health Expenditure (% of GDP)
India	1.1
China	3.2
S. Africa	4.4
Brazil	3.8
Russia	3.4
United States	8.5
United Kingdom	7.9
Germany	9.4

Source: Public health expenditure (% of GDP), World Health Organization, 2015; PRS.

covered under any financial protection scheme. In India, such expenditure is typically financed by household revenues (69 percent). Hardly, nine countries (out of 192) have a higher out of pocket spending as a proportion of total healthcare expenditure!

Thus, it becomes quite clear that as India prepares to step out in the new world and take up the new challenges and responsibilities that the health sector, offers, it also requires the adequate amount of finance to accept them. The new social interventions in the health sector primarily explores the opportunities and avenues through private-public participation (PPP) models and other alike. This would also make the public more accountable to the programme.

Rastriya Swasthya Bima Yojana (RSBY)

Interventions in the field of health sector in India has not been a new event. In fact, its roots could be traced down to pre-Independence days when colonial rule was in vogue. However, the abysmal performance and condition of the sector, partly because of colonial rulers, made the government concern and they a number of committees constituted committees to look into the problem and suggest streamline its functioning and corrective measure to improve the performance of health sector. Bhure Lal committee in 1946, Murlidahar Committee in 1962, Chadha Committee in 1963, Mukerjee Committee in 1965, Jungalwalla committee in 1967, Kartar Singh Committee 1973,

Srivastava Committee in 1975, Bajaj Committee in 1986, to name some are the living testaments to show how serious the government was to set the working of the health sector in correct perspectives. Based on the findings and suggestions of these reports helped the government to form an important base of health planning in India and also to achieve the goals of National Health Planning in India declared in the document Health for All by the year 2000.

It may be reiterated that the first comprehensive health policy and plan document, Health Survey and Development Committee Report, i.e., Bhore Committee Report, was prepared in 1946, which comprehensively laid out the plan for National Health Service focusing on the universal coverage. However, prior to Bhore Committee, the government had also constituted Sokhey Committee (established in 1938), whose report was released in 1948. The recommendations of both committees concurred on many issues. However, the health disparity and coverage of health services still remained grave. It was not until 1983 when the first health policy was formulated and adopted. However, before 1983 the government schemes that were operational in the different five year plans had specific targets. For instance, the programmes in the 1950s and the 1960s focused on managing the epidemic and to achieve that widespread national-level campaigns were organized to overcome the loss by malaria, smallpox, tuberculosis, leprosy, filaria, cholera and others. It was based on techno-centric approach whereby the health workers were trained to prevent and control disease spread. International experts and ideologies influenced the mission. The necessary chemicals, medicines and vaccines were provided by the international agencies and the role of social and economic conditions, environment, diet, nutrition, housing and clothing was ignored.

Unfortunately, the structure of public healthcare delivery system more or less remained unchanged in first two Five Year Plans and urban areas received the major share of resources. The Murlidhar Committee was set up in 1959 to evaluate the progress made in the first two plans and provide recommendations. The committee highlighted the achievements of the plans particularly in the areas of controlling disease-specific deaths, improvements in life expectancy and reduction in death rate it also brought forth the issues of availability and accessibility to healthcare services whereby the primary health centres (PHC) were understaffed and ill-equipped, the health practitioners were less in number and asserted that there was an urgent need to improve healthcare facilities. The third, fourth and fifth plan were primarily the extensions of the previous plans with minor modifications in the delivery mechanism.

The Sixth Five Year Plan was influenced by the international declaration 'Health for all by 2000 AD' and ICSSR and ICMR report of 1980. The plan emphasized the development of a community-based health system and horizontal and vertical linkages had to be established among all the interrelated programmes, like water supply, environmental sanitation, hygiene, nutrition, education, family planning and MCH. However, these programmes failed to make any significant impact on the field and promote the concept of inclusiveness. Many radical measures were suggested by Sixth and also in the Seventh plan but the action taken was minimal. Privatization became an overarching characteristic in the 1980–90s. Finally, in the year 1983, the first National Health Policy (NHP) was announced. It aimed to achieve the goal of universal health care that is affordable and as per the needs of the people. Emphasis was laid on preventive, promotive and rehabilitative primary health care; decentralization and community participation and increased role of private investors. In the Eighth Five-Year Plan, the country was embroiled in the massive economic crisis that pushed forward the plan by two years. However, no new fresh thinking went into this plan. It continued the support the private initiatives in the field. It was in the nineth five year plan that efforts were made to strategize on achievements hitherto and learn from them in order to move forward. It brought forth many new initiatives that included consolidation of PHCs and SCs and an assurance that the requirements for its proper functioning would be made a priority the Basic Minimum Services Program. It was on the eve of the tenth plan, the draft National Health Policy 2001 was announced and for the, first time, feedback was also invited from the public. The draft on national health policy was path breaking effort on government's part where it was not only bent on regulating the private health sector through statutory licensing and monitoring of minimum standards by creating a regulatory mechanism but also on controlling the influence of foreign international agencies.

Strengthening of Rural Healthcare Services

Since public health and hospitals segment has been a state subject, the primary responsibility of strengthening public healthcare system, including for provision of quality healthcare and advanced treatment and diagnostic facilities, lies with the respective State Governments. However, the Ministry of Health and Family Welfare, on her behalf, provides technical and financial support to the States/UTs to strengthen the public healthcare delivery at public healthcare facilities. Under the National Health Mission (NHM), financial and technical support is provided to States/UTs to strengthen their health care systems

including setting-up/upgrading public health facilities and augmenting health human resource on contractual basis for providing equitable, affordable and quality healthcare with modern treatment methods and diagnostic facilities in the public healthcare facilities of the country, including the rural areas, based on the requirements posed by the States in their Programme Implementation Plans (PIPs). Further, NHM also supports range of free services related to maternal health, child health, adolescent health, family planning, universal immunization programme, and for major diseases such as tuberculosis, vector borne diseases like Malaria, Dengue and Kala Azar, Leprosy etc. The other major initiatives undertaken by NHM included the launching of Janani Shishu Suraksha Karyakram (JSSK) (under which free drugs, free diagnostics, free blood and diet, free transport from home to institution, between facilities in case of a referral and drop back home is provided), Rashtriya Bal Swasthya Karyakram (RBSK) (which provides newborn and child health screening and early interventions services free of cost for birth defects, diseases, deficiencies and developmental delays to improve the quality of survival), implementation of Free Drugs and Free Diagnostics Service Initiatives, PM National Dialysis Programme and implementation of National Quality Assurance Framework in all public health facilities including in rural areas. In addition, Mobile Medical Units (MMUs) & Tele-consultation services are also being implemented to improve access to healthcare particularly in rural areas. Thus, in its 15 years of implementation, the NHM has enabled to achieve most of the Millennium Development Goals (MDGs) for health. This has also led to a significant improvement in maternal, new-born, and child health indicators, particularly for maternal mortality ratio, infant and under five mortality rates, wherein the rates of decline in India are much higher than the global averages and these declines have accelerated during the period of implementation of NHM.

However, it was also observed that in the Indian economy, the workers in the unorganized sector constituted about 93percent of the total work force in the country. These labours primarily come from the rural areas to the urban areas in search for jobs and other menial works. On account of their poor vocational skills, they get absorbed in the urban areas un organized sectors. The Government has been implementing some social security measures for certain occupational groups but their coverage is miniscule. Majority of the workers were still without any social security coverage and one of the major insecurities for workers in the unorganized sector was the frequent incidences of illness and need for medical care and hospitalization of such workers and their family members. Despite the expansion in the health facilities, illness remained one of the most prevalent causes of

human deprivation for them. Thus, it was recognized that the health insurance was one way of safe ways of providing protection to poor households against the risk of health spending that invariably led to their poverty. The poor were unable or unwilling to take up health insurance because of its cost, or lack of perceived benefits. Organizing and administering health insurance, especially in rural areas, is also difficult. Recognizing the need for providing social security to these workers, the Central Government, subsequently, introduced the Rastriya Swasthya Bima Yojana (RSBY). Till March 25, 2013, the scheme had 34,285,737 Smart Cards and 5,097,128 hospitalization cases.

The Genisis of RSBY

In the past also the Government had 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. Among the factors that inflicted the scheme were either related to their designing or with their implementation. Hence, keeping these limitations in the background, 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 to provides a world class model. A critical review of the existing and earlier health insurance schemes was also done with the objective of learning from their good practices as well as to 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, RSBY was designed. The scheme was launched on 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. It is eligible to the unorganized sector workers belonging to BPL category and their family members (a family unit of five) and shall be the beneficiaries under the scheme. It will be the responsibility of the implementing agencies to verify the eligibility of the unorganized sector workers and his family members who are proposed to be benefited under the scheme. The beneficiaries will be issued smart cards for the purpose of identification.

The beneficiary shall be eligible for such in - patient health care insurance benefits as would be designed by the respective State Governments based on the requirement of the people/ geographical area. However, the State Governments were advised to incorporate at least the following minimum benefits in the package / scheme:

(a) The unorganized sector worker and his family (unit of five) will be covered.

(b) Total sum insured would be Rs. 30,000/- per family per annum on a family floater basis.

(c) Cashless attendance to all covered ailments

(d) Hospitalization expenses, taking care of most common illnesses with as few exclusions as possible

(e) All pre-existing diseases to be covered

(f) Transportation costs (actual with maximum limit of Rs. 100 per visit) within an overall limit of Rs. 1000.

Since RSBY is the latest and most comprehensible scheme ever launched by the Government of India under National Health Mission Programme after critically evaluating the performance of earlier health related programmes and addressing their limitations. However, it has been applicable to only those set of beneficiaries who have been enrolled under the programme or are their card holders.

Objectives

Rastriya Swasthya Bima Yogana has now been in operation for about twenty- three years, it is time to have a look of what has been its performance so far and whether it has succeeded to achieve its objectives? Since the scheme is operational only to the BPL members who are its card holders, the ensuing exercise attempts to see to what extent it has been able to improve or enhance the quality of life of their members. Broadly speaking the study aims at the following objectives:

(a) Whether the people are aware about the benefits of the scheme in general?

(b) Whether the scheme has succeeded in lowering the medical expenses of the people and lowered the incidence of morbidity.

(c) The extent to which it the females have benefitted from the scheme and promoted gender parity.

(d) Identify the factors that have been restricting the people from participating in the scheme.

(e) Suggest appropriate strategy for better utilization of the scheme.

Methodology

The study has been carried out in the city of Allahabad which is now called as Prayagraj which falls in the state of Uttar Pradesh.

According to the latest selected health statistics released by Niti Ayog, 2023, Uttar Pradesh figures at the bottom of the hierarchy along with Bihar on the basis of the performance (Annexure One). Out of twenty development blocks, the study was carried out in four development blocks randomly selected out of which two were from the trans Ganga and the remaining two from the trans Yamuna region.

Besides deploying structured questionnaire to collect information from the households on the different aspects of the health and health care that the programme was offering, direct observation method was also used to collect and collate and enrich the information collected. The study also conducted focus group discussion and personal interview to have a deeper look into the working of the programme and also the household's perception about the programme. However, prior to final data collection, pre testing of the tools was also conducted in the nearby region carrying similar features of the sample area.

Sample of the Study

As has been stated earlier also that RSBY covers only the card holders and therefore to study the performance of the scheme, it was decided that the sample would be classified into two groups- the first would be those set of households who are enrolled in the scheme or the card holders and hence forth called the experimental group while the other one would consist of households other set of households hence forth called the control group. The selection of the beneficiaries in both the groups was done on the random basis.

Prayagraj district, incidentally, is bifurcated by two rivers namely the Ganges and the Yamuna; dividing the region, broadly into three distinct parts viz. the trans Ganga, trans Yamuna and the doab area. Accordingly, the blocks of the districts are also spread out in these regions.

Selection of the Sample Blocks

The selection of the blocks for the study was done by using stratified random sampling method where all the blocks were listed first into these regions and two blocks one containing the highest enrollment and the other the lowest enrollment of the beneficiaries was made. In view of the time and resource constraint, a total of four blocks was selected for the study and the two regions figured prominently were the trans Ganga and the trans Yamuna. From these blocks, three villages were randomly selected using the same criteria of high and low enrollment of households. Further, from these villages a set of twenty households was selected. Thus, the total sample contained 240

households from the experimental group. However, for comparison, sixty-eight households from the controlled group were also selected randomly for cross sectional comparison. The lower number of the non -card holders was largely because the villages had lesser amount of them. A brief outline of the sampling has been summarized below:

Table 3: Lay Out of the Sample Design

Levels	Particulars	Sample Size
State	Uttar Pradesh	01
District	Prayagraj	01
Blocks:		
Trans Ganga	Bahadurpur & Phulpur	2 } 04
Trans Yamuna	Shankargarh & Chaka	2
Villages	Three from each block	04 x 3 = 12
BPL households	Card Holders }	20 x 12 = 240
	Non -Card Holders	68

Thus, the sample for the study covered a total of 240 households of which 172 were from the experimental group and the remaining 68 were from the control group. The detail break-up of the sample households has also been summarized below:

Table 4: Distribution of Sample Households

Sl.No	Blocks	Control Group	Experimental Group	Total
1	Bahadurpur	43	17	60
2	Phulpur	43	17	60
3	Shankargarh	43	17	60
4	Chaka	43	17	60
Total	Four	172	68	240

Source: Field Survey, 2018

Objectives of the Study

The ensuing study attempts to evaluate the overall performance of Rastriya Swasthya Bima Yojana that has been operational in Prayagraj. In other words, it would examine the following:

(1) To study the to what extent the scheme RSBY has been able to address the issue of gender parity.

(2) What has been the pattern of utilization of the scheme by the stake holders.

(3) To identify the factors influencing the stakeholders to buy the scheme.

(4) To what extent the scheme has been able to change the perception of the respondents regarding the scheme.

(5) To suggest appropriate measure for forceful enforcement of the scheme.

Hypothesis Used

The following hypothesis has been tested during the course of the study:

(1) H_0 : There is no difference in the perception level of the households belonging to control group towards their enrollment in the scheme.

(2) H_0 : There has been no perceptible change among the respondents towards seeking of illegal health loans.

(3) H_0 : There is no difference in the perception of male and females towards the scheme.

(4) H_0 : The is no difference in the pattern of utilization of health expenses between control group and experimental group households.

Tools Used

The study uses Chi-Square Test for hypothesis testing. The basic idea behind the test is to compare the observed values in your data to the expected values that you would see if the null hypothesis is true. The two groups on which the test would be applied would be controlled group and the experimental group. The controlled group would be the respondents having card of the scheme while the experimental scheme would be no card holders. The results of the chi square test would be compared with the table value of chi square to make assessment regarding the significance of the association between the two set of householders.

The following formula will be used for chi-square test:

$$\chi 2 = \sum \frac{(O - E)2}{E}$$

The $\chi 2$ value is compared with the table value to ascertain whether the difference between observed and expected value is significant or at 5 % level of probability at a particular degree of freedom (df).

where, O: Observed value

E: Expected value

df: (c-1)(r-1)

Result and Discussion

The analysis of the field data has been attempted on several fronts. In the first case, the perception of the households based on gender and their status (card holders or non- card holders) has been attempted.

(A): Analysis of Households perception towards buying of Micro-Insurance Schemes

The study of the sample households towards buying the buying the micro-insurance scheme has been analyzed. The chi square (÷ ²) test has been used to evaluate a relationship between two categorical variables. Accordingly, the households have been classified, broadly, into two categories experimental group and controlled groups. While the controlled group households were those have been the card holders of the scheme and the experimental group of households were those who have not bought the scheme. The Chi -square test has been applied on both set of data. The analysis shows that in the experimental group, it was the females whose number was far mote than that of the males (Table 5).

Table 5: Perception of the Households towards buying of Micro-Health Insurance

Category	Micro Health Insurance	Male	Female	$\chi 2$	df	Status
Control Group	Yes	6	10	19.7	1	Significance
	No	27	25			
	Total	33	35			
Experimental Group	Yes	47	37	8.3	1	Significant
	No	30	58			
	Total	77	95			

Source: Field Survey, 20018

The analysis is attempted at the two levels. In the first level, the comparison of control group of house-holds i.e those set of households who have not taken the health card has been attempted. The calculated value of ÷ ² (19.7) was found to be much higher than the table value and therefore the difference between the male and female was found to be significant at 5 percent level at one degree of freedom. The analysis, thus, rejected the null hypothesis and it justifies that the perception of females towards buying of micro-insurance was significantly lower than that of the males. Likewise, in the case of experimental group, the value of $\chi 2$ was worked to be 8.3, which was also found to be statistically significant at 5 % level of probability at one degree of freedom. The analysis of the sample households, thus, clearly shows that the perception of females, towards buying the health card, both in experimental or control group was much lower than that of their male

counterparts. All this rejects the first hypothesis which claims parity between male and female perceptions. Among the probable reason of the women not going for micro health insurance was largely because majority of them have not been able to utilize the services under the scheme in times of emergencies or when it was needed most. Some of the households expressed their inhibitions about the scheme's relevance and also its effectiveness this was largely because the alleged that the government officials, often, did not disclose the full features of the scheme and how this could prove to be beneficial for them. The execution of the scheme, according to the households was quite ritualistic and lacked the passion needed to make the scheme successful. Even the distribution of card to the householder was marked with inconsistencies as some of them got it on the spot while others were told to wait as it would be sent to them via post to their respective addresses.

(B): Utilization Pattern of Health Expenses between Control Group and Experimental group households

One of the guiding forces of the micro-health scheme was that it would prevent the sample households from the clutches of money shark who charged exorbitantly and pushed them into the vicious cycles of poverty. The perception of the households was classified into three broad categories as low, moderate and high. The low perception entailed when the household did not have full information about the scheme and recalled only the following three features viz. about registration fee, overall expenses covered and health benefit extend to the number of family members; the moderate perception households besides knowing these three features also knew that it was the government scheme and the card given to them needs to be renewed every year. The high perception was identified to those set of households who also knew the transport facility being offered under the scheme, hospitalization facility could be availed in any of the empaneled government or private hospitals and after the discharge of the patient, the medicines to be provided free for five days (Table 6).

Table 6: Perception of Households towards Micro-Insurance Scheme

Categories	Experimental Group	Control Group	χ^2	df	Status
Low	16	3	5.00	2	Insignificant
Moderate	131	47			
High	25	18			
Total	172	68			

Source: Field Survey, 2018

The comparative analysis of the data between the experimental and control group of households shows that the difference between the two was found to be statistically insignificant as the value of χ^2 was observed to be 5 which was higher than the table value 5.99 at 5 % percent of significance at 2 degrees of freedom. It may be recalled that one of the primary aims of the micro-health scheme was also to discourage the household to avail the loan from private money sharks to meet out their medical expenses. These shark charges to households the interest about 10 percent per month! However, the unavailability of the micro-insurance scheme to cut through all section of the society enabled the sharks to have a firm hold on the sample area. Another factor that goes in favours the sharks was their presence and making the loan available without collectorate. Thus, the study upholds the second null hypothesis that the scheme has not be able to bring about any significant change in the health expenses of the beneficiaries.

(C): Pattern of Awareness of the Households towards Micro-Insurance Scheme

As has been already stated earlier that micro-insurance health has now been operative for more than two decades. It is a high time to assess and evaluate the whether the scheme has succeeded to any kind of significant impact on the perception of the households in general and the beneficiaries or the card holders figuring in the control group. The perception level of the beneficiaries has been classified into three categories as low, medium and high. The perception of the households was classified into three broad categories as low, moderate and high. The low perception entailed when the household did not have full information about the scheme and recalled only the following three features viz. about registration fee, overall expenses covered and health benefit extend to the number of family members; the moderate perception households besides knowing these three features also knew that it was the government scheme and the card given to them needs to be renewed every year. The high perception was identified to those set of households who also knew the transport facility being offered under the scheme, hospitalization facility could be availed in any of the empaneled government or private hospitals and after the discharge of the patient, the medicines to be provided free for five days. The analysis thus rejects the hypothesis that awareness level plays no significant role in the (Table 7). The scale of awareness has been summarized in the annexure- 1.

Table7: Level of Awareness Level towards Micro Insurance Health Scheme

Category	Awareness Level	Male	Female	χ2	df	Status
Card Holders	Low	18	54	26.5	2	Significant
	Moderate	17	16			
	High	42	25			
	Total	77	95			

Source: Field Survey, 2018

The analysis was performed comparing the perception of male and female beneficiaries, using ÷2 test. Since, the calculated value of ÷2 was worked to be 26.5 which was much higher than the table value 5.99. Therefore, difference in the perception between male and female households was also found to be statistically significant at 5 % level of probability at 2 degrees of freedom. Thus, the study firmly rejects the null hypothesis and our first hypothesis. The study also shows that the perception level among the male beneficiary was higher than that of the female beneficiaries. Some of the plausible reasons for the females having low perception level towards the scheme could be their intensively busy schedule tending the household works which gives them very little time for themselves and outside world, lack of orientation programme organized for females was another reason and the officials only visited them on the day of enrollment, all this created a lot of confusion and suspicion on their mind. Since the officials did not organize any kind of follow-up programmes, the situation for females remained grim. What has really come up as a surprise was that even the community health workers like the ANMs who are females themselves also fail to take interest in the programme and worked on ritualistic pattern that failed to uplift the performance of the programme. Even the onset of new technology like digitization also worked in favour of the rich beneficiaries thereby creating a greater divide between the two groups.

(D): Pattern of Utilization of Health Insurance Scheme Among Male and Female Beneficiaries (Experimental Group)

One of the primary focus and objectives of the micro-health insurance scheme was to protect the experimental group beneficiaries was to mitigate or substantially reduce the expenses occurring on the health and protect them into going to the private money lenders. To what extent the scheme succeeded in its endeavour? How have the male and female beneficiaries have responded to this intervention? The ensuing exercise has been attempted to understand this

phenomenon. The impact of the scheme has been analyzed on the following three levels; viz. gender of the beneficiaries, awareness level and socio-economic factors. The analysis would enable us to understand and identify which of these factors have been more proactive and which of them have been docile. (Table 8)

Table 8: Role of Gender, Awareness level and Socio-Economic Factors on Utilization of Health Insurance Scheme

Category	Gender/ Awarness Level/ Socio-Economic Status	Not Utilized	Utilized	χ2	df	Status
Gender	Male	37	40	11.4	1	Significant
	Female	63	32			
	Total	100	72			
Awarness Level	Low	13	2	117.1	2	Significant
	Moderate	84	9			
	High	3	61			
	Total	100	72			
Socio-Economic Factors	Low	24	13	76.5	2	Significant
	Moderate	68	41			
	High	8	18			
	Total	199	72			

Source: Field Survey, 2018

The role of gender in the utilization of micro-health scheme shows that the proportion of female who were not able to utilize the cards was exceptionally high than that of the males. The value of the ÷2 test was worked out to be 11.54 which was much higher than that of its table value of 3.84. Thus, the difference was significant at 5% level of significance at one degree of freedom. The high level of non-utilization of card holders particularly among the female beneficiaries was largely on account of the lack of information about the empaneled hospitals, followed by non-renewal of the card that had also expired. Though both of these problems also affected the male segment, however it became particularly stressful for females because for every out-door activity they had to depend on the male counter-part.

The study of socio-economic status of the beneficiaries that it varied with their status as the incidence of non-utilization of the card was much higher among the low and moderate set of households and quite moderate among the high socio-economic status. The value of ÷2 was found to be 76.5 which was much higher than the table value of 5.99 at 5% level of significance at 2 degrees of freedom. Thus, it can be

stated that socio-economic status also has a strong bearing on the utilization or non-utilization of health card. The non utilization of health card is not only dependent on their low income but also on their low awareness levels which needs to be addressed through appropriate social interventions.

The third variable that affected the utilization of health card was the awareness level of the beneficiaries. The calculated value of ÷2 was found to be 117.1 which way above the table value of 5.99 at 5 % level of significance at 2 degrees of freedom. Thus, the analysis rejects the hypothesis awareness level of the beneficiaries plays no role in the utilization of health cards.

The study clearly shows that low utilization of health cards or the beneficiaries non enrollment in the micro-insurance scheme to a large extent is guided by their gender, awareness level and socio-economic status. Apart from this, the other factors that also inhibited the growth of scheme have been summarized below:

Self-Perception	Hesitancy to discuss health related issues with the doctors as they think they are illiterate.
	Think that they have fragmented social support.
	Think that get the same medicine for every kind of disease.
	Fear that they may get the wrong medicine as the doctors don't treat them well.
	Think that they lack opportunities for treatment.
Dependency	No household member accompanies them to health centres.
	No freedom given to make decision.
	Lack of sensitivity towards disease trust of other members.
	Lack financial independence.
	Lack of awareness about the hospitals.
	Delay in treatment often makes the treatment costly.
Structural Factors	Distance of the Hospitals.
	Low levels of transport facilities.
	Lack of female doctors.
	Long waiting hours for treatment
	No specific time of opening of health centres
	Non availability of doctors.
	Non availability of medicines
	No facility for performing emergency treatment
	Except gynecology, no other services are offered to treat other kind of diseases.

Conclusion

The study of Rastriya Swasthya Bima Yojana (RSBY) in the two sample blocks of Prayagraj district shows that its performance has not been up to mark and the scheme suffers from many socio-economic and other factors, some of them have been summarized below.

(a) Socio economic factors: the study shows that a good majority of the household's low status in terms of education, occupation, ownership of the house, poor sanitation and living conditions, problem of drinking water and assured electricity supply. All these factors have adversely impacted the life of the people differently. Diseases like malaria, lung infections, stomach related problem were rampant and scheme like RSBY could have been an ideal foil to address these multiple adversaries. However, poor awareness level on part of the households in general and females in particular hampered the progress of the programme.

(b) The poor network of disseminating the information from one place to another. The study found that the main source of providing the information about the programme was Pradhan who, on account of handling multiple tasks, often took up the job as a routine matter that lacked commitment. All this adversely affected the progress and spread of the programme to beneficiaries.

(c) The poor awareness level of beneficiaries in general and the female house hold members in particular, were most affected ones. It was also found that most of them were totally unaware of the running of the scheme in their area and the subsequent benefits it brought to them, were not known to them. All this also adversely affected the performance of the scheme and the female were the most hapless victims suffering the most. Often the beneficiaries were also unaware about the empaneled hospital where they could get treatment.

(d) The poor maintenance of the health centres in the area also sent wrong messages to the people in general. It was alleged by the experimental households that these centres most of the time did not have the basic medicines and were also located at far flung areas which annoyed the beneficiaries that their efforts to visit got wasted.

(e) The skeleton staff that these health center occupied also failed to induce the beneficiaries in general and the female in

particular. It was also reported by the beneficiaries that these centres did not have specialist and were being by some general practitioner on which they did not trust.

(f) What has been the most unfortunate of the scheme is that it has failed to bridge the divide between the upper and the lower cast. While the upper caste was able to move out to urban areas and avail the medical facilities, this was not the case with the poorer classes.

(g) The poor awareness level along with poor educational skills proved to be a deadly combination that failed to induce the beneficiaries in general and females in particular to adopt a positive outlook at the government's initiatives and come forward to participate in it.

Suggestions

It may be recalled that the primary aim of the scheme was to bring about substantial transformation in the health scenario among the sample households. However, on account of poor execution and regional factor, the scheme failed to take off. The study come up with several suggestion that would help to streamline its functioning and up lift the performance. Some of them have been presented below:

(a) The study shows that the awareness levels of the sample households belonging to the controlled group in general and the females was particularly low. If one adds the households of the controlled group, then the level of awareness would further dip. So, under these circumstances, launching the programme without sensitizing the sample households would be like putting the horse before the cart. The results show that no such exercise was undertaken so as to make the households aware of such a programme that intends to address their health and financial requirements. It is therefore, recommended that the programme functionaries be encouraged to should visit the sample areas regularly and on sustained basis to help the sample households to overcome their inhibitions and come forward to participate in the programme.

(b) The study also shows that the sample households' dependence on middle men was very high. These were the people who catered to every kind of needs of the sample households and come to their rescue even at odd hours. It must be reminded that the nexus of the sample households with the middle men has been cultivated and nurtured over the period of time and has also

heralded an unflinching trust and loyalty for each other, which may be difficult to dislodge unless the programme was executed on missionary mode. The focus should now be to provide an equally reliable and vibrant alternative to the sample households so that they can escape from the clutches of these vultures who exploit them ruthlessly.

(c) The analysis also shows that the females of the sample households have remained the most vulnerable not only in terms of their awareness level but also in terms of exercising their rights. The total indifferent attitude deployed by the male members towards their treatment is also appalling. It must be remembered that their role in managing the households' affairs is second to none, therefore, it becomes imperative that they be treated properly and special sensitizing programmes to be organized them where they be made aware of their rights and the development that was happening around them and how they can also avail the benefits to uplift their life. The welfare and development of the family can only take place when the females are also encouraged and groomed to take up some of the responsibilities.

(d) The study also shows that the sample area is infected with personnels who are working in the informal sector and provide miscellaneous services to the sample households. Their bond with each has also grown because of their unflinching vested interest. One of the purposes of the health insurance scheme was also to break this vicious cycle to enable the households to lead a debt free life. Unfortunately, this has not happened, this has largely been because the households have not been taken into confidence by the programme functionaries and made aware of the broad features of the scheme and how to avail the benefits from it. This requires constant monitoring and repeated visits to the field so that the households also develop some trust towards them.

(e) It was also observed that the major concern of the sample households in general and the females in particular was that the doctors in the hospital were male and the females were not very comfortable to discuss their problems with them. This needs to sorted out on priority basis both from the government side as well as from the household's side. One of the reasons of such concern was also the low awareness level of the females who have no such experience of facing such situations because even at home they are subjugated by their males and have no voice

to protest. It should be remembered that the doctors manning the hospital are professionals and therefore are there with some specific reason and there should be no fear or hesitation to discuss their problem with them. This may take time but of the programme functionaries work tirelessly towards addressing them, it would gradually subside.

(f) The problem of the location of the hospital located at distant places is a genuine one on which neither the government not the programme executing agency can do anything. This is where the convergence with other department of the area should pitch in. Institutions like the Panchayats, Blocks, Schools, Pradhan, local administration etc., who so ever has the vehicle be encouraged to share with the programme executing agency. The panchayats who with the commencement of 73 rd Constitutional Act have become very resourceful be asked to play a more proactive role to address these local problems.

(g) The demographic and gender profile of the sample households shows that persons in the age group of 35 to 50 years were active and participated in the health insurance programme, while the level of participation in the other groups was quite subdued. The study also shows that the participation of SC was higher than that of OBC in both Hindu and Muslim categories. For holistic development, it is necessary to motivate the households of other groups as well. Therefore, it is suggested that the government and the related programme functionaries should organize short duration camps, seminars, puppets show, rallies displaying play cards etc., that highlight the advantages of the health insurance programme to motivate and make the people aware of the broad features of the health insurance programme and encourage them to step out of the shell and participate.

(h) Another features that causes considerable amount of concern was the high level of illiteracy among the households in general and controlled group in particular. The study also shows that the proportion of married couples, in both the categories, was exceptionally high. This additional social responsibility of the households who also do not have health coverage, becomes the major cause of concern. The high rate of morbidity in the region and their dependence on local (informal) sources for financial assistance plays a key role in pushing the households into the perpetual web of poverty and exploitation. Hence, there is an urgent need to intervene and extricate these hapless households

with an array of social interventions that address their ill literacy, provides them sound health coverage, hones their skills and subsequently links them to formal financial institutions.

(i) The study also shows that majority of sample households had nuclear family the health insurance coverage in the experimental group was over 81 percent as compared to just 19 percent for joint family. The plausible reason for low coverage in the joint family could be their poor economic status which, did not leave much behind, after taking care of the needs of their large family to take up health insurance coverage and secondly the social support it provided in the joint families. The study also shows that that level of health insurance go down further if the households of the controlled group were also inducted. Though the study negates any kind of association between the nature of family and their participation in the health insurance programme, but the high level of participation coming from the nuclear families in the experimental group substantially reflects their level of insecurity. Therefore, efforts need to be made through appropriate social interventions to induct the sample households of the controlled group also.

(j) Education level has a profound impact on the level of awareness and participation of households in the health insurance programme. The study shows that the incidence of illiteracy and that of low or poor literacy level was exceptionally high in the sample households. Further, the gender-wise comparison also shows that the female lagged behind the males in both the segments and the difference was also found to be statistically significant. The study also shows that the difference between the educational levels of the households in the experimental and controlled group was also found to be statistically significant. This explains why the households of the sample had low participation rate in the health insurance programme.

(k) The study of comparison of the assets owned by the sample households provides an interesting insight of the socio-economic levels of the people. The study further shows that the distribution of assets between the two groups were, by and large, evenly matched. Thus, it can be stated that the sample was more or less homogenous. The study also shows that the difference between the two segments was also not found to be statistically significant. Therefore, it can be states that health insurance scheme has not been able to make any significant impact on the level of participation of the households, however, the ongoing

trend also supplements the fact the households belonging to experimental group were better place in some of the socio-economic parameters.

(l) The study distress selling of land also substantiates how the health insurance scheme has positively impacted the process of the level of participation sample households. The analysis shows that over 77 percent of households did not sell their land in distress and only about 23 percent of the households have sold their lane in distress. The study also shows that the proportion of households in the experimental group, not selling their land in distress, was visibly higher than the households belonging to controlled group. The study also shows that the incidence of morbidity was one of the major factors that contributed to distress selling and this proportion was much lesser in the experimental group and this probably reflects the positive impact of the health insurance scheme.

(m) Similarly, the study of incidence of loaning among the sample households also substantiates how the socio-economic position of experimental group of households was better than that of controlled group of households. How deep is the problem of indebtness is seen in the region, where over 96 percent of the sample households have taken loan at one point or the other. Further, there were only about 4 percent of the households that were debt free. The study also shows that the proportion of households belonging to experimental group, who had taken loan, was much lower than that of the households of controlled group; though, the difference was not found to be statistically significant. However, the on-going trend clearly reflects the influence that the health insurance scheme has been exercising over the sample households.

(n) The sources and reasons for availing loan also shows the extent and dependence of the sample households on the local or informal sources. The analysis also shows that about 39 percent of the households, about 25 percent relied on contractors and another 21 percent on shopkeepers; while the dependence formal sources was less than one percent! The study also shows that this incidence of loan among the experimental group was also much higher than that of the controlled group and the difference between the two was also statistically significant. Thus, it can be stated that participation of households in the health insurance scheme has not succeeded in lowering the dependence of households on loans from the informal sources.

Among the major reasons for seeking loan was the high incidence of morbidity and scant use of health cards. However, this incidence of morbidity was more profound in the controlled group of households which amply demonstrates the impact of health insurance scheme and this was also found to be statistically significant.

(o) The impact of health insurance scheme has also been visible on their status of borrowing of loans, the average outstanding loan on sample households, the amount that still remaining pending and the amount of interest, at which they had procured the loan. The study shows that the sample households had, on an average, borrowed Rs. 8119 on 9 percent interest rate and, so far, they have paid Rs. 25120 and still have to pay Rs. 5460. The comparison between the experimental and controlled group of households shows that the house holds belonging to experimental group very much better off in respect of all these parameters than the households of controlled group and the difference was also found to be statistically significant. Therefore, it can be stated that participation in the health insurance programme has positively impacted the sample households by lowering the intensity and scale of loans.

(p) The study of annual income distribution pattern of sample households shows that there were about 39 percent of the households whose annual income level was less that Rs. 8000, another about 36 percent of the household's income level was between Rs. 8000 to Rs. 16000. The study also shows that there were hardly 3 percent of the households whose annual income level was above Rs. 20,000. Thus, it can be said that the income distribution was skewed where the position of majority of the sample households were located at the bottom of the socio-economic or to be precise economic hierarchy. The comparative of households belonging to experimental and controlled group shows that this pattern was more skewed in the controlled than that of the experimental group, though the socio-economic pattern of the two groups was more or less even! However, the difference was not found to be statistically significant.

(q) The study of average expenditure pattern of the sample households shows that major expenditure of were largely on fooding, health, clothing, repayment of loans, animal husbandry etc., this consumed major chunk of their expenses. However, the minor expenditure was on festivals, electricity, water, residence, intoxicant etc. The comparison also shows that the

position of the households belonging to experimental group was much better than the households belonging to controlled group and the difference between them was also found to be statistically significant. The analysis also shows that the expenditure on health was much lesser in experimental group as compared to the expenditure of households belonging to controlled group and this could be called to be the positive contribution of health insurance scheme.

(r) The study of awareness level of the sample households shows that they did not have full awareness about the scheme. They had partial knowledge and that too on some aspects of the scheme and had a very low level of awareness in a majority of the aspects of the scheme. The comparison also shows that male household's level of awareness was higher than that of the female beneficiaries. The difference between them was also found to be statistically significant. Therefore, it can be stated that poor performance of the health insurance scheme could also be attributed to the prevailing low level of awareness about the health insurance scheme by the sample households in general and female households in particular.

(s) The study of sample household's awareness level towards health insurance programme provides a very dismal scenario. The analysis shows that over one-third of the total households were not even aware of the source from to get the insurance policy, another about one-third of them did not have the resource to pay out the premium for health policy. Together these two accounted for mote than two-third of the total perceptions of the households. Among the minor reasons some could be summarized as: not aware of the claims that the policy brought in, lot of paper work required to get the policy, prevalence of fraud in policy business etc. The comparison of the households belonging to experimental and controlled group shows that that the incidence of low awareness was more prevalent in the controlled group of households. The perusal of the responses, apart from highlighting the low awareness of the households also exemplifies how little field work was carried out by the programme functionaries to address many of the mis-conceptions that the sample households were carrying in. It should be remembered that health insurance policy was a cashless online policy in which no money transaction, at any level, was carried out and all these mis-conceptions about the policy were prevailing largely because there was no authority to

clarify the doubts among the sample households. The study, therefore, recommends rigorous implementation of the policy to alleviate the health and finance related problems of the sample households.

(t) It was also observed that the currently the amount of coverage that is displayed under the health insurance scheme was Rs. 30000. It was also felt that this amount was not sufficient specially when looking at the inflation rate and the prices of other supplementary goods are taken into account. Therefore, it is recommended that this amount needs to be enhance to Rs. 1,00.000.

(u) The also found that the sample beneficiary, at the time of discharge, was being provided medicines for only five days, which was quite low and should be given for at least for ten to fifteen days taking his residential location in to account.

(v) Efforts also needs to be made to improve the quality of services of public health centers. It was observed that these centers were often ill equipped both in terms of manpower and medicines and deter the people into visiting them. This requires regular monitoring by the higher officials.

(w) Efforts also need to be made to mobilize other NGOs working in the area and the services of ANMs and ASHA workers to involve the households by organizing the group discussions and other mode of imparting awareness about the programme and the broad features that it entails.

(x) The study also shows the presence of male doctors and other professionals in the sub centers and other health clinics that also acts as a deterrent to the female households. There is therefore a need to indict more females to attract the female households to these health centers.

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