RASHTRIYA SWASTHYA BIMA YOJNA WITH OTHER GOVERNMENT SPONSORED HEALTH INSURANCE SCHEMES: A COMPARATIVE PERFORMANCE

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ABSTRACT

Prior to the introduction of government sponsored health insurance schemes (GSHIS's), nearly all public financing was directed towards the government-owned and operated service delivery system to support an implicit (often undelivered) benefits package. In an environment of low public health financing, entrenched accountability issues in the public delivery system, and pre-dominance of out-of-pocket spending, particularly by the poor, GSHIS's represents an alternative form of mobility and allocating public funds and have introduced a new set of arrangements to administer, allocate and manage public resources for health. The objective of this study is to compare Rasthriya Swasthya Bima Yojna (RSBY) (central one) with other public sector health Insurance schemes. The comparison of Government sponsored health insurance schemes shows that RSBY provides the wide range of hospitalization benefits to the beneficiaries across India.

Key Words- Comparative Performance, GSHIS's, Health Insurance, Out of Pocket Spending.

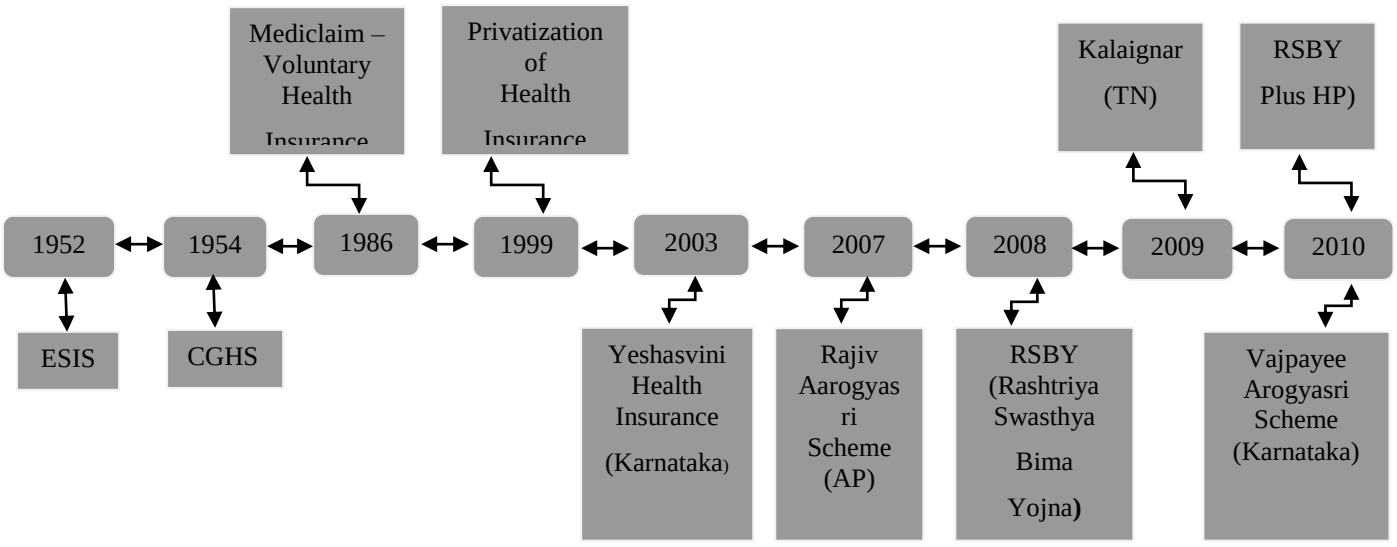
INTRODUCTION

Since Independence, India has struggling to provide universal health insurance coverage to millions of the poor, needy and destitute people. Whether defined in terms of financial provision or access to and effective use of health care system, the majority of Indians remain deprived of an assured delivery system in this matter. Such headaches as the traditionally low public spending on health (currently about 1 percent of GDP), the high levels of informal or unorganized labor (93 percent of the labor force), a large but dispersed rural population (72 percent), high levels of poverty (27.5 percent), un-regulated service delivery, and low quality of service providers serving the poor have passed a big challenge to the public policy makers. Despite this depressing scenario, success efforts to reverse the trend have recently come to the fore. As specified in the National Health Policy and the government's framework for governance (Common Minimum Programme) (GOI, 2004), the government is committed to public health spending (central and state governments put together) from one percent to two-three percent of GDP. This has been reflected in recent pronouncements by the government relating to the preparation of the 12th five-year development plan (2012–17) (Planning Commission, 2011). Simultaneously, the insurance industry has crafted innovative products to improve benefit coverage. The central and state governments have been trying to devise schemes for the purpose.

The Government sponsored health insurance schemes appeared on the scene in late 1940s when the central government introduced the Employees' State Insurance Scheme (ESIS) for blue-collar workers employed in the private sector. This was followed in the mid- 1950's by the Central Government Health Scheme (CGHS) for central government employees and for their dependants. Other government schemes for employees in Railways and Defense and other departments, also emerged their after shortly. Since after the ESIS and CGHS, it took

nearly five decades before a new wave of GSHIS's emerged. However, India since 2007 has witnessed a plethora of new initiatives, both by the union government and a most of state governments entering the arena. One of the reasons for initiating such schemes by the governments in India has made to boost up public spending in health care. Among others, these include enhanced access and availability of essential health care services, thereby protecting the BPL households from penury through such schemes as National Rural Health Mission (NRHM) and Rashtriya Swasthya Bima Yojana (RSBY) etc. The State specific initiatives include Rajiv Aarogyasri Scheme in Andhra Pradesh, Kalaignar's Health Insurance Scheme for Life Saving Treatment in Tamil Nadu, Vajpayee Arogyasri Scheme in Karnataka. Each of these schemes was built upon the earlier experience of the health insurance industry over a 20-year period. The designs and structures of these new schemes were drawn from the experience of existing social insurance schemes and private insurance products in India. This new wave of schemes provides fully subsidized coverage for a limited package of secondary or tertiary in-patient care, targeting BPL population. Figure 1 traces the genealogy of GSHIS's and the linkages among them.

Figure 1: The Landscape of Health Insurance Schemes in India



In this context the basic objective of the present study is to study the government sponsored health insurance schemes. Attempt has also been made to compare Rashtriya Swasthya Bima Yojna with other government sponsored health insurance schemes. In India, some studies such as Gupta and Trivedi (2006), Nagpal, Devadasan and Jain (2007), Swarup (2008), Reddy et al. (2011) Gerard and Nagpal (2012) and Gupta (2013) have tried to study the government sponsored health insurance schemes. However, scanty of literature is available on performance of Rashtriya Swasthya Bima Yojna and Government sponsored health insurance schemes. The present study is an endeavour in this direction and tries to fill the existing void in the literature on analysing the performance of Government sponsored health insurance schemes.

To accomplish this objective, the paper has been divided into four broad sections. Section I introduces the Government sponsored health insurance schemes in India. Section II deals with review of the empirical work done on various government sponsored health insurance schemes. Section III compares the performance of Rashtriya Swasthya Bima Yojna with other public sector health insurance schemes. Section IV concludes the discussion.

EVIDENCE FROM LITERATURE

The review of these studies provides a broad spectrum of work done in the area of health insurance and provided basis for the formulation of appropriate objective and methodology for the present study. Gupta and Trivedi (2006) found that central government and a few state government have initiated a scheme to cover population that do not have health insurance, especially for the vulnerable sections of society under the net of social security. The study found that currently it is planned that Central Government will pay the entire premium of Rs. 550 per family per year and also proposed that if there is problem in levying of a health cess, the government may provide funds amounting to ₹ 6500 crore, which is equivalent to .02 percent of the GDP, out of the general budget. At the state level, experiments are on to

promote health insurance either by means of covering state employees or offering coverage to entire population of the state. The study suggested that it is necessary to plan the spread of health insurance on national scale and to set up an apex body that would be in charge of implementing health insurance in the country. Nagpal, Devadasan and Jain (2007) attempted to trace the recent government initiatives by central, state and local government bodies in providing health insurance coverage within their perspective jurisdictions. The study described state wise schemes for critical illness like personal accident scheme in Assam, Sanjivini Scheme in Punjab and Kudumbashree in Kerala. The Rashtriya Swasthya Bima Yojna (RSBY) is the most recent health insurance scheme started by state government with premium subsidy up to 75 percent by the central government. This premium plans to cover all the BPL families in the country and is implemented by the Ministry of Labour. Swarup (2008) suggested that health insurance is one way of providing protection to poor households against the risk of health spending leading to poverty. In India, around 94% of the total workforce is in the unorganized sector and in absolute terms too, the numbers (around 433 million) are mind boggling. The study proposed that the unorganized sector workers below poverty line (BPL) and their families are to be covered under Rashtriya Swasthya Bima Yojana (RSBY) during the next five years (2008-09 to 2012-2013). The response of the State Governments and other stakeholders has been very encouraging. Reddy et al. (2011) stated that to sustain the positive economic trajectory, India had during the past decade, and to honour the fundamental right of all citizens to adequate health care, the health of all Indian people has to be given the highest priority in public policy. The study proposed the creation of the Integrated National Health System in India through provision of universal health insurance, establishment of autonomous organisations to enable accountable and evidence-based good-quality health-care practices and development of appropriately trained human resources, the restructuring of health governance to make it coordinated and decentralised,

and legislation of health entitlement for all Indian people. Gupta (2013) examined distinct phases of evolution of health insurance and builds a case for next phase of reforms and initiatives so that future growth in this segment creates a win-win for all stakeholders– government, insurers, providers, society and above all the policyholder. The study stated that as we stand on the threshold of transition of the health insurance industry in the next 10- 12 years, we need to define the vision and the path required to achieve it. The building blocks of the next paradigm will comprise numerous structural changes including regulatory, legal, product-related, new operating entities, partnership with providers, universal health coverage etc.

COMPARISON OF GOVERNMENT SPONSORED HEALTH INSURANCE SCHEMES

This section compares Rasthriya Swasthya Bima Yojna (RSBY) with other public sector health Insurance schemes viz Rajiv Aarogyasri scheme of Andhra Pradesh, Chief Minister Kalaignar Health Insurance Scheme of Tamil Naidu, Vajpayee Arogyasri Scheme of Karnataka and reviews these in terms of revenue generation, pooling, purchasing and provision, coverage, benefits package, premium collection process, schemes utilization, claims processing and selection of providers.

1.3.1 Flashlight on Health Insurance Coverage

India's landscape of health insurance coverage has undergone tremendous change since 2007. The estimated number of people covered by health insurance has risen to unprecedented levels due to four initiatives (Rashtriya Swasthya Bima Yojna, Rajiv Aarogya Sri, Vajpayee Arogya Sri and Kalaignar health insurance scheme) taken by the union and state government. Three of the giant schemes (RSBY, Rajiv Aarogyasri and Kalaignar) in a span of three years have a share of roughly 185 million in 2010. Government sponsored health insurance

schemes showed a remarkable performance in case of enrolment of beneficiaries i.e. 237.73 millions from the years 2010 to 2013. Table 1 presents coverage across schemes.

Table 1: Coverage under GSHIS

S. No.	Total Covered Population 2013 (in Millions)				
	Scheme	**Unit of Enrolment**	**No. of Families**	**No. of Beneficiaries**	**Population**
1	Rashtriya Swasthya Bima Yojna(RSBY)	Family	34.81	121.83	269.3* (1270)
2	Rajiv Aarogya Sri (RAS-AP)	Family	22.3	77.7	91.93
3	Kalaignar (TN)	Family	13.6	35	72.13
4	Vajpayee Arogyasri Scheme (VAS-KN)	Family	2.2	3.2	61.13
	Total		73	237.73	

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in .

*** : Total BPL Population in India**

It has been revealed that a substantial share of coverage is through RSBY and other state sponsored health insurance schemes that together covered 238 million individuals. This scenario changed drastically in the last five years because of introduction of new health insurance schemes by various state governments specifically targeting the BPL population. RAS was introduced in Andhra Pradesh in 2007. By 2013, approximately 22.3 million families and 77.7 million beneficiaries were covered by RAS, which is about 85 percent of the total population of the state. It is an interesting to revelation that a scheme, which was originally meant for the BPL families, embraced almost the entire population of the state. In the same fashion, other state governments have introduced or are in the process of introducing health insurance schemes targeting the BPL. Notable among these are Kalaignar health insurance scheme that currently covers 13.6 million families and 35 million beneficiaries, which is about 49 percent of total population of Tamil Nadu. Vajpayee Arogyasri currently in its pilot phase in the Gulbarga division of Karnataka covers any 5 members of family holding a BPL card. The scheme covered 3.2 million people which is

about 5 percent population of Karnataka. The scheme is designed to extend coverage to 6.3 million BPL families each year in a phased manner. The RSBY was initiated by the Central Government as a national health insurance scheme targeting the BPL population. The scheme currently covers approximately 122 million individuals across the country in 2013**.** RSBY covered 45 percent below poverty line population in India. Among the government sponsored health insurance schemes, the coverage of RAS, RSBY and Kailagnar is vast and the schemes covered large number of BPL population all over country. RSBY is covering the BPL population after completing the target BPL people the scheme, the scheme has already extends to above poverty line people.

1.3.2 Sources of Finance and Mechanism Fund Policy

The pivot of GSHIS's revives around revenue collection, risk pooling and purchasing. The source of funds, mechanisms used to collect funds and the agency that pools funds together are constitute.

Table 2: Sources of Finance for Government Sponsored Health Insurance Schemes

S. No.	Scheme	Beneficiary Contribution	Subsidiaries (percentage)	Average Premium Rates*(In ₹)	Coverage (in ₹)
1	RSBY	No	100 Centre (75) and State(25)	347 to 750	30,000 per family per year
2	Rajiv Aarogyasri Scheme (RAS-AP)	No	100 State	267	150,000 per family per year with additional buffer of 50,000
3	Chief Minister Kalaignar Health Insurance Scheme (CMKHIS-TN)	No	100 State	NA	100,000 per family (floating over 4 years)
4	Vajpayee Arogyasri Scheme (VAS-KN)	No	100 State	469	150,000 per family per year with additional buffer of 50,000

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in .
*** : Per family per year**
N. A. : Not applicable, scheme is free.

From table 2, it was found that the state governments pay full premium for the beneficiaries in three schemes- Kalaignar Health Insurance Scheme, Rajiv Aarogyasri Scheme and Vajpayee Arogyasri Scheme while 25 percent of the premium in case of RSBY is paid by the state government and 75 percent is paid by the central government. The financial sustainability of the government-sponsored schemes for the poor is a major concern for all stakeholders. The premium dependents upon the type of benefit coverage. The RSBY premium payable falls in the range of ₹ 347 to ₹ 750 for a benefit cover of ₹ 30,000, whereas the premium for a cover of ₹ 2,00,000 (₹ 1,50,000 + ₹ 50,000 buffer) under Rajiv Aarogyasri scheme is ₹ 267. The premium of Kalaignar health insurance scheme for a cover of ₹ 1,00,000 per family is ₹ 469. In case of Vajpayee Arogyasri scheme, there are no premium charges because the scheme is free. Under RSBY, the coverage cap of BPL families (₹ 30,000) is less than the other schemes and the insurance companies charged a high premium amount in RSBY but in 2012 the premium was ₹ 370 for fresh districts attributed to price correction over the years on the basis of utilization data of economies of scale, decrease in cost of smart cards, installation of hardware etc. This could be attributed to price correction over the years on the basis of utilization data of economies of scale, decrease in cost of smart cards, installation of hardware etc. This is in keeping with the policy of extending RSBY to the poor free of cost and a big achievement for the RSBY beneficiaries over the five years as compared to other GSHIS's.

1.3.3 Benefits Package

Most of the latest state government sponsored schemes cover hospitalization. While this helps poor households survive catastrophic emergencies, the large share of out-of-pocket payments occurs on outpatient visits. As such, the poor people remain inadequately provided for medical care. Table 3 given below presents a comprehensive view of kinds of care

provided under each scheme. In addition, all the schemes have limited follow up coverage. However, there is no coverage of preventive/wellness and ambulatory services.

Table 3: Government Sponsored Health Insurance Care Scenario

S. No.	Insurance Scheme	Chronic Diseases	Maternity	Preventive and Wellness Care	AYUSH	Outpatient	Inpatient
1	RSBY	✓	✓	✗	✗	✗	✓
2	Rajiv Aarogyasri Scheme (AP)	✓	✗	✗	✗	✗	✓
3	Kalaignar(TN)	✓	✓	✗	✗	✗	✓
4	Vajpayee Arogyasri Scheme (KN)	✓	✗	✗	✗	✗	✓

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in.

The table also reveals care scenario of government sponsored health insurance schemes. The benefits package under the RSBY is mainly focused on the provision of secondary care. Primary care is not included in any of the schemes for variety of reasons. In Tamil Nadu, for example, the primary care and secondary care are already well provided by the public sector. Wherever the primary care is not so sound, health insurance schemes must aim of better integration with the public sector through referral system. The governments can also use the data generated by health insurance schemes for strengthening primary care. Kalaignar scheme covers chronic diseases, maternity and inpatient where as Rajiv Aarogya Sri and Vajpayee Arogya Sri Scheme only covers chronic diseases and inpatient. The RSBY scheme provides the health care at a large scale than the other schemes. RSBY covers mostly secondary care including maternity, chronic diseases and inpatient. In this matter health protection can play a key role in reducing inequities and providing health care access to women.

In most new GSHIS's, benefits are defined in terms of treatment packages covered by the scheme. Table 7.4 brings out that RSBY covers all forms of hospital treatment but the depth of coverage is limited by the annual cap of ₹ 30,000 per family. Charges for most tertiary care would inevitably far exceed this cap.

Table 4: Treatment Packages under GSHIS

S. No.	Scheme	Benefit Type	No. of Inpatient Packages	Coverage Extends Beyond Specified Packages	Maximum Annual Coverage (₹)
1	RSBY	Inpatient Secondary Care	727	Yes	30,000/Family
2	Rajiv Aarogyasri (RAS-AP)	Inpatient Tertiary Care	938*	No	150,000/Family+ 50,000 buffer
3	Kalaignar (TN)	Inpatient Tertiary Care	412*	No	100,000/Family (floating over 4 yrs)
4	Vajpayee Arogyasri (VAS-KA)	Inpatient Tertiary Care	402*	No	150,000/Family+ 50,000 buffer

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in.
*** : Mostly surgical.**

As a result, RSBY packages cover only secondary care. The remaining schemes lay emphasis on tertiary care, including cardiovascular, renal, neurological, and cancer treatment, and only for the defined conditions or procedures that have been priced on a package basis. The higher annual caps such as RAS and VAS (cap of ₹ 150,000/Family+ 50,000 buffer) and CMKHIS (cap of ₹ 100,000/Family which is floating over 4 yrs) which are related to the higher premium package rates for covered services, due to the tertiary nature of the services covered. All package rates fall within the cap. The treatment packages under GSHIS's compares with RSBY provide all the hospitalization coverage with in cap of ₹ 30000, which is minimum cap as compared to other GSHIS's. This clearly defined that RSBY beneficiaries seek all the benefits in the given cap.

Table 5: Packages Classified by Major Disease Group- by Surgical and Medical Treatment

Sr. No.	Disease Group Classified by Surgical (S) and Medical (M)	Surgical (S) Medical (M)	RSBY	RAS	CMKHIS	VAS
1	Cardiology	S	N.A	109	24	134
		M		11	1	
2	Nephrology	S	109	54	9	21
		M		5		

3	Neurology	S	50	67	70	55
		M		12		
4	Orthopaedics	S	131	68	29	8
		M		0		
5	Gastroenterology	S	73	55	37	N.A
		M		19		
6	Oncology	S	23	132	121	106
		M		62	57	60
7	Ophthalmology	S	41	26	14	
		M				N.A
8	Ear, nose, and throat (ENT)	S	71	23	3	
		M				N.A
9	Obstetrics and Gynaecology (OBGYN)	S	46	17	5	
		M				N.A
10	General surgery	S	148	79	10	11
		M				
11	Paediatrics	S	31	57	56	7
		M		67		
12	Others	S	4	29	N.A	N.A
		M		46		
TOTAL			**727**	**938**	**436**	**402**
Percentage of Surgical			**100**	**77**	**87**	**86**
Percentage of Medical			**0**	**23**	**13**	**14**

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in.

Table 5 displays the number of packages by specialty classified by type of treatment (surgical or medical). RSBY covered 727 packages in all disease groups and 100 percent are under surgical treatment with inpatient care. 938 packages are covered under Rajiv Aarogyasri with surgical and medical ratio of 77:23, Kalaignar scheme covered 436 packages with surgical and medical ratio of 87:13 percent and Vajpayee Arogya sri scheme covered 402 packages with surgical and medical ratio of 86:14. Cardiology, neurosurgery, nephrology, orthopaedics, oncology, and general surgery account for 60 percent of packages. It has come to light the areas of paediatrics and obstetrics and gynaecology (OBGYN) possess relatively fewer kinds of treatments and procedures. These account for only about 9 percent of the total surgical procedures. However these cases representing 96 percent of all inpatient packages. In

case of Nephrology 109 packages provided under RSBY and other state sponsored schemes covered 84 packages in surgical care, where as in case of Orthopaedics 131 packages covered by RSBY and RAS, Kalaignar, Vajpayee covers 68, 29 and 8 packages respectively. In case of Gastroenterology, Ophthalmology, Ear, Nose and Throat (ENT), Obstetrics and Gynaecology (OBGYN) and general surgery RSBY covers the more packages in surgery as compared to RAS, Kalaignar and Vajpayee Arogya Sri Scheme which clearly defines that RSBY covers all types of in-patient care though within ₹ 30,000 as compared to other schemes. The RSBY also covers residual forms of inpatient treatment beyond the common packaged conditions. Treatment for non packaged conditions is done for on a fee for- service basis. For instance, unlike the tertiary-focused state schemes,

Table 6: Variation in Package Rates for Similar Procedures under GSHIS's (in ₹)

S. No.	Procedure	Rajiv Aarogyasri (AP)	Kalaignar (TN)	Vajpayee Arogyasri Scheme (KA)	RSBY
1	Coronary Bypass Surgery	95,000	90,000	95,000	Up to 30,000
2	Coronary Angioplasty	60,000	60,000	60,000	
3	Transurethral Resection of Prostate	30,000	25,000	20,000	14,250
4	Nephrolithotomy	10,000	25,000	10,000	10,000
5	Nephrectomy	40,000	40,000	10,000	10,000
6	Appendectomy	18,000	N.A.	N.A.	6,000
7	Cholecystectomy	20,000	25,000	N.A.	10,000
8	Hysterectomy	20,000	25,000	N.A.	10,000
9	Tympanoplasty	15,000	N.A	N.A.	7,000
10	Normal delivery	N.A	N.A	N.A	2,500

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in.
N.A : Not applicable

Table 6 shows large variation in rates paid for similar packages for all procedures under various schemes. The RSBY generally pays the lowest rates than the other schemes. The state schemes pay more but only for the specified modality of treatment (i.e., only endoscopic surgery). Generally private insurance providers have charged higher package rates across the states since there has not been any standardization or norms for them. The variation ranges

from ₹ 30,000 to ₹ 95,000 in case of coronary bypass heart surgery, under various schemes variation is more than double in some categories. RSBY provides the package rate of ₹ 14,250 in case of transurethral resection of prostate, where as Rajiv Aarogyasri Scheme, Chief Minister Kalaignar Health Insurance Scheme and Vajpayee Arogyasri Scheme provides ₹ 30,000, 25,000 and 20,000. Under the procedure Appendectomy RSBY provides package rate of ₹ 6,000 and RAS provides ₹ 18,000 and in case of Cholecystectomy, Hysterectomy, Tympanoplasty RSBY provides the package rates are less than the state sponsored schemes. This clearly demonstrates that RSBY package rates cover the procedures in fewer amounts as compared to state sponsored schemes. It seems imperative that GSHIS's should coordinate with each other to influence the price determination of services rather than serve as mere price takers. Similarly, such steps may be taken to ensure that health insurance schemes extract better prices from providers for the beneficiaries

1.3.4 Processing of Claims and Use of Information Technology

It rests with the insurance companies and in all the cases it is hastle free for the beneficiary. Under the RSBY, the TPA empanelled by respective insurance company is responsible for processing claims and this is done through a representative of insurance company at the network hospital itself. Once a beneficiary reaches the network hospital, the company representative list him/her for service access and ensures availability of funds as well as coverage of the package. The only requirement for the beneficiaries is production of the smart cards. Once approved by the doctors of the network hospital and after treatment of the beneficiary, expenses of treatment is deducted from the smart card of the beneficiary. The payment is made to the network hospital later. Similar processes are followed under Kalaignar and Rajiv Aarogyasri, wherein once the patient gets registered through the representative of insurance company at the network hospital, he or she undergoes pre-authorization process. The only difference is the pre- authorization process, where in pre-

authorization diagnosis and procedures are communicated to the insurance company electronically for approval. Then a panel of medical doctors approves the claim, based on the need and services provided to the beneficiary. Post-services information is sent to the insurance provider as it is a pre-requisite for claim settlement.

Under the government-sponsored schemes such as, RSBY, Kalaignar, Rajiv Aarogyasri and Vajpayee, smart card is being used for enrolment of the beneficiaries. Biometric chip based smart cards contain information of beneficiary's family such as name of family members, thumb impression and photographs and amount available for accessing services. Non RSBY beneficiaries are provided these cards free. However, under the RSBY a nominal fee of Rs. 30 is charged. The smart card allows service portability across the network hospitals and for RSBY across India. The smart card is also utilized by the insurance company for pre-authorization process, based on availability of funds and approval of package in the scheme and subsequent settlement of the claims. Kalaignar, Rajiv Aarogyasri and Vajpayee Arogyasri schemes also use smart cards for claim processing and monitoring of the performance of scheme.

1.3.5 Empanelment of Network Hospitals

The insurer is entrusted with the creation of a network of hospitals to treat patients under health insurance schemes. However, the nodal agency plays a role in forming criteria for empanelment, monitoring the performance and taking necessary action in case of deficient service provision. The RSBY has laid down empanelment criteria of 10 in-patient beds, fully equipped medical, surgical, diagnostic facility, qualified doctors, nursing staff, operation theatre and registration facility. There are empanelled 7855 private and 4014 public hospitals in the network of service providers. Under the Chief Minister Kalaignar Health Insurance Scheme there is a network of 692 hospitals, inclusive of public and private hospitals. However, the share of public hospital is much smaller than that of the private hospitals, there

are only 56 public hospital empanelled out of 692 empanelled hospitals. In case of Rajiv Aarogyasri, the share of 78 percent and 22 percent is by private and public hospitals respectively. It has currently 356 private and 98 government hospitals empanelled, with public hospital numbers much higher compared to those empanelled in Chief Minister Kalaignar Health Insurance Scheme.

Table 7: Status of Hospitals Network -2013

Scheme	Networked Hospitals				Total
	Public	Percentage	Private	Percentage	
RSBY	4014	34	7855	66	11869
Rajiv Aarogyasri Scheme (AP)	98	22	356	78	454
Chief Minister Kalaignar Health Insurance Scheme (TN)	56	8	636	92	692
Vajpayee Aarogyasri Scheme (KN)	13	10	118	90	131

Source: www.rsby.gov.in, www.aarogyasri.org, www.tnhsp.org, www.sas.gov.in.

As far as the Vajpayee Arogyasri scheme has more stringent criteria for empanelment of hospitals. They have been able to empanel 118 public and 13 private hospitals. The maximum numbers of hospitals 11869 are in RSBY scheme, in which 66 percent share of private hospitals and 34 percent of public. The highest number of hospitals under RSBY scheme reveals the coverage at large scheme and success of the scheme.

SECTION IV

CONCLUSION

Efforts have been made to compare the government sponsored health insurance schemes (GSHISs) on the basis of implementation, coverage, sources of finance, benefits package, premium collection process, expenditure on medical services, claims processing, revenue generation, and selection of providers etc. GSHISs such as Rashtriya Swasthya Bima Yojna (Central scheme) and state specific initiatives include Rajiv Aarogyasri Scheme (RAS) in Andhra Pradesh, Chief Minister Kalaignar's Health Insurance Scheme (KHIS) in Tamil Nadu

and Vajpayee Arogyasri Scheme (VAS) in Karnataka. It was found that approximately 22.3 million families were covered under Rajiv Arogyasri scheme and Chief Minister Kalaignar health insurance scheme covered 13.6 million families in Tamil Nadu. Vajpayee Arogyasri Scheme covered 2.2 million families in 2013 and RSBY covered approximately 34.8 million BPL families across the country in January, 2014. Among the government sponsored health insurance schemes, the coverage of RSBY was the largest and the scheme covered large number of BPL population at central level. All the state schemes are 100 percent financed by the state governments but RSBY is financed in the ratio of 75:25 by central and state governments. The average premium of RSBY was higher than the state sponsored schemes but it decreased for fresh districts in year 2012. This is in keeping with the policy of extending health insurance to the poor free of cost. The RSBY scheme provided the health care at a large scale than the state schemes. Rajiv Aarogyasri and Vajpayee Arogyasri Scheme only covered chronic diseases and inpatient. The comparison of government sponsored health insurance schemes showed that RSBY provided the wide range of hospitalization benefits to the beneficiaries across India. This is in keeping with the policy of extending RSBY to the poor free of cost and a remarkable achievement for the RSBY beneficiaries over the five years as compared to state specific schemes. RSBY covered mostly secondary care including maternity, chronic diseases and inpatient. In this context, health insurance schemes could play a key role in reducing inequities and providing health care access to the women.

The extent and efficiency of health financing arrangements, the reach and performance of service delivery and the evolution of risk-protection mechanisms in India have profoundly shaped the development of government sponsored health insurance schemes. Innovative organisational structures had been formed for designing, implementing and monitoring schemes like RSBY, Rajiv Aaorgyasri Scheme, Chief Minister Kalaignar Health

Insurance Scheme and Vajpayee Arogyasri scheme. The GSHISs are a new form of mobilizing government resources in an underfinanced system while pioneering a set of design features and institutional arrangements to govern, allocate, and manage the use of these resources. The implementation of government sponsored health insurance schemes revealed that implementation has been quite successful and remarkable. RSBY provides health insurance coverage at large scale and more packages in lesser amount as compared to state specific schemes and the performance of RSBY has been quite overwhelming and up to mark.

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