Available online at http://www.ijims.com
ISSN: 2348 – 0343

The Evaluation of implementation of Rashtriya Swasthya Bima Yojna:A Study of AMRELI district

Arun Singh Rana [1*], Yogesh[1], Narender Jangra [2], Anita Gupta [3,] Vishal Trivedi [4]

1.Public Health Foundation of India, India

2. STATE RMNCH +A Consultant (UNICEF), Arunachal Pradesh, India

3. ERNST & YOUNG LLP, India

4. District M & E Assistant, Government of Gujarat, India

*Corresponding author: Arun Singh Rana

Abstract

According to the World Health Organization, health insurance covers less than 10% of the Indian population. GOI launched a scheme in 2008 as RSBY (Rashtriya Swasthya Bima Yojna). The purpose of the scheme is to provide financial security to BPL for hospitalization related expenses, improve access to quality health care, demand side financing and scheme which is simple to use.This study was aimed to study awareness; understand the various issues, challenges and out of pocket expenditure faced by beneficiaries and hospitals, empaneled under RSBY Scheme.This study was conducted at district Amreli, Gujarat with the sample size of 124 beneficiaries and 10 empaneled hospitals through a cross sectional survey. Data analysis was done through SPSS and MS Excel'11.The findings revealed that nearly 50% of the beneficiaries could utilized the SMART card under the scheme, 38% of the respondents had to bear indirect costs of Rs 150 on average while 35% had to pay for their treatment money which had been reimbursed later, had to travel more than 8 Km's to reach nearest RSBY empaneled hospital.One of the main issue is precise population coverage which remains very low, it covers BPL population and but not all of them, leaving behind more than two-third of total population uncovered. In order to improve the scenario, we have to increase awareness and involvement of community at implementation, monitoring and handling grievances.

Keywords: - Health insurance, RSBY, OOPE, BPL population, empaneled hospitals, TPA, Insurance Company

Introduction

India has started its social protection programs since the mid-2000s. The Eleventh Five Year Plan (2007-12) and Common Minimum Program, were an indication of the growing importance of social protection in government policy. The allocation of 4.3% of Gross Domestic Product (GDP) to social sector spending (Weigand & Gros, 2008) compares favorably with other countries with similar GDP per capita. However, public health spending in India is very low. India ranks 171 out of 175 countries in per capita public health spending[1]. As a percentage of GDP, Indian public health spending was 2.3%at the end of 12th plan[2, 3]. According to the World Health Organization[4], health insurance covers less than 10% of the Indian population. The low penetration levels of commercial insurance and the presence of very few community risk-pooling initiatives place a huge burden of healthcare financing on the poor. India has one of the highest rates of out-of-pocket health spending in the world at 78% of total health spending, and 94% of all private health spending (Rao,2005).This, however, does not imply or insures that the quality of private care is good (Das& Hammer, 2007), or that it is equitably distributed.

Health expenses per capita in India are high because it suffers blow from the double disease burden, i.e. while it ranks among the top ten countries for communicable diseases[5], it also has increasing cases of lifestyle diseases like coronary heart disease, diabetes and hypertension, the treatment expenses of which are of high value and low periodicity, with a potentially catastrophic impact on household finances. Workers in the unorganized sector constitute about 93 percent of the total workforce in India. One of the major hindrances faced by these workers in the unorganized sector is the frequent incidence of illnesses and the need for medical care and hospitalization of such workers and their family members

Learning from the experiences of other major government and non-government health insurance schemes in India e.g. Arogyashree etc., it was decided to launch a health insurance scheme which later came to be known as Rashtriya Swasthya Bima Yojana[6] (RSBY) for Below Poverty Line population (BPL) along with unorganized sector workers. As the targeted beneficiaries were poor, was largely illiterate and some of it was migratory in nature, the scheme has to be PAN INDIA [6, 7].

Objectives

This study was carried out with the following objectives:

1. To determine the level of awareness regarding RSBY and its benefits among RSBY card holders.
2. To understand the various issues and challenges faced by RSBY Card holders & empaneled hospitals under RSBY Scheme.
3. To determine the out of pocket expenditure among RSBY beneficiaries and to suggest the way forward.

Materials and Methods

Study design and Setting: A population based cross sectional research design was adopted, was done in Amreli district, Gujarat with 124 participants who are or were enrolled in RSBY scheme and were selected randomly. Mixed methods approach including both quantitative and qualitative techniques was undertaken. Pretested interview schedule was used as a tool for data collection and personal interview was the technique used. For the **quantitative component**, the sample size was calculated using enrolment rate at the district level as a key indicator. For the **qualitative component**, Interview was conducted with the 50% of the empaneled hospitals (both public & private) along with one district coordinator from the insurance company & one representative from TPA to understand the whole universe of RSBY program effectively.

Results

*Socioeconomic and demographic details:*This table shows the socio-demographic profile of the respondents under the study. Majority of the respondents were male (65%), belonging to the rural background (83%) and age group of more than 40 years. The most of the respondents were laborers followed by household work (Table 1).

Awareness regarding Scheme and Enrollment

In Amreli district, out of all the sources available for the dissemination of information on RSBY enrollment, Health staff is the main source of information (85%) for the beneficiaries followed by word of mouth by relatives & neighbors (10%) and communication material (5%).It was observed that awareness of user's regarding various key aspects in RSBY varies, awareness regarding mostly general parameters are good but its low when it's become bit technical e.g. Majority i.e. **90%** of the respondents were not aware with the concept that head of the family is compulsory under the scheme, 55% were not aware regarding type of services under this scheme, **37%** of the

respondents admitted that some of their eligible family member left from the enrolment. The main reason was absenteeism (59%) of the family member at the time of enrolment. (Table 2)

Majority of respondents i.e. 64%got the enrolment process completed within 30 min's but around **25%** respondent have to wait for more than one hour to complete the process despite the fact that all the enrolment stations are placed within each village at 5-10 min distance.

Knowledge and issues regarding Scheme/Service utilization

At Amreli district, 80% of respondents were aware about the nearest RSBY empaneled hospital, out of thesethe troubled view is that nearly **56%** of respondents have to travel for more than 8 km's to reach nearest RSBY empaneled hospital, while 6% said that they don't know about any empaneled hospital (Figure 1).In a cross tabulation analysis between socio demographic variable &knowledge about compulsory member of family clause, it comes out that males knew more than female, urban area is more aware than rural &knowledge about the same increases with the education (Table 3),

In an another cross tabulation analysis between socio demographic variable & knowledge of coverage benefit, males were more aware, surprisingly rural area is more aware than urban, it can also attribute to the fact that most of the rural families are enrolled from year one while enrolment in urban area started in later years & knowledge about the same increases with the education (Table 4).

Out of all the beneficiaries who availed the health services in the hospital, only 25% were aware about RSBY help desk. 75% of the beneficiaries reached to help desk after asking others and with the help of signages.Around 33% of the respondents said to take 5 – 15 min to complete the process while 67% have to wait for more than 15 minutes, while 21% of respondents had to wait more than half an hour.Out of the all the respondents who visited hospital **58%** had experienced some problem to avail services, the major problem were card was not working, name was not enrolled and other's as software dis-functioning (**45%, 12% and 43%** respectively).Only 16% respondents know whom to contact in case of broken/lost card, while 60% said it to be health worker which can lead them to right source, along with 24% who don't know anything about it.

Out of pocket expenditure

22 beneficiaries out of total 57 who availed services i.e. **38%** has reported to pay for different services at the hospital despite of having RSBY card. These services are transportation, food and lodging for family members, medicines &diagnostic tests, which comes to an average of Rs **150 per head** as indirect cost to them, out of these beneficiaries, 55% had to pay more than Rs 3000 treatment money upfront to avail services which will reimbursed later. Mean treatment cost in such cases found to be Rs **5786** ±5.4 (Mean ± S.D)(Figure 2)

Problems in Implementation of RSBY with empaneled hospitals

Another objective of this study was to learn about the provider side difficulties and issues, it shows that **40%** of the empaneled hospitals are not happy with the performance & support they get from the side of TPA & Insurance Company, while rest of **60%** said that support is fine but out of them **80%** also mentioned the huge scope and need of improvement in TPA's approach & service delivery. Out of all empaneled hospitals, majority raised the issue of delay in response and no proper support from the side of TPA & Insurance Company (60% & 40%) respectively, along with lots of documentation asked from their side.

It's also come out that empaneled hospitals major issue in implementing the scheme are delayed response from TPA side; patients without RSBY cards came in and ask for free treatment and other reasons such as approval of less package approval from TPA side.

Utilization and Satisfaction rate

Nearly half of the respondents had not utilized their card reason being 50% of total respondents were not fallen ill while 2.5% had taken treatment but it was day care treatment so they could not get the benefits if this scheme while nearly 47% respondents have utilized the services. Out of all the beneficiaries **97%** beneficiaries has replied that they will enroll again in the scheme for next year also, along with suggesting others also to get enrolled, if asked. However around **21%** beneficiary also mentioned & questioned the benefits of scheme for them as they haven't utilized the RSBY benefits last year.

Discussion

This study found that there are gaps & problems in awareness & IEC activities for beneficiaries and it needs more effort and focus towards the aim of increasing the awareness of beneficiaries about RSBY process and coverage benefits with the use of already established work force of health workers.

RSBY awareness

Our study shows that health staff at ground level played the most important role in disseminating knowledge and awareness. It was observed that awareness of user's regarding various key aspects in RSBY varies subject to subject, awareness regarding mostly general parameters are good but its low when it's become bit technical. Beneficiaries were unaware regarding various key factors such as head of the family concept, pre-post hospitalization coverage, transport allowances, food expenses etc. This shows that there is dire need of imparting adequate knowledge to community.

This information bias put beneficiaries at loss as they should know all the facilities as well as limitations of scheme. This prevents hospitals to do malpractices and increases the utilization rate also.

Enrolment Procedures

One of the finding showed that **25%** respondent have to wait for more than one hour to complete the process all the enrolment stations are placed within each village at 5-10 min distance. One aspect would need to be strengthened upon as nearly half of the total respondents did not know about the travel allowance of Rs 100 in RSBY .This factor needs to be strengthened all round as only 16% respondents know whom to contact in case of broken/lost card.

Out of pocket expenditure

One of the main objectives of the scheme is to improve access and reduce out of pocket expenditure on health, but our study suggests that more than one third of patient's i.e.**38%** has reported to pay for different services at the hospital despite of having RSBY card, such findings correlate with the study in Delhi by Grover and Palacios (2011). These services are transportation, food and lodging for family members, medicines, diagnostic tests & treatment by paying upfront and then wait for the reimbursement later. This nullify the objectives and ethos of RSBY which was designed as a cushion for poor families for preventing such situations.

Family member covered:

Another finding of the study showed that more than one third i.e.**37%** of the beneficiary reported that one or more eligible members have been left out of coverage, out of these, **41%** said its due to limit of 5 members per family,

hence they have to choose between their family members and this puts females, girls, elderly and person with disability at greater risk of vulnerability if they opt their other family members over them for enrolment either voluntary or involuntary.

Empaneled Providers

Another stakeholder in this processi.e. providers, told us that**40%** of the empaneled hospitals are not happy with the performance & support they get from the side of TPA & Insurance Company, while rest of **60%** said that support is fine but out of them **80%** also mentioned the huge scope and need of improvement in TPA's approach & service delivery. Majority of providers raised the issue of delay in response and no proper support from the side of TPA & Insurance Company.

It's also been stated that there is lots of documentation asked from their side for claim management especially lots of "HARD COPIES" have to submitted for getting the claim, which is again against the ethos of the PAPERLESS scheme which we believe is in paper only.

Since RSBY is not entirely free and beneficiary has to pay Rs. 30 for enrolment, the question whether they would renew next year or not was very critical. RSBY provides for hospitalization cover only. This means that only 47% of the beneficiaries utilized it. The rest of the enrolled families would renew only if they see some value in the scheme. In this context the finding in the study that 97% of the families are willing to renew next year is an important one. This demonstrates that the poor and marginalized sections of society consider the scheme to be beneficial and are willing to spend Rs 30/-.

Thus, RSBY is beneficial as reduces financial burden of poor families. Furthermore, if more public hospitals are empaneled then share of Government hospitals can increase in RSBY further.

Conclusion

Now a days, there is lots of discussions and talks on Universal Health coverage. Government, civil societies, Ngo's, academicians and health activists are talking and participating for the design, implementation and package for the universal health coverage, the role of private sector and insurance in it.An article in lancet series in universal health care in India talks about achieving UHC through insurance schemes like RSBY as well as the active participation of private sector (Shiva Kumar et al 2011). On the contrary, high level expert group (HLEG) considering experiences and shortfalls of insurance worldwide has rejected this insurance model, instead HLEG suggested a system where government will be acting as buyer as well as regulator of the private providers services, which will be a tax based financed system.

The objectives of the RSBY scheme are in accordance to the current health scenario in India. RSBY has the potential of protecting people from the ill burden of high catastrophic expenditures in case of illness and thereby preventing their more and more impoverishment, various services available to people under RSBY give them the power and choice to opt for private treatment. However there are number of challenges and roadblocks present in the scheme as illustrated by our study.

One of the main issue is precise population coverage which remains very low, RSBY is designed for the population under below poverty line (BPL) and not covering all of them too, leaving behind more than two-third of population uncovered above BPL line. It's also a bitter truth that there are serious flaws and corruption in defining, identifying and registration of BPL population.

Another issue is implementation of RSBY at all levels, there is lack of accountability, transparency and minimal involvement of community in all this processes. These steps are; selection of insurance companies and TPA's; listing and enrolling of BPL population; informing mechanisms for the population regarding RSBY; empanelment of hospitals; patient's hospitals visits. This all has been discussed and measured in our study where we noted gaps and information bias at ground level. This lack of information among beneficiaries, ambiguity and physical un-accessibility of providers, prevents them from seeking medical services under RSBY. This also give chance to many providers to follow malpractices and make profit at the expense of public funds. Out of pocket expenditure still remains high for poor RSBY beneficiaries despite using RSBY and hospitals selectively deny/filter services as per their ease.

In order to improve the scenario, we have to make beneficiaries more aware and more involvement of community at implementation, monitoring and handling grievances. RSBY does not cover any of primary healthcare level services e.g. curative, preventive and promotive) which is needed for population level impact.

Our study therefore highlights few of its shortcomings and flaws. At times, when RSBY has presented as solution for poor's plight and still not covering the basic services. The question remains whether to invest in primary healthcare services and its infrastructure which caters to larger population or put RSBY in front and invest in it as a solution to provide financial security to poor.

References

1. Globalcenters.columbia.edu. Model Districts Health Project | Columbia Global Centres [Internet]. 2015 [cited 13 October 2015]. Available from: http://globalcenters.columbia.edu/content/model-districts-health-project-0
2. Planning Commission of India. Health, Nutrition and Family Welfare [Internet]. 2015 [cited 01 July 2013]. Available from: http://planningcommission.gov.in/sectors/index.php?sectors=hea
3. Planning Commission of India. High level expert group report on universal health coverage for India [Internet]. 2015 [cited 19 June 2013]. Available from: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf
4. World Health Organization Regional Office for South-East Asia; 2003. Health insurance in India: current scenario. In: Regional overview in south-east Asia. [Internet]. 2003 [cited 10 June 2013]. Available from: 2. http://www.searo.who.int/linkfiles/social_health_insurance_an2.pdf
5. Times of India. Healthcare spending in India [Internet]. 2009. Available from: http://articles.timesofindia.indiatimes.com/2009-08-11/india/28154929_1_healthcare-spending-health- tourism-health-budget
6. Rsby.gov.in. RSBY::Rashtriya Swasthya Bima Yojna [Internet]. 2015 [cited 15 July 2015]. Available from: http://www.rsby.gov.in
7. Rsbygujarat.org. RSBY- Gujarat Website [Internet]. 2015 [cited 15 June 2013]. Available from: http://www.rsbygujarat.org

Table 1: Distribution by socio-demographic characteristics (n=124)

Background Characteristics (N=124)	**Percentage distribution (%)**
Age	
0-20	13
20-40	29
More than 40	58
Gender	
Male	65
Female	35
Residence	
Rural	83
Urban	17
Marital Status	
Married	87
Unmarried	13
Education Status	
No education	58
Primary education	29
Secondary education	13
Occupation	
Student	13
Labour work	45
Household work	30
No work	12

Table 2: Awareness regarding different parameters under RSBY

Parameters	Aware (%)	Not Aware (%)
Aware regarding the concept of "Head of Family"	10%	90%
Awareness regarding maximum member coverage under the Scheme.	74%	26%
Aware regarding registration fees of Rs 30 under the scheme	92%	08%
Aware on Rs 30000/- coverage under RSBY scheme	70%	30%
Aware regarding type of treatment included in RSBY	45%	55%
Aware on provision of Travel allowance under RSBY	53%	47%
Aware regarding renew process of RSBY	75%	25%

Table 3 – Relationship between socio- demographic variable & compulsory member in family

Independent Variable	dependent Variable (compulsory member)	
	Father	***Don't Know***
Gender		
Male	50%	50%
Female	33%	67%
Residence		
Rural	35%	65%
Urban	75%	25%
Education		
No education	21%	79%
Primary education	71%	29%
Secondary education	67%	33%

Table 4 – Relationship between socio demographic variable & knowledge of coverage benefit.

Independent Variable	dependent Variable (knowledge of coverage benefit)		
	Up to Rs 10000	***Rs 30000***	***Don't Know***
Gender			
Male	0	83%	17%
Female	8%	67%	25%
Residence			
Rural	5%	80%	15%
Urban	0	50%	50%
Education			
No education	7%	71%	22%
Primary education	0	85%	15%
Secondary education	0	67%	33%

FIGURES:

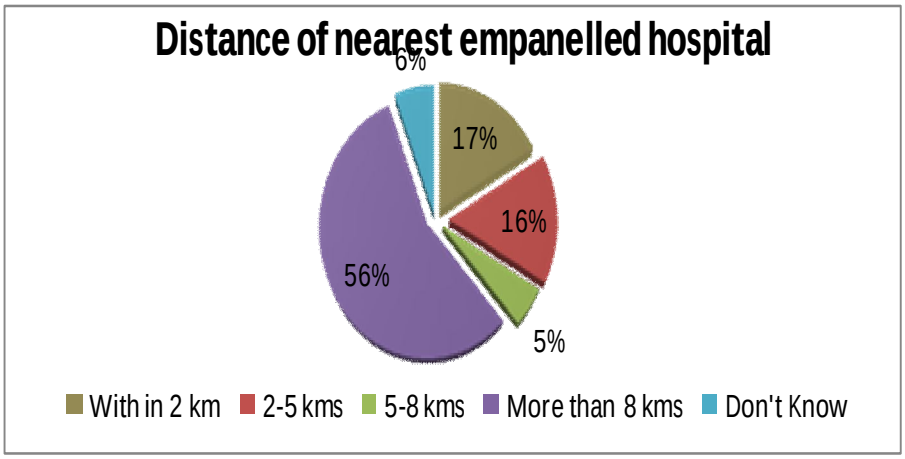

Fig1- Percentage of respondent's aware on distance of nearest empaneled RSBY hospital

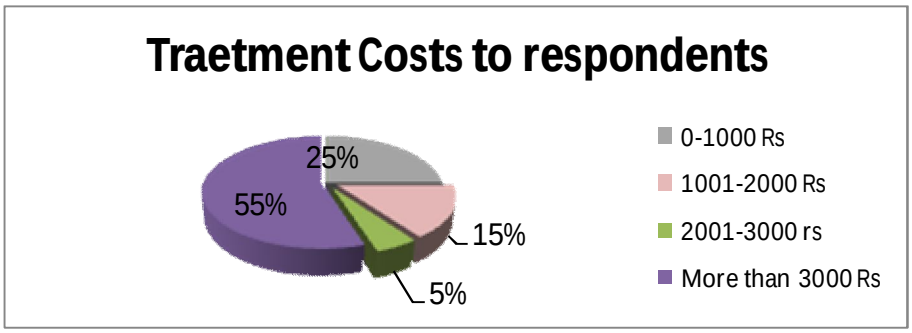

Fig 2 – Percentage of respondent's have to spent to avail services