HEALTH, CULTURE and SOCIETY

The Implementation of RSBY in Chhattisgarh, India:

A study of the Durg district

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Abstract

The Rashtriya Swasthya Bima Yojana (RSBY) scheme is a health insurance model currently being implemented by the Indian government. It is a model, however, still in nascent state, subject to tensions and value testing. Very few studies have hitherto assessed the scheme's implementation and whether the stated objectives of the government initiative are being fulfilled. This short study undertaken in the Durg district of Chhattisgarh reveals that RSBY fails to cover the population living Below the Poverty Line (BPL). Likewise there is discrepancy in the consistency of information and knowledge regarding the scheme among the beneficiaries who are themselves continuing to incur high out-of-pocket expenses.

There are thus severe issues in transparency and accountability within the RSBY scheme. Unless the public health delivery system is strengthened and the private sector regulated and indeed monitored, the scheme will not yield the desired results, and the cost of healthcare will further escalate for the poor. In the absence of regulated health services there needs to be more debate, and indeed greater research, on the implementation and the design of RSBY.

Keywords: Rashtriya Swasthya Bima Yojana (RSBY); insurance; Chhattisgarh; out-of-pocket expenditure

The Implementation of RSBY in Chhattisgarh, India:

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1. Introduction

Providing financial protection against the cost of ill-health is stated as one of the fundamental objectives of health systems. This is in recognition of the fact that the health of individuals and that of the population are severely affected by the accelerating cost of health. The health system in India aims to provide universal coverage to the entire population of the country offering preventive as well as curative health services. The health sub-centre (HSC), primary health centre (PHC), community health centre (CHC) and district hospital play an important role in catering to the healthcare demands at various levels[9]. Nevertheless, India remains one of the countries with poor government spending towards health and a record of high out of pocket expenses.

In India, the private sector accounts for more than 80% of the total healthcare spending in India. In addition to private sector spending, the share of out of pocket expenditure in the country runs high which ultimately creates a financial burden on the households, pushing them increasingly towards poverty. According to Berman et al (2010) more than ten million households in India were pushed below the poverty line (BPL) due to spiraling healthcare spending in 2004.

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[9] A health sub-center (HSC) covers a population of 5000 in all areas except in tribal, hilly or desert areas where there is one HSC for a population of 3000. A Primary Health Center (PHC) covers a population of 30,000 in plain regions and 20,000 in hilly, tribal and difficult regions. Community Health Centers (CHC) are 30-bed hospitals, with laboratory facilities, labor room and an operation theater. These cater for the need of 1.2 lakh of population and 80,000 in hilly or tribal areas. As per the norms, a CHC provides referral back up to about 4 PHCs and 20 HSCs. A district hospital can be 100-bedded or even more with specialists for surgery; gynecology; medicine and pediatrics. The diagnostics need to be sufficiently advanced for it to act as a referral centre.

The burden of costs incurred for accessing medical care has increased over the last two decades. The latest data of the National Sample Survey (NSS) shows that on average, households spend Rs 295[10]for outpatient care and Rs 7,116 for in-patient care. The National Sample Survey 61, moreover, reports per capita expenditure in India to be Rs. 804 in the rural area and Rs. 958 in the urban area (Gupta 2009). In India, health expenditure constitutes approximately 4.7% of the total household outlay (Gupta 2009). Likewise, the average expenditure for every hospitalization has been estimated by Dilip & Duggal at Rs. 3990/- (Dilip & Duggal 2002).The analysis of the NSS 60th round suggests that around 6.2% of the total households (6.6% in the rural areas and 5% in the urban areas) fell below the poverty line as a result of healthcare spending in 2004. Approximately 1.3% of the total households became BPL as a result of expenditure on inpatient care, while 4.9% of households became so as a result of outpatient care (Berman et al 2010).

If the expenditure is disaggregated for private and public facilities, the expenditure is evidenced to be much higher in the former (Selvaraj and Karan 2009). The National Rural Health Mission (NRHM) was launched by the government in 2005 in order to address what was described as the, "systemic flaws in the health system namely, the lack of a holistic approach; absence of linkages with collateral health determinants; gross shortage of infrastructure and human resources; lack of community ownership and accountability; non-integration of vertical disease control programs; inadequate responsiveness to community needs and lack of financial resources" (Planning Commission 2011). Within the paradigm of the NRHM, flexible financing was seen as one of the main approaches. This included risk pooling and demand side financing where money follows patients. However, even with the NRHM initiative and its emphasis on zero user fee services, many are still paying for health care services and out of pocket expenditure for most, is a common occurrence. To reduce out-of-pocket expenditures for health care and lessen a considerable financial burden on the poor, the Indian Government launched the national health insurance scheme Rashtriya Swasthya Bima Yojana (RSBY) in 2007 (Jain 2010)

There have been various studies and commentaries on Rashtriya Swasthya Bima Yojana (RSBY), especially in the last year, like by Narayana (2010), Rathi (2011), Das & Leino (2011), Centre for Policy Research (2011), and Reddy *et al* (2011). These studies have looked at the implementation of RSBY, specifically issues of enrolment; utilization; hospitalization; empanelment of hospitals and out of pocket expenditure incurred by the beneficiaries.

In this study we first introduce the readers to the various components of RSBY design, such as enrolment; empanelment; utilization and the cost of hospitalization; out-of-pocket expenditure; transparency and governance; along with review of relevant literature. We then we go on to describe the study setting, measuring implementation of RSBY as given per secondary sources. The study objectives and methodology will then be introduced in detail. Subsequently, the findings related to the profile of the respondents, their level of awareness, experience of enrolment and of hospitalization, as expenditure incurred, are presented, allowing us to follow on with conclusive discussion.

II. Background to RSBY

In India, health insurance coverage has been limited to those in the organized sector and to those who can purchase insurance privately. There has been a growing concern over the last decade about the lack of social security measures and access possibilities for the 90 percent of the population who are in the unorganized sector. Evidence of

[10] One US Dollar is equivalent to around Rs. 53 (Indian Rupees)

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growing inequities and lack of protection for the majority of the population has consequently led to a renewed interest in health insurance as a way of providing financial protection during times of illness with some of the debates focusing on ways of providing financial protection to the poor so that they do not face indebtedness or slip off the healthcare radar.

There are very few health insurance schemes available for the unorganized sector. There have been several community based insurance schemes mostly run by non-governmental organizations that are scattered with limited coverage. The past decade has witnessed governments introduce and experiment with various kinds of health financing strategies. We remember that a Universal Health Insurance Scheme was launched by the Ministry of Finance in 2003 but failed to take off due to weak design and lack of commitment from the state governments and governing principalities. Few experiments moreover, such as the Rajiv Arogyashri Community Health Insurance Scheme (RACHI) which was launched for BPL families in Andhra Pradesh by the state government in 2007, seemed to gain the necessary momentum for successful implementation.

The debates on universal health insurance culminated with the launch of the Rashtriya Swasthya Bima Yojana (RSBY) in 2007. This was the first scheme to be launched nationally by the central government for the unorganized sector, targeting insurance cover for Below Poverty Line (BPL) households struck by major health trauma necessitating hospitalization. Some of the major actors involved in designing the programme other than the Ministry of Labor included the GTZ[11]; the World Bank and the ILO[12]. RSBY did not replicate any existing insurance model but borrowed design features from several successful community-based insurance systems and nationalized health insurance systems of other countries such as Thailand; Canada; Germany and Chile. RSBY recognizes the absence of health cover as a major insecurity amongst workers in the unorganized sector. It also acknowledges that expenditure relating to medical care and hospitalization pushes people to seek recourse to inadequate, incompetent as well as incomplete treatment. Also taken into account by RSBY is the relative economic loss of work days, this affecting both the livelihood of people as well as the economy (www.rsby.in). The definition for BPL is that which is prescribed by the Planning Commission for determining eligible BPL populations in State/districts[13]. The responsibility of verifying the eligibility of BPL families thus lies with the respective State Governments who have to share the information with the insurance provider.

III. RSBY Design

The cost of running the scheme is divided between the centralized and individual State governments, with the former bearing the major financing input (about 75%) for the scheme. Rs. 30,000 was the set figure as the cap for families, and the scheme was initiated to extend to five members of a family i.e. a unit (up to a unit of five): the household head, spouse, and up to three dependents and/ or dependents would include such children and/ or parents

[11] Since 2007, GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit GmbH) and then its successor organization, the GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit, formed on 1 January 2011 through the merger of DED, GTZ and Inwent) has been supporting the Indian Government in designing and implementing the insurance model on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ). http://www.giz.de/en/mediacenter/672.html .

[12] International Labor Organization

[13] Below Poverty Line classification is calculated by the Planning Commission based on per capita consumption levels

of the head of the family. There was a set registration fee of Rs. 30 to be paid by the family. The scheme was established to cover pre and post hospitalization expenses as well as pre-existing diseases.

RSBY is said to be rooted in a 'business model' in which "all the stakeholders as the service provider, the insurance company etc. have direct benefits, would take a proactive role in making this scheme successful (Government of Chhattisgarh 2008)[14]. The State calls for a private or a public insurance company (licensed by the Insurance Regulatory Development Authority (IRDA) for the bidding process[15]. Some of the requirements of the government on the bids submitted include a benefit package in the form of a cashless facility where smart cards are issued to all qualifying persons. Likewise the package seeks to facilitate engagement with local intermediaries (NGOs etc) for reaching out to BPL families and for assisting members to utilize health services after enrolment. A list of empanelled hospitals participating in the cashless arrangement is required to be submitted by the Insurer to qualifying community members. The empanelled public or private hospitals must meet the basic minimum of government requirements, these being, size and registration; the set up of a special RSBY desk with a smart card reader and trained staff. Compensation for the insurer is based on the number of Smart Cards issued; keeping in mind that the households covered are based on the number of Smart Cards issued, that is, one card per household where up to five members are able to avail facilities. The eligibility of BPL households for the purposes of the scheme is provided by issuing Smart Cards to all beneficiary households.

Enrolment

As per the RSBY website, around 47% of the BPL families are currently enrolled on the RSBY scheme nationwide (www.rsby.in). Tripura has the highest enrollment with 85%, followed by Himachal Pradesh and Nagaland each recording 80%. This nevertheless evidences the substantial gap in scheme accessibility for the Indian population which is largely rural and non-literate. Sun (2011) has studied enrolment patterns at village, household and individual levels using administrative data. The findings indicate that there are wide variations in enrolment rates across villages, districts, regions and demographic groups. Among the selected villages studied, 10% of the villages were without enrolment and only in 2.5% of the villages was every eligible family enrolled (Sun 2011, 94). These variations may be linked to various factors such as discrepancies in BPL data which has not taken into account factors of birth; death; migration or marriage in the subsequent years after the BPL survey was conducted; poor power back up in the villages; low awareness among the people about the scheme and enrollment schedule in their respective villages etc. (Sun 2011). Sun (2011, 95) further asserts that in terms of the insurer's behavior there may be "geographic discrimination based on the cost of enrolment" or "healthier" villages may deliberately be selected for enrolment.

Similarly, Rathi (2011) in his evaluation of RSBY in Amravati, Maharashtra, found that the lack of information and late enrolment led to only 39% enrolment in the district. The tribal blocks of the district which have the maximum number of poor households saw the least enrolment. The study further suggests that beneficiaries were concentrated in certain areas and villages.

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[14] Mr. Anil Swarup, Director General (Labor Welfare) at the State level workshop on Rashtriya Swasthya Bima Yojana held at Hotel Tulip, Raipur on October 15, 2008

[15] The financial bid is an annual premium per enrolled household. Each contract is specified on the basis of an individual State district where the insurer agrees to set up an office in each district. While more than one insurer can operate in a particular State, only one insurer can do so in a single district at any given point in time (http://rsby.in/)

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Evidence was further found in the study by Sun (2011) that even within the enrolled families, five members of the family are not being enrolled under the RSBY scheme (Sun 2011). According to the study, in 31.2% of the families, less than five members were enrolled, and only in 16.1% of the families, all or up to five members of the family successfully became part of the scheme.

Narayana's (2010) study shows that RSBY in its third round covers only one-third (200) of the Indian districts and out of these districts more than 60% belong to just four states; Uttar Pradesh, Punjab, Haryana and Maharashtra. Apart from the above mentioned states and Chhattisgarh, Gujarat, Bihar and Kerala, hardly any enrolment has elsewhere been reported. The study also indicates huge enrolment variation within the states themselves, evidencing low enrolment in poorer districts.

It has been argued that any scheme which targets only BPL families, risks leaving out a large number of actual poor communities due to exclusion errors in the BPL list itself. In Chhattisgarh, the government recognizes 74% of its population as poor and provides subsidized grain (Wadhwa 2010). However, central government has fixed the percentage of BPL in the State at 46%. Hence, there is a huge population of poor people who have not been even considered eligible for the RSBY scheme.

Empanelment

The government has empanelled public as well as private hospitals under the RSBY scheme giving families the choice of selection depending on their accessibility and convenience. According to a survey by Westat India School of Social Sciences (2010), by November 2010 nearly 5000 hospitals were empanelled under the RSBY scheme nationwide. The RSBY review study by Narayana (2010) indeed indicates that the percentage of public hospitals out of those empanelled in the sample States varies from 45.86% in Kerala to 4.95% in Haryana. The study signals that there is no public hospital empanelled under the RSBY scheme in Maharashtra.

Utilization and cost of Hospitalization

Globally, various studies have been undertaken in order to determine utilization and out of pocket expenditure under government insurance schemes. However in India as most of the programs are new, such as the Aarogyasri scheme in Andra Pradesh and the Chief Minister Kalaignar's Insurance Scheme for Life Saving Treatments in Tamil Nadu; extensive data on these aspects remains scant if not unavailable. Research undertaken by Das & Leino (2011) indicates that although spreading awareness through the strategy of IEC (Information Education and Communication)[16], did not have a major impact on scheme enrolment, it did nevertheless have an impact on the utilization rates of those who finally became enrolled. About 4.6% of enrolled households that received the IEC (and 4% of households that received both the IEC and the household survey) have at least once used the services provided under the scheme (Das & Leino 2011).

[16] IEC or 'Information, Education and Communication' is the name given to the communication and education strategy introduced in India first in the 1960s to spread messages regarding family planning. This approach, focused on "driving home a few key messages", has since been criticized for being 'communicator (rather than receiver) centric' and has been discarded in favor of BCC or Behavior Change Communication which involves first understanding people's situations and influences, developing messages to respond to their concerns and using relevant and cultural specific communication processes and media to persuade them to increase knowledge and change risky behavior and practices (PHRN 2009). However, unfortunately, often both nomenclatures are used interchangeably and without appreciating their differences.

According to the study by Hou & Palacios (2011), utilization rates vary largely across villages and districts. Their research reveals that districts served by three of the six insurance companies have higher utilization rates than areas where two of the three are private insurers. It also found that the likelihood of RSBY scheme access depends on the number of people in the same village who have already utilized the benefits and the number of hospitals empanelled under the scheme in the area. The utilization rate is also found to be concentrated to a select few empanelled hospitals in the district (Hou & Palacios 2011).

According to the same study, by June 2010 there were approximately 80,000 hospitalizations per month. The average utilization for all the villages studied stood at 4.3%, and excluding villages where no hospitalization was recorded, the rate rises to around 11%. Only 26% of the sampled villages experienced at least one hospitalization under the RSBY scheme, with the annualized utilization rate being 1.2% for such villages (Hou & Palacios 2011).

Narayana's (2010) findings show that the average hospitalization rate per 1000 persons over a scope of 365 days varies from 3.91 in Punjab to 24.78 in Gujarat. The study also reports the highest hospitalization rate of 196.41 in the Dangs district of Gujarat and the lowest in 0.07 in the Jalandhar district of Punjab. Among the selected States studied, the average cost of hospitalization was highest for Punjab (Rs. 6606) and lowest for Kerala (Rs. 3101). Narayana suggests that the low density of empanelled hospitals and the lower empanelment of the private hospitals in total as the probable factor for variation in district hospitalization rates.

In a study assessing existing health insurance schemes, Reddy et al (2011) find that the nationwide hospitalization rate per 1000 persons for 2009-10 stands at 20, taking into consideration those districts which have completed one year of the RSBY scheme. Assam, Goa, Chandigarh report the lowest hospitalization rates of a mere 1while Gujarat reports the highest at 42. The hospitalization rate per 1000 beneficiaries in other state based insurance schemes is reported to be five in the Rajiv Aarogyashri scheme; four in the Vajpayee Aarogyashri and Kalaignar schemes and 22 in the Yesaswini scheme. This number is high (64) for private health insurance.

As per the study, the average nationwide hospital expenditure for RSBY is approximately Rs. 4262 (Reddy et al 2011). The lowest expenses are reported in Tamil Nadu (Rs. 886) and highest in the state of Punjab (Rs.6554). The claims ratio in this study is found to be 7.15%, with Gujarat having the highest claims ratio of 14.53% and Goa the lowest of 0.20% (Reddy et al 2011).

Out-of-pocket expenditure

A study on the implementation of RSBY in Delhi by Grover & Palacios (2011) found that of the patients interviewed, more than one-third had incurred out of pocket expenditure. The average claim amount was Rs. 3700 and the additional average out of pocket expenditure was Rs. 1690. More than two-thirds of out of pocket expenditure was due to prescribed medicines.

A study conducted to evaluate the Rajiv Aarogyasri Community Health Insurance Scheme in Andhra Pradesh revealed that nearly 60% of the beneficiaries of the scheme incurred out of pocket expenditure of approximately Rs.3600 mainly due to transport, medicine and pre-diagnostic investigations (Rao et al 2010).

Transparency and governance

Narayana (2010) notes that there is very little information available in the public domain and emphasizes the need for greater transparency and proactive disclosure about the details of admissions, the types of illnesses reported, and the procedures for a more comprehensive and cohesive analysis. Rathi (2011) in his evaluation of RSBY raises the issue of lack of a grievance redressal mechanism under the scheme and the lack of coordination

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among the various government departments in implementing the scheme.

IV. Chhattisgarh

Chhattisgarh, a central Indian state, once a part of Madhya Pradesh, came into being in 2000. Chhattisgarh is the 10th largest State in India with an area of 135,191 km^2. With a total population of more than 25 million (Census 2011), it is the 17th largest State of the country by population, having 18 districts[17] (recently further divided into 27 districts) with Raipur as its capital city.

According to the National Family Health Survey (NFHS) -3[18] (2005-06) in Chhattisgarh only 22% of the households are situated in urban areas, with the remaining 78% in rural areas. Of the total households 30% belong to Scheduled Tribes (STs); 14% to Scheduled castes (SCs) and 45% to what is classified as Other Backward Classes (OBC). 72% of the children aged 6-17 years attend school in the State, with 45% of the females and 74% of the males in the 15-49 age group being literate.

According to the Sample Registration Survey (SRS) 2007, the Infant Mortality Rate in Chhattisgarh stands at 59 and according to the SRS of 2004-05, Maternal Mortality Rate stood at 335.

Soon after it came into being in 2000, Chhattisgarh launched a series of health sector reforms in order improve its public health system such as the Mitanin Program[19], a three year medical course, and the formation of a cadre for rural and remote areas. The public health system in Chhattisgarh currently has around 4741 Health Sub-Centers, 721 Primary Health Centers and 136 Community Health Centers in addition to 18 District Hospitals and three Medical Colleges in place.

According to Berman et al (2010), in Chhattisgarh, around 5% of the total households became poor (classified as BPL) due to spiraling healthcare costs in 2004. Of this, 0.5% was due to inpatient care while 4.5% was due to outpatient care in both rural and urban areas. Approximately 5.3% of total household expenditure (5.2% in the rural areas and 5.9% in the urban area) is allotted to health (Berman et al 2010).

[17] In January 2012, the 18 districts were further divided into 27 districts. However, for the purpose of this article we will continue with 18 districts as disaggregated data is not yet available for the new districts.

[18] The National Family Health Surveys (NFHS) program, initiated in the early 1990s, is one of the most important, exhaustive and credible sources of data on population, health, and nutrition for India and its States and is led by the International Institute for Population Sciences. The NFHS-3(2005-06), is the third in the series of these national surveys, and was preceded by NFHS-1 in 1992-93 and NFHS-2 in 1998-99. This survey has been designed to provide estimates of critical indicators on family welfare, maternal and child health, and nutrition along with information on family life education; safe injections; peri-natal mortality; adolescent reproductive health; high-risk sexual behavior; tuberculosis and malaria (IIPS 2007).

[19] The Mitanin Programme is a government Community Health Worker (CHW) program in Chhattisgarh which aimed to facilitate people's access to health services within the village through community-organization building and social mobilization (EUSPP 2011). Lessons from the Mitanin program have helped in the formulation of a countrywide CHW program called ASHA (Accredited Social Health Activist) steered by the National Rural Health Mission (NRHM).

RSBY in Chhattisgarh

In Chhattisgarh, RSBY was launched in June 2009 and Durg was the first district to be enrolled on the scheme. Chhattisgarh was one of the 15 states to have advertised RSBY in 2008. The distribution of Smart Cards began in 2009. A Memorandum of Understanding between the Centre and the State was signed by Director General Labor Welfare and Health Secretary respectively, the former keeping in view that the scheme is to extend to cover all workers in the unorganized sector under the Unorganized Workers Social Security Act.

The partners of the scheme are the Government; the Insurance Company; the Third Party Administrator (TPA) and the empanelled hospitals. As per the guidelines of the scheme, in Chhattisgarh, the insurers were selected through a bidding process. These in turn selected the TPA who is responsible for enrolment.

The RSBY scheme is currently functional in 16 out of 18 districts of Chhattisgarh. Only 47% of all the total of 22, 29,350 BPL families have been enrolled for the purpose of the scheme (Table 1). The enrolment rates vary across the districts with Dhamtari having the highest (65%) and Koriya the lowest (9%) rates (Table 1). The district of our study – Durg – has a total of 257,844 BPL families out of which currently 95,670 families (37%) have been enrolled.

SN	Name of District*	Year of Policy	Percentage enrolled (no. of families enrolled/total no. of BPL families)
1	Koriya	2	9
2	Dantewada	1	12
3	Raipur	2	26
4	Bastar	1	28
5	Kawardha	2	30
6	Durg**	2	37
7	Bilaspur**	2	45
8	Kanker	1	47
9	Mahasamund	2	52
10	Janjgir Champa	1	53
11	Raigarh	1	58
12	Korba	1	63
13	Dhamtari	1	65
14	Rajnandgaon**	2	69
15	Jashpur	1	87
16	Surguja**	2	119***

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	Chhattisgarh		47

Table 1: status of enrolment in Chhattisgarh up to 18th March 2011

*Data not available for Bijapur and Narayanpur
**Total families based on website accessed on 6th August as data unavailable on 18th March 2011
***Enrolment data uploaded on the website could be erroneous of both rounds of enrolment combined
Source: http://rsby.gov.in/Statewise.aspx?state=13 viewed on 18 March 2011

A total of 207 private hospitals and 327 public hospitals have been empanelled under the scheme in Chhattisgarh (Table 2). It is significant that districts with difficulty of access to public facilities, for example the tribal districts of Dantewada; Kanker; Koriya, also do not have private providers who have been empanelled. While in Raipur district, where public facilities are relatively better than the above districts, 72% of the hospitals empanelled are private hospitals. Thus entry of the private sector in providing health services fails to live up to the logic that in the absence or poor functioning of public health services the private sector can effectively take up the task.

SN	District	Private	Public
1	Bastar	4	18
2	Bijapur	0	0
3	Bilaspur	34	55
4	Dantewada	0	11
5	Dhamtari	6	5
6	Durg	20	39
7	Janjgir Champa	9	10
8	Jashpur	2	9
9	Kanker	0	10
10	Kawardha	6	4
11	Korba	13	10
12	Koriya	0	6
13	Mahasamund	5	5
14	Narayanpur	0	0
15	Raigarh	7	10
16	Raipur	91	36
17	Rajnandgaon	3	28
18	Surguja	7	71
	Chhattisgarh	207	327

Table 2: Distribution of empanelled hospitals

Source: http://rsby.gov.in/Statewise.aspx?state=13 accessed 18 March 2011

The utilization status under the RSBY scheme, as per available data, is very low (Table 3). For Chhattisgarh the percentage of hospitalization is 0.39% (20,403 cases). Here too, the highest rate of hospitalization

is in Dhamtari (1.07%), followed by Durg (0.89%) (Table 3). At the time of study, Durg had the highest percentage of hospitalizations.

S.No.	District	Enrolled BPL families	Enrolled population (assuming Five members enrolled per family)	Number of hospitalizations	Percentage of hospitalizations (No. of cases hospitalised/total enrolled population)
1	Kawardha	25372	126860	0	0
2	Koriya	5499	27495	0	0
3	Mahasamund	62390	311950	0	0
4	Dantewada	9924	49620	44	0.09
5	Bilaspur	104626	523130	977	0.19
6	Rajnandgaon	78062	390310	858	0.22
7	Surguja	139192	695960	1617	0.23
8	Raipur	96516	482580	1663	0.34
9	Korba	72131	360655	1263	0.35
10	Kanker	27822	139110	511	0.37
11	Jashpur	57552	287760	1145	0.4
12	Janjgir Champa	68558	342790	1453	0.42
13	Bastar	43770	218850	1119	0.51
14	Raigarh	114695	573475	3505	0.61
15	Durg	95670	478350	4255	0.89
16	Dhamtari	37344	186720	1993	1.07
17	**Chhattisgarh**	**1039123**	**5195615**	**20403**	0.39

Table 3: Status of utilization as of March 2011

Source: http://rsby.gov.in/Statewise.aspx?state=13 accessed 18 March 2011

The total cost of hospitalization comes to approximately Rs. 95 million. The average cost of hospitalization for the State is Rs. 4,650 (per case). The cost of hospitalization for all the districts is detailed in Table 4. We find that the highest average cost of hospitalization is in Raipur district (Rs. 6,678), which incidentally also has the highest percentage of private hospitals empanelled (72%) (Table 2).

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S. No.	Name of District*	Number of Hospitalizations	Cost of Hospitalization	Average Cost of Hospitalization
1	Raipur	1663	11106335	6678
2	Bilaspur	977	6193850	6340
3	Janjgir Champa	1453	7806662	5373
4	Dhamtari	1993	10405190	5221
5	Raigarh	3505	16801475	4794
6	Jashpur	1145	5487550	4793
7	Korba	1263	6035175	4778
8	Dantewada	44	210000	4773
9	Surguja	1617	6463405	3997
10	Kanker	511	2001925	3918
11	Durg	4255	15780228	3709
12	Bastar	1119	3895700	3481
13	Rajnandgaon	858	2678050	3121
	Chhattisgarh	20403	94865545	4650

Table 4: Cost of hospitalization as of March 2011

*No hospitalizations reported in Bijapur, Kawardha, Koriya, Mahasamund and Narayanpur districts.

Source: http://rsby.gov.in/Statewise.aspx?state=13 accessed 18 March 2011

In eight out of the thirteen districts reporting hospitalizations, the average cost of hospitalization is higher than the State average.

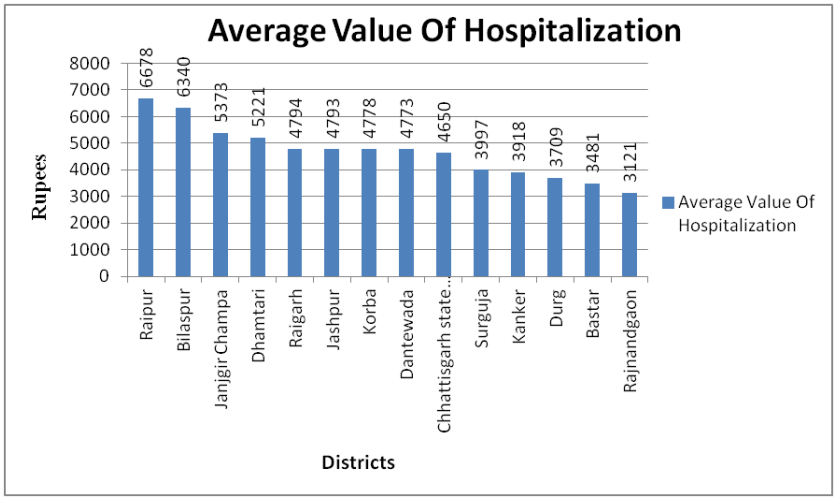

Figure 1: Cost of hospitalization as of March 2011

*No hospitalizations reported in Bijapur, Kawardha, Koriya, Mahasamund and Narayanpur districts.

Source: http://rsby.gov.in/Statewise.aspx?state=13 accessed 18 March 2011

The Durg district

The district of our study, Durg, had a total of 3,196 RSBY cases as of May 2010 (DPMU 2010)[20]. The majority of cases (82%) were from private hospitals while only 18% were from public hospitals. The information accessed from the District Programme Management Unit (DPMU) shows that compared to private hospitals, a higher percentage of cases from public hospitals were rejected by the Insurance company (Table 5).

Type of Facility	No. of cases	No. of cases rejected	% of cases rejected out of total claimed
Private	2633	252	10
Public	563	86	15
Total	3196	338	11

Table 5: Details of RSBY cases in Durg (as of May 2010)

Source: DPMU, 2010

V. Study Objectives and Methodology

The objective of our present study is to assess the implementation and viability of the RSBY scheme in Chhattisgarh in order to identify RSBY Policy gaps and program inconsistencies in terms of enrolment; information dissemination; service utilization; empanelment; availability of services in hospitals; transparency and the extent of out-of-pocket expenditure incurred by beneficiaries.

Secondary data was collected from the RSBY website (http://rsby.gov.in/Statewise.aspx?state=13), first accessed in April 2010 and then in March 2011. Data analysis was undertaken on equity aspects: enrolment; coverage; hospitalization and empanelment.

District selection

The district of Durg was selected as it had the highest percentage of hospitalization under the scheme at the time (April 2010) and was also the first district to be enrolled.

Hospital selection

Data was collected from two public hospitals and five private hospitals in the Durg district of Chhattisgarh. The selection of the hospitals was based on those with the highest number of cases served under the RSBY scheme, as per data provided by the District Programme Management Unit (DPMU). Two public hospitals with the highest number of hospitalizations were selected for our study. The private hospitals were selected through convenience sampling from among those with the highest utilization. Four days were spent at each hospital.

[20] Report given by the District Program Management Unit till May 2010

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Name of Hospital	Type	Number of cases under the RSBY scheme as of May10 *	No. of Respondents
CHC Gunderdehi Villages- Khalari and Khamrod	Public	34	30
District Hospital	Public	518	20
Chandu Lal Hospital	Private	380	7
Gayatri hospital	Private	328	18
Verama hospiatal	Private	255	10
SS hospital	Private	213	8
City Hospital	Private	74	7

Table 6: Details of sample hospitals

* Source: DPMU, Durg (2010)

Sample selection

A total of 52 people from public and 50 people from private hospitals were interviewed. This comprises of 4% of total hospitalized cases in the Durg district and 2% of total cases in Chhattisgarh (as of 30 April 2010). The study covered two out of the total of 16 empanelled public hospitals and 5 out of the total 10 empanelled private district hospitals study (Table 6).

Primary data was gathered through patient interviews availing the RSBY scheme both from public and private health facilities and was collected during May and June 2010. The selection was done as per patients available on the particular days researchers visited the hospitals. For the CHC, initially, exit interviews of the patients were conducted with an alternative methodology thereafter being adopted owing to the hospital ceasing to admit patients under the RSBY scheme for a week in June as the RSBY supervisor had taken leave. The team therefore identified two villages with the highest RSBY beneficiaries through discussions with CHC staff and visited those villages (Khallari and Kamraud). In the villages, the research team took the help of the ASHAs (Accredited Social Health Activists) known as Mitanins in Chhattisgarh, to identify beneficiaries who had availed RSBY in the CHC over the last two months. The beneficiaries were then interviewed.

An attempt was made to cover 10 cases (10 such patients who had utilized the RSBY scheme) per hospital. The selection of the patients was based on convenience both in the hospitals and the villages.

Interview method

The study was undertaken using a structured questionnaire in the form of exit interviews. The questionnaire used was first pilot tested on five patients. Information regarding the awareness of the scheme and enrolment procedure was gleaned by assessing sources of available information on RSBY; public awareness of the breadth of coverage; knowledge of treatment covered; enrolment sites and respective locales; public awareness of costs

incurred in reaching enrolment sites and venues; awareness of the registration fee incurred and knowledge of the validity of the Smart Card and its renewal procedure.

To elicit information on hospital procedures, our questionnaire focused on the illness/symptoms that prompted patients to seek health assistance; the hospital approached for treatment; the mode of travel to hospital; the assistance received at the RSBY counter; the diagnostic test undertaken and knowledge of credits blocked from the card following hospitalization and those remaining to be utilized.

Information was also gathered on access to medicine; expenditures incurred through out-of-pocket expenses during hospitalization (whether these be for medicines or tips). Our questionnaire sought to elicit responses on the procedures undergone by the patients and whether they had been duly informed of diagnostic procedures and the respective costing this incurred.

Demographic profile/s

Our study collated responses from a sample of 50 beneficiaries who were admitted and treated at public institutions and 52 at private sector hospitals.

56% (57) of the respondents were female and 44% (45) male (Table 7). There were 25 male and 27 female respondents from public hospitals with 20 male and 30 female respondents from private hospitals. Most of the cases were aged between 19 and 59 years.

Among the respondents, around one fourth was not literate. Though the average number of family members of the respondents was 5, significantly, 37% had more than five members in their family. 77 % of respondents in public hospital and 34% respondents from private hospitals were from rural areas.

Particulars		**Percentage**	**Number**
Sex	Female	56	(57)
	Male	44	(45)
Age	Below 5 years	1	(1)
	5-18 years	11	(11)
	19-59 years	75	(76)
	60 years and above	14	(14)
Caste	ST	27	(28)
	SC	21	(21)
	OBC	9	(9)
	General	43	(44)
Marital status	Unmarried	25	(25)
	Married	67	(68)
	Widowed	8	(8)
	Divorced	1	(1)

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Level of schooling	Primary	58	(59)
	Secondary	19	(19)
	No education	24	(24)
Number of family members	5 and below	63	(64)
	Above 5	37	(38)

Table 7: Distribution by demographic characteristics (n=102)

Awareness of RSBY and respective enrolment procedures

The success of any program depends on the awareness levels of the people it is meant to engage with. A significant number of the respondents came to know of the scheme through Panchayat/ward members[21], this, being understood as word-of-mouth. None of the respondents affirmed that they had received RSBY information through government health practitioners.

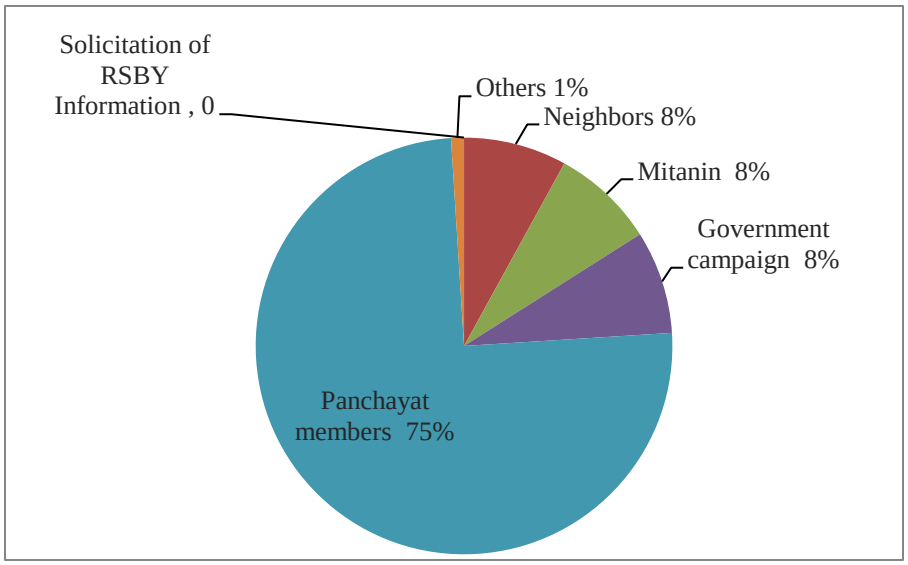

Figure 2: Persons giving information about RSBY

When inquired as to the purposes of the Smart Card, what it stood for and how it could be utilized, the majority of patients simply understood it to be along the lines of "health insurance" or a "free medical services". Patients, however, remained unaware of the details of scheme entitlement and usage. Although awareness regarding the amount available under the scheme was high, knowledge of the Smart Card validity period and the qualifying number of family members to be enrolled in a family was scant (Table 8).

[21] Panchayat members are elected representatives who are part of the Panchayat Raj System, a system of local self governance involving village councils, in India.

Parameters	Aware	Unaware
Awareness regarding scheme purpose	84%	16%
Awareness regarding amount covered under scheme	90%	10%
Awareness regarding the Smart Card validity period	25%	75%
Awareness regarding the number of family members who could be covered under scheme	31%	69%

Table 8: RSBY awareness

Enrolment onto the RSBY scheme is undertaken by the TPA. The procedure includes taking thumb prints and photographs of the family members to be covered and a deposit of Rs.30 per family. The Smart Card is prepared on the spot, with the enrolment team handing over the card to the beneficiary before it leaves the village. The card becomes functional one month later. The TPA is also supposed to provide all the families with an RSBY brochure listing empanelled hospitals and the respective scheme entitlements.

Our study found that at the time of enrolment, both thumbprints and photos were effectively taken of all the respondents. However, in 99% of studied cases, the RSBY brochure was not given; consequently, respondents were without the list of empanelled hospitals at the time of enrolment. All the respondents reported paying the registration fee of Rs 30.

In 92% of cases, family members accompanied the head of family. In 6 out of the remaining 8 families, only the head of the family was enrolled. Although more than one third of the families had more than five family members, an average of four family members per family was enrolled onto the scheme.

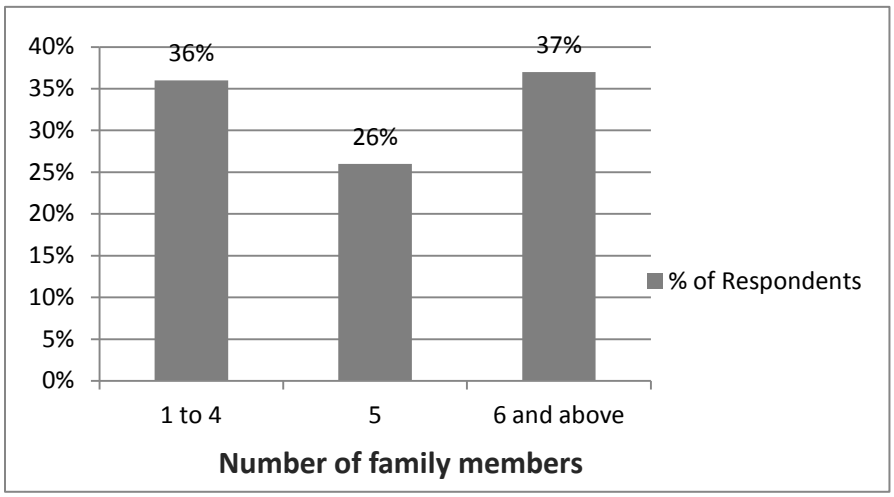

Figure 3: Number of family members

The average number of days taken to receive the Smart Card was 29. Only 4% of the respondents received the card on the same day, whereas for the rest, the time taken to receive their cards ranged from two to an excess of 150 days (Figure 4). The guideline, however, states that the card is supposed to be given to the beneficiary on the day of enrolment as the RSBY entitlement starts from that day itself. A delay in receiving the Card thus can logically signal a delay in accessing health care and assistance.

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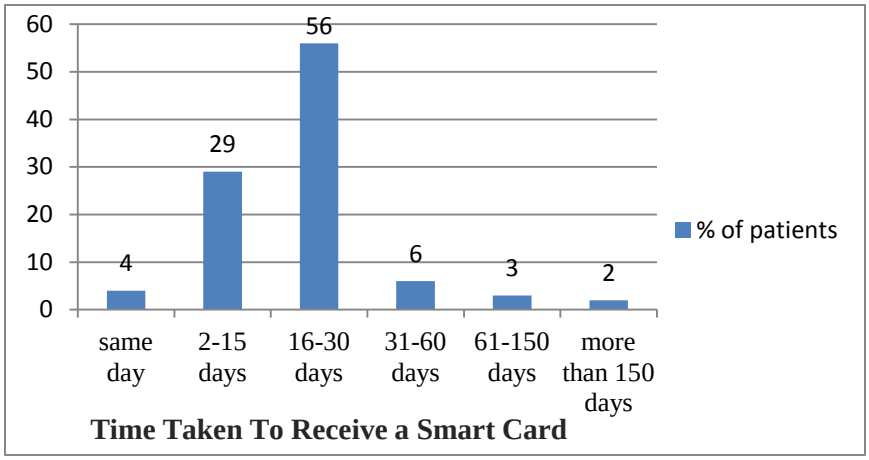

Figure 4: Waiting time for the Smart Card

While 77% of the respondents had visited local schools for enrolment, 17% were enrolled in their Panchayat, with four percent in the community hall. None of the respondents had to spend any money in reaching enrolment venues.

Hospital selection

The respondents were asked as to who had suggested services/treatment from the respective hospital: 24% stated neighbors; 21% stated the Mitanin (ASHA in Chhattisgarh) as the source of information; 16% said that either relatives or the TPA who enrolled them were the source of information; 9% stated that health staff had recommended access services from a particular hospital. If we compare the respondents at the public facility and the private facility, it was found that 40% of the patients at former were informed by the Mitanin (ASHA) to access services from that particular facility while the health staff suggested private hospitals (Figure 5).

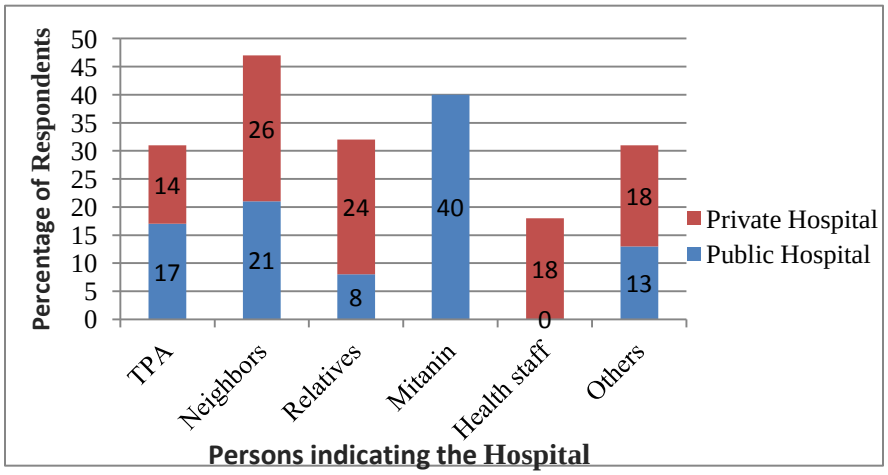

Figure 5: Persons suggesting a private/public facility

In order to reach the hospital, 60% of the respondents required public transport, whilst 37% opted for private transport. Three percent walked. 99 out of 102 patients used some form of transport and the average amount spent on such was Rs. 57.

Reasons for which medical care was sought

In terms of the reasons for which medical care and assistance was sought, 33% said they did so because of weakness; 18% stated fever; 13% said they came for surgery; 10% due to abdominal pain, and nine percent because of accidents. Other than this, 5% sought treatment for diarrhoea/dysentery/vomiting; 3% for undergoing C-Section; 2% had paralysis and one person had come to seek treatment for AIDS.

Reason for Hospital visit / admission	Male % (n=45)	Female % (n=57)	Total % (n=102)
Weakness	29	33	31
Fever	22	12	17
Surgery	4	5	5
Abdominal pain	4	12	9
Accidents	11	2	6
ENT	4	5	5
Diarrhea/dysentery/vomiting	2	7	5
Delivery	0	7	4
Paralysis	4	0	2
AIDS	2	0	1
Fracture	7	0	3
Uterus problems	0	12	7
Others	9	4	6

Table 9: Reasons for accessing care

Hospital experience

At the hospital, 97% said that their card was seen first and verified by the RSBY Registration Counter (RRC). For the remaining 3% the card was seen at the OPD (Out Patient Department) counter. According to registration norms and RSBY protocol, it is mandatory for the hospital to issue verification slips which then need to be presented to the attending clinician. In 70% of the cases, no verification slips were issued.

Patients were mostly unaware of Smart Card verification. In 70% of cases, the doctor had requested the card be verified. Others requesting verifications were attendants (13%); receptionists (11%); nurses (3%) and data entry operators (1%).

The average waiting time for verification was 14 minutes. The average waiting time for medical consultation and assistance was nine minutes, and the average time of consultation was 11 minutes.

Diagnostic facilities and medicines

Diagnostic tests were indicated for 63% of patients with 17% not requiring such procedure. 40% of the patients in the public hospital and 86% of the patients in the private hospital were asked to get diagnostic tests done. Of the patients who were prescribed tests, nearly all had to get their blood tested (Figure 5). Other tests were those of Urine; stool; X-Ray; Sonography; ECG, and a CT Scan.14% of the respondents were unaware of the nature and intent of the tests requested (Figure 6).

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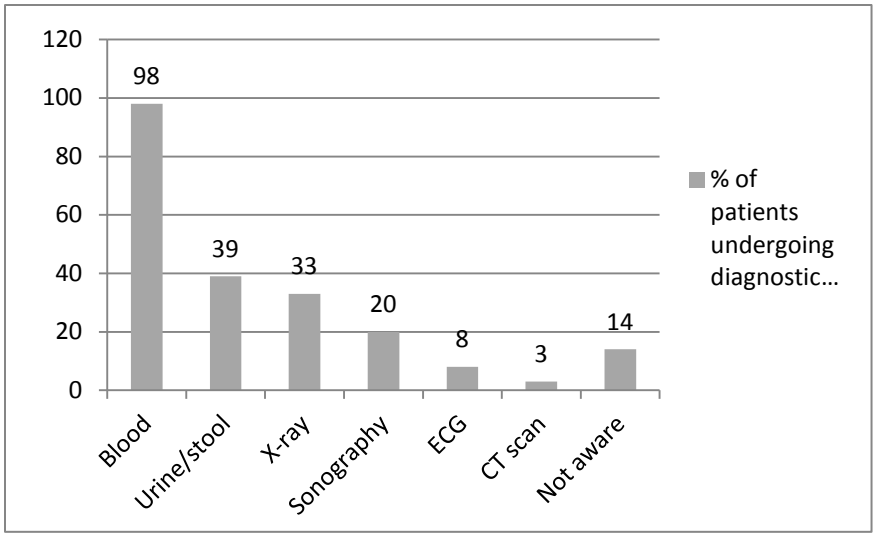

Figure 6: Diagnostic tests (n=64)

In 75% of cases, the requisite tests were undertaken on site at the hospital itself, with 19% of cases being undertaken outside in private laboratories (Figure 7).

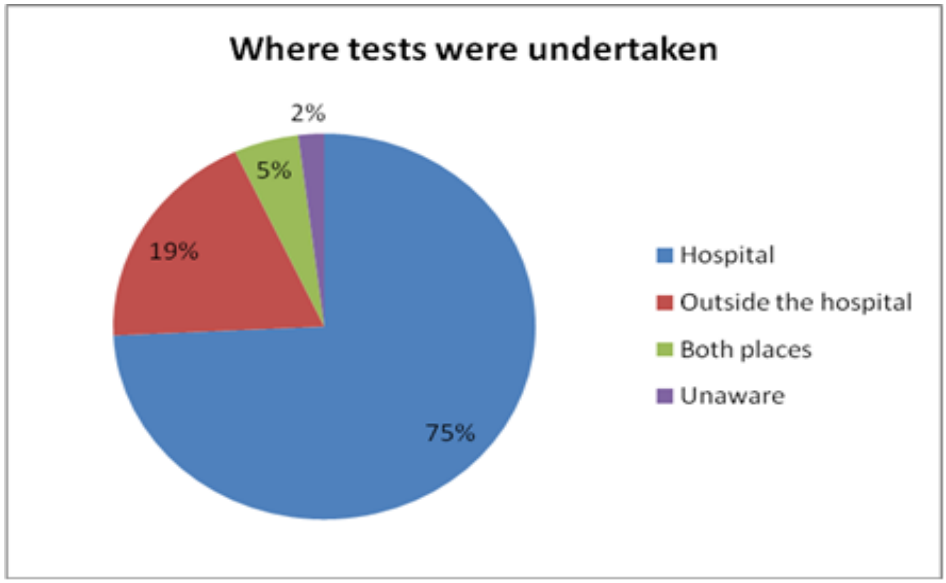

Figure 7: Site of diagnostic test

For 60% of the respondents, medicines were available in the hospital while for 38% of patients, medicines had to be purchased from private pharmacies (Figure 8).

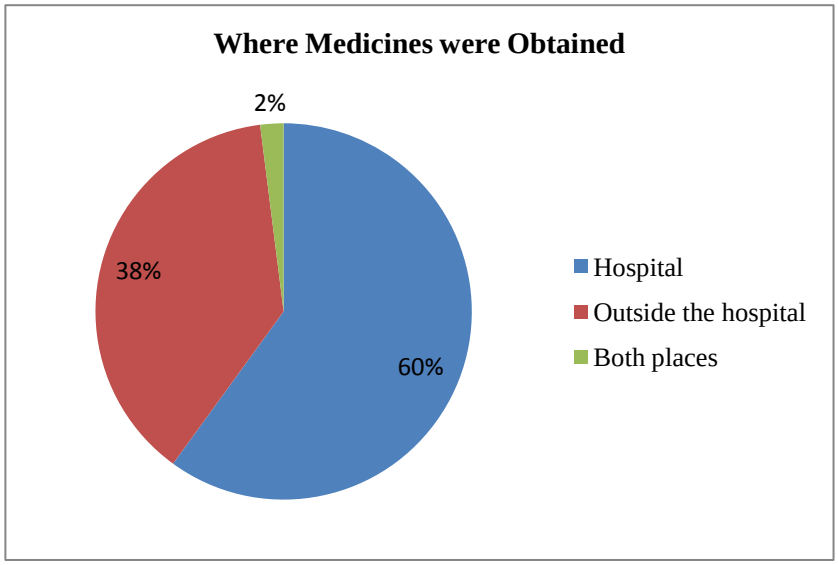

Figure 8: Availability of medicines

Among the respondents who purchased medicines off-site, the respective pharmacy was indicated by the RSBY nodal person in 50% of cases; in 45% of cases it was the attending clinician whilst others indicated for the remaining five percent of cases.

Hospitalization period

The average days of hospitalization recorded were five. Though all patients were recorded as being hospitalized, 26 (25%) said that they were never hospitalized. Six of these patients were from the private hospitals and 20 were from public sector hospitals. Of the persons hospitalized, most of them were admitted to the general ward (Figure 9). Furthermore, 50% of patients required a form of procedure during their stay.

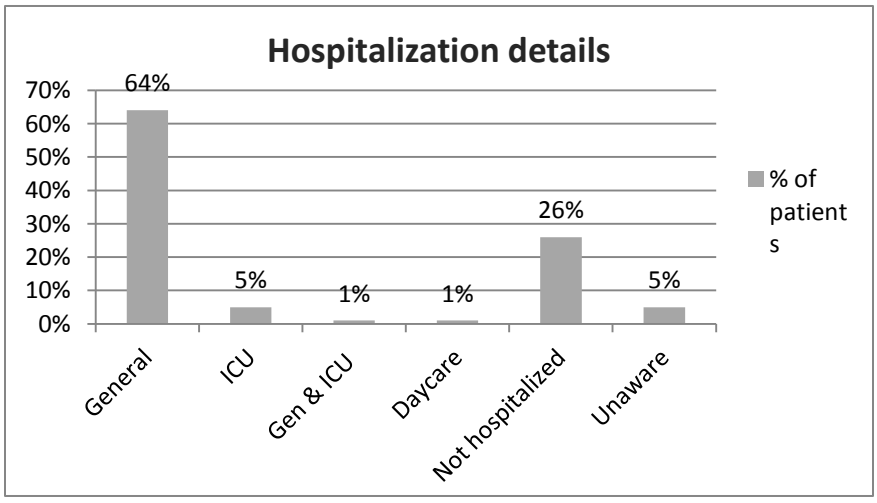

Figure 9: Details of hospitalization

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RSBY entitlement and scheme utilization

Among the patients, 77% of had previously utilized the RSBY scheme. Out of the total respondents, 63% were aware of the amount of money blocked by the hospital for the current hospitalization while 37% were unaware of how much money had been blocked by the hospital or indeed how many credits remains on the Smart Card.

The average amount blocked was Rs 6622. This was higher in the private hospitals than in the public hospitals (Figure 10). 59% of the respondents were not given any receipt for the amount blocked from their RSBY card. 99% of the respondents received transport charges of Rs 100 by the hospital as per RSBY norms.

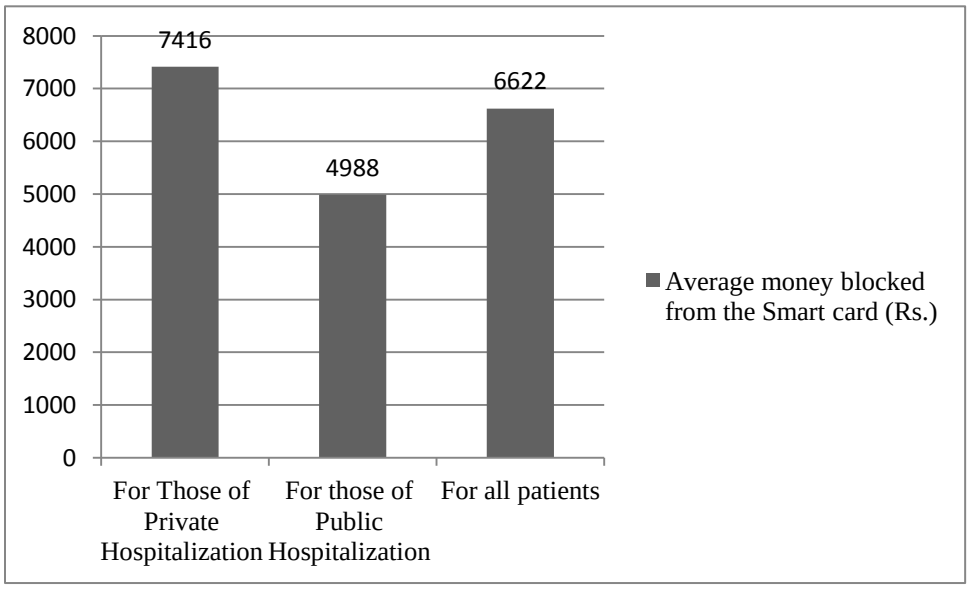

FIGURE 10: Money blocked from Smart Card

Out-of-pocket expenditure

Of all the respondents, 37% incurred out of pocket expenditure. 58% who went to private hospitals incurred out of pocket costs as compared to the 17% of public hospital respondents.

The average amount of out of pocket expenditure was Rs 686. In the public hospitals the average amount the beneficiaries had to spend was Rs 309 while in the private hospitals it stood at Rs 1079 (Figure 11).

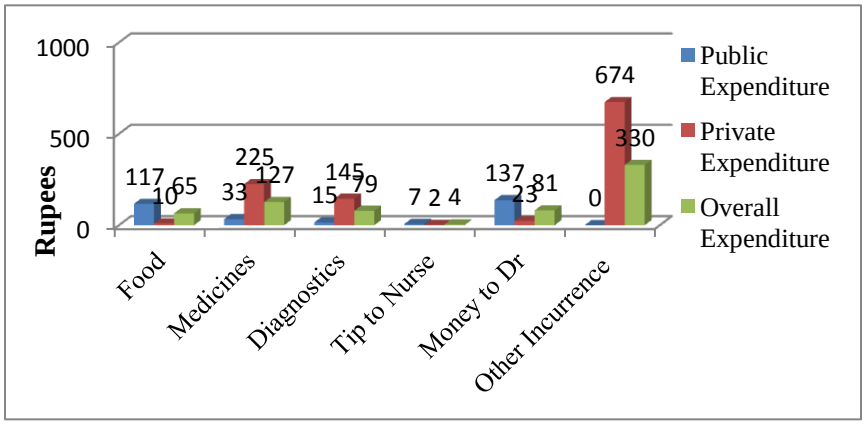

Figure 11: Expenses incurred

19% of the expenditure was on medicines; 12% as money given to doctor; 11% in diagnostics; 9% on food; and one had to tip the nurse (Table 15). 48% of the respondents were not aware of the purpose for which all the money had been solicited

Expenditure Head	% to Total spent		
	Public	Private	Total
Food	38	1	9
Medicines	11	21	19
Diagnostics	5	13	11
Tip to Nurse	2	0	1
Money to Doctor	44	2	12
Others	-	63	48
	100	100	100

Table 10: Head-wise percentage for out-of-pocket expenditure

VI. Discussion

Low Coverage of poor families in the State

Enrolment and coverage of the poor: Analysis of secondary data shows that less than half of BPL families in the district and the State have been enrolled onto the RSBY scheme. Although the scope of our study did not reach to exploring the factors for low enrolment in Durg, such a low rate signals that a significant number of poor families are still excluded from the scheme. This finding correlates with other research undertaken by Sun (2011), Rathi (2011) and Narayana (2010). It also emphasises the need for identifying the reasons for low enrolment, as well as the necessity for stricter monitoring of the TPA and formulating strategies in order to ensure that the poorest are not excluded. The actual number of poor in the State, moreover, may be resolved only through universal coverage of RSBY. The Central Government has agreed to expand RSBY to all workers under the National Rural Employment Guarantee Scheme (NREGS)[22], yet this still remains to be implemented.

Number of family members covered: The scheme stipulates that a maximum of five members may be covered in a family. In the study, 37% of the respondents had more than five family members, hence they had to make a decision as to who to include and who to exclude. This finding corresponds to data collated by Sun (2011) showing that .in a society with such widespread discrimination against women; young girls; disabled persons and the elderly, there is a danger of the most vulnerable members of the family being left out.

[22] The National Rural Employment Guarantee Act provides a minimum of 100 days of work annually for all rural families.

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RSBY awareness

Our study shows that Panchayat members have played an important part in introducing the scheme to the people while in rural areas Mitanins also proved instrumental in facilitating scheme access. Nevertheless, community awareness regarding the details of the scheme was low. A brochure along with the list of hospitals was to be distributed at the time of enrolment, as scheme protocol, but our research shows that this simply was not the case. Consequently, the respondents saw RSBY as a health insurance scheme; they were unaware of pre and post hospitalization coverage; diagnostic, transportation, follow-up and food expenses. Likewise, respondents knew little if not nothing about scheme choices and entitlements; the empanelled hospitals or the money blocked for each spell in the hospital. This demonstrates that necessary and adequate information was not shared with people during enrolment or afterwards, and that there is a weakness in the community dissemination of crucial scheme information.

For ensuring successful implementation and optimum utilization of any health insurance scheme (and indeed in order to optimize community access), beneficiaries need to have knowledge and information about the scheme, its workings as well as its limitations. The strategy of IEC has shown to have a positive role in increasing utilization trends (Das & Leino 2011). The lack of knowledge and information not only prevents utilization of health insurance benefits but may also lead to malpractice by the hospitals. Therefore in order to empower beneficiaries, spreading awareness through the use of both written and oral media is adamantly necessary. The possible ways of spreading scheme awareness could be through community wall writings and billboards, radio/TV program similarly, and the use of local folk media such as street theatre, songs, etc. Orientation about the scheme to key persons in the village or to Panchayat members could also prove equally useful.

Enrolment procedures

Our study indicates that families are at risk to losing out on precious time to utilize the card: the Smart Card has to be given to the beneficiary before the enrolment team leave the village, however, this has not been the case for there have been delays in card issuance.

The enrolment procedure itself did not cause inconvenience incurring little financial burden other than Rs 30 per registering family. Requisite scheme information such as the list of empanelled hospitals, an RSBY brochure or key phone numbers of the respective officials was lacking. For a number of families, only the head of the family received scheme coverage for the rest of the family members did not attend the enrolment session. Such patterns and tendencies indicate a failure to follow-up and ensure coverage for all family members at a later date.

Empanelled institutions

In Chhattisgarh 61% of the empanelled facilities are public. This is a positive trend, considering that nationally, 70% of the empanelled hospitals are from the private sector (Narayana 2010).

The process of empanelment is, however, without transparency and remains independent of the public domain for hospitals with highly inadequate facilities were also clustered and empanelled under the scheme. The empanelment of private facilities had also been propagated in order to increase access to health services in areas where the public health system was not functioning well. Yet when we look at secondary data it is evident that this is not the case. Districts with a weak public health system simply do not have the adequate number of private facilities to fulfil the demands of access and coverage. For example, although tribal districts represent nearly half the number of total districts in Chhattisgarh, RSBY has not been initiated in two of the districts and in remaining districts only 6 % of the total private hospitals have been empanelled. 44 % of the total private hospitals empanelled in the State are in Raipur, where the State capital is situated, which at the same time has functional public health facilities.

None of the private hospitals have been empanelled in remote districts such as Kanker, Koriya, and Dantewada thus no additional facilities have emerged through RSBY.

Low utilization rates

The rate of utilization may be analyzed in two ways. One would be to assess the hospitalization rate for a particular population and to what extent RSBY is able to cover demand. The second analysis would be to see how healthy the claims ratio is.

In terms of hospitalizations, secondary data shows an abysmally low rate of hospitalizations, a mere 0.39% in fact. The need is much higher for as we find in some states scheme utilization has reached more than 20% (Reddy et al 2011, Narayana 2010).

In addition to low utilization trends, the study also reveals that around one fourth of the patients who were shown to be hospitalized were not actually hospitalized. This, points to the risk of fraud and malpractice by empanelled hospitals that artificially increase the utilization rate for the ends of financial return. More stringent checks, protocols and balances need to be put into place to reduce the tendency of scheme fraudulence.

The low rate of hospitalizations in Chhattisgarh further signals that in proportion to the premium paid by the Government to the insurance companies, claims have been miniscule. Literature reveals that the claims ratio of a well functioning insurance scheme has to be around 80% (PHRN 2009). Studies show that nationally the claims ratio in RSBY is low (Reddy et al 2011). Past evidence suggests the response of targeted groups to insurance schemes may be disappointing. This however relates to informational and administrative impediments rather than a deliberate choice or risky behavior.

Hospitalization costs under the RSBY scheme

The Chhattisgarh study shows that the cost of hospitalization is significantly higher than in other Indian States (Reddy et al 2011, Narayana 2010). As the amount does not include the out of pocket expenditure incurred by the patients, it therefore may be concluded that the actual expenditure per hospitalization is much higher. This, therefore, signals the increasing cost of care which may be artificially created.

Out-of-pocket expenditure

Our study evidences that more than one third of the beneficiaries had to incur out-of-pocket expenditure and this was more the case in private hospitals. Such findings correlate with the study in Delhi by Grover & Palacios (2011). In private hospitals, maximum expenditure is on medicines, and diagnostics. This too mirrors the findings of Grover & Palacios (2011). In the public hospital, most of the expenditure was on food and money given to the doctor. Such high expenditure in this 'cashless' scheme is of serious concern as the RSBY initiative was seen as a model to remove such healthcare costs.

Our study thus points to high expenditure despite the ethos of the scheme. RSBY was initiated with the logic of cushioning the poorer section of the population. This philosophy nevertheless seems to be compromised as expenditure is still incurred and continues to be high.

Issues of transparency

Transparency of the scheme seems to be highly questionable considering that many patients were unaware of the amount deducted from the Smart Card and receipts were not given to beneficiaries after the treatment. The hospitals too are not informed of the reasons for the rejection of claims while in the study we found that a significant number (11%) of cases had been rejected. During data collection, details of hospitalizations and hospital wise data

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were not made available. A detailed and meaningful analysis can only be possible through a higher level of disclosure (Narayana 2010).

VII. Conclusion

Currently, there have been many discussions and debates on the model for universal healthcare coverage in India. We have seen the participation of Government, committees set up for health planning and policy; academicians; civil society and health activists regarding the design and universalization of healthcare and within it, the role of insurance and the private sector. An article in the Lancet series on Universal health care in India signaled the move towards universalizing health coverage through insurance schemes akin to the RSBY scheme, as well as the active participation of the private sector (Shiva Kumar et al 2011). However, the High Level Expert Group (HLEG) on Universal Health Care established by the Planning Commission, taking cognizance of the shortcomings of insurance and experiences worldwide, has rejected the insurance model (HLEG 2011). The HLEG has instead recommended a tax-based system for universalizing healthcare coverage where the government rather than an external agency like the TPA buys the services of private providers.

In order to understand the scope and impact of RSBY, investigative and planning effort needs to be placed within the wider health policy and strategy of India. RSBY came on the heels of the government's flagship program, the National Rural Health Mission (NRHM) which started in 2005 and which continues to provide the framework within which health programs are being designed. NRHM is seen as a comprehensive healthcare model aimed at improving access to quality health services in rural areas through decentralization; flexible financing; improved management capacity and community participation. RSBY on the other hand uses an insurance route with the high involvement of the private sector. There thus seems to be a lack of symmetry between NRHM and RSBY.

The objectives of the RSBY scheme are nevertheless pertinent to the current health scenario in India. RSBY has the possibility of protecting the poor from high hospitalization expenses thereby preventing such a proportion of the population from further impoverishment. For the people utilizing RSBY, the services available seem to have expanded with the choice of accessing private healthcare providers. However there are a number of challenges and weaknesses in the scheme as illustrated by our study.

One main issue is precisely population coverage which remains very low in India. In contrast, we find that many countries such as Canada, Germany and Thailand have achieved very high nationwide coverage through their health insurance schemes. RSBY is supposed to cover only a third of India's population, specifically those living Below the Poverty Line (BPL).Yet it is a well known and documented reality that there are serious problems in definition, estimation and identification of the poor in BPL surveys.

Another set of issues are in the implementation of RSBY at all levels; from selection of the insurance companies and TPAs; enrolling of the BPL population; mechanisms for informing the population about the scheme; empanelment of hospitals, to the patients' hospital visits. At all levels there are concerns relating to accountability and transparency. This has been largely discussed in our study where we evidence major gaps and the lack of structural cohesion. The slow pace of enrolment combined with the lack of information and ambiguity about the scheme amongst the beneficiaries, prevents them from seeking medical care under the scheme. This results in a low claims ratio benefiting the insurance company at the cost of public funds. Out-of-pocket expenses for the poor continue to be very high despite the utilization of RSBY and hospitals have been found to selectively deny and filter certain services to the poor. In order to improve the implementation of RSBY, more information needs to be made available to the beneficiaries. Involvement of the community both in implementation and monitoring is critical to ensuring that the poor are actually benefitted from such insurance programs (Desai 2009). In the case of RSBY, in-built mechanisms for such community processes are absent.

Many of the above concerns have been addressed by countries such as Germany; Thailand; the Philippines, Canada and Chile through setting up strong regulatory frameworks, and empowering the beneficiary. While RSBY can take a lead from these countries, it is also important to understand the differences of context. RSBY is meant for people in the unorganized/informal sector in India who are in fact highly scattered, disunited, impoverished, disempowered and who have low bargaining power. This scheme pits the unorganized sector poor in India against the powerful private for-profit agencies like insurance companies, TPAs and hospitals, which, as experience has shown can hardly be expected to work in favor of BPL families. For many other developing countries the challenges have remained in terms of health equity, poor health infrastructure, problems of geographical access and unhealthy competition between public and private providers. The challenge, both structural and ethical, is great.

Furthermore, there are serious doubts as to whether the health outcomes at the population level would improve through such a scheme as RSBY – it simply does not cover the range of primary health care services (curative, preventive and promotive) required for such an impact. There remains a fundamental design-flaw, namely the lack of access to free and quality primary healthcare and the low coverage of catastrophic illnesses striking the poor. While today in India, the availability of free health care for primary illnesses and low health status of the rural poor are serious concerns, experiences world-wide have shown that insurance schemes may lead to an artificial increase in costs and inferior health outcomes.

Our study therefore throws serious doubts on whether RSBY is actually making free and quality healthcare more accessible to the poor. At a time when RSBY is being showcased by some as the confident step towards universal health care coverage, the question remains whether it is not simpler to invest in strengthening the public health system in providing services and building their capacities to regulate private providers, rather than bringing in complex mechanisms like RSBY. Are such insurance schemes the only way forward to providing financial security to the poor against spiraling healthcare costs especially when its impact on health outcomes is contentious?

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