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Hospitalisation Insurance: An Analysis of the The Rashtriya Swasthya Bima Yojana in India

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ABSTRACT

Health hazards threaten the quality of life of people and more so for the poor who have meagre savings and low earnings. Since these expenditures are lump sum and often come unwarranted they create devastations to a poor family. The Rashtriya Swasthya Bima Yojana (RSBY) is a historical effort by the Government of India, in the field of health insurance, to provide hospitalisation benefits to poor people upon the payment of a very reasonable premium. The scheme is also a pioneer to use the smart card and the bio-metric information technology. There is also an effort to cordially bond up with the private sector hospitals and nursing homes to provide hospitalisation services to the poor. This paper gives a short account of the health insurance scenario in India for the poor and then analyses the working of the scheme based on the field level secondary reports. There is an effort to find out whether the scheme can be sustainable in the future and whether the problems reported so far from the field can be efficiently tackled so as to make such schemes a support to the poor against sudden financial burden due to health risks.

Key Words : RSBY, Health insurance for the poor, Hospitalisation insurance

INTRODUCTION

Hospitalisation and the poor patients :

The hospitalisation expenses cause severe difficulties to the poor patients particularly in the lean period of their earnings. The Institute for Social and Economic Change (ISEC), The London School of Economics (LSE) and the Centre for the study of the African Economies (CSAE), in a report published in 2010, state that 69% of the poor people's healthcare expenses relate to hospitalisation expenses. The burden of expenses also makes the poor very reluctant to visit hospitals as soon as the ailment is discovered. They tend to delay the visits till the situation goes out of control and the expenses increase all the more. A disaggregation of the health expenses show that surgery cost of medicines, transport, hospitalisation and consultation were the major categories of expenditure. The study also shows that whereas the non-poor relied on their own resources for the hospitalisation and treatment, the poor very often resorted to money-lenders, pawn-brokers, relatives and friends for borrowing money to cover the treatment and hospitalisation costs (IIG Briefing Paper).

Another study by Li *et al.* (2012) found out from a national level health survey data in China

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that catastrophic health expenditure levels varied inversely with household economic level. Moreover rural households were at a greater risk against sudden onslaughts of hospital expenditures that the urban poor. Another study by Adhikary (2009) on Nepal also corroborates this view.

Health insurance against sudden hospitalisation expenses seem to be a good panacea. Though there are studies which point out that in some cases health insurance does not provide financial protection, it is context-specific depending on the particular insurance package and the associated service delivery mechanism (Ekman, 2007). However studies like that of Xu *et al.* (2003) emphasise that risk protection policies are especially important to support poor households. Out-of-pocket expenditures are regressive and poor families pay a comparatively larger proportion of their income on such expenses and the chronically ill patients are particularly vulnerable in this aspect (Ruger and Kim, 2007).

Government expenditure on health as a percentage of Gross Domestic Product (GDP) declined from 1.3 in 1990, to 0.6% in 2002. This was well below the 5% of GDP recommended by the World Health Organisation. While the budgetary allocation in the health sector by the central government over the last decade has been stagnant, in the states it has declined from 7% to 5.5% (Draft National Health Policy, 2001). Thus the case for subsidised universal health care is weak given the resource utilisation of the government of India and most governments of less developed countries. A totally dependent group of citizens is not better than a group of citizens who contribute towards the provision of health services for themselves.

The traditional theory of health insurance is to transfer risk. However people usually prefer a risk of no-loss. Whatever the reason may be people do purchase insurance and particularly when the premiums are low compared to the coverage of benefits. Moral hazard and adverse selection makes the purchase of health insurance less likely. A tax subsidy can reduce the effective health insurance premium. Since most people consider health as a precious human capital and like to access increasingly expensive health services, health insurance is a way of gaining access to all these medical facilities (Nvman, 1998). In a later theory Nyman (2004) proposed a 'new' theory which stated the welfare 'gains' of moral hazard. He suggests that health insurance brings about an economy-wide redistribution of income from the healthy people to the people who are sick. Those who remain healthy pay without coercion because everyone has an equal chance of falling ill. The new theory says that people value the income they receive from the health insurance more when the fall ill than the loss in income when they pay the premium. Thus this distribution is efficient and efficiency is seen to be a strong justification to adopt a national health insurance policy.

The dire need for an effective health insurance scheme to support lump sum hospitalisation expenditures of the people in India, particularly people in the lower income brackets was shown by Narayana (2010). He compared proportion of the eligible families in the BPL category with the fraction of those hospitalized who are covered. The study showed that the proportion of poor families who were enrolled varied across the states, between 39% in Maharashtra to 81% in Kerala. States such UP and Bihar reported poor enrollment. So did hospitalisation rates which varied from 3.91 hospitalisations a year per 1,000 persons in Punjab to 26.17 in Kerala. There was a big inequality in value of hospitalisation across states and between districts within the states. The reason cited was inadequacy of empanelled hospitals as well as low proportion of private hospitals. Another somewhat different observation but nonetheless significant was the fact there is a need for a greater system of disclosure by a disaggregated value of hospitalisation by diseases treated, services provided etc. is required for a meaningful analysis.

Health Insurance before RSBY in India :

In India insurance business was brought under the Indian Company Act in 1866. There were no specific regulations, but the Swadeshi Movement in 1905 gave birth to dozens of indigenous life insurance and provident fund companies. Health insurance Act was introduced only in 1912. In the year 1937 the Government of India set up a consultative committee, which finally gave birth to the Insurance Act, 1938. Since then there was little change till 1972 when the insurance industry was nationalized and private insurance companies were brought under the umbrella of the General Insurance Corporation (GIC). Private and foreign entrepreneurs were allowed to enter the market with the enactment of the IRDA in 1999. In October 2000, the Insurance Regulatory and Development Authority (IRDA) issued license papers to three companies, HDFC Life Standard, Royal Sundaram Alliance Insurance Company and Reliance General Insurance. At the same time, 'in-principle approval' was given to Max New York Life, ICICI Prudential Life Insurance Company and IFFCO Tokyo General Insurance Company. Today, we have 22 life insurance companies including Life Insurance Corporation (LIC) that are successfully operating. The penetration of health insurance in India has been low before the year 2003. It was estimated that only about 3% to 5% of Indians were covered under any form of health insurance. The market share of the commercial insurance was barely 1% of the total health spending in the country. The Indian health insurance scenario is a mix of mandatory Social Health Insurance (SHI), Voluntary Private Health Insurance and Community-Based Health Insurance (CBHI). Health insurance is thus really a minor player in the health ecosystem though it is one of the fastest growing sectors in India.

Health insurance in a narrow sense would be 'an individual or group purchasing health care coverage in advance by paying a fee called *premium*.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes;

(2) Employer-based schemes;

(3) Insurance offered by NGOs / community based health insurance, and

(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

Voluntary health insurance schemes or private-for-profit schemes :

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer's income. In the public sector, the General Insurance Corporation (GIC) and its four subsidiary companies (National Insurance Corporation, New India Assurance Company, Oriental Insurance Company and United Insurance Company) and the Life Insurance Corporation (LIC) of India provide voluntary insurance schemes.

The year 1999 marked the beginning of a new era for health insurance in the Indian context. With the passing of the Insurance Regulatory Development Authority Bill (IRDA) the insurance sector was opened to private and foreign participation, thereby paving the way for the entry of private health insurance companies. The Bill also facilitated the establishment of an authority to protect the interests of the insurance holders by regulating, promoting and ensuring orderly growth

of the insurance industry.

Employer-based schemes :

Employers in both the public and private sector offers employer-based insurance schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or covering them under the group health insurance policy. The railways, defence and security forces, plantations sector, mining sector and most medium to big private companies provide medical services and / or benefits to its own employees.

Insurance offered by NGOs / community-based health insurance :

Community-based health insurance (CBHI) schemes—also referred to as micro-insurance units and mutual health insurance—are mechanisms wherein people prepay for some component of health care and there is some pooling of revenues and risks such that the healthy cross-subsidies health-care for the sick. Policy makers generally see CBHI as a means of improving access to effective health care, particularly among the poor, and preventing indebtedness and impoverishment as a result of trying to access such care (WHO, 2000).

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits. Community-based schemes are typically targeted at poorer populations living in communities, in which they are involved in defining contribution level and collecting mechanisms, defining the content of the benefit package, and / or allocating the schemes, financial resources.

Such schemes are generally run by trust hospitals or nongovernmental organizations (NGOs).

The benefits offered are mainly in terms of preventive care, though ambulatory and in-patient care is also covered. Such schemes tend to be financed through patient collection, government grants and donations. Increasingly in India, CBHI schemes are negotiating with the for profit insurers for the purchase of custom designed group insurance policies. Many community-based insurance schemes suffer from poor design and management, fail to include the poorest-of-the poor, have low membership and require extensive financial support. Other issues relate to sustainability and replication of such schemes (Acharya and Ranson, 2005).

Various community health insurance schemes have been developed in India which can provide health care supplements to the state efforts at providing universal insurance cover. There is also the chance of a positive public-private partnership in this regard. The Self Employed Women's Association (SEWA) is a trade union of informal sector women workers started by Ela Bhatt in 1972, in Ahmedabad. In 1992 SEWA started an integrated insurance program for its women members. Under the Tribhuvandas Foundation, the health insurance scheme was named as Sardar Patel Aarogya Mandal and it came into existence on January 26, 2001. There are also two schemes with the Aga Khan Health Services. Navsarjan was started in 1988 in Andhra Pradesh. This NGO bought the Mediclaim policy from the New India Assurance for a year. Navsarjan was primarily set up to work for the Dalits. ACCORD is a non-governmental organisation (NGO) staffed by a

group of professionals and adivasi youth. Established in 1986, it works exclusively for indigenous groups, or 'the adivasis', of Gudalur taluk, Nilgiris district, Tamil Nadu. The Student's Health Home (SHH) is the oldest community based health insurance programme in our country. Initiated in 1952 by students, the main objectives were to organise the students for health awareness and to ensure both preventive and curative health care for the student community.

Mandatory health insurance schemes or government schemes (namely the ESIS, CGHS):

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk. The benefit packages are standardized and contributions are earmarked for spending on health services. The government schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS).

Central Government Health Scheme (CGHS) :

Since 1954, all employees of the Central Government (present and retired); some autonomous and semi-government organizations, MPs, judges, freedom fighters and journalists are covered under the Central Government Health Scheme (CGHS). It aims at providing comprehensive medical care to the Central Government employees and the benefits offered include all outpatient facilities, and preventive and promotive care in dispensaries. Inpatient facilities in government hospitals and approved private hospitals are also covered. This scheme is mainly funded through Central Government funds with a range of premiums per month based on salary scales.

Employee and State Insurance Scheme (ESIS) :

The enactment of the Employees State Insurance Act in 1948 led to formulation of the Employees State Insurance Scheme. This scheme provides protection to employees against loss of wages due to inability to work due to sickness, maternity, disability and death due to employment injury. It offers medical and cash benefits, preventive and promotive care and health education. The scheme is managed and financed by the Employees State Insurance Corporation (a public undertaking) through the state governments.

Other Government Initiatives :

The Rajiv Gandhi Shilpi Swasthya Bima Yojana is another health insurance scheme which has the objective of providing insurance cover to all craft persons, male and female (and their family of maximum four containing self and any of three dependents), between the age of one day to eighty years. The scheme will be for initially three years. The total premium will be Rs. 800 per annum (Rs. 650 by central government and Rs. 150 by the artisans). The annual limit per family is Rs. 15,000 with Rs. 1 lakh cover for accident and death. Health Cards will be given to the artisans for the cashless facilities at the empanelled hospitals. The Office of the Development Commissioner for Handicrafts will monitor the progress through its various field offices and by convening meetings with the State Governments and Insurance Company from time to time.

Given this scenario, the challenge for Indian policy-makers is to find ways to improve upon the existing situation in the health care sector like innovative products, competitive pricing, alternative distribution channels and aggressive marketing strategies in the industry, to make equitable, affordable and quality health care accessible to the population, especially the poor and the vulnerable sections

of the society. It is in a way inevitable that the state reforms its public health delivery system and explores other social security options like health insurance. Implementing regulations would be the best mechanism to control provider behaviour and costs.

The RSBY-a historical endeavour :

The most popular state run scheme at present in India is the Rashtriya Swasthya Bima Yojana (RSBY). Below Poverty Line population (BPL) unorganised sector workers are considered the first target of this scheme. RSBY provided hospitalization coverage for up to Rs. 30,000 (approximately $650) for a family of five on a floater basis. Transportation charges are also covered up to a maximum of Rs. 1,000 (approximately $22) with a limit of Rs. 100/- (approximately $2.2) per hospitalization. Pre and post hospitalization expenses are also covered up to 1 day prior to hospitalization and up to 5 days from the date of discharge from the hospital. All pre-existing diseases are covered from day one. There is no age limit on the enrolment of beneficiaries. More than 5000 hospitals (more than 70% are private) are included in the RSBY delivery network. The funding for premium of the scheme comes jointly from central and state governments (75:25). The beneficiaries paid Rs. 30 as registration fees.

Rashtriya Swasthya Bima Yojana (RSBY), a comprehensive health insurance scheme for thousands living below poverty line, has been launched by Ministry of Labour and Employment, Government of India. The model of RSBY has been built upon strengthening weak areas of other models of insurance schemes. Most of Insurance Schemes funded by Central and State Government have been handicapped due to lack of sustained efforts in implementation and poor policy design. The other drawbacks are absence of clear accountability at state level, weak monitoring and evaluation, confusing roles and responsibilities of stakeholders and little drive for creation of awareness among beneficiaries.

RSBY is only innovative model that involves multi stakeholders' participation eliminating all above bottlenecks. This scheme has enabled poor people availing medical services from government and private hospitals. The RSBY scheme has been implemented through mass campaign and insurance advocacy across different states in India.

RSBY Scheme is innovative and poor friendly health insurance model of India. The model of this scheme has been characterized with following unique features:

- IT friendly model
- Portability
- Cashless and paperless Transaction
- Multi-stakeholders participation
- Empowerment of beneficiaries
- In-built mechanism for Monitoring and Evaluation

The use and benefits of RSBY Card popularly known as "Smart Card" have been reflected in following components of the scheme. The scheme has outlined specific facilities and health care packages awarded to the beneficiaries.

- Enrolment
- Smart Card
- Eligible beneficiaries
- Insurance coverage
- Hospitalization and health care packages
- Pre-existing diseases

- Maternity benefit
- Pre and post hospitalization
- Food charges
- Transportation allowance

Such a detailed and well –thought out scheme was designed for the first time for the poor by the government of India. In that aspect it was surely a historical endeavour. It remains to be made fully successful by sincere implementation and appropriate research.

The RSBY- will it be practically sustainable? :

In 2011, there was a survey of 3,647 households in Karnataka covering 222 villages. The data were collected during June-August, 2010. The survey established that 85% of the households were aware and 68% of the households were enrolled for the scheme. But 74% of the households paid Rs. 30 as registration fees whereas the remaining paid around Rs. 5.20 extra as Rs. 2 had to be given to Anganwadi workers for helping in the process of enrollment and Rs.100 -200 were paid to rectify erroneous names. Utilisation of the scheme was also very poor (only 0.4% after six months of enrollment). Coordination between the departments was also very poor, particularly between the health and the labour departments. Lack of attention to installation and operation of smart card technology created utilisation problems. Some of the hospitals even backed out of the scheme (Rajasekhar *et al.*, 2011)

Dror and Vellakkal (2012) had an important observation on the viability of the RSBY. The overall expected cost of the fully rolled out RSBY was estimated with BPL estimates and national average premiums and then the expected cost was compared with the budget allocations made for RSBY. According to the Tendulkar Committee estimates approximately 27.8% of BPL households with Rs.530 as the premium expected at least Rs.33.5 billion which was 0.3% of total budget allocation. However the budget allocated only 0.037% in the financial year 2010-11 sufficient to pay only 34% of the enrolled BPL household.

Some states, (Chhatisgarh) had tried to extend the RSBY to APL families, but the health care providers, particularly the private hospitals, resisted as they said that this was not feasible. The rates had to increase. For example for craniotomy- a critical surgery performed on patients suffering from brain lesions or traumatic brain injury, epilepsy and cerebella tremor, the package paid Rs. 28000 whereas the cost was Rs. 1.5 lakh. This provided a thought for universalisation of RSBY. (TOI, March 31, 2013)

Das and Leino (2011) raised two important questions from a different perspective – i) whether the contracted insurance companies have indulged in 'cream skimming', that is, to selectively enroll 'healthier' households and ii) whether there is any effect of financial protection and improvement of health as resultant effects of the scheme. The study carried out a pilot information and education campaign (IEC) and a household survey in six administrative circles of New Delhi in 2008 among randomly selected households from a list of beneficiaries. The authors tried to find the causal effects of the IEC on enrolment and hospital claims. There were four blocks of data (IEC only, IEC + household survey, household survey only, neither). Means-comparison across blocks was used to give the causal impact analysis. The reports were that IEC by itself did not have any effect on enrolment. This could be because IEC was carried out much ahead of actual enrolment and also perhaps because IEC dispelled some of the wrong notions among the people that it was obligatory and not enrolling with it would deprive people from other benefits like the PDS (Public Distribution System). The marginal increase in enrolment of even well-timed campaigns was insignificant.

However households who experienced the IEC and the household survey quite some time apart reported the highest enrolment. This confirmed that information repeatedly with a time lag had a significant effect. There was also an increase in the net profit of the insurance companies as hospitalisation claims for these marginal households was lower. The study pointed out that since RSBY covered pre-existing illnesses and the comparatively 'sicker' people got enrolled first and the 'healthier' people got enrolled only after the campaigns.

The following are some of the factors behind the successful implementation of RSBY in most of the states in India.

– Partnership – Right from the designing of the scheme, attempts were made to bring all the stakeholders on board A partnership approach was adopted with all the private players.

– Standardisation – A National scheme like RSBY required a high degree of standardisation so that it could work uniformly across India. In addition to all the key documents, all the software and hardware were standardized and guidelines were issued regarding their preparation, usage and certification.

– Flexible Approach – RSBY has evolved continuously since inception. Different provisions and processes of the scheme have been revised in response to the ground realities.

– Attention to the details – Each process and step related to the implementation of the scheme has been elaborated and documented clearly. Similarly, roles of each stakeholder and their relationship with others have been clearly defined so as to avoid any ambiguity.

However, there are some challenges before RSBY to make it a complete success. They are:

– Getting Buy-in of the Stakeholders – First major challenge before implementing RSBY was to get the buy-in of not only people within the Central and State Government but also of the insurance and smart card industry. Intensive meetings were organised with all the stakeholders to explain the scheme design and to get them on board.

– Supply of Necessary Hardware and Software – RSBY needed supply of smart card related equipments in large numbers. These machines were not available in the required numbers. The buy-in of the industry helped in their responding to the demand and import of the equipments to match the demand.

– Development of Key Management System (KMS) – One of the main features of RSBY design was to provide a foolproof secure system to prevent any fraud or misuse. Therefore, it was a big challenge to develop a KMS specific to RSBY and able to provide necessary security at different levels.

– Improving the enrollment and hospitalisation – Issue of smart cards in the village is one of the most challenging aspects of RSBY as the smart cards are issued in difficult terrains. Once the smart cards are issued another challenge is to improve the awareness of the beneficiaries about the usage of the smart card in RSBY.

– Lack of Capacities at different levels – Building the capacities at each level to implement a complex scheme like RSBY was another challenge.

H A Study on the Changing :

A wide range of gaps and differences in enrolment and hospitalization process has been identified. There is an urgent need to initiate appropriate corrective measures which will add the robust strength to the programme. Poverty is main determinant of illness and health needs of poor people. The poor people are exposed to catastrophic spending and distress financing during illness. These poor people are exposed to risk of disease and deprived of access to health care. RSBY, a

poor friendly health insurance scheme has developed a mechanism for promoting poor people's access to health care. The acceptability, financial accessibility, availability and geographical accessibility are four major determinants of poor people's accessibility to health care. An innovative mechanism has been adopted to promote consorted effort to reach poor people and involved them through local adaptation. Careful monitoring has been made to assess its impact on poor. Steps have been taken to encourage more clinics and hospitals to be empanelled in rural area and facilitate timely referrals in emergency. Utmost efforts have been made for easy distribution of drugs and others supplies to the health facilities. Healthy involvement of civil society organizations would pave pathways for effective IEC (Information, Education and Communication), BCC (Behaviour Change Communication) and extensive enrollment coverage.

Survey (RSBY Working Paper, 2011) has revealed that at the time of admission, the card holders have not been informed about approximate expenditure to be incurred in the treatment. Such information is essential to create preparedness among the beneficiaries to meet excess expenditure beyond limit of the card. Sometimes, the hospitalization expenses exceed the insured value of card. The lack of preparedness among relatives of the patient poses serious threat to process of hospitalization. There is no dearth of cases where patients have left hospitals without notice of the hospital authority.

The implementers of RSBY scheme grapple with shortage of resources and manpower. At initial stage, the momentum of implementation process has been accelerated exploring support from NRHM (National Rural Health Mission) and other schemes like Janani Suraksha Yojana implemented through the Department of Health and Family Welfare. Ministry of Labour and Employment, Government of India has been implementing Employees State Insurance Scheme (ESIS) through wide network of hospitals. A significant section of the network lies unutilized. A healthy linkage of RSBY with ESIS Scheme would not only facilitate using unutilized infrastructure and personnel but also throw open many facilities for RSBY beneficiaries. The involvement of State Labour Department is drastically missing Assistant Labour Officers need to be involved in effective supervision of enrolment process at grass roots. Similarly, arrangement of linkage with Life Insurance Corporation (LIC) will open pathways for exploring benefits of Janashree Bima Policy and Aam Admi Bima Policy.

In some areas large scale out-migration of workers, death of head of the households, change of residence, negligence of enrolment team, target oriented approach adopted by TPA or smart card vendors has skipped off a significant section of BPL households from remote villages in different rounds of enrolment. Non-inclusion of genuine beneficiaries is a serious concern. The government has taken serious steps to cover these beneficiaries for enrolment and renewal at District Kiosk Centre. There is an urgent need to enhance the number of stationeries stations at block headquarters for facilitating renewal and enrolment of households not covered in enrolment camps. This will minimize burden on District Kiosk Centre.

It has been observed that pregnant women living in inaccessible remote villages prefer to avail hospitalization in Primary Health Centres (P.H.C.) nearer to their village but not to the District Hospitals which are located at distance places. As the provision on use of smart card is not available in P.H.C., they are forced to visit District Hospitals or Private Hospitals located far away from their villages. It is unanimously recommended by the beneficiaries that P.H.Cs. conducting more than 50 deliveries need to be included as empanelled service delivery facility of RSBY.

Rashtriya Swasthya Bima Yojana (RSBY) Scheme has been implemented with limited resources and manpower. At initial stage, the scheme is rolled out drawing manpower support from NRHM.

The scheme has employed one officer to look after the implementation of the scheme in entire district. He is over tasked to carry out multiple assignments. The District Nodal Officer (DNO) is overburdened with multifarious responsibilities. The inordinate delay in claim settlement overshadows the active involvement of both private and government hospitals. There is an urgent need to allot more resources and manpower for effective implementation of the scheme. At block level, there is no block level RSBY staff. The District RSBY Consultant is handicapped to coordinate the block level claim settlement, reporting and proper implementation of the programme. There is an urgent need for employment of Block Level Consultant to be attached with the Community Health Centres. Accuracy in documentation, reporting and proper mention of disease is a challenging issue. There is an urgent need also to develop a data base on smart card beneficiaries and inventory of claims settled. Due to paucity of manpower, more than 85% hospitalized cases are not uploaded in the server within 24 hours. This is the reason for rejection of large number of hospitalized case by Insurance Companies. At empanelled hospitals, there is dearth of staff to manage RSBY hospitalization and registration. In most of the hospitals, the RSBY help desk is closed in the evening. The patients reported at night for hospitalization are kept waiting for next day. There is an urgent need to employ a separate RSBY operator in all empanelled hospitals. The Insurance Companies also need to develop district-wise data base of claim settled so that appropriate steps can be taken for monitoring of the progress.

The Enrolment Team deputed by the TPA lack training on use of software and knowledge on medical terms and local culture. Most of the team members deployed are recruited from Kolkata and Delhi based firms. They enter erroneous data in terms of mismatching of age, gender, father's name for which a good number of smart cards are rejected in hospitals. They fail to ensure healthy coordination with Gram Panchayat, Local NGOs and facilitators. Healthy coordination among health workers and officials of C.M.O's Office is ignored. The team ignores initiation of healthy IEC activities. They do not carry with them generators to facilitate enrolment in case of power failure. The card making process is poor. Very often, the printer becomes defunct and smart cards are not prepared at enrolment camp. The effective involvement of Gram Panchayat and local NGOs will promote 100% enrolment in outreach and remote villages of the state. Sarpanch of Gram Panchayat play a crucial role in facilitating village level motivation with the help of Anganwadi workers.

A significant section of officials involved in implementation of RSBY scheme can organise monthly village level screening camps not only to provide health check up, but also to give effective counseling on use of smart cards by Doctors of P.H.C.s. This will streamline the periodic visits of doctors to remote villages and generate community participation in on-going health programme.

Except a couple of districts, the agenda of RSBY has not been included in District Level Review Meeting. Inclusion of agenda on RSBY in District Level Review Meeting will create involvement of District Level Officers for effective enrolment and rolling out of the scheme. The medicines for hospitalized cases are procured through authorized medicine shops attached to empanelled hospitals. These medicine shops cooperate with the empanelled hospitals in supplying medicines to hospitalized cases on the prescription. In remote blocks of good number of districts the required number of authorized medicine shops is not present. Appropriate steps need to be taken to encourage potential shop owners to open medicine shops in these areas. This will facilitate effective implementation of the programme. A number of C.H.Cs. also do not possess the scanners and adequate number of computer systems. The existing computer systems have not been uploaded with compatible software such as WINDOWS XP for which the software for RSBY transactions

could not be operated properly. They are compelled to execute offline cashless formalities by filling the application form. The timely management of off-line or manual cashless operation is handicapped due to non availability of computer systems and scanners in good number of CHCs. A large section of potential card holders are denied timely hospitalization and benefits of the scheme in emergency. The manual process of cashless operation involves filling up the cashless form, scanning it and forwarding it to headquarter of Insurance Company through fax for immediate approval. The Headquarter of Insurance Company confirms its approval through fax within an hour. Without approval by the Head Office of Insurance Company, the patients are denied hospitalization. The CHCs without facility of scanners cannot fax the scanned copy of application and obtain approval from Head Office of Insurance Company within the same day. A large number of smart card beneficiaries are deprived off hospitalization on this ground. The manual cashless operation is applicable to those smart card holders whose smart cards have been expired without renewal. There is an urgent need to provide scanners, fax and additional sets of computers well equipped with appropriate software to all CHCs in remote areas, so that operational transaction relating to the RSBY scheme shall not be blocked.

The success and great momentum of RSBY implementation process have been reflected in hike of hospitalization incidences from first round to second round both in Private and Public Hospitals across all districts of the state. It is observed that the claims of Private Hospitals are comparatively higher than Government Hospitals. Because, medical service provided by the team of reputed specialists coupled with well furnished laboratory and ICU, relaxation of procedural formalities for hospitalization, well maintained wards and toilets, soothing behaviour of doctors and health staff, high expectations of patient from Private Hospital have attracted large number of smart card holder from rural area. The Government Hospitals suffer from shortage of surgeons and specialists, hi-tech laboratory and medical instruments and drugs. The hospitalization of smart card holders has been boosted up by efforts of private hospitals. Their contribution cannot be ignored. Most of the Private Hospitals across all the districts of the state have huge amount of bills pending for settlement with Insurance Companies. The timely online settlement of claims will boost up the implementation of RSBY in a great way.

The reporting system is very poor at district and block level. The weakness in reporting of hospital-wise claims creates problems for monitoring and timely claim settlements. The development of a healthy mechanism for reporting will add additional feathers to achievement of RSBY. There is wide range of complaints regarding exploitation of poor smart card holders by Private Hospitals. There is no dearth of cases where serious allegations are made. Some private hospitals have deducted higher charges of hospitalization in ICU, but only provided hospitalization in general wards. The healthy reporting system will sort out such irregularities and streamline healthy process of implementation.

It is observed that a good number of beneficiaries have been forced to incur out of pocket expenses for conducting expensive clinical tests like C.T. Scan and sonography. These clinical tests have been excluded from the packages. A good number of empanelled private hospitals and CHCs do not have medical equipments and laboratory for conducting such tests. It is suggested that the empanelled hi-tech hospital without facilities of C.T. Scan and Sonography shall be de-empanelled on the recommendation of District Collector and Chief Medical Officer. Adequate budgetary provision need to be allotted for upgrading CHCs with equipments and facilities of C.T. Scan and sonography. This will facilitate reduction in out of pocket expenses of smart card holders and attract more beneficiaries to be diverted from private hospitals to CHCs and district hospitals.

The biometric devices attached to RSBY help desk in Government and Private Hospitals are not portable. It is reported that a good number of patients under serious conditions cannot be brought to biometric devices for screening of finger prints and meeting the formalities of hospitalization. Under such circumstances, the card could not be blocked even if the beneficiaries have been provided hospitalization with anticipation that biometrics screening will be made and documents would be regularized at the time of discharge. There are good numbers of instances where the patients have left the hospitals without collecting discharge certificate and smart card. The smart cards need to be swabbed within 24 hours of hospitalization. The relaxation of these procedural formalities on sympathetic ground has created lot of problems for hospital administration. Such cases have led to lot of irregularities in reporting and adjustment of expenses incurred towards hospitalization. There is an urgent need to develop mechanism for making these devices portable, so that screening of finger prints of serious patients can be done at their beds.

It is alleged that certain packages under RSBY scheme have been commercialized. For example, the cataract surgery in all government hospitals are provided free of cost. The schematic provision of the government has been brutally violated in implementation of RSBY scheme. The package for cataract operation under RSBY has been provided with Rs. 3,500/-. The smart card holders undergoing cataract operation in Government Hospital are liable for deduction of Rs. 3,500/- from their cards, where as other patients are treated free of cost. This is a serious discrimination and deviation of schematic provisions. This package needs to be revised on priority basis. It is reported that the hospitals where doctors and attending nurses provide periodic counselling and moral support to patients, more and more smart card holders voluntarily opt for hospitalization in such facility. The satisfied users have strongly recommended these hospitals to large number of non-users of their villages. The inappropriate dealing and harsh behaviour of hospital staff very often create ripple off effects in multiplying negative attitude of patients and general public towards overall administration of these hospitals. This is a very serious gap which needs to be rectified. In some C.H.Cs., the doctors instead of providing moral support and cooperation to attendants and relatives of patients who die in hospital avoid providing legitimate support on vague ground. The request for ambulance for transporting of dead bodies from hospital to village has been refused by hospital administration in some cases. This petty issue has aggravated mass agitation and protest against the hospital. Such incidences have created agitation and negative vive not only in one village but also in entire area towards reputation, staff and integrity of management of hospital. There is an urgent need to upgrade managerial behavior of hospital administration through value based moral behavior. In absence of capacity building workshops and training, the behavior of hospital staff cannot be upgraded and ethic loaded. It is suggested that a series of capacity building workshops need to be organized at periodic intervals for doctors and medical staff towards up gradation of ethical component on patient management. This is very important.

In a good number of backward districts the required number of Government and Private Hospitals has not been reached so far. A very little step has been taken to encourage high profile private hospitals and nursing homes to get empanelled with RSBY and operate in these districts. This is the main reason for growing incidences of referral cases from CHCs to district hospitals and district hospitals to city based Private Hospitals. The people have strong preference for hospitalization at private hospitals ignoring government facilities.

The absence of specialists on Kidney disease and Cancer has stimulated wide scale referrals from backward districts to city based private hospitals within and outside the state. There is an urgent need to encourage high profile private hospitals and nursing homes to open their branches in

backward districts Secondly, all the empanelled hospitals are also located in district headquarters. The private hospitals and nursing homes need to be encouraged for opening their branches in block headquarters and rural areas

A section of empanelled private hospitals fail to follow the guidelines of RSBY scheme. These hospitals are not well equipped with hardware and software supported by IT platform to operate online transaction for hospitalization. These hospitals do not have ICU facilities. But, they claim service charges on ICU. The software installed does not work. The operator attached to RSBY desk is not well trained. These hospitals are reluctant to invest in up gradation of software and hardware. The facilitation for hospitalization and discharge of smart card holders suffer a lot in good number of remote blocks of all the districts. Stringent disciplinary action needs to be taken against these un-prepared hospitals by State Nodal Agency.

The enhanced enrolment from first round to second round and from second round to third round does not indicate the sign of penetration of this health insurance scheme among all poor households. The quality of hospital care and extent of penetration of this scheme in remote and tribal regions of state needs to be assessed. The enrolment combined with hospitalization will contribute to meaningful utilization of this scheme by poor people of the state. The inventory and data base of hospitalization cases and empirical analysis for corrective measures is missing. There is an urgent need to analyze quality of medical care in terms of quality of services provided by hospital, type of infrastructure, facility available and coverage of disease group through different packages of services. Such analysis has not been made so far. The involvement of Civil Society Organisations through intensive IEC activities is drastically missing. No NGO has been involved so far not only in creation of awareness but also in facilitation of enrolment process. The involvement of NGOs in organizing awareness campaign through health camps with support from Gram Panchayat will create adequate preparedness for enrolment and hospitalization among enrolled BPL households. The NGOs would not only involve Gram Panchayats, Anganwadi workers and health workers but also doctors in organizing village level health camps as well as awareness generation camps. Appropriate steps need to be initiated for identification and involvement of effective and active local NGOs both in enrolment and hospitalization process. The involvement of NGOs will contribute not only towards enhanced enrolment and hospitalization but also towards promotion of intensive mass awareness of the scheme.

There is an urgent need to organize capacity building workshops separately for NGOs, Hospitals, PRI Representatives and district level functionaries. Adequate numbers of capacity building workshops have not been organized since implementation of the scheme by TPA. Appropriate communication modules need to be developed for intensive IEC and BCC interventions. The strengthening of institutional factors will influence not only the health care providers but also determinants of scheme performance. Greater co-ordination needs to be promoted between IEC and enrolment team. The involvement of local NGOs will facilitate periodic village level meetings of beneficiaries and inform them well in advance about enrolment programme. Involvement of NGOs will sensitize the beneficiaries and ensure elimination of misconceptions relating to use of smart cards. The misconceptions on smart cards are numerous and complex. Many illiterate smart card holders misconceive it as an A.T.M. card and always prefer to carry with them. They believe, if the card is handed over to someone, he will withdraw money from this card. A section of smart card holders prefer to submit the smart card after hospitalization and at the time of discharge. They are guided by the misconceptions and wrong notions about smart cards. At the time of admission, they do not reveal anything about smart card. They get hospitalized. They submit card at the time

of discharge. These card holders are refused benefits of hospitalization packages under RSBY. Local NGOs can appropriately sensitize the illiterate card holders.

The Senior Officers of District Hospitals and CHCs feel handicapped for undertaking required IEC interventions. They complain about budgetary constraints. The fund available with them is not sufficient to organize periodic health camps clubbed with RSBY awareness campaign and sponsoring jingle in Radio, advertisement in Newspapers, printing of posters and wall paintings. Budgetary provisions may be allocated for organizing training of peripheral health workers on RSBY. The peripheral staff has very little knowledge about enrolment process, hospitalization packages and appropriate utilization of smart cards. They fail to clarify multiple questions raised by the illiterate villagers. Inability of health workers to clarify the queries raised by illiterate villagers on the spot adds more confusion to prevailing misconception among illiterate mass relating to RSBY scheme.

Universal Health Insurance is still a far cry for the less developed countries. However schemes like the RSBY can be extended to cover the entire country gradually only if the resource base of the government increases to firstly raise the government funded premium levels and secondly to improve the infrastructure of the health delivery system. ILO (2010) had proposed certain innovative measures to raise resources for betterment of health of its citizens like Special levy on large and profitable companies, Tobacco excise tax, Excise tax on unhealthy food (sugar, salt), Tourism tax, Diaspora bonds etc. That a developing country can manage to raise resources for its health sector through simple yet stern measures was also cited. The DGT drafted tax laws and regulations that were clear, accessible and consistently applied, and adopted a policy of zero-tolerance towards corruption. The DGT also introduced procedures to resolve disputes quickly, cheaply and impartially, and encouraged transparency by making all actions taken by the tax administration subject to public scrutiny. Performance and efficiency were improved partly by digitizing a previously paper-based process. Positive results followed, with the tax yield rising from 9.9% to 11% of non-oil GDP in the four years after implementation. The additional tax revenues meant that overall government spending could be increased; health spending.

Role of social work :

The necessity inclusion of trained social workers in the implementation of welfare programmes has been brought again with the analysis of the RSBY programme. That the need for proper campaigning to make people aware about the absolutely new benefit required trained intervention at the field level. Networking with the various stakeholders through outreach activities is a stronghold of the social workers. In fact there is a need for linkages at all levels to bring the beneficiaries, the health service providers and the insurance agents together in a smooth tendon. Capacity building for the various field staff and the hospital staff specially recruited for RSBY can also be done by professional social workers. Finally and not the least there can be social workers to provide post and pre-operative counselling to the patient-beneficiaries of the scheme.

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