# The Emerging Experience of RSBY in Chhattisgarh: What can the Informal Sector Workers Expect?

## Background paper for MFC Annual Meet 2012

**Authors: Sulakshana Nandi, Dr. Rajib Dasgupta, Dr. Madhurima Nundy, Dr. Ganapathy Murugan, Kanica Kanungo**

In India, health insurance has always been mostly limited to workers in the organized sector and to people who can purchase insurance privately. There have been very few health insurance schemes catering to the needs of the informal sector. These have been in the form of community-based insurance schemes mostly run by non-governmental organizations with limited coverage and scope. However, the past decade has seen an increase in the number of insurance schemes being introduced by central and state governments with a focus on protecting the poor and the informal sector workers against catastrophic expenditure on health. The Yeshasvini Health Insurance Scheme in Karnataka in 2003 and the Rajiv Aarogyasri Scheme in Andhra Pradesh in 2007 were precursors to the Rashtriya Swasthya BimaYojana (RSBY) launched by the Ministry of Labor, Government of India in 2007. The RSBY seeks to address workers in non-formal sectors and those self-employed.

RSBY provides an annual cover of Rs. 30,000 per family of five persons for hospitalizations. The packages included are for surgical procedures and also for reimbursements for hospital admissions for medical causes. Though the central scheme restricts this to those below poverty line (BPL), few state governments like Kerala and Chhattisgarh have extended it or are planning to extend it to the whole population. While seeking to protect the BPL families against catastrophic health expenses increase their access to healthcare and expanding their choice of providers, in a bid to make this a win-win proposition RSBY has also been conceived of as a 'business model' in which "all the stakeholders as the service provider, the insurance company etc. have direct benefits, (and) would take a proactive role in making this scheme successful"[1].

The state government selects the insurance provider (private or public) through a bidding process. The insurance company in turn empanels the hospitals and selects the Third Party Administrator (TPA), which is responsible for enrolment, annual renewal of cards and processing claims.

This paper briefly relates the experience of RSBY, gauged through a series of studies in Chhattisgarh. The list of studies is given in Table 1 and the related publications and other references are given at the end of the paper:

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[1] Government of Chhattisgarh. "Minutes of the State Level Workshop on RSBY, 15 October." Raipur, 2008. http://health.cg.gov.in/.../RSBY%20-%20State%20workshop%20oct%202008.pdf

Table 1: List of studies on RSBY in Chhattisgarh

| Study | Year | Type | Sample | Data Collection | Agency |
|---|---|---|---|---|---|
| Study to analyse implementation of RSBY in Chhattisgarh | 2010 | Quantitative | 52 beneficiaries in public hospitals and 50 in private hospitals in Durg district | Patient Interviews Secondary data | Public Health Resource Network (PHRN) |
| Study on enrolment | 2012 | Quantitative | 270 Villages 32 Blocks 18 Districts | Village level questionnaire | Jan Swasthya Abhiyan Chhattisgarh |
| Study on design issues in RSBY through mapping provider perspectives | 2012 | Qualitative | 5 public hospitals 9 private hospitals 4 non-for-profit hospitals 50 respondent interviews | Rapid Appraisal Procedures (RAP) | PHRN and Centre of Social Medicine & Community Health, JNU |
| Study on access of Particularly Vulnerable Tribal Groups (PTGs) to health and nutrition services | 2012 | Quantitative | 1200 PTG families | Household questionnaire | PHRN, SHRC CG and local NGOs |

While it is still early days for the RSBY, the emerging experience of issues related to coverage, availability of services and hospitals, impact on the public health system and the private sector are pointers to the potential benefits and limitations that the workers in the informal sector may experience.

**Which hospitals are being empanelled and where?**

Though in many states, more private hospitals have been empanelled than public hospitals, in Chhattisgarh, the number of public facilities is higher than private ones. This is also because a number of Community Health Centers (CHCs) and Primary Health Centers (PHCs) have also been empanelled. The private facilities are concentrated mainly in the mainstream areas and cities. Lesser number of private hospitals is available and therefore empanelled in rural, tribal and remote areas. For example, 40% of the private hospitals empanelled are in the state capital of Raipur. In order to increase the reach of the scheme, smaller (4-5 bedded) private hospitals have

been empanelled; the quality of these institutions is not being adequately examined through pre-empanelment inspections.

**Who are being enrolled and who are left out?**

Enrolment is annual and is being done by the TPA, which was considered a conflict of interest by a few respondents, including a senior administrator.

Enrolment rates vary widely across villages, districts, regions and demographic groups. Beneficiaries were often found to be concentrated in the easier to reach villages and left out in the hard to reach villages or hamlets, particularly in tribal majority blocks; this was confirmed by some of the empanelled local institutions too. Enrolment in such areas ranges from 30%-50%. One study found that only 32% of Particularly Vulnerable Tribal Group (PTG) families had been enrolled even though they are the poorest and most vulnerable.

Our study in Durg district showed that 37% of respondents had above five members in their family (benefits are limited to only five members in a family). This begets the possibility of the most vulnerable members of the family, like the aged, the widows or the disabled getting left out. This is doubly significant for Particularly Vulnerable Tribal Groups as their family sizes are much larger, as since 1979, the state government has imposed restrictions on them for permanent methods of family planning in an attempt to increase their once dwindling populations. This was done ignoring the fact that extremely high mortality rates (which remains high even today) and not low fertility rates was the reason for the population decrease[2]. Therefore they have been forced to have large families who are now just partly covered through RSBY.

Our studies have also found that though RSBY cards are to be given to the beneficiaries within a few hours, there are considerable delays, up to months. Therefore, though a family may be 'enrolled', they are not able to utilize the scheme till they receive the card. Disruptions in utilization also happened because of the practice of yearly renewals. Moreover, people receive inadequate information about the services and hospitals under this scheme and are unaware about specific entitlements under RSBY.

**How are the public and private and not-for-profit hospitals functioning differently under RSBY?**

Our study on design issues in Chhattisgarh found that the private sector was cherry picking profitable procedures and providing narrow and selective range of services; most hospitals reported a rise in incomes. They were treating simple and uncomplicated conditions, and referring the complicated cases to the public sector. They were also treating fewer medical conditions (malaria, typhoid etc.) than the public sector. In many private facilities, a fixed number of beds were earmarked for RSBY patients. RSBY inpatients were few and far between in corporate hospitals that were capable of delivering tertiary care or complicated procedures; catastrophic health events were thus not being covered adequately.

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[2] Public health advocacy to reinstate reproductive rights of Particularly Vulnerable Tribal Groups (PTGs) in Chhattisgarh. Poster presentation at EPHP-2 Conference, IPH Bangalore, 2012. http://www.biomedcentral.com/1753-6561/6/S5/P1

The CHCs and PHCs were mostly treating common medical conditions including diarrhea, anemia, malaria, and typhoid. It was only in the district hospitals and medical colleges that surgical and other conditions are being treated, most commonly, cancer chemotherapy and animal bites. However, within medical conditions, the conditions requiring longer hospitalizations like snake bite, poisoning and burns are not being treated under RSBY, as the packages are inadequate.

The public hospitals (particularly, CHCs and PHCs) were often buying medicines from private shops at retail prices whereas much of those medicines should be available at the facility free of cost. The pressure on the public health system to show higher utilization and incentives to staff was resulting in irrational hospitalizations and prescriptions.

The not-for-profit hospitals were providing a larger range of services and experienced increases in patient load. Most RSBY rates were somewhat higher than what they usually charged (their patients, outside of the RSBY) and therefore they also reported increase in incomes.

The findings on the range of services being provided, the impact on the hospitals and their nature of practice under RSBY are summarized in Table 2:

Table 2: Summary of Findings[3]

[3] "Challenges in attaining universal health coverage: empirical findings from Rashtriya Swashthya Bima Yojana in Chhattisgarh". Oral presentation at EPHP-2 Conference, IPH Bangalore, 2012. https://docs.google.com/file/d/0B5-T9KvZEHU6b2pPNjZLemp0Nk0/edit?pli=1

| Range of Services Provided | | |
|---|---|---|
| **Private** | **Not-for-Profit** | **Public** |
| ▪ Narrow and selective range of services- Cherry picking | ▪ Large range of services | ▪ Limited range of services |
| ▪ Fewer medical conditions than public<br>▪ Largely simple and uncomplicated conditions, rest referred to public | ▪ Medical conditions plus surgeries<br>▪ Eg. Orthopedic procedures and chemotherapy | ▪ Mostly medical conditions<br>▪ Surgical procedures less except in Medical College |
| **Impact on Hospital** | | |
| ▪ Increase in caseload<br>▪ Small hospitals biggest gainers<br>▪ Corporate hospitals- 5-10% RSBY occupancy | ▪ Increase in caseload | ▪ Decline in patients<br>▪ Decline in range of services<br>▪ Increase in patients in tribal block |
| ▪ Increase in income | ▪ Losses if calling surgeons from outside | ▪ No significant increase in revenues<br>▪ Previous maintenance funds withdrawn |
| **Suitability of Packages and Practices Followed** | | |
| **Private** | **Not-for-Profit** | **Public** |
| ▪ Most packages priced lower than hospital rates | ▪ RSBY packages usually higher than hospital rates | ▪ Not possible to provide long-drawn hospitalization, cost intensive treatment |
| ▪ Fixed number of beds for RSBY | ▪ Cost-cutting measures, without compromising quality<br>▪ Eg. Silk sutures | ▪ Patients admitted for OPD-level conditions<br>▪ Cost of treatment escalated |
| ▪ Hysterectomy preferred but not cesarean section<br>▪ Ophthalmology- more cataracts | ▪ | ▪ Commonly- diarrhea, respiratory infections, anaemia, weakness, hypocalcaemia |

**Is insurance like RSBY the way forward for ensuring health of the informal sector workers?**

The gaps and concerns emerging from our studies are also echoed in the findings of the recent external evaluation of RSBY in Chhattisgarh commissioned by the State Nodal Agency, RSBY (CTRD 2012). Much of the morbidity in the community is of primary illnesses, treatable at the primary level. The RSBY (and many insurance schemes) focuses on specific treatment procedures rather than on treatment of illnesses and therefore conditions treatable at primary level end up being admitted (for example, for uncomplicated anemia or diabetes mellitus) or transferred to

secondary/tertiary levels. This also results in public funds being shifted from primary level care to secondary and tertiary level care, or to private providers (JSA 2012).

RSBY seems to be incentivizing irrational hospitalization and procedures. This is borne out by our findings as well as and from subsequent reports of mass hysterectomies (under RSBY) in Chhattisgarh and Bihar. Increase in irrational and expensive procedures implies that the cost of care is also being artificially inflated. The most vulnerable communities and remote areas are once again being 'underserved' in this scheme and issues of exclusion and discrimination against patients exist.

There is no real choice to the consumer. For them 'choice', especially with respect to the private sector, is restricted to the range of services the particular hospital has chosen to provide them. There is no service guarantee at the facilities, neither by the level (primary/secondary/tertiary) not by the specialty (surgery, gynecology, eye and so on). While private hospital are 'cherry picking' the most profitable conditions/procedures, public hospitals are unable to compete. However, in tribal areas, the public facilities are seeing an increase in patients. The lack of transparency at all levels and near-absent grievance redressal mechanisms is shocking especially as RSBY is utilizing public funds.

Though intended to cover catastrophic health expenses, facilities are not able to provide long-drawn hospitalization (burns or poisoning), cost-intensive treatment (high-tech and thus the most expensive surgeries) or treatment of chronic diseases like hypertension, heart disease. High out of pocket expenditure has been a consistent finding in all studies including the independent official evaluation. Therefore, the poor are scarcely protected from catastrophic expenditure, the *raison d'être* of the RSBY. The penchant for a 'business model' has become an obstacle for inclusiveness and comprehensiveness of services.

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