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Abstract

The Rashtriya Swasthya Bima Yojana (RSBY) is a state funded health insurance scheme targeted for families below poverty line (BPL) in India providing a coverage of ₹30,000 for a family of five. This qualitative study covered three districts in Chhattisgarh, India, and included empanelled private for-profit, public and not-for-profit institutions. RSBY beneficiaries constituted a miniscule proportion of the total patient load in large multispecialty hospitals, institutions capable of providing treatment for serious illnesses. Small private nursing homes were the biggest gainers. There was evidence of complicated conditions being booked instead of simpler ones. Some government hospitals reported declines in patient loads after the introduction of the RSBY, clearly signalling a shift from the public to the private sector. Community and Primary Health Centres are unable to compete with private providers as the latter have relatively better patient facilities and specialists. Significantly, for the not-for-profit sector, used to functioning on tight price lines, the RSBY is beginning to provide the elusive sustainability.

Keywords

RSBY, design issues, sustainability, Chhattisgarh

Introduction

In India, households account for almost 70 per cent of the total health expenditure, much of which is in the form of out-of-pocket expenditure (Chowdhary, 2009). In 2004–05, about 39 million (30.6 million in rural areas and 8.4 million in urban areas) Indians fell into poverty as a result of out-of-pocket expenditure (Balarajan et al., 2011). According to a survey report by Shahrawat and Rao (2001), poverty headcount ratio increased by 3.5 per cent due to out-of-pocket payments during the reference period of 30 days of the survey; the increase being higher among the rural (3.8 per cent) than the urban (2.7 per cent) population. Further, the increase amongst the BPL population was significantly larger than that Above Poverty Line (APL). While treatment in private hospitals is generally far more expensive, patients going to public institutions (which are mandated to offer free services) may have to procure drugs and diagnostic services from private providers due to their unavailability at the public hospitals, thereby adding expenses and narrowing down the cost difference between public and private health care facilities (Selvaraj & Karan, 2009). Recently, there has been a profusion of publicly financed health insurance schemes by the central and several state governments, aiming to cushion the catastrophic expenditure incurred by the poor. The Yeshasvini Health Insurance Scheme to provide free health services to the farmers was launched by the Karnataka state government in 2003. Subsequently, from 2007 India witnessed a number of new initiatives. Andhra Pradesh was the pioneer, launching the Rajiv Aarogyasri Scheme in 2007 under which the BPL families in the state can avail health benefits up to ₹2 lakh (Selvaraj & Karan,

2012). Later in 2009, Tamil Nadu launched the Kalaingar Insurance Scheme for life-saving treatment, which has since been renamed as the Tamil Nadu Insurance Scheme for Life Saving Treatment. Karnataka's Vajpayee Aarogyashri Scheme was also launched in the same year providing coverage of ₹2 lakh, the same as the Rajiv Aarogyashri Scheme. The RSBY was launched by the Ministry of Labour and Employment in 2008 for BPL families. Noted as an innovative and pro-poor scheme for providing equitable health care and cushioning from catastrophic health expenditure, RSBY is of considerable interest to both public health scholars and practitioners. Coverage is provided for a family of up to five members; the cap per year is ₹30,000 (\$600, approximately). The scheme provides standardised packages for surgical procedures as well as reimbursements for hospital admissions for medical causes. The State invites bids from private and public insurance companies (licensed by the Insurance Regulatory Development Authority (IRDA)) to provide insurance cover. Enrolment and annual renewal of cards is the responsibility of a Third-party Administrator (TPA), which is selected by the insurance company. Academic research and reviews of RSBY have generally focused on issues pertaining to experiences of beneficiaries. This study was conducted in Chhattisgarh (socio-economically one of the weakest among the states of the Indian union, with a high proportion of tribal population) to gain an understanding of the provider perspectives in order to focus on design issues that have relevance for both policy and practice.

The Experience So Far

The success of insurance schemes depends on how effectively the benefits reach the poor (Desai, 2009). A plethora of state-supported insurance schemes have been in operation for several years and provide experience on issues of enrolment, empanelment of hospitals, utilisation and cost of hospitalisation, out-of-pocket expenditure, insurance premium, adequacy and appropriateness of the packages, issues in access, and systems of monitoring, transparency and grievance redressal. Several such schemes have had limited effectiveness due to poor design, lack of clear accountability, lack of sustained efforts in implementation, weak monitoring and evaluation, unclear roles and responsibilities of stakeholders and poor awareness among beneficiaries (R4D, n.d.).

Enrolment

While RSBY covers approximately 350 million of the BPL population, it still leaves out significant proportions of the target group (Reddy et al., 2011). Wide variations in RSBY enrolment rates have been reported across districts, regions and demographic groups. Among the selected villages in a study, 10 per cent were without enrolment and only in 2.5 per cent villages were BPL families enrolled (Sun, 2011). Another study suggests that the households that had prior experience

of health shocks were more likely to enrol for RSBY; average enrolment per household was 2.6 though eligible household members were 4.6 (Das & Leino, 2011). Till July 2010, only 46 per cent of the eligible families were enrolled for RSBY in Chhattisgarh; most of the private hospitals kept a RSBY/BPL 'quota' beyond which they refused to admit patients (Nandi et al., 2010).

A study conducted in Delhi noted that Information, Education and Communication (IEC) alone had no impact on enrolment; IEC with a household survey reported the highest enrolment rate (Das et al., 2011). In Chhattisgarh only 4 per cent of the beneficiaries received their smart cards on the spot (Nandi et al., 2010). In Karnataka even after about 5–6 months of commencement of the scheme (June–August 2010), 38 per cent of enrolled households still had not received their cards. Some gram panchayats have received the cards but did not distribute them, linking it to payment of local taxes (Rajasekhar et al., 2011).

Empanelment and Reach

More than 8500 hospitals are currently empanelled under the RSBY scheme. The proportion of public hospitals among those empanelled in the sample states varied from 45.86 per cent in Kerala to 4.95 per cent in Haryana (Narayana, 2010). The empanelment rate was highest in private sector hospitals in Karnataka at 63 per cent (Rajasekhar et al., 2011).

The ILO (n.d.) reported on the Yeshasvini scheme that many health care institutes upgraded their services to match the accreditation requirements. In terms of geographical spread of hospitals, it suggested that the insurer should empanel enough hospitals in the district so that beneficiaries need not travel very far (Basu, n.d.).

Utilisation and Cost of Hospitalisation

An increase in hospital admission rates among the poor was reported by Mahal and Fan (2011), from 1 per cent in 2004 (when there was no RSBY) to 2.7 per cent under RSBY. Hospitalisation rate in India under RSBY was found to be about 20 per thousand beneficiaries (Reddy et al., 2011); with large variations, ranging from 38 per thousand beneficiaries in Kerala to 1 in Assam. Utilisation rates are dependent on various factors including insurance companies operating in the areas, number of people in the same village who have already utilised the benefits and number of empanelled hospitals in the district (Hou & Palacios, 2011). Variations have been noted in the average cost of hospitalisation among the selected states; the average hospitalisation cost was highest in Punjab (₹6,606) and lowest (and less than half) in Kerala at ₹3,101 (Narayana, 2010).

Das and Leino (2011) in their study questioned whether all hospitalisations made under RSBY were medically necessary and if done, what impact it would have on the health of the household. Desai (2009) in her study on the community insurance scheme being run by Self-Employed Women's Association (SEWA)

cautioned that RSBY may promote unnecessary hospitalisation, at the expense of public sector efforts to prevent and treat primary illness.

Out-of-Pocket Expenditure

A study on the implementation of RSBY in Delhi by Grover and Palacios (2011) found that of the patients interviewed, more than a third had incurred out-of-pocket expenditure. The average claim amount was ₹3,700 and the additional average out-of-pocket expenditure ₹1,690. More than two-thirds of the out-of-pocket expenditure was due to medicines.

Nandi et al. (2010) mentioned that 58 per cent and 17 per cent of the respondents utilising private and public health care services, respectively, incurred out-of-pocket expenditure. The average expenditure incurred was ₹1,078 in the private sector and ₹309 in the public sector. Shahrawat et al. (2011) in their study on out-of-pocket expenditure for health found that the share of expenses made by the people below the poverty line was highest (88 per cent) and declined progressively for those above the poverty line (Shahrawat et al., 2011).

Insurance Premium

The annual premium for the RSBY varies from state to state and district to district in the range of ₹400 to ₹600 (R4D, n.d.). The state governments provide support to the insurers but it is the responsibility of the insurers to operationalise the scheme on the ground. Some state governments like Kerala have extended the coverage of the scheme to APL families, while Himachal Pradesh has extended the upper limit to ₹175,000 for every family with five members (Selvaraj & Karan, 2012).

Adequacy and Appropriateness of Packages

RSBY covers more than one thousand surgeries and procedures. The non-surgical medical treatment is priced at ₹750 per day which includes bed charges, nursing and boarding charges, doctor's consultation fees, medicines and diagnostic tests, food to patients, etc. RSBY package rates for a single surgery/procedure vary widely, starting from as low as ₹100 (Intra oral X-ray) to as high as ₹28,000 (Dissecting Aneurysms).

The ceiling of ₹30,000 in RSBY has been considered to be too less for major surgeries in private hospitals (Basu, n.d.). Selvaraj and Karan (2012) noted that while RSBY benefit packages are modest and largely cover secondary care hospitalisation, other state insurance schemes like Rajiv Aarogyashri and the Tamil Nadu scheme cover high-end surgical procedures at the tertiary level. The major design flaw of RSBY and the other state insurance programmes is their narrow focus on secondary and tertiary hospitalisation (Selvaraj & Karan, 2012).

In the context of the Arogyasri scheme, Shukla et al. (2011) argued that payments should be made for disease conditions rather than procedures so that hospitals have an incentive to follow a strategy of the best treatment rather than fall back on exorbitant advanced equipment and technology. They pointed out that lack of a comprehensive disease management protocol can lead to unnecessary and undefined medicalisation under the scheme. Medical conditions such as malaria, typhoid and cholera were neither listed as a disease nor for a procedure, though their complications such as cerebral malaria can be life-threatening and involve catastrophic expenditure. Annual schemes were inadequate for complex conditions that may require lifelong medical support. Undertaking unnecessary procedures such as hysterectomies have been reported in both Aarogyashri and RSBY schemes (NHRC, 2012; Shukla et al., 2011).

Similar issues emerged in the study of the insurance scheme run by SEWA (Desai, 2009). It found the following: (a) 40 per cent of claims were conditions that could be treated without hospitalisation; (b) expenditure on drugs was a major component of expenditure; (c) hysterectomy was the top reasons for using insurance in women; and (d) claim patterns were inequitable.

Issues of Access

The availability of hospitals in remote areas continues to be a major challenge though the initial problems of severe shortage of hardware in RSBY have been reasonably streamlined (Basu, n.d.).

Nine out of 39 hospitals surveyed by Rajasekhar et al. (2011) had not treated any patient under RSBY; the reasons were either technology-related or reimbursement-related. The first category included issues like insufficient training in the operation of technology; improper installation or malfunctioning; and, information stored on some cards was incorrect or of low quality. Reimbursement problems included delay in settling submitted bills; partial reimbursement; cap on admission days; and, maximum limit of cost of treatment.

Monitoring Systems

Currently there are no quality standards within the RSBY; however, a process is on to grade hospitals on parameters of quality. Hospitals providing better quality services could thus be paid a higher package rate by the insurer (R4D, n.d.).

The monitoring of RSBY is being made more rigorous and reports are periodically made public. Separate set of preformatted tables are generated for insurers and government, allowing insurers to track claims, transfer claims to hospitals, investigate suspicious claims and allow governments to monitor programme use and impact (Dimovska et al., 2009). There have been instances of RSBY funds being used to pay salaries of NRHM staff recruited in government hospitals (Basu, n.d.).

Transparency and Grievance Redressal

Narayana (2010) highlighted that little information was available in the public domain and emphasised the need for greater transparency and proactive disclosure about details of admissions, types of illnesses treated, and procedures for a more comprehensive and cohesive analysis. The lack of a grievance redressal mechanism and poor coordination among various government departments implementing the scheme was reported from Amravati, Maharashtra (Rathi, 2011). Nandi et al. (2010) observed the lack of transparency in Chhattisgarh; a large number of beneficiaries were not aware about the amount deducted from their cards after treatment; they suggested proactive disclosure by health care facilities for informing the patients. While RSBY has the potential to provide social and economic security to the targeted population, Selvaraj and Karan (2009) stressed on scalability and sustainability of the policies. A regime change or burgeoning fiscal deficit could be inimical to the sustainability of the scheme. They opined that the strengthening of private providers could be an unintended consequence of RSBY.

A plethora of studies have analysed the implementation of RSBY and beneficiary experiences. Information about the issues highlighting the providers' perspectives is very limited. A scheme can successfully reach its targeted population and deliver the expected results when it is designed wisely. Keeping these concerns centre stage, this study was undertaken to critically examine the design issues in RSBY and the perspectives of the providers in Chhattisgarh, India.

Methodology

This article describes in detail the findings of a qualitative study on the RSBY scheme, focussing on provider perspectives and design-related issues in order to be able to inform policy and suggest appropriate modifications. We covered three districts in Chhattisgarh from among those in the second phase of RSBY implementation and included empanelled private for-profit (small 10–20 bed nursing homes and multi-specialty corporate hospitals), public (medical college, district and sub-district hospitals) and not-for-profit (low-cost and Christian missionary) institutions; state-level administrators were also interviewed. An attempt was made to search for opinions, motivations, behaviours and attitudes of key stakeholders within their organisational and socio-cultural matrix. Emphasis was laid on identifying design related issues that could affect treatment procedures and implementation of the universal insurance scheme. Open-ended semi-structured in-depth interviews (with pre-defined topic guides) were conducted with a range of providers. Detailed notes were taken by research team members and analysed to assess similarities and differences in perceptions across stakeholders. Fieldwork was conducted in two phases from December 2011 to February

Table 1. Typology and Numbers of Institutions

Units	Numbers
Districts	3 (Raipur, Dhamtari and Balod)
Private hospitals	9
• Super-specialty	2
• Nursing homes	7
Public hospitals	5
• Medical college	1
• District hospital	1
• Community health centre	2
• Primary health centre	1
Not-for-profit hospitals	4
• Mission hospitals	3
• Trust hospital	1

Table 2. Respondent Profile

Units	Numbers
Doctors cum RSBY in-charges (hospitals)	9
Doctors	8
Hospital managers	5
Medical college official	1
Block level officials	6
RSBY data entry operators	10
District level officials	6
State-level officials	3

Source: RGSB Data.

2012. We did not find differences in observations between the districts. Tables 1 and 2 detail the institutional and respondent profiles. The results are discussed under the five major emergent domains: technology, settlement of claims, private (for-profit) hospitals, public hospitals and not-for-profit hospitals.

Major Findings

Technology

Internet-based technology involves swiping the beneficiary card and doubly verifying the thumb impression with a scanner. Some rural areas of the study districts, particularly the remote blocks, lack reliable Internet connectivity and this is a major hurdle for facilities in these areas in providing services under RSBY. Though there is a provision for offline operations, it is hardly being used due to fear of rejection of claims. Therefore it was often not possible to swipe the card within 24 hours of admission or discharge. This, along with the lack of training to the implementers, was leading to rejection of claims. The RSBY has been

designed, to prevent corrupt practices, so that a card cannot be swiped more than once within 24 hours. This has emerged as a critical limitation as this is a necessity, for example (and fairly commonly) from normal delivery to Caesarean section and, referral to a higher-level institution.

Annual renewal of cards was consistently reported as affecting the beneficiaries as well as the providers. The software at the institutions needs to be changed with the change of TPA. Following the change of the TPA a year earlier from E MediTek to MedSave, three out of four Primary Health Centres (PHCs) in Raipur district had not had the software updated and were unable to treat RSBY patients till the time study was conducted. State level administrators considered enrolment of beneficiaries being done by the TPAs as a conflict of interest. Most providers with grassroots presence and a state level administrator stated that in many villages, especially in the remote and inaccessible ones, cards had not been made by the TPA. This was corroborated by two studies undertaken in Chhattisgarh during 2011–12 on enrolment and coverage in tribal and remote areas. The studies found that no enrolment was done in remote and inaccessible villages (Nandi et al., 2012). Enrolment was low (32 per cent) among the Particularly Vulnerable Tribal groups (PVTGs).

Settlement of Claims

Settlement was irregular except for the medical college (located at the state capital, Raipur). The current TPA was unanimously reported to be more responsive than the previous one, notwithstanding the delays. Private hospitals were of the view that though some reimbursements kept coming in, delays could be up to six months to two years. About 10–15 per cent of the settlements were rejected. The bigger private institutions explained that the claims were resolved when a detailed explanation was provided. The commonest cause for rejection was the number of days of stay exceeding that given in the package. Ten per cent tax was deducted at source as per standard government regulations. Not-for-profit institutions claimed that they were exempted from this tax; this was a provision not being implemented. There was no functioning grievance redressal system. The providers met once a month with the officials of the State Nodal Agency (SNA) to discuss these issues; there was unanimity in their opinions that much of their problems remained unresolved. One state-level respondent reported that the TPA was supposed to settle claims within 15 days of transaction but often took a longer period to earn interest; there are no penalty clauses in case of delays. This is also reflected in the data given presented on the state RSBY website, which shows that only 17.2 per cent of the total claims were settled within 21 days till July 2012.

Private (for-profit) Hospitals

These institutions were generally providing a narrow and selective range of services. Small nursing homes, typically owned by specialist husband-wife

partnerships have made the most of the scheme. Patients with chronic conditions, complications or requiring prolonged and costly treatment were mostly referred to government institutions. Patient volumes have increased considerably in these hospitals and incomes have gone up. Most institutions reported up to 50–70 per cent occupancy on account of RSBY patients. The corporate hospitals reported only 5 to 10 per cent of occupancy was on account of RSBY smart card holders. They are also empanelled with other public and private insurance companies and also have a large clientele who pay out-of-pocket.

As the institutions are not accredited for specific services, institutions/doctors could pick and choose conditions that have profitable package rates. The doctors also reported largely treating simple/uncomplicated conditions. Thus, most of the hospitals were providing an extremely narrow and selective band of services. Gynaecologists preferred hysterectomy that offered a fair bit of margin but not Caesarean section. In ophthalmology, it was cataract which was being performed more than any other procedure.

Packages were unanimously reported to be priced considerably lower than those charged to the paying patients. This was more so for major surgeries/procedures. Onco-surgeries, neurosurgeries or complex orthopaedic procedures were hardly performed as the package cost barely covered expenditures. Several packages were discussed with key respondents who dismissed their rates as irrational; these included: total thyroidectomy and block dissection (₹17,000); hip internal fixation (₹15,000); brain tumours (₹20,000); intestinal resection (₹13,500); or, intestinal perforation resection anastomosis—contrast this with appendicectomy (₹11,000) or excision of unilateral fibroadenoma (₹7,000)! This is equally true of medical conditions; for example, serious ailments such as acute renal failure or dengue haemorrhagic fever have a package of ₹750 per day just as plasmodium vivax malaria or diarrhoea. The packages did not cover for treatment of most serious ailments as those often entailed multiple conditions which the packages did not account for. Few medical conditions were being treated. In order to limit RSBY patients several institutions reported earmarking a fixed number of beds. One super-specialty hospital, treating patients from different districts of the state, reported difficulty in reimbursement in cases of patients from districts with other TPAs.

Public Hospitals

Across levels (primary–secondary–tertiary), about 80–90 per cent of the claims were for medical conditions. Surgical conditions/procedures formed a minuscule proportion of the claims, except in the medical college where a multitude of conditions were being treated; the most frequent ones included cancer chemotherapy and animal bites. Minor surgeries (such as incision/drainage of abscesses), closed reduction of fractures and tubectomies were commonly being performed under this scheme.

Social Change, 43, 2 (2013): 227–243

There were no packages for specific medical conditions; they are claimed at the rate of ₹750 (approximately, \$15) per day of hospitalisation. Within this limit, it was not possible to provide for conditions that require long-drawn hospitalisation and cost-intensive treatment such as snake bite, poisoning (commonly, organo-phosphorus poisoning) and burns. Conditions such as psychiatric illnesses and suicidal attempts were not covered. Cases of animal bites were often admitted for anti-rabies vaccination.

Analysis of samples of claims (for different seasons) revealed that common conditions such as diarrhoea and respiratory infections formed about half the admissions. The other half consisted of conditions such as anaemia and weakness (innovatively billed as 'weakness and hypocalcaemia'). Patients were typically admitted for three to five days, investigated (for anaemia and other chronic conditions, say blood sugar) and provided a stock of medicines such as haematinics and anti-diabetics. An analysis of costs of treatment (using Standard Treatment Guidelines of the state and current prices of generic medicines available through outlets run in government hospitals) revealed that cost of medicines for treating common morbidities such as diarrhoea, malaria, respiratory infections and viral fevers was about ₹100, whereas hospitals were admitting patients for up to five days and charging ₹3,750.

Although 25 per cent of the package cost is earmarked for incentives to all categories of personnel (in public institutions) including administrative staff; no institution reported disbursing it. State-level administrators explained that the purpose of the incentive was to prevent patients being diverted to private facilities by the hospital staff. An administrator at one of the public hospitals observed that there has not been any significant increase in revenue being earned by them due to RSBY. Some of the funds earlier given for maintenance have been withdrawn after RSBY was introduced.

Not-for-profit Hospitals

These institutions provided a natural 'control', located somewhere in the middle of the spectrum of experience of private and public institutions. The three sampled hospitals had bed strengths ranging from 75 to 200. The larger of these institutions performed a fair range of services including general surgeries, orthopaedic procedures and chemotherapy. Many of the RSBY packages were priced somewhat higher than the rates they usually charged their clients (outside of the RSBY). The pattern was opposite in the smaller 75-bed mission hospital. They reported incurring losses if they had to hire a surgeon or gynaecologist not on their staff; this phenomenon was also reported by smaller for-profit nursing homes. These bigger institutions reported sizeable increase in the number of patients. One of the mission hospitals had a separate RSBY medicine counter to keep accounts of the costs incurred. While not compromising on the quality of services, certain cost-cutting measures were commonly resorted to; for example, cheaper silk sutures were used rather than the absorbable ones.

Discussion

In order to reach out to the maximum numbers, the state is facilitating empanelment of private providers as much in large towns as in the most peripheral of locations. Few owners of smaller nursing homes reported doctors being pressurised to join the scheme. The provision of a minimum of 10 beds is being relaxed to enable the entry of the smallest of providers. Christian missionary hospitals, a significant player in this state, have joined the scheme. All state government institutions are part of the network. Yet, RSBY beneficiaries constituted a minuscule proportion of the total patient load in large multi-specialty hospitals, though these are the only institutions capable of providing treatment for serious illnesses that result in catastrophic expenditure (myocardial infarctions, strokes or cancers).

Table 3 provides a summary of the findings.

Thus we find that for the small private nursing homes, the RSBY has been quite a bonanza. The more successful ones have seen their turnover, and incomes, soar.

Table 3. Summary of Findings

Private	Not-for-Profit	Public
Range of Services Provided		
<ul style="list-style-type: none"> • Narrow and selective range of services—Cherry picking • Fewer medical conditions than public • Largely simple and uncomplicated conditions, rest referred to public 	<ul style="list-style-type: none"> • Large range of services • Medical conditions plus surgeries • For example, Orthopaedic procedures and chemotherapy 	<ul style="list-style-type: none"> • Limited range of services • Mostly medical conditions • Surgical procedures less except in Medical College
Impact on Hospital		
<ul style="list-style-type: none"> • Increase in caseload • Small hospitals biggest gainers • Corporate hospitals—5–10 per cent RSBY occupancy • Increase in income 	<ul style="list-style-type: none"> • Increase in caseload • Losses if calling surgeons from outside 	<ul style="list-style-type: none"> • Decline in patients • Decline in range of services • Increase in patients in tribal block • No significant increase in revenues • Previous maintenance funds withdrawn
Suitability of Packages and Practices Followed		
Private	Not-for-Profit	Public
<ul style="list-style-type: none"> • Most packages priced lower than hospital rates 	<ul style="list-style-type: none"> • RSBY packages usually higher than hospital rates 	<ul style="list-style-type: none"> • Not possible to provide long-drawn hospitalisation, cost-intensive treatment

Private	Not-for-Profit	Public
<ul style="list-style-type: none"> • Fixed number of beds for RSBY • Hysterectomy preferred but not Caesarean section • Ophthalmology—more cataracts 	<ul style="list-style-type: none"> • Cost-cutting measures, without compromising quality • For example, silk sutures 	<ul style="list-style-type: none"> • Patients admitted for OPD-level conditions • Cost of treatment escalated • Commonly—diarrhoea, respiratory infections, anaemia, weakness, hypocalcaemia

There was anecdotal evidence of complicated conditions being booked instead of simpler ones (examples: strangulated hernia instead of simple hernias, or caesarean section instead of normal delivery). This was justified as a ‘defensive’ practice since the option for revising the diagnosis of the patient was not available (the patient would need to be discharged and the entry for the ‘new’ condition entered after 24 hours). While this is a genuine problem, it opens the doors for corrupt practices, including more blatant ones such as patently false entries and the ‘patient’ provided with tonics or health drinks. The more conscientious ones (including those in the not-for-profit hospitals) would often book the case after the diagnosis is established or the baby delivered; this has obvious medico-legal implications though. In most cases, the package rates leave little room for complications that result in longer hospitalisation or expensive medication (particularly, antibiotics). One of the most frequently encountered problems was the lack of packages for newborn babies who often needed intervention immediately or soon after birth. The state institutions can get round this problem by having access to free government supply of medicines or through the funds of the Jeevan Deep Samitis (Patient Welfare Societies).

Some government hospitals reported decline in patient load after the introduction of the RSBY, signalling a shift from the public to the private sector; the range of services in one district hospital in our sample has also declined. Community and Primary Health Centres are unable to compete with private providers as the latter have relatively better patient amenities (such as air-conditioning) and specialists, particularly for surgeries and procedures.

With 40 per cent of the package rate being deducted from reimbursements to government institutions for contribution to the Chief Minister’s Welfare Fund (a Chhattisgarh Government ‘innovation’ and not a part of this centrally designed scheme), it is well nigh impossible to provide for certain treatments such as Anti-Rabies Vaccine being purchased by rural institutions at market rates. This innovation has been designed in order to reduce pilferage of funds at the facility level and improve hospitals through capital investments, including those hospitals with few RSBY patients. However, these funds are currently being managed by the SNA and none of it has been spent as yet. Guidelines have been issued asking for proposals from the districts for capital investments in hospitals.

Government institutions have been empanelled within the RSBY with two purposes (as reported by administrators): to infuse funding support and to strengthen the demand side (the BPL patients being 'now empowered to demand' was a frequent perception). As our data shows, RSBY brings in a relatively minuscule contribution in large government institutions (such as district hospitals and medical colleges) in terms of resource strengthening; a new pattern of 'denial' has emerged with RSBY patients excluded out of free medicines and not infrequent fallbacks on Jeevan Deep Samitis. This has also meant certain medicines that are available free at secondary and tertiary levels being purchased by CHCs and PHCs from local shops at retail (and obviously higher prices). It is inexplicable why government doctors and staff are being paid incentives out of the RSBY package in government hospitals. Are government doctors and staff similarly allowed to be paid by commercial medical insurance should they treat such patients in state institutions? As for empowering the underprivileged to get better treatment in government hospitals, the independent evaluation undertaken by the State Nodal Agency, Chhattisgarh found that government doctors actually discriminated against RSBY patients as they were considered an 'additional burden' (CTRD, 2012).

Significantly, for the not-for-profit sector, used to functioning on tight price lines the RSBY has provided the elusive sustainability. There was no provision for reimbursement of costs involved in follow-up of patients; some institutions admitted follow-up patients and charged it as a medical package.

Private accredited institutions are highly selective in what they choose to provide. Service guarantees, appropriate to levels of providers, is an urgent necessity. With high-end procedures being hardly performed by any institution (due to low package rates), BPL families have scarce insulation from catastrophic expenditure and impoverishment from medical costs. RSBY should help strengthen the public institutions and not weaken them. For RSBY to work well government hospitals must meet the public health standards and the private sector better monitored and regulated. The regulatory framework was conspicuous by absence: weak accreditation mechanisms, poor grievance redressal mechanisms and no clinical audits.

In Chhattisgarh, the government has instructed the TPA to post all transactions in real time with the department. It has recruited a data management agency to periodically check the data. There is a move that the same software be used by all the TPAs and insurance companies. Inspection of the facilities before empanelment is critical to ensure proper implementation of the scheme. The doctors argued strongly for time-bound settlement of claims, upward revision of several packages and a seamless system for referral.

The National Rural Health Mission (NRHM) sought to energise the public health services through a multi-pronged strategy of building infrastructure, manpower and working of district health systems; the RSBY hoped to complement the strengthening of system by providing coverage for serious illness episodes. The scheme has also been considered to be the platform for universalising health

insurance (Dror & Velakkal, 2012). However, as a stand-alone initiative, without any institutional links (including referral links) to the existing tiers and levels of publicly provided health services may be out of sync with universalisation of health services. In fact by putting institutions like PHC and CHCs (visualised for very specific functions) in competition with clinical setups in the private sector, it undermines them and at the same time denies them of state resources. While the well-endowed private hospitals cherry pick cases, the public hospitals are left with the chronic and day-to-day cases for which the packages offered are not profitable, often these hospitals find inappropriate ways to compensate such as prolonging hospital stay. Our analysis also indicates that the RSBY is hardly fulfilling the *raison d'être*—treating conditions that entail catastrophic expenditure. Though focused on medical care it does not pay attention to levels of institutions and services they provide thereby giving free hand for profiteering.

Despite the acknowledged success of some community based health insurance schemes in India, this endeavour clearly has serious shortcomings in its design itself. Our critique of the design issues have been amply borne out by the detailed evaluation study conducted in 2012 (after this study and its presentation to the state government); a detailed reading of the recommendations section of the evaluation is instructive (CTRD, 2012). The emerging evidence from the providers calls for urgent rethink on these critical design issues.

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