The Rashtriya Swasthya Bima Yojana (RSBY) Experience in Chhattisgarh

What does it mean for Health for All?

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Introduction

Operationalized in 2007-2008, the Rashtriya Swasthya Bima Yojana (RSBY) is a state funded health insurance scheme targeted for families living below the poverty Line (BPL) in India. Noted as an innovative and pro-poor scheme for providing equitable health care and cushioning from catastrophic health expenditure, it has created considerable interest among both public health scholars and practitioners. The scheme provides coverage for a family of up to five members (packages for surgical procedures as well as for hospital admissions for medical causes); the cap per year is Rs.30,000 ($600). A key measure of success would be the manner in which the benefits are reaching or not reaching the target groups. A plethora of state-supported insurance schemes have been in operation for several years and provide insights on issues of enrolment, empanelment of hospitals, utilization and cost of hospitalization, 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 policy 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.

There has been a growing tendency to pass off health insurance as Health for All. As the Jan Swasthya Abhiyan (2012) argues, this has "critical implication for both the diminishing meaning of health for all and the role and responsibility of the government in ensuring that it is truly achieved". A recent article[1] announcing that by extending health insurance coverage through RSBY to the entire state, Chhattisgarh would attain "Health Cover for All" from October 2012 illustrates this.

Chhattisgarh: A Brief Profile

Chhattisgarh state, which came into being in the year 2000, has a total population of 25.5 million (Census 2011). Around 41% of its total geographical area comes

[1] http://articles.economictimes.indiatimes.com/2012-08-08/news/33100921_1_rsby-health-insurance-chhattisgarh-government.

under forests (FSI, 2011). The population is mostly rural with only 22% of the households living in urban areas, (NFHS, 2007). Nearly 86% of the households in the State belong to marginalized and socially excluded groups out of which 32% are from tribal communities (Census, 2001). Though it has an abundance of minerals and other natural resources, Chhattisgarh is considered one of the poorest states in the country with the second lowest monthly per capital household consumption expenditure (NSO, 2011).

At the time of its formation, Chhattisgarh lost most of it trained human resource and training facilities to Madhya Pradesh. Chhattisgarh has tried to fill this gap by launching a series of health reforms in order improve its public health system such as the Mitanin Programme[2], a three year medical course, the formation of a cadre for rural and remote areas and increased the number of health training facilities. The public health system in Chhattisgarh currently has in place, around 5076 Health Sub-Centers, 741 Primary Health Centers and 148 Community Health Centers in addition to 27 District Hospitals, three Medical Colleges and district level ANM schools training health professionals (6th CRM, 2012). The formal private sector in health is concentrated only in a few of the bigger towns. Though the state has recorded improvements in health indicators like IMR, MMR, Immunisation and ANC coverage (AHS, 2010-11; SRS, 2002 & 2011), the challenges remain of providing quality health services. The latest Common Review Mission report of the NRHM recognizes that though the state is ranked 23rd as per the human development index, it has achieved a lot after its formation, considering the "immense problems faced in terms of lack of human resource, infrastructure, difficult terrain as well as the issue of left wing extremism" (6th CRM, 2012).

Current Status of RSBY in Chhattisgarh

The RSBY has been operational for the last four years in Chhattisgarh. In August 2012, the state Government announced the Mukhyamantri Swasthya Bima Yojana (MSBY), extending RSBY to non-BPL families in the state. The current target of enrolment under RSBY and MSBY are 6,228,354 families[3]. Out of this,

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

[3] http://cg.nic.in/healthrsby/.

in Round 4, enrollment of 2,827,852 families, 45% of the target, have been completed done till June 2013. The average family size of those families enrolled under RSBY and MSBY is 3.4.

The total premium paid for RSBY amounts to Rs.5066.44 lakhs currently at the rate of Rs.314 per family. The total premium paid for MSBY is Rs.3790.46 lakhs. 38556 claims had been submitted till the first week of June 2013; 51% by public hospitals and 48% by the private ones. Interestingly, 37% of the claims were made by public hospitals while 63% of the amount was claimed by the private hospitals. During the week of reporting, 44% of the empanelled hospitals (30% of the public and 58% of the private empanelled hospitals) had submitted claims; only 50% of the claims were settled within 31 days while 5% are rejected. The average claim for RSBY and MSBY is Rs.4,824. The claims ratio comes to 21%, which is very low.

About 48% of the hospitals empanelled in the state are private. Raipur has the highest number of private hospitals empanelled under RSBY and MSBY (91% private), followed by Bilaspur (77% private).

The percentage of private and public hospitals empanelled in the state under RSBY and MSBY are as follows:

S.No.	District	% of Public Hospitals Empanelled	% of Private Hospitals Empanelled
1	Raipur	9%	91%
2	Bilaspur	23%	77%
3	Korba	30%	70%
4	Durg	31%	69%
5	Kawardha	47%	53%
6	Raigarh	48%	52%
7	Balod	50%	50%
8	Baloda Bazar	54%	46%
9	Mahasamund	58%	42%
10	Janjgir	63%	37%
11	Dhamtari	63%	37%
12	Mungeli	67%	33%
13	Narayanpur	67%	33%
14	Sarguja	69%	31%
15	Bastar	69%	31%
16	Koriya	82%	18%
17	Kanker	83%	17%
18	Rajnandgaon	84%	16%
19	Bemetara	86%	14%
20	Gariyaband	86%	14%
21	Kondagaon	88%	13%
22	Jashpur	88%	12%
23	Surajpur	100%	0%
24	Balrampur	100%	0%
25	Bijapur	100%	0%
26	Sukma	100%	0%
27	Dantewada	100%	0%
	Total	**52%**	**48%**

Five of the most under-served districts, Surajpur, Balrampur, Bijapur, Sukma and Dantewada, have no private hospitals empanelled under RSBY-MSBY; all the empanelled ones are public.

Public Health Resource Network (PHRN) and its collaborators like the Center of Social Medicine and Community Health (CSMCH) of the Jawaharlal Nehru University (JNU), Chaupal and Jan Swasthya Abhiyan (JSA) have been closely following the experiences and the performance of the scheme in the state. The first study on patient experiences was undertaken in Durg in 2010; a pioneer study in the country.

This was followed by two studies in 2012: (i) an exercise on examining problems encountered during enrolment (which is a key process) across 18 districts, and (ii) understanding issues of access faced by the Particularly Vulnerable Tribal Groups (PVTGs) (as part of a larger study). While most scholars continued to focus on beneficiary issues, we examined the provider perspectives in a study in three districts in 2011-12 in order to unravel the design-related issues as viewed by different categories of providers and the implications of the scheme for each one's 'business model'. This was followed by two more studies in 2013 across 12 districts that sought to capture patient experiences.

This paper collates the findings of these six studies that cover nearly all districts of Chhattisgarh and presents a composite and comprehensive experience of the RSBY in the context of Health for All in one of the poorest states of India.

Studies and Methodologies

Study I: Implementation of RSBY

This quantitative study was conducted by the Public Health Resource Network (PHRN) in Durg district in 2010 to assess the implementation and viability of the RSBY scheme in Chhattisgarh in order to identify policy gaps and program inconsistencies in terms of: enrolment, information dissemination, service utilization, empanelment, availability of services, transparency and the extent of out-of-pocket expenditure incurred by beneficiaries.

102 exit interviews of RSBY utilizers during May-June 2010 from the selected private and public hospitals were conducted using a structured questionnaire. The district was selected as it had the highest utilization rate. Hospitals selected for the study included two public and five private hospitals, randomly selected from among those with the highest number of cases under the RSBY scheme. The sample (102 respondents) was fairly representative as it constituted 4% of the total hospitalized cases in Durg district and 2% of the total hospitalized cases in the state at the time.

Study II: Enrolment in RSBY

This study on RSBY enrolment was conducted by constituent organizations of Jan Swasthya Abhiyan (JSA) Chhattisgarh in December 2011 and January 2012. It covered 270 villages of 32 blocks in 18 districts. The villages were selected through convenience sampling in the block where the various organizations are working. Data on enrolment and utilization status was collected through village-level questionnaires.

Study III: Access of Particularly Vulnerable Tribal Groups (PVTGs) to Health and Nutrition Services

A study was conducted by PHRN along with the State Health Resource Center (SHRC), Chhattisgarh and local non-governmental organizations (NGOs) in 2012 on Particularly Vulnerable Tribal Groups (PVTGs). 1,200 PVTG families from Baiga, Kamar and Pahari Korwa communities **(Table 1)** were interviewed using a household questionnaire.

Table 1: PVTGs and sample covered			
District	**Block**	**Name of PVTG**	**Number of respondent households**
Sarguja	Lundra	Pahari Korwa	860
Gariaband	Chura	Kamar	220
Kawardha	Pandariya	Baiga	120

This study, in addition to covering access to health services, covered livelihood status, ownership of resources, access to social security schemes and participation in local governance.

Study IV: Design Issues in RSBY through Mapping Provider Perspectives

This qualitative study conducted by PHRN and the Centre of Social Medicine and Community Health, Jawaharlal Nehru University during October 2011 – March 2012 covered three districts of the state, viz. Raipur, Dhamtari and Balod, in order to understand the issues around the design of the scheme through mapping perspectives of both public and private providers. The hospitals covered during the study included private for-profit (small 10-20 bedded nursing homes and multi-specialty corporate hospitals), public (medical college, district and sub-district hospitals) and

Table 2: Typology and numbers of institutions		
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 Center	2
	Primary Health Center	1
Not-for-profit Hospitals		**4**
	Mission Hospitals	3
	Trust Hospital	1
Respondent Profile		
	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

not-for-profit (low cost and Christian missionary) hospitals **(Table 2)**. State level administrators were also interviewed. Five public hospitals, nine private hospitals and four not-for-profit hospitals were covered wherein 48 respondent interviews were undertaken in three districts: Raipur, Dhamtari and Balod. Open-ended semi-structured tools with pre-defined topic guides were used to conduct in-depth interviews with the providers. The interviews were analyzed to assess similarities and differences in perceptions across stakeholders.

Study V: Health Services at Various Levels

Chaupal (2013b) conducted a study on status of Health Services at the sub-center, PHC, CHC and district hospital levels in Chhattisgarh during January to April 2013. While at the Sub-center and PHC levels, information regarding availability of services

Table 3

Sl. No	District	CHC	District Hospital
1	Sarguja	Dhorpur (Lundra)	Ambikapur
2		Lakhanpur	
3		Udaipur	
4		Narmadapur (Mainpath)	
5		Batauli	
6		Sitapur	
7	Koriya	Patna	Baikunthpur
8		Khadgoava	
9		Sonhat	
10		Manendragarh	
11		Janakpur	
12	Raigarh	Tamnar	Raigarh
13		Pussaur	
14		Dharamjaygarh	
15		Gharghoda	
16	Dhamtari	Nagri	Dhamtari
17	Jashpur	Kunkuri	Jashpur
18		Bagicha	
19	Raipur	Abhanpur	
20	Kawardha	Pandariya	Kawardha
21	Baster	Tokapal	Jagdalpur
22	Kanker	Charama	Kanker
23	Balrampur	Rajpur	
24	Gariyaband	Chhura	Gariyaband
25	Balodabajar	Kasdol	Balodabajar
26	Mahasammund	Basna	Mahasammund
27	Janjgir-Champa	Pamgarh	Janjgir-Champa

was collected through group discussions in the villages, exit interviews were used at the CHCs and District Hospitals in order to gauge the experience of the patients. Exit interviews, using a structured questionnaire, were conducted with 185 in-patients admitted in selected CHCs and District Hospitals (DHs) along with 169 outpatients in order to analyze their experiences. The questionnaire also included items on RSBY, the findings of which will be presented in this note. Five in-patients were interviewed in each facility across 12 district hospitals and 27 CHCs **(Table 3)**.

Study VI: Experiences of Beneficiaries in Private Hospitals

This study undertaken by Chaupal (2013a) in January-February 2013 sought to document patient experiences in availing RSBY benefits in 13 empanelled private hospitals. The hospitals were selected through convenience sampling among the hospitals showing higher number of claims. The interviewers visited the hospitals and undertook exit interviews with patients who had been discharged. 35 patients were interviewed (21 in Dhamtari, six in Raigarh and eight in Raipur) from the hospitals. The data collection had to be suspended as private hospitals stopped providing services under RSBY and demanded that the government increase the 'package' rates.

Findings

I. Design Issues

The Public-Private Mix

An enigma of the RSBY has been the empanelment of the public sector institutions along with the private sector providers. This 'private public mix' was ordained to 'empower' the beneficiaries by giving them the 'freedom of choice' in selection of providers (Results for Development Institute, undated).

The study on design issues (PHRN & CSMCH-JNU, 2012) found that there was no real choice for the beneficiary. 'Choice' was restricted to the services that a hospital was willing to provide. The private hospitals were found to provide a narrow and selective range of services (PHRN & CSMCH JNU, 2012); they would pick and choose more profitable packages. In addition to this, the private hospitals were treating simple and uncomplicated conditions while referring complicated cases to the public hospitals. The smaller hospitals were also experiencing increase in caseloads as more patients were coming to them with the RSBY cards.

On the other hand, patients were declining in public hospitals especially in the areas where there was strong competition from the private hospitals. However, in tribal areas, caseloads were increasing for CHCs and PHCs. Public hospitals were found to be treating common medical conditions such as diarrhea, anemia, weakness, malaria and hypocalcaemia with a few surgical conditions/procedures (Nandi et al, 2013). District hospitals and medical colleges were treating conditions such as cancer, chemotherapy and animal bites (Nandi et al, 2013).

Unlike public and private hospitals, not-for-profit institutions were providing a large range of services, including surgeries. They too reported an increase in caseloads. These hospitals, without compromising on the quality, undertook cost-cutting measures such as using silk sutures instead of absorbable ones (PHRN & CSMCH-JNU, 2012). Instead of strengthening public institutions with more patients and revenue inflow, RSBY seemed to have weakened them by weaning patients away from public sector to private sector (Dasgupta et al, 2012).

The Use of Technology

The use of technology has been much talked about with regard to RSBY. Our study found that there were a number of bottlenecks; poor internet connectivity, especially in the Primary Health Centers (PHCs), emerged as a critical constraint. Though the facility for offline transactions exists, it is not being used. The hospitals were unable to swipe the card more than once in 24 hours in case of changing package or referrals. Training for using the software and the technology was found to be inadequate or non-existent. The software itself posed a number of problems; it needed to be updated with changes in Third Party Administrators (TPAs), which was subsequently rectified. Three out of four CHCs in Raipur district were not providing services under RSBY at the time of the survey due to software problems. These problems in technology often led to rejection of claims for the hospitals (PHRN & CSMCH-JNU, 2012).

Settlement of Claims

At the time of the study, the RSBY guidelines were such that claims had to be settled within 21 days. However, our study with the providers revealed that periodicity for settling claims in most hospitals extended from six months to two years; hospital administrators reported that the change in the TPA had led to faster clearance of claims. The time period for settlement of claims has since then been increased from 21 days to 31 days. About 10-15% of the settlements were rejected; reasons for rejection of claims were not usually clear to the hospitals and no grievance redressal system was in place in order to address this. No penalty was put on the TPA for delays in claim settlement and the hospitals faced difficulties in reimbursement for patients from districts or states having a different TPA (PHRN & CSMCH-JNU, 2012). The settlement/rejection of claims was perceived to be ad hoc; providers, especially the private ones, adopted defensive (sometimes corrupt) practices against losses (PHRN & CSMCH-JNU, 2012).

Pricing of Packages

Most of the private providers said that RSBY packages were priced much lower than the rates charged by these hospital to the paying patients. This resulted in several distortions; for example, hospitals preferred hysterectomies (which had "better rates") but not cesarean sections and the number of cataract surgeries was also found to be increasing (Nandi et al, 2013). Due to the perceived inadequacy of the package, medical problems / conditions requiring longer stays, such as snakebite, poisoning or burns, were not treated under RSBY. One of the

most frequently encountered problems at the hospitals was the lack of packages for newborn babies who often needed intervention immediately or soon after birth (Dasgupta et al, 2012).

Our study (Nandi et al, 2013) further indicates irrational hospitalizations and prescriptions by doctors in the public health facilities due to the pressure of increasing utilization. The RSBY has led to no significant increase in the revenues at the public hospitals. Administrators at the public health facilities stated that there has been a reduction in the hospital maintenance funds. In case of not-for-profit institutions, the RSBY package rates were higher than their usual rates and thus increased their income. However, hospitals had to face "losses" in case they needed services from specialists (especially surgeons/obstetricians) from outside their staff (PHRN & CSMCH-JNU, 2012).

II. Enrolment and Coverage

Enrolment under RSBY is an annual feature and is carried out by the TPA. Our study on design issues found that annual enrolment seemed to have questionable utility. Some administrators considered the exercise undertaken by the TPA as a conflict of interest. This is because the TPA is hired by the insurance provider, and as non-enrolment or non-distribution of RSBY cards by the TPA to the beneficiaries could be intentional in order to reduce utilization and thereby increase profits for the Insurance agency. Providers stated that enrolment is not being done in remote and inaccessible villages (PHRN & CSMCH-JNU, 2012).

We explored the issues in enrolment from the perspective of the beneficiaries in three of the studies. As per guidelines, the TPA sends a team to the village for enrolment and the RSBY smart card has to be prepared and handed over to the beneficiary on the same day.

However, according to the Durg study, only 4% respondents received smart cards at the time of enrolment itself (Nandi et al, 2012a). The average time taken to receive the smart card was found to be about a month (Nandi et al, 2012b). The study conducted by JSA in 270 villages in tribal and remote blocks found very low enrolment, ranging from 30% to 50% (Nandi et al, 2013). The study done with PVTGs (identified as the most vulnerable and impoverished of tribal groups) revealed that only 32% families interviewed were enrolled under RSBY; most of these families had Antyodaya Cards (for accessing the Public Distribution System for subsidized grains) though (Nandi et al, 2012c).

Under the provisions of the RSBY, a maximum of five members of a family are insured. The Durg study found an average of four members enrolled onto the scheme per family despite 37% of the families having more than five members in (Nandi et al, 2012b).

III. Beneficiary Experiences

The studies that explored the experience of beneficiaries in utilizing RSBY found instances of low utilization and at times denial of health services, lack of transparency and lack of sharing of information with beneficiaries and high out of pocket expenditure (Nandi et al, 2012c).

Access and Utilization of Services

The Durg study and programme reports show that very few private hospitals were empanelled in remote and tribal areas. Instead, a large percentage of the empanelled private hospitals were in towns and cities (a vast majority in Raipur) that already have functioning public health facilities. Further, a "quota system" was practiced by many private hospitals who did not admit more than a certain number of RSBY patients (Nandi et al, 2012a).

The study on PVTGs found that 4% of the families interviewed had availed of services under RSBY (Nandi et al, 2012c). This was in contrast to the JSA study that found cards being used only in 25 % of the villages for treatment in the network hospitals.

The main symptoms for which the beneficiaries used RSBY included: weakness (33%), fever (18%), surgery (13%) and abdominal pain (10%) (Nandi et al, 2012a). Average hospitalization duration was of four days. 64% of those hospitalized were admitted to the general wards (Nandi et al, 2012b). Significantly, during the survey it was found that 25% of the patients (6 from private and 20 from public hospitals) interviewed had not actually been hospitalized, but were recorded to be so (Nandi et al, 2012b).

This means that the patients were shown to have been hospitalized in order to utilize the RSBY, whereas they were undergoing treatment as outpatients. The usual way of doing this was to send the patient home with medicines after swiping the card and asking them to come back after a few days to swipe the card once again. In a few cases, the cards were deposited by the hospital and the patient was told to come and get the card after the prescribed number of days under RSBY for that condition.

Seventy five percent of the respondents undertook the prescribed diagnostic tests on site at the hospital whereas 19% respondents had to do so from private laboratories. Almost all were asked to go for hematological tests. The other tests commonly prescribed included: urine and stool tests, X-rays, ultrasonography, ECGs and CT scans. 60% of the respondents received medicines from the hospital itself while 38% of the patients had to purchase from private pharmacies (Nandi et al, 2012b).

The Chaupal (2013b) study found that while 64% of the inpatients interviewed in the CHCs and District Hospitals belonged to the Below Poverty Line (BPL) category, only 32% had a RSBY smart card. Of the 59 patients who had smart cards, the hospital used the card in case of 18 patients (31%). The main reasons for not utilizing the card were: the patient was not carrying it (47%); the hospital did not admit people under RSBY (17%); the smart card had not been renewed (17%); and, the smart card amount had been spent (5%).

In private hospitals, 80% of the patients interviewed were first time users of the RSBY smart card (Chaupal, 2013a). Seven out of the 35 patients (20%) interviewed were denied admission to the hospitals for treatment under RSBY despite having smart cards. Five of these seven patients were not given any reasons for refusal. One was refused on the premise that the package amount was “not sufficient” to treat her condition. The other patient was told that the smart card did not have any balance despite the fact that the card had been received in the same month and had not been used ever. The most frequent reason for admission was surgery (71%) followed by medical causes (23%) and diagnostics (6%).

Awareness of Beneficiaries and Transparency Measures

The Durg study found that most of the patients were neither aware about the details of the scheme and entitlements nor about the empanelled hospitals. 37% of the respondents were unaware about the amount blocked from their card or the balance remaining. The average amount blocked for those aware about it was Rs. 6,622 (Nandi et al, 2012b). The average value of hospitalization was Rs. 4,988 in public facilities and Rs. 7,416 in private facilities (Nandi et al, 2012a).

In the Chaupal study (2013b) of public hospitals, of the 18 who were able to use their RSBY cards, only four patients were informed of the amount spent from their card and the remaining balance. As per the study in private hospitals, only half of the patients received a receipt from hospitals after treatment. Further, 23 patients were informed of the amount booked and remaining balance in their card while five patients were not told about the balance.

Out of Pocket Expenditure

Out of pocket expenditure was incurred by 58% of the respondents in the Durg study who used private healthcare services and 17% of those using public services. The expenditure was mainly on account of medicines (19%) followed by money paid to doctors (12%) and diagnostics (11%) (Nandi et al, 2012b). In private facilities, the average out of pocket expenditure was Rs.1,078, while it was Rs. 309 in public facilities (Nandi et al, 2012b).

The Chaupal study (2013b) found that in the public sector hospitals, out of 59 patients who had RSBY smart cards, 56 incurred out of pocket expenditure. This is also because only 18 out of the 59 patients having RSBY cards, were hospitalized under RSBY. The average out of pocket expenditure in the CHC for the RSBY card holders was Rs. 548 and in the DH it was Rs. 2,644. The difference was on account of more complicated conditions being treated at the DH with longer hospital stays. Of the 18 patients who were able to use their cards, three (17%) incurred out of pocket expenditure, at an average of Rs. 181. The expenditure was on medicines, transport, money paid to staff and for buying treatment supplies.

The Chaupal study in private hospitals found that even after using smart card for treatment, five patients out of the 35 interviewed had to incur out of pocket expenditure (Chaupal, 2013a). The five patients incurred an average amount of Rs. 3,794 each. The hospitals charged the patients extra for medicines and other supplies.

Emerging Issues in RSBY

Increase in Hysterectomies

Unusually large numbers of unnecessary hysterectomies were reported to having been performed under RSBY and other similar insurance schemes. Such irregularities have mostly been reported in Bihar, Chhattisgarh and Andhra Pradesh. According to media reports[4] 16,000 hysterectomies took place in private hospitals under the RSBY in Bihar during 2011. 7000 such cases were recorded under RSBY in Chhattisgarh within 30 months, and 11,000 under the Rajiv Gandhi Arogyasri scheme in Andhra Pradesh in a span of two years[5]. Cases of unnecessary hysterectomies related to RSBY have recently re-emerged in Bihar. An enquiry by the East Champaran district administration found that many of the hospitals did not have MBBS doctors, nor did they have proper operating or diagnostics facilities[6]. Licenses of 22 hospitals were suspended in Chhattisgarh by the Health Department after the Health Minister admitted that 1,800 hysterectomies had taken place in eighteen months [7] many of which were unnecessary.

Private Hospitals Suspend Treatment under RSBY

The Chhattisgarh state government announced the Mukhyamantri Swasthya Bima Yojana (MSBY) in August 2012 for families Above the Poverty Line (APL), on similar lines of RSBY. Ever since the announcement, there has been growing discontent among the private hospitals regarding the packages in RSBY and MSBY. While the MSBY was yet to take off, the private hospitals (61 on last count) surrendered

[4] http://www.indianexpress.com/story-print/993625/.
http://indiatoday.intoday.in/story/bpl-women-in-bihar-losing-their-wombs-over-insurance/1/210927.html.
http://www.hindustantimes.com/India-news/Patna/In-Bihar-hysterectomy-on-14-yr-olds/Article1-910513.aspx.

[5] http://www.theweekendleader.com/Causes/1537/chilling-findings.html.

[6] http://www.downtoearth.org.in/content/30-health-clinics-east-champaran-face-action-performing-illegal-hysterectomies-avail-insuran.

[7] http://week.manoramaonline.com/cgi-bin/MMOnline.dll/portal/ep/theWeekContent.do?contentId=13857015&programId=1073755753&tabId=13&categoryId=-199981.

their Master Hospital Cards in February 2013 refusing to provide treatment under RSBY. They demanded a 30-40% increase in package rates and increase in the cover to Rs. 100,000 in lieu of the current Rs. 30,000. Additionally, there were disagreements between the bigger hospitals and smaller nursing homes, with the bigger hospitals demanding increases for high-end and sophisticated procedures.

After the hospitals stopped providing services under RSBY, several rounds of negotiations were held between them and the government. Meanwhile the Government threatened to cancel their empanelment for the other government schemes like ESI, Sanjeevani Kosh and Bal Hriday Yojana. The Indian Medical Association (IMA), who had been leading the protests, and the Chief Minister came to a consensus in the last week of April 2013; the hospitals agreed to resume services under RSBY subject to certain conditions. However, it took up to a month for the RSBY services to resume in many hospitals.

As part of the negotiations, the RSBY/MSBY rates were revised from 1st April 2013; this would be effective from October 2013 once the existing contracts/ rates came to an end. Until then, high-end procedures will be funded from the Sanjeevani Sahayata Kosh, a pre-existing scheme of the Chhattisgarh Government to provide financial support for listed critical care coverage to families belonging to BPL families and poor non-BPL beneficiaries. The number of procedures under this scheme has been increased from 13 to 30. The Government has decided that more hospitals will be empanelled under Sanjeevani scheme, including public sector hospitals.

The increase in the package rates from 1st April 2013 has not been as high as demanded by the IMA and certain procedures and diagnostics have been removed. For example, in the revised list for the current round (Round 4), packages for MRI, blood transfusion and CT scan have been removed. Some of the packages for which rates have been revised are hysteroscopic tubal cannulation (Rs.12,500 from Rs.7,500), Young's Operation (Rs.11,000 from Rs.5,600), Rhinoplasty (Rs.12,300 from Rs.9,720), Vulvectomy–Radical (Rs.11,000 from Rs.7,500), Hysterectomy–Wertheims Operations (Rs.18,000 from Rs.12,500), Laprotomy for ectopic rupture (Rs.14,000 from Rs.8,500). Additionally, new packages, such as, for antenatal-care have been added.

We followed up with respondents from private and non-profit hospitals that were covered in the design study undertaken by PHRN and JNU, in order to get their feedback regarding the changes in rates and understand their current positions on implementing RSBY/MSBY.

The doctors were unanimous in their view that the package rates still remain inadequate. One doctor complained that many of the packages are not revised adequately such as most of the cancer surgeries, and cystocele. The package for caesarean section though revised to Rs.13,000 is inadequate to cover any complications. The doctor of an ENT hospital said that the packages are still inadequate for many ear surgeries like tympanoplasty or oscicoplasty. He further claimed that in around 15-20% of cases, additional procedures need to be done for which they are unable to block more money from the RSBY card and nor are they able to charge the patients.

The Hospital Administrator of a super specialty Hospital differed with this view and said that packages related to the ear and eye are higher whereas they are being provided at lower rates in general. According to him, the revised package rates are adequate to normal conditions to a certain extent but for complicated cases they are not sufficient, for example, it is difficult to treat patients of septicemia where all his organs have been damaged and require extensive care. He opined that the RSBY packages have been designed keeping in mind only the public health facilities where the government already provides human resource, drugs, equipments. It was difficult for a private tertiary hospital to maintain all the services at the rates considered under RSBY. RSBY/MSBY patients constitute around 15% of the patients in the hospital and he stated that though private hospitals like theirs are willing to treat patients under RSBY, they do not want to continue with MSBY unless the entitlement per card is raised to Rs 100,000-150,000.

The problem of delay in reimbursement of claims for up to two to three months still continues was a common grievance. For the non-profit hospital, the major concern was getting timely payments and not the inadequate package rates. According to one doctor, in negotiating the readmission of RSBY patients after the hospitals suspended RSBY, government assured them timely payments. One of the respondents revealed that during the final discussions, they were given 'permission' by state RSBY official to charge fees after the amount of Rs.30, 000 is exhausted from a patient's card.

Discussion

Several challenges emerge from the RSBY experience of Chhattisgarh that highlight shortcomings in the design, constraints faced by public and private providers, and a range of beneficiary related issues. The reach of RSBY is unfulfilled as a large proportion of the vulnerable population still remains out of its ambit due to low enrolment rates even as evidence of experience among those enrolled points to high out-of-pocket expenditures. These issues gain more significance when seen in the context of the Right to Health.

There is evidence from several states (PHFI, 2011) that such insurance schemes are not successful due to rising costs over a period of time. There is a continuous demand from the private sector to increase the ceiling of packages, which is not surprising, given that their main motive was to maximize profits. More recent reports from Chhattisgarh and Andhra Pradesh have shown that RSBY and Arogyashri respectively are not in the pink of health as demands from private sector increase and some hospitals even stopped providing services under the insurance schemes thus holding the government to ransom.

RSBY as a new design of an insurance model was launched with much fervor few years back as an innovative financing model in providing health services. The design was singularly different from other insurance schemes as it was a demand-side financing model. In economic terms it meant that that the consumer (in this case the RSBY card holder) is able to choose from the list of providers. The logic this scheme follows is that it allows suppliers to compete for the consumer's budget (in this case the government funds) and the consumer decides which institute will receive the public money. It is assumed then that the quality of services will improve due to the competition between providers to attract RSBY patients however, as the studies have shown, this has not happened.

Within a public health perspective, one has to think clearly whether such a business model of financing in health care works in India as there are several distortions. The private sector generally feels that some packages are priced unfairly while others are satisfactorily priced. They therefore select their patients according to procedures that benefit them. This leads to denial of services at one end and irrational practices by over 'utilizing' some packages.

Service guarantees, appropriate to levels of providers, are an urgent necessity. With high-end procedures being hardly performed by any private institution

(due to low package rates), BPL families have scarce insulation from catastrophic expenditure and impoverishment from medical costs -- the raison d'etre of RSBY. What choice do the poor beneficiaries have? This leads to the issue of information that beneficiaries receive from all players and who is more empowered in the process. Information about the scheme is poorly disseminated and hence in many cases the beneficiaries are in the dark about their entitlements while seeking care with little control over the rationality of the care they will or will not receive. Are there any rights given to the patients in RSBY as they do not get to know when they are denied services? What are the implications of the RSBY for the existing public system? It is generally acknowledged that a lot needs to be done to strengthen the public health system but is RSBY an answer to that?

RSBY has created a schism with the government's role as a purchaser and regulator while shifting the larger role of provisioning to the private actors. Consequently it has brought into play market mechanisms within the public institutions by incentivizing personnel who treat RSBY patients. Instead of investing more on public health services there is a flight of revenues to the private sector. Further, in poorer regions where the number of private players is limited, people continue to rely on the public health services.

Consequently, three important principles - comprehensiveness, universality and equitable health services - within the larger context of right to health and health care have suffered. RSBY services are largely limited to the secondary level and have not been extended to out-patient services where maximum number of morbidities is treated. Unfortunately, this is also being replicated in other schemes piggy backing on RSBY and thereby creating a false sense of universal health care and coverage. In the recent plan to privatize diagnostics in Chhattisgarh, the government has stated that RSBY/MSBY will take care of inpatients, while the government will pay for the BPL patients attending the OPD. The percentage of BPL in Chhattisgarh is 43% of population, which is in contrast to its food law, which considers 75% of population poor and deserving of subsidized ration. The implication is that most tests would need to be done in OPD and thereby a large percentage of patients will end up incurring high expenditure for diagnostics.

The focus on funding procedures encourages irrational practices as we have seen in the case of unnecessary hysterectomies. Emphasis and incentivization of secondary and tertiary care undermines rational primary level care. This too goes against the principle of comprehensiveness. The spilt of purchaser and provider creates a situation where there is constant need to maximize profits in this case by the private providers and hence creates a market situation where they vie for greater share of the funds.

In this scheme of things, the most important component, the people who seek care is lost. Lastly, a targeted system of insurance undermines the principle of universality and creates ambiguities on who falls within the purview of getting the benefit and who does not.

The studies discussed above show that most vulnerable communities and remote areas still remain underserved and issues of exclusion and discrimination still exist. In the larger debate on right to health in recent years, universal health coverage seems to have taken much of the space that has undermined addressing social determinants and has narrowed focus on exploring innovations in health financing as a way of universalizing coverage. As a result a people-centric approach to planning as is posed by proponents of right to health is missing. Financial efficiency has become a central issue to shape services rather than people's health needs and the inequali¬ties they face in accessing healthcare and achieving a reasonable health status. This deals a fatal blow to the vision and the path towards the Right to Health for All.

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