



RSBY Studies in Chhattisgarh

*Presented to the Planning Commission
07th August 2012*

Layout of the presentation

1. Implementation issues: Beneficiary perspectives, Durg District [2010]
2. Design issues: Provider perspectives, 3 Districts [2012]
3. Key findings from Final Report on Evaluation of RSBY in Chhattisgarh [CTRD]
4. Experiences from other states

“Experience with the RSBY, and with the other State-specific insurance schemes, needs to be thoroughly studied so that suitable corrective measure can be introduced as the system is expended.”

[Health Chapter: 12th Plan, (as on 27th July, 2012)]

**The implementation of RSBY in
Chhattisgarh: A study of Durg district**

2010

Objectives

- To assess the implementation and viability of the RSBY scheme in Chhattisgarh
- To identify gaps and inconsistencies in terms of enrolment; information dissemination; service utilization; empanelment; availability of services in hospitals; transparency and the extent of out-of-pocket expenditure incurred by beneficiaries.

Methodology

Primary data collection

Interviews of 102 people utilising RSBY in May & June 2010

Secondary data

Official RSBY Website

Sample size (at the time of study)

4% of Total Hospitalised cases in Durg district

2% of Total Hospitalised cases in Chhattisgarh

Sampling

- **Selection of district with highest hospitalisation rate:** Durg
- **Selection of hospitals:**
 - 2 Public hospitals with high hospitalisation rates
 - 5 Private hospitals- (convenience sampling among high hospitalisation rates)
- **Selection of Beneficiaries:** 52 in public and 50 in private facility

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

Status of RSBY in CG (July 2012)

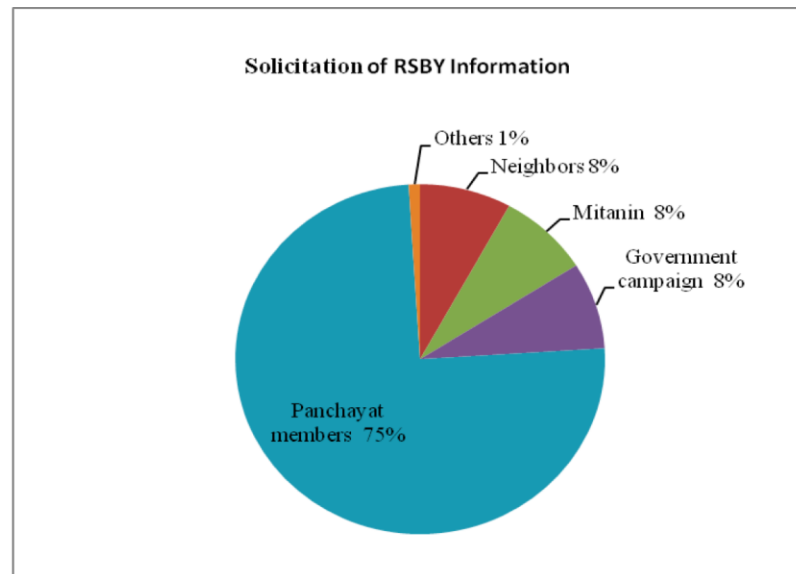
- Enrollment: 66% of eligible beneficiaries enrolled in first three years of implementation (July 2012)
- 302 (40%) Private and 453 (60%) Public hospitals empanelled
- Public facilities include PHCs
- Tribal districts are half the number of total districts but only 12% of the total private hospitals and 42% of the total public hospitals empanelled are in these districts - hence no additional facilities through RSBY
- 40% of the private hospitals empanelled are in state capital Raipur
- Low rate of hospitalisation in Chhattisgarh- 10 per 1000 enrolled

Coverage

- Enrollment being done by the TPA- conflict of interest?
- No transparency or grievance redressal mechanisms
- 37% of respondents had above five members in their family- aged/women/disabled getting left out?

Awareness about RSBY

Parameters	Aware	Not aware
Awareness regarding scheme purpose	84%	16%
Awareness regarding amount covered under scheme	90%	10%
Awareness regarding the Smart Card validity period	25%	75%
Awareness regarding the number of family members who could be covered under scheme	31%	69%

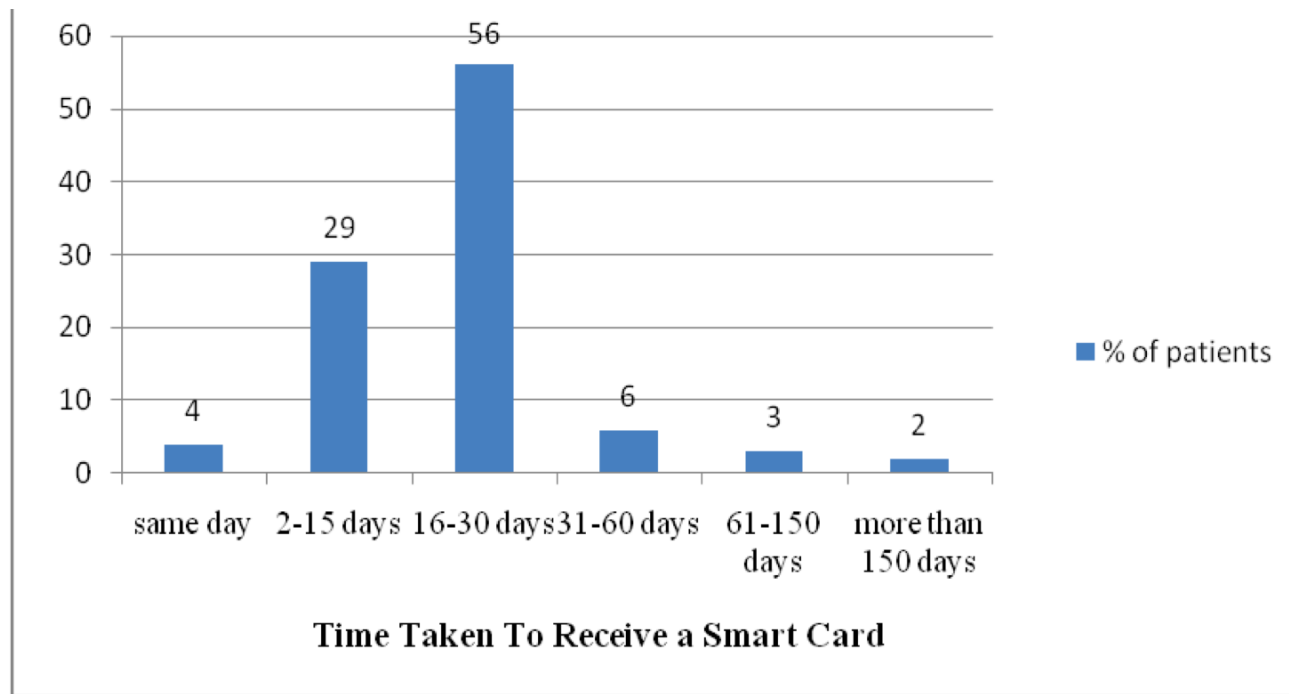


Enrollment Process

- Place of enrollment- local school/panchayat bhawan
- No extra travel costs
- Both thumbprints and photo taken
- 99% not given RSBY brochure or list of hospitals
- Information given only about a certain private hospital
- No extra payment (other than Rs 30) for card

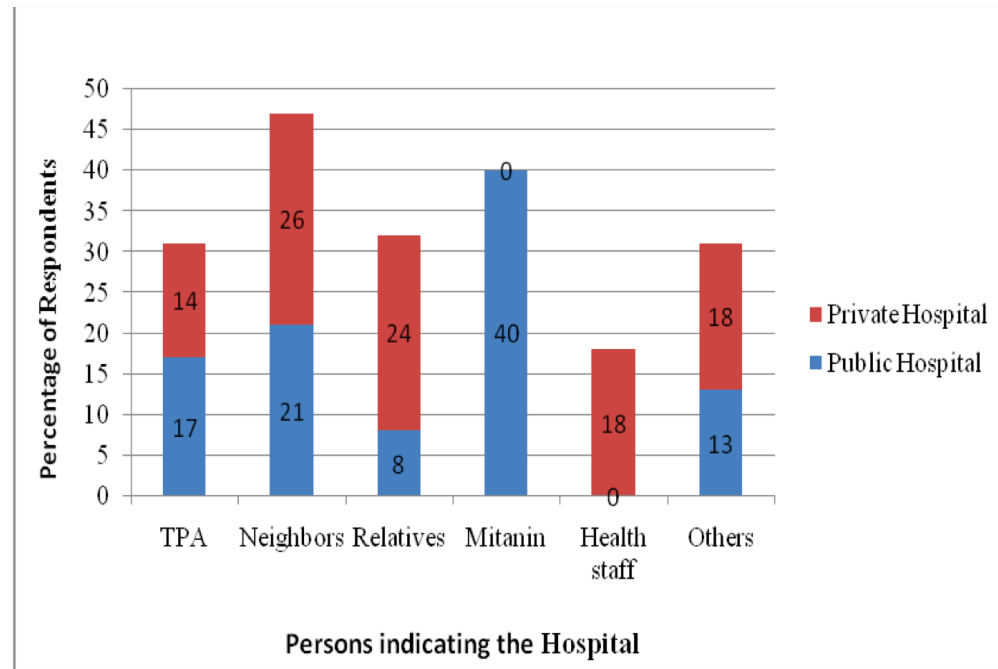
Enrollment Process

- **Only 4 percent got the smart card on the same day**
- **Average days taken to receive the smart card- 29**
- For 8% families, members other than the head of family were left out



Hospitalisation

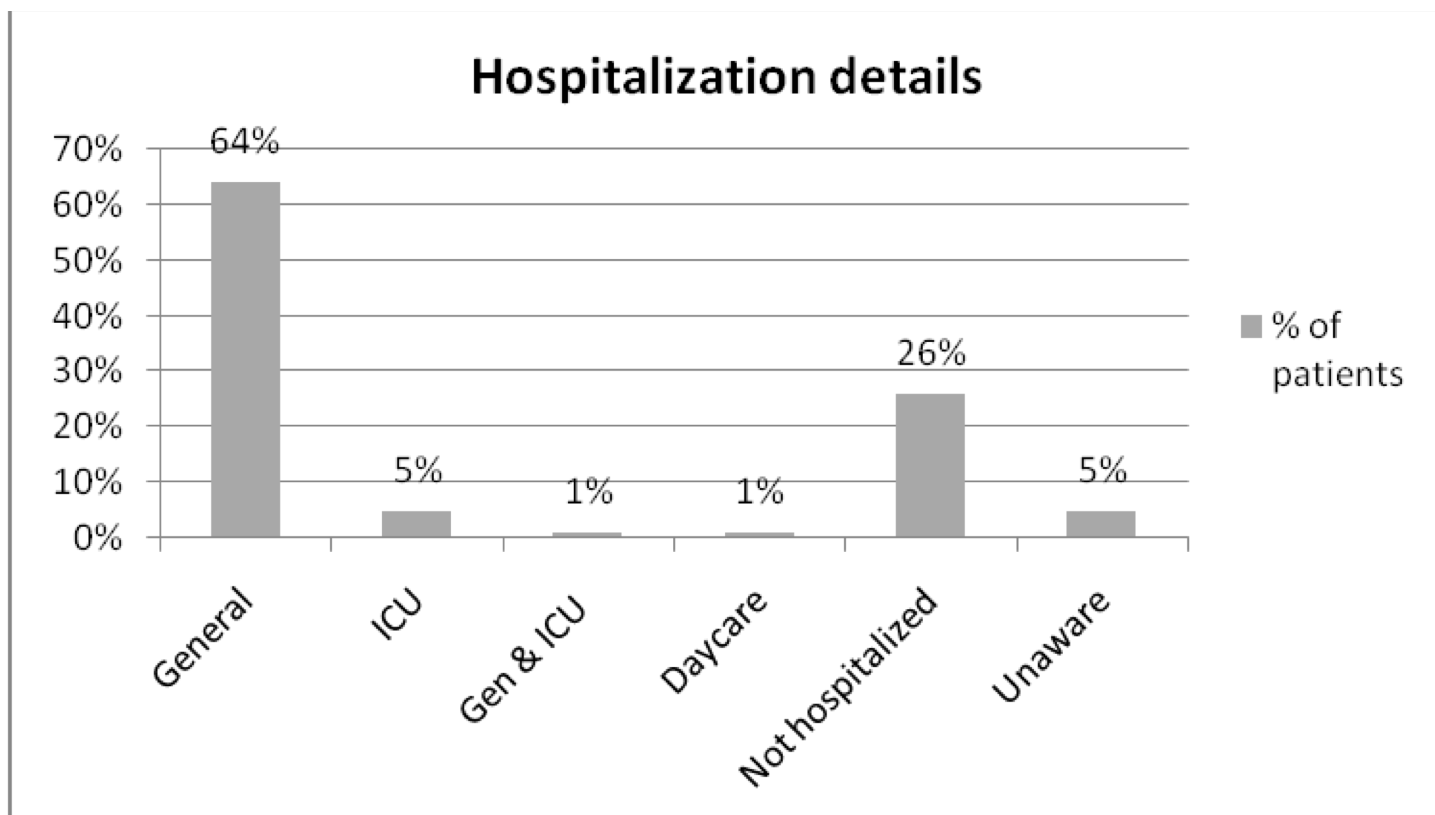
- 77% of respondents in public hospital were from rural areas and 66% of respondents in private were from urban areas
- Mitanins (ASHAs) significantly referring to public hospitals



- Reasons for coming for treatment mostly general weakness and fever

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

- Average days of hospitalisation recorded: 5
- 25% of the patients not hospitalised but recorded as hospitalised
- Private sector discrimination against the poor fixing quotas of beds
- Some hospitals (mostly CHC) empanelled do not have functional in patient facilities- need for improvement

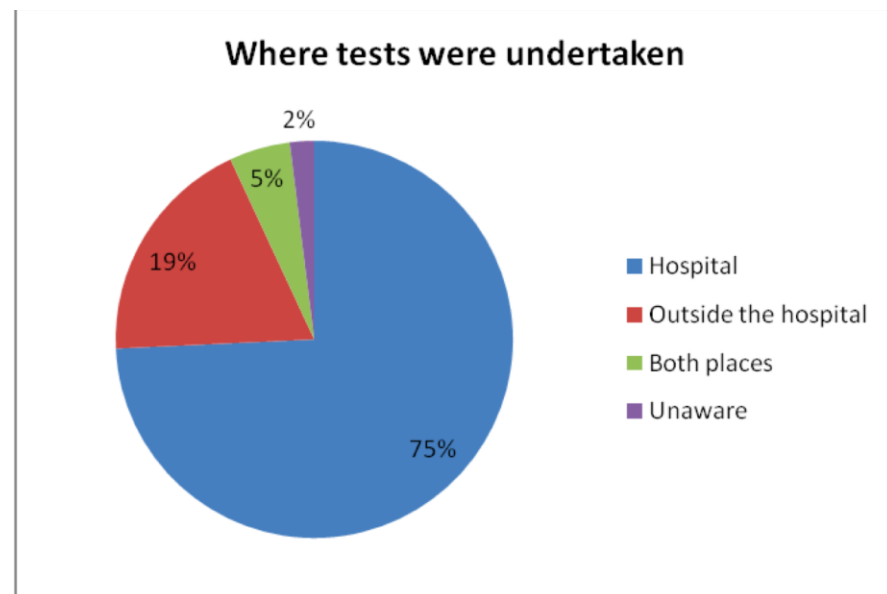
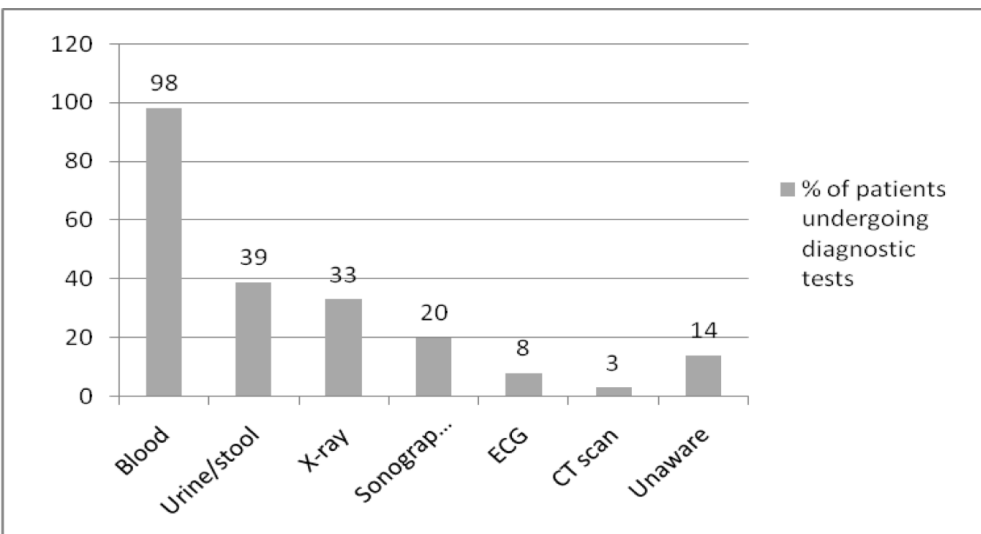


Diagnosics

- Diagnostic tests prescribed to 63%

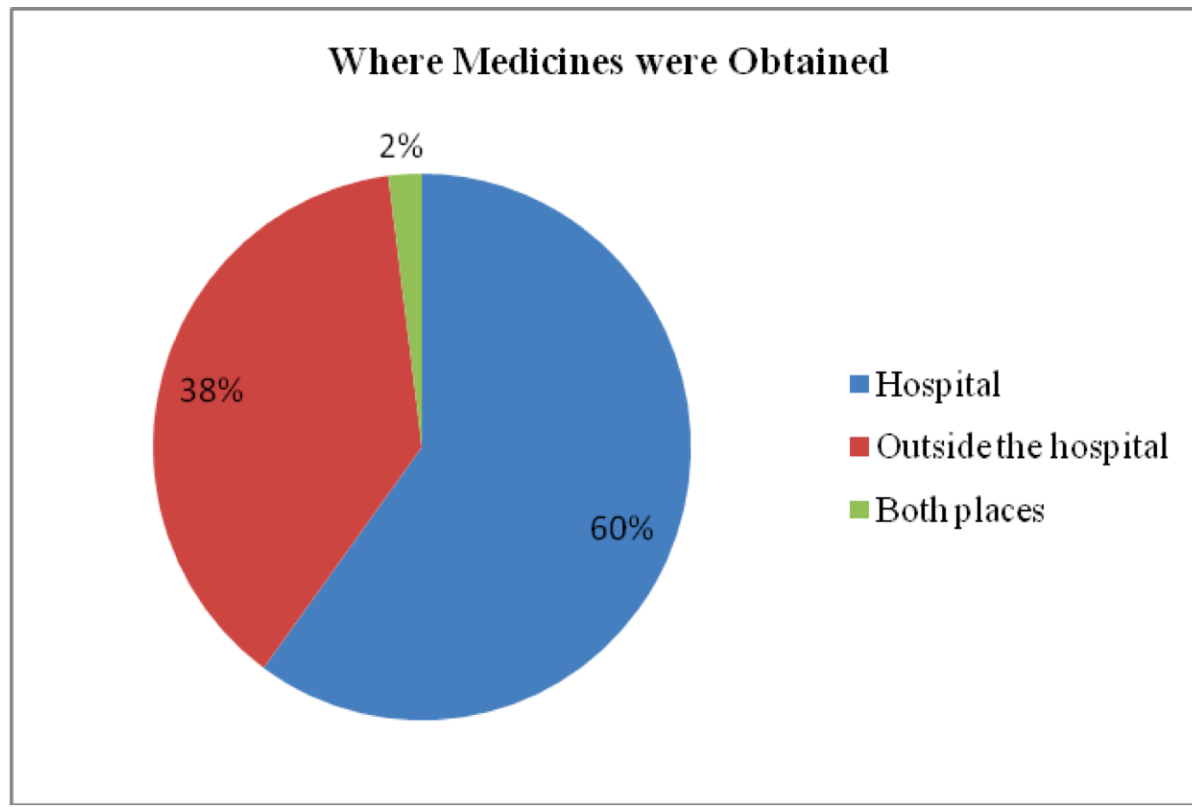
- 40% in public hospital
- 86% in private hospital

- 75% of the cases, tests done in the hospital itself



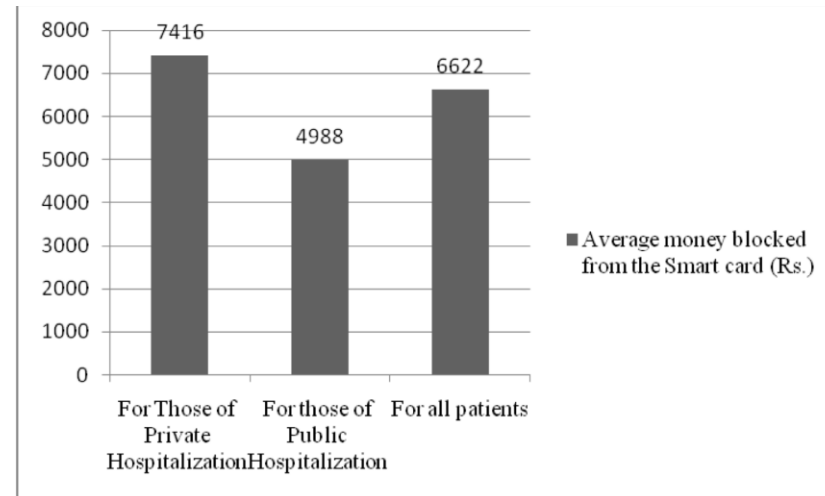
Medicines

- For 60% medicines available in the hospital



Utilisation

- 77% had utilized RSBY for more than one episode
- **37% not aware** of the amount of money blocked by the hospital
- Average amount blocked = **Rs 6622**
- Private hospital= **Rs. 7416**
- Public hospital = **Rs. 4988**
- 99% received transport charges of Rs.100
- **59% not given RSBY receipt**
- 90% given medicines at discharge



Out of pocket expenditure

37% incurred out of pocket expenditure

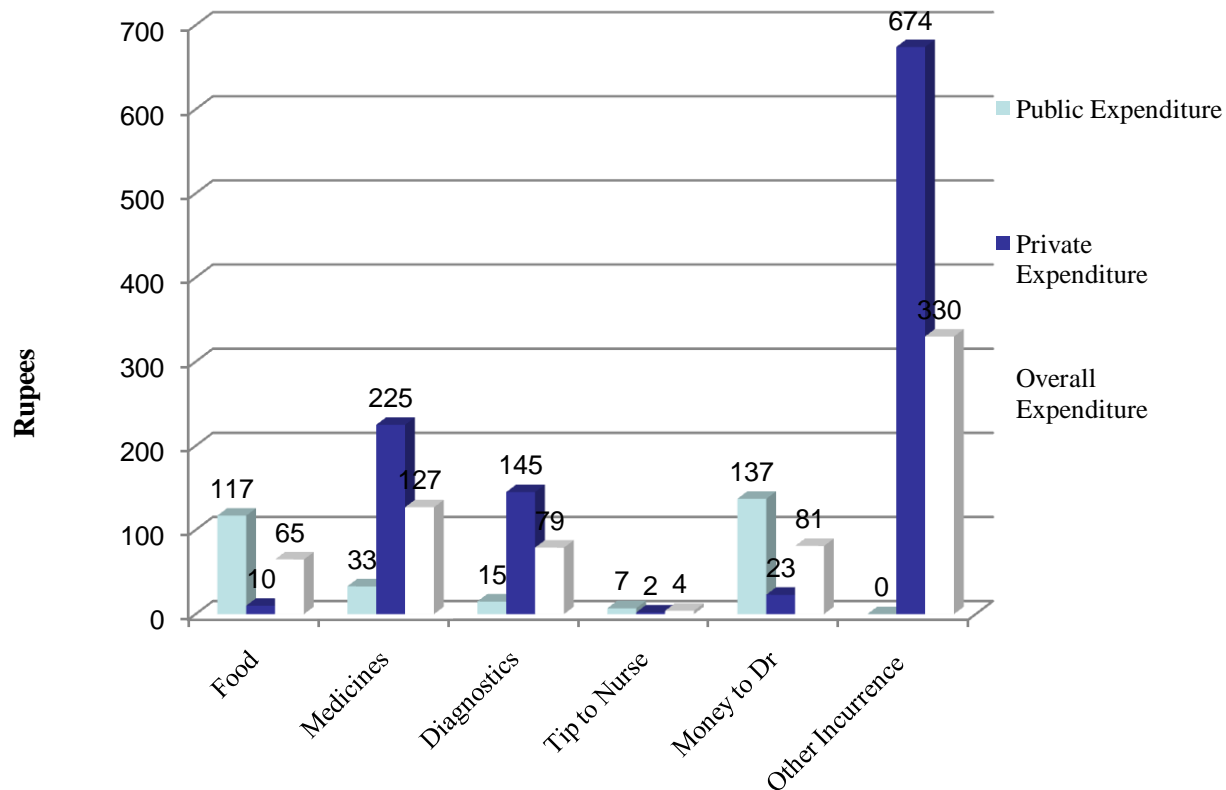
- 58% going to private hospitals incurred out of pocket expenditure
- 17% going to public hospitals incurred out of pocket expenditure
- Out of the total expenditure in private sector, 63% of the amount was incurred on items not disclosed by the hospital to the patients

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

Average out of pocket expenditure= Rs 686

Public hospital= Rs 309

Private hospital= Rs 1078



Transparency and Accountability

- Incentives to Health staff and Rogi Kalyan Samitis- paying the well paid, encouraging false and higher claims
- Transparency: Names enrolled not available, Case wise data not available, hospital wise data also kept secret, reasons for rejection not disclosed even to hospitals, beneficiaries not given receipts
- No grievance redressal mechanism- if you don't get RSBY card, if photo/name is wrongly printed, if any family members have been left out, if empanelled hospital refuses to admit, if TPA tells that no money left in the card even if never been used (i.e. Card is 'cashless'), if hospital/TPA retains the smart card

Two more recent studies

2012

Study on enrolment (2012)- Jan Swasthya Abhiyan (JSA) Chhattisgarh

270 Villages, 32 Blocks, 18 Districts

Findings:

- Very low enrolment (30 to 50 %)
- No enrolment in remote and inaccessible villages
- Lack of information to beneficiaries-The majority of villages (67%) had not received the list of hospitals.
- Only in 25 % villages had anyone used card for treatment in Network Hospitals.

Study on Particularly Vulnerable Tribal Groups (PTGs) (2012) by PHRN/SHRC/Local NGO

1200 PTG families- Baiga, Kamar, Pahari
Korwa

Findings:

- 32% families enrolled though 85% Antyodaya card holders
- 4% families had used RSBY

Conclusions

Health insurance route to deliver services: the experience so far in Chhattisgarh :

- **Severe implications on exchequer**
- **Exclusion, inequity in access, especially for the most marginalised and needy groups still exist**
- **Accountability of public health system compromised**
- **Out of pocket expenditure still persists despite the 'cashless scheme'**
- **Private sector is still unregulated**

Critical questions:

- **Is RSBY leading to the poor getting access to free and good quality health care?**
- **Is the public health system being strengthened through this mechanism?**
- **Is it a actually 'cost effective' model?**

A Critical Examination of Design Issues

2012

Objective

Examining the design of the scheme [that influence translation of the policy on to practice], focusing through provider perspectives

Methodology

- **Qualitative research methods**
 - **Rapid Appraisal Procedures (RAP) were adopted to derive the reality by synthesizing multiple sources of information**
- **Search for opinions, motivations, behaviors and attitudes of key stakeholders**
 - **Within their organizational and socio-cultural matrix**
 - **Emphasis on identifying design related issues that could affect treatment procedures and implementation of the scheme**
- **Open-ended semi-structured in-depth interviews**
 - **Pre-defined topic guides**

Table 1: Typology and numbers of institutions

Units	Numbers
Districts	3 [Raipur, Dhamtari and Balod]
Private Hospitals	9
<ul style="list-style-type: none">• Super-specialty	2
<ul style="list-style-type: none">• Nursing Homes	7
Public Hospitals	5
<ul style="list-style-type: none">• Medical College	1
<ul style="list-style-type: none">• District Hospital	1
<ul style="list-style-type: none">• Community Health Center	2
<ul style="list-style-type: none">• Primary Health Center	1
Not-for-profit Hospitals	4
<ul style="list-style-type: none">• Mission Hospitals	3
<ul style="list-style-type: none">• Trust Hospital	1

Table 2: Respondent Profile

Respondents	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

Technology

- **Standard internet-based technology**
- **Problems of poor internet connectivity (PHCs)**
- **Training: inadequate or non-existent**
- **Unable to swipe within 24hrs of admission/discharge**
 - **Rejections**
 - **Offline transactions not happening**
- **Inability to swipe the card more than once in 24 hours, in case of changing package or referrals**

Technology

- **Software problems:**
 - **Need to be updated with change of TPAs**
 - **3 out of 4 CHCs in Raipur district not functioning**
- **Enrolment:**
 - **Annual enrolment: questionable utility**
 - **By TPA: conflict of interest?**
 - **No enrolment in remote and inaccessible villages**

Settlement of Claims

- **Periodicity irregular except for Medical College**
- **About 10-15% of the settlements rejected**
- **Current TPA more responsive than the previous one**
 - **Faster clearance of claims**
- **Delays: up to 6 months to 2 years**

Settlement of Claims

- **No grievance redressal system in place**
- **10% tax deducted at source**
 - **Exemption for not-for profit institutions not implemented**
- **Period for clearing claims reportedly 15 days**
 - **No penalty on TPA for delays**
- **Difficulty in reimbursement in cases of patients from districts with other TPAs**

Experiences of Providers

Private

- **Providing narrow and selective range of services**
- **Reporting increase in case load**
- **Small nursing homes -- biggest gainers**
- **Hospitals not empanelled for specific services/specialities**
 - **picking and choosing more profitable conditions/packages**

Private

- **Treating fewer medical conditions than public hospitals**
- **Very few high-end procedures, especially those unrealistically priced**
- **Most packages priced much lower than what paying patients are charged**

Public

- **Experience varied across levels**
- **80-90% medical conditions treated**
- **Surgical conditions/procedures less except in Medical College**
- **Not possible to provide for conditions requiring long-drawn hospitalization and cost-intensive treatment such as snake bite, poisoning and burns**

Public

- **No incentives disbursed so far**
- **Patient admitted for 3-5 days for investigations and given medicines**
- **Private pharmacy given contract by many CHCs/PHCs for supply of drugs**
- **Common conditions treated- 50%: diarrhea and respiratory infections; and 50%: anemia and weakness**
 - **innovatively billed as “weakness and hypocalcemia”**

Public

- **Analysis of costs of treatment**
 - **Using STG, CG and rates of generic medicines**
 - **Cost of medicines for common morbidities [diarrhea, malaria, respiratory infections and viral fevers]: about Rs. 100**
 - **Hospitals admitting patients for up to five days; charging Rs. 3,750**

Not-for-profit

- **Bed strength: 75-200**
- **RSBY packages higher than their rates for many conditions**
- **Providing large range of services: medical conditions + surgeries; orthopedic procedures and chemotherapy in bigger ones**

Not-for-profit

- **Smaller ones reported losses if required to call surgeon/specialists from outside their staff**
 - **Similar experience with small nursing homes**
- **Increase in case loads**
- **Some cost-cutting measures, without compromising on quality**
 - **e.g., silk sutures instead of absorbable ones**

Discussion

- **Firm commitment of the state to empanel private providers**
- **Norm of minimum of 10 beds relaxed to include small providers**
- **Private and not-for-profit providers fear decrease in patients unless empanelled**

- **Huge advantage for private nursing homes**
 - **Turnover and incomes increased**
- **Public hospitals reported decline in patients**
 - **Decline in range of services**
- **CHCs and PHCs unable to compete with private hospitals [better amenities, specialists]**
 - **Higher numbers of beneficiaries in tribal blocks**

- **‘Defensive’ (sometimes corrupt) practice against losses (due to: (i) inability to swipe within 24hrs; (ii) inadequate package rates)**
 - **Complicated conditions booked instead of simpler ones**
 - **Case booked only after treatment / delivery**
 - **Pre-determined number of days booked as per condition (eg. 10 days for PF malaria)**

- **No provisions for neonates (normal delivery or CS package), chronic diseases, psychiatric care**
- **Minimal/grossly inadequate training/orientation given to providers**
- **Package rates not sufficient for complications requiring long stay or expensive antibiotics**
 - **Public institutions resolving through JDS (RKS)**
- **RSBY beneficiaries constitute miniscule proportion of total patient load in large multi-specialty hospitals**

- **Regulatory framework:**
 - **Weak accreditation mechanisms**
 - **Grievance redressal mechanisms: not adequately responsive**
 - **Claims**
 - **Software**
 - **Sporadic checks; no systematic clinical audits**
- **High-end and expensive procedures: few and far between**

Recommendations

- **Same software to be used by all TPAs and insurance companies**
- **Inspection of facilities before empanelment**
- **Strong monitoring and grievance redressal mechanism**
- **Enrolment of beneficiaries for a longer duration instead of a year**
- **Time-bound settlement of claims**
 - **Penalty for delay**

- **TDS exemption for not-for-profit institutions**
- **Devise system for referral and complications**
 - **Increasing length of stay**
 - **Changing the packages when diagnosis is revised**
- **Separate packages included for new born**
- **Charter of services guarantees for specialities and levels**
- **Cost for high-end packages needs to be revised and made realistic**
- **Reconsider incentivizing government doctors**
- **Utilization of contribution to Chief Minister's Welfare Fund**

FINAL REPORT
ON

**EVALUATION OF “RASHTRIYA
SWASTHYA BIMA YOJANA SCHEME” IN
CHHATTISGARH**



Submitted To

**The State Nodal Agency RSBY Chhattisgarh
Department of Health and Family Welfare
Raipur – 492001**

	Preference for Public Hospitals	Preference for Private Hospitals
Rural area	45.7%	54.4%
Urban areas	40.7%	59.3%

- **Medical packages availed in the four divisions of the state varies from 68.1% to 73.6% while surgical packages varies from 26.4% to 31.9%**
- **Majority of the patients are hospitalized for 3-5 days under RSBY**

- **Close proximity is one of the main reasons for hospital selection by the patients which is then followed by doctors referral**
- **Out of 54% of institutional deliveries, only 3.6% at private hospitals. Rest are in government facilities**
- **The Panchayat members are the main source of information on RSBY followed by the health workers**
- **21.7% - 27.3% of the beneficiaries were not aware about the eligibility criteria for RSBY**
- **50.4% of the respondents of the state evaluation survey did not enrolled under the scheme in 2009 as they thought it is of no use whereas 20.8% said of receiving similar kind of facilities at government hospitals**

- **More than 60% of the respondents did not receive any information at the time of enrollment about utilization of the scheme**
- **More than 80% of the patients were provided free medicines and got diagnostic tests done at the hospitals**
- **57.3% of the respondents incurred out of pocket expenditure**
- **91.5% of the respondents had to incur expenditure of less than Rs.500 whereas 5.1% had to incurred Rs.500-Rs.2,000. 1.7% had to incur Rs. 20,100-30,000.**

- **Nearly one fourth of respondents emphasized that they would have visited Government Hospitals.**
- **The study signifies that Government and Public Hospitals are more dependable for poor people compared to private hospitals.**
- **44.8% of the total cases have been denied free clinical tests**

Experiences from other states

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References.docx

Enrolment

- Wide variation in enrolment rates across villages, districts, regions and demographic groups
 - As few as 2.5% of eligible families in some villages
- Concentration of beneficiaries in certain areas and villages
 - 39% enrolment in a district with least enrolment in the tribal blocks of the district
- Third round of enrolment covered one-third of the Indian districts and among these districts more than 60% were from four states
- Households with prior experience of health shocks are more likely to enroll

Empanelment

- Empanelment of public hospitals varies from 45.86% in Kerala to 4.95% in Haryana among the sample states of a study
- No public hospital empanelled in Maharashtra till 2010

Utilization

- Increase in hospital admission rate from 1% in 2004 to 2.7% after the launch of RSBY
- Nationwide hospitalization rate per 1000 persons for 2009-10 was 20, considering districts those completed one year of RSBY
- However, extreme variations within states is found; Kerala has 38 per 1000 beneficiaries while Assam has only 1 per 1000 beneficiaries
- Hospitalization rate varied from 196.41 in Gujarat to 0.07 in Punjab in 2010

Cost of Hospitalization

- In 2011, the average nationwide hospital expenditure for RSBY is Rs. 4262
- The expenditure ranged from Rs. 886 in Tamil Nadu to Rs. 6554 in Punjab
- In 2010, the average cost of hospitalization was highest for Punjab (Rs. 6606) and lowest for Kerala (Rs.3101)
- Claims ratio varies from 14.35% in Gujarat to 0.20% in Goa and average outs to 7.15%

Out of Pocket Expenditure

- Average claim amount under RSBY was Rs. 3,700 and the additional average out of pocket expenditure was Rs. 1,690

Insurance Premium

- Insurance premium for RSBY varies from state to state and district to district in the present range of Rs 400 to Rs 600

Issues of access

- Earlier severe shortage of hardware like smart card printers and fingerprint scanners
- Now the availability of hospitals in remote areas is a major challenge
- 9 out of 39 hospitals surveyed during a study had not treated any patients due to technology-related or reimbursement-related reasons

Monitoring Systems

- No quality standards being utilized by RSBY but process is on to grade the hospitals on quality parameters
- Delays in insurance payment to the Medical College Hospitals
- Monitoring of RSBY is made rigorous and it is provisioned to make periodic reports public and separate set of preformatted tables are generated for insurers and government

Transparency and Grievance Redressal

- Very little information available in the public domain and the need for greater transparency and proactive disclosure about the details is being emphasized
- Lack of a grievance redressal mechanism and coordination among the various government departments in implementing the scheme