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BIMA YOJANA IN

NORTH EAST INDIA

Process evaluation of India's health
insurance scheme for the poor

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The Indo German Social Security Programme (IGSSP), on behalf of the German Federal Ministry for Economic Cooperation and Development (BMZ), has extensively supported the Indian Ministry of Labour & Employment (MoLE) on the design and roll-out of India's flagship health insurance programme for the poor – '*Rashtriya Swasthya Bima Yojana* (RSBY). RSBY targets below poverty line families and unorganised workers. It aims at improving their access to health services and at reducing out-of-pocket expenditure during their hospitalisation.

As part of the cooperation with the Government of India, the Indo-German Social Security Programme, operated by Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), has carried out regular studies that evaluate the envisaged outcomes of RSBY and other social security schemes. One such evaluation of RSBY was conducted in four states of North East India between May and November 2013. Its results are presented in this publication. It is the first of the Indo-German Social Security Papers, which are meant to document learnings and good practices in order to contribute to future policy decisions.

The evaluation study of RSBY in North East India has come out of the efforts of many. I would like to thank and appreciate the work of the researchers and interviewers of IMRB Social and Rural Research Institute, New Delhi and Prognosis Management & Research Consultants, Pune for conducting this evaluation. Thank you also to my colleagues from GIZ Dr. Urvashi Chandra for authoring the publication, Dr. Nishant Jain for his technical inputs and Tanushree Sengupta for editing.

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ABBREVIATIONS

ANMs	Auxiliary Nurse Midwives
ASHAs	Accredited Social Health Activists
AWWs	Anganwadi workers
BPL	Below the poverty line
GDP	Gross Domestic Product
GIZ	Gesellschaft für Internationale Zusammenarbeit, GmbH
IMR	Infant mortality rate
OOPE	Out-of-pocket expenditure
Rs.	Indian Rupees
RSBY	<i>Rashtriya Swasthya Bima Yojana</i>
SNA	State Nodal Agency
TPA	Third party administrator

India's national health insurance scheme—*Rashtriya Swasthya Bima Yojana* or RSBY, as it is commonly known—was launched in 2008 with an initial focus on Below Poverty Line (BPL) families. The dual objectives of RSBY are to improve access to health services and reduce out-of-pocket expenditure during hospitalisation. The federal states are responsible for implementation of the scheme while the Ministry of Labour & Employment in the central government holds charge of its overall management. To ensure effective implementation, the ministry outlined certain processes to be followed by the states that implement the scheme. Since RSBY covers such a vast and diverse population, its implementation inevitably threw up challenges and systemic issues that could not be foreseen at the outset. Process evaluations of the scheme have been commissioned by the ministry from time to time in order to learn and improve the implementation from the experiences in the field.

One such evaluation was conducted between May and November 2013 in four states of North East India – Manipur, Meghalaya, Mizoram and Nagaland. This geographically remote region has a serious infrastructure crunch and is difficult to access. Nevertheless, the states largely fare better than the national average in most of the development indicators such as literacy, health, nutrition and gender balance. The process evaluation of the four selected states was undertaken in one district each, selected on the basis of indicators such as conversion ratio, hospitalisation and claims ratio, and number of

years of RSBY implementation. The aspects broadly covered under the study were awareness of the scheme, process of enrolment, utilisation of services and satisfaction levels. The results of the evaluation threw up certain commonalities as well as some significant divergences.

Despite the difficult terrain and infrastructure constraints, the national health insurance scheme did reach out to remote corners of the North East. However, there were some lacunae in implementation of the programme. These included lack of information on details such as coverage for the cost of medicines, diagnostics and consultation fees and the provision of transportation allowance, non-issuance of cards at the time of enrolment, existence of out-of-pocket expenditure for enrollees, failure of the cashless system in some cases, and lack of information on or availability of adequate health services in the remote districts. Despite the shortcomings however, a large majority of the enrollees expressed high levels of satisfaction. In addition, a high percentage of both enrollees as well as the non-enrolled were willing to enrol in the scheme in subsequent years. This shows that the scheme does have a positive impact on lives of the poor in the states, though there is definite scope for improving the processes to have them avail the benefits fully. Above all, it is evident that RSBY needs to be implemented in toto as per the guidelines to ensure that it fulfills the dual objectives of better access to health care and protection from impoverishment in the event of hospitalisation.

Background

Providing health care that is accessible, affordable and fulfils basic quality standards has been a challenge in India. This is especially so, as India has an estimated 363 million people below the poverty line (BPL)¹, for whom quality health care is neither affordable, nor easy to access. India's public spending on health is roughly 1 percent of the gross domestic product (GDP), one of the lowest figures worldwide. This has resulted in poor quality of public health services, greater reliance on private providers and therefore high out-of-pocket expenditure (OOPE).

For the poor, financing their health needs is back-breaking. Till 2008, only 5 percent of households across

the country had at least one member covered by medical insurance². An estimate prepared by the Insurance Regulatory and Development Authority (IRDA) says that just 17 percent of the population, or roughly 220 million people in India, had health insurance at the end of March 2014³.

Several factors have accounted for the low coverage of medical insurance in India. Significant among them is that more than 90 percent of the country's workforce, that is over 400 million people, belong to the unorganised sector with no formal work contracts or social security. For such people, a regular premium pay-out is an added burden they cannot take on.

1. Report of the Expert Group to Review the Methodology for Measurement of Poverty, Planning Commission, June 2014
2. District Level Household Survey (DLHS), Ministry of Health & Family Welfare, Government of India, 2007-08
3. <http://www.ambitionias.com/just-17-of-indians-have-health-coverage.html>

Two thirds of health expenses are paid through private sources, of which 86 percent comes from out-of-pocket spending⁴. As a result, over 2 percent of India's population slips into poverty every year due to catastrophic illness-related expenditure⁵. Even though a major part of healthcare spending is on outpatient expenses, hospitalisation is a leading cause of indebtedness amongst the poor. A retrospective study undertaken in rural India identified the cost of ill health and health expenses as one of the main factors responsible for 85 percent of all cases of impoverishment⁶.

Health Insurance for the poor

Taking into consideration the lessons learnt from many community-based insurance schemes, and after reviewing other successful models of health insurance across the world in similar settings, in April 2008 the Indian government launched *Rashtriya Swasthya Bima Yojana* (RSBY), a national health insurance scheme for BPL families and progressively expanding categories of unorganised sector workers. The central Ministry of Labour and Employment is the nodal ministry managing the scheme. The main objective is to protect beneficiaries against catastrophic health expenses by providing free and cashless hospitalisation cover.

Under RSBY, beneficiaries are entitled to hospitalisation coverage of up to Rs. 30,000 per family per year, including transportation costs up to Rs. 1,000. The scheme is valid for most hospitalisation expenses and rates have been fixed for almost 1,100 conditions. Pre-existing conditions are covered from day one and there is no age limit for inclusion of beneficiaries. Coverage extends to five members of the family, which includes the head of household, spouse and up to three dependents⁷.

Even though RSBY is a central government scheme, as per India's federal governance structure the implementation rests with the state governments. The insurers are

selected through an open tendering process by the states; for families below the national poverty line, the central government pays 75 percent of the insurance premium and the state government 25 percent (90 percent and 10 percent respectively in the North Eastern states and Jammu & Kashmir). Beneficiary families pay a nominal Rs. 30 annual registration fee. The programme is currently being implemented in 26 federal states and two union territories, providing coverage to more than 37 million poor households, or approximately 120 million people⁸.

North East India and RSBY

The north eastern shoulder of India is formed by the eight states of Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura. They constitute roughly 8 percent of India's landmass, but a population of about 3 percent or 40 million persons⁹. The North Eastern states have very distinctive identities and their own set of developmental challenges.

The density of population varies from 17 per sq km. in Arunachal Pradesh to 397 per sq km. in Assam.¹⁰ An overwhelming proportion of people belong to close-knit tribal communities; the region has over 160 Scheduled Tribes and over 400 other sub-tribal communities and groups. The population is predominantly rural, with over 84 percent living in the countryside, subsisting largely on an agrarian economy.

Most of the states perform well on Human Development Indicators such as literacy, sex ratio or nutritional levels as compared to India's national average. However, there are gaps arising out of geographical and social dynamics. Many areas are difficult to access because of the hilly terrain, dense jungles, heavy rains, thunderstorms and landslides.

There are significant challenges due to a difficult terrain and inadequacy of skilled human resources. Habitations are scattered over long distances and infrastructure is poor

4. World Health Statistics 2014, WHO

5. WHO Country Cooperation Strategy 2013

6. Krishna A. 2004. *Escaping poverty and becoming poor, Who Gains, Who Loses and Why?* World Development, Vol 32: 121-136

7. RSBY website: <http://www.rsby.gov.in/>

8. RSBY website: <http://www.rsby.gov.in/>, December 2014

9. Census of India, Office of Registrar General of India, Ministry of Home Affairs, 2011

10. Ministry of Development of North Eastern Region (MDONER), Government of India: <http://mdoner.gov.in/>

in many parts of the region. Though literacy levels are by-and-large high, communication across states and with the rest of the country is patchy. These factors often make it difficult for the government or any other agencies to provide adequate health care services in the states. What is noteworthy is that despite gaps in the health system, overall health and nutritional status of the North Eastern states is better than in most other states of India. One of the main reasons for this is the traditional food habits and lifestyles of the tribal communities.

RSBY is being implemented in all the eight North Eastern states since 2009, beginning with Nagaland. Trend analysis of the routine data of these states from RSBY's monitoring and information system showed wide differences in performance based on key indicators of conversion, hospitalisation and claims ratios. There are variations within the region as well as with the rest of India. Observed through a gender lens, the North Eastern states were found to be better than the rest of India.

About this study

Against this backdrop, in order to have a better understanding of the actual implementation process and outcome of RSBY in the North East, the Ministry of Labour and Employment decided to carry out an evaluation across selected districts of the four states of Manipur, Meghalaya, Mizoram and Nagaland. The development

indicators of these four states are on the whole better than the national average (cf. Table 1).

These states were selected for the evaluation keeping three main factors in mind:

- RSBY indicators such as conversion, hospitalisation and claims ratio;
- RSBY was implemented in these states for at least two years; and
- The State Nodal Agencies (SNAs) requested for an evaluation in their respective states.

The evaluation was conducted with funding from Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH between May 2013 and November 2013. The objective was to study whether RSBY was being implemented effectively and also compare access to health services and out-of-pocket expenditure during hospitalisation of those enrolled in RSBY versus those not enrolled.

Methodology

A quasi experimental research design was adopted for measuring the performance of RSBY with regard to process, output and outcome indicators. Three groups of beneficiaries were studied through this design. These three groups included RSBY enrollees who underwent a hospitalisation event in the past one year, RSBY enrollees with no hospitalisation event the past in year, and those

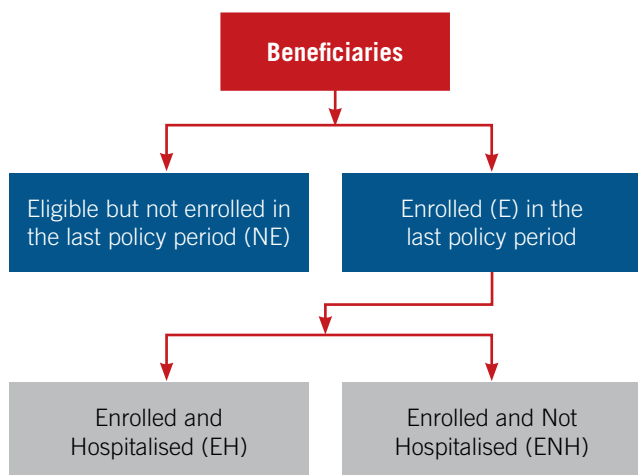
Table 1

Development indicators in 4 North Eastern states of India

	India	Manipur	Meghalaya	Mizoram	Nagaland
Population growth rate (%)	17.64	12.05	27.95	23.48	-0.58
Literacy rate (%)	74.04	79.2	74.4	91.3	79.6
Sex Ratio (females per 1000 males)	940	992	989	976	931
Infant mortality rate (per 1000 live births)	43	8	52	31	15
Children aged 6 - 59 months anaemic (%)	69.5	41.1	64.4	44.2	-
Ever married women 15 - 49 years anaemic (%)	55.3	35.7	47.2	38.6	-
Ever married men 15 - 49 years anaemic (%)	24.2	11.4	36.7	19.4	-

Source: Census of India, Office of Registrar General of India, Ministry of Home Affairs, 2011; Sample Registration System, Office of Registrar General of India, Ministry of Home Affairs, 2011; Health status indicators, National Health Profile 2012, Central Bureau of Health Intelligence, India.

eligible for RSBY but not enrolled in the scheme. These groups were purposively defined. Within each group, the sampled beneficiaries were randomly selected from the pre-enrolment, enrolment and utilisation lists provided by the Ministry. The different groups of beneficiaries covered are illustrated in the diagram below:



The evaluation covered one district from each of the four states, and had a total sample size of 1,200 RSBY eligible beneficiaries. To select the districts for evaluation, a composite index was developed based on the following indicators:

- Conversion ratio
- Hospitalisation ratio
- Number of empanelled hospitals
- Year of operation

Following this, a weighted mean was assigned to all the districts and they were ranked. In addition, geographical contiguity to the capital district was considered at the time of selection. The final selection was approved by the State Nodal Agencies, which are responsible for implementation of RSBY in the states.

The blocks were chosen on the basis of a higher hospitalisation ratio to ensure reaching out to the total sample of enrolled and hospitalised respondents. The villages were covered after forming clusters with high concentration of enrollees undergoing hospitalisation.

Respondents were identified randomly from the lists shared by the Ministry of Labour and Employment in the ratio of 60:40 for enrollees and non-enrollees. Furthermore, among the enrollees, there was a division of 60:40 for hospitalised and non-hospitalised.

Results from the evaluation for each state are presented in the following sections.



MANIPUR

RSBY in Thoubal district

BACKGROUND

Manipur is at the crossroads of economic and cultural exchange between India and Southeast Asia. It also known by its ancient names such as 'Kangleipak' and 'Meiteileipak'. The state is divided into hilly and low-lying regions. People in the hills are mainly Nagas and Kukis as well as other smaller tribal communities. The valley is dominated by the Meitei, Manipuri Brahmins and the Pangal. The average literacy rate of Manipur is 79.2. In 2011, the sex ratio was 992 per 1000 males against an average national sex ratio of 940¹¹. As indicated in Table 1 earlier, the overall health and nutritional

status of people living in Manipur is better than the national average.

Rashtriya Swasthya Bima Yojana was launched in the state in 2011. The conversion ratio (the proportion of eligible families enrolled in the scheme) in the state in 2013 was 50.7 as against the national average of 50.9¹². In Manipur, district Thoubal was selected for the evaluation. At the time of the evaluation, the conversion ratio in Thoubal was 48.2. There were no empanelled hospitals within the district at that time. In fact, there were only four empanelled hospitals in Imphal, the state capital.

RSBY IN THOUBAL DISTRICT

AWARENESS OF RSBY

For RSBY to meet its objectives, those eligible need to have a complete understanding of the enrolment process and benefits under the scheme. In this regard, it is the responsibility of the insurance companies or their representative organisations such as third party administrators (TPAs) to create awareness among the intended beneficiaries.

In Thoubal, variations were noted in awareness levels for eligible beneficiaries of RSBY with regard to general

parameters for enrolment in the scheme. For some parameters, such as the registration fees and total health cover, there was a high level of awareness among enrollees. In case of other general features of RSBY such as number of family members covered under RSBY and coverage of hospitalisation costs, knowledge levels among the enrollees were substantially lower. Overall, it was observed that enrollees were more aware than non-enrollees.

Awareness on general features of RSBY ensures enrolment in the scheme. But beyond enrolment is utilisation. For

11. Census of India, Office of Registrar General of India, Ministry of Home Affairs, 2011

12. www.rsby.gov.in

optimal utilisation of the benefits under RSBY, those eligible need to be aware of all aspects of the scheme. In this regard, moderate level of awareness was observed on RSBY covering costs for medicines during hospitalisation (54 percent enrollees; 46 percent non-enrollees). Eligible households were less likely to be aware of RSBY covering costs for diagnostic tests (35 percent enrollees; 30 percent non-enrollees). Significantly low level of awareness was found regarding provision of free food to RSBY patients at the empanelled hospitals (3 percent enrollees; 4 percent non-enrollees).

Being informed about the scheme is the first step. But this knowledge needs to then be translated into action.

In the context of RSBY, action is at different levels. First and foremost, the aware beneficiaries need to enrol in the scheme. To ensure that maximum number of beneficiaries enrol, both awareness and ease of enrolment process are equally important. In the preceding section, it was evident from the results that awareness levels were varying. Now the next pertinent question is, what was the enrolment process in Thoubal?

PROCESS OF ENROLMENT

For most (62 percent) of the RSBY enrollees, the enrolment centres were located in the middle of their villages. For few (12 percent), the centres were at the periphery of the



Rameshor is a proud father thanks to RSBY

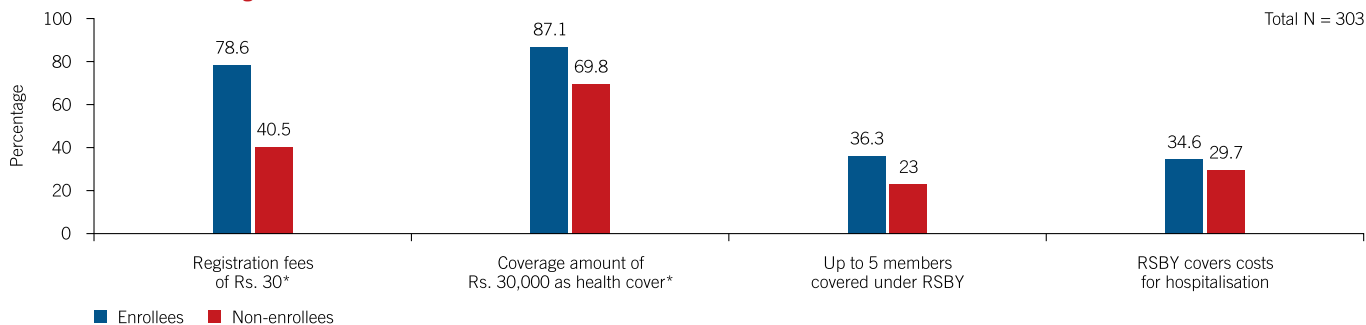
Rameshor lives in a village of Thoubal district in Manipur. His wife was expecting their second child and Rameshor was worried, since their first child was born through a Caesarean section. This time too, her gynaecologist informed Rameshor that attempting a normal delivery would be risky. Not only was Rameshor

worried about the lives of his wife and their unborn child, but also about the financial burden of a C-section. The last time, Rameshor had to borrow money from his relatives to pay for the hospital charges.

While discussing these issues with his friend, Rameshor learnt of RSBY. Fortunately, an enrolment drive was on in his village at that time and Rameshor had also received a slip with his wife's and his names on the Below Poverty Line (BPL) list, making them eligible under RSBY. He, along with his wife and son, enrolled in the scheme. At the time of his wife's delivery, Rameshor took her to the empanelled hospital in Imphal, 30 kms away from his village. A baby girl was born through C-section. Rameshor was happy as his family was now complete. That too, without having to bear any costs at the hospital!

Figure 1

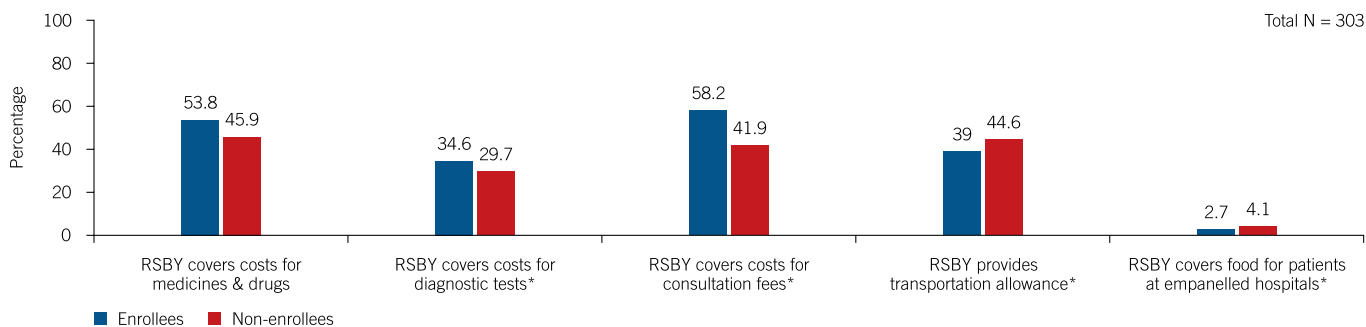
Awareness levels on general attributes of RSBY in Thoubal



* Significant differences at p value $\leq .05$

Figure 2

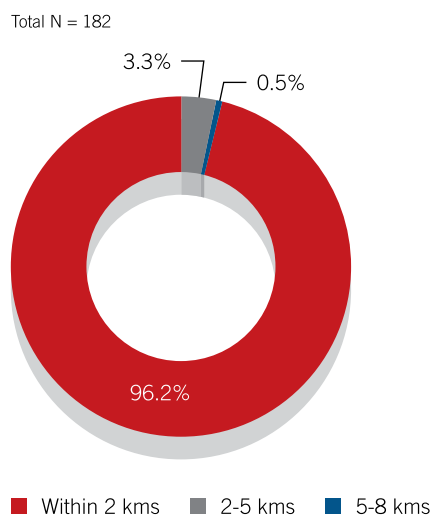
Awareness levels on utilisation benefits of RSBY in Thoubal



*Significant differences at p value <= .05

Figure 3

Distance of enrolment centres from hamlets in Thoubal



village. Whatever be the location of the enrolment centres, an overwhelming majority (96.2 percent) mentioned the distance to be less than two kms. from their hamlets. Thus, given the short distance, it was easy for the beneficiaries to reach the enrolment centres.

The waiting time at the enrolment centres varied. For slightly more than half of the enrollees, it took about 10-15 minutes, while for another 39 percent it was about half an hour (cf. Figure 4).

Once the waiting time was over, for most (63.7 percent) of the families, it took less than 10 minutes for the enrolment process to be completed. Also, slightly more than a fourth mentioned 10 – 15 minutes as the time taken for completion of the enrolment process (cf. Figure 5). Overall the entire enrolment process, including waiting time, for most families in Thoubal was reported to be in the range of 30 to 45 minutes.

Figure 4

Waiting time at enrolment centres in Thoubal

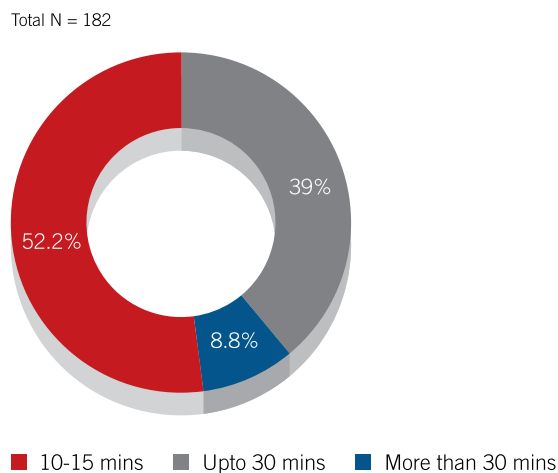
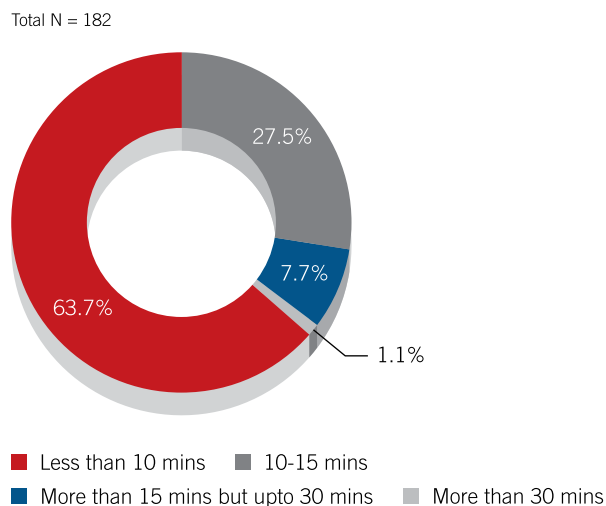


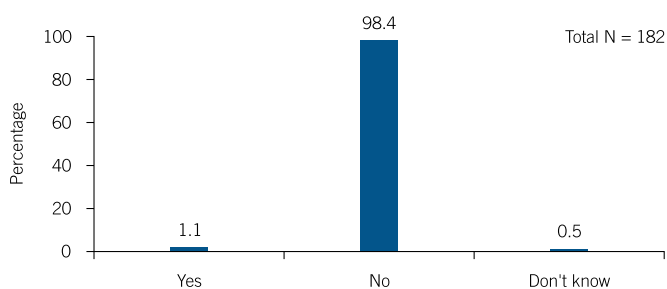
Figure 5

Time taken for enrolment process in Thoubal (apart from waiting time)



The caveat here in relation to the enrolment process was that it was not completed as per RSBY guidelines. The reason was that about 96 percent did not receive the smart cards instantly. In fact, 91 percent of them reported receiving the cards only after a period of one month. It was the village council member who distributed these cards at a later date, as reported by most (81 percent) enrollees. However, a noteworthy point is that no additional charges were levied on the enrollees at the time of distribution.

Figure 6
Received documents with list of empanelled hospitals in Thoubal



According to the guidelines, enrollees should receive documents with the list of empanelled hospitals with the cards. But almost none of them received any such documents (cf. Figure 6). Also, only 39 percent of the enrollees recalled receiving verbal information (cf. Figure 7) on where and how to use these smart cards.

Figure 7
Verbal information received on where and how to use RSBY smart card in Thoubal

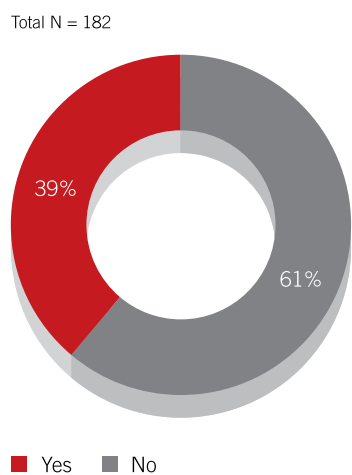
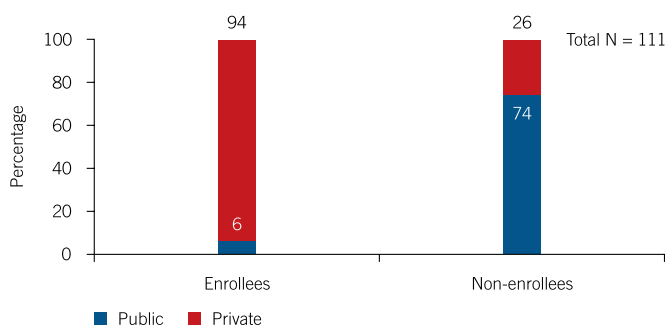


Figure 8
Type of health facility accessed for hospitalisation in Manipur



* Significant differences at p value = .000

This clearly brings out the absence of a uniform process of enrolment, resulting in rather fragmented pieces of information being available with the beneficiaries.

UTILISATION OF RSBY BENEFITS

The goals of RSBY can be measured only when the enrollees have an opportunity to avail the benefits as outlined in the scheme. In Manipur, a majority of the enrollees requiring hospitalisation accessed a private health facility (94 percent), while more than four fifths of the non-enrollees availed treatment in a public health facility (74 percent). This was because primarily private hospitals were empanelled in the state. In fact there were no hospitals in Thoubal district itself where RSBY beneficiaries could avail services. Almost all enrollees requiring hospitalisation had to travel a distance of more than eight kms. to reach any empanelled hospital as they had to go to the state capital Imphal for utilising benefits under RSBY. Furthermore, only four health facilities were empanelled in Imphal at the time of the evaluation. With limited number of hospitals available, the beneficiaries were restricted in their choice.

Given the distance travelled to reach the empanelled hospitals, the enrollees mainly hired taxi. This resulted in incurring high transportation costs. What is noteworthy is that only 15 percent of these enrollees recalled receiving the transportation allowance of Rs. 100 from the accessed hospitals, while on an average they spent Rs. 250. Ideally, all empanelled hospitals should have provided the benefit

Table 2

Out-of-pocket expenditure (OOPE) for hospitalisation in Thoubal

Average OOPE (mean)	Enrollees (N=73) (Rs.)	Non-enrollees (N=71) (Rs.)
Total	1,710	1,868
Medicines	1,448	1,428
Diagnostic tests	248	363
Consultation fees	14	77

* Mean includes those that did not incur any out-of-pocket expenditure

of Rs. 100 to all the enrolled beneficiaries requiring hospitalisation. But for 85 percent of the enrollees, this was not the case.

Apart from transportation expenses, slightly more than half (51 percent) of the enrollees did not incur any further out-of-pocket expenditure during hospitalisation, as all the costs were covered through the RSBY smart cards. For another 18 percent of the enrollees requiring hospitalisation, RSBY was beneficial to a limited extent as the RSBY card could be used only for partial payment. The reasons cited included purchase of medicines / drugs from outside the empanelled hospitals, and costs for treatment being more than the money available in their respective cards. Slightly more than a fourth (31 percent) of enrollees stated their inability to use the cards because they were not carrying them, or due to problems with the machines at the empanelled hospitals.

75.3 percent of enrollees mentioned incurring no costs on medicines, diagnostic tests and consultation fees. In comparison, 73.2 percent of the non-enrollees reported the same. These costs exclude the transportation expenses

borne by both the groups. Given that more than 70 percent each of enrollees and non-enrollees incurred no out-of-pocket expenditure, the median was Rs. 0 for both.

The average OOPE (mean) for the enrolled groups was lower than the non-enrolled groups (cf. Table 2). However, specifically on medicines, the average OOPE incurred by the enrollees was marginally higher than the non-enrollees. What needs to be noted is that 94 percent of the enrollees accessed a private health facility, while 74 percent of the non-enrollees accessed a public health facility. The expenditure incurred by both groups on medicines and drugs was significantly high as patients were often sent outside the hospitals to purchase them. In case of the enrollees, these costs were not reimbursed by the empanelled hospitals, which is against the RSBY guidelines.

Certain processes are outlined at empanelled hospitals for the convenience of RSBY patients. So far as these are concerned, more than 90 percent each reported the presence of a separate RSBY help desk and the staff being helpful respectively. Also, almost all the enrollees

Figure 9

RSBY processes at empanelled hospitals in Thoubal

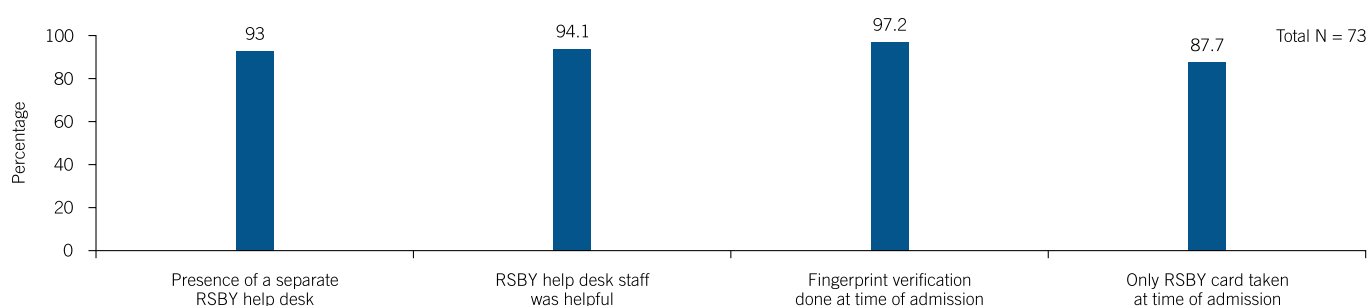
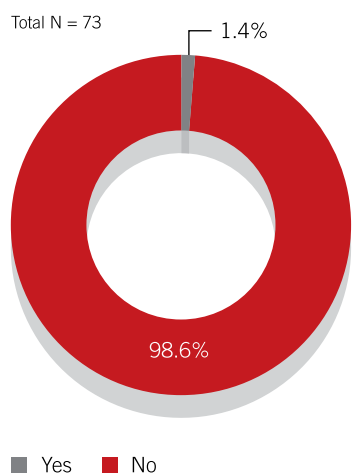


Figure 10

Ever forced to give money at empanelled hospitals in Thoubal



mentioned that fingerprint verification was done at the time of admission (cf. Figure 9), and that they were never forced to give any money to the hospitals (cf. Figure 10).

SATISFACTION WITH RSBY

Satisfaction is an important indicator for ensuring continuous engagement with the scheme. In this regard, a majority (89 percent) of the enrollees were satisfied with the scheme. The main reasons cited were polite and friendly behaviour of the health staff at empanelled hospitals and cashless treatment. This can be connected

Figure 11

Satisfied with RSBY in Thoubal

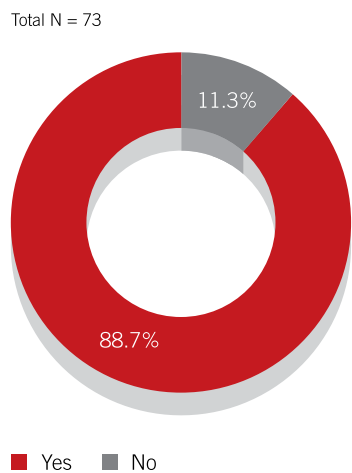
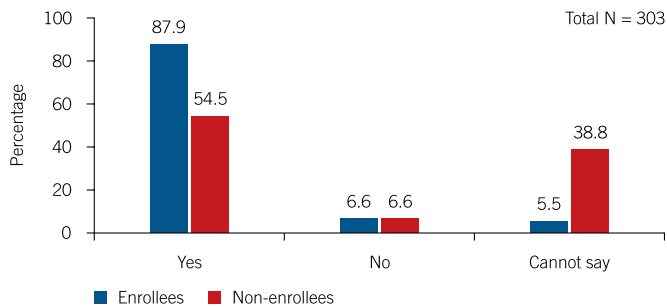


Figure 12

Willingness to enrol in RSBY in Thoubal



Significant differences at p value =.000

to the fact that the empanelled hospitals in Imphal, albeit few in number, do actually adhere to many of the processes of RSBY.

Given the high satisfaction level among the enrollees, it is foreseen that there would be willingness to continue in the scheme. This was the case for 88 percent of the enrollees. But what needs to be taken into account is the fact that this group of enrollees also included those who did not get an opportunity to use the cards as no member fell ill in that period. Since word-of-mouth plays a pivotal role, probably positive views from those who used the services spread to others as well. This could be a plausible reason for 55 percent of the non-enrollees too holding a similar view. The reasons given by the willing enrollees and non-enrollees were ‘scheme is good and useful’ and ‘helps poor to cover their health care needs’. For those who did not want to enrol in RSBY in the future, it was predominantly because of their inability to perceive any benefits through the scheme.



MEGHALAYA

RSBY in Ri Bhoi district



BACKGROUND

Meghalaya's population is primarily composed of tribes such as Khasis, Garos and Jaintias. Among all the North Eastern states, Meghalaya reported the highest decennial population growth of 27.9 percent¹³. Most of the people in this state follow a matrilineal system where lineage and inheritance are traced through women. The youngest daughter inherits all the property and takes care of aged parents and unmarried siblings. The literacy rate is at 74.4, which is close to the national average of 74.04. As per the census of India 2011, the sex ratio in the state was 989 females per 1,000 males,

which is far higher than the national average of 940. While the infant mortality rate (IMR) of 52 is higher than the national average of 43, nutritional status of men, women and children is better when compared to the national average (cf. Table 1).

The conversion ratio of RSBY in Meghalaya was 46.5 in 2013. Ri Bhoi was selected for this evaluation, with a conversion ratio of 51.9 prior to the start of the evaluation. Six hospitals were empanelled in Ri Bhoi when the evaluation took place.

RSBY IN RI BHOI DISTRICT

As with the section on Manipur, here too, our focus is first on the awareness level of RSBY eligible beneficiaries.

AWARENESS OF RSBY

Looking at RSBY through the broad lens of the community, it is clear that beneficiaries were aware of the general attributes of the scheme. However, a huge disparity was observed in the awareness levels of enrollees as compared to non-enrollees with regard to features such as the

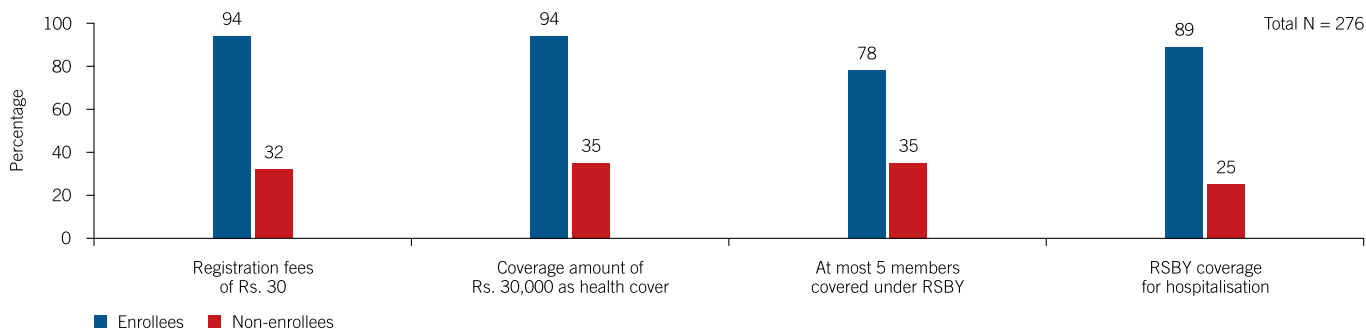
enrolment fee, health cover for hospitalisation, coverage amount, number of family members covered and type of empanelled hospitals (cf. Figure 13). Results clearly showed that enrollees were more knowledgeable than non-enrollees. In fact, significantly low level of awareness among the non-enrollees was probably one of the reasons for non-enrolment.

Knowledge of general attributes of RSBY is necessary, but not a sufficient condition for utilisation. For optimal

13. Census of India, Office of Registrar General of India, Ministry of Home Affairs, 2011

Figure 13

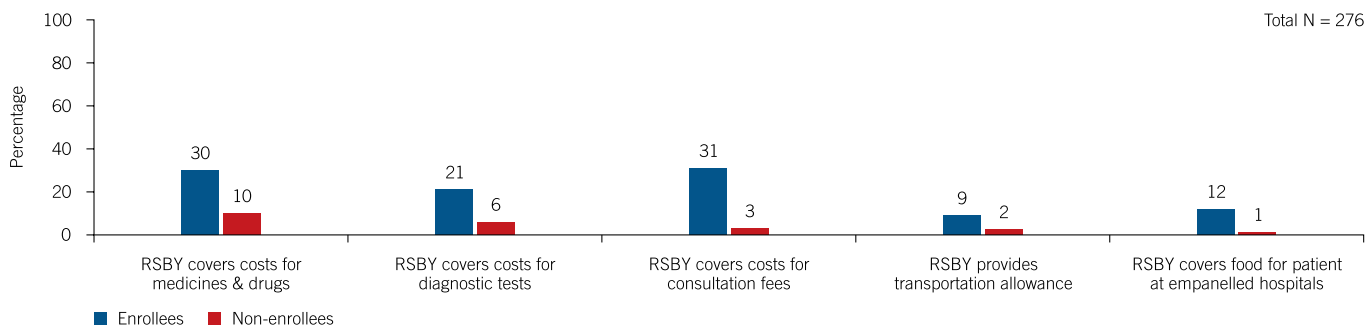
Awareness levels on general attributes of RSBY in Ri Bhoi



Significant differences at p value <= .05

Figure 14

Awareness levels on utilisation benefits of RSBY in Ri Bhoi



Significant differences at p value <= .05

utilisation of benefits, beneficiaries need to be well versed in the how, where and what of the scheme. In this regard, it was observed that the awareness levels even among the enrollees were much lower, as shown in Figure 14. Aspects such as coverage for medicines, diagnostics and consultation fees were known to a small percentage of beneficiaries. The provision of transportation allowance was known to only 9 and 2 percent of enrollees and non-enrollees respectively.

PROCESS OF ENROLMENT

If the enrolment process is cumbersome, it can become a probable bottleneck, leading to the failure of beneficiaries to register in the scheme. In this context, it has to be stated at the outset that Ri Bhoi has a hilly terrain and therefore access to enrolment centres could be a challenge both for the enrolment teams and the beneficiaries. While 45 percent of the RSBY enrollees mentioned enrolment centres to be located at the centre of their respective villages, for another 46 percent, these were located outside their villages (cf. Figure 15).

Given the geographical spread of the enrolment centres, the distance of the enrolment centres varied, with 68 percent listing it within two kms. About 17 percent reported a distance of two to five kms., while another 13.5 percent

Figure 15

Location of enrolment centres in Ri Bhoi

Total N = 156

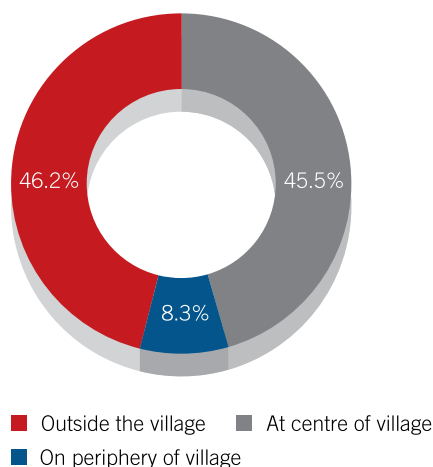
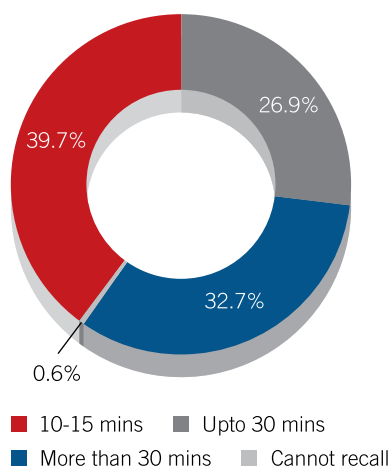


Figure 16

Waiting time at enrolment centres in Ri Bhoi

Total N = 156

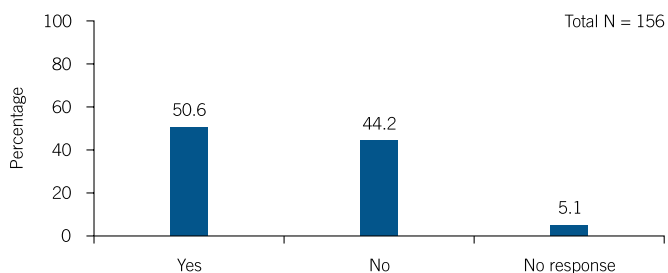


stated it to be more than five kms. Even though the time taken to reach and thereafter the waiting time at the enrolment centres (cf. Figure 16) varied depending upon the location, for a majority (82.1 percent) it took about 10 – 15 minutes for enrolment once their turn came.

Though the time for capturing photographs and collection of biometric information of the eligible families enrolling for the scheme was well within reasonable limits, the process was far from complete. This was because an overwhelming majority (96 percent) did not receive the cards on the spot. On being asked why, a majority (90.4 percent) of them said that they were not given any reasons. To be able to avail the benefits of RSBY for the entire one year policy period, it is necessary for the smart cards to be distributed instantly at the enrolment centres.

Figure 17

Received verbal information on RSBY in Ri Bhoi



Amongst enrollees who failed to get cards at the time of enrolment, almost three fourths (73.4 percent) expressed that they received the cards one month later. Another 15.1 percent mentioned that they received the smart cards more than a month later. These cards were distributed by the village council head without any additional charges, as stated by an overwhelming majority (93.4 percent) of the enrollees.

Not only did the enrollees receive the RSBY cards at a much later date, a large majority (94 percent) also stated that documents with the list of empanelled hospitals, as per the RSBY guidelines, were not distributed with the cards. However, verbal information on how and where to use the RSBY smart cards was received by about 51 percent of enrollees (cf. Figure 17) in Ri Bhoi which was better than Thoubal (39 percent) in Manipur.

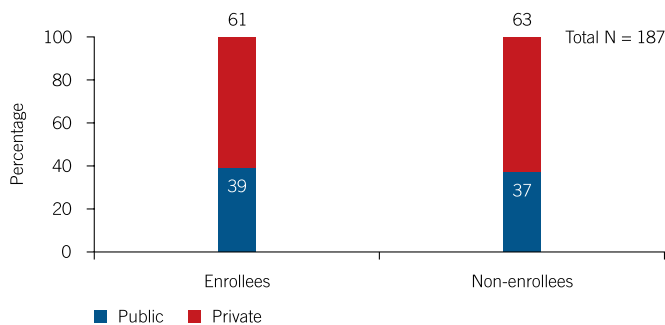
UTILISATION OF RSBY BENEFITS

As stated earlier, success of this scheme is measured by its two-fold objectives, namely, increasing access to health facilities and reduced out-of-pocket expenditure at the time of hospitalisation. Like Manipur, here too, the number of empanelled hospitals were rather limited (six in number). The difference was their presence within Ri Bhoi district, whereas in Manipur all of them were located at the state capital. Regarding the type of health facility accessed, results from this evaluation highlighted that both enrolled and non-enrolled were more likely to go to a private hospital for treatment. (cf. Figure 18).

While measuring the second objective of RSBY, results showed that 26 percent of enrollees reported incurring no

Figure 18

Type of health facility accessed in Ri Bhoi



Significant differences at p value =.000

Table 3

Out-of-pocket expenditure (OOPE) for hospitalisation in Ri Bhoi

Average OOPE (Mean)	Enrollees (N=100) (Rs.)	Non-enrollees (N=70) (Rs.)
Total	3,243	4,066
Medicines	2,487	3,116
Diagnostic tests	452.6	524.62
Consultation fees	308	425

Table 4

Median OOPE during hospitalisation in Ri Bhoi

Median OOPE	Enrollees (N=100) (Rs.)	Non-enrollees (N=70) (Rs.)
Total	1,250	775
Medicines	675	625
Diagnostic tests	0	0
Consultation fees	0	0

out-of-pocket expenditure on medicines / drugs, diagnostic tests and consultation fees. The remaining (74 percent) had to incur OOPE despite owning a RSBY card. The main reasons for this were 'need to purchase medicines and undergo diagnostic tests outside the empanelled hospitals', and 'failure to carry RSBY smart card at the time of treatment'. In comparison, amongst the non-enrollees, 24.3 percent mentioned no OOPE.

Table 3 shows that the average OOPE, including those who incurred none, was lower among enrollees as against non-enrollees. However, the median value was found to be higher in case of enrollees vis-à-vis non-enrollees (cf. Table 4). The out-of-pocket spending was primarily on medicines. Further exploration on this aspect revealed that one empanelled hospital in Ri Bhoi district continued to charge the RSBY patients standard rates irrespective of the RSBY package rates. Also, two other empanelled charitable hospitals had highly subsidised rates for poor families that were not covered by any government subsidy. These were a few probable reasons for enrollees incurring somewhat higher costs than non-enrollees.

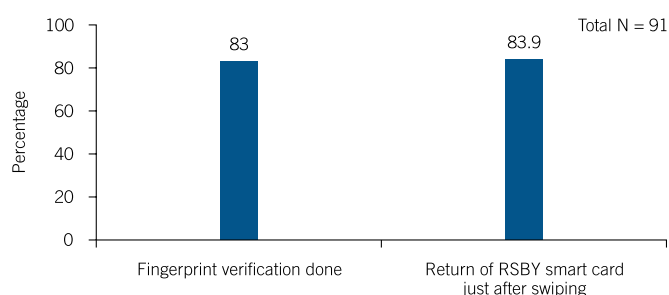
Like the results from Thoubal, even when the RSBY card was used, some of the respondents were asked to pay out of their own pockets for medicines and diagnostic tests, as

these were not available at the empanelled facilities. Often, these costs were not reimbursed by the insurance company, resulting in out-of-pocket payments.

Since the success of RSBY entails a certain process to be followed at the empanelled hospitals, it is pertinent to understand its status. Specific procedures such as fingerprint verification done at the time of admission, and return of RSBY smart cards just after swiping at the time of admission were recalled by most of the beneficiaries who availed services under RSBY (cf. Figure 19).

But on the other hand, a very small percentage of enrollees reported aspects such as presence of a separate help

Figure 19

RSBY processes on admission in Ri Bhoi

desk at the empanelled hospitals (28 percent), provision of transportation allowances (10 percent) and free food (9 percent) for patients at empanelled hospitals.



RSBY relieves Bonyta of prolonged suffering

Bonyta, a resident of Ri Bhoi district in Meghalaya, was suffering from acute stomachache for many months. The doctor at the nearby hospital diagnosed her with appendicitis and she was informed of the consequences if the surgery was delayed. Bonyta's husband then recalled that he had got himself, Bonyta and their three children enrolled in the 'smart card scheme', as RSBY is commonly known in the North Eastern states. He found out how and where to use the smart card from the head of the village council and then took Bonyta to the nearby empanelled private hospital.

The surgery was performed just in time; the surgeon later told the couple that the appendix could have burst if it had been delayed a few more days. Both Bonyta and her husband were extremely relieved. Not only was Bonyta's life saved, but the family did not have to spend any money on their own. The costs of the surgical procedure, including the stay and food at the hospital, were taken care of by RSBY.

SATISFACTION WITH RSBY

Overall, three fourths of the enrollees who had availed benefits of the scheme expressed satisfaction (cf. Figure 20). One of the primary reasons was RSBY being a cashless scheme, thus enabling families to save money that would otherwise be spent on health needs.

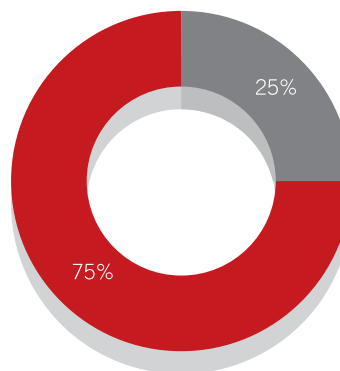
A comparative analysis with the results from Thoubal showed a lower level of satisfaction among enrollees availing RSBY services in Ri Bhoi. A probable reason could be higher out-of-pocket expenditure in comparison to other members of their communities who did not enrol in RSBY.

But interestingly, while 90 percent of the enrollees wanted to renew their RSBY enrolment in the subsequent policy periods, only 5 percent of the non-enrollees held a similar opinion. The reasons cited by the non-enrollees were low levels of awareness on benefits of RSBY, as well as dissatisfaction of some beneficiaries within their social circle.

Figure 20

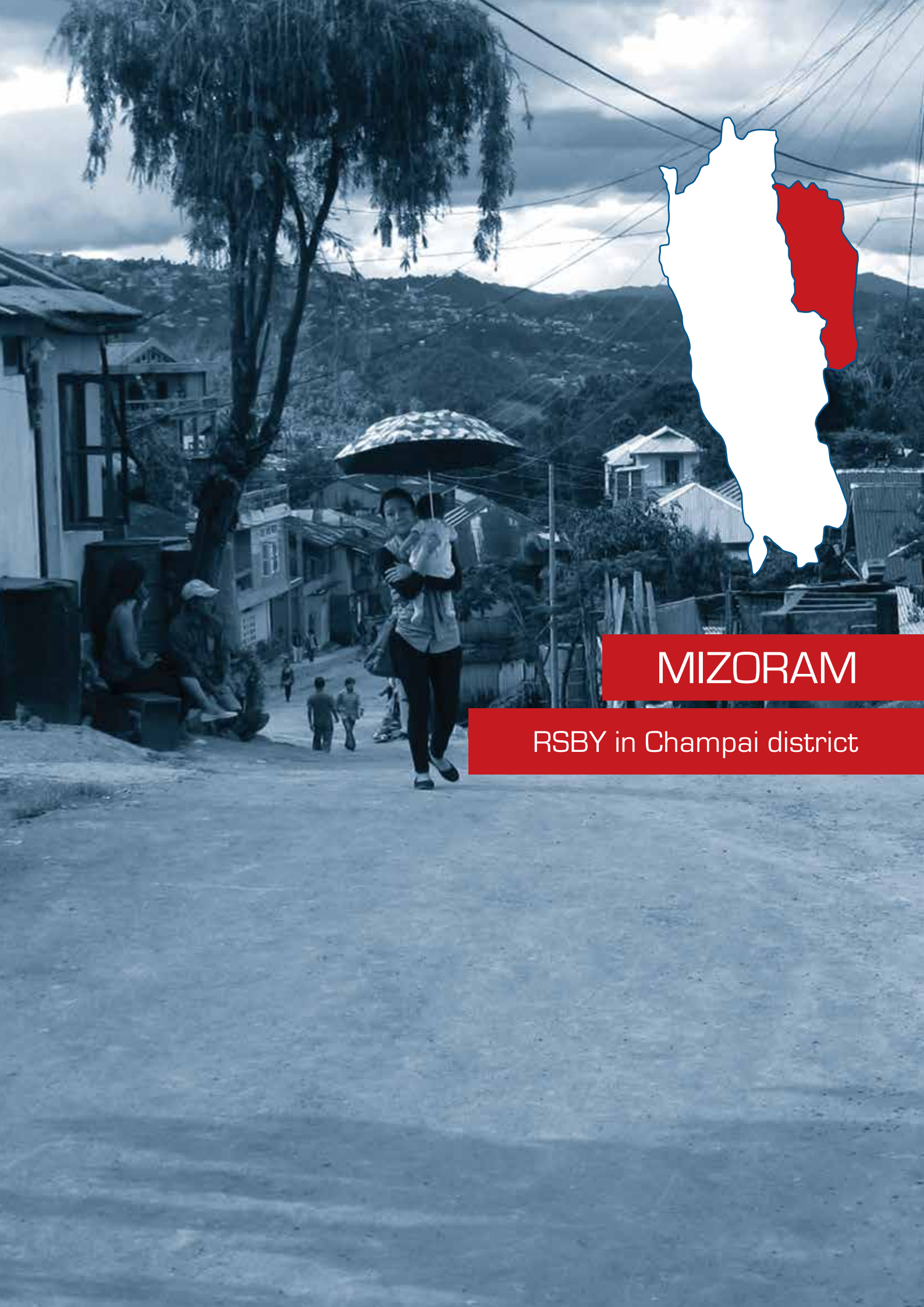
Satisfied with RSBY in Ri Bhoi

Total N = 91



■ Yes ■ No

Significant differences between enrolment status was at p value = .000.



MIZORAM

RSBY in Champai district

BACKGROUND

Mizoram has a large tribal population collectively known as 'Mizos' (Mi - people; Zo - hills). The tribes include Lushai, Paite, Lai, Mara, Ralte, Hmar, Thadou and several others. The Mizos live in a close-knit society with no class or gender discrimination. 90 percent are cultivators and the village unit functions as a large family. Village councils are the bedrock of democracy and leadership in the state. People have high levels of literacy (91.3)¹⁴. The decennial growth rate of population is 23.48 percent. The

state's sex ratio at 976 is better than the national average of 940. As Table 1 shows, the health and nutritional status of people from Mizoram is good when compared to the national average.

The conversion ratio of RSBY in Mizoram was 58.8 in 2013. Champai, where the evaluation was conducted, had a higher-than-average conversion ratio of 70 in 2013. There was only one empanelled hospital in the district at the time of the evaluation.

RSBY IN CHAMPAI DISTRICT

AWARENESS OF RSBY

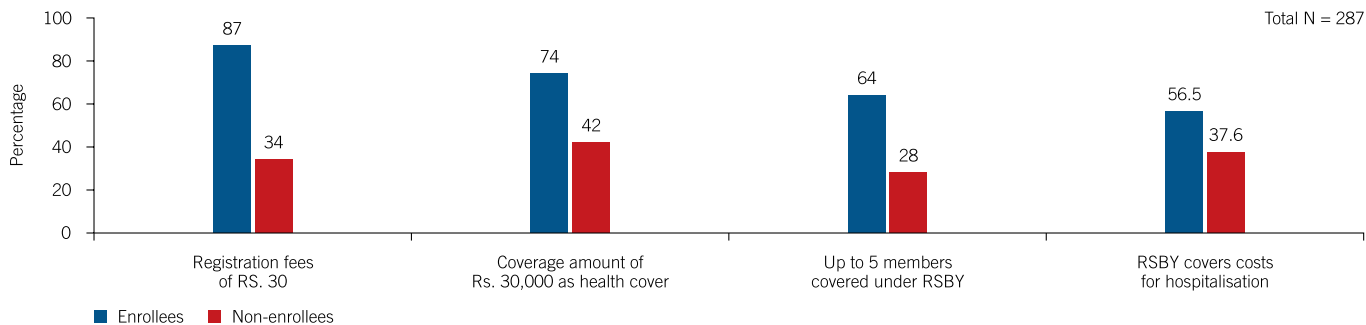
On a broad level, 70 percent of the beneficiaries covered in this evaluation had heard of RSBY. Disparities on awareness levels between enrollees and non-enrollees were significant on aspects pertaining to general features of RSBY. Differences were noted in awareness on registration fee, number of family members covered, total coverage amount and health cover for hospitalisation (cf. Figure 21).

Focusing on specific aspects of RSBY, it was observed that for most parameters, there was a substantially low level of awareness. Only 14 percent and 3 percent of enrollees and non-enrollees respectively recalled that the amount of Rs. 30,000 under RSBY covers costs for any diagnostic tests conducted at the empanelled hospitals where the patients are admitted. Recall of aspects such as 'consultation fees being covered by RSBY' and 'provision

14. Census of India, Office of Registrar General of India, Ministry of Home Affairs, 2011

Figure 21

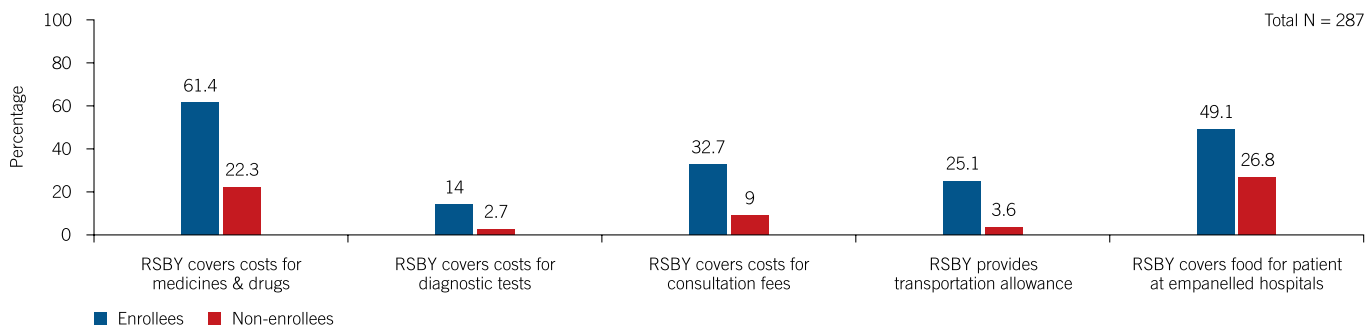
Awareness levels on general attributes of RSBY in Champai



Significant differences at p value =.000

Figure 22

Awareness levels on utilisation benefits of RSBY in Champai



Significant differences at p value =.000

of transportation allowance under RSBY’ was also found to be low (cf. Figure 22).

PROCESS OF ENROLMENT

Champai is located 166 kms. from Aizawl, the capital of Mizoram. This remote, mountainous district borders Myanmar. Reaching the district is itself an arduous task, and it is remarkable that RSBY has penetrated into such remote areas of the country. Accessibility is of utmost significance in hilly terrains such as Champai. On this aspect, the RSBY beneficiaries stated that enrolment centres were in the middle of their respective villages, thus easing access (cf. Figure 23). The distance traversed by 86 percent of those who enrolled was less than two kms.

The waiting time at enrolment centres was by-and-large 10 – 15 minutes. The total time taken for enrolment, apart from waiting time, was also about 10 – 15 minutes. Though this was well within reasonable limits, smart cards were not distributed

on the spot in Champai (cf. Figure 24). Not receiving smart cards at the time of enrolment denied the beneficiaries access to RSBY services for the entire policy period.

Figure 23

Location of enrolment centres in Champai

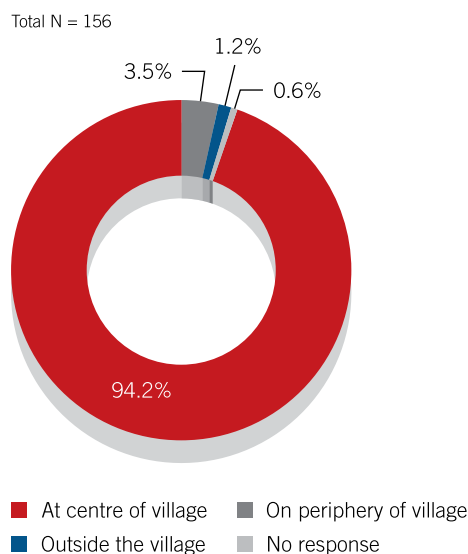
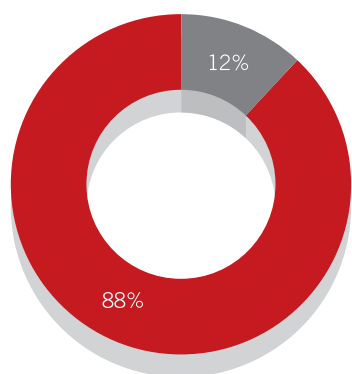


Figure 24

On-the-spot RSBY smart cards distribution in Champai

Total N = 166



■ Yes ■ No

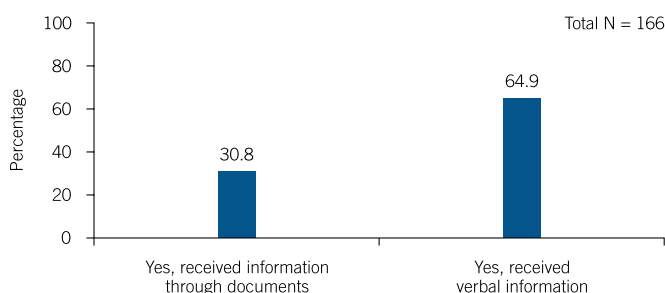
Delving deeper, it was observed that 67 percent of the enrollees were unaware of the reasons for not getting their RSBY smart cards on time. The remaining mentioned issues such as lack of regular electricity supply (22.2 percent) and problems in smart card machines (11 percent).

Almost 88 percent received their smart cards more than a month later. These cards were distributed at a later date by health workers (70.3 percent), or village council members (26.8 percent). It is heartening to note that almost all the enrollees said that they received the cards without any additional charges, apart from the registration fees paid at the time of enrolment. This was a common aspect observed across all the other states too.

For enrollees to be able to avail benefits of RSBY, complete information needs to be provided to them. According to the guidelines, enrollees have to be

Figure 25

Receipt of information with list of empanelled hospitals in Champai



informed of the empanelled hospitals where the card can be used in case of any hospitalisation event. Usually, third party administrators (TPAs), on behalf of insurance companies, apprise the beneficiaries through pamphlets or booklets. In this respect, only 31 percent mentioned receiving any such documents and about 65 percent said they were informed verbally (cf. Figure 25). About 69 percent of enrollees were aware of the exact date when they could start using the smart card and 59 percent clearly articulated the validity period. It is noteworthy that the access to this information in Mizoram was better than in Manipur and Meghalaya.

UTILISATION OF RSBY BENEFITS

Enrolment figures of the health insurance scheme are not adequate for measuring its success. This is the first step. Moving beyond enrolment, it is imperative that enrollees are well informed in order to progress to the next level, which is utilisation. Utilisation is dependent on information as well as availability of health services where RSBY can be accessed. A majority of the RSBY enrollees had to travel 166 kms. to Aizawl to access RSBY services. The main reason was that there was only one empanelled health facility in Champai at the time of the evaluation. The representative from the State Nodal Agency responsible for implementing RSBY highlighted the inadequate number of empanelled health facilities in Champai as one of the key challenges, requiring an early solution.

Enrollees surveyed in the district accessed a mix of public and private health facilities in Champai and the state capital Aizawl, while most of the non-enrollees went to public health facilities (cf. Figure 26).

Figure 26

Type of health facilities accessed in Champai

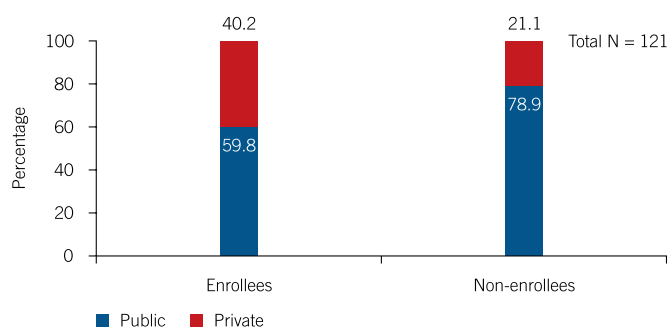


Table 5

Out-of-pocket expenditure (OOPE)* for hospitalisation in Champai

Average OOPE (mean)	Enrollees (N=108) (Rs.)	Non-enrollees (N=22) (Rs.)
Total	8,344	4,005
Medicines	7,959.44	3,734.09
Diagnostic tests	322.64	170.45
Consultation fees	61.96	100.00

* Average OOPE (mean) before reimbursement

Table 6

Median OOPE* during hospitalisation in Champai

Median OOPE	Enrollees (N=108) (Rs.)	Non-enrollees (N=22) (Rs.)
Total	3,480	2,110
Medicines	3,000.00	2,000.00
Diagnostic tests	00.00	50.00
Consultation fees	10.00	10.00

* Median OOPE before reimbursement

As far as the implementation of RSBY in Champai is concerned, it did not function as a paperless and cashless scheme. Results from this evaluation demonstrated that a majority (92 percent) of enrollees requiring hospitalisation reported making payments upfront for consultations, medicines and diagnostics at the empanelled hospitals. Probing further, it was observed that usage of RSBY was significant, despite some existing lacunae regarding the processes.

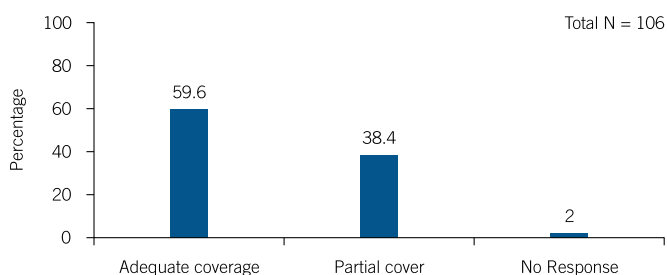
Contrary to the normal process of deducting the money from the smart cards of the patients at the time of hospitalisation, in Champai most often the smart card was not swiped due to systemic issues such as irregular electricity supply and poor internet connectivity. As a result, the enrollees were made to pay upfront and this amount was reimbursed once the hospital was able to settle claims. However, a certain amount was also deducted from the final reimbursement. The medical officer-in-charge from one of the empanelled hospitals explained this as the tax deducted by the insurance company while settling claims, which was the reason for enrollees getting less than the actual amount spent.

Before we compare the results on OOPE of the two groups, it is important to state that the number of non-enrollees who experienced a hospitalisation event in the last one year (at the time of the survey) was quite small (N=22). As a result, it is not possible to carry out a robust statistical analysis of this group. In comparison, the total number of enrollees who experienced hospitalisation in the same time period was 108. The reason for this wide difference was because the number of enrolled and hospitalised was pre-defined, while that of the non-enrolled and hospitalised was random. Another caveat here is that the out-of-pocket-expenditure as mentioned by the enrollees was before reimbursement. Since the enrollees could not recall the exact amount deducted as tax from the reimbursement, it is difficult to compare the average OOPE (mean) and median OOPE.

While it is true that RSBY was not being implemented as a paperless and cashless scheme in Mizoram, we cannot deny this state's intention to ensure that the scheme served intended beneficiaries. Consequently, in order to deal with systemic issues that have been outlined earlier, the empanelled hospitals in Mizoram devised their own

Figure 27

Whether coverage adequate or inadequate under RSBY in Champai



mechanisms. As the saying goes, “necessity is the mother of invention”. The patients paid for the treatment availed and detailed records of patients were kept in these hospitals. These hospitals then raised the claims with the insurance companies / TPAs, but again on paper. There was an understanding between the insurance companies / TPAs and the government for consideration of paper claims. After the payment was received by the hospital, the beneficiary was called to collect the reimbursement in cash. It usually took about three to four months for the patients to be reimbursed. This scenario was not just in Champai, but was also seen in the hospitals at Aizawl.

On being asked whether this process was suitable, beneficiaries did express the need for a cashless process

as designed in RSBY. But since something is better than nothing, most of the beneficiaries appeared to have accepted the system as it existed for the time being. They did, however, hope that the scheme would be cashless soon.

What is heartening to note is that the hospitals kept a record of all the RSBY beneficiaries and called them once claims had been settled. In fact, about 60 percent of the enrollees mentioned that the Rs. 30,000 coverage under RSBY was adequate to meet their hospitalisation costs (cf. Figure 27). For most of the remaining enrollees, whose costs exceeded the RSBY limit, the additional amount got covered by the Mizo State Health Care scheme. The scheme provides coverage of Rs. 2,70,000 (over and above RSBY coverage), and is available only for RSBY enrollees.

In the context of RSBY processes at empanelled hospitals, 63 percent reported a separate RSBY help desk. Almost all the enrollees mentioned polite and helpful behaviour of the hospital staff. Also, about 32 percent of enrollees reported being asked for additional documents other than RSBY cards (cf. Figure 28).

Food was provided to 59.6 percent of enrollees and 41.3 percent received the transportation allowance. Almost

Figure 28

Experience of RSBY patients at empanelled hospitals in Champai

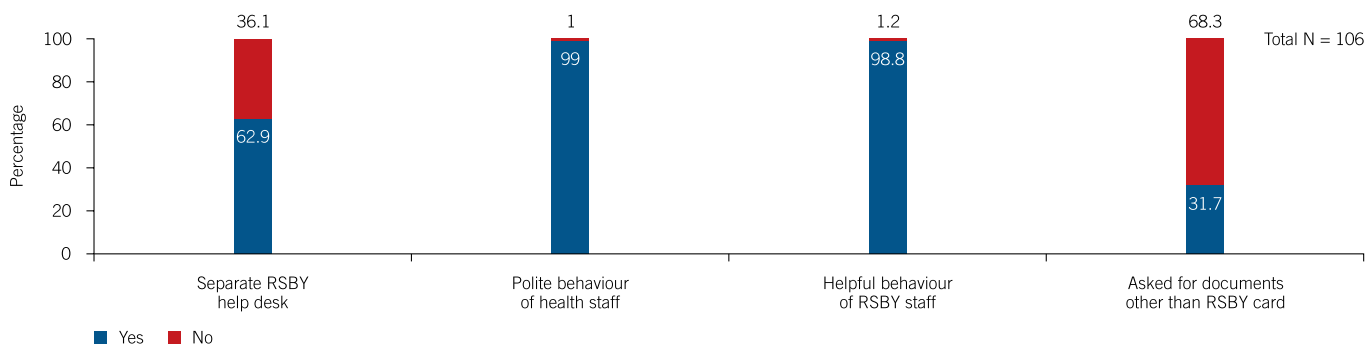
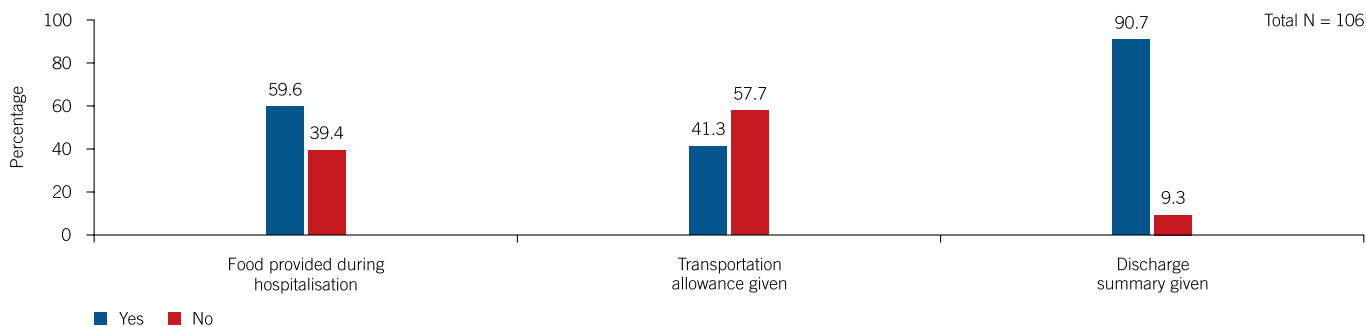


Figure 29

Availability of services for RSBY patients at empanelled hospitals in Champai



91 percent received a discharge summary (cf. Figure 29). These results were much better than what was observed in the other states.

SATISFACTION WITH RSBY

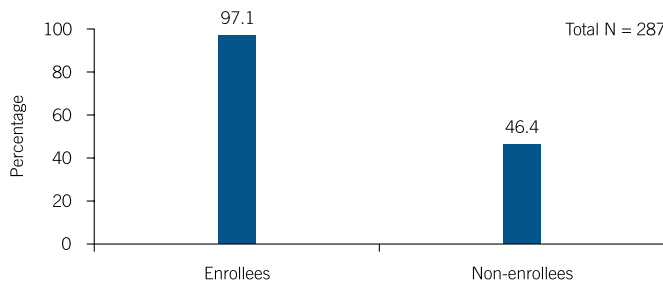
The satisfaction level in Champai was lower as compared to the enrollees in Thoubal (Manipur) and Ri Bhoi (Meghalaya). 65 percent of the enrollees were satisfied with the scheme. But interestingly, the satisfaction levels rose to 94 percent for enrollees who availed benefits. The reasons included friendly and polite behaviour of health care staff (39.6 percent), cashless hospitalisation (31.1 percent), shorter waiting time compared to other patients (13.2 percent) and option to choose the hospital (3.8 percent).

Despite a moderate satisfaction level, 97 percent of enrollees were willing to enrol in the subsequent years. Even amongst non-enrollees, 46 percent expressed their willingness to enrol in RSBY in the future (cf. Figure 30).

The reasons were similar to that cited by the RSBY beneficiaries in Thoubal (Manipur) and Ri Bhoi (Meghalaya), such as ‘scheme is good and useful’ and ‘helps the poor take care of health needs’. As far as non-enrollees were concerned, lack of information on features and benefits of RSBY were prime factors for their unwillingness to enrol in the future.

Figure 30

Willingness to enrol in RSBY in the future in Champai



Significant differences at p value =.000



NAGALAND

RSBY in Phek district



BACKGROUND

Nagaland also has a primarily mountainous landscape and is inhabited by a large tribal population. The people of Nagaland constitute 16 major tribes - Ao Naga, Angami Naga, Chang Naga, Konyak people, Lotha Naga, Sumi Naga, Chakhesang Naga, Khiamniungan people, Bodo-Kachari people, Phom Naga, Rengma Naga, Sangtam Naga, Yimchunger, Thadou people, Zeliang and Pochury as well as a number of sub-tribes. Each tribe is unique in character, with its own distinctive customs, language and dress. There are two threads common to all; English is the predominant language of communication and a majority of the

population are Christians. Tribe and clan traditions and loyalties play an important part in the life of Nagas. There is a negative demographic growth rate in Nagaland (-0.58 percent). The literacy rate is 79.6 percent as per the 2011 population census¹⁵, while the sex ratio is 931, which is below the national average of 940¹⁶.

The conversion ratio of RSBY in Nagaland was 59 percent in 2013. The district of Phek was selected for this evaluation. Compared to the state average, the conversion ratio in Phek in 2013 was at a high of 81 percent.

RSBY IN PHEK DISTRICT

AWARENESS OF RSBY

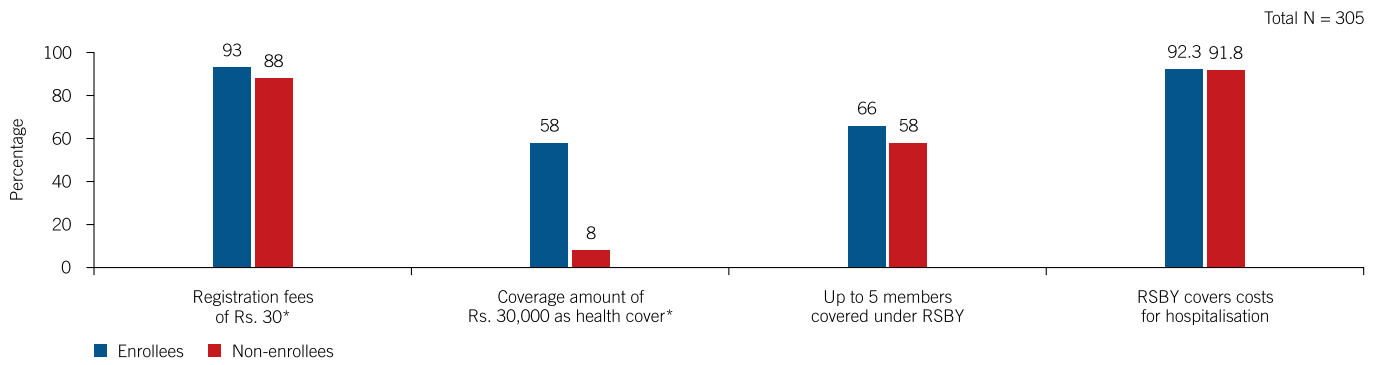
Similar to the findings from the other three states, awareness levels on general aspects of the enrolment process in RSBY was higher amongst enrollees than that of non-enrollees (cf. Figure 31). Features such as registration fee and coverage of hospitalisation events were known to an overwhelming majority of enrollees and non-enrollees.

Here too, non-enrollees were less aware of the specific attributes of RSBY as compared to enrollees. But it was also observed that a lower percentage of enrollees were completely apprised on all the benefits available under the RSBY health cover. Provision of transportation allowance and availability of free food for the RSBY patients at empanelled hospitals were known to only a miniscule percentage of the sampled beneficiaries (cf. Figure 32).

15. Census of India, Office of Registrar General of India, Ministry of Home Affairs, 2011
16. *ibid*

Figure 31

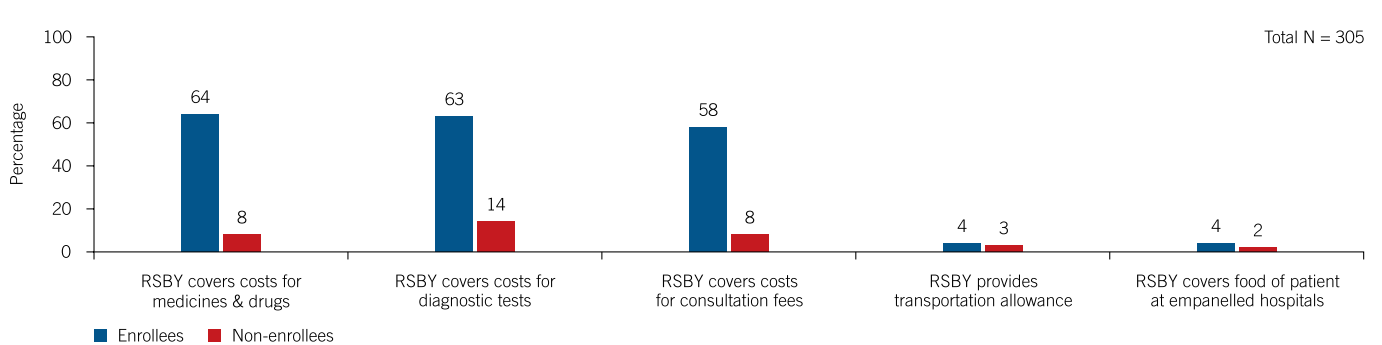
Awareness levels on general attributes of RSBY in Phek



* Significant differences at p value <=.05

Figure 32

Awareness levels on utilisation benefits of RSBY in Phek



Significant differences at p value =.000



Veyi does not get full benefits under RSBY

Veyi, a resident of Pholami village in Phek district of Nagaland, travelled 50 kms from his home to a private empanelled eye care hospital, hopeful that his father would regain his eyesight. Veyi’s father was suffering from cataract for a year, and after being enrolled in

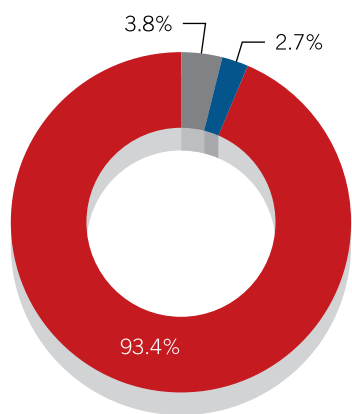
RSBY, Veyi took him to the hospital for surgery. Veyi spent a lot of money on travel, but he was willing to do this for his father, assuming that the costs would be covered through RSBY.

The cataract operation was performed successfully; while Veyi was very happy for his father, on the whole he was dissatisfied with the scheme. The RSBY card had only helped in partially covering the costs. The empanelled hospital used the RSBY card for some of the costs, but he was asked to pay additional charges for the lens and medicines from his own pocket. He was also not given the transportation allowance provided under RSBY. These were the reasons why Veyi did not find the scheme completely beneficial.

Figure 33

Location of enrolment centres in Phek

Total N = 183



■ At centre of village ■ On periphery of village
■ Other responses (Sarpanch's house, school)

PROCESS OF ENROLMENT

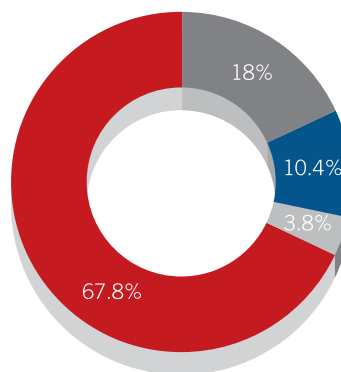
Despite the district being highly mountainous, a majority of enrollees articulated that enrolment centres were easily accessible, as they were located within two kms. of their respective hamlets. In this regard, over 90 percent of enrollees in Phek stated that the enrolment centres were in the middle of their villages (cf. Figure 33).

The waiting time at the enrolment centres (cf. Figure 34) and the ensuing time for completion of the enrolment process (cf. Figure 35) was noted to be up to 30 minutes each. One of the main reasons for this length of time was

Figure 35

Time taken for enrolment process in Phek (apart from waiting time)

Total N = 183



■ More than 15 mins but upto 30 mins ■ 10-15 mins
■ More than 30 mins ■ Less than 10 mins

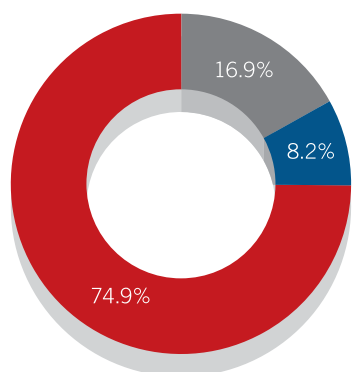
inadequate number of laptops and printers to deal with a large crowd at the time of enrolment.

As found in the other three states, RSBY smart cards were not distributed on the spot to 96 percent of the enrollees. Multiple reasons were provided for this delay such as 'absence of electricity back-up' (56 percent), 'problems in smart card machines' (14.9 percent), and 'failed to collect the cards instantly' (15.4 percent). In a somewhat different trend from the other three states, in Phek (Nagaland), few enrollees received their cards a day later (31 percent). Others did so in a month's time (51 percent), or later

Figure 34

Waiting time at enrolment centres in Phek

Total N = 183

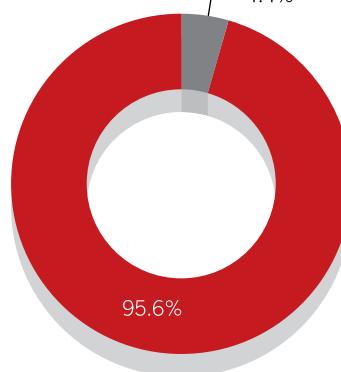


■ More than 15 mins but upto 30 mins
■ 10-15 mins ■ More than 30 mins

Figure 36

On-the-spot RSBY smart cards distribution in Phek

Total N = 183



■ Yes ■ No

than a month (15 percent). Given that the village councils play a pivotal role in the lives of the tribal people of North East India, it is no surprise to find the head of the village council distributing the smart cards at a later date. While delayed receipt of RSBY smart cards denies the beneficiaries an opportunity to utilise the scheme for the entire one year period, it is noteworthy that there was no report of demand for extra money to get the cards.

All the four North Eastern states covered in this evaluation have a similar story to tell regarding complete information on RSBY being provided to beneficiaries. Specifically, documents with list of empanelled hospitals along with the helpline number were not made available to any of the enrollees. Furthermore, only 15 percent of those enrolled stated receiving verbal information on how and where to use the smart cards.

In the absence of complete knowledge on usage of RSBY smart cards, not only is utilisation bound to be lower, but there is a tendency for the enrollees to accept whatever is told to them at the service points i.e., empanelled hospitals.

UTILISATION OF RSBY BENEFITS

As clearly stated in the section on methodology, the selection of the enrollees in this evaluation was purposive. Among the enrollees, those who had undergone hospitalisation in the past 12 months were purposively selected. On the other hand, since the data of hospitalisation among non-enrollees was not available beforehand, hospitalised cases were randomly chosen from that category. This was a limitation of the evaluation. In case of Phek, the number of non-enrollee households with any family member undergoing hospitalisation in the past 12 months was too few for any statistical analysis. Therefore, the aspect on utilisation of RSBY in Phek is being presented without any comparison with non-enrollees.

All enrolled households accessed private health facilities because only private facilities were empanelled under RSBY

in this district. 98 percent of the enrolled and hospitalised reported incurring out-of-pocket expenditure (OOPE) at the time of hospitalisation. This was despite 95 percent of the enrolled and hospitalised using their RSBY smart cards. The OOPE arose primarily due to purchase of medicines outside the empanelled hospitals and the failure of the health facilities to reimburse the patients. This can be connected to the awareness levels of beneficiaries as well as the absence of complete information on how and where to use RSBY, which is often why these enrollees cannot demand what is rightfully theirs. Also, on many occasions, hospitals charged more than the RSBY package rates. The amount defined as package rates for the specific illnesses were deducted from the RSBY cards while the remaining was paid by the patients in cash. On this aspect, the health service providers were of the view that the pre-defined package rates under RSBY were quite low and that is why the hospitals charged patients more than the stipulated amount.

Table 7

Out-of-pocket expenditure (OOPE) for hospitalisation in Phek

Average OOPE (Mean)	Enrollees (N=60) (Rs.)
Total	8,305
Medicines	6,785
Diagnostic tests	823
Consultation fees	697

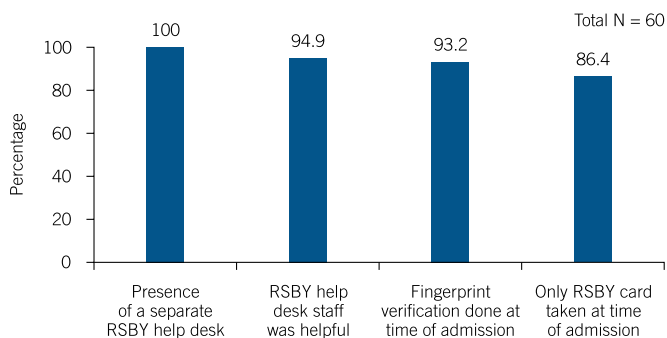
Table 8

Median OOPE* during hospitalisation in Phek

Median	Enrollees (N=60) (Rs.)
Total	7,400
Medicines	5,500
Diagnostic tests	600
Consultation fees	600

Figure 37

RSBY processes at empanelled hospitals in Phek



The empanelled hospitals may not have adhered to the RSBY guideline of reimbursing the enrollees in case of purchase of medicines and drugs from outside or had charged more than the package rates, but they did seem to follow some of the other RSBY processes. All enrollees reported the presence of an RSBY help desk, with about 95 percent stating that the staff were helpful. Another 93 percent acknowledged fingerprint verification was done at the time of admission (cf. Figure 37).

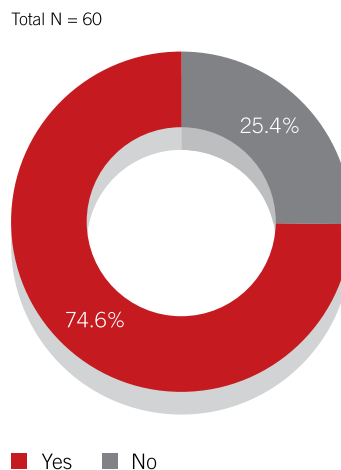
SATISFACTION WITH RSBY

In more or less a similar pattern as observed in the other three states, three fourths of the enrollees in Phek mentioned being satisfied with the scheme. Also, about 72 percent of enrollees and 67 percent of non-enrollees expressed their willingness to enrol in RSBY in the future.

The main reasons stated were ‘RSBY helps poor people cover their health care needs’ and ‘the scheme is good and useful’.

Figure 38

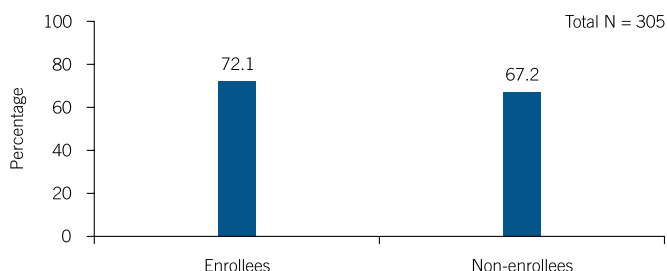
Satisfied with RSBY in Phek



■ Yes ■ No

Figure 39

Willingness to enrol in RSBY in Phek



CONCLUSION

RSBY reaches remote corners of North East India but one shoe cannot fit all

Better access to health services is one of the key objectives of the *Rashtriya Swasthya Bima Yojana* (RSBY) – India’s national health insurance scheme for the poor. In that sense, RSBY has made a positive change in the lives of people in the remote, hilly region of North East India. The scheme has reached out to areas that still remain difficult to access and are therefore often underserved. Though enrolment of beneficiaries is substantial, there is definite scope for improvement in implementation of this scheme, given the unique geo-political and social conditions of the region. The challenges in implementing RSBY need to be seen in the context of larger systemic issues that the states in the North East have to deal with.

Before moving on to the recommendations, let us summarize the commonalities and differences in the RSBY processes being followed across the four North Eastern states that were evaluated.

Beginning with awareness, undoubtedly people are aware of RSBY, locally known as the ‘smart card scheme’. Basic features for enrolment in RSBY, such as the registration fee and the annual coverage amount for hospitalisation, are known to beneficiaries who enrol in the scheme. Furthermore, with minor variations across the four states, beneficiaries are aware that a maximum of five members can enrol in RSBY in a year and that both public and private health facilities are empanelled under RSBY. On the other hand, more concerted efforts are required to improve the awareness levels of those who have not enrolled.



To fulfil the two-fold objectives of improving access to health care and reducing out-of-pocket expenditure during hospitalisation, it is essential that beneficiaries have clear information on where and how to use the RSBY smart cards. Knowledge levels of both enrollees and non-enrollees are significantly low regarding specific features such as coverage including the costs of medicines / drugs, diagnostic tests and consultation fees during hospitalisation, provision of free food to patients at empanelled hospitals and the transportation allowance provided under the scheme. State-wise variations were noted on these parameters, with Nagaland and Manipur faring better than Meghalaya and Mizoram.

Once awareness is generated, beneficiaries are willing to enrol, provided the enrolment process is easy and accessible. In Mizoram and Nagaland, enrolment centres are in the middle of the village and therefore the distance to travel is within two kms. Manipur and Meghalaya reported a spread of enrolment centres at central and peripheral locations of villages. But despite the geographical spread, the travelling distance was within acceptable limits.

Another positive point for enrollees, especially in Mizoram and Meghalaya, was that the waiting time at the enrolment centres was just 10 – 15 minutes. It took another 10 – 15 minutes for the enrolment process to be completed. As far as Manipur and Nagaland were concerned, there is a definite scope for improvement, as both waiting time and time for enrolment were stated to be up to 30 minutes each.

RSBY guidelines mandate distribution of smart cards on the spot at the time of enrolment across all enrolment centres. There was a gap in the process at this point for these four North Eastern states as smart cards were not issued on the spot in most of the cases. Because of the delay in receipt of smart cards, the enrollees could not avail benefits of the scheme for the entire policy period. Distribution was delayed because of systemic issues such as irregular electricity supply and inadequate number of printers and smart card machines to cater to all enrolment centres. As a result, the smart cards were printed later at the offices of the smart card providers and often distributed more than a month after enrolment by members of the village council, although without any additional charges.

Another key feature of RSBY is that beneficiaries are given the choice to select the health facility that is most suitable for their needs. To be able to exercise this choice, it is essential for them to know where to use the cards. As per the guidelines of RSBY, beneficiaries should be provided a list of empanelled hospitals in the district where their cards can be used. This process was not being adhered to across all the four states. Even worse, a majority of the enrollees were not given any verbal information either.

Despite low levels of awareness regarding empanelled health facilities, the beneficiaries did access them for treatment when the need arose. However, the choice was rather limited as most of the districts where the evaluation was undertaken did not have enough empanelled hospitals. Barring Meghalaya, in the other three states patients with RSBY smart cards had to travel long distances to reach empanelled hospitals located at district headquarters. Evidently, where the enrollees could choose between public and private health facilities, there was a higher likelihood of them to opt for private hospitals. The reasoning was that since public health

facilities are in any case supposed to provide free health care for the poor, beneficiaries utilised the coverage at private health facilities as they expected better quality of treatment.

As beneficiaries were not so well versed in the specific features of RSBY, they often continued to incur out-of-pocket expenditure at the time of hospitalisation. State-wise variations existed on this aspect. In case of Manipur, out-of-pocket expenditure of enrollees was lower as compared to non-enrollees. Meghalaya, on the other hand, had a different story to tell. The median out-of-pocket expenditure on medicines for those enrolled and with RSBY card at the time of hospitalisation was higher than non-enrollees. This was due to the unusual nature of empanelled health facilities such as charitable hospitals, which provided highly subsidised services to the poor who had no social security cover. However, this phenomenon would merit further analysis.

Mizoram does not have a cashless and paperless system due to poor internet connectivity and lack of continuous electricity supply. It goes to the credit of the state that they developed a modified system to ensure that the benefits under RSBY still reached those who were eligible. Undoubtedly, a fully functional cashless and paperless scheme would be more efficient and convenient, and the state government is working towards this.

In Nagaland, despite an overwhelming majority of the enrollees using their RSBY smart cards at the time of hospitalisation, a substantial amount of charges were paid in cash. The main reason was that the empanelled hospitals were charging more than the defined package rates under RSBY. The amount in line with the package rates was deducted from the RSBY smart cards of the patients while the remaining was settled through out-of-pocket payments. This aspect needs to be looked into further.

Even though there are many gaps to be closed with regard to implementation processes of RSBY in the North East, beneficiaries do express satisfaction as there is some relief from the financial burden of seeking treatment. This explains their willingness to continue enrolling in RSBY in the future. To address these gaps, some recommendations based on the findings of this evaluation are presented in the following chapter.

RECOMMENDATIONS

The overall aim of the recommendations is to improve the implementation of India's national health insurance scheme RSBY through measures to increase the conversion ratio, strengthen the quality and level of awareness amongst beneficiaries, and widen the network of empanelled hospitals.

a. Strengthen awareness

- Comprehensive communication strategy – There is need to develop a comprehensive communication strategy by focusing on a mix of mass and mid media. As the North Eastern region is characterised by strong community bonds, inter-personal communication also needs to be built into the communication strategy.
- Reach out through multiple channels: Grassroots level functionaries such as Accredited Social Health Activists (ASHAs), Anganwadi workers (AWWs), Auxiliary Nurse Midwives (ANMs), as well as local civil society organisations and village councils need to be engaged for awareness-building activities, as they already have a high level of interaction and rapport with the communities.
- Explain processes thoroughly: For beneficiaries to be



able to utilise the benefits of the scheme fully, it is essential that the entire process is explained in detail to them. This includes emphasizing the need to carry the card at the time of hospitalisation, so that they are not denied services when they need and what they have a right to.

b. Strengthen grievance redressal mechanism:

Beneficiaries need to be informed on grievance redressal mechanisms to ensure effective delivery as well as transparency in implementation of RSBY.

c. Increase density of enrolment centres:

There is need to increase the number of enrolment centres in inaccessible areas and villages widely scattered across rough terrains, so that they are within easy reach.

d. Make selection criteria for insurance providers more practical:

As critical components of the implementation process such as enrolment, issuing cards, awareness building and claims settlement rests with insurance companies, their selection should be based on technical evaluation of bids and not just on the lowest financial offer. This will ensure that the insurance companies and third party administrators (TPAs) have adequate technical capabilities to implement the processes as per guidelines laid down under RSBY.

e. Expand network of health services:

To make the health insurance scheme meaningful in terms of choice and ease of access, it is essential that more health facilities closer to the villages are empanelled.

f. Make it fully cashless and paperless: It is essential that the implementing agencies ensure empanelled hospitals adhere to the prescribed cashless and paperless system, so that beneficiaries can utilise the scheme effortlessly.

g. Minimize points of out-of-pocket expenditure: All empanelled hospitals need to maintain adequate stocks of medicines and have facilities for all essential diagnostic tests, as these are covered under RSBY. In case they are not available in the empanelled hospitals, there should be a tie-up with pharmacies and/or diagnostic centres. In the event that beneficiaries have to pay for these services, sincere efforts need to be made to ensure that they are reimbursed fully to avoid any out-of-pocket expenses.

h. Implement the scheme in toto: RSBY has been designed keeping in mind the special challenges of those who are poor, non-literate and not covered by any social security. Therefore it can fully benefit the target groups only if all elements are in place. In this context, providing transportation costs to all hospitalised RSBY enrollees and proper explanation of the nature of post-hospitalisation cover and compliance by hospitals are keys to leveraging the scheme fully.



i. Engage closely with stakeholders: The RSBY scheme is built upon the interrelation of multiple stakeholders. To ensure that the systems work correctly, there should be constant dialogue between insurance companies or TPAs and the State Nodal Agencies, and close monitoring of the way in which the scheme is being implemented on the ground.

In conclusion, RSBY is undoubtedly beneficial for the poor and can contribute to reducing indebtedness and poverty; yet, it is a long journey before we reach that goal. However, it is not recommended to look at RSBY, which is one of the world's largest health insurance schemes, through a "one shoe fits all" lens. It is imperative to understand the local challenges and devise innovative solutions to ensure that the two main objectives of RSBY are met, i.e. access to health care services and reduced out-of-pocket expenditure on hospitalisation.

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