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Systematic Review of research studies analysing Rashtriya Swasthya Bima Yojana in India

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ABSTRACT

Rashtriya Swasthiya Bima Yojana is a health insurance scheme for the poor in India. The scheme rolled out on the 1st of April 2008, it covers the hospitalization expenditure of the poor people. According to the United Nations and International Labour Organization the scheme is one of the best 18 insurance schemes of the world. This article reviews the progress of the scheme, gender analysis, outpatient initiative by the scheme, new initiatives by the scheme, various issues in the implementation and suitable recommendations in the light of the study findings.

Introduction

Improving health is vital to human welfare and indispensable to sustained social and economic development (WHO, 2000). This was recognized by the Alma-Ata Declaration in 1978, which noted that "Health for All" would contribute both to a better quality of life and also to global peace and security (WHO, 1978). In 2005, the World Health Assembly unanimously adopted a resolution urging countries to develop their health financing systems to achieve universal coverage, which was also called universal health coverage (WHO, 2005).(1)

Countries have progressed along different paths towards universal coverage through Social Health Insurance (SHI). Germany was the first nation to introduce SHI in 1883.

India's health insurance program goes back to the late 1940s and early 1950s when the Employees' State Insurance Scheme (ESIS) and Central Government Health Scheme (CGHS) were enrolled into a contributory but heavily subsidised health insurance programs. However, these schemes, were confined to only a small segment of the society. In addition to ESIS and CGHS, few experiments in India relate to the Community Based Health Insurance (CBHI) models with respect to the poor communities. The experiments are led by various community-based organisations (SEWA, Karuna Trust, etc.), although their reach, scalability and ability to keep going appear limited at present. To a great extent these schemes provide primary and secondary care to its target population, with contribution from the local hamlet and in some cases with supplementary financial support from external resources.(2)

Health is a highly unregulated market in India which has led to an unfettered proliferation of the private sector (about 77 percent of the total health care providers in India).The Indian public health care system suffers from insufficient funds, poor infrastructure, lack of eminent care and poor accessibility for large sections of the rural population. These factors force a number of low income households to visit private providers and relatively more expensive health care which result in significant out-of-pocket expenditure. To reduce out-of-pocket expenditure for health care and lessen a considerable financial burden on the poor, many initiatives have been taken up. The central government launched schemes like Jan Arogya Bima in 1996 and Universal Health Insurance scheme (UHIS) in 2003. State governments like Punjab launched the Sanjeevani scheme in 2005. A few Community Based Health Insurance Schemes were introduced by the Non- Governmental Organizations (NGOs). However most of these schemes have been dissolved due to pitiable policy design, lucid accountability at the state level, lack of sustainable efforts in functioning, frail monitoring and evaluation. Learning from experience of other major government and non government health insurance scheme for the poor in India, the government of India decided to launch a new scheme called **Rashtriya Swasthiya Bima Yojana** (RSBY).

The Hon'ble Prime Minister of India announced RSBY on the 15th of August 2007. The scheme rolled out on the 1st of April 2008. According to the UN and ILO, the scheme is one of the best models of the world and is one of the best 18 insurance schemes of the world. Many countries like Bangladesh, Vietnam, Nepal, Pakistan, Maldives, Ghana, Nigeria and Indonesia have shown interest in the scheme

With the current spurt in diseases in India and increase expenses along with the trend of insurance and security, it is clearly of great interest to evaluate the scheme. Large amount of money has been spent on the scheme and huge number of participation in the scheme it would be great interest to know the success of the scheme in these five years.

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Aim

To do a systematic review of research studies analysing Rashtriya Swasthya Bima Yojana in India

Objectives of the study

1)To review the progress of scheme in terms of coverage of target population and utilization of health services by the beneficiaries.

2)To identify the various issues being faced by the stake holders with the implementation of the scheme.

3)To make recommendations in light of the study findings.

Rationale of the Study

RSBY has witnessed unprecedented growth since its launch over the last five years. The scheme is emerging as one of the largest public health insurance programs not only in India but worldwide. Evaluation studies on RSBY have been undertaken in a few states which clearly reveal many shortcomings and issues in implementation at the field level. There exists lack of clarity about the implementation, particularly about coverage of eligible population, utilisation of health services under the scheme, huge variation in claim ratio, lack of data on renewal rate, empanelment of service providers, reimbursement related issues and premium fixation etc. The present study is therefore an attempt to review and compile all relevant information about the implementation of the scheme in various states in order to understand the present issues being faced by the scheme and to suggest suitable recommendations for the sustainability of the scheme.

Methodology

Study Design: Descriptive study which is qualitative and quantitative in nature.

Study Area: All India

Reference Period: The data is collected from literature available for the various states including survey reports, Data available from portal of RSBY, records from the Ministry of Health, Family Welfare and Ministry of Labour & Employment and various Evaluation studies conducted by different organizations. For guidance various journals, published papers and reports were also studied from May 2013 to July 2013.

Data Collection Tool: Secondary data was collected, compiled and presented as per predesigned Tables

Challenges during the study:

1)Lack of availability of previous years data

2)Lack of studies/evaluation in many states

3)Funding by the central is available but how much funding is given to each state and expenditure incurred by each state is not available

Scope of the study

The study covered only the following major areas

1)Coverage of target population-number of families and number of beneficiaries

2)Modifications in the scheme made by various states

3)Issues related to implementation of RSBY in various states

Rashtriya swasthya Bima Yojana

RSBY rolled out in April 2008. The aim of the scheme is to "improve access of below the poverty line (BPL) families to quality medical care for treatment of diseases involving hospitalisation and surgery through an identified network of healthcare provider

The main objective of the scheme was to give health insurance plan for the people who are poor and cannot afford the basic hospital expense and the people who are working in the unorganized sector. As on 30th May 2013, the scheme covered nearly 34.47 million BPL families (RSBY website). An estimated 172.3 million persons are a part of "BPL-families-with-an-RSBY-card. It has a national network of 12455 private and public empanelled hospitals. The scheme has been implemented across 28 States and Union Territories. As on 30th May 2013 around 5.21 million hospitalization cases from BPL families have benefitted since the inception of the scheme in 2008. A total of 15 Insurance Companies are present in around 487 districts across India.

Parameter	Description	Additional Comments
Benefits covered	Cost of hospitalization for 725+ procedures at empanelled hospitals up to Rs 30000 per annum per household plus Rs 100 transport cost per visit up to maximum of Rs1000	Pre-existing conditions are covered, minimal exclusions and day surgery covered.
Eligibility criteria	Must be on the official state BPL list; limited to five members of the household including household head, spouse and three dependents	All enrolled members must be present to be enrolled, infants are covered through mother
Premium and fees	30 rupee registration fee per household per annum paid by household; Per household premium payment determined through competitive bidding process	Average premium for active districts is around Rs 560.Maximum that can be given is Rs 750
Policy period	One year from the beginning of the month after first enrolment in a particular district	Enrolment can take place over four months
Financing	75%:25% Government of India/State government respectively	The ratio is 90%:10% in north east and J& K respectively

The annual premium per family ranges from Rs. 270 to Rs. 745. A total of 5,287,208 families were covered by the scheme till May 2013.(4)

Background of the study

Since inception of RSBY a number of evaluation studies have been conducted in various states. Most of the studies looked into various aspects like enrolment process, awareness of target population, experience in empanelled hospitals, hospitalization process and the degree of satisfaction by the beneficiaries. These studies have shown that there has been consistent increase in enrolment of target families and utilisation of hospital services under the scheme. These studies have also highlighted a number of issues being faced by the scheme in various states. In this section an effort has been made to review all the existing evaluation studies conducted in various states.

RSBY-CHIS(2009) conducted a study in Kerala. The objective of the study was to access the quality of hospitals in RSBY network and post utilization survey of RSBY patient experience at empanelled hospitals. There was a great variations among the hospitals empanelled from less than 10 bedded to more than 150 bedded hospitals were present. The study also showed that there was a lack of blood banks in the hospital empanelled. The reason cited by almost 60% hospitals that joined the scheme was that joining the scheme will lead to increase in good will but it was also seen by the study that the government hospitals were enforced to join the chain of RSBY empanelled hospitals. The medical expenditure incurred at the time of RSBY hospitalization varied between Rs.700/- to Rs. 7500/-. The inpatient experience showed that most were not aware about the cost incurred during the treatment and were also ignorant about the money left in their smart card. The patients had to spend Rs 200 to even up to Rs 5000 for their tests.

Amicus Advisory(2010) conducted a study in Jaunpur district of Uttar Pradesh. The objective of the scheme was to study the various aspects of the RSBY scheme in the district in order to understand the workability of the scheme, utilization and awareness levels. The study showed that only 51% of the target population was enrolled. This was attributable to the lack of awareness among the people and also because of the issues in the BPL list. Another point highlighted in the study was that the list having the synopsis of the scheme was absent. . Out of total beneficiaries $4/5^{th}$ of the beneficiaries had utilized the services and those who had not utilized reported that they did not have an empanelled hospital nearby. Another issue that was seen in this study was that the transportation cost was also not given to most of the people. But overall there was a level of satisfaction among the patients who used the services but still there is a need for measuring the effectiveness of RSBY scheme in the state.

Amicus Advisory(2010) conducted a study in Kangra and Shimla district of Himachal Pradesh. The main objective was to see the impact of RSBY scheme in the two districts. Among those who were studied 51% were only aware of RSBY scheme. The study also showed that most of the people were who were enrolled were not aware about the amount present in the RSBY card. Most of the people got information about the scheme from the local Panchayat, friends and families. More than 90% of the enrolled families utilized RSBY card. The card holders who utilized the services complained that they were not informed about the cost of treatment but the good part was that most of the hospitalized were provided free food and even some tests were done by the hospital which inculcated an overall level of satisfaction among the beneficiaries and most of beneficiaries would like to enrol again for this scheme.

AHPSR and WHO (2011) conducted a study in Patan district of Gujarat. The main objective of the study was to see the enrolment rate, access to quality hospital care, financial protection and to understand the issues in relation to the governance, utilization and monitoring of the scheme. The study showed that almost 94% had been enrolled in RSBY but overall only 51% of the Gujarat state was enrolled in the scheme .Out of those who got enrolled most got their card on time, maximum people enrolled had even visited the hospital .Those who did not visit the empanelled hospital stated that the reason for their not visiting the hospital was that there was no empanelled hospital nearby. In the study it was also seen that there was a lack of awareness among the people who had not joined the scheme and also those people who wanted to join, could not because of absence of their names in the BPL list. The study also showed that there is high OOP to the beneficiaries. Main reason behind this was OPD related expenses but as a whole most of those who utilized the services were satisfied.

Motts Mac Donald(2011) conducted a study in Kutch and Jamnagar in Gujarat. The main objective was the study of implementation of a post enrolment survey in the selected district. The study showed that more than 70% were aware of RSBY scheme but only 59% had obtained the health card. The source of information for maximum was Panchayat, friends and health staff showing lack of IEC. The study also showed that 30% of the people were only aware about the transportation allowance and 90% did not know that during hospitalization medicines are a part of this scheme. In the study it was also seen that almost 50% of the enrolees did not receive the card on the spot. Those beneficiaries who obtained the health card were satisfied with the scheme.

Motts Mac Donald(2011) conducted a study in Haryana. The main objective of the study was to undertake the implementation of post enrolment survey in the Faridabad and Yamuna Nagar districts of Haryana. The study showed that the out of the cross section of people that were taken in the study more than 50% were aware of the scheme and 38% had obtained the health card. The BPL families that did not have RSBY card were not found to be aware of the scheme. The main source of information obtained for the scheme was from friends & Panchayat. Although the enrolees were aware about the cost of scheme and about its benefits but hardly 14% knew about transportation allowance. Overall more than 70% were satisfied with the scheme and more than 50% would like to enrol in the next year policy.

In Delhi a study was conducted in all the eight districts by Nair et al (2011).The main objective of the study was to carry out rapid appraisal of RSBY in Delhi in respect to the process of implementation, procedural constraints and perception of major stake holders about the scheme. In the study it was seen that most of the people got information about the scheme from NGO, surveys and from friends. Study showed that BPL data was poor, inaccurate and outdated so those people who wanted to join the same could not be enrolled. The package rates that were set under the scheme were not feasible. Awareness about the scheme was also an area of concern .The study clearly revealed that only 4%-5% of the target families are fully aware about the service and benefits of the scheme. . In spite of all these issues overall there was level of satisfaction among the people and were desirous to enrol in the scheme again.

GIZ(2012) conducted a study in Bihar, Uttarakhand and Karnataka. The objective of the study was to understand the process of implementation of RSBY in select districts of the three states. High level of awareness was seen, word of mouth and inter personal communication was seen as the main source of awareness. .It was also seen in the study that detailed information about the scheme was lacking, no pamphlets or documents were given along with the smart card. Although Rs 30000 was seen to be sufficient for the enrolees but provision of information on treatment cost was also lacking along with the fact that transportation cost was also not paid to most of the enrolees. Operational issues such as data matching, strengthening of communication activities and capacity building need to be focused upon but still it was seen that an overall satisfaction was seen among the beneficiaries.

CTRD (2012) conducted a study in Chhattisgarh. The objective was to undertake post enrolment survey to check the process of enrolment, utilization pattern and measuring impact of the RSBY. It was seen that the maximum information which people got was from the village Panchayat, friends and family. Large number of pregnant women were attracted towards RSBY because of the maternal benefit coverage. The proportion of home deliveries have reduced by 35% and the institutional deliveries have gone up by 36%.There were large chunk of people from sarguja district (70%) who believed that RSBY scheme was of no use to them. . There was also a large section of people who did not have any idea about the instructions given along with RSBY card. An important analysis was seen in Chhattisgarh which was that, a large number of people came in OPD, out of that only $1/5^{th}$ became IPD. It was also seen that there were 30% people who were not been given transport allowance but in spite these issues over all it was seen that there was a level of satisfaction in the state.

Findings

The scheme is currently enrolled in 28 States and union territories. There are 487 districts that come under the RSBY

scheme and there are 15 insurance Companies working in the scheme.

Coverage of the Scheme (data as on 31st May on RSBY website)

In Andhra Pradesh data is only available for district Rangareddy where the policy is for a period of 1 year, at a premium of Rs.410. The total target population is 2759 out of which only were enrolled 2155. A total of 3 private and 14 public hospitals are empanelled.

No data is available for Dadar Nagar Haveli, Sikkim, Andaman and Nicobar Islands & Lakshwadeep. In J& K, data is only available for Jammu and Srinagar. In Madhya Pradesh data is available for only Bhopal and Datia. In Rajasthan RSBY has not been implemented for BPL population but it has only been implemented& dovetailed with NREGA .In West Bengal Kolkata has still not implemented the scheme, rest all the districts have implemented it.

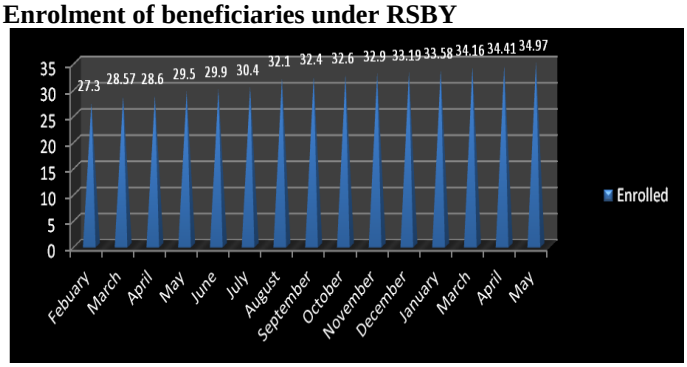
With the aim of universal coverage, the government across various states have extended the benefits of RSBY by combining it with various other schemes.

The various states that have quantified the scheme in order to increase enrolment as well its utility include the following.

Enrolment Status

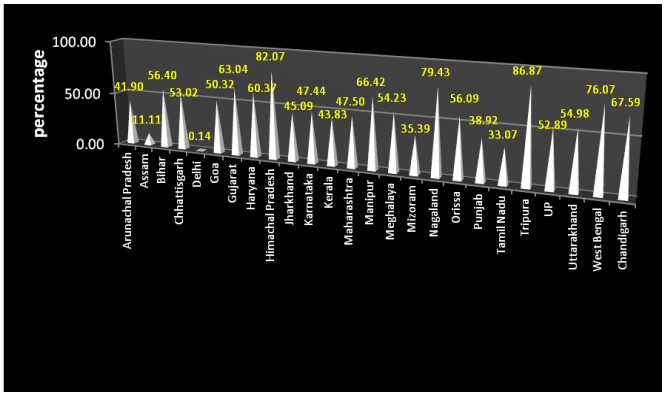
The impact of RSBY has been very significant. It can be seen that it has made remarkable improvement and the people have benefitted immensely from the scheme, and are actively participating in the scheme, which in turn motivates others to join the scheme as well. There has been tremendous progress in the country and a lot of people have benefitted from the scheme, The enrolment rate has increased manifold .

Enrolment of beneficiaries under RSBY



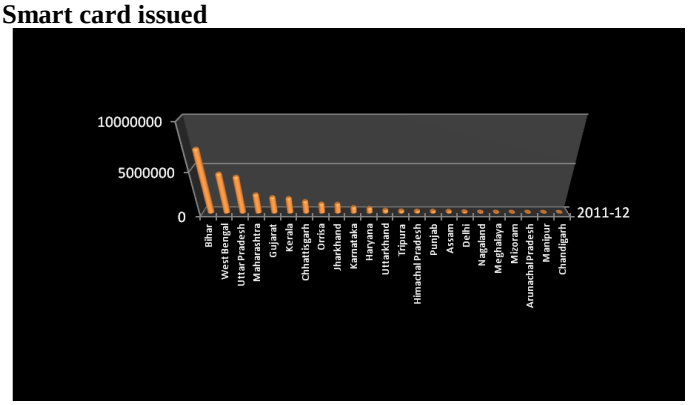
We can see from the graph that there is continuous increase in the enrolment on all India basis. The enrolment from February 2012 to May 2013 has gone from 27.3crores to 34.97crore which shows the popularity of the scheme. Most of the districts just belonged to four states that is UP, Maharashtra, Punjab and Haryana and together with Chhattisgarh, Gujarat, Bihar and Kerala make 85% of the enrolled population.

Conversion Ratio



Conversion Ratio is the ratio of families getting enrolled in relation to the target population. In this graph it can be seen that, Tripura and Himachal Pradesh have the highest conversion ratio. States of Delhi and Assam have the lowest conversion ratio

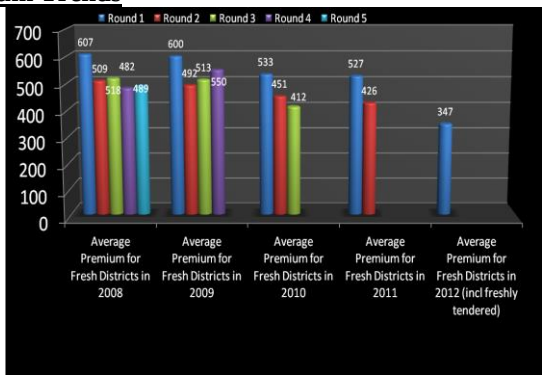
Smart card issued



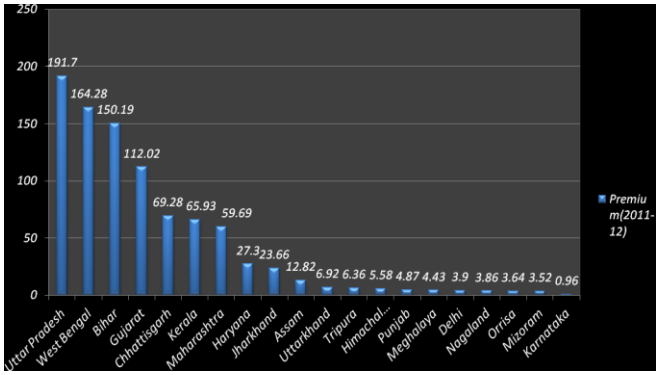
This graph depicts the total number of smart card that have been issued in various states during 2011-12. Bihar state has the maximum number of people that have smart cards. Then comes Uttar

Pradesh, followed by West Bengal.

Premium Trends



Premium given by States in year 2011-12(in crore)

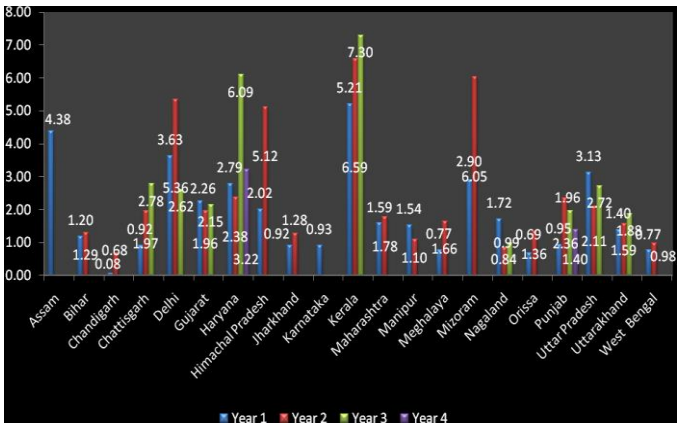


Premium trends mean the amount of premium that the government is giving for each household. The first graph shows that the premium trend from the first year of inception to the fifth round. It can be seen from the graph that there is a continuous decline in the premium from the first round till the fifth round.

The second graph shows the premiums given by the states in the year 2011-12. In this graph it can be seen that Uttar Pradesh has the highest premium of Rs 191.7crore and the lowest premium is of Karnataka Rs 0.96crore.

The state of Bihar has the highest target population as seen in earlier graph but it has a lower premium as compared to U.P and West Bengal.

Hospitalization Ratio



Hospitalization ratio is the number of people who have been hospitalized in comparison to those who have been enrolled .

In this graph we can see that in the state of Kerala and Mizoram the number of hospitalized is more. On the other hand in the state of West Bengal, Bihar and Karnataka the number of hospitalized are less.

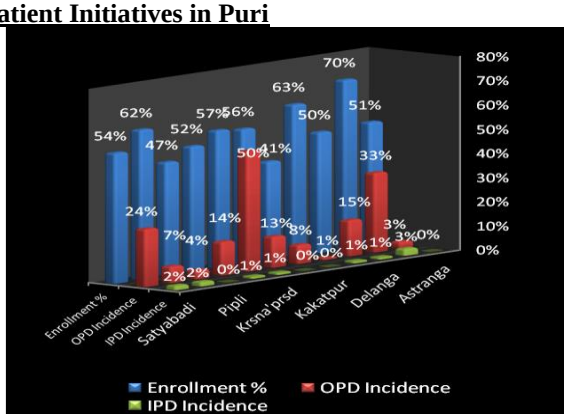
Outpatient initiative

Outpatient care accounts for 50-70% of total health expenditure.The Outpatient health care expenses financed by health insurance mechanism are very rare and they are most problematical to be covered due to moral hazard issues.A good model of Outpatient care will help in dropping unnecessary hospitalization**,**improving health outcomes and bringing down overall out of pocket health expenditure. Outpatient expenditures though small in amount are more frequent and needed by almost all the families.

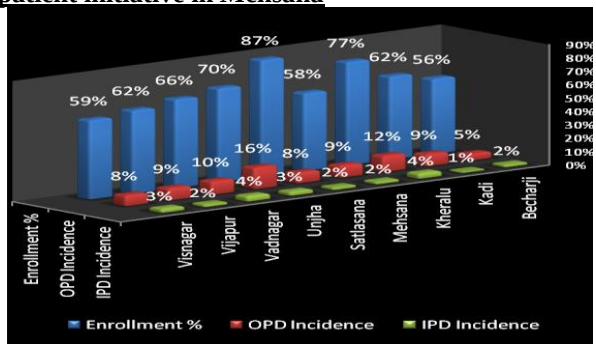
.The government conducted a pilot study in Puri district of Odisha and Mehsana District of Gujarat.The study showed that the number of people who enrolled were more as compared to previous round, Under the pilot more than 83,000 beneficiaries in Puri and around 45,000 in Mehsana have utilised RSBY outpatient services, till February 2013.

Result of the study showed the following –

Outpatient Initiatives in Puri



Outpatient initiative in Mehsana



Graphs clearly show that with the implementation of outpatient initiative in Puri and Mehsana districts the trend in inpatient has declined tremendously and demand for OPD is immense.

There were challenges while doing this pilot study which include awareness, shortage of medicines, software difficulties and capacity building. Overall the pilot study was successful and it has indeed given encouragement to other states like Punjab, Mizoram ,Andhra Pradesh to carry out similar studies.

This will indeed add a new dimension to RSBY growth and reduce the OOP expenditure.(5)

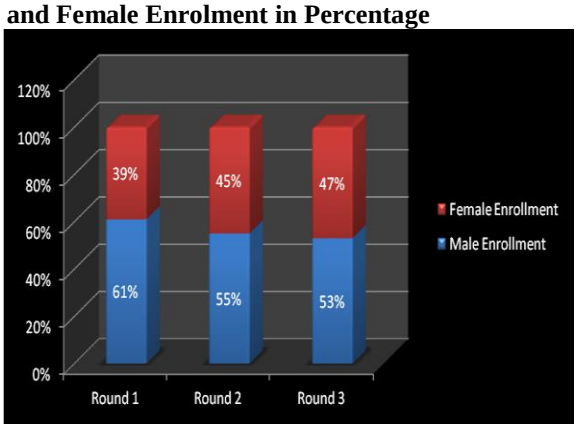
Gender Analysis

Women and men face different health needs and risks. Some of them are explained by biological differences (sex), others resulting from socially constructed norms and expectations.

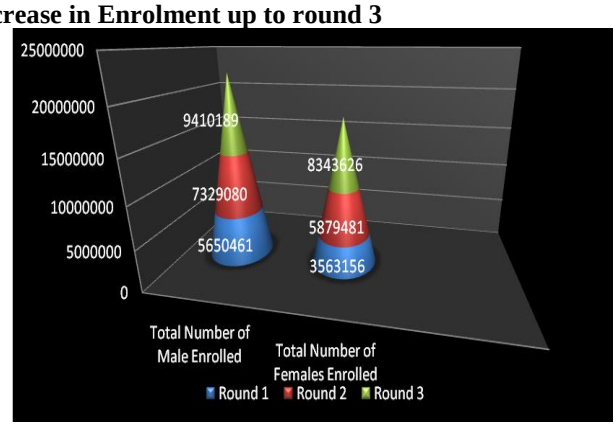
There is evidence that women, although having a higher life expectancy than men around the world, bear a greater burden of disease and spend more years living with a disability. Due to the unequal access to resources, capabilities and rights, women face greater barriers in seeking health care. Social health protection can play a key role in reducing these health inequalities and improving health care access for women.

RSBY has made a rule that the spouse of head of the family has to be enrolled. This entails lot of women to get involved in the scheme as well as lucrative benefits the scheme gives to the women gives an edge in comparison to other schemes.(4)

Male and Female Enrolment in Percentage



Increase in Enrolment up to round 3



We can see from the graphs that there is a gradual increase in the enrolment of women all over India.. In the first round enrolment was less whereas in the third round the enrolment of women is almost in sync with that of the men, so although slow but subsequent progress is present.

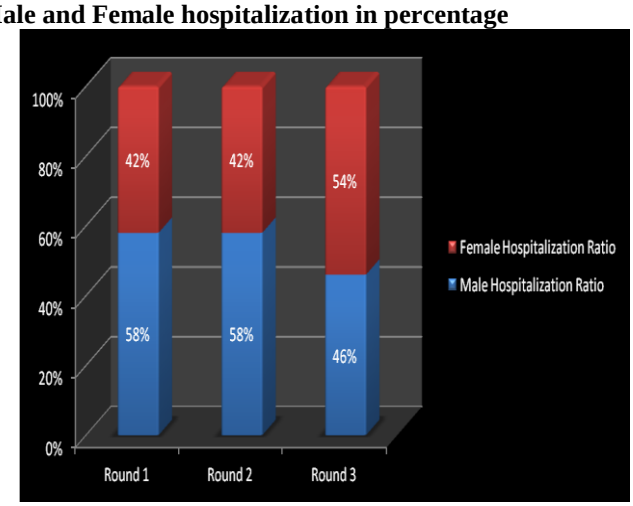
The ultimate objective of the scheme is to provide cover for hospitalization. The key in determining the success or failure of the scheme will be the ability of the scheme to provide improved access to hospitalization.

Serial No	State	Districts	Year of Policy	Premium	Total target families Enrolled	Empanelled hospital Public	Private
1.	Arunachal Pradesh	14 , Data For 10	0-1	674-744	90312	39615	0	11
2.	Assam	11, Data For 6	1-2	309	630093	189223	24	68
3.	Bihar	19	2-3	298-721	13644464	7344500	1011	118
4.	Chandigarh	-	2	545.90	9668	4913	8	3
5.	Chhattisgarh	25	3-4	314-437.89	3004055	1844231	367	501
6.	Delhi	-	4	491	987824	95597	35	-
7.	Goa	-	1					
8.	Gujarat	25	2-4	342-640	3950111	1671970	1205	537
9.	Haryana	21	3-5	342-640	1276994	458393	700	65
10.	Himachal Pradesh	12	3-4	398	541441	352305	41	179
11.	J & K	14,Data For 2	1	348	66005	35521	5	15
12.	Jharkhand	24	2-4	279-450	3334364	1419807	395	453
13.	Karnataka	30	1-2	360-403	4076642	1680913	546	328
14.	Kerala	14	5	738	2833282	1636221	200	156
15.	Madhya Pradesh	43,Data For 2	0-1	309	293937	116154	69	38
16.	Maharashtra	31	1-3	401-650.77	4373493	1907915	1200	15
17.	Manipur	5	1-3	597.32	111262	62664	4	-
18.	Meghalaya	11	1-4	288	486696	95788	12	189
19..	Mizoram	8	2-3	550-745	221814	103545	15	82
20.	Nagaland	11	1-4	487-608	348895	141844	11	1
21.	Odisha	30	1-2	311-370	5221931	3392551	160	466
22.	Pondicherry	-	1	400	15142	9486	4	0
23.	Punjab	22	3-5	394-545.90	453936	212371	403	240
24.	Rajasthan	11, Data For 7	1	301	1075380	732778	84	104
25.	Tripura	7	2	479	786913	506341	1	40
26.	Uttar Pradesh	75	3-4	329-634.22	11074061	4987685	895	682
27.	Uttarakhand	13	1-4	335-441.20	747050	325986	97	109
28.	West Bengal	19, Data For 18	2-4	380-459.65	9105854	5353752	601	36

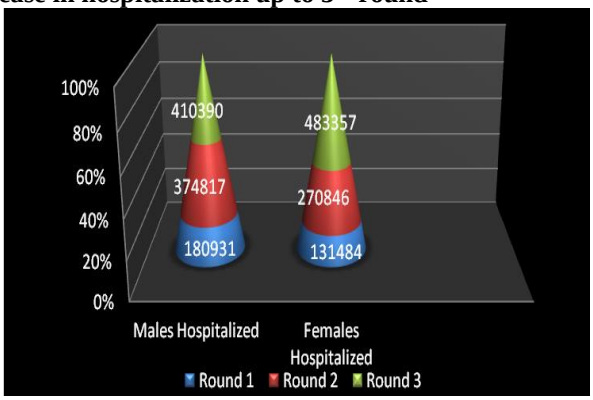
State	Scheme
Chhattisgarh	It includes Public Distribution System, Janani Shishu Suraksha Yojana, Jeevan deep Samiti Fund, Sanjeevani Express and the Red Crooss Fund.
Kerala	RSBY-CHIS(community health insurance scheme), it gives treatment benefits up to Rs 70,000.This scheme extends to all part of the society. The contribution include- Rs 30/- for absolute poor Rs 100/- for poor category Entire amount is paid by Above Poverty line
Himachal Pradesh	Has a critical care package that extends over and above Rs 30,000 to Rs 1,70000
Meghalaya	There is a Megha health Insurance scheme along with RSBY,Rs 30,000 for cancer and Rs 70,000 for critical care above Rs 30,000 of RSBY.

ISSUES	RECOMMENDATIONS
Lack of awareness about benefits under RSBY.	1) Educate enrolled households on the benefits of the scheme and how to obtain the same. 2) A state wise IEC plan should be drawn along with the insurer, so that a proper guideline can be set for the enrolment and awareness. 3) A detailed, local- flavored awareness campaign aimed at maximizing enrollments, making beneficiaries aware of benefits of RSBY and claims processes. A combination of radio & TV announcements , wall paintings , distribution of pamphlets in weekly bazaars and display of posters in all SCs / PHCs / CHCs 4) Involvement and incentives to the Panchayat.
Old BPL data	1) There are many agencies that are working on BPL. This sometimes leads to the fact that there is difference of information. Therefore one agency should be functioning and work on this aspect. This agency should update BPL data every year.
Enrolment process	1) Enrollment process should begin well in advance before the expiry of the old smart card so that there is no gap in utilizing the services or otherwise one year to be counted from date of issue of card. 2) Full name of the beneficiary is required on the card. 3) Enrollment schedule can be designed in such seasons when most of the members of the families are available in village. 4) More incentives should be given to the TPA for the enrolment process but proper monitoring should be done as well so that all the rules are properly abided 5) Relook by the government at five member family size.
Hospitalization difficulties to the beneficiaries	1) Support for diagnostics like CT scan, Sonography, even blood transfusion should also be included. 2) Organize seminar/classes for the hospital authorities about the various elements of the scheme and the roles they are expected to perform with respect to the scheme. 3) Rules for the empanelment should be stern, and a proper monitoring mechanism should be followed. 4) All empanelled hospitals should be advised to pay transport charges and provide food to the patients during their stay in the hospital. 5) RSBY help desk should be open in the night.
Difficulties faced by the hospitals	1)Upgradation of reimbursement rate of the hospitals. 2)Different criteria should be set for small, middle and big hospitals 3)Claim settlement process should be strictly adhered to by the scheme. Any rejection of the claim along with ground on which the claim is rejected and the possible solution should be intimidated to the empanelled hospital in stipulated time.. 4)Training in the area of computers and software upgradation. The problem of software corruption should be dealt seriously and should be considered in the interest of the empanelled hospital for smooth functioning. 5)It would be nice if a grievance cell is established in the hospitals 6)Online claim settlement of private hospitals
Difficulties faced by the insurer	1) Proper monitoring mechanism should be present to avoid fraud by the hospitals.
Capacity Building	· Capacity building is very necessary, RSBY does need a separate framework for working. Separate people should be hired specifically for RSBY from the central level to the village level

Male and Female hospitalization in percentage



Increase in hospitalization up to 3rd round



We can see from graph that in absolute numbers there has been a steady increase in the hospitalization of women. In the third round the hospitalization of women is much more than of the men.

This shows that RSBY has already made a difference in the

lives of many women and has improved their access to quality health care.

New Initiatives by RSBY

The **Poorest Areas Civil Society (PACS) Programme** is an initiative of the UK Government's Department for International Development (DFID) to partner with Indian Civil Society Organizations (CSOs) in assisting socially excluded people claim their rights and entitlements more effectively. PACS focuses on the flagship programmes of Government of India, Rashtriya Swasthya Bima Yojna being one of them.. PACS is strategically partnering with the State Nodal Agencies for ensuring effective community engagement in RSBY.

Aam Aadmi Bima Yojana extended to RSBY beneficiaries

The Ministry of Labour & Employment (MoLE) & the Ministry of Finance (MoF), (through Department of Financial Services) have joined hands to extend the Aam Admi Bima Yojana (AABY) to all categories of unorganized sector workers under RSBY, using the RSBY platform. The combination between RSBY and AABY will support and reinforce the implementation of the two schemes.

Further Extension of RSBY scheme

The RSBY scheme has been approved for extension to the sanitation workers , mine workers, auto rickshaw drivers , rickshaw pullers ,taxi drivers and rag pickers. The total number of unorganized workers approximately to be covered in these categories will be as under, Raj pickers-11.63lakh, Rickshaw drivers/pullers-13.68lakh, Sanitation workers-10.08lakh, Auto rickshaw drivers/ taxi drivers-35.59lakh and Mine workers-17.79lakh

Issues and Recommendations

Other suggestions

1)There should be a national unique identification number for BPL families, specifications of the minimal technical standards of the smart card, ensuring timely transfer of the central financing share of insurance premium, establishing a of common protocol for states as a part of the schemes.

2) Establishing a technical support cell within the ministry of labour and employment which would provide expert inputs to the central and state government on matters pertaining to the design, implementation and monitoring or evaluation of the scheme.

3) Setting up proper tracking mechanisms starting from the CHC to the insurance company to avoid fraud along with that a proper feedback of the patient using the services.

4) Public hospitals should be mandatory part of the RSBY to improve the reach of scheme.

5) Develop linkage with other insurance scheme like CGHS and ESIS

References

1. Public health foundation of India. A critical assessment of existing health insurance models in India. 2011 Jan 31. Available from planningcommission.nic.in/reports/sereport/ser/ser_heal1305.pdf
2. Rajasekhar D, Berg E, Ghatak M. Manjula R, Roy S. Implementing health insurance: The rollout of Rashtriya Swasthya Bima Yogna in Karnataka 2011 May 14; XLVI(20). Available from erlendberg.info/rsby_epw.pdf.
3. Rashtriya Swasthya Bima Yogna. (Cited on May 2013) Available from www.rsby.gov.in/
4. ICICI Lombard. Pilot project introducing outpatient health care on the RSBY card-A case study. Available from www.icicifoundation.org/.../OP_Report_Mar13_lowers_final_04-04-201.
5. Reddy KS, Selvaraja S. Critical assessment of the existing health insurance model in India. Public Health Foundation of India. Available from planningcomission.nic.in/reports/sereport/ser/ser_heal1305.pdf.
6. Swarup A, Jain N, RSBY- A case study from India, Ministry of Labour & employment, Government of India, New Delhi 2010. Available from www.rsby.gov.in
7. Westat India Social Sciences, RSBY Beneficiary Experience survey, 2010 Dec New Delhi. Available from www.westat.in/westat_india/.../RSBYAnalysisReport_13_December_201.
8. Comprehensive Health Insurance Agency of Kerala, RSBY-CHIS Evaluation Survey, 2009. Available from eprints.cscsarchive.org/354/1/RSBY_Kerala_experience.pdf.
9. Nandi S, Kanungo K, Khan H, Soibam H, Mishra T, Garg S. A study of Rashtriya Swasthya Bima Yogna In Chattisgarh, India. Biomed Central 2012 Jan 16;6(1). Available from http://www.biomedcentral.com/1753-6561/6/S1/05
10. Arora D. Towards alternative health financing: the experience of RSBY in Kerela RSBY working paper series 4 2010 Aug. Available from eprints.cscsarchive.org/354/1/RSBY_Kerala_experience.pdf.
11. Amicus Advisory Private Limited; Evaluation study of Rashtriya Swasthya Bima Yogna in Shimla & Kangra district in Himachal Pradesh. Available from www.amicusadvisory.com/pdf/RSBY-Himachal%20Pradesh.pdf
12. Alliance for Health policy & System Research & Indian Institute of Public Health; 2011 Study of Rashtriya Swasthya Bima Yojana: Health Insurance In India, Study Conducted in Gujarat India. Available from www.iphindia.org/v2/wp-content.../RSBY-report_2013_Jan_02.pdf
13. GIZ, 2012 Dec. Evaluation of Implementation Process of Rashtriya Swasthya BimaYojana in select districts of Bihar, Uttarkhand & Karnataka. Available from www.ilo.org/gimi/gess/RessourceDownload.action?ressource...5530
14. Council for Tribal & Rural Development, 2012 May. Evaluation of Rashtriya Swasthya BimaYojana scheme in Chhattisgarh. Available from rsbychhattisgarh.in/website/uploaddoc/70.pdf
15. Krisnaswamy K., Ruchismita R. Performance, Trends & Policy recommendations: An evaluation of the mass health insurance scheme of government of India. RSBY working paper. 2011 Sep. Available from www.slideshare.net/.../rashtriya-swasthya-bima-yogna-performance-tren.
16. Grover S and Palacios R. The First Two Years of RSBY in Delhi, RSBY Working Paper Series No.4, 2010. Available from eprints.cscsarchive.org/355/1/RSBY_Overview_Paper.pdf.
17. Palacios R. A New Approach to Providing Health Insurance to the Poor in India: The Early Experience of Rashtriya Swasthya Bima Yogna. World Bank, 2010 Oct. Available from eprints.cscsarchive.org/356/1/RSBY_Utilization_Paper.pdf.
18. Narayana D. Review of the Rashtriya Swasthya BimaYojana, EPW. XLV(29) 2010 July 17. Available from www.epw.in/authors/d-narayan
19. Dhanuraj D. Rashtriya Swasthya BimaYojana-Health Insurance for the poor: A brief Analysis with a focus State of Kerala. International Journal of Management. 2010 Aug-Sep; 1(2):208-21. Available from http://www.iaeme.com/MasterAdmin/UploadFolder/study%20on%20RSBY.pdf
20. Nandi A, Ashok A, Laxminarayan R. The socioeconomic and institutional determinants of participation in health scheme

for the poor. PLoS ONE. 2013 Jun 21; 8(6). Available from www.plosone.org/.../info%3Adoi%aF10.1371%2Fjournal.pone.0066296.
21. Nair KS, Nandan D, Piang LK, Tiwaru VK, Raj S, Goel T et al. Implementing Rashtriya Swasthiya Bima Yogna: Experience from Delhi. Journal of Health Management. 2013 Mar;15(1);127-40. Available from http://jhm.sagepub.com/content/15/1/127.abstract
22. Das J, Leino J. Evaluating the RSBY: Lessons from an experimental information campaign. Economic & Political weekly (Internet) 2011 Aug 6; XLVI Available from http://www.environmentportal.in/files/file/RSBY.pdf
23. Vellakkal S, Ebrahim S. Publicaly-Financed health insurance schemes, concern about impact assessment. Economuc & Political weekly (Internet). 2013 Jan 05; XLVIII. Available from http://www.epw.in/authors/sukumar-vellakkal
24. Rai S, Rai N. Rashtriya Swasthya Bima Yojana: Panacea for the poor (National Health Insurance Plan). Available from www.adbi.org/.../2010.12.11.cpp.sess3.c18.rai.paper.rsby.panacea.poor
25. Vasisht S, Pandit N. Experience of RSBY beneficiaries in a district of Western India- A Qualitative Study. IJEMR. 2012 July;2(7). Available from www.exclusivemba.com/ijemr/App_Theme1/Images/rsby.pdf
26. Amicus Advisory Pvt. Ltd. Rashtriya Swasthya Bima Yojana in Maharashtra, Statistical review round 1 &2. Available from www.amicusadvisory.com/pdf/RSBY-Maharashtra.pdf
27. Mor N. State Level Strategies for Health Insurance and Healthcare. Available from https://groups.google.com/d/topic/hsri-india/85cCnD5W_A
28. Sethivel S, Karan AK. Why publicly-Financed Health Insurance Scheme are ineffective in providing financial risk protection. Economuc & Political weekly (Internet). 2012 Mar 17; XLVII(11). Available from www.epw.in/.../why-publicly-financed-health-insurance-schemes-are-ine
29. Nandi S, Dasgupta R, Nundy M, Ganapathy M, Kanungo K. The emerging experience of RSBY in Chhattisgarh: What can the informal sector workers expect? Paper presented for MFC Annual Meet 2012. Available from. http://health.cg.gov.in/.../RSBY%20-%20State%20workshop%20oct%202008.pdf
30. Mott Mac Donald. Pilot post enrolment survey of RSBY programme in Gujarat. 2011 Mar. Available from eprints.cscsarchive.org/.../Mott_McDonald-_Post_Enrollment_Survey_R.
31. Mott Mac Donald. Pilot post enrolment survey of RSBY programme in Haryana. 2011 Mar. Available from www.scribd.com/.../Mott-McDonald-Post-Enrollment-survey-RSBY-Har...
32. Qifei Wu. What causes low enrolment rate and utilization of Rashtriya Swasthya Bima Yogna: Aqualitative study in two poor communities in India. Liverpool School of Tropical Medicine, 2012 Aug. Available from www.chsj.org/.../1/.../2/1/.../what_cause_the_low_enrolment_rate_and_u
33. Hou X, Palicios R. Hositalization pattern in RSBY: preliminary evidence from MIS. World Bank, RSBY working paper 6. 2012 Oct. Available from eprints.cscsarchive.org/356/1/RSBY_Utilization_Paper.pdf.
34. Basu R. Rashtriya Swasthya Bima Yojana: Pioneering Public-private Partenership in Healthcare. Available from www.napsipag.org/PDF/RUMKI%20BASU.pdf
35. Carrin G, James C. Social Health Insurance:Key factors affecting the transition towards universal coverage. WHO, International Social Security Review, 2005;58(1). Available from http://www.who.int/health_financing/documents/shi_key_factors.pdf
36. World Health Organization. Towards Universal Health Coverage: Concept, Lesson & Public Policy Challenges. 2013. Available from http://www.who.int/mediacentre/events/meetings/2013/uhc who worldbank feb2013 backgrounddocument.pdf