A Study on the Working of Rashtriya Swasthya Bima Yojana (RSBY)

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Abstract

Risk and uncertainty are incidental to life. These risk and uncertainties are increasing day by day due to increase in fastness in life. To provide against risk and insecurity of human life, insurance came into being. The main underlying principle of insurance is the pooling of risks. Health insurance is bought to cover medical costs for expensive treatments. It is a running fact that the premium on health insurance schemes is too expensive and unaffordable to an average human being. In this regard government responsibility to ensure the health security and health insurance to the financially unsecured becomes a crying need of the hour. To address the mentioned issue, Rashtriya Swasthya Bima Yojana (RSBY), a health insurance scheme for Below Poverty Line (BPL) families has been launched by the Ministry of Labour and Employment, Government of India. Literature shows that the benefit of the scheme is largely confined to rural India than urban. Further it raises the need to reach out to the poorest and the most vulnerable sections of the society, and make available affordable health care to them. Studies further reveals the fact that almost 50 percent of BPL households were found to be poor and only 30 percent of them were aware of RSBY. Lower awareness level and poor penetration are found to be the major hurdles. The beneficiaries of the scheme experience delays of several months to avail the smart cards; poor knowledge of how and where to utilize the scheme; hospitals not trained to use card-reading technology; and month-long delays and arbitrary caps in the reimbursement of treatment expenses to hospitals. Being this as the fact it would be meaningful to see the awareness of people of Kerala about the scheme, the rate of enrollment, the difficulties in enrollment and their real experience as the beneficiaries of the scheme.

Introduction

Wealth is an important constituent of human resource development. Good health is the real wealth of society. It not only increases human efficiency but also decreases private and public expenditure on sickness and diseases. Health has been declared as a fundamental human right. The present concern in both developed and developing countries is not only to reach the whole population with adequate healthcare services but also to secure an acceptable level of health for all through the application of primary healthcare programs. Healthcare services help to reduce infant mortality rate, check crud death rate, keep diseases under control and raise life expectancy. Health insurance is

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fast emerging as an important mechanism to finance health care needs of the people. The need for an insurance system that works on the basic principle of pooling of risks of unexpected costs of persons falling ill and needing hospitalization by charging premium from a wider population base of the same community.

Concept of Health Insurance

Health insurance is a method to finance healthcare. The International Labour Organisation (ILO) defines health insurance as "the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member". To put it more simply, in a health insurance programme, people who have the risk of a certain event contribute a small amount (premium) towards a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g. hospitalization). Today many countries are shifting to health insurance as a mechanism of financing their healthcare programme.

Most health insurance schemes can be classified into three broad categories, social health insurance, private health insurance and community (or micro) health insurance. In India, we have a fourth category called government-initiated health insurance schemes that do not fit into any of the above three categories. Each has its own specificities. However, there are some features that overlap among the three. The government usually introduces this type of schemes for the poorest and the most vulnerable sections of the community. In many of the schemes, the premium amount is paid by the people or totally subsidized by the government. Rarely, the community may be expected to pay a token amount. The insurance company or an independent body is the organizer of the scheme. These schemes last for a couple of years, depending on the political will and longevity of the government. These are seen more as populist welfare schemes rather than a long-lasting intervention.

Rashtriya Swasthya Bima Yojana (RSBY)

Rashtriya Swasthya Bima Yojana (RSBY), literally "National Health Insurance Program" is a government-run health insurance scheme for the Indian poor. It accommodates cashless protection for hospitalization out in the open and additionally private doctor's facilities. The scheme began enlisting on April 1, 2008 and has been executed in 25 states of India. A sum of 3.5 crore families have been enlisted in 2017-18 (PIB Delhi 2017). The RSBY is a venture having a place with the Ministry of Labor and Employment. Presently it has been exchanged to Ministry of Health and Family Welfare from April 1, 2015. The scheme has won acclamations from the World Bank, the UN and the ILO as noted RSBY is one of the world's best Health insurance schemes (rsby.gov.in). One of the big changes that this scheme entails is bringing investments to UN served areas. Most private investments in healthcare in India have focused on tertiary or specialized care in urban areas. For people living below poverty line, an illness not only represents a permanent threat to their income earning capacity, in many cases it could result in the family falling into a debt trap. When the need to get the treatment arises for poor families, they often ignore it because of lack of resources, fearing wage loss or they wait till the last moment when it is too late. Even if they do decide to get the desired healthcare, it consumes their savings forces them to sell their assets and property, or cut other important spending

like children's education. Alternatively, they have to take on huge debts. Ignoring the treatment may lead to unnecessary suffering and death while selling property or taking debts may end a family's hope of ever escaping poverty. These tragic outcomes can be avoided through a health insurance. Which shares the risk of a major health shock across many households by pooling them together. A well designed and implemented health insurance scheme may both increase access to health care and may even improve its quality over time.

Concept of RSBY

RSBY was propelled by the Ministry of Labour and Employment, Government of India to give Health Insurance coverage to BPL families. The goal of RSBY is to give assurance to BPL family units from monetary liabilities emerging out of health status including hospitalization. The beneficiary is any BPL family, whose information is included in the District BPL list prepared by the State Government. The eligible family needs to come to the enrollment station, and the identity of the head of the family needs to be verified and confirmed by the authorized official. RSBY provides cover for hospitalization expenses up to Rs.30,000 for a family of five members on a floater basis. Transportation charges are also covered up to a maximum of Rs.1,000 with Rs.100 per visit. Government pays premium on behalf of the beneficiary house holds for RSBY. Central Government pays 75 percentage of the total premium and the State the remaining 25 percentage. In Jammu and Kashmir and North Eastern States it is in the proportion 90 percentage and 10 percentage. Beneficiaries need to pay only Rs.30 per family at the time of enrolment in RSBY (rsby.gov.in).

Statement of Problem

In Kerala, most of the people work in unorganized sector and they find it difficult to meet their day to day living expenses. Most of them belong to lower-income groups. This Being the reality, spending additional sum for their medical expenses may increase their financial burden. RSBY is one of such health insurance schemes introduced by government to help poor families. It provides cashless insurance coverage to poor people who registered and keeping RSBY card provided by the authority. Majority of the studies come out with many apprehensions from entry level of the scheme to final settlement. Some of the major apprehensions were, lower awareness level of people about the scheme, non-addressing of urban poor, lower penetration, delay in issue of health cards, and delay in reimbursement to hospitals. Being this as the fact, the awareness of people about the scheme, enrolment formalities, difficulties encountered at different stages of the scheme, and the level of satisfaction of beneficiaries of this scheme in Kerala context is need to be addressed. Keeping this in view, the present paper examines, the working and effectiveness of RSBY scheme and also the satisfaction level of beneficiaries of this scheme.

Objectives of the Study

1. To examine the working of RSBY scheme
2. To evaluate the effectiveness of RSBY scheme from the beneficiary perspective

Methodology

Descriptive and analytical design have been used in the present paper. The population for the study comprising of the beneficiaries of the scheme in the state of Kerala. The sample for the study constitutes the beneficiaries of RSBY scheme in Mathur Grama Panchayat of Palakkad District in Kerala. The study uses

both the primary and secondary sources of data. A well-structured interview schedule has been administered to collect the primary data. The primary data have been collected from 100 beneficiaries of RSBY of Mathur Grama Panchayath by adopting simple random sampling method. The statistical tools such as ONE WAY ANOVA, TWO WAY ANOVA, MANN WHITNEY TEST, and INDEPENDENT SAMPLE t-TEST were used for testing hypotheses.

Result and Discussion

Enrollment Process

An electronic list of eligible BPL households is provided to the insurer using a pre-specified data format. Mobile enrolment stations are set up at local centers (e.g., public schools) at each village. These stations are equipped by the insurer with the hardware required to collect biometric information (fingerprints) and photographs of the members of the household covered and a printer to print smart cards with a photo. The smart card, along with an information pamphlet describing the scheme and the list of hospitals, is provided on the spot. The process normally takes less than ten minutes.

one-way ANOVA has been used to analyse the experience of beneficiaries at the different stages of enrollment process.

Table 1

Enrollment Experience and Level of Education

		Sum of Squares	Df	Mean Square	F	Sig.
Easy Enrollment Process	Between Groups	20.456	8	6.819	22.225	.000*
	Within Groups	11.044	91	.307		
	Total	31.500	99			
Adequate Info About Enrollment	Between Groups	13.322	8	4.441	13.021	.000*
	Within Groups	12.278	91	.341		
	Total	25.600	99			
Staff Co-Operation at Enrollment Time	Between Groups	7.722	8	2.574	5.098	.005*
	Within Groups	18.178	91	.505		
	Total	25.900	99			
Information about Document	Between Groups	15.722	8	5.241	12.854	.000*
	Within Groups	14.678	91	.408		
	Total	30.400	99			
Verification Process Time	Between Groups	2.089	8	.696	3.575	.023*
	Within Groups	7.011	91	.195		
	Total	9.100	99			

	Between Groups	6.800	8	2.267	11.493	.000*
Timely Issue of Smartcard	Within Groups	7.100	91	.197		
	Total	13.900	99			

Source: Primary data **Significant at 5 per cent*

The result of one-way ANOVA from the table 1, for the variables about enrollment process of the scheme based on the level of education level of sample shows that there is significant difference between the level of education of sample and enrollment experience such as easiness, availability of adequate information, staff cooperation, documents required, processing time and issue of smart card. In all the cases P value is less than 0.05, the results are significant at 5 percent. Hence the null hypothesis is rejected. It shows that higher the level of education higher the experience felt at the different stage of enrollment process.

Knowledge and Awareness Level

The level of awareness of people about the scheme has been collected and evaluated in terms of concept of the scheme, renewal amount, renewal process, hospitals enlisted, deceases covered, medical facilities available etc. The result of One-Way ANOVA is presented in table 2.

Table 2

Awareness Level and Level of Education

		Sum of Squares	df	MS	F	Sig.
	Between Groups	25.056	8	8.352	14.086	.000*
Easy Enrollment Process	Within Groups	21.344	91	.593		
	Total	46.400	99			
	Between Groups	4.889	8	1.630	2.374	.086
Adequate Info About Enrollment	Within Groups	24.711	91	.686		
	Total	29.600	99			
	Between Groups	3.422	8	1.141	7.233	.001*
Staff Co-Operation at Enrollment Time	Within Groups	5.678	91	.158		
	Total	9.100	99			
	Between Groups	1.556	8	.519	2.320	.092
Information about Document	Within Groups	8.044	91	.223		
	Total	.0019.600	99			
	Between Groups	12.300	8	4.100	15.375	.000*
Verification Process Time	Within Groups	9.600	91	.267		
	Total	21.900	99			

Utilization Of Benefit	Between Groups	6.300	8	2.100	6.517	.001*
	Within Groups	11.600	91	.322		
	Total	17.900	99			
Total Family Members Covered	Between Groups	5.089	8	1.696	2.713	.059
	Within Groups	22.511	91	.625		
	Total	27.600	99			
Other Medical Facilities	Between Groups	5.000	8	1.667	6.977	.056
	Within Groups	8.600	91	.239		
	Total	13.600	99			
Help Center Number	Between Groups	10.889	8	3.630	3.375	.029*
	Within Groups	38.711	91	1.075		
	Total	49.600	99			
Balance Information	Between Groups	11.289	8	3.763	12.192	.000*
	Within Groups	11.111	91	.309		
	Total	22.400	99			

Source: Primary data **Significance level at 5 per cent*

As shown in Table 2, the level of awareness and knowledge of the people about the scheme, in the light of their level of education, it is found that there is significant difference between the level of education and awareness level in terms of the concept of the scheme, information relating to the hospitals empaneled, renewal process, benefits available, help center number and balance information as P value is less than 0.05. At the same time, it failed to reject the null hypothesis in terms of renewal matters, diseases covered, number of family members covered and other medical benefits of the scheme. The class with highest mean value is regarded as the class with highest level of knowledge. Beneficiaries who completed under graduation has the highest mean value and beneficiaries where low educated poses lowest mean value in all variables.

Source of Information About the Scheme

The source of information to the sample about the scheme has been collected under the heads posters, word of mouth, NGO officials, doctors, health workers and public announcement. The same is ranked and presented in Table 3.

Table 3
Source of Information about the Scheme

	Posters	Word of Mouth	NGO Officials	Doctors	Health Workers	Public Announcement
Mann-Whitney U	116.000	170.000	98.000	142.000	146.000	162.000
Wilcoxon W	467.000	521.000	203.000	493.000	251.000	267.000
Z	-1.931	-.358	-2.466	-1.304	-1.064	-.609
Asymp. Sig. (2tailed)	.054	.721	.014*	.192	.287	.542
Exact Sig. [2*(1tailed Sig.)]	.063b	.747b	.017b	.266b	.318b	.585b

Source: Primary data **Significance level at 5 per cent*

As shown in Table 3, the most popular source of information about the scheme is word of mouth, next comes public announcement, the third one is through health workers and the least one is NGOs. As regards the level of education of sample and their preference on the source of information from NGOs, found a significant difference and otherwise in all the other cases there is no significant difference in the preference of information source based on the level of education of the sample.

Perception of Beneficiaries About RSBY Scheme

The perception of beneficiaries about the various aspects of RSBY scheme was collected in terms of risk coverage, reasonability of premium amount, time taken for enrollment, response from authorities, support etc. The same is analysed by using independent sample t test and is presented in Table 4

Table 4
Perception of Beneficiaries of RSBY Scheme Based on Gender

Gender		No. of respondents	Mean	Std. Deviation	F	Sig.
Risk Coverage	Male	65	2.69	.618	1.386	.246
	Female	35	3.43	.756		
Sense of Security	Male	65	2.54	.859	.840	.365
	Female	35	3.71	.726		
Time Taken for Registration	Male	65	3.77	.587	2.629	.113
	Female	35	3.57	.756		
Reasonability of Premium	Male	65	4.85	.543	9.434	.004*
	Female	35	4.14	.864		
Brochure Info	Male	65	3.31	.928	4.247	.046*
	Female	35	2.71	1.437		

Support in Difficulty	Male	65	3.15	.675	.049	.825
	Female	35	4.14	.663		
Reduce Pocket Expenses	Male	65	3.00	.800	.592	.446
	Female	35	3.86	.864		
Good Response to Queries	Male	65	2.92	.484	6.953	.012*
	Female	35	2.71	.726		

Source: Primary data **Significant level at 5 per cent*

Result of independent sample t test as shown in table 4, with respect to the perception of beneficiaries about RSBY scheme based on gender, shows that there is significant difference as regards reasonability of premium, information access, and response to enquiry at 5 per cent level of significance. While referring mean score of the said variables male respondents hold high perception about RSBY scheme as compared to female. In all the other cases no significant difference is found (P> 0.05), as the beneficiaries hold similar opinion.

Satisfaction Level of RSBY Benefeciaries

The level of satisfaction on enrollment and general working of the scheme has been analysed based on community, gender and income level of beneficiaries using Two Way ANOVA and the result is presented in Table 5

Table 5

Overall Satisfaction based on Community, Gender and Income

source	Dependent Variable	Type I Sum of Squares	Mean Square	F	Sig.
Community	Satisfaction on enrollment	525.749	175.250	1532.867	.000*
	Satisfaction on general working	338.094	112.698	709.479	.000*
Gender	Satisfaction on enrollment	.094	.094	.822	.371
	Satisfaction on general working	.048	.048	.305	.585
Monthly income	Satisfaction on enrollment	1.188	.594	5.197	.011*
		1.559	.780	4.908	.013*

Source: Primary data **Significant level at 5 per cent*

To test the mean variation of the scores for beneficiaries' satisfaction towards enrollment to the scheme based on community, gender and income category, Two-way ANOVA is used. It is found that mean score is found to be statistically significant in respect of respondents based on Community and income level as regards satisfaction on enrollment process. It is observed that the forward community (AM 3.46), and lowest income group (AM 3.21) are found to be satisfied on enrollment.

In the mean variation of the scores for beneficiaries' satisfaction towards general working of the scheme based on community, and average income, Two way ANOVA shows that mean score is found to be statistically significant at 5 per cent level of significance ($p<0.05$). There is significant difference in the mean score on satisfaction towards the working of RSBY scheme with respect to community, and average monthly income of beneficiaries. As such it can be inferred forward community (2.59), and the beneficiaries of lower income group (2. 55) are found to be high level of satisfaction on general working of the scheme.

Conclusion

Rashtriya Swasthya Bima Yojana (RSBY) is a right pill for poor people, Below the Poverty Line. Today's medical expenses are very high and is not affordable for low- and middle-income people. Free medical services increase the health status and standard of living of the people. This programme is a boom to the earning members in the family since it releases them from high medical expenses. Since the major share of medical expenditure met by RSBY scheme, the rural poor are left with more reasonable amount of disposable income for their daily needs. This definitely will improve their standard of living. The present paper focused on the overall working of the scheme and the satisfaction of the beneficiaries under this scheme. It is found that higher the level of education, higher the opinion about enrollment process. The awareness level about the scheme is also associated with the level of education. Information about the scheme is getting on passed by word of mouth even though many popular ways are available in the present day setting to make the people aware of. Regarding the perception of beneficiaries about the scheme, it is found that male holds high perception about the scheme than female. Similar is the case with overall satisfaction of the scheme, male is found to be more satisfied than the female. The need for popularizing the scheme among the less educated, poor common man who lives below poverty line becomes an urgent need. People are to be well informed and instructed about the scheme, enrollment process, documents required, hospitals empaneled, renewal of policy, diseases covered and so on. That will make the initiative more attractive, and all the deserved will be getting included as beneficiaries of the scheme. As any scheme it may also have many pitfalls but when the time progresses hopefully it will be get resolved and to make India healthy.

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