# CASE STUDY REPORT

**ON**

# "Social Exclusion and (RSBY) Rashtriya Swasthya Bima Yojana in Maharashtra"

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Date: 15th May 2013

**ACKNOWLEDGEMENTS**

This is a project report prepared under the consortium of London School of Economics and Political Sciences (LSE) in London, Institute of Tropical Medicine (ITM) in Antwerp, Tata Institute of Social Science (TISS) in Mumbai, Institute of Public Health (IPH) in Bangalore, the Centre for Research on Social Policies (CREPOS) in Senegal and the Institute of Statistical, Social and Economic Research (ISSER) in Ghana.

We take this opportunity to thank the consortium for this opportunity and look forward to mutual learning experiences. We also thank our consortium team members for their kind support, valuable suggestions and cooperation in conducting this study and preparing this report. We are also thankful to Prof. S Parasuraman, Director, TISS and Prof. CAK Yesudian, Dean, School of Health Systems Studies, TISS for their support to us throughout this period.

We would like to express gratitude towards research participants and the key stakeholder from 22 study sites in Maharashtra. The idea of understanding social health protection with the lens of social exclusion has been enriching one till now and we look forward for better policy option in the realm of universal health coverage by using the findings of this study. We extend our thanks to the support staff of TISS and state nodal agency that provided useful information from time to time. We thank our Research Officers, Research Assistants, Field Investigators and others who have been involved in one way or other in giving the final shape to this Report.

**FUNDING**

The research leading to these results has received funding from the European Commission's Seventh Framework Programme FP7/2007 under grant agreement No. 261440.

The views expressed in this document are the sole responsibility of the author and do not necessarily reflect the views of the European Commission.

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# CHAPTER 1

## INTRODUCTION

Out-of-pocket payments make up a large proportion of total health expenditure leading to inequity amongst the poorer sections. Recently government of India has instigated various demand side financing innovations which predominantly target the poorest of the poor. Some of the major innovative financing arrangements practiced are subsidies and health insurance for poor. The prepayment mode of health financing is present in the form of state sponsored targeted social health insurance or community based health insurance schemes. However limited coverage and target based approach often excludes various groups. These existing health protection mechanisms are reported to be poorly successful in mitigating inequities in health outcomes.

Acknowledging the health insecurity issue of the people working in the unorganized sector in India, Government of India (GoI) launched one of the world's largest social health protection initiatives called Rashtriya Swasthya Bima Yojana (RSBY) in 2008. Considering the geographical spread it can be considered as a National Health Scheme. Ministry of Labour and Employment has initiated the scheme in several states with involvement of similar departments in the state or department of health. In Maharashtra, like majority of the states 'Department of Labour' is being entrusted with the responsibility of administering RSBY. In a study carried out in districts that completed first year of enrolment in Maharashtra found that the proportion of poor families enrolled in the scheme was only 39%, way below the national average. Also, the proportion of poor families enrolled varies considerably across districts and the variation is more pronounced at the village level (Sun, 2011). Differential access to information, bureaucratic processes, complex eligibility rules and/or crude and stigmatizing criteria for means testing prevent socially excluded groups from enrolling in financing schemes which provide access to health care at an affordable price (e.g. community health insurance) or even free of charge (e.g. user charges exemptions). Leakage, on the other hand, may explain why more powerful and vocal groups are able to capture the benefits of targeted schemes that aim to cover the poor.

It was felt that after studying and evaluating the status of RSBY in Maharashtra, can we answer to following questions: What are the reasons for not achieving universal enrolment in places in which RSBY was introduced?; Is the enrolment pattern similar across social and religious groups?; What are the factors responsible for low utilization of RSBY scheme in the state?; Is the utilization rate same for males and females/all social groups?, etc.

The various research questions that underpin the social exclusionary processes and the overall performance of RSBY needed a multi methods approach to record success, failures and bottlenecks. Data was collected using both qualitative and quantitative techniques to address the research questions. Triangulation of the data was done to understand theoretical issues and make relevant recommendation for the policy.

# CHAPTER 2

# BACKGROUND

## 2.1 – Country/State context

Maharashtra is located in the western and central part of the country, with a coastline stretching nearly 720 kilometers along the Arabian Sea. It is the second largest state in India both in terms of population and geographical area spread over 308,000 sq km .With a population of 11, 23, 72,972, Maharashtra has almost 9% of the total population in India (Census, 2011). The state has 35 districts which are divided into six revenue divisions, Konkan, Pune, Nashik, Aurangabad, Amravati and Nagpur for administrative purposes. The state consists of 35 districts, 33 Zilla Parishads, 353 Tehsils, 27,946 gram Panchayat, 349 Panchayat Samitis, 222 Municipal Councils, 22 Municipal Corporations, 3 Nagar Panchayats, 41,095 inhabited villages, 2616 un-inhabited villages and 378 towns. On a socio-cultural basis, the state is divided into five regions, namely, Greater Mumbai, Marathwada, Konkan, Vidharbha (Amravati and Nagpur divisions) and western Maharashtra (GoM, 2004; GoI, 2005).
The growth rate in Maharashtra during 2001-11 has been 15.99% which is less than the national level at 17.64% putting India at the 21$^{st}$ rank in the country. Maharashtra has also painted a dismal picture as regards the sex ratio with 925 females per 1000 males against 940 at the national level. The child sex ratio too is 883 females per 1000 males against the national figure of 914. The state has fared better at literacy rate with 82.9% literacy rate against the national average of 74% and ranks 12th in literacy among the states (Census, 2011).

**Social, Political, Economic and Political context:**

Despite the fact that Maharashtra constitutes less than 10 percent of the total population of the country, it accounts for nearly one-fourth of the gross value of India's industrial sector. The per capita income (Net National Product at factor cost) stood at Rs 26,386 compared to the national average of Rs 18,912 in 2002-03 (Pethe & Lalvani, 2005). Despite these facts and figures, owing to fiscal deterioration Maharashtra had been branded as a state with "an impressive past but an uncertain future" (World Bank, 2002). There has been lop sided development with greater contribution by the tertiary sector at 56% in 2003-03 than the secondary (28%) and primary (15%) sectors, with an enabling environment for the secondary sector considered essential for fiscal growth. Other characteristics of the economic growth in Maharashtra are the regionally skewed pattern as well as dependence on the performance of Mumbai (Pethe & Lalvani, 2005).

2011 census indicates that Maharashtra is one of the rapidly increasing urban populations (62.8% of total population growth in past decade is reported to be urban). However, still majority of the population is from the rural area (54.77%). This has implications on the service delivery in the urban areas in the areas of health and sanitation along with other aspects. The literacy rate in Maharashtra is high. However the urban rural divide is very significant as male literacy rate (89.82%) is higher than female (75.48%) for the state.

In India Caste often forms the basic premise of exclusion in many spheres of life and limits the capabilities of individual to attain the desired level of development in India. Caste is recognized as a system of social and economic governance abiding with unique and specific norms and customs. (Scoville 1996, Beteille 2007) Administratively 59 castes are categorised as scheduled castes in Maharashtra (Ministry of Soc Justice 2012). As seen from Table 2.1, the population belonging to

scheduled caste (SC) and scheduled tribes (ST) is substantial in proportion. Caste based discrimination is not uncommon in Maharashtra as evident from the recent violence against specific castes in Maharashtra.

**Table 2.1 Population composition by caste groups**

| Year | | Population | | |
|---|---|---|---|---|
| | | Total | Scheduled Castes (SC) (%) | Scheduled Tribes (ST) (%) |
| 1991 | Maharashtra | 78,937,187 | 8,757,842 (11.0) | 7,318,281 (9.0) |
| 2001* | Maharashtra | 96,878,627 | 9,881,656(10.2) | 8,577,276 (8.9) |
| 2011** | Maharashtra | 96,878,627 | 9,881,656 (10.2) | 8,577,276 (8.9) |
| 2011 | India | 1028,737,436 | 166,635,700 (16.2) | 84,326,240 (8.2) |

* Census report 2001 available http://censusindia.gov.in/Tables_Published/SCST/dh_st_maha.pdf
** Census 2011

Specific castes have suffered the peril of untouchability, discrimination and exclusion in the history, today the State follows the principle of affirmative action and provides reservations in education, employment in private and public sectors (Thorat 2004). Irrespective of policy provision the uptake of social assistance programs is reported to be low for these groups (Kabeer 2006).

Access to educational resources (institutions and scholarships) is still difficult for scheduled castes members to attain educational levels comparable with their higher castes counterparts. (Chalam 1990, Chitnis 1972, Wankhede 2001) The discrimination is also reported to be prevalent in the job markets (Thorat 2007).

The Maharashtra state is currently under administration of coalition government formed between two National Parties who also represent at the Central Government; such government has ruled Maharashtra for majority of the years. The participation from the socially excluded groups is not pronounced. Differential access to political processes and participation to the excluded groups is well known. Participation in elections leading to representation has been poor for the scheduled castes in the Indian context and same can be applicable to Maharashtra (Brass 1997, Bhowmik 1992, Barthwal 1969, Joshi 1981, Mazumdar, 2012)

In India, health is a state subject (Bhalotra, 2007). Some schemes are lead and financed by the centre but the rest are lead and financed by the State. The state government in Maharashtra has initiated some schemes which are unique to it for instance the Rajiv Gandhi Jeevandayi Arogya Yojana in 2012.

The Population composition of the 22 study sites or districts is presented in Table 2.2.

**Table 2.2 Population composition by caste groups at district level**

| No | District | Total Population | Scheduled Castes | Scheduled tribes | Total BPL population in the district** |
|---|---|---|---|---|---|
| 1. | Ahmadnagar | 4,040,642 | 484,685 (12) | 303,255 (7.5) | 153,898 |
| 2. | Akola | 1,630,239 | 168,447 (10.3) | 100,088 (6.1) | 91,223 |
| 3. | Aurangabad | 2,897,013 | 376,181(13.0) | 100,416 (3.5) | 82,099 |
| 4. | Beed | 2,161,250 | 281,240 (13.0) | 24,193 (1.1) | 93,060 |
| 5. | Bhandara* | 1,136,146 | 201,949 (17.8) | 97,718 (8.6) | 113,229 |
| 6. | Buldana | 2,232,480 | 241,623 (10.8) | 115,156 (5.2) | 136,877 |
| 7. | Chandrapur | 2,071,101 | 296,927 (14.3) | 375,256 (18.1) | 168,120 |
| 8. | Hingoli | 987,160 | 100,697(10.2) | 86,898 (8.8) | 48,546 |
| 9. | Jalgaon | 3,682,690 | 286,777 (7.8) | 435,951 (11.8) | 245,191 |
| 10. | Jalna* | 1,612,980 | 181,017 (11.2) | 32,103 (2.0) | 62,497 |
| 11. | Kolhapur | 3,523,162 | 449,641 (12.8) | 21,387 (0.6) | 78,117 |
| 12. | Latur | 2,080,285 | 404,251 (19.2) | 47,836 (2.3) | 88,596 |
| 13. | Nandurbar* | 1,311,709 | 41,412 (3.2) | 859,574 (65.5) | 170,757 |
| 14. | Pune | 7,232,555 | 761,857 (10.5) | 261,722 (3.6) | 113,861 |
| 15. | Ratnagiri | 1,696,777 | 24,515 (1.4) | 20,102 (1.2) | 114,974 |
| 16. | Satara | 2,808,994 | 246110 (8.8) | 21,896 (0.8) | 69,199 |
| 17. | Sindhudurga | 868,825 | 38,536 (4.4) | 4,952 (0.6) | 61,446 |
| 18. | Thane* | 8,131,849 | 339,720 (4.2) | 1,199,290 (14.7) | 234,498 |
| 19. | Osmanabad* | 1,486,586 | 245,790 (16.5) | 27,857 (1.9) | 75,213 |
| 20. | Wardha | 1,236,736 | 158,630 (12.8) | 154,415 (12.5) | 87,258 |
| 21. | Yeotmal | 2,458,271 | 252,802 (10.3) | 473,370 (19.3) | 207,594 |
| 22. | Washim | 1,020,216 | 162,663 (15.9) | 70,987 (7.0) | 83,549 |

Source: http://www.censusindia.gov.in/Census_Data_2001
* The quantitative survey was done in all 22 districts. For the districts with * we also collected data with qualitative methods.
** http://tsc.gov.in/Report/PanchayatReport/RptStateWiseBaseLineServeyData.aspx

## 2.2 – Health systems context

Indian health care delivery system functions at various levels and handle the differential needs with multiple approaches. While the expenditure on health services is shared by both the central government and state government it's under the state's prerogative to manage these health services.

### Health System in Maharashtra

The curative health services are provided by both publicly financed institutions (public system) and privately financed institution (private system). The publicly financed services also provide preventive health services for instance the immunization programs.

Maharashtra (Fig 2.1) has a substantial proportion of urban population (45.2%) even though the rural population is large (54.8%). Both urban and rural areas of Maharashtra are served by a decentralized public health system operating at three levels of care viz. primary, secondary, and tertiary. The rural health infrastructure consists of a three-tiered system (NRHM – RHS 2011) with the 'sub-centers' located most peripherally and serving a population of 3,000 to 5,000 to act as the first point of contact between the community and the health system. Each sub-center is manned with one male and one female multipurpose health worker. For six sub-centers, there is one 4 to 6 bedded 'primary health center' (PHC) which serves as the first referral unit catering a population of 20,000 to 30,000, and is manned with a medical officer (MO) and 14 paramedical staff including one male and one female health worker / assistant. The referral unit for four PHCs is one 30 bedded hospital with specialized services at the block level known as the 'community health center' (CHC) serving a population of 80,000 to 120,000. (Census of India, 2011 and GoM, 2012)

**Figure 2.1 Map of Maharashtra**

Specialized curative and medical facilities and health services are provided at the district level where most of the urban population has access. The Additional Director of Health Services, the Civil Surgeon, and the District Health Officer (DHO) are the staff in charge of each district and are headed by the deputy director of health services at the divisional level. Maharashtra is divided into six administrative divisions. The Chief Secretary at the state level heads four departments viz. Health Services, National Rural Health Mission (NRHM), Maharashtra State AIDS Control Society (MSACS), and Employee State Insurance Scheme (ESIS). Each of these departments is headed by a Director.

As per the Rural Health Statistics (RHS) 2011, there is an acute shortage of health personnel at all levels of public health care ranging from the grass root level health services such as sub-centers and primary health centers to the more specialized health services at the district level (Table 2.4 and Table 2.6) (NRHM, 2009). In terms of the key health indicators, the state however shows better performance compared to the overall indicators for India as evident from the Sample Registration System (SRS) data of 2009 and 2010 (Table 2.3). (NRHM – RHS, 2011)

**Table 2.3: Health Infrastructure of Maharashtra**

| Particulars | Required | In position | Shortfall |
|---|---|---|---|
| Sub-centre | 13,410 | 10,580 | 2,830 |
| Primary Health Centre | 2,189 | 1,809 | 380 |
| Community Health Centre | 547 | 365 | 182 |
| Multipurpose worker (Female)/ANM at Sub Centres & PHCs | 5,384 | 4,173 | 1,211 |
| Health Worker (Male) at Sub Centres | 10,580 | 8,163 | 2,417 |
| Health Assistant (Female)/LHV at PHCs | 1,809 | 2,955 | - |
| Health Assistant (Male) at PHCs | 1,809 | 2,360 | - |
| Doctor at PHCs | 1,809 | 2,292 | - |
| Obstetricians & Gynaecologists at CHCs | 365 | 225 | 140 |
| Paediatricians at CHCs | 365 | 181 | 184 |
| Total specialists at CHCs | 1,460 | 600 | 860 |
| Radiographers | 365 | 130 | 235 |
| Pharmacist | 2,174 | 2,322 | - |
| Laboratory Technicians at PHC / CHC | 2,174 | 1,501 | 673 |
| Nursing staff at PHC / CHC | 4,364 | 8,154 | - |

Source: Bulletin on rural health statistics, March 2011, Ministry of Health and Family Welfare, Government of India.

**Table 2.4: Key Health Indicators of Maharashtra**

| Indicator | Maharashtra | India |
|---|---|---|
| Crude Birth Rate* | 17.1 | 22.1 |
| Crude Death Rate* | 6.5 | 7.2 |
| Total Fertility Rate* | 1.9 | 2.5 |
| Infant Mortality Rate* | 28 | 47 |
| Maternal Mortality Rate** | 104 | 212 |
| *Sample Registration System Survey 2010<br>** Sample Registration System Survey 2007-09 | | |

In addition to the national programs of the Ministry of Health and Family Welfare, Government of India [like National AIDS Control Program (NACP), National Program for Control of Blindness (NPCB), National Leprosy Eradication Program (NLEP), Revised National Tuberculosis Control Program (RNTCP), National Mental Health Program (NMHP), National Vector Borne Disease Control Program (NVBDCP), National Iodine Deficiency Disorders Control Program (NIDDCP), Reproductive and Child Health Program, National Minimum Needs Program, and National Rural Health Mission], Maharashtra also has some state specific programs viz. the establishment of a State Health Transport Organization, setting up a Public Health Institute and Public Health Laboratory, Information-Education-Communication Programs, and provision of hospital services (GoM, 2013).

The Government of India launched the (NRHM) in 2005 with a view to strengthen the existing rural health infrastructure. NRHM introduced a new cadre of community health worker known as the 'Accredited Social Health Activist' (ASHA) working at the grass root level in co-ordination with other health personnel in the system. The urban counterpart of the NRHM is the 'National Urban Health Mission' launched during the Eleventh Five Year Plan with an aim to meet the health needs

of the urban poor, particularly the slum dwellers by making available to them essential primary health care services (URHC, 2012)

Another facet to the health system of Maharashtra is the thriving private health sector which also presents a three-tiered pyramidal structure (Saxena, 2012) similar to the public health system and consists of the 'not for profit' and 'for profit' organizations. General practitioners and clinics are at the bottom of the pyramid where majority of the population turns to for immediate medical care. Next in line are the nursing homes followed by the trust and corporate hospitals for specialized services. As per the National Sample Survey Organization (NSSO) 2004, the utilization of private facilities for inpatient care as well as outpatient care in Maharashtra were much higher compared to utilization of public facilities (Mishra, 2008). There are 39 medical colleges, 23 district hospitals, 55 Ayurvedic hospitals, 45 Homeopathic hospitals, 5 Unani hospitals, 469 Ayurvedic dispensaries, and 25 Unani dispensaries in the state of Maharashtra (NRHM, 2012). 34.4% villages in Maharashtra have the presence of non-government organizations, which is the highest in India (Venkat Raman, 2005).

The Key health indicators and the Public health Infrastructure of the selected 22 study sites is presented in Table 2.5 and 2.6.

**Table 2.5: - Key health indicators of the 22 study sites**

| No | District | Crude birth rate | Crude Death Rate | Infant Mortality Rate |
|---|---|---|---|---|
| 1. | Ahmadnagar | 18.3 | 5.7 | 24 |
| 2. | Akola | 18.0 | 6.5 | 32 |
| 3. | Aurangabad | 18.3 | 5.8 | 35 |
| 4. | Beed | 19.8 | 6.1 | 31 |
| 5. | Bhandara | 16.2 | 7.2 | 30 |
| 6. | Buldana | 19.9 | 6.6 | 35 |
| 7. | Chandrapur | 14.9 | 6.3 | 36 |
| 8. | Hingoli | 18.7 | 5.0 | 28 |
| 9. | Jalgaon | 19.3 | 7.0 | 39 |
| 10. | Jalna | 23.7 | 6.5 | 31 |
| 11. | Kolhapur | 15.3 | 7.1 | 24 |
| 12. | Latur | 19.2 | 6.5 | 31 |
| 13. | Nandurbar | 20.5 | 4.8 | 31 |
| 14. | Pune | 17.3 | 6.5 | 25 |
| 15. | Ratnagiri | 12.5 | 10.1 | 26 |
| 16. | Satara | 15.6 | 8.1 | 22 |
| 17. | Sindhudurga | 12.4 | 10.1 | 31 |
| 18. | Thane | 20.0 | 5.7 | 29 |
| 19. | Osmanabad | 18.6 | 7.5 | 33 |
| 20. | Wardha | 15.2 | 7.6 | 28 |
| 21. | Yeotmal | 17.5 | 7.4 | 43 |
| 22. | Washim | 16.5 | 6.7 | 48 |

Source: http://www.maha-arogya.gov.in/publications/HealthStatus_PDF.pdf

**Table 2.6: Public health infrastructure in the study sites**

| No | District | Primary Health Centers | Sub centres | Rural hospitals | District Hospital |
|---|---|---|---|---|---|
| 1. | Ahmadnagar | 96 | 555 | 23 | 1 |
| 2. | Akola | 30 | 178 | 5 | 0 |
| 3. | Aurangabad | 50 | 279 | 10 | 0 |
| 4. | Beed | 50 | 280 | 7 | 1 |
| 5. | Bhandara | 33 | 193 | 7 | 1 |
| 6. | Buldana | 52 | 280 | 12 | 1 |
| 7. | Chandrapur | 58 | 339 | 11 | 1 |
| 8. | Hingoli | 24 | 132 | 3 | 1 |
| 9. | Jalgaon | 77 | 442 | 17 | 1 |
| 10. | Jalna | 40 | 213 | 9 | 1 |
| 11. | Kolhapur | 73 | 413 | 16 | 0 |
| 12. | Latur | 46 | 252 | 10 | 0 |
| 13. | Nandurbar | 58 | 290 | 11 | 1 |
| 14. | Pune | 42 | 206 | 11 | 1 |
| 15. | Ratnagiri | 96 | 539 | 21 | 1 |
| 16. | Satara | 67 | 378 | 8 | 1 |
| 17. | Sindhudurga | 71 | 400 | 15 | 1 |
| 18. | Thane | 38 | 248 | 7 | 1 |
| 19. | Osmanabad | 78 | 492 | 14 | 1 |
| 20. | Wardha | 27 | 181 | 6 | 1 |
| 21. | Yeotmal | 25 | 153 | 7 | 0 |
| 22. | Washim | 63 | 435 | 14 | 1 |

Source: Health Department website Maharashtra
http://www.maha-arogya.gov.in/services/primary/subcenter/default.htm
http://www.muhsnashik.com/Perspective_Plan_2012-17_160512.pdf

**Health care financing system in Maharashtra**

The Indian tax-based healthcare system is often claimed to be underfinanced, poorly managed, and insufficient in coverage of services. In principle it provides social health protection to every citizen. However, it has apparently failed in bridging existent historical, socioeconomic and geographic gaps in service delivery and health status among various social groups (Baru 2010).

The financing of curative health services in Maharashtra is mixed. Major share goes from the out of pocket expenditure for the curative services. The expenditure on the preventive and public health activities is borne by the publicly financed systems. Other than direct payments health insurance schemes, both public and private schemes are seen in Maharashtra.

Recent policy reforms in financing of health services advocate for better social health protection through innovative prepayment schemes to avoid further impoverishment (Marmot 2008). Maharashtra is also implementing various innovative mechanisms to finance curative health services, few of which are presented here:

a. **ESIS (Employees State Insurance Scheme)**: The scheme is administered by Employee's State Insurance Corporation (ESIC) and it mainly looks after central government employees and their families. The corporation comprises of members representing central and state governments, employers, employees, parliament and the medical profession. Union Minister of Labour and Employment function as the chairman of the corporation and Director General as the chief executive.

b. **Jeevandai Arogya Yojana**: Introduced in Maharashtra from 1997, and now modified to RGJAY in 2011. It is for weaker sections of the society and BPL families including students and children 0-6 yrs. Health care providers are Govt. & Govt. recognized private/ trust hospitals. The financial limit extended from 50,000 to Rs. 150,000 in 2006 and cancer illness was also added. Super-specialty services of heart, kidney, brain and spinal cord diseases are provided. 27,141 surgeries were performed during 1997-2010, out of which 23,529 were heart surgeries.

c. **Rajiv Gandhi Jeevandayee Arogya Yojana** (RGJAY): Since 2011 Government of Maharashtra has started an insurance scheme with coverage to entire household. The health services will be provided as packages of services through empanelled public and private hospitals. The scheme targets below poverty line household as well as those households who have annual income less than Rs. 100,000.
   i. Phase-I in 8 districts from 2 October 2011: Gadchiroli, Amravati, Nanded, Sholapur, Dhule, Raigad, Mumbai city and Suburban Mumbai – Maharashtra. Policy came into effect from 1 March 2012. Target population is BPL and in addition APL families whose annual income is less than Rs 100,000. Policy is being implemented in PPP mode with National Insurance Company.
   ii. Coverage: Phase-I will cover 30 specialized service categories having 972 procedures and 121 follow-up procedures; cashless hospitalization, transport costs and medicines are covered
   iii. Premium: The premium for this policy is financed by the state government and the benefits up to Rs. 150,000 per family per annum are provided on floater basis, i.e., all the members of the family can take the benefits, but the maximum ceiling is Rs. 150,000 per year.

d. **User Fees:** Maharashtra had introduced user fees in public hospitals in the early 1990s, which resulted in mixed response from various sections of the society. Special exemption policy was prepared for the poor households. However the benefits of exemption were largely accrued towards the non-poor families due to leakage and poor families were unable to utilize the exemption as they lacked the evidence of being poor (Thakur 2009).

### 2.3 – Social Health Protection (SHP)

Social protection has for long been considered a vital tool in industrialized countries and is being increasingly recognized as an essential instrument for poverty reduction in low and middle-income nations. Different agencies and institutions have defined social protection in various ways- reflecting different objectives and approaches (OECD 2009). Social protection has been defined as "a sub-set of public actions, carried out by the State or privately, that addresses risk, vulnerability and chronic poverty" (DFID 2005).

The International Labour Organization (ILO) has defined social protection as

- A set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment invalidity, old age and the death of the breadwinner).
- The provision of healthcare and
- The provision of benefits for families and children (Garcia & Gruat, 2003, pp. 13-14)

The overall objective of social protection is reduction in poverty, risk and vulnerability. While the essential elements vary across different social protection frameworks, social assistance, social insurance and minimum labour standards have been considered as categories of instruments by agencies such as the ILO. Other increasingly popular public initiatives include social assistance and social insurance mechanisms. Social health insurance mechanisms remove financial barriers and promote access to health services by means of risk sharing and risk pooling of financial resources within a society, thereby increasing the amount of prepayment and reducing out-of-pocket payments (Hormansdörfer, 2009). Broadening the ambit of social protection has also led to inclusion of human capital building services including education, health, sanitation, and community development (OECD 2009). Social cash transfers, with regular non-contributory payments of money by the government or non-governmental organizations to individuals or households, have been emerging in developing countries as a key social protection instrument (Samson 2009).

For social protection instruments to be effective they need to be comprehensive mix addressing vulnerability across the life-cycle as well as support at critical stages of the life-cycle. Interventions have also been designed to prevent vulnerable households sinking into poverty owing to shocks linked to lifecycle changes (OECD 2009).Social health protection has been an important intervention in this direction. Lack of access to health services owing to limited financial means has underlined the priority accorded to affordable healthcare in the development agendas of middle and low-income countries. Over100 million people are pushed into poverty every year by the need to pay for healthcare (WHO 2004). In such a context the concept of social health protection takes precedence in health systems the world over and more so in middle and low-income countries.

With the foundation of health and social security as human rights the ILO has defined social health protection as a series of public or publicly organized and mandated private measures against social distress and economic loss caused by stoppage or reduction of earnings or the cost of necessary treatment that can result from ill health. Universal health protection ensures that all people have effective access to at least essential care. It seen as contributing to building social capital since a healthier populace translates into economic profits through increase in productivity and thereby higher macroeconomic growth (ILO 2007).

The following section reviews the concept of below poverty line and social protection in India. A broad overview of social protection as well as social health protection schemes in the state of Maharashtra is presented. .

**Below Poverty Line (BPL) scheme**

Historically, the need to target the poor was felt in the late 1960s and early 1970s when several studies revealed that economic growth in developing countries ironically bypassed the backward areas and poorer sections of the population (Hirway, 1986). The BPL scheme, funded by the Centre

and State governments in their poverty reduction drive, has been unique to India. The BPL scheme involved identifying the poor for welfare schemes by means of objective measures and the issuance of “Below Poverty Line” or BPL cards to such households. These BPL cards have been distributed after identifying households based on population based surveys in each state in accordance with the guidance provided by the ministry of rural development. So far three BPL surveys have been conducted throughout the country in 1992, 1997 and 2002 using three different methodologies (Ram, Mohanty, & Ram, 2009).

While the 1992 BPL survey used the household income criteria with a limit of Rs 11,000 annually, the 1997 BPL survey used two schedules namely schedule A and B for the identification of the poor households. Schedule A used exclusion criteria based on five variables including ownership of a *pucca* house, or of more than two hectares of land, consumer durables such as television, refrigerator, ceiling fan, motorcycle/scooter, three wheeler, tractor, power tiller, combined thresher/harvester as well as an the annual income of the family being more Rs 20,000. Schedule B canvassed only the ‘visibly non poor’ families identified using Schedule A. The consumption expenditure of the household for the last 30 days along with other demographic and social information was assessed and if found less than the Planning Commission’s estimates of the poverty line, the household was categorized as poor. This methodology was criticised for the exclusion criteria, lack of a standard poverty line for all states, inconsistency of results as well as absence of provision for the inclusion of people who become poor subsequent to the BPL list (Sundaram, 2003). Prior to the launch of the 2002 BPL survey, an expert group was constituted to include central and state government representatives, academia and other professional to guide on the methodology of inclusion. The committee recommended a score based ranking of each household from 0 to 4, using 13 socio-economic indicators including size of operational land holding, food security, sanitation, ownership of consumer durables, literacy status, status of household labour force and school-going children, type of indebtedness and reason for migration were used. The total score ranged from 0 to 52 and the flexibility to decide the cut-off points rested with the states. Analysis of the 2002 BPL list however found inconsistency in this distribution too, with non-poor households also possessing a BPL card. The study also fund misuse of the BPL card in certain states with the poorest of poor failing to benefit from the scheme (Ram, Mohanty, & Ram, 2009).

Earlier studies assessing the relative misuse and lack of identification of poor households have ironically identified the privileges granted to BPL households as leading to inequity in disbursement of the BPL card. BPL households can get a subsidized asset with a bank loan without payment of any money, a free house up to Rs 30,000, subsidized or free food grains, stipend for skill training. BPL households are the core beneficiaries of several welfare schemes giving assured work at minimum wages, old-age pension, widow pension, free food grain, life insurance as well as other social security schemes. The subsequent melee for inclusion finds the non-poor making use of loopholes to enter the scheme while the weakest sections find it difficult to access the scheme. The BPL scheme has been dubbed more a major political activity than a statistical exercise (Hirway, 2003).

**Social health protection in India**

The directive principles of state policy in the Constitution of India enjoin upon each state to undertake within its means a number of welfare measures. Article 41 of the directive principles directs the state to provide public assistance to its citizens in case of unemployment, old age, sickness and disablement and in other cases within the limits of its economic capacity and development. Welfare schemes and poverty alleviation programmes have been integral to different

five-year plans of the Indian government. India spends annually about 2 percent of GDP on such social security programmes funded by the central government (Dev *et al.* 2007).

The different social protection schemes can be broadly segregated into common themes including social pension schemes, food and nutrition schemes, wage /self-employment scheme, housing scheme and health security schemes as well as unorganized workers social security.

**Social health protection in Maharashtra**

The social health protection schemes launched by Maharashtra would be reviewed in the context of vulnerable populations including the BPL (below-poverty-line) category, gender based schemes, caste based schemes as well as for other categories such as migrants and differently able as presented in the Table 2.7.

**Table 2.7: Overview of Social Health Protection Schemes in Maharashtra and benefiting category**

| Food Security Schemes | | |
|---|---|---|
| **Scheme** | **Salient Features** | **Benefiting Category** |
| **Targeted Public Distribution System** (TPDS) | **Maharashtra:** Targeted Public Distribution System has been implemented in the State since 1997. Procurement, allocation and transportation of food grains by Centre, operational responsibility with Sate. Classification of PDS beneficiaries into BPL/AAY as well as APL is done on the basis of annual income. Tricolor Ration Cards Scheme introduced by State in May 1999. Government is also giving BPL ration card on temporary basis to abandoned women, bidi workers; Pardhi and Kolhati community vide GR dated 29/9/2008 and 21/2/2009.<br>**India -** Since 1997, the TPDS has played an important role in the provision of food security to the people. It is a joint responsibility between Centre and Sate. | Below poverty line, abandoned women<br>Tribal community<br>Non-working factory workers from cotton, cloth and sugar mills. |
| **Antyodaya Anna Yojana** | **Maharashtra:** poorest of poor provided food grains w.e.f 1/5/2001. Extended AAY First extension – target of 501,100 in State for terminally ill, disabled persons, persons above 60, primitive tribal households. Second extension of AAY- target of 481,000 beneficiaries includes landless agriculture laborers, carpenters, slum dwellers, informal sector workers including porters, coolies, hand cart pullers, fruit and flower sellers, rag pickers, cobblers and destitute. Also benefits single widows, terminally ill, persons aged 60 and above, primitive tribal households | Poorest of poor families identified from BPL families. Landless agriculture laborers, carpenters, slum dwellers, informal sector workers including porters, coolies, hand cart pullers, fruit and flower sellers, rag pickers, cobblers and destitute. Single widows, terminally ill, persons aged 60 and above, primitive tribal |

| | | |
|---|---|---|
| | (Madia, Kolam, Katkari), leprosy affected patients, priority for HIV/AIDS affected persons.<br>**India** - Antyodaya Anna yojana was launched in December 2000. The scheme is meant for the poorest of the poor. Coverage has been expanded over the years with almost 250,000,000 families targeted till 2005 in AAY category. As reported on 31st august 2012, a total of 243,025,000 families issued AAY cards. | households (Madia, Kolam, Katkari), leprosy affected patients, priority for HIV/AIDS affected persons. |
| **Annapurna scheme** | **Maharashtra:** implemented in Sate from 1st April 2001. 10 kg food grains given free of cost to people of 65 years and above not in receipt of National Old Age Pension Scheme (NOAPS) or state pension scheme. 100 percent centrally sponsored scheme.<br>**India-** Annapurna Yojana introduced in April 2004 by GoI for older destitute persons. 10 kg of food grains per month given free of cost. Central assistance on one installment given for this scheme to the State Food and Civil Supplies Dept., which ties up with Food Corporation of India (FCI) to release grains district-wise on payment of economic cost of the food grains. | Indigent senior citizen of 65 years age and above not covered by NOAPS (National Old Age Pension Scheme) |
| **Cooked Mid-day meal** | **Maharashtra:** The **Cooked Mid Day Meal** scheme was implemented in Maharashtra since 2002 as per writ petition no 196 of 2001 by the Supreme Court wherein instead of providing dry ration; hot cooked meals were to be given. This scheme was implemented from 2002 in 15 tribal districts and in 2003 to all districts of Maharashtra. Earlier for std 1-5, since 2008 for all upper primary schools (VI-V111).<br>**India-** Cooked Mid-day meal scheme was launched on 15th August, 1995 by the GoI, as a centrally sponsored scheme to supplement the efforts for universalizing elementary education. | Primary and upper primary school children<br>Tribal districts of Maharashtra<br>Children from 6-14 years<br>Coverage in Maharashtra-84,87,366 (2007-8) |
| **Integrated Child Development Scheme (ICDS)** | **Maharashtra:** 416 ICDS projects and 75,308 Anganwadi in operation as of Sep 2007.<br>**ICDS** was introduced by the GoI in 1975. It is the world's largest programme. Introduced with the objective of early childhood development through anganwadi providing education and specific health services for pregnant and lactating mothers and children | Pregnant and lactating mothers and children (0 to 6 years)<br>Coverage in Maharashtra – 55,35,359 children up to 6 years and 9,20,335 mothers |

| | | |
|---|---|---|
| | (0 to 6 years). It is a 100 per cent centrally sponsored scheme. | |
| **National Food Security Bill 2010** | 25 kg of food grains guaranteed to every identified BPL household | BPL households |
| **Social Pension schemes** | | |
| **National Old Age Pension Scheme (NOAPS)** | **Maharashtr**a: launched in collaboration with Govt of India on 15th Aug, 1995. Indigent destitute elderly aged 65. The state govt bears Rs175/- pm and the Govt of India bears Rs 75/- pm under this scheme. Beneficiaries get Rs 250/- pm. (Government of Maharshtra: Collector Office Akola)<br>**India -** Was launched on 15th August 1995 as part of the National Social Assistance Programme, and is a centrally sponsored programme. | BPL / Destitute Elderly |
| **National Family Benefit Scheme (NFBS)** | **Maharashtra and India**: Started with a view to provide financial aid to BPL families in the incident of death (natural or accidental) on 15th August 1995. 100 per cent sponsored by GoI. Financial aid of Rs 10,000/- given. | BPL families |
| **National Maternity Benefit Scheme (NMBS)** | **Maharashtra and India**: Started with a view to provide financial aid to BPL pregnant women for safe delivery on 15th August 1995. Rs 500/- provided per delivery up to 2 living children. | BPL Pregnant and lactating women |
| **Sanjay Gandhi Niradhar yojana** | Started by the Govt. of Maharashtra to provide financial assistance to physically handicapped and destitute persons on 2nd Oct, 1980. | Differently abled / patients suffering from TB/Paralysis/Brain Haemorraghe/Cancer/AIDS below 65 years who are not able to earn livelihood<br>BPL destitute widows |
| **Indira Gandhi Niradhar yojana** | Started on 19th NOV 1991, State initiated financial assistance given to landless farm labour women, destitute widows, physically harassed or rape victims, wives of prisoners who are family head, liberated prostitutes, and orphan girls. | landless farm labour women, destitute widows, physically harassed or rape victims, wives of prisoners who are family head, liberated prostitutes, orphaned girls |
| **Wage Employment / Self Employment Schemes** | | |
| **National Rural Employment Guarantee Act (NREGA)** | **Maharashtra:** Maharashtra Employment Guarantee Scheme (MEGS) in State was used as the base for NREGA (Datar, 2007). NREGA notified on 7th Sep 2005 (Government of India, 2008). In February 2006, MEGS in Sate was converted to | Rural poor |

| | | |
|---|---|---|
| | Maharashtra Rural Employment Guarantee scheme (MREGS). 12 districts selected in State in first phase followed by 14 in second, State then shelved MEGS and switched to NREGA. MREGS has extended the 100 days of work to any number of days (Datar, 2007).<br>**India** – 100 days of employment guaranteed to rural household in a financial year. (Sampoorna Grameen Rozgar Yojana and National Food for Work Programme subsumed with NREGA). 330 districts covered as of 2007-8 (Government of India, 2008). Funded by Govt. proportion (Centre- 90%, State- 10%). | |
| **Maharashtra Employment Guarantee Scheme (defunct)** | Maharashtra: EGS act levied a special professional tax on all salaried people in Maharashtra. Since 1976, tax has been collected, urban people shared tax burden of rural poor. Employment as per demand. Employment guaranteed for 365 days a year. Nature of job- Unskilled to Skilled was 60:40. Wages as per Minimum Wages Act (Datar, 2007). | Rural poor |
| | **Health security schemes** | |
| **National Rural Health Mission (NRHM)-** | **Maharashtra -** Progress of NRHM<br>ASHAs- 5969<br>Rogi Kalyan Samitis- 1077<br>Beneficiaries- 2,31,169<br>**India** - launched in April 2005. | Under privileged and vulnerable sections of society especially women and children |
| **Janani Suraksha Yojana** | **Maharashtra:** Sanctioned in 2005-6 by Govt, was given to rural areas only initially. Benefit given to urban areas BPL and also to SC and ST in 2006. Cash incentive given.<br>**India - JSY** launched in country during 2005- to promote safe delivery. Cash incentive for BPL families of Rs 1300 in EAG States, Assam, J&K and Rs 1000 in all other states for delivering their babies in a health facility | SC<br>ST<br>BPL<br>From 20008 beneficiaries in 2005-6 to 354108 beneficiaries in 2010-11. |
| **Janani-Shishu Suraksha Karyakram** | **India:** launched in 2011,free and cashless service to pregnant women in normal deliveries an caesarean sections and sick new born up to 30 days in Govt health institutions rural and urban areas | pregnant women in govt institute delivery |
| **Navasanjeevani Yojana** | **Maharashtr**a: Since June 1995, the scheme is only for tribal areas, it is being implemented in 15 tribal districts of Maharashtra.<br>**India**- initiated in 1995-96 with the aim of reducing IMR and MMR. | Tribal children |

| | | |
|---|---|---|
| **Integrated tribal development project (ITDP)** | **Maharashtra:** initiated in 1992-93to reduce IMR/MMR in 6 tribal districts (Thane, Nashik, Nandurbar, Amravati, Gadchiroli and Nanded). | Tribal children |
| **Rajiv Gandhi Jeevandayee Arogya Yojana** | **Maharashtra**: established Aug 2011, to improve access of BPL and APL families (excluding white card). Currently present in 8 districts, the scheme would provide 972 surgeries/therapies/procedures along with121 follow up packages in 30 identified specialized categories. | BPL<br>APL (excluding white card holders) |
| **Maher Ghar Scheme** | **Maharashtra**: The Govt. of Maharashtra under NRHM started the Maher Ghar scheme for safe delivery of pregnant women in tribal areas. The scheme has been implemented in Thane, Nashik, Nandurbar, Gadchiroli, Amravati, Gondia, Yavatmal, Chandrapur and Nanded. | Tribal areas<br>Currently being implemented in 57 PHCs of nine tribal districts |
| **Sickle Cell Disease Control Programme** | **Maharashtra:** implemented in State under NRHM since 2008 in 19 high prevalence districts. Screening general population and provision of screening facilities. Provision of yellow cards to carriers and red cards to diseased. Counseling carriers and diseased. Prophylactic and symptomatic treatment at PHC, speciality treatment at district hospital and medical college (Government of Maharashtra) | Target age group -1 to 30 years, pregnant women, family members |
| **Matrutva Anudan Yojana** | **Maharashtra**: Under Navsanjeevani Yojana, in the 15 tribal districts a pregnant woman is paid Rs 400/- in cash for visiting health centre for ANC (Government of Maharashtra) | Tribal women for current pregnancy and two live issues |
| **Other state specific schemes** | | |
| **Janashree Bima Yojana** | According to decision of State government of Maharashtra [Dated 12-08-2004] Janshree Bima Yojana is introduced for the labors from the unorganised sector covering almost all the small scale businesses and domestic jobs. Persons living below Poverty line or just above the poverty line, from the age group from 18 years to 60 years are entitled to be beneficiary of this scheme. The annual premium of the scheme is fixed at Rs. 200/-, out of which Rs. 100/- are to be paid from the social security fund of central government, Rs. 50/- to be paid by the State government and remaining Rs. 50/- by the beneficiary. | Coverage of accidental insurance, accidental death, grave injuries (750,000 INR).<br><br>Support for the family members through scholarships |

## 2.4 – Program studied: Rashtriya Swasthya Bima Yojana (RSBY) in Maharashtra

**Historical Background:** In India attempts have been made to provide comprehensive healthcare to all however it has not been easy for the policy implementers to do so (Ashford 2006). The attempts are made at state and national level to provide health insurance cover to selected beneficiaries however these schemes are not known to be inclusive and are also claimed to be ill managed (http://www.rsby.gov.in/about_rsby.aspx). Acknowledging the health insecurity issue of the people working in the unorganized sector[1] in India, Government of India (GoI) launched one of the world's largest social health protection initiatives called Rashtriya Swasthya Bima Yojana (RSBY) - National Health Insurance in 2008.

**India:** The scheme has been initiated in 30 states and union territories in India, different states have made slight changes in the scheme. For instance Rajasthan also includes non BPL households; in Kerala the state decided to formulate a Comprehensive Health Insurance Agency of Kerala (CHIAK) which decided to provide health insurance benefits to the below poverty line households already identified under RSBY as well as extend the benefits to the other above poverty line households in the name of comprehensive health insurance scheme (CHIAK website).

**Maharashtra:** Based on the data provided by state nodal agency in Maharashtra; the scheme is active in different parts of the state since the year 2008 and was rolled out in 32 (out of 35) districts. As per the orders issued by the Government of Maharashtra in 2008, seven districts were supposed to be covered with the help of a public sector insurance company followed by subsequent coverage in 7 districts each year. However as per the reports the scheme was initiated in several districts in 2009-10. Sangali, Gondia and Parbhani were the districts to be covered latest in 2011. Recently the Government of Maharashtra started the state specific scheme in 8 districts, because of this the RSBY scheme was withdrawn from 6 districts (the additional two are Mumbai and Mumbai suburban where the RSBY scheme never started.)

**Structure**:

a. **Central:** Under the leadership of Secretary (Labor) the scheme is implemented by a nodal agency established at the state offices. Presently the scheme is coordinated by Additional Secretary, (Directorate General Labour Welfare Division, and Ministry of Labour & Employment) at Ministry of labour. The structure at the central level processes the guidelines and directs the program implementation for example the grievance mechanism.

b. **State:** The cell established works with the involvement of Director Health Services, Deputy Secretary (Labor, Rural development, Health) and NIC designated officers (Government Order 24.03.2008). At the state level primary stakeholders are the Development Commissioner, representatives of Directorate of Health Services, Insurance companies and their associated agencies engaged in enrolment, smart card issuing agencies, and National Informatics centre. The day to day transactions are manned with the team of state government officials under leadership of state nodal officer. However the scheme has poor infrastructure at the district level.[2]

**Funding:** Government pays the premium for RSBY. Central Government pays 75% of the total premium while State Government pays the remaining premium.

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[1]Note: Unorganized sector constitutes 86% of total employment in India as per the report submitted by expert group on informal sector statistics.

[2]As quoted by the assistant commissioner and RSBY coordinator at RSBY, Mumbai, Maharashtra

**Key Processes:**

a. **Selection of insurance companies:** The insurance companies contracted under the scheme are selected by authorized bidding process and are allocated number of districts based on their capacity and presence by the nodal agency. Currently there are 4 private insurance companies involved in the scheme. The third party administration of the insurance claims has been allocated to different agencies through insurance companies, so as the card distribution
b. **Selection of beneficiaries:** RSBY provides health insurance for the enrolled BPL families from each district up to a maximum number of households based on the definition and the figures provided for each state by the union Planning Commission (RSBY Website). .
c. **Hospital Empanelment:** The providers are selected on the basis of the basic fulfilment criteria. Unlike the newly established Rajiv Gandhi Jeevandayi scheme, the process of empanelment is not open. The hospitals are examined for the basic amenities and technical expertise and are further entitled the status of being empanelled. In most of the district the service providers are private, except for Akola where the service providers also consist of public sector hospitals. Insurance companies based on the norms and criteria approved by government.
d. **How BPLs are enrolled? -** Enrollment process of BPL households for RSBY involves the provision of an electronic list of eligible BPL households to the insurer, using a pre-specified data format. An enrollment schedule is prepared for each village by the insurance company with the help of the district level officials. An enrollment campaign is launched with the BPL list posted at the enrolment station and prominent places prior to the event (Ministry of Labour and Employment). Enrollment campaigns are conducted by the insurance company and the state nodal agency in order to ensure availability of maximum beneficiaries on the agreed date (GoI, 2008).An electronic list of eligible BPL households is provided to the insurance company or TPA. Mobile enrollment stations are set up at local centres such as public schools. The insurer equips these stations with the hard ware necessary for capturing biometric information and photographs of the members of the BPL household. The authenticated smart card is handed over to the beneficiary at the enrollment station in the presence of a Field Key Officer (FKO) who are government representatives such as health workers, gram vikas adhikaris etc . A ceiling of five members has been fixed per BPL household wherein the husband, spouse and three dependents can be enrolled. In the event of the beneficiary travelling to another district, the beneficiary can get a spilt card for use at different places. The card can be split in two parts only with the beneficiary getting only one additional card (GoI, 2008).
e. **How are the hospitals reimbursed? -** The functioning of RSBY has several unique features. The insurance companies / Third Party Administrators (TPAs) are selected by competitive bidding in each district and receive a premium for every household enrolled by them in the scheme, with 75% paid by the central government and 25% by the state government. The insurance companies / TPAs empanel in-patient care facilities (ICFS) and reimburse ICFS for in-patient care provided to enrolled households. ICFS can be either public or private: public facilities can retain payments from RSBY in self-governed societies known as Rogi Kalyan Samitis (Das & Leino, 2011).TPAs arose with the Insurance Regulatory and Development Bill bill passed in 2000, heralding the entry of private players in the insurance sector. TPAs, introduced as intermediaries to facilitate claim settlements between the insurer and the insured, are paid by the insurer. They act a service integrator between the insurer, the insured and the health service provider (Gupta, Roy, & Trivedi, 2004). Health insurance companies generally tie up with TPAs for the back-office function of managing claims and reimbursements. TPAs sign a memorandum of understanding with insurance companies

according to which they inform policyholders about the network of healthcare delivery facilities and various systems and processes for settling claim. The medical referee of the TPA examines the admissibility of the case and accordingly informs the healthcare facility to proceed with the treatment. In the Indian context, TPAs face a number of challenges including lack of defined minimum standards of care resulting in higher bargaining power for healthcare service providers, lack of standardization / accreditation leading to pricing or billing concerns as well as lack of standardization of charges across hospitals leading to significant variations in cost ranges (Bhat & Babu, 2004).

**Programme features:** The primary features of the scheme acclaimed by RSBY are as below

a. RSBY provides coverage for hospitalization expenses up to Rs. 30,000 for a family of five on a floater basis, for the below-poverty-line households.
b. State government selects insurance companies through open tendering process and technically qualified lowest bid is selected.
c. Government pays the premium for RSBY. Central government pays 75% of the total premium (90% in case of Jammu & Kashmir and North-East states) while state government pays the remaining premium.
d. The scheme is highly regarded for its use of technology in the implementation and the scheme is considering up- gradation of the smart cards to ensure that they can use it for capturing more information.

**Current status of the scheme:**

a. Based on the data provided by state nodal agency; the scheme is active in different parts of the state and can be classified as shown in Table 2.8. The enrolment was conducted in rounds in the targeted districts, while there is variation in the proportion of BPL families enrolled in the scheme, the average enrolment rate is 45% per round. The scheme lacked infrastructure at the district level the IEC activities were responsibility of the insurance scheme which has resulted in poor awareness. The scheme is supposed to stop or replaced in the districts where there will be initiation of new state run insurance scheme (Rajiv Gandhi Jeevandayee Arogya Yojana).
b. There is a gap between the policy period and the renewal in the next rounds as reported by the state nodal agency.

**Table 2.8 Status of RSBY in the state**

| Status | Districts | Number |
|---|---|---|
| Never started | Nashik, Mumbai and Mumbai Suburban region | 3 |
| Started but Discontinued | Nagpur | 1 |
| Active for more than 3 years | Jalna, Nanded, Solapur, Hingoli, Jalgaon, Thane, Amravati and Yeotmal | 8 |
| Active for 2 – 3 years | Ahmadnagar, Bhandara, Washim, Buldana, Nandurbar, Pune, Chandrapur, Ratnagiri, Raigad, Satara, Sindhudurga, Osmanabad, Wardha, Latur, Akola, Gadchiroli, Beed, Dhule, Kolhapur and Aurangabad | 20 |
| Active for 0 – 2 years | Sangli, Parbhani, Gondia | 3 |
| Note: The RSBY scheme was withdrawn from Gadchiroli, Amravati, Nanded, Sholapur, Dhule, Raigad as the new scheme (RGJAY) was initiated in these 6 districts in 2011. | | |

**Review**:

a. In a study carried out in districts that completed first year of enrolment in Maharashtra found that the proportion of poor families enrolled in the scheme was only 39%, way below the national average (Narayana 2010).
b. Apart from low enrolment rate and large variations in enrolment rate, results from an evaluation study suggest that only 1.8% of the cardholders have actually utilised the services (Jain 2011).
c. Also, the proportion of poor families enrolled varies considerably across districts and the variation is more pronounced at the village level (Sun, 2011).
d. According to the Department of Labour and the agency carrying out the enrolment process, reasons such as migration of BPL households (25%), absence of head of the family (7%), flawed BPL data base (non-inclusion of new members as the survey was carried out in 2002), logistic issues, poor response or show up of people because of inadequate IEC campaign and 'cream-skimming' behaviour of insurance companies might be responsible for such low enrolment rate and large differences.
e. With a few years of RSBY experience in place, researchers have begun to focus on experiences of different aspects of the RSBY programme (Narayana, 2010; Das & Leino, 2011; Mitchell, Mahal, & Bossert, 2011). A recent study of the RSBY programme in Amaravati district of Maharashtra in 2009-10 found significant flaws in the very design and implementation of the programme. Amaravati was chosen as the study site since it was one of the first five districts wherein RSBY had been implemented, besides ranking as one of the 250 most underdeveloped districts of India. The study found the enrollment ratio for the entire district to be only 39% of the total BPL population. Tribal dominated blocks had the lowest enrollment. The study also found that 60% of the non enrollees had not enrolled for the scheme since they were not present during the enrollment visit by the TPA. The survey found only 15% of the enrollees knew about RSBY due to institutional efforts while most were aware of it due their own networks. Empanelled hospitals too were located far from the remote ST-dominated blocks creating lack of access to enrollees. While RSBY is predominantly meant for secondary care the hospitalization data found that the RSBY scheme led to beneficiaries accessing care in the empanelled hospitals for low severity diseases, which could have been treated in government facilities, which are closer and thereby go underutilized. Reasons contributing to higher disease quartiles being unused included poor access, uncertainty in cost structure for treating higher severity diseases, also unattractive RSBY-defined treatment packages for hospital providers since higher disease quartile involved uncertain cost of care as well as follow-up post discharge. The study also found instances of misuse of the scheme in the form of false claims since the TPA data is unaudited. Another issue dogging the scheme was the year long tenure for the RSBY insurer, creating continuity problems amongst beneficiaries since most hospitals would not accept the RSBY card in the interim. Programme and contract design issues therefore led to lower utilization of the RSBY scheme in the district (Rathi, Mukherji, & Sen, 2012).

### 2.5 – Gaps in evidence

As the burden of untreated ailments is considerably high amongst the poor, it was expected that RSBY would catapult the utilization of inpatient services in this population group. However, it is evident that RSBY has hardly made any impact on utilization. The Ministry of Labour and Employment, GoI is understandably not happy with the performance of the scheme in the state and is seriously considering shifting the responsibility of implementing RSBY from Department of

Labour to Department of Health, Government of Maharashtra. Many of the reasons cited for low utilization are actually based on anecdotal evidence or field observations but there has not been any scientific study in Maharashtra to investigate the real causes for low utilization amongst the RSBY insured population in the state.

After analyzing the preliminary data regarding the implementation status of RSBY in Maharashtra, several pertinent questions have emerged:

- What are the reasons for not achieving universal enrolment in places in which RSBY was introduced?
- Is the enrolment pattern similar across social and religious groups?
- What are the factors responsible for low utilization of RSBY scheme in the state?
- Is the utilization rate same for males and females/all social groups?

Furthermore, as RSBY was a mechanism to empower the poor in accessing good quality health care and provide financial security against risk of catastrophic health payments and deeper impoverishment, it was expected to help reducing social exclusion. So, it would be interesting to see whether it has lived up to its promise or there are latent factors such as social exclusion still acting as obstacles for the success of RSBY. In addition, it is important to understand how RSBY has impacted the out of pocket health payments.

### 2.6 – Research objectives, questions and hypotheses

The common research questions for consortium partner in West Africa (Ghana and Senegal) and India (Maharashtra and Karnataka) focussed on understanding reasons associated with limited success of health financing arrangements and the role of social exclusion in limited success of financing mechanisms. The broader research questions are later disintegrated in smaller research questions which are specific to context and the health financing mechanism in question.

#### Health Inc. common research questions

- What are the reasons for the limited success of the health financing arrangement in providing free or "affordable" access to care to the below poverty households in Maharashtra?
- What does social exclusion mean or how is it understood in Maharashtra and what are the indicators of social exclusion in Maharashtra?
- Does social exclusion prevent the development of health care financing for the informal sector in Maharashtra and how?
- Does current health financing mechanism (RSBY) reduce or increase social exclusion in Maharashtra and how?
- What is the potential of current health financing mechanism (RSBY) for reducing social exclusion in Maharashtra?
- What is the potential of policy makers in health and other sectors for reducing social exclusion in RSBY in Maharashtra?

# CHAPTER 3

# METHODOLOGY

## 3.1 – Selection of study sites

The methodology planned as per the Research Protocol was followed. But during actual study, some minor modifications were needed to be carried out for practical and feasible purpose. The sample in Maharashtra is designed to provide estimates for the state as a whole, for urban and rural areas. All 22 districts that met the inclusion criterion of at least two years of RSBY implementation were selected for this purpose. The inclusion criteria included those districts (administrative block below the level of state), which have completed implementation of the scheme for more than two years. The State Nodal Agency provided the information on the status of scheme and furnished the level of enrolment and duration, which further helped the Health Inc TISS team to narrow down on the study sites.

## 3.2 – Mixed methods approach

The various research questions that underpin the social exclusionary processes and the overall performance of RSBY need a multi methods approach to record success, failures and bottlenecks. Both the qualitative and quantitative data are collected for answering the research questions. Most of the policy recommendation and the theoretical issues are addressed through triangulation of the data and the inference of the entire research finding. It was an observational, cross-sectional study that applied mixed methods to answer the research questions. Following Figure 3.1 shows the diagrammatical presentations of the mixed methods approach.

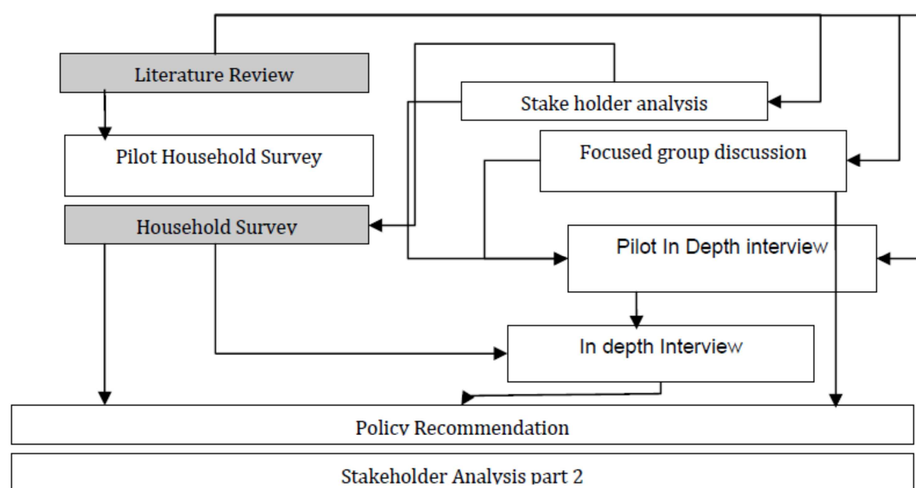



**Fig 3.1: Mixed Methods Approach**

The Table 3.1 indicates which method will be predominantly used for addressing the research question.

**Table 3.1: Methodology adopted to answer various research questions**

| Research Question | Literature review | Household Questionnaire | Focused group Discussion | In Depth interview |
|---|---|---|---|---|
| What are the reasons for low enrolment where RSBY was introduced? | Yes | Yes | No | Yes |
| Are the smaller households less likely to be enrolled? | Yes | Yes | No | No |
| Are households with elderly less likely to be enrolled? | Yes | No | Yes | Yes |
| Why did the families not enrol all eligible members? | Yes | Yes | Yes | No |
| Does restricting enrolment to only five members per household promote social exclusion within households? | Yes | Yes | No | No |
| Who are more likely to be excluded and why? | Yes | Yes | Yes | Yes |
| What are the reasons for not issuing cards to some enrolled families? Does social exclusion play a role in it? | Yes | Yes | Yes | Yes |
| Why did some families receive the card late? Can social exclusion be attributed as one of the reasons for the delay in issuance of card? | Yes | Yes | Yes | Yes |
| Why did the RSBY family members not utilise services covered under RSBY? Can social exclusion be attributed as one of the major causes for low utilisation? | Yes | Yes | Yes | Yes |
| Were they denied care at network hospitals? If yes, what are the reasons for refusal of admission? | No | Yes | Yes | Yes |
| Has ‘balance billing’ become a phenomenon in this market? Is it acting as a barrier for utilisation? | Yes | No | No | Yes |
| Why some beneficiaries were not able to use full insurance coverage? | No | Yes | Yes | No |
| Has RSBY provided financial security against catastrophic health payments to the ‘Poor’? | No | Yes | Yes | Yes |
| Did the enrolment pick up in the second or third year? What are the reasons for drop-out? | No | Yes | Yes | Yes |

**Literature Review –**We conducted a systematic review of literature to understand the social health protection mechanisms. The focus of this review was the schemes which are targeted to below poverty line population and are being operated in India and Maharashtra in particular. Further review is required in the assessment of the role of social exclusion in successful health care financing and will be continued for the duration of the study. While providing an overview of the published literature on social health protection, the literature review will also throw light on the extent to which social exclusion has been measured as a determinate for evaluating the performance of various social health protection mechanisms in general and in RSBY in particular in Maharashtra. SPEC– by– Step tool was used to identify the gap in evidence. A secondary objective of the literature review will be to help identify characteristics (age, sex, religion, residence, etc) that may be associated with the socially excluded and also possibly give an indication of the process of social exclusion in Maharashtra.

### 3.3 – Quantitative method: Household survey

**Sample Size**

The sample in Maharashtra was designed to provide estimates for the state as a whole, for urban and rural areas. As can be seen in table 2.8, 22 districts meet the inclusion criterion of at least two years of RSBY implementation out of the total 35 districts in the state. We selected these districts for household survey. However, the survey was not large enough to provide reliable estimates for individual districts. A target sample size of 6,000 completed interviews with BPL households was initially divided between urban and rural areas by allocating the sample proportionally to the population of these two areas. In order to address the issue of non-response rates at the household level, a replacement strategy was adopted to achieve the target number of completed interviews. In case, any selected household could not participate in the survey for some reason, next household was selected for interview.

**Sampling Design**

There are two sampling domains: rural areas and urban areas. Within each of the sampling domains, a systematic, multi-stage stratified sampling design was used. The rural sample was typically selected in two stages: the selection of Primary Sampling Units (PSUs), which are villages or groups of villages (in the case of small linked villages), with probability proportional to population size (PPS) in the first stage, followed by the selection of 'below poverty line' (BPL) households using systematic sampling within each selected PSU in the second stage.

In the urban domain, a three-stage sampling procedure was followed. The reason for adopting a three-stage sampling design is that urban areas are quite large and therefore, it is difficult to list all the households directly from the resulting list. In the first stage, wards were selected with PPS. From each selected ward, one or two segment/s was selected with PPS in the second stage, followed by selection of BPL households using systematic sampling within each selected segment in the third stage.

**Sample selection in rural and urban areas**

The BPL census conducted in 2002 by Ministry of Rural Development, Government of India was used by the Department of Rural Development, Maharashtra for preparing the BPL list for the state. The total number of households identified as BPL in the state is in conformity with the poverty

headcount estimate[3] provided by Planning Commission of India. This list has been used by the Department of Labour (DoL), nodal agency for RSBY implementation in rural areas. For urban population, the DoL relied on the BPL list prepared by the Directorate of municipal administration, Government of Maharashtra. This list could have served as the sampling frame. But there are several problems with the BPL list. First, the list was created in 2002 and is dated. This results in gaps due to migration, deaths, births and marriage. Second, the list contains many errors due to poor quality control of data entry (Murgai and Palacios 2010). Furthermore, evidences from many studies suggest that the list is incomplete to a great extent (Dreze and Khera 2010; Usami, Sarkar and Ramachandran 2010). Because of all these reasons, the list did not serve as the sampling frame in our study.

The 2001 Census list of villages was used as the sampling frame. The Census of India, 2001, provides data on the number of households, persons, males, females, persons belonging to the scheduled castes (SC), scheduled tribes (ST), employed persons, etc. for all the villages in each district of India. All the villages with fewer than five households were deleted from the list. As the population in all such villages was only 0.2 percent of the total rural population, the exclusion of small villages from the sampling frame would not affect the representativeness of the sample. In addition, all the smaller villages with 5-49 households were merged with a nearby village so that the required number of households can be selected from the selected PSUs. In this way, a minimum size of 50 households in each village was ascertained in all the villages in the sampling frame.

**Stratification:**

In order to capture the heterogeneity of villages in terms of socio-economic characteristics in the sample, stratified sampling was adopted at the first stage of sample selection. The list of villages was stratified by a number of variables. The first level of stratification was geographic, with districts being classified into six contiguous regions. The district categorization of the six geographic regions (based on the 22 selected districts in Maharashtra) is as follows:

Region I: Thane, Ratnagiri, Sindhudurg .
Region II: Jalgaon and Nandurbar
Region III: Ahmednagar, Pune, Satara, Kolhapur.
Region IV: Aurangabad, Jalna, Bid, Latur, Osmanabad, Buldana, Akola, Hingoli and Washim.
Region V: Yeotmal, Wardha.
Region VI: Bhandara, Chandrapur.

Within each of these regions, villages were further stratified by village size and the percentage of the population belonging to scheduled castes or scheduled tribes. Table 3.2 provides details of the sample stratification in rural areas, along with the population of each stratum. The final level of stratification was implicit for all the strata, consisting of an ordering of villages within each stratum according to the proportion of females who were literate. From the list arranged in this way, the number of PSUs to be selected from each stratum was proportional to the size of the stratum.

A household listing operation was carried out in each selected PSU to provide the necessary frame for selecting households at the second stage. The house-listing operation involved preparing up-to-date layout and sketch maps, assigning a number to each structure, identifying residential structures, listing the names of heads of households and BPL households. Listing of all households in large

[3] Poverty headcount ratio is the share of the population whose consumption expenditure is below the poverty line set by the Planning Commission of India.

villages with more than 350 households is a challenging task, potentially prone to errors of omission or duplication. Hence, villages larger than 350 households were segmented into three or more segments (depending on village size) of approximately equal size (usually, about 100 to 200 households). From all the segments in each large village, two segments were selected randomly using the PPS method. House-listing was then done only in the two selected segments. Therefore, in all such large villages, the sampling design became a three-stage design. From each selected village, 20 BPL households were selected with systematic sampling.

**Table 3.2: Sampling stratification**

| Sampling stratification procedure in rural areas, Maharashtra | | | | |
|---|---|---|---|---|
| Stratification variables | | | | |
| Stratum | Region | Village population (Households) | Percent SC/ST population | Total Population (Households) |
| 1 | 1 | <=300 | NU | 459873 |
| 2 | 1 | >300 | NU | 433930 |
| 1 | 2 | <=400 | NU | 349060 |
| 2 | 2 | >400 | NU | 392189 |
| 1 | 3 | <300 | <10 | 334260 |
| 2 | 3 | <300 | >=10 | 266397 |
| 3 | 3 | 300-534 | <=12 | 255736 |
| 4 | 3 | 300-534 | >12 | 245450 |
| 5 | 3 | 535-900 | <=13 | 266735 |
| 6 | 3 | 535-900 | >13 | 265630 |
| 7 | 3 | >900 | <15 | 335057 |
| 8 | 3 | >900 | >=15 | 304824 |
| 1 | 4 | <200 | <13 | 253283 |
| 2 | 4 | <300 | ≥13 | 259063 |
| 3 | 4 | 200-350 | ≤16 | 313499 |
| 4 | 4 | 200-350 | >16 | 317831 |
| 5 | 4 | 350-650 | ≤16 | 297748 |
| 6 | 4 | 350-650 | >16 | 319003 |
| 7 | 4 | > 650 | ≤15 | 302339 |
| 8 | 4 | > 650 | >15 | 317747 |
| 1 | 5 | ≤ 300 | NU | 304615 |
| 2 | 5 | > 300 | NU | 325112 |
| 1 | 6 | ≤ 350 | NU | 272520 |
| 2 | 6 | > 350 | NU | 254689 |
| Total | NA | NA | NA | 7446590 |

Note: NA: Not applicable; NU: Not used.

**Sample selection in urban areas**

In urban areas, all urban wards were arranged according to geographical regions and then within regions, by female literacy. A sample of urban wards was drawn by adopting a two-stage sampling. A ward in a township is a large area comprising a large number of households. Each ward consists of several segments or blocks. In the selected ward, a list of segments was created with the help of local ward officials. Each segment is comprised of about 150-200 households. A sample of households from a ward was drawn in two stages. One or two segments are selected (depending upon the size of

the ward) from each selected ward at the first stage. Then as a household list was prepared in the **rural areas**, a similar household listing was carried out in the selected segment and 20 households were targeted for selection.

**Design of the questionnaire**

The questionnaire is divided in 12 parts with different functions and objectives. The identification details are captured in the initial section so as to generate a unique number of that household. The section on household characteristics cover the socio economic details of the household; here a special emphasis is given on the household consumption details with reference periods of one month and one year for perishable and nonperishable consumption items. Educational attainment for all the members (+5), and participation in economic activities (+15) are captured in separate sections. Section D is divided in four subsection, "self perceived health status", presence or absence of chronic ailments", " occurrence of diseases in past 15 days and the household response", "financing mechanism used for treatment" are the themes covered under this section. The perceived health status will be asked to each of the members while rest of the subsections will be answered by main respondent. The section on hospitalization is designed so that the unmet need of hospitalization in past one year is captured, the other subsections cover information on occurrence of hospitalization in past one year, amount of money spent on several individual services (viz. investigations, doctor's fees, transport charges and few more), financing mechanism for the reported hospitalization. While recording the information on hospitalization the field investigators also ask about the presence of death in the given household and record the hospitalization details accordingly. The coping mechanism and the financing mechanism are covered in the last subsection in the section. Section F will collect information on presence or absence of the pregnancy related outcomes in the given household. If there is a pregnancy reported in the household, then specific question on the expenditure on the ante natal care, intra-natal care will be asked. In case there is a complication in the antenatal period, intra natal period or postnatal period the details of such events will be captured. This section also covers the details on the financial arrangements and the coping mechanism in the similar fashion as that in the hospitalization section. Section G collected information on the enrollment status of the household members, where we intend to seek individual's enrollment status. The questions in this section are designed for both types of household - those who are enrolled in the scheme as well as those who are not. Section H captures respondent's view on public sector hospitals, access to market and similar places, and frequency of visits to such places. Section I covers the issues associated with the respondent's access to financial institutions and his perceptions towards them. The specific questions asked are about the banks and availability of funds for expenditure as per their will. Section on social dimension covers issues such as participation in social organization, the level of active participation in them; the opportunities of access to and association with the members of other social classes and castes; the opportunities to socialize and create connections, the barriers in doing so. The respondent will also be asked to rate the institutions in the society based on their perception. The section also tries to analyse their social network. The section on the political dimension asks questions on the participation of the individual and their families in the recent elections, their participation as the contestant and the results, their ability to connect to the local politicians and influence the decision in the village (or in the community) . In the end the section L asks questions on their cultural perception. Once the questions are asked the investigators are supposed to enter the level of responsiveness and the time taken for the interview.

**Localising SPEC Framework in the HHS:**

Social Dimension: Some of the important social organization which form the primary basis of information exchange and channels to exert the right to use of services conferred (to an individual) were focused in the household survey tool. Participation in several social groups was probed with the

help of household survey. The association reported by individuals were then examined for the frequency, the importance and the way they present themselves in this organization. The indicators covered in the social dimension also include frequency of socialization, characters and multitudes of their social contact, their belief in certain social institutions.

Political Dimension: The SPEC framework when adopted to the context of Maharashtra retained key indicators such as participation in the electoral processes in recent past, attempts to represent self as a political ideology (e.g. become member of political party), reasons for particular behaviour of participation and non participation in political processes. The dimension substantially is covered by collecting indicators through household survey tools as well as through the focused group discussions where the perceptions of key social groups towards "social health protection schemes" will be materialized.

Economic Dimension: We perceive economic dimension as participation in workforce, the ability to earn income, the avenues to manage the wealth. While data was collected on the household income, few household assets, and access to social welfare schemes (e.g. pension schemes for elderly and pension schemes for disabled). We also included the indictors on hunger, ability to purchase the consumables and information to comment on how far has the public distribution system has helped the population under consideration.

Cultural Dimension: The localised cultural dimension stresses on practices of immediate social concerns which are deeply rooted in the cultural values of the society; for instance perception of individuals toward women empowerment, social role of women in the household etc. were studied.

**Data collection process**

**Village Questionnaire: -** The Context Questionnaire is named as Village Questionnaire in this survey. The bilingual questionnaire was answered by the key informant from the village for instance the local government member known as Panchayat Raj Samiti Sadasya or other well informed individual of the village. The data was collected by the supervisors of the data collection team. The information was collected from all study sites. The Village questionnaire further captures information on the political participation, frequency of village meetings, decisions that are collectively taken regarding issues of sanitation and health.

**Data Collection Process** – Once the household list for the segments was available 20 households were selected using systematic random sampling. The respondent for the household survey was the head of household; in case of absence of head of household other members who were above age of 16 years and were found knowledgeable were selected. The data collection was completed with the help of 40 field investigators in the selected regions. The team comprised of 5 members where one of them was supervisor. The completed questionnaires were submitted to the field supervisor who checked for the completeness and reported to the field coordinators. The field checks and edits were done at the level of supervisor and the field coordinators. The field coordinators then prepared the list of household id covered and shared them with the research officers at Health Inc. The hard copies of the questionnaires were sent to the data entry center.

**Data entry and processing**

The hard copies of the questionnaire were screened for the completeness, accuracy in the responses. Once confirmed the data was entered in the statistical package for social sciences (SPSS) version 15 using data entry packages such as CS-Pro. The data entry was done in the institute premises with the help of agency and field officers hired.

**Data analysis**

Based on the theory and the factors associated with enrolment and utilization of the health insurance services, both the quantitative and qualitative data was collected. Various hypothesis mentioned at each step of SPEC-by-Step framework were examined with the help of this data. The analysis was carried out to understand the existing factors associated with poor enrolment, utilization of RSBY. The research questions were understood and answered using the various methods; some of the question required significant affirmation with the statistical methods. The data collected from various methods was categorised as per the steps identified. Data classified as variables explaining the outcome variables was analysed based on the step wise hypothesis. Analysis was modified during the course of time. The outcome variables were explored by platting cross tabulation across the explanatory variables. Most of the data analysis plan was based on the analytical framework.

## 3.4 – Qualitative methods

**Stakeholder analysis –** Stakeholder analysis was conducted in two parts. The first part consisted of a 'stakeholder scoping' exercise that describes national and regional stakeholders (their motives, influence and role), restricting to the RSBY scheme in Maharashtra. After understanding the stakeholders involved, in depth interviews of those who are closely related with the scheme were conducted. This included RSBY state nodal agency officer, the RSBY program officer of Insurance Company who is responsible for implementation of RSBY scheme in 6 districts, the Insurance Company official who is responsible for implementation of RSBY enrolment camps. The findings were used to understand the issues in program implementation and sampling methods. **(see Annexure VI)**

**Focus Group Discussions (FGD)** – The purpose of FGD was to record the views of the socially excluded groups on the performance of RSBY and to identify the barriers they face at each step on the basis of SPEC – by – step tool.

**In Depth interviews with household members** – In depth interviews were conducted to describe the process of social exclusion based on the narratives of individual experience. The in-depth interviews helped to understand the gravity of discrimination faced, social exclusionary practices and perceived nature of the healthcare financing mechanism amongst those who are supposed to use them. Overall this method enabled us to understand why and how some individuals are excluded and how social exclusion affects health care utilization. Specific hypotheses like intra-household selection of members for enrolment have been supported by the data from these interviews.

**Sampling strategy**

The sites for data collection (through FGD and In Depth interviews) were selected randomly from the five geographical regions allocated to different insurance companies by the state nodal agency implementing the scheme (Fig 3.2 and Table 3.3). The selected districts also represented different geographical regions in Maharashtra as follows: Thane representing the western part of Maharashtra; Osmanabad representing the south; Jalna representing the central part of the state; Bhandara representing the east and Nandurbar representing northern Maharashtra.

**Figure 3.2: Location of district where data with qualitative methods was collected**

**Table 3.3: Geographical Distribution of the Insurance Companies**

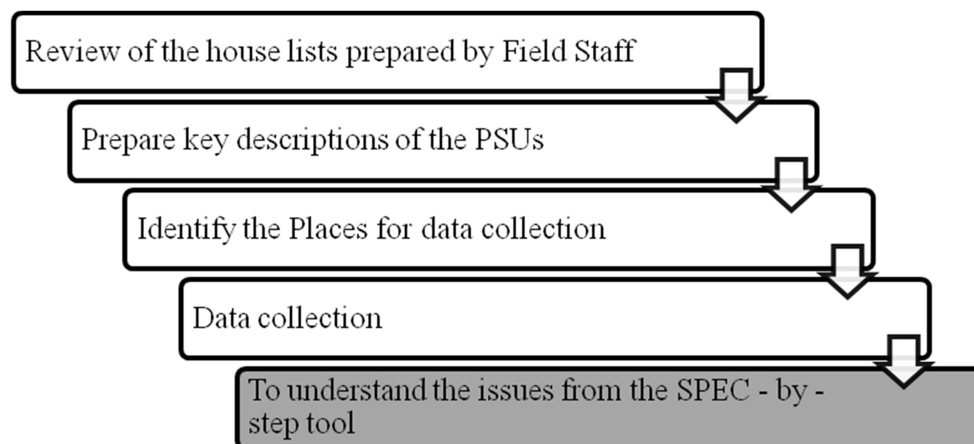
| No | Health Insurance Company | Districts covered | Selected District | Whether Tribal or not? |
|---|---|---|---|---|
| 1 | ICICI Lombard | Yeotmal, Thane, Jalgaon, Sindhudurga, Ratnagiri | Thane | Tribal |
| 2 | Apollo Munich | Beed, Osmanabad, Pune, Kolhapur, Satara | Osmanabad | Non Tribal |
| 3 | Cholamandalam | Jalana, Akola, Wardha, Buldhana, Washim | Jalna | Non Tribal |
| 4 | Tata AIG | Hingoli, Chandrapur, Bhandara | Bhandara | Non Tribal |
| 5 | ICICI Lombard* | Aurangabad, Latur, Nandurbar, Ahmadnagar | Nandurbar | Tribal |
| Source: RSBY State Nodal Agency. | | | | |

* - initially looked after by other health insurance company, now transferred to ICICI Lombard

Earlier it was decided to select the PSUs from each district randomly. On cursory review of the data from household survey we decided to include the PSUs based on their RSBY enrollment status. Thus, for a given district, a PSU with higher proportion of RSBY enrollment was selected along with a PSU with poor enrollment status, in order to understand the possible reasons behind the differences across settings. The aforementioned selection procedure was applied to the rural PSUs since the average number of urban PSUs per district was two, and where ever there were more than 2 PSU we

applied the same method of selecting PSU with higher enrollment and PSU with lower enrollment (Fig 3.3).

**Figure: 3.3 Process of data collection**




From each district a total of four PSUs were selected. Two out of them were rural and two were urban. In districts identified as "tribal districts" of Maharashtra (Nandurbar and Thane), we selected one PSU with tribal population for data collection.

Based on preliminary data analysis of the four PSUs (that is Nandurbar, Osmanabad, Jalna, and Bhandara), it was found that more qualitative information was required on non-utilization of RSBY scheme by valid RSBY card holders who reported hospitalization and non-enrollment of eligible households in the scheme. Thus, the methodology for Thane district was modified to gather qualitative data that could not be generated from the earlier four PSUs. In Thane district, three PSUs representing one each from the urban, rural, and tribal areas were selected. Table 3.4 provides brief profiles of selected districts and criteria for selection of PSUs within the district for Qualitative survey.

**Table 3.4: District profiles and criteria for selection of PSUs within the district for Qualitative survey**

| District | District Profile | Criteria for selection of PSU |
|---|---|---|
| **Jalna** | Jalna district is situated centrally in the Marathwada region of Maharashtra. It was separated from Aurangabad in 1981 into an independent district having Eight blocks (Jalna, Ambad, Bhokardan, Badnapur, Ghansavangi, Partur, Mantha, and Jafrabad). The Rashtriya Swasthya Bima Yojana (RSBY scheme) was implemented in the district for the first time in June 2009 with 'Chola Mandalam' as the insurance company. The official statistics indicate that the scheme was | Based on the estimates of quantitative data, it was decided to visit two urban and two rural PSUs in each district. For Jalna district, Jalgaon Sapkal and Paradh (both from Bhokardan block) were selected from among four rural PSUs where quantitative data was collected. These two PSUs were selected based on the enrolment status in the RSBY scheme (Jalgaon Sapkal was selected because it had the lowest enrolment and Paradh was selected because it had the highest enrolment, as indicated from the household |

| | | |
|---|---|---|
| | implemented in two rounds (or phases) wherein the rural parts were covered first followed by the urban areas of the district | list data).<br><br>Ward Number 32 was the only urban PSU which was selected for quantitative data collection and hence it was the only choice available for qualitative data collection as well.<br><br>Two FGDs were conducted in the urban PSU (Ward Number 32) as the research team while preliminary exploration of the PSU found three distinct sections within the PSU with a group of Muslims inhabiting one area that looked isolated from the other two sections which had a mixed population of both Hindus and Muslims. Therefore, the research team decided to conduct two FGDs – one with the Muslim community and the other with one of the mixed communities. |
| **Osmanabad** | Osmanabad district is situated in the southern region of the state and shares border with the neighboring states. Rashtriya Swasthya Bima Yojana was started in Osmanabad in the July 2009 and for the entire district the target set was 77586 below poverty line households which are deemed eligible for the scheme. For the initial round the insurance company was able to complete 53 % enrollment of the targeted household. Currently the scheme is implemented by the Insurance Company known as Apollo Munich. | Based on the estimates of quantitative data, it was decided to visit two urban and two rural PSUs in each district with higher enrollment and lower enrollment. For Osmanabad district, Ambernagar, Hangarga Nal (Rural) and Omerga, Bhum (Urban) were selected from among 7 rural PSUs and 2 urban PSU where quantitative data was collected. |
| **Nandurbar** | Nandurbar is situated in North Western Region of Maharashtra; it is surrounded by Gujarat and Madhya Pradesh on north side. It is known for the significant population of tribal population. Akkalkuwa, Dhadgao (Akrani), Shahada, Taloda, Nawapur and Nandurbar are the six blocks of this district. It has 62% tribal population and 75% of the rural population. Affirmative action is taken for the political representation of tribal individuals of this area and thus the seats for state assembly and | Based on the estimates of quantitative data, it was decided to visit two urban and two rural PSUs in each district. For Nandurbar district, Navagaon (tribal PSU), Nashinde and Chichpada (Rural PSU) and Nawapur (Urban PSU) were selected. |

| | | |
|---|---|---|
| | national parliament are reserved for tribal candidates. | |
| **Bhandara** | Bhandara District is a part of Vidarbha region surrounded by Madhya Pradesh in the north, Nagpur in the west and Chhattisgarh in the eastern region. The district was one of the most backward districts as classified by Ministry o Rural Development in 2006. The district is divided in 2 divisions and 7 blocks. The Rashtriya Swasthya Bima Yojana was started in the district in December 2009. The hospitals empanelled in the district are primarily located in the urban regions and most of them are located in Bhandara. | Based on the estimates of quantitative data we decided to visit 2 urban and 2 rural PSU in the district, we visited Sakoli-Gadkumbhali, Lakhandur in rural areas and Bhandara Ward no2 and Pawani Ward no. 9 in urban areas where there was relatively good Enrolment. |
| **Thane** | Thane occupies the west region of the state and is known for its population composition with significant no of tribal population in the rural areas and increasing urban population in the cities close to state capital – Mumbai. Thane has 15 blocks which vary significantly in the population composition and socioeconomic details. The RSBY scheme was initiated in 2008 in this district; however the enrollment indices for this district were low due to poor functioning of the insurance companies[4]. | Based on the inputs from the earlier data analysis it was decided to visit Thane to identify areas with higher enrollment to locate cases which might have utilized the scheme. Thus the number of PSUs we decided was reduced to three from the earlier four. The research team visited one of the high enrollment areas; however found that the cards distributed to the enrollees were not valid. The motive of finding cases in such a scenario was defeated. |

The participants for the FGD and IDI were selected with different strategies. For the FGD we used the household list to identify the potential participants for discussion. The field investigators went house to house to search for at least 15-20 individuals from both types of households i.e. RSBY enrolled and RSBY non - enrolled. We ensured the representation from both the genders, different castes, religious groups and elderly.

The respondents for In-depth interviews were selected from amongst the focus group participants, based on the identification of known cases of RSBY enrolled and RSBY utilization. For all the focus group discussions the essential criteria for selection of participant was being an individual from a BPL household. Further selection was made based on whether participants were from RSBY enrolled households or non-enrolled households. In addition to these broader criteria we made sure that the representation of scheduled caste, tribes, elderly, women, minority religious groups was reflected. The different age groups were considered for the focus group discussion. All of the participants may or may not be part of the house hold survey.

[4] Source: State Nodal Agency office for RSBY

**Design of the topic guides**

**FGDs –** The main objective of FGDs was to understand perceptions and views of the socially excluded on the performance of RSBY and to identify the barriers they face at each step of the SPEC tool.

Following were some of the questions that were answered during the process…
1. Are households with elderly less likely to be enrolled?
2. Why did the families not enroll all eligible members?
3. Who are more likely to be excluded and why?
4. What are the reasons for not issuing cards to some enrolled families? Does social exclusion play a role in it?
5. How were the cards distributed to them?
6. Why did some families receive the card late? Can social exclusion be attributed as one of the reasons for the delay in issuance of card?
7. Why did the RSBY family members not utilise services covered under RSBY?
8. Were they denied care at network hospitals? If yes, what are the reasons for refusal of admission?
9. Has 'balance billing' become a phenomenon in this market? Is it acting as a barrier for utilisation?
10. Has RSBY provided financial security against catastrophic health payments to the 'Poor'?

The FGD details (consent and discussion guide) are attached in **Annexure IVa and IVb**.

**In Depth interviews –** From each selected PSU, 3-4 In Depth interviews were carried out.

The objectives of In Depth interviews were as follows…
1. To describe how some individuals are excluded from social health protection (in the form of public financed health care services and RSBY in specific)
2. To describe the perceptions (awareness, willingness to participate, perceived utility of health insurance /scheme) about RSBY and its utilization (denial, attempt to use and incidence of partial coverage) by such socially excluded individuals.
3. To describe the intra-household exclusion of the individuals.
4. To describe the experience of those who have been enrolled in RSBY and utilised the scheme
5. To describe the experience of those who have been enrolled in RSBY and not utilised the scheme.

The In Depth interviews details (consent and interview guide) are attached **in Annexure III and IV**.

**Data collection process**
**FGDs –** From each selected PSU, one FGD was carried out. The team formed at Health Inc TISS consisting of research officers, research assistants, social workers and field assistants identified the PSUs for conducting FGD in both urban and rural areas. The field assistants helped ingathering participants and making other arrangements for the FGD.

**Profile of FGD participants:**
The following categories of participants were invited to participate in FGD…
1. RSBY member – male- hospitalized / undergone day care surgery
2. RSBY member – male- not hospitalized / not undergone day care surgery
3. RSBY member –female- hospitalized / undergone day care surgery
4. RSBY member –female- not hospitalized / not undergone day care surgery
5. Non RSBY Members-male- hospitalized / undergone day care surgery

6. Non RSBY Members-male- not hospitalized / not undergone day care surgery
7. Non RSBY Members-female- hospitalized / undergone day care surgery
8. Non RSBY Members-female- not hospitalized / not undergone day care surgery

**Process to conduct FGD:**
The household list was used as primary criteria for identifying the geographical area in the PSU and to identify participants for the Focus Group. We did this for the administrative ease and identification of BPL household. For the focus group we communicated with more than 15 members per PSU who were satisfying the eligibility criteria. Amongst them few individuals declined to participate owing to verity of reasons such as other commitments.

Each FGD consisted of 8 to 10 participants on average and approximately lasted from 40 minutes to an hour. One of the team member / field staff shielded additional people from entering the discussion room by explaining to them the RSBY scheme and its features. This mechanism proved useful in the following way: giving information to those wanting to enter the discussion room to witness the discussion proceedings helped in limiting the number of participants and preventing overcrowding and jeopardizing the discussion process, while also satisfying the information needs of a large crowd.

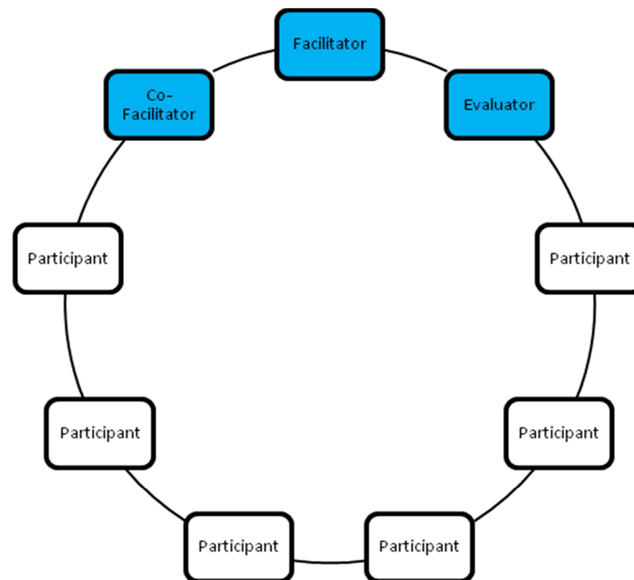
The FGDs were conducted in community centers, temples or schools within the village or town which were calm and non-disturbing places accessible to the participants. Each FGD was conducted by a facilitator along with a co-facilitator. All the FGDs were audio recorded and notes of the discussion were taken after following informed consent procedures. The groups also consented to be photographed. Besides this every group discussion was supervised by an **Evaluator**.

Before starting the discussion, the facilitator introduced himself, the research team members present, and explained the purpose of the FGD and took an informed consent from all of the participants and assured them of confidentiality and anonymity. An evaluator monitored the group discussion process objectively by noting following things such as: key issues discussed and not discussed, level of the participation of each of the member, the enthusiasm of the group on particular issue, disturbances during the discussion, discussion on sensitive issues, self-disclosure or experience sharing, facilitation and probing skills of the facilitator, general comment on the type of group – homogeneity/ heterogeneity among the participants, proceeding of the discussion, Questions raised, Questions unanswered by the Facilitator, overall rating for the FGD, etc.

**Positioning:**
For almost all the group discussion we attempted to organize the sitting arrangement in the way so that they will have a direct intra group communication. However not all FGDs were conducted like this.

The group should be arranged considering the positioning. All of the participants including both the Facilitator should sit in a circle so that each of the participants can see others face and discuss among them with ease. This conveys the message of equality and freedom of speech to every participant. An evaluator might sit not in a circle and he may not contribute to the ongoing discussion. He will just objectively observe the process and document important aspects of the FGD as noted above. The positioning should be represented diagrammatically in the notes. One example is given in Fig 3.4.

**Figure 3.4: Position of participants for FGD**




The focus group discussions were recorded and latter were analysed by making notes to answer the key research question and record the emerging themes associated with the research questions by the team of two individuals. The findings were examined by other set of researchers from Health Inc to ensure the findings were appropriate.

**In Depth interviews** – We used "hospitalization or day care surgery "as one of the indicator to identify possible participants. The participants were a mix of individuals who had suffered some kind of illness within the past one year and were at different stages of exclusion from the services. For instance those who did not receive RSBY cards, those who received it and were not able to use it in spite of need. We included the participants from those households which were not part of quantitative survey. To understand intra household exclusion, exclusion based on the basis of gender and age, respondents were identified within the pre identified respondents which predominantly included:

- BPL household members but not enrolled in RSBY
- Enrolled in RSBY and have utilized the services
- Enrolled in RSBY however were not able to use the services
- Enrolled in RSBY but were not able to receive complete cashless hospitalization services

On average nine in depth interviews per district were conducted.. Interviews were conducted in the setting so as to ensure minimum disturbance thus generally they were carried out in their home. Some In Depth interviews were conducted in pairs (two interviewers) from Health Inc team. After introduction, informed consents were taken from the respondents for interview, audio recording and note taking of the points discussed during the interview. Complete confidentiality and anonymity of the interviewee was maintained.

**Instruction to the interviewers:**

1. The interviews were in depth and were based on the probe guides. The probe points or guide lines were meant to understand different breaking questions. Thus the interviewer used the probe guide according to his or her convenience. At some times, the interview began with a random

start. However, the interviewer was advised to cover as many as topics / questions listed in guideline.

2. The questions were asked at interviewee's convenience. However, it was encouraged to complete all the probing points in order to capture all the aspects of research questions.
3. **Terminating the interview:** The respondents as explained in the informed consent form had a right to withdraw from the interview.
4. It was ensured that the process of interviewing was not being disturbed by the surroundings. For the interviews which involved sensitive issues, females and elderly, caution was taken to ensure **privacy** as much as possible.
5. The personal details of the individual were **confidential**.
6. Although the data collection form had space for specific probing points, interviewer carried a notebook to keep track of day to day notes.
7. All interviews were recorded in the audio recorder provided to interviewer after taking informed consent form the interviewee.
8. Instruction for each probing point was provided at the bottom of each set of questions. The interviewers were encouraged to allow the interviewee to expresses his / her thoughts freely without interruption. The schedules were recorded and the notes were taken as per the unique identification code conferred to the respondents.

**Data entry and processing**

The data was transcribed and translated for one of the districts, however considering the time that is required for transcription and translation we decided to prepare notes by listening to the audio recordings repetitively and record observations on key research questions that are supposed to be answered by individual methods.

**Data analysis**

The research team comprising of those who were present for data collection was divided in 2 groups of 2 individuals each. These groups listened to the recordings of Focus Group discussions and In-depth interviews repeatedly to prepare notes on chief findings. These notes were compiled as a district profile separately. At the second level of analysis the researchers reviewed the notes and the recordings to vet the findings and analyse the patterns and the host of reasons behind them.

We prepared the types of information that will be gathered from individual focus group and in depth interview, on the basis of social exclusion as primary criteria. We plotted the findings recorded in the pre decided format and tried to answer the reasons for the same. The SPEC – By Steps framework was taken as the explanatory framework for the types of findings we received all over the districts.

**Methodological challenges faced**

1. The disturbances in the interview
   a. Presence of other members: The presence of other members and onlookers is difficult to manage. The answers are influenced in the FGD when the participants know each other, where as for the qualitative interviews some respondents reply with difficulty. It is critical to explain the purpose of both the Focus Group and In depth interview to the participants, we were able to overcome the barriers in Focus Group, however it was difficult to take the family members out during the in depth interview.

b. No availability of community spaces in some PSU: Is some PSUs specially those where Muslim communities are residing it was difficult for us to find a place for conducting the focus group discussions. We managed to conduct some of the focus groups in houses of people.

2. Identification of BPL household: Due to various reasons some of the households on the list were not available for further discussions.
   a. Migration of the households: The migration of households both in quantitative and qualitative data collection was an issue that was difficult to overcome. For the quantitative data collection we replaced the household with the next available household from the house list; however for qualitative data collection it was difficult to find suitable household.
3. The household was an enrolment criterion and thus become defining criteria for selection of individual participants, this excluded those who were poorest of poor and were without any documented proof.
4. Language: There is huge variation in the dialects of Marathi that are used in four different corners of the state. For instance the Marathi in North Maharashtra region is a difficult to understand dialect called as – "*Ahirani*". This style of speaking has words from Gujarathi and Hindi Languages leading to a pattern of language that is not easily comprehended by the outsiders. Additionally in the areas where we conducted focus group discussion in the north Maharashtra there was people who were speaking their tribal language. Since one of the team members had lived in this area, he understood the dialect; it was possible to understand the discussions.
5. Apathy about the RSBY Scheme: In some of the interviews conducted among the BPL household members, the respondents were not only unaware about the scheme but also were frustrated due to non utility of the scheme.

**Limitations of the present study**

- This study was conducted in very limited and short time frame. We had to carry out data collection (both qualitative and quantitative) quite hurriedly to meet the steep deadlines set in the protocol during the initial planning stages.
- The fact that RSBY is gradually closing down in Maharashtra might have affected some results. Few participants who were aware about this were quite reluctant to talk about RSBY.
- Maharashtra is a very huge state and we had to cover 22 districts all over the state in a short time. It was added by other hurdles like difficult geographical terrain, language issues, etc.
- RSBY is being implemented in Maharashtra since only last 4-5 years. The scheme started and then immediately after few years being gradually closed in favour of RGJAY. It is possible that RSBY did not get sufficient time to settle down. Otherwise we have seen better results. So there is a possibility that RSBY might have been the wrong choice for selection as study topic.

# CHAPTER 4

# ETHICAL CONSIDERATIONS

## 4.1 – Ethical clearance

The Institutional Ethics Committee / Institutional Review Board (IEC/IRB) at Tata Institute of Social Sciences, Mumbai provided opportunity to Health Inc TISS team to present the study in front of them on 13 January 2012. The IEC/IRB conveyed their approval through letter dated 13 February 2012 for the period of 2 years.

## 4.2 – Data protection

The household questionnaire in the identification section asked the details of the investigators, field correctors, and data entry operators in the form of codes. The identity of the respondents was masked with the unique identification code. Since all of these individuals had access to the questionnaire they were monitored for strict conduct of activities. The completed questionnaires were collated at the localised facilities and mailed with courier to the data entry centers. The data was entered in the secured place and stored in a password protected database. In addition, data was stored in encrypted files. The access to the database was differential with different controls for the data entry operator, the editor and the viewer. The data protection measures were implemented for the data entry package that was used for quantitative data. The user, moderator and editing procedures were monitored with the help of team members at TISS Health Inc. The data was stored in the secured facilities at TISS. No individual level data will be published.

## 4.3 – Consent forms and permissions

Written consents were taken from all the respondents for household survey. The consent forms are attached as Annexures.

# CHAPTER 5

# RESULTS

## 5.1 – Qualitative Methods Findings

### Findings from Stakeholder Analysis

**Stakeholder Analysis:** As a part of stakeholder analysis, In Depth interviews of the deputy commissioner from State Nodal Agency, project manager and project implementer from one of the insurance company were conducted to understand few aspects of RSBY implementation in the state such as

- Selection criteria, the baseline list used for reaching the eligible population.
- Reasons for low enrolment where RSBY was introduced.
- Quality and extent to IEC activities conducted.
- Perceptions towards social exclusion and strategies adopted to reach the excluded population.
- Reasons for delay in issuance of cards and delay in card distribution.
- Quality of service delivery, mechanism to monitor the service delivery; incidences of denial of services
- Has 'balance billing' become a phenomenon in this market?
- Reasons for poor pace of enrolment during the subsequent year, proportion of renewal of the cards.
- There is a gap between the policy period and the renewal in the next rounds; was the gap substantial for many districts?

**Development Commissioner: State nodal agency**

- **Poor enrollment:** Respondent feels that primarily poor quality data has been used for enrollment of the households.

  *"The location, structure of the household has changed over the period of time which limits the efficacy of the enrollment agency in identification of the true beneficiaries quickly. For instance in Nagpur district we noticed that the data was not applicable at all with very poor conversion rate we decided not to implement the scheme in this particular district. "*

- **Information Education and Communication Activities:** The state nodal agency officer does not feel that the quality of IEC activities being conducted by the insurance company is the reason for poor enrollment status. He in fact quoted few success stories from the nearby district where the camp based enrollment of the beneficiaries helped them to enrol in a better manner.
- The respondent feels that the exclusion exists, however he found it theoretical to comment upon. He said that the scheme is grappling with several issues such as lack of manpower to monitor the implementation, to revive the list of beneficiaries etc. However he does not deny the possibility of some sections being excluded from enrollment due to reasons such as migration.
- The respondent reported that in the initial years the scheme was being implemented with the help of public sector company which failed to ensure sufficient coverage of the BPL families in

the allotted districts, as a result of this these districts were left behind in the enrollment status in the initial years.

**Insurance company 1: project manager**

- **Profile:** The respondent is responsible for implementation in six districts of Maharashtra.
- **Poor Enrollment:** He feels that the list was in a bad shape the reason being the data was taken from BPL surveys of 2002 and the quota as per the data of 1997. There were problems in identification of the households in a particular village.
- **Eligibility criteria and process of appeal for inclusion:** On asking if there was a provision for granting eligibility status to the family who fails to locate him in the BPL list he said insurance companies are not empowered to do that. However in a case where the household feels that it is eligible, it should go and request the block development officers through a formal application that is available with the RSBY functionaries (website). then the BDO has to verify their eligibility the up-gradation is reported back to state nodal agency and the state nodal agency then sends us the list in that case we can modify the scenario and enroll that particular household.
- When asked about existence of such practice in Maharashtra he reported that it is not happening in this state.

  *"Since the people don't understand the process at administration, some see that the card is just an identification card and don't know the use of it. In such cases the chances that these type of application will come to state are low. One may also notice that the institutional support at RSBY state nodal agency is weak; Mr XXX is the only man who has handled the scheme since the beginning. There is no man power to handle the stupendous task. In addition their office (labour) has own responsibilities (related to labor ministry).*"

- The respondent feels that the political parties at the local level create nuance and sometimes they can be of help. He narrated a incidence where the local politicians from the ruling party helped them to arrange the camp and spread the word in the village.
- The respondent feels that social exclusion might be there however it is government's responsibility to assist us and ensure that the enrollment take up even in these socially excluded people.
- He feels that the hospitals may not be always honest, those who have a attitude of service give much better services and with better consistency as compared to those who signed up for forgeries and earn money. The insurance companies will always black list such hospitals.

**The Insurance agent 2**

- The respondent feels that the enrollment coverage and the depth of enrollment depend on support of local administration. In of their districts they were supported by the local administrators which helped them to reach maximum number of people.
- The respondent feels that the field key officer (the government authorized person who is resident in the area of enrollment) has to be proactive. The insurance agency has to spend a lot of energy in mobilizing them and this is not a success story always.
- The respondent is aware about those who are excluded from the BPL list of 2002 may not always be deemed as non poor people. He indicated that there are issues of corruption and

nepotism at the very beginning of ascertaining the BPL status. Thus a lot of eligible people get excluded from the enrollment. Similarly the incorrect information in the BPL data make the matter worse, in absence of sufficient identification information the enrolling agents find it difficult to share the cards.

- The respondent feels that the funds that are drying up in some cases and in some cases there is no utilization. The premium of the scheme should be proportionate to the amount of money that is insured. The doctors consulting fees is zero in the scheme (non surgical) doctors have no incentive to use the schemes. RSBY is good in many ways for instance it covers all of the pre-existing diseases.

**Findings from Focus Group Discussions and In Depth interviews**

A district-wise comparison of key emerging findings from focus group discussions and in depth interviews has been presented in Table 5.1 and 5.2 respectively. Further, Tables 5.3 and 5.4 give an overview of the State level summary of key emerging findings and its possible explanations for reaching RSBY to its intended beneficiaries.

**Possible explanations for findings of Focus Group Discussions**

***RSBY awareness, enrollment, renewal, and utilization:*** The information and awareness that the participants had about RSBY was mixed. In Jalna, no one knew about the benefits of the scheme or how to use the card. In Osmanabad and Nandurbar, people identified the RSBY card as 'hospital card' and 'insurance card' respectively. Participants in Osmanabad and Bhandara were also aware about the use of the scheme for hospitalization expenses up to Rs. 30,000. The reasons for this mixed information could be attributed to factors such as the level of involvement of the enrollment agency in IEC activities and the political and social contacts of the people. Of those who knew about the scheme, they recognized the scheme when shown a sample RSBY card and not when told its name. Enrollment in all districts was not conducted by the same enrollment agency and that could have led to differential levels of IEC activities for RSBY. In Jalna in particular, the rural PSUs were located very remotely and the urban PSU had a sizeable Muslim population not enjoying good political involvement. Apart from not being aware about RSBY, the people in urban Jalna were not even enrolled in the scheme. However, RSBY enrollment was observed in the rural PSUs of Jalna. Similarly, all PSUs except a tribal PSU in Osmanabad had a good number of people who were enrolled and some even knew about the scheme benefits. Migration for employment could be one of the reasons for non enrollment in many PSUs. Also, the enrollment agency conducted only one day enrollment camps except in Nandurbar where the enrollment agency returned again after a week to enroll missed out beneficiaries. In Nandurbar the cards were also distributed immediately after enrollment and hospital list was also provided. Of the four districts, renewal also was reported in Nandurbar. Due to the tribal nature of Nandurbar, the authorities may have been under pressure to cover maximum number of people for enrollment. Utilization of RSBY was reported only in Nandurbar and Osmanabad. In Nandurbar, one of the beneficiaries who utilized RSBY turned out to be a non tribal and a relative of the ASHA worker. In Osmanabad, multiple utilizations were reported in one of the PSUs for minor ailments. New enrollments were not considered during renewal camps and that could be one of the reasons for non enrollment of beneficiaries who missed initial enrollment camps.

***Health system information:*** Majority of the people prefer to go to private hospitals as opposed to government ones. Government systems and infrastructure are poor as compared to private set ups. Moreover, the people trust private health care providers and feel that government employed doctors do not provide quality services.

***Other findings and observations:*** Being unemployed emerged as a major issue in all districts and perhaps migration for work opportunities could have led to low enrollments rates. Also, majority of the people who are below poverty line work as daily wage laborers and are uneducated and poor. The dominance of power and wealth leads to suppression of the poor and vulnerable thereby reducing their access to various information sources. In Jalna, geographical segregation was observed on the basis of caste (being tribal or from a supposedly lower caste) and religious identity (being Muslim).

**Possible explanations for findings of In Depth interviews**

***RSBY awareness, enrollment, renewal, and utilization:*** Almost all respondent of in-depth interviews had incomplete or wrong information about RSBY. For instance, in Jalna and Nandurbar, the respondent felt the RSBY card was an identification card. Enrollment was reported in all districts except in urban Jalna with Muslim population and one tribal PSU in Osmanabad. Renewal of RSBY cards was found to be negligible. Few respondents in Bhandara reported that their old RSBY card was renewed without providing them a new renewed card.

All those who needed hospitalizations were not able to utilize the scheme. The respondents in a PSU in Osmanabad from where multiple utilizations were reported knew more about the scheme and its benefits compared to those who had not utilized it. Those who utilized the scheme reported that the scheme was beneficial for the poor.

***Other findings and observations:*** Majority of the people who underwent hospitalizations experienced out of pocket expenditures and managed the funds from loans taken from relatives and friends.

**Table 5.1: Key emerging findings from focus group discussions conducted in four districts**

| Key Parameters | Findings | | | |
|---|---|---|---|---|
| | Jalna | Osmanabad | Nandurbar | Bhandara |
| ***Information about RSBY*** | • The beneficiaries enrolled in the scheme and having the RSBY smart cards were not aware of the benefits of the scheme and how to use the card. | • Participants did not recognize the scheme by its name but they could identify when a sample RSBY card was shown to them.<br>• Some people referred to it as the "Hospital Card".<br>• Some participants knew the coverage was INR 30,000 and food and transportation was covered under the scheme.<br>• Hospital list was provided only in Bhum (Urban) PSU. | • There was mixed awareness, some participants of the FGD participants were aware about the scheme but did not know the details.<br>• In one of the Rural FGD the participants correctly identified it as an "Insurance Scheme Card".<br>*(Research Team's Note: Nowhere in the other districts was this word used but still they were aware about the scheme.)* | • The information that was available with the respondents with regard to the RSBY scheme and its utility was incomplete.<br>• Participants don't know about the transportation cost and the free medicine provision after discharge from hospital which is feature of the scheme.<br>• Most of the respondents know that this is some scheme for hospitalization and very few know the financial coverage of Rs. 30,000.<br>• Participants identified the RSBY smart cards from the images.<br>• None of the participants were able to recognize the scheme on the basis of its name. |

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| ***RSBY Enrollment Status*** | • No enrollment in the RSBY scheme was found in the urban PSU, whereas in the remote / distant villages enrollment as well as renewal was reported.<br>• There was delay in card distribution and the mechanism of card distribution was not in line with the RSBY enrollment procedures. | • The rural PSU of Ambarnagar reported no enrollment, whereas the rest of the PSUs reported RSBY enrollment.<br>• The 2002 BPL list was used for enrollment leading to exclusion of many eligible households from getting the scheme benefits in PSUs that reported enrollment. | • In many of the visited PSUs enrollment was reported and cards were given to the beneficiaries immediately.<br>• The insurance company also distributed information booklets in some PSUs.<br>• For one of the PSU located in a remote area the insurance company visited twice with a gap of 7 days to enroll those who were left in the initial round.<br>• The focus group felt that the distribution of RSBY card was unjust, explaining further they said that those who were not in the DRD list did not receive the RSBY card which was unfair.<br>• They also feel that those who migrate for work were more likely to be excluded from such benefits (RSBY scheme) | • There was enrollment in all the PSUs.<br>• Participants from three out of four FGDs discussed that the list of empanelled hospital was not given. The enrollment agency only verbally shared names of some hospitals.<br>• Most of the focus group participants reported that the RSBY cards were not received immediately after the enrollment.<br>• Participant in one out of the four FGDs discussed that the elderly family member was excluded from enrollment in RSBY in case there were more than five family members. |

| ***RSBY Renewal Status*** | • Renewal was reported in the rural PSUs only. | • No Information available through the FGDs. | • In two of the four rural PSU the renewal was reported.<br>• New enrollments were denied at the time of renewal in Chinchpada PSU, the hospital lists were given during the renewal and not enrollment. | • Some of the FGD participants indicated that their cards were not renewed. |
|---|---|---|---|---|
| ***Health System Information*** | • No utilization was reported in PSUs which reported enrollment since the past two years. | • Bhum (Urban) was the only PSU that reported multiple utilizations at the same hospital even for minor ailments. | • People generally prefer to go to private hospital rather than government as they feel the treatment in government is not good.<br>• RSBY Utilization reported only in one PSU out of the four PSUs where FGDs were conducted. (This person was the relative of the ASHA worker). | • Most of the PSU reported that they prefer the private hospitals |
| ***Any Other Findings*** | • In one of the focus group the participants identified a social group (koli caste) as continuously being neglected.<br>• In two FGDs the | • Unemployment was a major issue and most of the villagers worked as daily wage laborers having no permanent job security. | • The research team had seen that the minority groups such as Muslim and Tribal face discrimination in the form of geographical segregation or | • People are not happy with the interaction with the public administration.<br>• They feel that there is corruption present in the system. The rich and powerful exploit the |

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|  | participants reported that political influence lead to poor implementation of social protection schemes.<br>• Participants felt that the documentation process for the below poverty line list and the ration card is complex and the administrative machinery declines their efforts to attain a BPL status or to obtain benefits of social protection mechanism such as ration cards.<br>• Unemployment emerged as a major issue in all PSUs.<br>• Many people were excluded from many social protection mechanisms. |  | isolation. Being separate from the main village was associated with poor awareness about details of RSBY and other social protection schemes. | poor. There was a feeling that the rich and powerful people have access to all resources as compared to the poor. For instance the feeling is that they will indulge in corrupt practices and take away the benefits meant for the poor people. In some instances those who are in power were reported as non considerate of the grief of poor.<br>• Participants suggested that the minor illnesses should be covered in the scheme. |
| ***Interviewer's Observations*** | • The urban PSU of Jalna was well connected to main market and had good public transport system.<br>• The rural PSUs were | -- | -- | -- |

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| | very remote and public transport connectivity was poor.<br>• Geographical segregation was observed in all the PSUs based on caste and religious identities.<br>• Participants did not recognize the scheme by its name but they could identify when a sample RSBY card was shown to them while gathering participants for the FGD in the rural PSUs. | | | |

**Table 5.2: Key emerging findings from in depth interviews conducted in four districts**

| Key Parameters | Findings | | | |
|---|---|---|---|---|
| | **Jalna** | **Osmanabad** | **Nandurbar** | **Bhandara** |
| ***Information about RSBY*** | • Respondents identified the RSBY smart cards from the images<br>• None of the respondents were able to recognize the scheme on the basis of its name.<br>• One of the respondents | • People in Ambarnagar were not aware about the scheme.<br>• Majority of the respondents in the enrolled PSUs received the list of empaneled hospitals but all were | • The beneficiaries did not know the scheme by its name.<br>• However they were able to identify when shown the sample RSBY card.<br>• The understanding | • Nearly most of the respondent was aware about the RSBY card.<br>• The information that was available with the respondents with regard to the RSBY scheme and its utility was |

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| | felt that it is “Adhaar card” (a government identity card).<br>• The information that was available with the respondents with regard to the RSBY scheme and its utility was incomplete. | not aware of the contents of the list.<br>• People in Bhum PSU (urban) were much more aware about the utility of the RSBY scheme for hospitalization purpose compared to the other PSUs where there was enrollment. People in Bhum referred to the RSBY card as the “Hospital Card”. | about the utility of the scheme was mixed.<br>• While most of them knew it has something to do with hospitals, few mentioned that it is an important document and can be useful as an identity proof.<br>• Majority of the respondents including tribals had received the RSBY card.<br>*Research Team’s Note: Thus one can say that the penetration of the scheme was comparatively better in this district. It needs to be compared with quantitative findings.* | incomplete. |
| ***RSBY Enrollment Status*** | • Amongst those interviewed majority of the respondents did not have the RSBY cards (only two respondents reported having the cards and they were from the rural PSU<br>*Research Team's Note: needs to be validated* | • No enrollment was reported from Ambarnagar, whereas all other PSUs reported enrollment. | • Majority of the respondents including tribal had received the RSBY card.<br>• While the cards were distributed in the district few villages were left in case of renewal. | • Amongst those interviewed all respondents have the RSBY cards except one respondent. |

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| | *from the quantitative data.*<br>• One respondent mentioned that there was dominance of the people from upper caste and those living in the main village. | | | |
| ***RSBY Renewal Status*** | -- | • Only one renewal was found in one of the IDI in Bhum PSU (Urban). | • Renewal of RSBY card was not reported by any of the respondents. *Research Team's Note: This has left them with more confusion the research team feels that this will lead to even lesser utilization if the scheme is continued.*<br>• One respondent was denied enrollment by enrollment agency when they visited his PSU during the renewal in the year 2011. | • Renewal was reported by some respondents.<br>• However those of who said that their cards were renewed some reported that they were not provided with reprinted cards.<br>• In one case the card was renewed by writing the date of renewal with pen and utilization was reported by that respondent on the basis of hand written renewal. |
| ***History of Hospitalization*** | • Borrowing loan from relatives was a common coping strategy in case of catastrophic health events.<br>• While one case reported that he had taken loan | • Utilization of RSBY amongst the respondents of Osmanabad is not a common phenomenon except for Bhum PSU.<br>• In Bhum all the | • Few hospitalizations were reported by the cases from tribal population. Those who reported hospitalization have not used the RSBY card that they | • Out of pocket expenses in spite of having RSBY cards were reported. For instance the themes discussed were that some of the ailments will not be |

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| | from the bank two reported selling of assets.<br>• Five out of six interviewed respondents felt that private hospitals are a better option compared to government hospitals. | respondents had used the card irrespective of the level of awareness, and knowledge of the scheme. The utilization was for minor ailments such as fever and hospitalization was for about three days in each case studied.<br>• No utilization in other PSUs.<br>• Some RSBY card holders in PSUs other than Bhum who required hospitalization in past one year were not able to use the services of the scheme. | have with them.<br>• Utilization of the RSBY scheme was reported by two respondents and two more reported non utilization in spite of having the need to do so | covered in the scheme (sometimes the amount covered in the insurance scheme package for a particular disease will be lesser), and there will always be a need of additional money which is borrowed from friends and family<br>• Two respondents having valid RSBY card reported denial of medical services by the hospital.<br>• Borrowing loan from relatives was a common coping strategy in case of catastrophic health events. |
| ***Any Other Findings*** | • There is dominance of few social groups such as higher castes, political groups, and wealthy people. | • Majority of respondents were daily wage laborers and belonged to minority groups such as Muslims and tribals. | • One of the respondents who utilized the RSBY card reported that she was given the bills by the hospital and was told how much amount was balance in her card account.<br>• This was not generally | -- |

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| | | | the case, in other places we found that those who used the scheme were not informed by the service providers about the costs and the money that was balance in the card. | |
| ***Interviewer's Observations*** | • The urban PSU of Jalna was well connected to main market and had good public transport system. The rural PSUs were very remote and public transport connectivity was poor. | -- | • The language and appearance of tribal members is very different from those who live in the urban areas.<br>• The respondents reported that they find it difficult to read and comprehend the Marathi text and speak the language too.<br>• Considering the fact that most of the hospitals are located in urban areas we felt that the tribal people were not very keen to explore the options that are available for hospitalization. | -- |

**Table 5.3: Common key emerging findings of FGDs from all four districts**

| Key Parameters | Key Emerging Findings | Possible Explanations |
|---|---|---|
| ***Information about RSBY*** | • There was mixed awareness about the scheme.<br>• At some places, such as Jalna and tribal PSUs of other districts, the participants did not know about the scheme at all.<br>• In places such as Osmanabad and Bhandara the awareness was much better and ranged from being aware about the card benefit and the coverage amount. However, detailed information was not known to anyone.<br>• In fact, the participants in one of the PSU in Osmanabad identified the card as "Hospital Card" and in one PSU in Nandurbar it was termed as an "Insurance Card".<br>• However, no one knew the name of the scheme and identified only when a sample RSBY card was shown to them. | • The enrollment agencies were not properly trained to give information about the RSBY.<br>• Districts with active political leaders may report better enrollment and awareness about RSBY.<br>• The name of the scheme is too long for the common man to remember. Thus, a simple yet appealing and self explanatory name might help in generating awareness about the scheme. |
| ***RSBY Enrollment Status*** | • In Jalna, enrollment was found in the rural and remote PSUs whereas in other districts the opposite was true.<br>• Even within the PSUs in a district wide variations in enrollment status were seen. | • Political active local leaders and strong enrollment campaigns by enrollment agencies could possibly be the reason for better enrollment in some areas than the others.<br>• Another reason for lower enrollment could be migration outside for employment purpose. |
| ***RSBY Renewal Status*** | • Compared to enrollment, not many beneficiaries were renewed in the scheme. In majority of the cases the renewal camps were not conducted in their villages / cities. Secondly the lack of information about renewal leads to missing of the renewal camp. In one of the study sites we noticed that the same smart card was given back to the beneficiary without printing a new one. This is a potential breach in the RSBY guideline. | • Beneficiaries may have migrated outside for work purposes and may have missed the renewal camp.<br>• Some may be excluded because their names did not appear in the 2002 DRD (BPL) list. |
| ***Health System Information*** | • Almost everyone preferred to visit private health care facility and not a government one. | • People did not believe in the government systems due to its time consuming procedures, inefficient resources and callous nature towards the poor. |

| | | |
|---|---|---|
| ***Any Other Findings*** | • Unemployment emerged as a major issue almost everywhere and migration to outside towns for work was a natural result of it.<br>• Many participants were daily wage laborers. | • The rich and powerful exploited the poor putting them into a web of poverty and helplessness. |
| ***Interviewer's Observations*** | • Geographical segregation was observed on the basis of religion and social identity (Muslims and Tribals).<br>• It was seen that elderly were excluded if there were more than five family members; however it was not the case always, and due to cultural factors elderly were enrolled instead of children in some households. | • This phenomenon may be deep rooted in cultural beliefs and traditions. |

**Table 5.4: Common key emerging findings of IDIs from all four districts**

| Key Parameters | Key Emerging Findings | Possible Explanations |
|---|---|---|
| ***Information about RSBY*** | • All most all the respondents identified the scheme when showed a sample RSBY card.<br>• No one knew the scheme by its name.<br>• There was mixed awareness about the scheme.<br>• Some respondents felt that it was the "Aadhar Card" (a unique identity card provided by the government of India).<br>• Some respondents felt it was the "Hospital Card".<br>• Only a few people knew the benefit of the RSBY card and the coverage amount.<br>• Some respondents reported having the list of empanelled hospitals but did not know what the contents of that list were. Many did not receive any such list. | • The enrollment agency perhaps provided very superficial information and hence many did not even know what the card was about.<br>• People close to the political system or having powerful contacts may have the understanding of the "Hospital Card" and may even know the hospital where the card works.<br>• Many people in the visited PSUs were uneducated and did not know even to read, so even if they were given the list of empanelled hospitals, it was unlikely that they may have read it. |
| ***RSBY Enrollment Status*** | • Enrollment in the scheme was mixed.<br>• Areas having specific groups such as Muslims and Tribals seemed to report less or no enrollment compared to others. | • Some eligible beneficiaries may have migrated for employment and may have missed the enrollment camp.<br>• Adequate publicity for enrollment may not have taken place.<br>• Inactivity of the local leadership could lead to certain PSUs being excluded completely. |

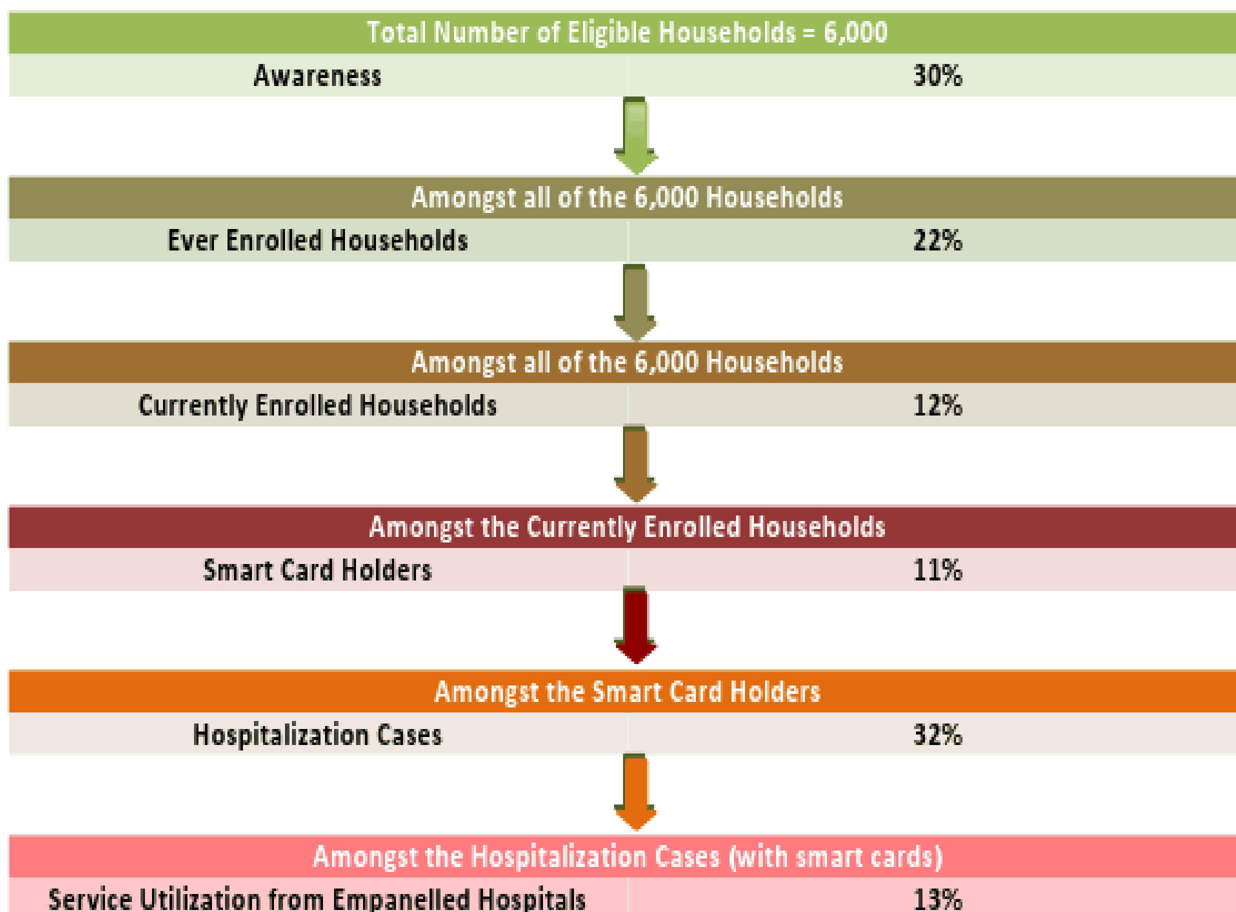
| *RSBY Renewal Status* | • The renewal was not as much as enrollment.<br>• In some PSUs renewal was reported but when asked about the renewed card, it was reported that new card was not provided. | • The enrollment agencies may not have actively tried to locate previously enrolled members for the purpose of renewal.<br>• Some enrolled beneficiaries may have migrated for employment and may have missed the renewal camp.<br>• Adequate publicity for renewal may not have taken place.<br>• Inactivity of the local leadership could lead to certain PSUs being excluded completely.<br>• There possibly could be an angle of corruption wherein the enrollment agency may be taking the renewal fees and not providing the new cards, in order to pocket some extra money. |
|---|---|---|
| *History of Hospitalization* | • People generally preferred to go to private health care facilities.<br>• There were instances where some of the households reported catastrophic medical expenditure and borrowing of money from relatives and villagers but were not able to utilize the RSBY scheme. | • There was a general anger and resentment towards government system.<br>• Eligible people do not get RSBY cards or if they have cards they are denied utilization due to non renewal or lack of awareness about empanelled hospital. |
| *Any Other Findings* | - | - |
| *Interviewer's Observations* | - | - |

## 5.2 – Quantitative Methods Findings

### SPEC-BY-STEP Findings

The household data was analyzed using the localized SPEC-by-STEP analytical framework to assess the efficacy of the RSBY implementation in Maharashtra. We broke down the RSBY coverage into a cascade of steps shown in Figure 5.1 with each step determining the number of people excluded and non-excluded by the programme. The non-excluded are shown to the right, in each shaded bar.

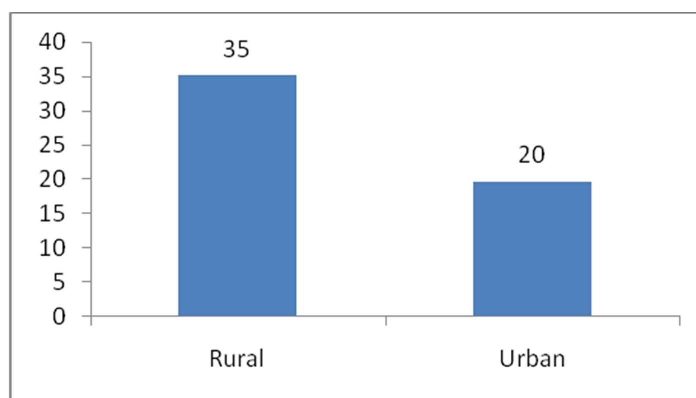
**Figure 5.1: Description of Steps in the SPEC-BY-STEP framework**




**STEP 1:** *From population targeted to sub-population reached (N=1781 Households)*

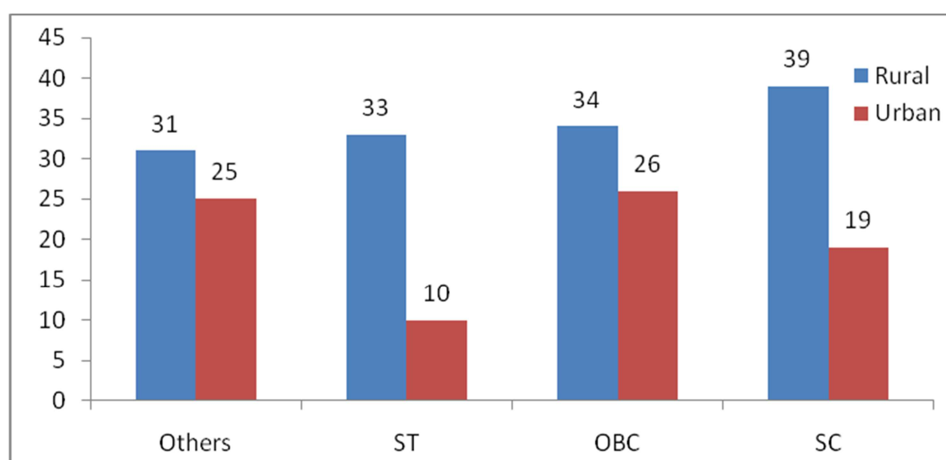
In Maharashtra, across 22 districts, 6000 households were contacted for the survey. Since all these households belong to the BPL category, they were eligible for the scheme. Of these households, only 30% reported that they were aware about the scheme. Theoretically speaking, the programme is supposed to generate 100% awareness about the scheme but the findings suggest that it could so far achieve a very limited awareness amongst its target population, even after 4 years of implementation in the state.

**Figure 5.2 Households aware about the scheme by place of residence**




As shown in figure 5.2, differences are found between rural and urban areas in terms of awareness about the scheme. The awareness level regarding RSBY was considerably higher amongst the households in rural Maharashtra than amongst the households in urban parts of the state.

**Figure 5.3 Households aware about the scheme by caste**



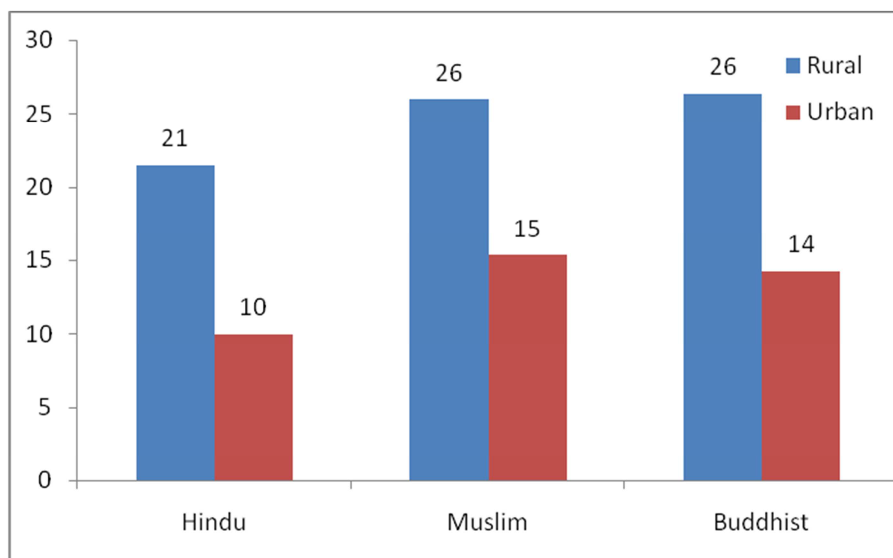

*Caste*

Figure 5.3 depicts the proportion of households aware about the RSBY scheme across social groups in Maharashtra. It is observed that social differentials in awareness about RSBY were not very significant in rural areas compared to urban areas. In rural areas, the level of awareness was highest amongst the respondents of SC households (39%), followed by OBC households (34%), ST (33%) and others (31%). In urban areas, 10% of ST households are aware compared to 19% of SC households, 25% of 'others' and 26% of OBC households.

*Religion*

Figure 5.4 presents the level of awareness of the eligible households by their religious background in rural and urban areas. The proportion of 'aware' households was highest among Muslims and Buddhists (26% each), followed by Hindus (21%) in the rural areas. Similarly, in urban areas, the proportion of households having awareness about RSBY was highest among Muslims (15 %), followed by Buddhists (14%) and Hindu (10%).

**Figure 5.4 Households aware about the scheme by religion in rural and urban areas**



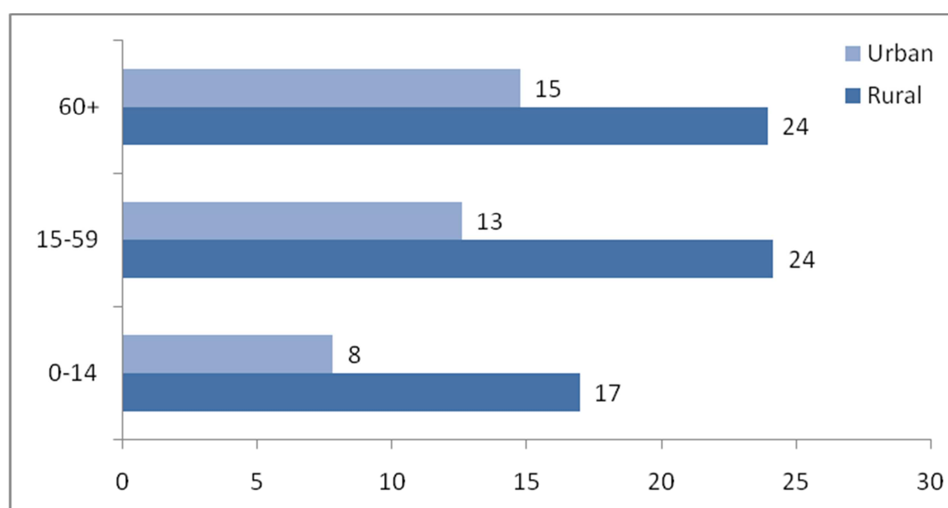

**STEP 2:** *From sub-population reached (aware) to those ever enrolled (N=1295 Households)*

Interestingly, upon enquiring about the insurance status of the BPL households, it was found that 22% were ever enrolled under RSBY. The ever enrollment rate of BPL households was considerably higher in rural areas (27%) than in urban areas (13%). Ever enrolled are those who became the member of RSBY at some point since the beginning of the scheme but may not necessarily be still enrolled with the scheme. We looked at the socio-demographic differentials in ever-enrollment.

*Age*

Both rural and urban areas have highest proportion of ever-enrolled population in the 60 plus age group (24 and 15 percent respectively) and lowest in 0-14 younger age group (17 and 8 percent respectively). The finding of low enrollment amongst the younger age groups is on expected lines as many of them may not have been born at the time of 2002 BPL census. About one-fourth of the working age group (15-59 years) population was ever-enrolled in rural areas compared to 13 percent in urban areas.

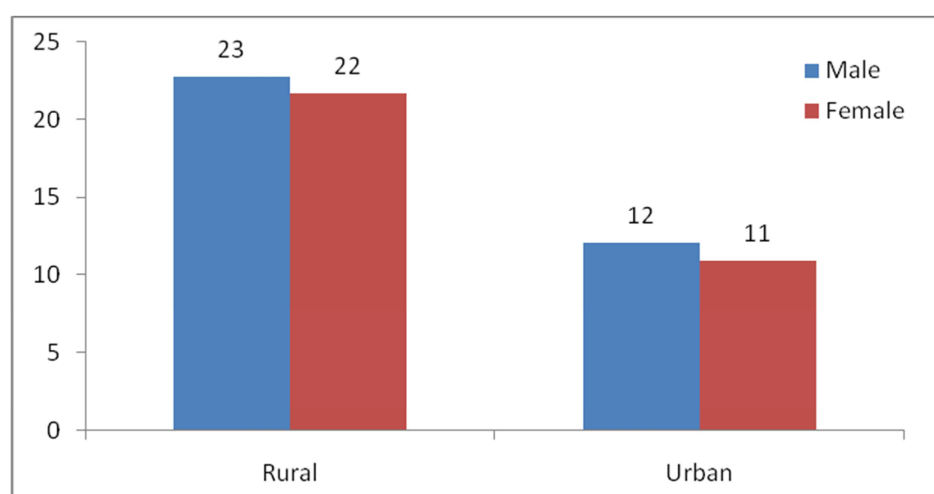
**Figure 5.5 Ever-enrollment rate by age in rural and urban areas**




*Sex*

Figure 5.6 shows the rate of ever-enrollment by sex in rural and urban Maharashtra. The ever enrollment rate was slightly higher amongst males than amongst females in both rural and urban areas. It was 23 and 22 percent for males and females respectively in the rural areas while the same was found to be 12 and 11 percent for males and females respectively in the urban areas.

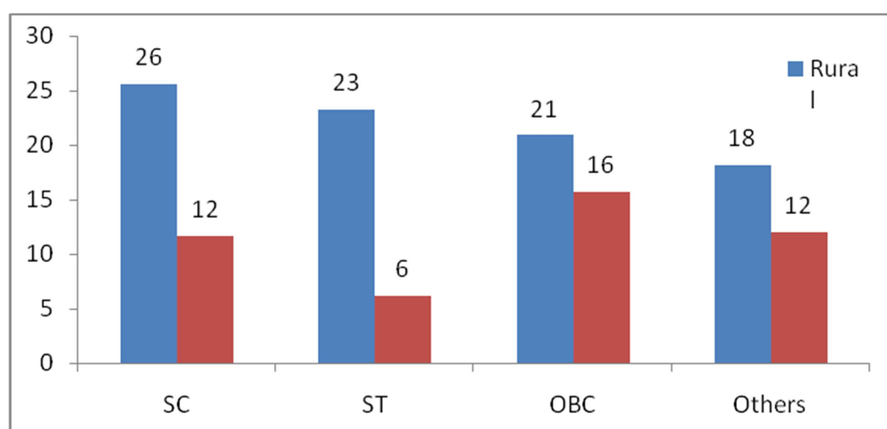
**Figure 5.6 Ever enrolled members by sex, 2012-13**




*Caste*

Figure 5.7 shows the caste-wise ever-enrollment rate by place of residence. The proportion of ever enrolled individuals was found to be the lowest amongst the STs (6%) compared to OBCs (16%), SCs and other castes (12% each) in the urban area. However, the caste-differentials in ever-enrollment of RSBY in rural area were not as pronounced as in the urban area. Rather, in the rural areas, highest enrollment was recorded amongst the SCs (26%) followed by ST (23%), OBCs (21%), and 'others' (18%),

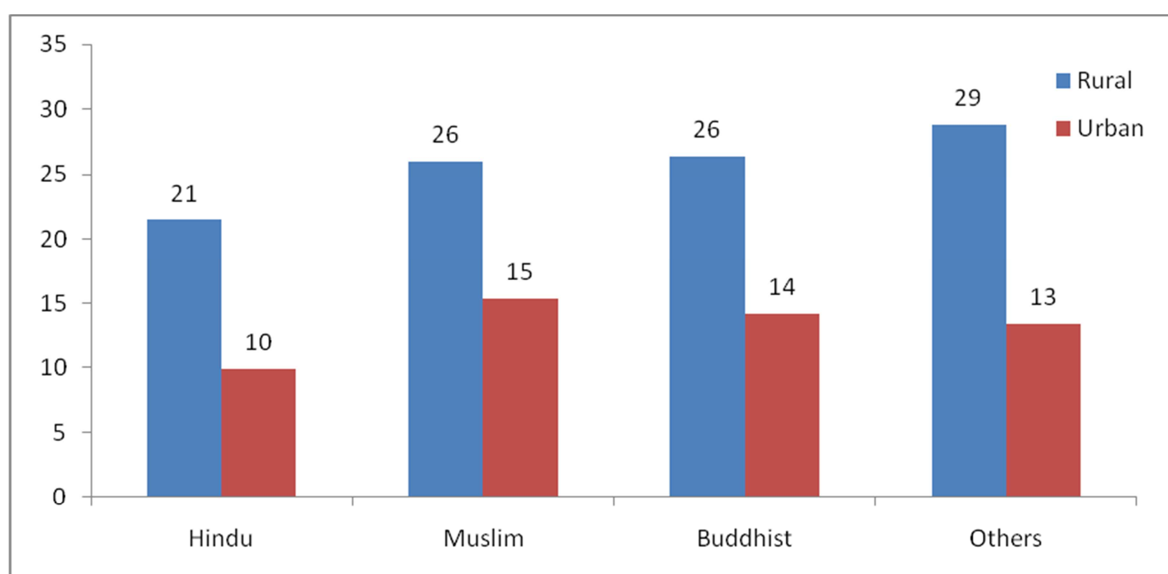
**Figure 5.7 Caste-wise ever enrollment rate amongst members in rural and urban areas**




*Religion*

According to figure 5.8, amongst those who reported "ever enrollment" in rural areas, 26% of them are Muslims and Buddhists respectively whereas 21% are Hindus. The reported ever enrollment rate was highest amongst people belonging to 'other' religious minorities including Christians, Sikhs and Jains (29%) than respondents from religious groups mentioned above. Similarly, in urban areas, 10% are Hindus, 13% are from other religious minorities, 14% are Buddhists and 15% are Muslims.

**Figure 5.8 Ever-enrollment rate by religion and place of residence**

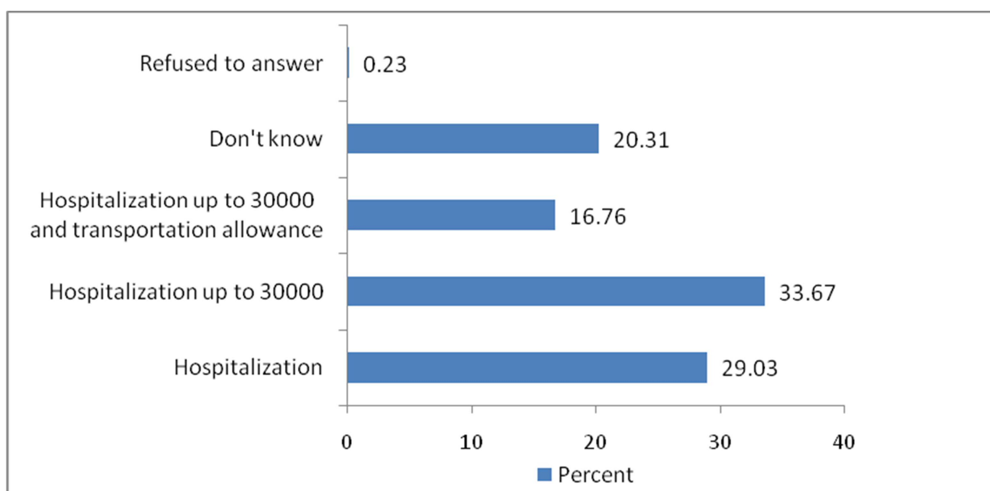



We have also analyzed the data to understand the basic awareness level of the ever enrolled households about RSBY scheme of the government.

**Basic Awareness about RSBY**

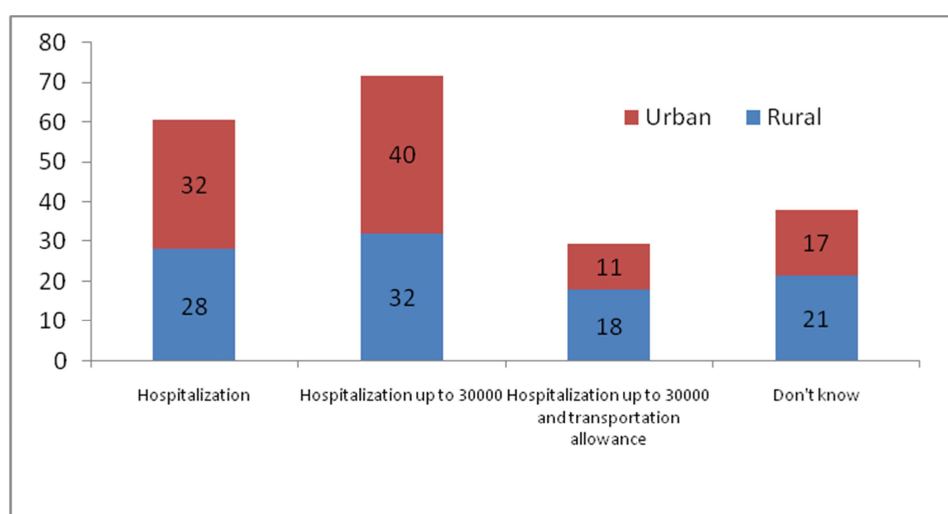
Figure 5.9 displays the percentage of ever-enrolled respondents being aware about the provisions of expenditure under RSBY. Of those, 79 % were able to say that the scheme was about hospitalization. But only 17 % were aware about all three necessary components such as hospitalization, the expenditure coverage and the transportation allowance. While 50 % knew about the limit for hospitalization, 20 % of the respondents indicated that they were not aware about any of these details regarding RSBY.

**Figure 5.9 Awareness about provisions of expenditure under RSBY**




However, as evident in figure 5.10, there was no pattern observed based on the urban – rural divide in the awareness about provisions of expenditure amongst the respondents.

**Figure 5.10 Provisions of expenditure by place of residence (in percent)**




**Depth of awareness**

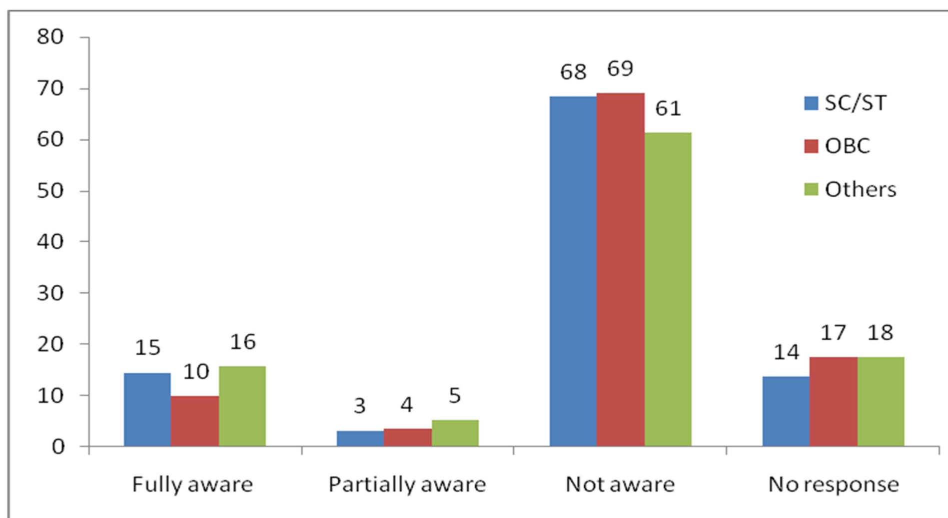
In order to understand the depth of their awareness about the scheme, further analysis was carried out. In the survey, the respondents were asked to state about what benefits are included in the RSBY package. This information was used to understand the extent of awareness amongst them. We classified them into three categories-'fully aware'- those who could tell about all the components, 'partially aware'- those who had knowledge about any of the components and' not aware' are those not able to provide any correct answer. Table 5.5 shows that the proportion of those who were 'fully aware' was much lower in the rural population (3%) as compared to their urban counterparts (7%), though there is no such differential found in case of 'partially aware' respondents. Notably, the proportion of 'not aware' was higher in the urban areas (16%) than in the rural areas (13%).

**Table 5.5 Depth of awareness about the RSBY benefit package by place of residence (in percent)**

| | Rural | Urban |
|---|---|---|
| Fully aware | 3 | 7 |
| Partially aware | 66 | 67 |
| Not aware | 13 | 16 |
| No response | 19 | 11 |

Importantly, caste differentials are observed amongst those who were 'fully aware'-16% belong to 'others', 15% to scheduled caste and scheduled tribe and 10% to OBC category (figure 5.11). There was no variation in the proportion of those who were 'partially aware' about the scheme based on their caste affiliation. Of those who said that they were 'not aware' about the scheme, majority of the respondents are from OBC (69%), followed by SC and ST (68%) and others (61%).

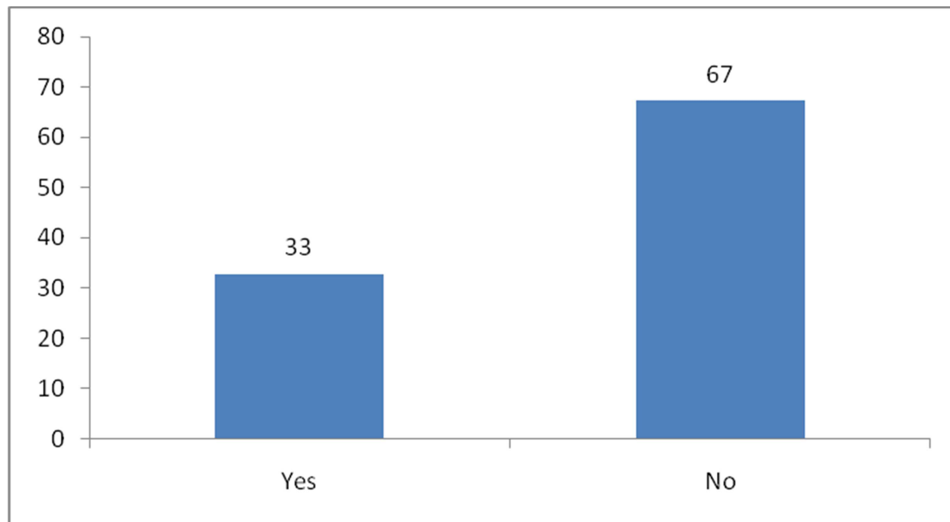
**Figure 5.11 Depth of awareness about the RSBY benefit package by caste (in percent)**




**Information provided by Insurance Company about listed hospitals in RSBY**

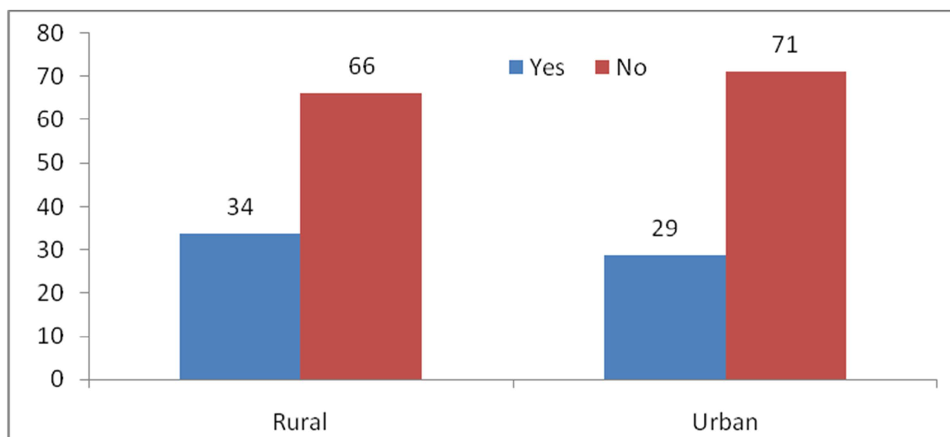
In the survey, questions were also asked to affirm whether they knew about the listed hospitals under RSBY as this is likely to affect the utilization of services. About 33% of the respondents reported that they were provided information regarding the empanelled hospitals by the insurance company.

**Figure 5.12 Information provided by insurance company about empanelled hospitals**



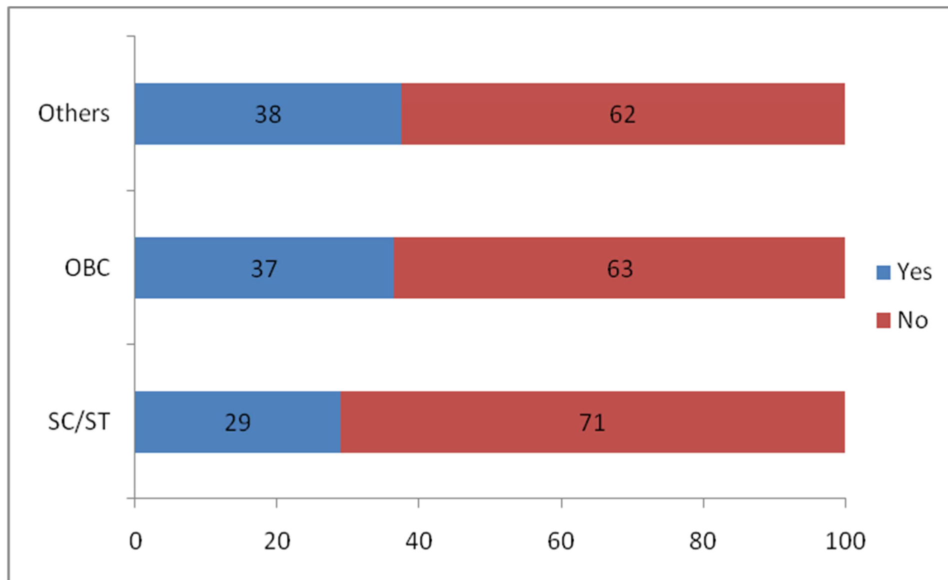

It can be observed from figure 5.13 that the proportion of the respondents who said that the insurance company provided them information about the empanelled hospital was higher in rural area (34%) as compared with urban area (29%).

**Figure 5.13 Information provided by insurance company about empanelled hospitals by place of residence**




It is evident from figure 5.14 that SC/STs were at disadvantage in terms of receiving information on empanelled hospitals than other social groups. The proportion of those who said that they were provided the information about the same was 29%, 37% and 36% amongst the SC/STs, OBCs and Other category respondents respectively.

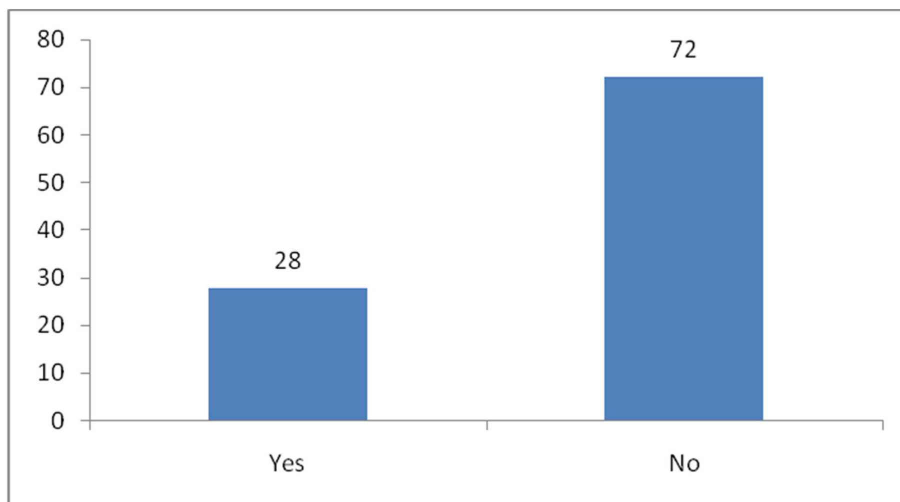
**Figure 5.14 Information provided by insurance company about empanelled hospitals by caste**




**Knowledge about the location of empanelled hospitals**

Further the ever enrolled respondents were probed to find out if they knew about the location of empanelled hospitals as this can affect the utilization of services when required.

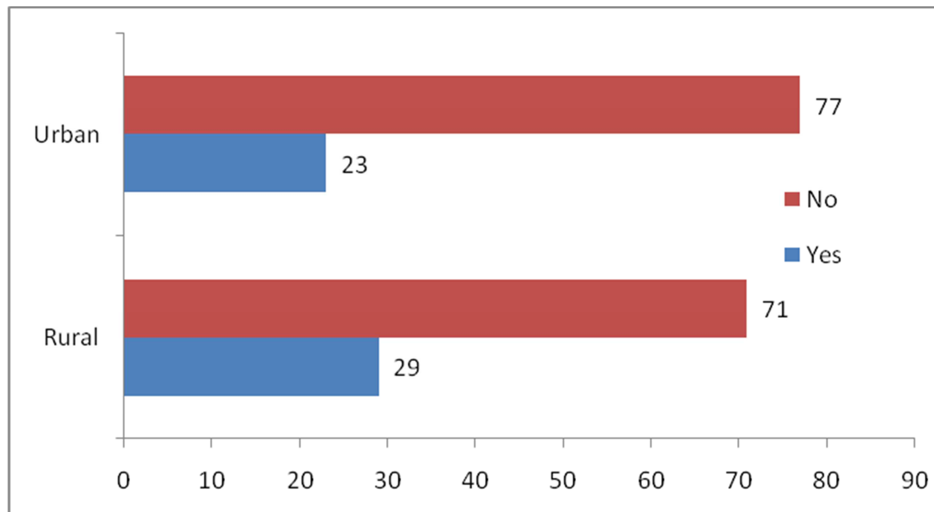
**Figure 5.15 Knowledge about the location of empanelled hospitals**




**Knowledge about empanelled hospitals**

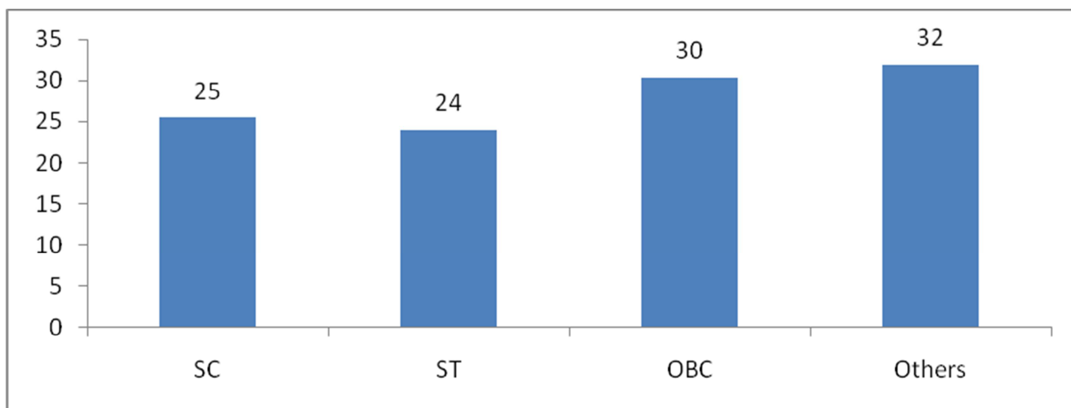
Figure 5.16 shows the percentage of ever-enrolled respondents having knowledge about the location of listed hospitals by place of residence. The proportion of the respondents who were aware about where the empanelled hospitals were located was found to be higher in rural area (29%) than in urban area (23%).

**Figure 5.16 Knowledge about the location of empanelled hospitals by place of residence**




Social class differentials are observed in terms of having knowledge regarding the location of listed hospitals under RSBY (Figure 5.17). While only 24% of the ST respondents were able to tell where are the empanelled hospitals located, the knowledge of this information was much higher amongst respondents belonging to other social groups-25% amongst the SCs, 30% amongst OBCs and 32% amongst the 'others' category.

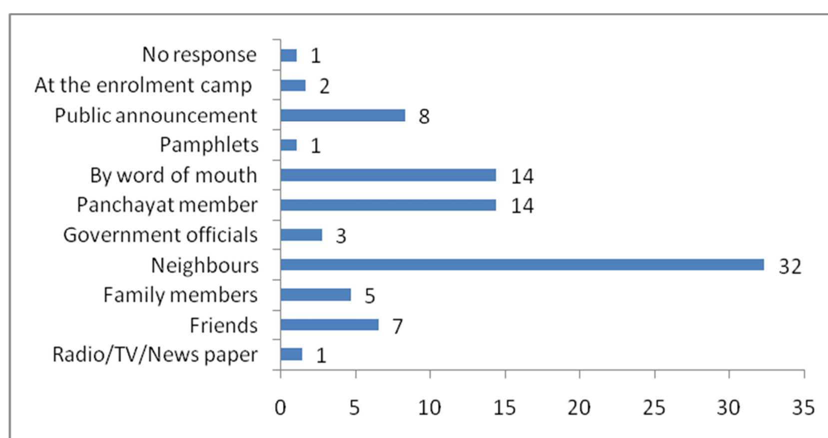
**Figure 5.17 Knowledge about the location of empanelled hospitals by caste**




**Source of information for ever enrolled**

The source of information can have an impact on the way beneficiaries understand the scheme and recall exact particulars.

**Figure 5.18 Source of information regarding RSBY**




It can be seen from figure 5.18 that majority of the respondents received information about RSBY by word of mouth. The information was passed on to them by their neighbours (32%), panchayat member (14%), friends (7%) and family members (5%). Only 8% of the respondents said that they got to know about it through public announcement. Other source of information included enrollment camp (2%), radio/television/newspaper (1%), pamplets (1%) and ASHA or ANM (0.31%).

**Awareness amongst never enrolled**

The analysis suggests that the level of basic awareness amongst the never enrolled is very low as only 10% and 9% of the respondents in the rural and urban areas respectively said that they were aware about the scheme.

**Table 5.6 Knowledge about RSBY (heard of RSBY)**

| | Percent |
|---|---|
| Rural | 9.61 |
| Urban | 8.8 |

**What is the scheme about?**

Those who heard about the scheme identified it mostly as an insurance scheme (46%) though some thought of it as a card needed for free hospital treatment (22%). Thus majority of individuals could relate it with hospitalization. However, about a third of them did not know anything more than the name of the scheme.

**Table 5.7 Meaning of RSBY amongst those who heard of RSBY but not enrolled**

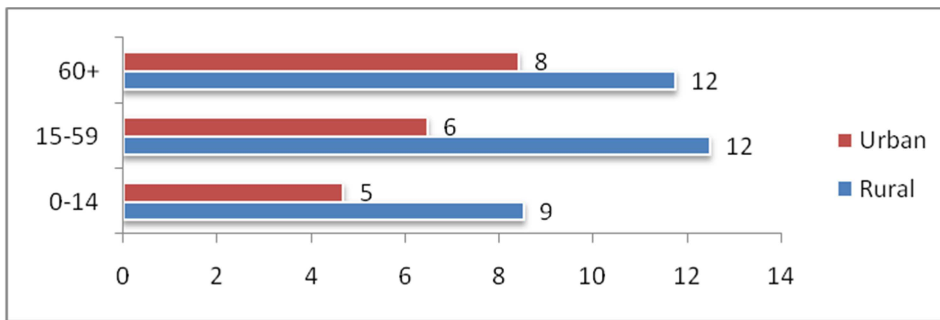
| | Percent |
|---|---|
| Health insurance scheme | 46 |
| Identity card | 3 |
| Free hospital treatment | 22 |
| Don't know | 28 |
| Refused to answer | 1 |

**STEP 3:** *From those ever enrolled to currently enrolled (N=718 households)*

Notably, the analysis revealed that only 12% of the BPL households are currently enrolled in the scheme in Maharashtra. As observed in case of ever enrollment, the current RSBY enrollment rate of the BPL population was higher in rural areas (14%) compared to urban areas (8%). Notably, the current enrollment for the BPL population further declines to 9 percent in Maharashtra with 11% in rural and 6% in urban areas.

*Age*

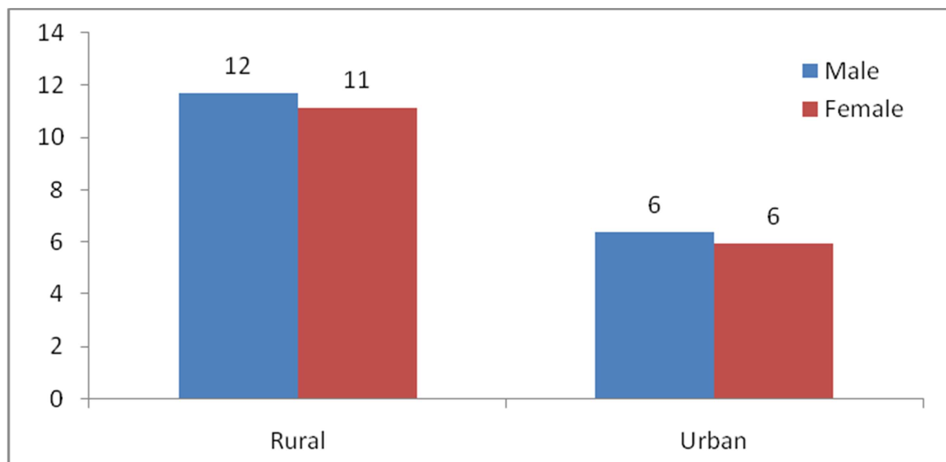
**Figure 5.19 Current enrollment rate by age, Maharashtra, 2012-13**




*Sex*

Differences are indicated between sexes in terms of current enrollment rates in rural population, though not in urban population. The current enrollment rate was slightly higher amongst males (12%) than amongst females (11%) in urban areas. On the other hand, the current enrollment rate was 6% amongst males and females in urban areas.

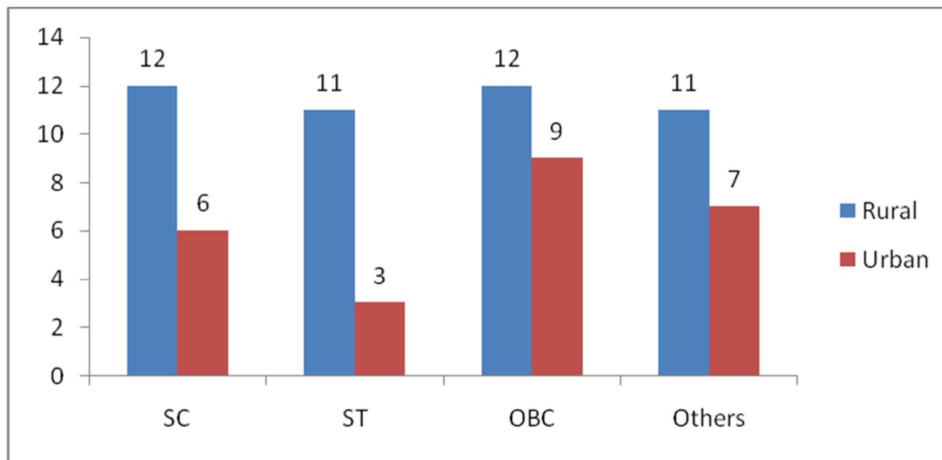
**Figure 5.20 Currently enrolled members by sex, 2012-13**




**Caste**

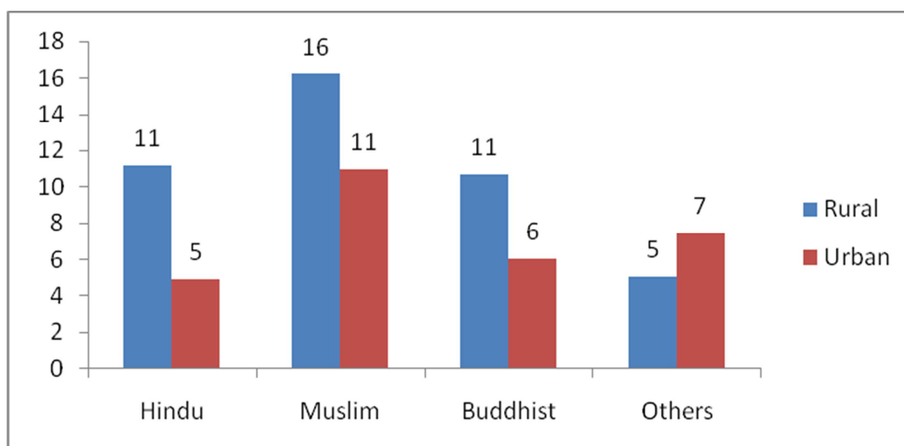
Caste differences are observed more in terms of current enrollment in urban areas compared to rural areas. In urban areas, the current enrollment rate was lowest amongst the STs (3%), compared to other social groups-SCs (6%), 'other castes' (7%), and OBCs (9%). However, in the rural areas, the proportion of currently enrolled was relatively lower amongst STs (11%) and "other castes" (11%) than OBCs (12%) and SCs (12%).

**Figure 5.21 Current enrollment rate by caste, 2012-13**



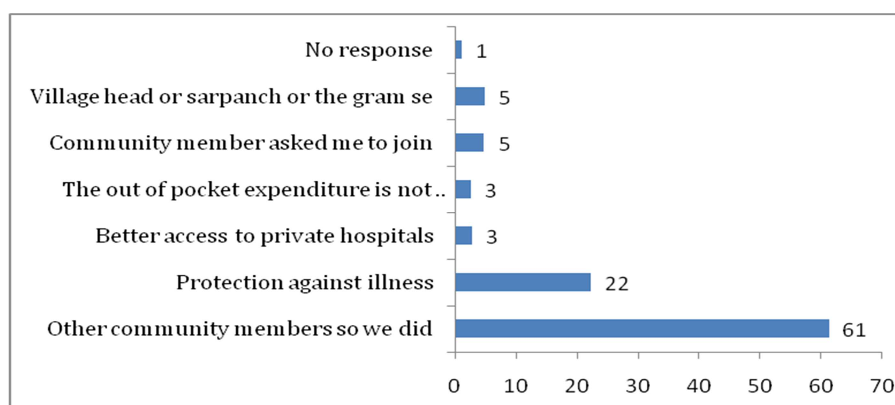

*Religion*
In rural areas, the differences in the proportion of currently enrolled members across the religious groups were significant. Of the currently enrolled respondents, 11% were Hindus and Buddhist respectively and 16% were Muslims and 5% were 'others'. In case of urban areas, 11% were Muslims, 7% from 'others', 6% from Buddhist and 5% from Hindus. The 'others' category included Christians, Sikhs and Jains.

**Figure 5.22 Current enrollment rate by religion in rural and urban areas, Maharashtra, 2012-13**




**Reasons for getting enrolled under RSBY**
For those who said they were ever enrolled in the scheme, main reason cited for getting enrolled was that they got the motivation from their fellow community members who got enrolled in the scheme.

**Figure 5.23 Reasons cited for enrolling under the scheme**




*Reason other than medical expenses:* When asked about the reason for enrollment, 61.24% said that they decided to enroll in the scheme since other community members were doing so. About 5% of the ever enrolled respondents said that they became part of it because the Sarpanch or village head or the Gram Sevak asked them to enroll in the scheme. Also, a small proportion (about 5%) of the ever enrolled respondents indicated that they enrolled because the fellow community members actively asked them to do so.

*Reason related to medical expenses and health care facilities:* While 22.32 and 2.55 % indicated that they enrolled since the scheme will help them to avert out of pocket expenditure. Also 3 % of the currently enrolled respondents stated that by becoming part of the scheme, they would have access to private health care facilities.

**Reasons for non enrollment**

Efforts were made to understand the reasons for non-enrollment amongst eligible people who attempted to enroll in the scheme. According to them, (53%) said that they were not able to enroll because they were away when the enrolment camp was held (45.45%). Of those, 35% reported lack of information as the reason for their inability to enroll in the scheme. Importantly, as high as 8% of them said that they were not able to enroll as their names were missing from the list.

**Table 5.8 Reason for not being part of RSBY**

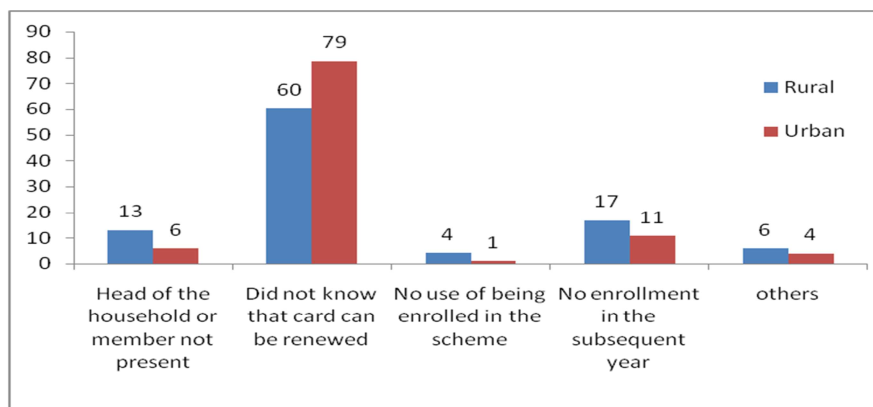
| | Percent |
|---|---|
| No information | 35 |
| Name missing from BPL list | 8 |
| No documented proof of being BPL | 2 |
| Was away during the enrolment | 45 |
| Don't want to seek care at the empanelled hospitals | 1 |
| Registered but card not received | 9 |
| Total (N) | 165 |

**Reasons for non renewal**

The proportion of those who were currently enrolled was only 12%. This indicates that many households were not re-enrolled in the scheme; for those who were previously enrolled but could not renew this year indicated that they did not know about the provision of renewal. The proportion of such respondents constituted the majority, though it was higher in urban areas (79%) compared to rural areas (60%). Non renewal in the following year by the insurance company has emerged as the second important reason for not renewing the membership. This was reported by 17% and 11% respondents in rural and urban areas respectively. This indicates that in a significant number of villages and urban areas, there was no renewal camp held. The other reason could be that although there was a renewal camp organized, many were not aware about it. Thirdly, the absence of household head was cited as main reason for inability to enroll by

13% and 6% in rural and urban areas respectively. Also, for a small proportion of respondents (4 and 1% in rural and urban areas respectively) the non-utility of the scheme was main factor for not renewing their membership.

**Figure 5.24 Reasons for not renewing the membership of RSBY by place of residence**




Note. In the above figure, 'Others' constitute all other reasons cited by respondents for not getting enrolled under RSBY again.

**STEP 4:** *From those currently enrolled to those with valid RSBY cards (N=685 HH)*

Amongst those who said that they were currently enrolled, 95% respondents possessed the smart cards. For the rest of the respondents the reasons are as below:

**Table 5.9 Reasons for not being able to get RSBY smart card**

| | |
|---|---|
| Technical problems | 37.14 |
| Don't know | 31.43 |
| Others | 31.43 |
| Total (N) | 35 |

Technical problems were reported as a reason for not getting the smart card by 37.14% of the respondents. 31% said that they don't know why they have not received the card and equal proportion of respondents indicated other reasons

**STEP 5:** *From those with valid RSBY cards to utilization* **(21 cases)**

It was found that among the households with valid RSBY card with at least one hospitalization case in the past one year prior to the survey date, only 13 percent of them had used the cash-less services from the listed hospitals of RSBY.

# CHAPTER 6

# DISCUSSION

In this section, we made an attempt to explain the implications of the findings of our study. The main objective of this part is to answer the questions that we posed in our research, explain the answers with the support of our results, evidences from other studies and grey literature on the topic.

## Level of awareness about the RSBY:

In general the awareness about social health protection mechanisms, especially health insurance amongst the BPL population in Maharashtra is low, and the same was found for RSBY. We noticed that the awareness level amongst the below poverty line household was relatively low with only 30% of the total households indicating that they have "heard about it". This is matter of serious concern as 'sufficient awareness' about the program is one of the pre-requisites for utilization of any health insurance scheme Further, the role of information becomes all the more important as the penetration of health insurance schemes has remained very low amongst the low income population in India (Aggarwal, 2011; Devdasan, 2004; Ghosh and Mondol 2011). Poor awareness level about RSBY among the BPL households indicates flaws in the insurance scheme's design as DoL currently relies on the insurance companies for dissemination of information to the target population which in turn bestowed the the task of spreading the information on the TPAs.

The households in rural areas were found to be more aware about the scheme compared to the households in urban areas. One of the possible explanations for this could be the manner in which RSBY has been implemented in rural and urban areas of Maharashtra. It may be noted that the scheme has first been implemented in the rural areas as the BPL list prepared by the Ministry of Rural Development was available for the same. However, in case of urban areas, there was no such readymade list available for the state and that has hindered the implementation of the programme considerably. The DoL had to approach each municipality and municipal corporation to obtain the list of urban BPL households eligible for social welfare programmes. This has delayed the initiation of the programme in urban areas. The data was also of poor quality which has substantially limited the efficacy of the enrollment agency (TPA) in reaching out to the target population. The relatively low level of awareness of the urban population also suggests inadequate IEC campaign carried out by the TPAs in urban parts of the state.

Interestingly, the quantitative results do not suggest any difference in the level of awareness across the social groups in the rural parts though the caste-differences in awareness level were large in urban areas. However, we are aware of the fact that no rigorous statistical tests have been applied to confirm the above findings and therefore, we do not attempt to make any conclusion based on these findings. We also tried to find out how people perceive RSBY. Majority of those aware about the scheme see RSBY card as something else, rather than a health insurance scheme membership card. By and large they recognised it as 'Hospital card', 'Smart card, '30,000 rupees card' and a small proportion of them also perceive it as AADHAR (Unique Identification card) card. This is in line with the findings of other studies (Pandit, 2012). Further, we explored the extent to which the enrollees of the programme were aware about the benefit package of the scheme. While a small proportion of the ever-enrolled respondents could spell out all the components of the benefit package, almost two-third of them were found to be partially aware about the benefit package. Most importantly, about one-fourth of the respondents did not have any knowledge about the same.

To understand the reasons for the above trends, we analysed the qualitative data. The focus group discussions and in depth interviews indicate that the dominant groups in their villages will know much better about the social protection schemes such as RSBY, this feeling was associated with poor literacy level, poor political participation by the respondents. The anecdotal evidence indicates that those who are powerful and have a voice may have better access to information and benefits (Pattenden, 2011).

## Levels of enrollment

Expectedly, in Maharashtra, the ever-enrollment rate of RSBY amongst BPL households (22%) was even lower than the proportion of households that reported to be aware about the scheme. This implies that a significant proportion of the target households that knew about the programme could not get enrolled under RSBY.

Notably, the ever-enrollment rate was higher amongst the SCs and STs compared to 'other' social group in the rural areas. But the proportion of ever enrolled was lowest amongst the STs in urban areas. This is in contrary to the findings of low enrollment in the tribal population in Amravati district of Maharashtra (Rathi, 2012).

The primary reasons for poor enrollment rate from the beneficiaries' perspective can be attributed to lack of awareness and errant below poverty line data that was used for enrollment. Secondly inadequate time and lack of pre enrollment information dissemination emerge as key reasons for why majority of the households were not able to enroll in the scheme.

The present study found that only 12% of the eligible households reported that they were currently enrolled under the RSBY programme, though a small proportion of them were not having valid RSBY card during the period of data collection. The estimated current enrollment rate is clearly on the lower side. As the RSBY website does not provide the enrollment data on a periodic basis (e.g., for a given year) for all the covered districts, it becomes difficult to understand what proportion of population targeted for the scheme is actually enrolled and is actively a member of RSBY scheme according to official statistics of DoL at any point in time (Dror and Vellakal 2012). Nevertheless, the above finding suggests a dismal picture of RSBY enrollment in the state where majority of the BPL households are yet to be included in the programme. This finding also raises important questions about the potential coverage conferred by the insurance companies upon the poor households. With further delay in delivery of the smart cards, the policy period of RSBY gets truncated.

The local political interference was often referred by the Insurance companies as a hurdle rather than help. While political assertiveness is associated with better implementation of some of the social protection programs here we noticed that there was a practice of nepotism in allocation of cards to the beneficiaries (Banerjee, 2007).

As per the stakeholder analysis the scheme was rolled out in multiple layers to achieve the present state of geographical presence of the scheme. First the districts were covered with batches, within that rural enrollment was undertaken first and the urban area enrollment followed it with a substantial gap (Assistant Development Commissioner RSBY) some of the districts have seen poorly managed RSBY owing to the change in the Insurance companies allotted to them. This has resulted in the better enrollment in the rural areas as compared to urban area.

**Delays in delivery of card**

The field observations indicate that the mode of disbursement of RSBY card for each of the study sites is different. For instance the cards were distributed all at once after printing. In one of the study sites the cards were distributed through couriers who might have lead to loss and there by reduction in the proportion of those who have the RSBY card in the previous financial year (reference period for the data collection). The delay in disbursement of card can be associated with the indirect cost associated with the enrollment at the receiver's end (i.e. loss of wages). In one of the study sites the cards were disbursed through a PRI intermediary who failed to understand the importance and retained all the cards without distributing it.

**Level of utilization and hospitalization**

Amongst those who reported that there were hospitalisations in their household in past one year and have a valid RSBY card, very few (13% households) indicated that they were able to use the RSBY scheme

While the qualitative research findings highlights the ‘lack of information’ as a primary reason, ‘denial from the hospitals’ with respect to provision of complete cashless services is also reported. Another reason cited by respondents was the distance of these empanelled hospitals. As indicated in other studies the barriers of distance, lack of information hinders the utilization of services from the empanelled hospitals (Rathi, 2012; Das, 2011; Rajshekhar 2011)

The in depth interviews suggest that the respondents were not able to avail complete cashless services except for those cases which incurred costs well within the limit of approved treatment package. In one of the study sites the hospital promoted use of RSBY cards for not so serious hospitalization and were not able to handle the critical conditions. The services available at empanelled hospitals were not sufficient to address the variety of conditions reported by the respondents. This has lead to a widespread dissatisfaction. Partial payment were reported by some of the respondents where the hospitals asked them to pay the additional costs where they felt that the treatment package does not in particular proves adequate for the hospital. However proportion of such cases is trivial.

For those who were ever enrolled in the scheme and had hospitalizations in past one year could not use the scheme as their RSBY cards were not valid on the date of hospitalization.

**Table 6.1 Description of the literature reviewed**

| State | Questions / Themes / Ideas / key messages |
|---|---|
| Kerala (Dhanuraj, 2010) | This study principally discuss about health insurance market in India, challenges in management of scheme (RSBY) by stake holders and other management perspectives. |
| Himachal Pradesh (RSBY, 2011) | There is quantitative information given regarding various factors related to RSBY e.g. awareness, utilization, issues of card distribution etc. According to findings Panchayat is the main source of information, Those who are related to SHG, Panchayat are more aware about the scheme, majority (85%)of persons are not aware about limit of 30,000,,food was provided in the hospital. (Awareness- 86% Enrolment- 80% Utilization- 90% Received card- 98%) |
| Uttar Pradesh (RSBY, 2011) | Assessment to map out situational realities in the study sites to highlight coverage, efficacies and barriers in RSBY. Social distribution at study site- Hindu (84%), Muslim (16%), ST (3%), SC, OBC. Health workers, local leaders, peer groups are main sources of information and motivators for enrolment. Females are less aware. (Awareness- 42% Enrolment- 60% Utilization- 67% Received card- 69%) |
| Gujarat (Pandit, 2012) | Study Demographics- maximum male participants (75%), low literacy rate (23%). Reasons of not having cards were- out of station for work; were not knowing about scheme; name was not in the BPL list; card was lost and don’t know where to go for new card. Delay in card distribution. Panchayat is main source of information in 95% of cases. People from study site recognize RSBY card as" Dawakhana card" but do not have knowledge about it. Hospital list was not given at any study site. Villagers tried to utilize card for OPD procedures. Low rate of utilization (2/47) (Enrolment- Utilization-4.2%, Received card- 90%) |
| Haryana (RSBY website) | It was feasibility study. According to this study satisfaction ratings on the RSBY Beneficiary Experience Survey were extremely high. Due to RSBY card respondent decided to take treatment for illness. Only 3 percent of RSBY patients reported learning of RSBY empanelled hospitals through enrollment materials. 50% respondent had previous hospitalization, friends and family members were source of information (69%) |
| Gujarat (Seshadri , 2013) | Higher enrolment (94%),Hospital card’, ‘Smart card, ’30,000 rupees card’ and ‘BPL card are the names use by locals for RSBY Card. Panchayat , |

| | |
|---|---|
| | Anganwadi worker, ASHA are the main sources of information. Respondents are not aware about details of RSBY, empanelled hospitals and coverage; Main reasons of non-enrolment were unawareness, loss of daily wages, previous experience of RSBY, recent death in the family. Political leader are not encouraging for enrolment, Issues of BPL list. Low rates of utilization due to card issues (wrong name, gender, age) and package system. (Awareness- Enrolment-94% Utilization- 56% Received card- 97%) |
| Karnataka (Rajasekhar, 2011) | Majority of the people were aware about the scheme, but less than half of them were enrolled in the scheme. Involvement of Anganwadi teachers for pre enrollment IEC campaigns. Non- enrolled excluded because they were unavailable at the time of enrollment due to employment related travel or personal travel. Problems with the BPL list existed and non eligible households were enrolled whereas some eligible ones were left out. There was a delay in distribution of smart cards. Some of the card-holding respondents reported that they had tried to obtain treatment under RSBY at an empanelled hospital but had been rejected. (Awareness- 85% Enrolment-68% Utilization- 0.4% Received card- 42%) |
| Delhi (Das, 2011) | Innovative IEC campaign had an impact on utilization of the RSBY scheme. The campaign engaged multiple channels through use of leaflets, pasting posters at ration shops, and using other pictorial content to give information about RSBY. |
| Amravati, Maharashtra (Rathi, 2012) | Study focuses mainly on issues related to design of RSBY. Tribal dominated blocks do not have RSBY coverage. Seventy per cent of the sample report loss of wage due to inability to work, while another 33% report OOP expenditures prior to reaching an RSBY empanelled hospital. Most people learnt about RSBY through their own networks, either through newspapers, or announcements or from friends, |

# CHAPTER 7

# CONCLUSIONS

The conclusion has been written keeping in the mind the common and state specific research questions and should be read along with the limitations of the study mentioned in the methodology section.

**What are the reasons for the limited success of the health financing arrangement in providing free or "affordable" access to care to the below poverty households in Maharashtra?**

- Before the study it was assumed that there is a limited success of the health financing arrangement (RSBY) in providing free or affordable access to health care to the below poverty households in Maharashtra. This was based on available literature. Our study results do confirm that RSBY has a very limited success. At every STEP, the proportion of covered population was coming down.
- The reasons are many, but the few main reasons are as follows…
    - Poor planning of RSBY as it was planned at national level without taking different social / cultural factors in Maharashtra.
    - Poor implementation by Ministry of Labour in Maharashtra. Here Ministry of Health was not involved. Even the plan for implementation of RSBY was not proper with inefficient utilisation of resources, untrained manpower, etc.
- There was poor awareness among all the expected beneficiaries (community, BPL families, etc.) as well as stakeholders (like implementers, policy makers, etc.). Surprisingly awareness was better among rural areas compared to urban areas but overall awareness was quite poor.
- There was denial for potential beneficiaries at various levels like –
    - Decade old list of BPL was used for identification and enrollment of BPL families.
    - Limited numbers of enrollment camps were conducted for very few days to enrol BPL families.
    - Information was not properly disseminated during these camps by insurance companies.
    - Cards were not received at all or received very late by many families.
    - Since card does not mention any names, families were not sure whose names were included in it.
    - Renewal was necessary every year leading to further denial.
    - People were not aware which types of diseases were covered, whether OPD services were covered or not.
    - Utilisation of the benefits was another major problem because of limited number of empanelled hospitals, unawareness about this, etc.
    - Distance required to travel to reach empanelled hospitals was also important reason since transport cost is covered in the scheme.
- There are lot of problems with RSBY scheme itself like – renewal required every year, only 5 members per family can be enrolled, no mention of names on the card, not sure of receiving cards, limited hospitals empanelled, limited coverage of only Rs. 30,000, etc.
- Ministry of Health in Maharashtra started new health insurance scheme RGJAY (Rajiv Gandhi Jeevandayee Aarogya Yojana) since last 2-3 years with better and improved features and benefits. This also resulted in gradual closure of RSBY in Maharashtra.
- Other possible reasons are like…
    - Physical – differential geographical coverage (for rural / urban / tribal areas).
    - Social / cultural – excluded groups like SC / ST / OBC, women, elder, children, minorities like Muslim in some areas.
    - Economical – denial of benefits, leakage of benefits to well off families.
    - Political – policy makers and implementers were not interested in implementation.
- There was a unanimous feeling among the participants that social protection schemes did not reach their intended beneficiaries and a nexus of greed, corruption, and political power existed.

**What does social exclusion mean or how is it understood in Maharashtra and what are the indicators of social exclusion in Maharashtra?**

- Participants felt that those who are poor are usually 'neglected' by the government and the various benefits that the government has to offer. Poverty also leads to being powerless due to lack of education and employment opportunities, which puts the poor at a greater vulnerability of being excluded from getting desirable information and utilizing it.
- Social exclusion in Maharashtra – Participants felt that following groups are socially excluded… (not necessarily in order)
    - Poor
    - SC / ST / OBC
    - Women
    - Elderly
    - Children
    - Minorities like Muslims
    - Not politically connected
    - Geographically difficult terrains
    - Migrants
    - Rural more than urban

**Does social exclusion prevent the development of health care financing for the informal sector in Maharashtra and how?**

- Yes, social exclusion prevents the development of health care financing for the informal sector in Maharashtra.
- The mechanism can be as follows…
    - Policies / schemes / plans are made but not implemented properly.
    - It was felt that policies are usually made only for political mileage and later on they suitably forgotten or neglected. Again during the time of elections, these policies / schemes are revived.
    - In RSBY, as such the informal sector / socially excluded groups are not organised.
    - Now some groups are getting organised, but again mainly for political gains and not for social / health gains which is usually a secondary objective
    - For some groups (like children / elderly), it is very difficult to get organised, so they have to depend upon NGOs / Govt departments attention and actions.

**Does current health financing mechanism (RSBY) reduce or increase social exclusion in Maharashtra and how?**

- It was not sure from the present study, whether RSBY is increasing or decreasing social exclusion in Maharashtra. One of the main reasons being, as such RSBY was very poorly formulated and implemented in different parts of Maharashtra.
- Ideally it is expected that RSBY will decrease social exclusion, but we found evidence for both…
  - In some cases, RSBY increased social exclusion, e.g., hamlets located outside villages were usually not visited for the enrollment purpose, and these people (mainly SC / ST etc.) are also lack awareness and information.
  - In some cases, RSBY decreased social exclusion, e.g., intra-household – since only 5 members per family can be enrolled, families usually covered elderly and young children rather than adults.
- Malpractices are very rampant at different levels or STEPs, from enrollment to utilisation. It was noticed that all the stakeholders excluding potential beneficiaries were interested in getting maximum possible benefits for themselves or their contacts rather than those really deserved it.
- The poor who are in need to health financing mechanisms already face exclusion at different levels. Not being able to get the benefits of such mechanisms further brings them down on to the poverty ladder leading to a vicious cycle of social and economic exclusion.

**What is the potential of current health financing mechanism (RSBY) for reducing social exclusion in Maharashtra? And**
**What is the potential of policy makers in health and other sectors for reducing social exclusion in RSBY in Maharashtra?**

- We do not feel that there is any potential of current health financing mechanism (RSBY) for reducing social exclusion in Maharashtra. One of the main reasons being it is closing down and it is getting replaced by better scheme like RGJAY.
- Schemes like RSBY take care of only certain aspects of secondary and tertiary health care (i.e., hospitalisation of certain ailments within given limits). Many other important aspects of secondary and tertiary health care like out patient treatment, transportation, out of pocket expenses, etc are not covered at all. Primary health care services are not touched at all by these schemes. Social exclusion is a very broad topic and so it is not possible that such schemes can reduce social exclusion in Maharashtra.
- But we feel that new / other existing schemes can definitely learn from mistakes committed by RSBY and avoid those errors.
- Since RSBY is being implemented at national level by Ministry of Labour, they may still think of continuing it in Maharashtra with modified features and benefits. It can be definitely run simultaneously along with other schemes provided there is a political and social will and commitment.
- We feel that at the current situation, the policy makers in health and other sectors can not reduce social exclusion in RSBY in Maharashtra. But as said earlier it depends on willingness and commitment.

# CHAPTER 8

# RECOMMENDATIONS

Based on the RSBY study in Maharashtra, TISS team will like to make following recommendations. These can be useful for academicians, policy makers, policy implementers and those who are interested in working in the field of social exclusion in health sector.

## A. RSBY specific Recommendations

- RGJAY (Rajiv Gandhi Jeevandayee Aarogya Yojana) and other existing schemes can definitely learn few important lessons from RSBY like – need to improve awareness and coverage, issuing prompt cards with proper details, achieving universal enrollment, ongoing and prompt renewal (even automatic), giving useful benefits at the current cost etc.

- RSBY running in other states of India can also learn from RSBY experience in Maharashtra.

- Ministry of Labour (MoL) is already running ESIS (Employees State Insurance Scheme). ESIS is quite popular, useful and successful insurance scheme running all over India. We feel that with modified focus along with good and improved strategy (e.g., only for groups like elderly, SC / ST, etc.), RSBY might still be reintroduced in Maharashtra by Ministry of Labour.

- Another important issue is monitoring and evaluation of currently existing health care financing schemes at national / state / local level. This is important so that policy makers or implementers can make corrective changes at suitable time without wastage of scarce resources.

- We found it very difficult to get secondary data on RSBY. Ideally it should be easily available on the internet or some suitable site to policy makers, academicians and other interested individuals.

- There are so many schemes simultaneously operated in the country and even in Maharashtra that it creates confusion for all. So obviously common man and especially socially excluded people need proper Information, Education and Communication.

- Further research is required in the field of social exclusion and RSBY to get answers to many questions which went unanswered with this study like – what are the regional variations in enrollment?, is public private mix or participation is affecting the outcome?, etc.

## B. General Recommendations

- There is definite need to make overall socio economic development with more focus on health. We can not only depend upon health insurance schemes to improve the health situation. Health care should be made available, accessible, affordable, acceptable and accountable to all. For this we can not depend upon private sector. Govt has to play proactive role in this.

**C. Future plans within the Health Inc project at regional and national level**

- As part of this particular Health Inc project, TISS is planning to conduct following activities within next few months –
  - Epilogue case studies in the form of dissemination cum workshops / seminars will be conducted both at the state level (Mumbai) and national level (New Delhi).
  - This will be mainly for stakeholders like policy makers, implementers, etc.
  - Even other health insurance scheme implementers like RGJAY in Maharashtra will be invited so that they can benefit and contribute.
  - This will help to identify policy issues and also we will understand their concerns.
  - Other Health Inc partners especially IPH from Karnataka will be invited to attend state level workshop. The national level workshop will be jointly organised with them. We can also attend the state level meetings organised by IPH in Karnataka.

## CHAPTER 9

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## CHAPTER 10

## ABBREVIATIONS

| | |
|---|---|
| AAY | Antyodaya Anna Yojana |
| ANM | Auxiliary Nurse Midwife |
| APL | Above poverty Line |
| ASHA | Accredited Social Health Activist |
| BDO | Block Development Officer |
| BPL | Below Poverty Line |
| CHC | Community Health Centres |
| DHO | District health officer |
| DOL | Department of Labour |
| DRD | Department of Rural Development |
| ESIC | Employee’s State Insurance Corporation |
| ESIS | Employees' State Insurance Scheme |
| FCI | Food Corporation of India |
| FGD | Focus Group Discussion |
| FKO | Field Key Officer |
| GDP | Gross domestic product |
| GOI | Government of India |
| HH | Household |
| HHS | House hold survey |
| ICDS | Integrated Child Development Scheme |
| ICFS | In-patient care facilities (ICFS |
| IDI | In depth interview |
| IEC | Information Education and Communication |
| IEC | Institutional Ethics Committee |
| ILO | International Labour organisation |
| IMR | Infant mortality rate |
| INR | Indian National Rupees |
| IRB | Institutional Review Board |
| IRDA | Insurance Regulatory and Development Authority of India |
| ITDP | Integrated tribal development project |
| JSY | Janani Suraksha Yojana |
| MEGS | Maharashtra Employment Guarantee Scheme |
| MMR | Maternal mortality rate |
| MO | Medical officer |
| MSACS | Maharashtra State AIDS Control Society |
| NACP | National AIDS Control programme |
| NFBS | National Family Benefit Scheme |
| NIC | National informatics centre |
| NIDDCP | National Iodine Deficiency Disorders Control programme |
| NLEP | National Leprosy Eradication programme |
| NMBS | National Maternity Benefit Scheme |
| NMHP | National Mental Health programme |
| NOAPS | National Old Age Pension Scheme |
| NPCB | National programme for Control of Blindness |
| NREGA | National Rural Employment Guarantee Act |

| NRHM | National Rural Health Mission |
|---|---|
| NSSO | National Sample Survey Organisation |
| NVBDCP | National Vector Borne Disease Control programme |
| OBC | Other Backward Class |
| OECD | Organisation for Economic Co-operation and Development |
| OOP | Out of Pocket |
| PPS | Probability proportional to population size |
| PRI | Panchayat Raj Institution |
| PSU | Primary Sampling Unit |
| RCH - 1 | Reproductive and Child Health programme |
| RGJAY | Rajiv Gandhi Jeevandayee Arogya Yojana |
| RHS | Rural Health Statistics |
| RNTCP | Revised National Tuberculosis Control programme |
| RSBY | Rashtriya Swasthya Bima Yojana |
| SC | Schedule Caste |
| SHP | Social Health Protection |
| SNA | State Nodal Agency |
| SPSS | statistical package forsocial sciences |
| SRS | Sample Registration System |
| ST | Schedule Tribe |
| TISS | Tata Institute of Social Sciences |
| TPDS | Targeted Public Distribution System |

# CHAPTER 10

## ANNEXURES

| | |
|---|---|
| Annex I | Focused Group Discussion Consent |
| Annex II | Focused Group Discussion Question Guide |
| Annex III | In Depth Interview Consent |
| Annex IV | In Depth Interview Question Guide |
| Annex V | Stakeholder Interview |

## ANNEX I – Consent for Focus Group Discussion

Consent

Greetings

My name is ………………………………………………………………………………………. and these (say names) are my colleagues.

And, we are conducting a study at Tata Institute of Social Sciences, Mumbai on "health financing mechanisms" in our state. The study is actually conducted by a consortium of academic institutes such as Tata Institute of Social Sciences, Mumbai, London School of Economics, London, Institute of Tropical Medicine, Antwerp, Belgium etc. This is a multi-country study that aims to identify the factors responsible for limited success of various health financing mechanisms in providing free or affordable 'access' to health care to the poor people The study will also try to assess whether 'social exclusion' is acting as a barrier for the success of these health financing models in the countries under study. In India "Rashtriya Swasthya Bima Yojana" has been chosen to understand whether this scheme has achieved the goal of universal enrolment for the BPL population; if not what are the main reasons for it?

In India the study is taking place in 2 states namely Karnataka and Maharashtra. We are interested in learning about important aspects of people's lives; such as their socio-economic and health conditions. We will also try to know what social exclusion means to the people of Maharashtra. We would also like to learn about people's experience about RSBY. We are also interested in learning about your household.

Our aim is to share the results of study with policy makers to help them formulate better effective policies on social health protection. In the village some households are randomly selected to participate in the study and your household happens to be one of them. We would like to ask questions about your household. The questions are regarding demographic, socio-economic and health related conditions of all household members. There are also questions on health care utilization and expenditure.

We would also like to know your experiences regarding use of RSBY scheme in the form of group discussion. The discussion might last for 40-60 minutes. We would like to audio record the discussion as well as take notes about the points discussed. Audio recording and note taking will help us to keep track of each and every details discussed and concerns raised by the group. We would also like to take a photograph of the group.

We assure all of you that the information shared by you will be kept completely confidential and anonymous, and only be used for academic purpose.

Based on the information that I provided you, you are now free to decide whether you want to be part of it. If you agree these parts then we can proceed to discuss. However, if you are uncomfortable with any question, you can refuse to answer that question. Also, if you want to discontinue for any reason, you are free to do so.

## ANNEX II – Question guidelines for Focus Group Discussions

### Section 1: General Community – Resources and Problems

- What are the prominent resources in community? (such as land, water bodies, access to forest, communications, infrastructure, market places, health services, etc.)
- Who are the people in the community or village who have access to resources?
- Why some people do not have access to resources?
- What are the barriers in accessing resources?
- How do the poor access resources? (including health care services)
- What could be the barriers to access resources? (including health services)

### Section 2: Socially excluded groups and Concept of Exclusion and Inclusion

- What according to you is poverty?
- What are the mechanisms available to protect the poor?
- What is the effectiveness of such mechanisms?
- Apart from poor people, who are the other groups of people (socially excluded) who do not have access to basic resources such as health care services? (women, children, elderly, minority castes, tribal, people living in remote areas, etc.)
- Why do you think differentiation or discrimination exists in society? (reasons)
- What do you think about the role of socio-economic, political and religious factors in discrimination?
- Do people from different social groups interact with each other? How frequently
- Are some social groups more likely to interact with each other / come together compared to other groups? What could be the reasons for this difference?
- Is there any presence of conflicts between groups / networks?
- How can conflicts or discrimination be reduced to maintain cohesion in the community?
- What is the pattern of involvement or participation of the community / vulnerable groups in the decision making / implementation process?
- Whether decision is socially inclusive? (that is involves / includes all social groups such as women, children, elderly, tribals, people from remote areas, etc.)

### Section 3: Social Institutions in enabling access to resources or services

- Availability of community based organizations such as Mandals or Mahila Mandals
- Help provided by CBOs to poor individuals; their explicit and implicit functions
- How do groups or associations get started (grassroots initiative, government initiated, through government donations, NGO donations, etc.)?

### Section 4: Presence or absence of collective action

- What are the problems in community?
- What efforts are made to work together to solve problems in the following areas:
- Health, Education, Recreation and cultural resources (Samaj Mandir, etc.), Political rights, Roads and transport, Irrigation, Agricultural services, Access to forest land, Access to entitled cards, Public services, Credit, etc.
- What are your experiences about receiving help / support from local officers and community leaders / members?

### Section 5: RSBY

1. Awareness about RSBY?
2. What do you think about the RSBY?
3. How did you get to know about the 'scheme'?
4. What was the process of enrollment in the 'scheme'?
5. What was the process of distribution of cards (smart cards)? (given on the spot / delays / mis-print of names / photos, etc.)
6. Is the list of empanelled hospitals where the 'scheme' can be availed provided at the time of enrollment?
7. What is the procedure for replacement of lost cards?
8. Are all groups of people included in the enrollment process of the 'scheme'?
9. Are any groups excluded? Which are those groups?
10. What could be the reasons for exclusion of these groups of people from the 'scheme'?
11. What were your experiences about utilization of services under the scheme? (Medical care and its quality, transportation, and food?
12. How far are the empanelled hospitals from your village?

**13.** Was there any delay in provision of the services under the 'scheme'?

**14.** Was there any denial of care at the empanelled hospital and what were the reasons for refusal of admission or provision of appropriate services?

**15.** How does the RSBY help to mitigate the vulnerabilities that were prevailing earlier to the 'scheme'? (or What do you think are the benefits of the RSBY?)

**16.** What do you think are the loopholes in RSBY? (Probing question: Corruption in the process, etc.)

**17.** What are your perceptions / views about improved or diminished access to health services as a result of the RSBY scheme?

**ANNEX III - In Depth Interview format**

The purpose of selecting the specific individual:

If applicable,

| Meeting | 1 | 2 | 3 |
|---|---|---|---|
| Date | | | |

1. Respondent no
2. Name of the respondent
3. Age
4. Sex
5. Village
6. Block
7. District
8. Date of contact
9. Time of interview initiation
10. Date of interview initiation
11. Marital Status
12. No of children
13. No of family member
14. No. of earning members in the family
15. Occupation
16. Whether Migrant
17. Religion
18. Respondent No
19. Criteria
    a. Is the respondent a member of BPL household? (Y/N)
    b. Enrolled in RSBY? (Y/N)
    c. If all the members enrolled from household? (Y/N)
    d. Special notes
        i. Respondent is disabled (Y/N)
        ii. Respondent is shy (Y/N)
        iii. The infrastructure is very poor in this village (Y/N)
        iv. Others

## ANNEX IV – In depth interview guide

### Guidelines/Probing points and questions
### Section 1: (To be asked to all three groups of respondents)
### Illness episode:

1. Was there an illness in your household recently?
2. If yes what kind of illness was it? (Note details about the onset, duration and progress of illness.)
3. Whether it was a chronic illness?
4. How long the person has been suffering from that illness?
5. What treatment did the patient receive for the illness (including allopathic, homeopathic, ayurvedic, unani, traditional healers, etc.)??
6. Did it require hospitalization or any day care surgery?
7. How did the person manage to reach the facility / hospital?
8. How did you decide to approach the specific doctor / hospital?
9. How did the doctors or nurses at the hospital behave with the patient and family members?
10. What medical treatment and other services were provided to the patient at the hospital?
11. How do you rate the quality of treatment or services that were provided to you at the hospital?
12. What financial help did you seek for the illness?
13. What do you feel about the accessibility to health care services as and when required?
14. Did the person use the financing mechanisms such as RSBY?
15. What is the RSBY (according to the respondent)?
16. Has the respondent been enrolled for the scheme? If not enrolled, then what were the reasons for not enrolling (barriers to enroll in the scheme)?

### Section 2.1: If respondent has been enrolled for RSBY (both those who utilized and those who did not utilize RSBY)

1. How did you get to know about the 'scheme'?
2. When and how did you enroll for the RSBY?
3. What was the process of enrollment in the 'scheme'?
4. Was the list of empanelled hospitals where the 'scheme' can be availed provided at the time of enrollment?
5. How far are the empanelled hospitals from your village?
6. How did the respondent select the individuals for enrollment?
7. Who was preferred member among the rest in the family? Why?
8. What was the process of distribution of cards (smart cards)? (given on the spot / delays / mis-print of names / photos, etc.)
9. Was there any issue in case of disbursement, reinsurance, delivery of the card such as delay, or issues related to number of individuals to be enrolled?

### Section 2.2: Those who are enrolled in RSBY and utilized it

1. What were your experiences about utilization of services under the scheme? (Medical care and its quality, transportation, and food)? Was the transportation cost borne by the hospital? How much transportation charges were given?
2. Was there any delay in provision of the services under the 'scheme'? If delayed, them which services were delayed? What according to you was the reason for delay?

3. Was there any denial of care at the empanelled hospital?
4. If yes, what services were denied by the hospital? How did you manage to meet the expenditure?
5. What were the feelings associated with it? Was the denial justified? Was there any such denial in the past?
6. What according to you were the reasons for refusal (of admission or provision of appropriate services)?
7. Did you report the denial or refusal to any authority? If yes, to whom did you report the complaint to? Was any action taken? If yes, what action was taken?
8. Was there difference in the treatment as patient / family member was carrying RSBY card? In what way, the experience was different?

**Section 3: Common Opinions (for all three groups)**

1. Whether the respondent feels that knowing someone in the health facility is a beneficial thing?
2. How the scheme benefited him or can benefit in the future?
3. How does the RSBY help to mitigate the vulnerabilities that were prevailing earlier to the ‘scheme'? (or What do you think are the benefits of the RSBY?)
4. What do you think are the loopholes in RSBY? (Probing question: Corruption in the process, etc.)
5. What are your perceptions / views about improved or diminished access to health services as a result of the RSBY scheme?
6. Are all groups of people included in the enrollment process of the 'scheme'?
7. Are any groups excluded? Which are those groups?
8. What could be the reasons for exclusion of these groups of people from the 'scheme'?
9. What is the respondent’s perception about the quality and presence of the scheme?
10. Is there any reference to the episode where anyone whom the person knows could not utilize card for hospitalization? Why?

Date of interview completion:
Time of interview completion:

**ANNEX V - Stakeholder Interview Guide**

**Stakeholder Interview**

**Stakeholder Interviews:** Stakeholder Interviews will describe national and regional stakeholder's motives, influence and role, restricting to the RSBY scheme in Maharashtra. Along with the stakeholders from socially excluded groups, such as key informants from NGOs, working with them, called as experts by experience will be interviewed.

**Objective:** To understand the implementation of the scheme, the factors associated with the limited success and perceived role of social exclusion in the limited success of the scheme.

The interviews will follow informed consent form, and will be recorded, and translated to English. The transcripts will be analysed using the N-Vivo (or Atlas Ti) software.

The financing mechanism in question i.e. RSBY is implemented by department of labour and involves many stakeholders. For identifying the stakeholders involved, the order issued by government of Maharashtra has been used.

The primary stakeholder and their presence as institutional arrangement can be described as below:

1. **Personnel from Department of Labour:** Include the implementing agency for interviews along with other allied functionaries at the state level office. Include Data Managers, Statistical Officers, and Key field officers as & when required.

2. **Members of Nodal agency:** There is a technical assisting body at the state level consisting of experts from domains such as health, information technology and labour department. Thus this Nodal agency forms a fulcrum between department of labour and other supportive administrative bodies of the government. The specific departments being represented in this nodal agency are

| Principal Secretary- | Labour Department |
|---|---|
| Appropriate person | Directorate of Health Services |
| Appropriate person | National Informatics Centre |
| Appropriate person | Insurance companies |

3. **Insurance Companies:** There are four insurance companies allotted with certain districts to be covered by the office of development commissioner for the financial year 2011-12. Insurance companies such as ICICI Lombard, Cholamandalam, Tata AIG, and Bajaj Allianz are currently engaged; earlier the new India insurance company was elected. Their role is crucial in case of Maharashtra where the IEC activities are predominantly a function of insurance companies.

4. **Card Distributing Agencies:** The card distributing agencies include private entities such as FINO. The possible questions that can be posed relate with technical problems that hamper the enrolment and are creating issues with the operations in real time.

5. **Health care providers:** Health providers are to be interviewed in depth to understand their perceptions regarding the implementation of scheme. The concerns about the costs of services are well known informally. Thus a discussion should be conducted on cost effectiveness of the services covered under RSBY.

6. **Experts by Experience:** This group includes people from the field who are working in socially excluded population and individuals who have worked for the poor sections of the society.

**Number of stakeholders:** At the state level minimum 6 individuals and at the district level, at least 2 individuals along with the key healthcare providers are to be interviewed.
**Data collection and Analysis:** The data from in depth interviews will be captured with notes, transcripts and the audio recordings. The notes and transcripts will be captured on the MS office word. The transcripts will then be subjected to rigorous reading and data analysis.

**Key Questions to be asked to stake holders:**
**For State Nodal Agency Officers:**
**Selection Criteria:** What are the Selection criteria, the baseline list used for reaching the eligible population? How acquisition and distribution of list is done? What are the experiences of the lead beneficiaries?
**Low Enrolment:** What are the reasons for low enrolment where RSBY was introduced? Is there any regional disparity? Which are the best performing areas? What are the issues with the equitable performance of the scheme?
**IEC activities:** Details of Quality and extent to IEC activities conducted such as who were primarily responsible for the information, education and communication themes of the program? How are these IEC activities performed?
**Social Exclusion and strategies used:** Do you consider any threats of exclusion? Have you seen exclusion in the recent scheme fall out? If yes, what are the main reasons for social exclusion happening?
**Delay:** What are the reasons for delay in issuance of cards? What are the reasons for delay in distribution of cards?
**Service:** What is quality of service delivery? What is the mechanism to monitor the service delivery? What kind of issue was faced by the empanelled hospitals? What are the reported problems with the scheme and its utilization?
**Balance Billing:** What is your opinion on the balance billing practice? Have you encountered any such issues in recent past?
**Enrolment and Renewal:** What are the reasons for poor pace of enrolment during the subsequent year, proportion of renewal of the cards? Is the gap between the policy period and the renewal in the next rounds substantial for many districts?

**For Insurance companies:**
Name of the interviewee
Agency
Processes involved
Duration
Brief about the agency's work

**Reaching eligible population:** What are the issues in reaching the eligible population?
Give us details about issues involved in acquisition of the list, Rollout of the data collection and reaching the beneficiaries.

**Actual field experience:** When did you start enrolling? How was the enrolment done for instance in a district? Do you have a method or model of reaching the targeted population?

**Including the population:** How did you reach those who are located in the vicinity of the village? How did the field level officers conduct the enrollment? Was there any support from the PRI members?