# How Inclusive is the Universalised Insurance Scheme (RSBY) in Chhattisgarh?

## Experience of Urban Poor Women in Slums of Raipur

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Sumitra was taken to a private Nursing home late at night when she experienced labour pains. Despite carrying her RSBY card, the hospital staff told them to pay extra night charges of Rs. 2000, without which she would not be admitted. She had a Caesarean section, for which the hospital deducted Rs.12000 from her RSBY card and additionally demanded Rs.16000 cash, which the family had to pay up.

When twelve-year old Pravin fractured his leg, the local quack referred them to a private hospital. Despite having the RSBY card with them, they were told to first deposit Rs. 6000 for his operation. His parents foraged for the money and could deposit it only on the second day, after which he got operated on. At the time of discharge seven days later, the hospital additionally deducted Rs. 10,000 from their RSBY card. The Mitanin of their locality suggested that they register a complaint with the RSBY helpline. But the family refused, saying that they have to keep going back to that hospital and so they cannot complain against it.

*Both Sumitra and Pravin were entitled to completely 'cashless' service in empanelled private facilities. However, despite utilizing RSBY, their families were forced to incur expenditure, putting them in great financial distress.*

The Rashtriya Swasthya Bima Yojana (RSBY) became a 'flagship' programme of the Chhattisgarh Government with its universalisation in 2012 through expanding coverage to the Above Poverty Line (APL) families under the state funded Mukhyamantri Swasthya Bima Yojana (MSBY). But, the above two case studies beg the question, what really has been the impact of this universalization on the urban poor? Are they able to utilize it effectively? This paper explores this question through a study that was undertaken by the Public Health Resource Network and Chaupal Gramin Vikas Prashikshan Evum Shodh Sansthan (Chaupal) Chhattisgarh in the urban slums of Raipur. The objective of the study was to understand the experience of poor women in accessing RSBY/MSBY for hospitalization.

Raipur city (Municipal Corporation), with a population of over ten lakhs, has nearly 40% of its population living in some 282 slums. The healthcare services in Raipur are provided by the health department, Raipur Municipal Corporation, and by the formal and non-formal private sector. In 2013, the state government expanded primary health care services by implementing the Mukhyamantri Sheheri Swasthya Karyakram (MSSK), and thereby introducing 103 sub centers or Swasthya Suvidha Kendras (SSKs) managed by an ANM, one Mitanin (Community Health Worker) per 1000 slum population and 10 Urban Primary Health Centres (PHCs). Tertiary public sector institutions in Raipur include the District Hospital, Medical College and the All India Institute of Medical Sciences (AIIMS), Raipur. More than one third of the empanelled private hospitals in Chhattisgarh under RSBY/MSBY,are situated in Raipur and thus account for the highest claim amounts sought in the state. In the last couple of years, the city has seen strengthening of the public health system leading to increased coverage of primary outreach services like immunization and increased institutional deliveries. But it has also seen recent annual outbreaks of hepatitis E, with the private health sector continuing to play an extortionist role in such vulnerable situations.

In this quantitative study, 367 patients who had been hospitalised in the six months prior to the study were identified through Mitanins (Community Health Workers - CHWs) and interviewed using a structured interview schedule. Family level data was collected using a family questionnaire. The tools were piloted in two rounds. The survey was undertaken during February 2014 by a team of surveyors, supervised by SN, SS and RM. Data was entered in Excel and analysed using SPSS by the authors. Informed consent was taken verbally from the respondents and noted. Confidentiality has been maintained during data analysis and report writing.

Of the hospitalised patients,, 282 were women (65% from OBC category, 17% SC, 13% General Category and 4% ST) who accessed health facilities within the state. Their experience is enumerated as follows:

### *Enrolment*

The study shows that coverage of the universal scheme is only a bit more than half (57 per cent) among the families of the women patients with the rest still remaining uninsured. However, enrolment among women (68%) was slightly higher than men (65%).

Though nearly 90% of the families were aware of the scheme, many were unable to enrol due to problems in the enrolment process, like not being informed of the enrolment drive, name not being on the list, family members being absent, etc. Nearly 40% of the families surveyed did not receive the insurance smart card on the same day of enrolment, as is the rule. However, most families reported not having to pay any extra money for enrolment, other than the stipulated amount of Rs. 30. Though it is stipulated that the list of empanelled facilities should be given along with the insurance smart card, only 5% reported receiving it. Similar gaps have been found in the official evaluation RSBY/MSBY in Chhattisgarh. This aspect is significant as one of the stated objectives of this scheme is to provide 'choice' to the patient in selection of facilities. However, in the absence of information on empanelled facilities, what nature of 'choice' could people be expected to make?

### *Hospitalisation*

The challenges faced by women accessing healthcare is well documented. Here too, there was a gender bias in accessing hospitalisation for non-obstetrics/gynaecological conditions. A greater proportion of men, as compared to women, reported hospitalisation for non-obstetric/ gynaecological conditions. This was seen specifically in conditions like respiratory disease, jaundice/typhoid, gastrointestinal problems and others.

Most women, regardless of enrolment status, went to public health facilities for obstetrics/gynaecological conditions. Around 63 per cent of women who delivered,

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went to public facilities for delivery, a pattern which seems to have been brought on due to the efforts of the MSSK. However, a greater proportion (55%) of women went to private facilities as compared to public facilities for non-gynaecological conditions (respiratory diseases, fracture, and heart related conditions and so on),.

The reasons for selecting a particular facility did not include RSBY/MSBY as a determinant. In fact, the main determinants in hospital selection were being familiar with the hospital, and referral by a friend or acquaintance. Moreover, the study shows that out of the enrolled women who visited private facilities, 42% visited non-empanelled facilities. This puts a question on just how useful the patients perceive RSBY/MSBY, considering that it does not significantly determine hospital selection.

***Utilization of RSBY/MSBY***

The efficacy of insurance is seen in whether an enrolled patient was able to use insurance and get cashless treatment. Raipur district, with the largest number of empanelled facilities and claims, all concentrated Raipur city, should have seen very high utilisation by the urban poor. However, the study finds that for poor women, usage of RSBY was very low and also selective. Only one third of women whose families had insurance reported its use for treatment, more so in the private (71% of women) than in the public (25% of women) sector. When used, it was used mainly for non-gynaecological conditions (49%), and that too mostly for surgical procedures.

***Out of Pocket Expenditure (OOPE)***

Protecting people from financial risk and catastrophic expenditure is the primary stated goal of RSBY/MSBY. However, the study finds that nearly all (96%) women had to incur OOPE with an average OOPE of Rs. 9,947 per hospitalisation case. Nearly all women (90%) had to spend money on transportation, two-thirds had to spend on medicines and nearly half of the women had to pay money for health personnel and fees charged by the facility. In terms of how each item contributed to the total OOPE, we find that the largest expenditure, i.e. 52% of the total OOPE, was on fees or unspecified amounts charged by the facilities, 18% on medicines and 15% on diagnostics.

Condition-wise, the highest expenditures were on hospitalisation for heart related conditions (Rs. 1,22,800 per hospitalisation case), cancer (Rs. 52828 per hospitalisation case), appendicitis (Rs. 52980), fracture (Rs. 44000) and kidney related conditions (Rs. 40780). Such high expenditure can be catastrophic for the urban poor and such medical conditions should have been covered by insurance.

For women who used insurance, the OOPE in private facilities (Rs. 10,733 per hospital visit) was more than six times higher than the public facilities (Rs. 2,518 per hospital visit).

In order to meet the hospitalisation costs, around 61% women used their own savings, while more than one third (37%) had to borrow money and seven women (2%) had to sell or mortgage valuables.

**Conclusions**

The health sector in urban areas is characterized by multiple health providers, both formal and non-formal and is usually highly medicalised. Raipur city is no different. The study shows that universal health insurance has not been able to provide coverage to all the urban poor. Even when the poor are covered, they are often not able to utilize the insurance, nor receive free treatment. This has led them to believe that 'cashless' treatment even under RSBY/MSBY is really not possible. On the other hand, the claims data show that the private hospitals in urban centers like Raipur are actually the largest beneficiaries of the universal health insurance scheme. These are the health providers who also negotiate aggressively with the government through the Indian Medical Association (IMA), in order to increase the RSBY/MSBY package rates. In fact, prior to this survey, in the beginning of 2013, they went on strike for nearly three months when they suspended all services under RSBY/MSBY.

The study shows that the urban poor, especially women, are utilizing the public health system wherever it is providing services, regardless of insurance coverage. For the rest of the services, they have to go to the private sector, which remains very expensive and exploitative and selective in its use of RSBY/MSBY. The study raises doubts regarding the efficacy and utility of universal insurance in providing free and quality health services to the urban poor and this needs to be kept in mind while building strategies for providing healthcare to the poor and vulnerable groups in urban areas.

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