The Gap in Awareness Generation and its Impact on the Utilisation: A Case of RSBY in India

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Introduction

In India, most of the population has no health coverage. Healthcare financing in India is dominated by out-of-pocket (OOP) spending. It is estimated that around two-thirds of the total healthcare spending of an average Indian is out-of-pocket spending (Sahu, 2023). Van Doorsaler et al. (2007) state that because of high OOP expenditure, about 2 to 3 per cent of the Indian population is pushed below the poverty line each year. The low level of public spending on healthcare and the low quality of services provided at public hospitals in India are the leading causes behind the high OOP. Thus, considering the urgent need for health security, the planning commission of India constituted a high-level expert group to rework the financial and physical norms needed to ensure quality, universal reach and access to health care services (Sen, 2011). The commission recommended increasing public expenditure on health and ensuring that every citizen is entitled to essential primary, secondary, and tertiary health care services guaranteed by the central government (ibid). Thus, as a step forward towards providing universal health coverage and reducing the OOP expenditure on health in India, Rashtriya Swashthya Bima Yojna (RSBY) was introduced in 2008. It aims to provide financial protection to households below the poverty line (BPL households). The objective of the scheme was to provide financial protection to poor families from financial crises arising out of health shocks that involve hospitalisation. For a nominal fee of INR 30, families covered under this program were entitled to free coverage to 700 different inpatient medical procedures, up to an annual limit of INR 30,000 (~360 US$) per family per year (Sen, 2011). The major stakeholders in RSBY are central and state government, insurance companies, empanelled private and public hospitals, and the BPL households.

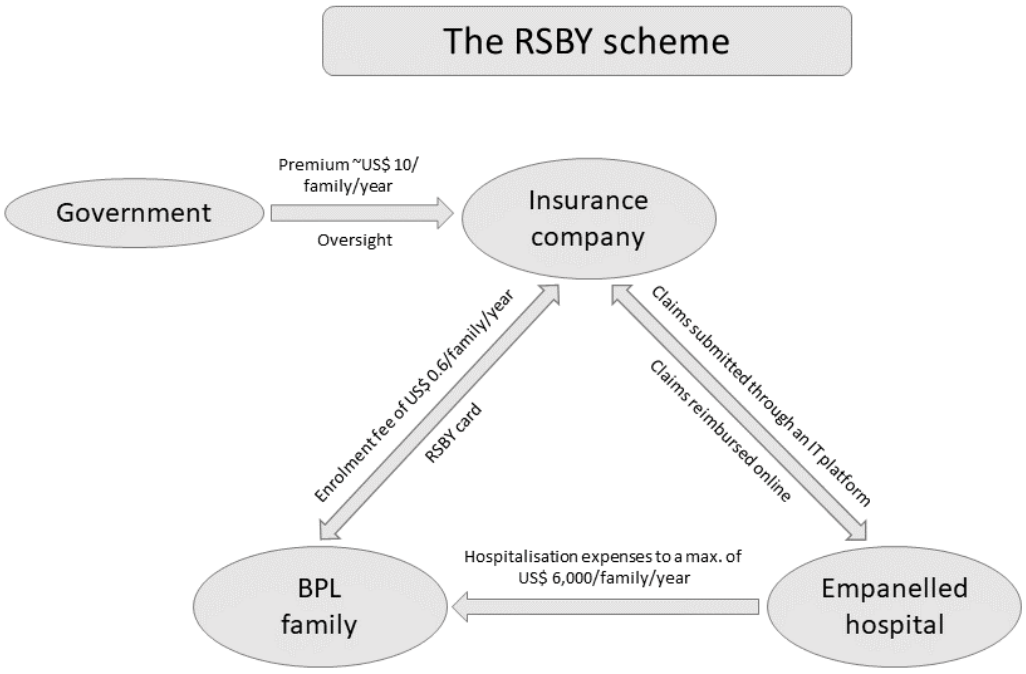

Fig1: RSBY at a glance. Source: Devadasan et al., 2013, p. 2, modified

Studies conducted on analysing the enrolment, dropout and effectiveness of RSBY (Rajasekhar et al., 2011; Raza et al., 2016) state that there is a variation across the states in India between the RSBY membership and healthcare use. Further, it has been argued that RSBY has the potential to move towards universal health coverage, given that the awareness of the program has increased (Raza et al., 2016). On the surface level, the awareness about RSBY seems reasonable; however, when studies delved deeper into identifying the awareness of the target population about the features of the program and the process of utilisation, the awareness was found to be low to none. One independent knowledge, attitude and practices (KAP) study by Taneja & Sihare, 2011 found that the beneficiaries were aware of the amount of total coverage available, the number of family members covered and the amount required to pay before enrolment, etc. However, they were completely uninformed about various entitlements related to the scheme, such as transportation allowance coverage, nature of treatments covered, coverage for expenses on OPD treatment, and amount of claim coverage available for specific diseases, among others. A study by Rajasekhar et al. (2011) claims that many beneficiaries were not aware of how and where they could utilise the benefits of the program. The existing literature concluded that low awareness is a reason behind the low utilisation of the benefits of the program (Thakur, 2016; Bandyopadhyay & Sen, 2017). Thus, it is important to understand the gaps in the process of awareness generation that might be causing the low utilisation of the programs. It is required to understand the sources of information dissemination and the type of information communicated to the potential beneficiaries about the program. Thus, this research attempts to fill the gap in the literature by exploring the primary sources of awareness generation for RSBY. Further, I explore the gaps in these mediums, which might impact the (low) utilisation of the program's benefits.

Methods

This paper is part of an ongoing PhD project focusing on the health security of the informal workers in India. It is based on the first part of the project, aiming to explore the gaps and challenges in the implementation of health security programs in India, which impact informal workers' access to benefits. For the PhD project, I conducted expert interviews with the stakeholders engaged in the implementation of RSBY in the Begusarai district of Bihar, India, to identify the gaps in the implementation process. The interviews were conducted for three months, from March to May 2019. For ethical reasons, I cannot disclose the current or previous position holdings of the interviewees. However, I am sharing an overview of the departments where the interviews were conducted in Table 1. Further, I used thematic analysis (Ryan & Bernard, 2003; Bogdan & Biklen, 1997) to analyse the interview data, keeping the research question in mind.

Table 1 List of interviewees

No.	Name of departments	Total n
1.	District Health Society	6
2.	District Public Hospital	1
3.	Private Empanelled Hospital (at district)	1
4.	Private Insurance company & Third-Party Administrators (TPA)	2
5.	Front-line workers	2
6.	Panchayati Raj Institutions Representatives (PRIs)	2
	Total	**14**

Findings

The process of awareness generation is a vital step in the implementation of any social welfare program. It directly impacts access to the program, the success of the program, and, eventually, the attitude of intended beneficiaries toward the program. Various problems such as misinformation, partial information, and distorted information could pose a threat to the outcome of the program. Misinformation about the features of the program can have a negative impact on the program outcome (Thakur, 2016; Bandyopadhyay & Sen, 2017). In contrast, partial or distorted information will directly impact the beneficiaries' access to the program. In RSBY, the responsibility for awareness generation is primarily given to the insurance company (IC). The process of awareness generation in the Begusarai district was conducted through various mediums, such as front-line workers engaged in the program implementation, elected representatives, and program documents, among others.

Through front-line workers

As per the implementation structure of the RSBY program, a front-line worker was designated as the Field Key Officer (FKO) as a government representative for the on-ground implementation. FKOs have been engaged in awareness generation by the IC through the distribution of a printed "intimation slip" with information such as the name of the family head, names of family members, and date of enrollment to each eligible beneficiary household. The FKO's visit to the potential beneficiary's household was envisioned to be an

effective strategy in terms of outreach to the program and spreading awareness about the program's features among the beneficiaries.

However, the front-line workers themselves lacked an understanding of the software-based program. It brings upfront the challenge of half or misinformation being communicated to the eligible households. The district officials also highlighted this potential threat during the interviews. There are no accountability measures to check on the information being shared by the front-line workers.

Through the Panchayati Raj Institution (PRI) members

The PRIs have been engaged in the implementation of several welfare programs of the government in the village. As for the awareness generation of RSBY, the PRIs were expected to inform the beneficiaries about the features and functioning of the program. However, during the interviews, the PRIs informed me that due to a lack of resources, such as a lack of technical skills and poor internet connectivity in rural areas, they were not updated on the latest developments in software-based programs.

Moreover, the political affiliation of the elected representatives of the village and the central government has an impact on the successful implementation of the program. The elected representatives belonging to the same political party as the central government would have higher motivation to implement the welfare program introduced by their political party rather than their opposition party. Thus, the generation of awareness of a program depends on the political affiliation of the PRIs.

Through program documents

Program documents include pamphlets, flyers, or any document designed precisely for a particular program. It contains information about the program features and the benefits available for the beneficiaries. For RSBY, the program documents were pamphlets and brochures to be shared with each enrolled beneficiary, together with the health insurance card at the enrolment station. The pamphlet of RSBY had details about the program, such as empanelled hospitals in the district, toll-free numbers, etc. for the beneficiaries.

The program documents were not distributed uniformly across the districts, leaving many potential beneficiaries with no information on the functioning of RSBY. The non-distribution of the program documents left the beneficiaries with no choice but to choose the public hospitals with poor- and low-quality services (please see Das & Hammer, 2007; Rajasekhar et al., 2011 for detailed discussion) or incur out-of-pocket expenditure. In either of these cases, the objective of RSBY to provide quality health care and reduce financial burden has not been achieved. Moreover, the expectation of the planning body from the illiterate and low education group to understand the program features and functioning through the program documents is further an ambitious approach.

Other means of awareness generation

Apart from these, other means used to spread awareness about the program include loudspeaker announcements in the village, jingles, advertisements on various communication channels such as newspapers, television and radio, and banners and posters, among others. All of these means focused on the surface information about RSBY while missing out on how and where to utilise the program benefits.

The gap in awareness generation

Above, I have discussed the various means of awareness generation used for health insurance programs. For RSBY, the primary responsibility of conducting an awareness generation program was given to the insurance company. The responsibility of generating awareness through the insurance company has two significant problems. The first is the model of functioning of the insurance company, which functions on higher premiums and fewer claims. Following this model, the awareness generation campaigns focused on spreading information about the enrolment process of the program while ignoring the information about the utilisation of the benefits of the program. The second problem is a structural problem. The insurance companies that are experienced in dealing with the middle- and upper-middle-class population had to deal with the lower socio-economic groups under RSBY, whose needs and requirements were different. This population group requires extra effort in terms of awareness. Thus, the awareness generation through the insurance company side-lined the information about the process of utilisation of RSBY, which resulted in the low utilisation of the program's benefits.

Conclusion

RSBY is a social health insurance scheme focused on improving poor people's access to health systems without financial burden. However, the gaps in the on-ground implementation of the program have resulted in the lower utilisation of the benefits. The program implementation is a vital stage in planning a welfare program. The strategies used at the different stages of the implementation process as adjustments to the initial implementation plan had a direct impact on the outcome of the program. In RSBY, the awareness about the utilisation of these health insurance programs has remained an ignored aspect in the awareness generation campaigns. It can be argued that the campaigns were intentionally designed to skip information on the process of utilisation of the program. The findings of this research complement the findings of the studies by

Thomas et al. (2019) and Thakur (2016) conducted on RSBY, showing low awareness of certain aspects of the program. Furthermore, the findings of this study will help to improve the implementation of the currently functioning Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (AB-PMJAY), which has replaced the previously running RSBY with better financial coverage.

References

Bandyopadhyay, S., & Sen, K. (2018). Challenges of Rasthryia Swasthya Bima Yojana (RSBY) in West Bengal, India: An exploratory study. The International Journal of Health Planning and Management, 33(2), 294-308. https://doi.org/10.1002/hpm.2453.

Das, J., & Hammer, J. (2007). Money for nothing: the dire straits of medical practice in Delhi, India. Journal of Development Economics, 83(1), 1-36. https://doi.org/10.1016/j.jdeveco.2006.05.004.

Devadasan, N., Seshadri, T., Trivedi, M., & Criel, B. (2013). Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. Health research policy and systems, 11(1), 1-8. https://doi.org/10.1186/1478-4505-11-29.

Jena, B. B. (2020). Challenges in Implementing Pradhan Mantri Jan Arogya Yojana (PMJAY): Empirical Findings from RSBY Study. In: Ranjan Chaurasia, A. & Jungari, R. (eds): India 2019. Population and Sustainable Development, pp. 31-42. Bhopal, Madhya Pradesh : MLC Foundation.

Rajasekhar, D., Berg, E., Ghatak, M., Manjula, R., & Roy, S. (2011). Implementing health insurance: the rollout of Rashtriya Swasthya Bima Yojana in Karnataka. Economic and Political Weekly XI.VI(20): 56-63. https://www.jstor.org/stable/23018214.

Raza, W., Van de Poel, E., & Panda, P. (2016). Analyses of enrolment, dropout and effectiveness of RSBY in northern rural India. MPRA Paper No. 70081. München.

Ryan, G. W., & Bernard, H. R. (2003). Techniques to identify themes. Field Methods, 15(1), 85-109. https://doi.org/10.1177/1525822X02239569

Sahu, S. (2023). The Politics of the Public Health System in India. In: Kumar Jha, M., & Nayan Choubey, K. (Eds.) Indian Politics and Political Processes: Ideas, Institutions and Practices. London: Routledge, pp. 512-526. https://doi.org/10.4324/9781003434443-27.

Sen, G., Bang, A., Chatterjee, M., Dasgupta, J., Garg, A., Jain, Y., & Varkey, L. C. (2011). High-level expert group for universal health coverage. New Delhi: Planning Commission of India.

Taneja, P. K., & Sihare, H. (2011). Pros & cons of micro health insurance to eradicate health problems in the Below Poverty Line (BPL) population: empirical evidence from India. Italian Journal of Public Health, 8(4): 359-374. https://doi.org/10.2427/5683.

Thakur, H. (2016). Study of awareness, enrollment, and utilization of Rashtriya Swasthya Bima Yojana (national health insurance scheme) in Maharashtra, India. Frontiers in Public Health 3:282. https://doi.org/10.3389/fpubh.2015.00282.

Thomas, B., Mishra, S., Nimbalkar, S., Phatak, A., Shinde, M., & Talati, K. (2019). Study on Level of Awareness and Factors Contributing to Non-Utilization of Rashtriya Swasthya Bima Yojna (RSBY) in Charotar Region, Gujarat. Social Work Chronicle, 8(1): 80-93.

Wagstaff, A., O'Donnell, O., Van Doorslaer, E., & Lindelow, M. (2007). Analyzing health equity using household survey data: a guide to techniques and their implementation. Washington, D.C.: World Bank Publications.

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