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Periodic Research

RSBY Scheme and Out of Pocket Expenditure- A Case Study From Chhattisgarh

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Abstract

RashriyaSwasthyaBimaYojana (RSBY) has been implementing in Chhattisgarh from june 2009 onwards. The state has ranked sixth in terms of the enrollment among the 18 states as per the Final Report on RSBY Post Enrolment Evaluation held at May, 2012. As the enrollment alone cannot judge the success of the programme, the researcher has conducted a minor study in Sendri gram Panchayat, a panchayat in Bilaspur to look into the health seeking behaviour of the population. The research is specially focused on the BPL population and their health care seeking behaviour.

Case study method is used to have a in-depth understanding about the case. The samples are selected using stratified sampling method i.e. samples selected randomly from different social status such as SCs, STs and OBCs and who belong to different wards in the panchayat.

The findings throw light into areas such as the disease pattern and prevalence among the BPL population in the panchayat, health seeking behaviour of the BPL population before and after enrolling to the health card, and learned preference for private or clinics hospitals etc. The highlight of the study is the population's preference for the private health care institutions over the public health institutions in matters of health care choices and health seeking behaviour.

Keyword: Learned preferences, health seeking behaviour, health insurance, out of pocket expenditure, health care institutions.

Introduction

In April 2008, GOI has introduced the RashtriyaSwasthyaBimaYojana – an insurance scheme for ensuring cashless treatment for In-patient health care services for the BPL sections of India. These measures are implemented to ensure the reduction of gap between the rich and poor in accessing costly and necessary treatment offered at secondary and tertiary level of health care.For the poor people, illness is a way to loss of income as well as trap to debt. Due to lack of resources, these population often ignores their vulnerable health condition which often takes them to serious impairment.

The need for health insurance among the poor population is a long cherished dream that came into existence only after the 61st years of Independence. During the 61 years, the health care seeking behaviour of the Indian population has changed from micro level to macro level. The failure of the public health system to satisfactorily cater the needs of the population has brought them to opt for private players. As the out of pocket expenditure in India turned to be one of the highest in the world, the government sponsored health insurance scheme is a centre of attraction for different stakeholders in the health sector.

As it is the 6th year of the implementation of the RSBY scheme across India, several reports and studies conducted by GOI, research groups and research scholars have acclaimed the success of the programme across different states. Here the researcher tries to analyze learned preferences of the community over their health seeking bahaviour and choices of treatment providers before and after the RSBY enrollment.

Health seeking behaviour of marginalized group: literature review

Previously government and other health providing agencies were of the hypothesis that the more the individual is informed of the illness and the health care facilities, the more the health seeking behaviour. Later, studies have highlighted the inherent and external components that influence the health seeking behaviour of the individuals as well as population.

Health seeking behaviour means the identification of pathways to the formal health care system (Grundy, J & Annear, P.,2010). Often it starts from traditional healers or local healers and in course of time, they reach at the formal system. This identification of pathways for health care is influenced by different components. According to Parson's theory of sick role (Andersen, R. (1968. Cited in Rebhan, D.P), the individual seeks to get out of his role of being sick, which is an undesirable state. Andersen's Behavioral Model of Health Services Utilization in 1968 has described three categories of determinants such as predisposing characteristics, enabling characteristics and need based characteristics that contribute to the health seeking behaviour. In 1970, health system also added to it as the fourth determinant to health seeking behaviour. Later in 1978, Mechanic in his theory of help seeking behaviour described the psychological approach of individual involved in the health seeking behaviour. The health belief model proposed by Rosenstock, Strecher& Becker in 1994 has described the four central variables in health seeking behaviour such as perceived susceptibility, perceived severity, perceived benefits and perceived cost.

Health seeking bahaviour of the marginalized and utilization of the services within the existing government and private health service providers are always burning topics in academic field as well as among health advocacy groups and activists. The globalization has opened the box of opportunities in accessing and using highly effective and complex health care facilities in India. The rich and ever growing middle class in India has seen it as development and turned their attention to these facilities. On the other hand, the vulnerable population of India, which constitutes more than 60% of the population, has still preferred for quacks and local healers, village clinics etc. They found the new 'developments' in health care were unaffordable and would put them in the poverty trap if they approached it. This chasm between the perceptions and experiences of the vulnerable population and the utilization of available health resources has taken India in lagging position in matters of health scenario.

According to Achary&Ranson (2005), 5.1 percent of India's GDP spends on health care expenditure and its 82 per cent is from out of pocket expenditure. The hither to history shows the burden of health related out of pocket expenditure puts the rural and urban population in the trap of debt or losing all their savings. The recent years' evidence shows an increasing (80%) dependence on the private sector for outpatient care and it is largely due to the weakness in the delivery of public health services (Rao, S, 2005).

Different studies on the health seeking behaviour of the marginalized sections of society reveals the factors that influences or hinders their choices, delays and influence the preferences in accessing or not accessing health care services. It includes indirect cost such as expenses on transport, food/stay, tips given to secure access to any person or facility, opportunity cost of lost wages of the sick as well as the accompanying person, etc associate with the illness (Sodani, 1997), cost of services, proximity, convenience of timing and perceived quality of health services (Yesudian, 1999), reputation of the provider, cost and physical accessibility (Ager, A. and Pepper, K., 2005), lack of social space for the marginalized groups in the existing health sector from policy to implementation (Prasad, P. 2000), macro environments such as local areas, districts, states (Gordon, D., Kelly, M., Subramanian, and Nandy, S., 2004), price and distance to a health facility (Borah, B.J., 2006), unequal power relations between systems of medicine and between givers and receivers (Prasad, P., 2007), quality of services, behaviour of the health personnel (Baru ,R., Acharya , A., Acharyua, S., Kumar, S. and Nagraju, K., 2010), acceptability and accessibility of the services provided (Gurung, A., Narayanan, P., Prabhakar, P., et.al, 2011), Micro-health insurance (Savitha,S. and Kiran, K., 2013).

Among these factors, the role of health insurance as a resource in facilitating the health and health seeking behaviour of the marginalized group is worth investing. After the introduction of RSBY scheme, there were several studies (Trivedi M, Saxena DB.,2013; Nandi S, Kanungo K, Khan MH, Soibam H, Mishra T and Garg S, 2010; Seshadri T, Trivedi M, Saxena D, Soors W, Criel B, Devadasan N, (2012; Wu Q, 2012; Palacios, R, 2010; Arora D, 2010; Patel, J P, Shah, J, Agarwal, M &Kedia, G, 2013; Sinha R K, 2013; Dasgupta R, 2013) which highlights the scheme as well as criticizing the need for strengthening primary health care rather than initiating insurance scheme. The present study is looking more into the changes of the health seeking behaviour of Sendiri group, a population which includes SCs, STs and OBCs, in pre and post enrollment period.

RSBY in Chhattisgarh

RashriyaSwasthyaBimaYojana (RSBY) has been implementing in Chhattisgarh from June 2009 onwards. The state has ranked sixth in terms of the enrollment among the 18 states as per the Final Report on RSBY Post Enrolment Evaluation held at May, 2012.The 27 districts in Chhattisgarh has a total number of 6418545 families out of which 3797574 families have already enrolled to the programme. The empanelled hospital under the scheme is 349 private hospitals and 279 public hospitals.The final report prepared by the Council for Tribal and Rural Development for the State Nodal Agency of RSBY Chhattisgarh claims that RSBY has covered not less than 57.13% of BPL household of the state by third round of enrolment.

The District wise Claims for RSBY speaks about the puicture of the RSBY implementation and the who are benefiting out of the scheme.

Round	Total Hospital			Total Claims			Total Claim Amount (in lacs)		
	Govt	Pvt	Total	Govt	Pvt	Total	Govt	Pvt	Total
Round 4	253	335	588	92905	140900	233805	4174.249	10852.358	15026.607
Round 3	243	240	483	72826	90265	163091	2200.55	5097.11	7297.66
Round 2	233	234	467	30525	38436	68961	887.01	2262.66	3149.67

Source:
http://cg.nic.in/healthrsby/reports/rpt64kbclaims.aspx retrieved on 25/04/2014

the data shows the prominence of private players over the public health care institutions. The health seeking behaviour of the people towards the private players are seen in the form increasing flow of insurance amount to private players. While govt. hospitals got a increase of claim from 30525 to 92905, private hospitals witnessed a shoot up in claims from 38436 to 140900. Accordingly, the fund flow also differs such as Government hospitals have secured 4174.249 lacs in the Round 4 of the district claim whereas private players have secured 10852.358 lacs from the claims. The state is witnessing an ever increasing and favourable healthcare seeking behaviour towards the private empanelled hospitals. In this context, the health seeking behaviour of the BPL population is worth investingating. The present study is looking more into the changes of the health seeking behaviour of Sendiri group, a population which includes SCs, STs and OBCs, in pre and post enrollment period.

Research Design, tools and methods of data collection

The descriptive design using case study method is applied. Interview schedule is administered and observation technique is used throughout the study. The samples are selected using stratified sampling method i.e. samples selected randomly from different social status such as SCs, STs and OBCs and who belong to different wards in the panchayat.

Results

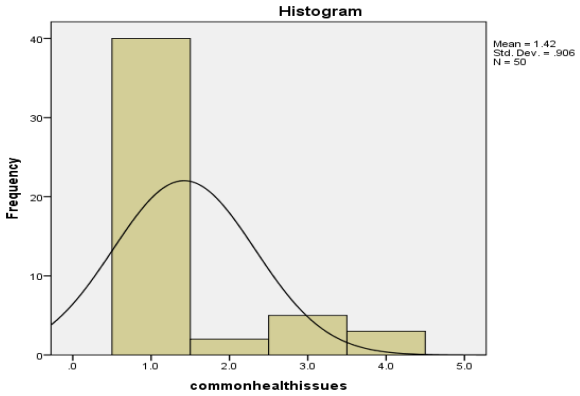
Basic profile of the respondents

Variable		Frequency
Gender	Male	43
	Female	7
Age	20-29 years	6
	30-39 years	11
	40-49 years	15
	50-59	9
	60-69	8
	70-79	1
Education	Illiterate	20
	below 10 the class	27
	plus two and more	3
Religion	Hindu	50
Social status	SC	27
	ST	7
	OBC	16
Occupation	daily wage labourer	21
	self employed	2
	farmer	25
	any other	2

The basic profile shows the vulnerable factors of the population of the panchayat. The education level of the samples was very low and majority is dropouts before completing their matriculation. Their occupation also signifies their economic condition as the 92% of the sample are engaged either in agriculture or daily wage labour. There found a correlation between the education level of the sample population and the occupation they engaged i.e. the illiterate and those who are below the qualification of the SSLC has chosen their occupation either in agriculture or daily wage. Their social status as a SC, ST or OBC further puts them into more socially and economically vulnerable.

The disease pattern and prevalence in the Sendiri panchayat

Common health issues	Frequency	Percent	Valid Percent
seasonal disease	40	80.0	80.0
lifestyle disease	2	4.0	4.0
seasonal disease and life style disease	5	10.0	10.0
seasonal disease and accident	3	6.0	6.0
Total	50	100.0	100.0



The table and histogram shows the distribution of disease pattern and prevalence and it points out the higher prevalence of seasonal diseases such as malaria, cough, viral fever etc. in the panchayat. The diseases are rather preventable and it requires intensification of the primary health care. The prevalence of other major health events like life style diseases, accidents are reported very few which requires secondary and tertiary level health care. So the strong dissociation between the projected need of

health seeking behaviour under the RSBY scheme and actual need of the health seeking behaviour of the population.

Minor Disease and place of treatment

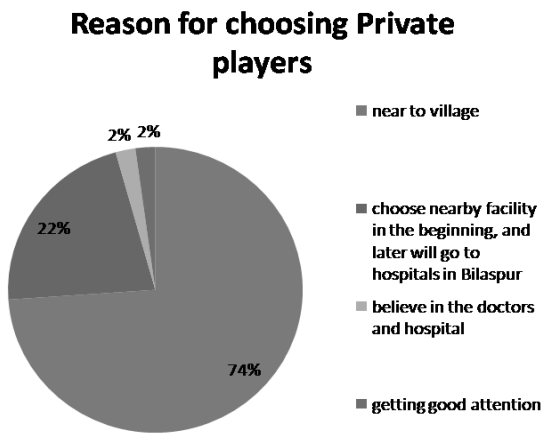
The minor diseases affecting the villagers include fever, body pain, headache, diarrhea, minor injuries with sharp objects, etc. At times of the minor diseases, they depend on the private or public health institutions for the treatment.

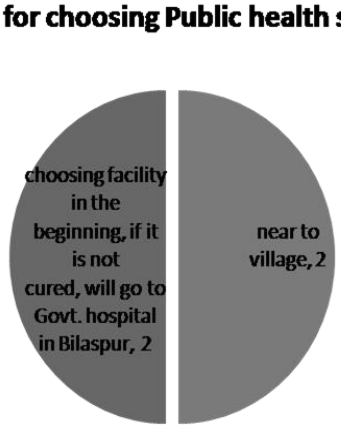
Place of treatment	No. of beneficiaries
Private players, which include local healers, clinics in the village, and private hospitals nearby the Panchayat.	46
Public health system includes PHC at local level and other government hospital nearby the Panchayat	4
Total	50

The table explains the health seeking behaviour of the sample population in relation to the minor and seasonal diseases. The preferences are always made in connection with private players such as local healers (11), clinics in the village (8), private hospitals (6) and its different compositions. PHC is been reportedly utilized by just 2 households!

Dependency on Different Health care institutions and the reasons

Reason for choosing the institution		Frequency	Percent
Private players	near to village	36	72.0
	choose nearby facility in the beginning, and later will go to hospitals in Bilaspur	12	24.0
	believe in the doctors and hospital	1	2.0
	getting good attention	1	2.0
Public health system	near to village	2	50.0
	choosing facility in the beginning, if it is not cured, will go to Govt. hospital in Bilaspur	2	50.0





A table and pie diagrams gives answer to the preference of village population towards the private player. The chart shows that people prefer private players because they are nearby village and they believe in the quality of doctor and their treatment. The same village has a PHC nearby. But the utilization is very poor because it was reported and observed irregular in its services and people are not feeling confident with the service of the personnel and the institution namely PHC. However, between these two variables such as proximity and quality, people prefer the former.

Awareness about the RSBY scheme and provision of health card

The researcher asked about the enrollment of the household under the RSBY scheme. 42 out of 50 household responded “yes”. Further analysis of the same question by the researcher and field investigator found that majority of these cards belongs to either 2011-12 or 2012-13. These cardholders are not aware that it has to be renewed every year and they will be provided with the new card. In addition, it was found that some are dissatisfied by the health card because they are not benefitted from the card. They approached the hospitals with these expired cards and were denied the services. The current beneficiaries are also not fully aware about the provisions and benefits of the health card and the utilization pattern is also found less effective.

Utilization of RSBY Card at different health care institution

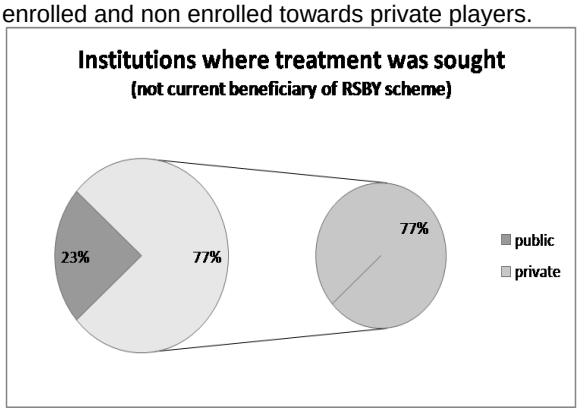
Use of health card in 2013-14			
	Frequency	Percent	Valid Percent
Yes	4	8.0	8.0
No	46	92.0	92.0
Total	50	100.0	100.0

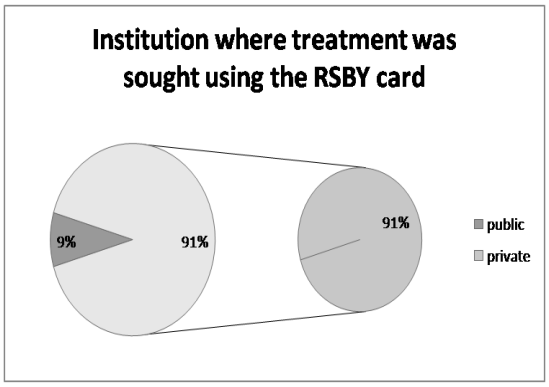
Usage of the RSBY card after the first enrollment to 2013-14			
	Frequency	Percent	Valid Percent
0	39	78.0	78.0
1-2	9	18.0	18.0

more than 3	2	4.0	4.0
Total	50	100.0	100.0

The tables show the utilization pattern and dependency of the sample population on RSBY scheme. Only a minority (4 persons) has utilized the card in the current year i.e. 2013-14 and the rest were not used the card. Again, the usage of the card from first enrollment of the current year also marks very low. 18% of households has used the card for 1-2 times and 4% households for more than 3 times.

The preference for the health institutions and services used by the beneficiaries also maters. The below charts diagram shows the preferences of enrolled and non enrolled towards private players.





Major health events in the village and usage of the card

The samples from the panchayat have reported with major health events such as health issues of elderly (Stroke, paralysis, cardio Vascular diseases, hepatitis B etc.) or children (injuries due to accidents, severing of seasonal diseases like malaria, dengue, viral fever etc.), and accidents. These are the rare occasions they have used the card. The number of the health card usage thus ranges from 0, 1-2, more than 3. The no. of people comes in this category is very less.

Another question on the recent use of the RSBY card revealed that only four members have used it. The rest are further asked about the status of their RSBY card and it was found that majority is having expired card which cannot be used in the current year.

Discussion

The health behaviour of individual depends on the beliefs and attitude sufficiently supported with external factors. The minor presence of perceived susceptibility and severity towards the seasonal diseases which is coupled with the absence of regular and decent service from the PHC has influenced the health behaviour of the population under the study. The socioeconomic status of the population is a handicap to their development. According toAmartya Sen, India has an unbalanced growth because the enabling environments are missing (Sen, A, (1994). As the educational status of the population is comparable low, the health behaviour also is influenced. The utilization of public health resources is found abysmally low. The misapprehended notion of replacing the use of the service of public health system for private players has contributed little to the health of the population, rather it has its own inflicting burden on the individuals themselves.

Preference for the private players is the highlighting theme of the study. Over the years, the population has transformed their health seeking behaviour in favour the private clinics and private hospitals. The tables and charts show the fatal drop in the use of PHC in the village. Their preference for health institution is primarily influenced by the proximity of the institution. Even then, the nearby PHC never comes into the preferences. On further analysis, the irregularity and unfriendly response from the health system has influenced behaviour. The factor of social space of the population who depend on the existing government health system is a matter of discussion. While conversing, many household members have reported the unfriendly treatment from the government health institutions. Whereas, the same population is satisfied over the private players because they make the patients feel that they are been treated well for the money they spend for.

The profile of the sample denote the socio-economic conditions of the panchayat. The scheduled groups and other backward groups are the major population of the village. Addressing the question of economic access to health care through RSBY scheme for the BPL families is found questionable. The out of pocket expenditure is very high before the RSBY scheme and even after the enrollment. The scheme was there with ‘last mile challenges’ like lack of sensitization over the provisions, benefits, and related information, inconsistency in enrolling all the beneficiaries to the scheme. The villagers have cards which are not properly utilized because either the cards are expired or they do not know the provisions and the institutions where it is available.

The Alma Ata declaration speaks about the role of primary health care in the health service system. An analysis of the disease pattern and prevalence shows the high need of strengthening primary health care though effectively functioning PHC. The panchayat witnessed a PHC which rarely opens and its services are poor in quality. Over the years, the health seeking behaviour of the villagers too changes to private clinics and hospitals because they are never been offered satisfactory service from the public health system functioning ate panchayat level. The ruling parties in the Gram panchayat also could not effectively address the issue.

If we consider the factors influencing access to curative care (Bajpai, V. and Saraya, A.2012) such as availability of better developed infrastructure, lesser levels of poverty, transportation facilities to reach the hospital facilities, literacy and education to utilize the scheme with prudent choices, demographic composition, political mobilization, the samples and area under study has considerable implications. The population is socially and economically poor. The marginal groups are often victims to the poverty traps through unemployment or failure of the crops. The family structure is also very high that the earning are spent on the daily maintenance of the family. The prevalence of seasonal health issues and consultation at private clinics and hospitals also put them under poverty burden. The distance to the secondary and tertiary level care units are also little far from their village. The illiteracy and low levels of education is the main villain and the majority of the vulnerable population in the panchayat is unable to make optimum utilization of all possible provisions under different schemes.

The case of irregular PHC in the village has given a wrong notion about the public health system in the psyche of the villagers. The health service seekers negative perception and experience in relation with the public health system has influenced their choices. The Panchayat is been witnessing the poor and irregular service pattern by the PHC over the few years. The researcher has a personal experience from the PHC i.e. when the researcher and other fieldwork trainees visited the building, some other person were there who were preparing food and other refreshments for their leisure. The picture depicted by the villagers about the PHC can also summoned as irregular.

Asymmetric power relation between caregivers and beneficiaries is another area. The private health care players are attractive to the villagers because they show courtesy with the customers. The customers are paid for the service and in return they are treated in a dignified way. Whereas in public health system, the villagers reported about the negative experiences from the personnel. If the RSBY card can help them in accessing the private players, they prefer it to expecting the same behaviour from the caregivers.

Suggestions and recommendations

The researcher would like to suggest the following points.

- The need for sensitization about RSBY scheme and its service providing centres
- The need for credibility building of public health system through better health care and service provisions.
- The need for strengthening primary health care at grass root level rather than promoting the curative level.

For these, the following actions are recommended such as

- ✓ Restoring and regularizing the functioning of the PHC and its services.
- ✓ Improved participation of the people in regularizing the services of PHC.
- ✓ Special attention of PRI system on the health aspects of the panchayat.
- ✓ Mass sensitization over the RSBY scheme and its provisions through notices, leaflets and other ICT measures for imparting the relevant information.

Conclusion

The case of Sendiri is copy of hundreds of villages and Panchayats in Chhattisgarh and in India where the health seeking behaviour of the population is moulded through a number of environmental factors. The lagging of public health system has significantly contributing to the profit of private players and loss for the common person who manages his/her life with limited source of money. The out of pocket expenditure puts him/her again into further deteriorating situation, which ultimately affects his/her health. So there need an urgent attention to the infiltrating risk namely learned preference for private health care and denouncing of public health system. To conclude the health seeking behaviour is a learned behaviour which is facilitated by the response of health system

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