Third Angle of RSBY: Service Providers’ Perspective to RSBY-operational Issues in Gujarat

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ABSTRACT

Context: Government of India in 2008, launched its flagship health insurance scheme for the poor. The Rashtriya Swasthya Bima Yojana (RSBY) combines cutting edge technology with an unusual reliance on incentives to provide inpatient insurance coverage. The scheme allows for cashless hospitalization services at any of the empaneled hospitals. Stakeholders in RSBY include members of the community, Insurance Company and the service provider. Aim: The study manuscript is an attempt to get an insight to understand the bottle necks in faced by the service providers with an overall goal to understand issues in complete roll out of RSBY and its successful implementation across country. It was conducted to undertake the stakeholder analysis and understand the service providers’ perspective to RSBY. Setting and Design: The present study was conducted in the Patan district of Gujarat state. Qualitative tool mainly in-depth interview of service providers of RSBY in Patan district of Gujarat state was utilized for the data collection. Results and Conclusion: Service providers opined an ineffective IEC around the utility of the RSBY service in the community. In spite of the claim that scheme relies heavily on technology to ensure paperless cashless services, on field, it was observed in the present study that the claim settlements are done through physical documents. The service providers had a perceived threat of being suspended from the list/de-empanelment of the provider by the insurance company. There is an urgent need for improved and effective IEC for the service and possibilities of an arrangement for to settle the case of grievances around suspensions ao that genuine hospitals can have fair deal as well. There definitely remains a greater and more serious role of government, which ranges from ownership to larger issue of governance.

Keywords: BPL community, insurance companies, Rashtriya Swasthya Bima Yojana, service provider

Introduction

In 2008, the Government of India launched its flagship health insurance scheme for the poor. The Rashtriya Swasthya Bima Yojana (RSBY) combines cutting edge technology with an unusual reliance on incentives to provide inpatient insurance coverage up to an annual sum of Rs. 30,000 for eligible enrolled households. Presently, RSBY is being implemented in 27 states across India, covering more than 27 million families. The comprehensive demand-side financing scheme offers a business plan that offers adequate incentives for all the key players of the program, i.e. the beneficiary, the insurance company, healthcare providers or hospitals, and the government.

The scheme offers a front-end that starts from village-level enrollment so as to enable the beneficiary to receive a smart card almost at his doorstep, with the only eligibility criterion being his/her name has to be in the BPL list. RSBY is an intervention that enables consumer choices among competing facilities through a demand-side subsidy. It aims to provide greater financial protection for poor households and foster better quality care through increased competition. The scheme allows for cashless hospitalization services at any of the empaneled hospitals across the country for up to Rs. 30,000 per family per year.

The national interoperability feature is one of the many unique features that have been designed to be the most important asset of the scheme. Additionally, the scheme is supposed to be paperless with features of “online data transfer.” The use of technology enables the hospitals to submit the claims online and the insurers are also supposed to make online payment to the hospitals. Finally, a robust backend data management system ensures smooth flow of data from across India to both the state and central governments in real time that can ensure effective monitoring of the scheme.

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Almost 4 years into the scheme, and despite having the potential of changing the “access to healthcare” scenario in the country, the scheme seems to be crippled with many problems being faced by all the stakeholders.[1–5] The present paper is an attempt to get an insight to understand the bottlenecks faced by the service providers, with an overall goal to understand the issues in complete roll out of RSBY and its successful implementation across country.

RSBY was implemented in the five pilot districts of Gujarat in 2008–2009. In the year 2009–2010, additional five tribal districts were also covered. Finally, in 2010–2011, the entire rural below poverty line (BPL) populations of all the 26 districts of Gujarat were covered under the RSBY scheme. Out of the total 29.69 lakh rural BPL families, 19.1 lakh were enrolled in the scheme.

Materials and Methods

The objective of the present study was to undertake the stakeholder analysis and understand the service providers’ perspective to RSBY. The broader objective of the present study was to ensure effective implementation of RSBY in India. The qualitative tool utilized in the present study was in-depth interview of service providers of RSBY in Patan district of Gujarat state. Patan district was the first district in Gujarat where phase I of RSBY was implemented. In-depth interview of practitioners associated with empanelled hospital in the district Patan was conducted. A desk review of the 2010 claims in the district under RSBY by the service provider was undertaken. Selection of the practitioner/hospital was based on the claim rates under RSBY for the district Patan. It was attempted to interview service providers from different specialties like Obstetrics and Gynecology, Surgery, and Medicine. In all, 10 in-depth interviews were conducted. Informed consent was obtained from the service providers and all efforts were taken to maintain the confidentiality of the respondents. The themes of the in-depth interview and open-ended interviews were based on the qualitative analysis of the published articles and studies published in journals, government website, case studies, and other available documents on RSBY. Audio recording of the interview was done wherever respondents permitted, or else the notebook method was followed to capture the responses.

Observations

The review of the present status of RSBY reflects a huge disparity in uptake of RSBY at a national level; while states like Delhi and Karnataka have less than 20% enrollment, Himachal Pradesh has more than 85% of its BPL population covered under the scheme.[6] On one hand, the scheme is being extended to many newer states; on the other hand, there are states like Andhra Pradesh who are not keen on adopting RSBY as it has its own parallel scheme – Rajiv Gandhi Aarogya Shri. There are other states like Karnataka, Maharashtra, and Tamil Nadu which are offering RSBY, along with piloting state-owned health insurance scheme that although in theory can complement RSBY, can generate possibility of competition as well as corruption at grassroot level.[5] The extreme example comes from Rajasthan, which after initial experimentation, stopped implementing RSBY altogether and has started its own scheme that covers hospitalization at government hospitals. In the states that are implementing RSBY, including Gujarat, the recent enrollment drive – the annual mission to renew the policy by providing fresh smart cards – has shown decline in the enrollment of the scheme.[6] In Gujarat, while the overall enrollment rate is 57%, the same in the nine districts where the scheme is in third year, the enrollment is only 48%. The enrollment in pioneer districts like Banaskantha and Patan remain abysmally low at 40% and 45%, respectively.

Stakeholders in RSBY include members of the community, insurance company, and the service provider. While members of the community have been studied, the other two stakeholders have either never been studied or not been adequately studied. The present study reports qualitative observations from service providers’ perspective on RSBY, which are discussed below.

Service providers’ perception about insurance company

The healthcare providers are the most important supply-side stakeholders. The scheme offers excellent business proposition to hospitals in terms of a) untapped rural market that was not being able to access services and b) ability to not refuse healthcare services to the needy eligible clients who otherwise could not have been catered to. The very same reasons can also make the scheme prone to excessive claims through fraudulent or unnecessary procedures. Some such examples have been observed and also documented elsewhere.[7]

Majority of the public and the private service providers of the studied district opined that even though theoretically the insurance companies abide to make efforts to enroll high percent of eligible members of the community and make the smart card available at the village level, they rarely undertake this step. Hence, the awareness about its utility remains a challenge owing to a) poor literacy, b) ineffective Information Education and Communication (IEC), and c) mere power equation wherein hired staff of the insurance company along with government staff visits the selected portion of community and “provides” a card using sophisticated technology to the family.

As per the views of the service providers, an ineffective IEC around the utility was documented during the present study. This ineffective IEC for the usefulness of smart card can originate from a) the fact that the role of IEC has been heavily relied upon by the insurance company, which possibly has wasted interest in not promoting the “utility” of the card to reduce claims, and b) the added responsibility of IEC on the ever-burdened peripheral health staff.
One of the stakeholders at the district level narrated: “The annual renewal is at times a cumbersome effort at all levels; while insurance companies that are struggling with burning portfolios would be interested in enrolling less people, the beneficiaries may not even understand the need of renewing the card that they have got previously.” Similarly, one of the providers opined, “Since the premium is per card issued, there is no incentive to ensure enrollment of all five members.” It was also observed that the district authorities, with the only responsibility of enrollment and limited or no authority to ensure it, can have limited interest in enrollment drive vis-à-vis other “indicator-driven” health programs.

One of the respondents also believed, “Beneficiaries who have either experienced or have known about experience of refusal to enrollment or utilization can have lesser interest in utilization in the absence of a strong IEC.”

While the scheme relies heavily on technology to ensure paperless cashless services, on field, it was observed in the present study that the claim settlements are done through physical documents. The physical documents like identity proof – to verify age and gender – at times become a necessity as the quality of smart card data is suboptimal. However, there are instances of insurance companies insisting on hard copies of every case paper to be sent to state headquarters, in addition to the online transfers. One of the empanelled service providers narrated: “Without submitting the hard copies, original or Xerox, you cannot receive your legitimate claims. RSBY being a paperless scheme is only on paper.”

Another important issue is of delay in payment, as narrated by majority of empanelled service providers, which was of inter-insurance claim settlement. Although the draft MOU between an insurance company and state nodal agency (SNA) indicates that “all the payments shall be made electronically within 21 days of the receipt of electronic claim documents,” this cannot be followed as there are more than one insurance company operating in the state. Even the state government in one of the presentations admitted that more than half of the claims in RSBY have been settled beyond 4 weeks time. This delay is peculiar in inter-insurance company claim settlements. As per the Guidelines for Inter Insurance Company Claim Settlement, in case of usage of cards in a hospital not empanelled by the issuing insurance company or in a district where the issuing insurance company is not operating the district server, it is the responsibility of the insurance company operating the district server to ensure that the transaction data reaches the nodal person of the concerned insurance company. Given that the draining of patients from one district to another is very common and if a different insurer is operating in the neighboring district, the inter-insurer payment transfer becomes cumbersome. There have been instances of delays and in some cases denials altogether after a few months. With these happening, the source hospitals prefer to avoid the clients from destination districts, and on the other hand, the destination insurance companies are found to be influencing the choices of the clients by encouraging them to take services of the respective district. This kind of practice defeats the very “national portability” purpose of the scheme.

One of the observations as narrated by the service providers was a constant threat of being suspended from the list/de-empanelment of the provider by the insurance company.

One of the providers narrated: “It is just one email that makes you from being empanelled to de-empanelled.” The service provider further added: “Insurance company is always skeptical about work load, they feel the more you work, the more claim you generate, which is essentially false.” The service providers opined thus: “Insurance companies are the happiest if you generate no claim, but if you work, you are doing malpractice as companies have to pay the claims.”

The implementation of RSBY is heavily dependent on the smooth coordination amongst insurance company, the state and district administration, and the hospitals. These partnerships make the interaction of these players quite complex.

As perceived by many, one of the common features of any health insurance scheme, more so in case of a scheme like RSBY, is supply-side moral hazards. The hospitals theoretically have short-term incentive to undertake malpractices to generate more business out of the scheme. In the light of various complaints of such fraudulent practices, RSBY issued advisory for de-empanelment of hospitals in May 2011. According to this, there is a three step procedure for de-listing the empanelled hospital, viz. a) putting the hospital on “watchlist” at any doubt on the performance of a hospital, b) suspension of the hospital, and c) detailed investigation and action by insurance company, which can lead to de-empanelment. This directive gives “absolute” power to the insurance company to suspend the empanelment of any hospital, followed by intimation to SNA and a formal investigation. The process of investigation, i.e. from suspension to result of investigation, can take up to 30 days, during which the said hospital remains suspended and no RSBY transaction is valid. The hospital, on the other hand, has been given the option to approach the Grievance Redressal Committee for the redressal, which will take a final view within 30 days of the receipt of representation. The hospital continues to be de-empanelled till the time a final view is taken by the Grievance Redressal Committee.

The procedure for suspension can be initiated solely by the insurance company, and the investigation as well as de-empanelment involves interaction only between insurance company and state authorities; however, the hospitals are left to start their redressal from the district-level agencies. This arrangement can create power imbalance as insurance company can unilaterally generate suspension that can go unchallenged for at least 30 days. While such a provision is indeed necessary to curb malpractices by certain providers, it has the potential to be used as a vehicle to ensure cream skimming by insurance providers by at least initiating 30-day suspension against hospitals that are not
conducive for profit maximizing. Such cases can be on the rise if the SNA colludes with insurance company, which in the long run can affect the virtuous cycle of better enrollment – better utilization – better renewal.

District Patan has witnessed change in the insurance company in recent years; many of the service providers narrated instances of negotiation of settlement of claim to a much lesser amount than actual by the outgoing insurance company and the service provider has to accept the formula of negotiation fearing a loss of entire claims, and hence settle for no profit or even low loss in the claimed amount.

Conclusions

RSBY is a very innovative scheme with noble objectives. It is emerging as a boon for millions of poor patients who were not able to access healthcare due to financial inaccessibility.

While the scheme is being expanded nationwide and with declining enrollment in recent years, there is a need to set and monitor control knobs to ensure smooth functioning of the scheme at all levels. Three such knobs are already discussed in MOUs between various state government and insurance companies. To ensure effective enrollment, there can be a penalty for insurance company for not enrolling sufficient proportion of BPL families and also members within families; calculation of premium rate can be directly linked to this proportion. The promotion role of insurance company needs to be critically looked at; instead of leaving the IEC job entirely to the insurance company, there can be a mechanism wherein the insurer allocates some percentage of the premium for the IEC/BCC activity and the fund can be passed onto a neutral organization which can promote the scheme. Similarly, instead of leaving the hospital–insurance company to deal with each other, a tripartite MOU should be arranged wherein in case of grievances around suspensions, genuine hospitals can have fair deal as well. There definitely remains a greater and more serious role of government, which ranges from ownership to larger issue of governance.

However, like any other government-sponsored schemes, there are several limitations that the scheme is struggling with. There are also loopholes that have left ample opportunities for collusions between various players, and thus scope for corruption. It is imperative that genuine interests of all stakeholders are addressed and possibilities of corruption are minimized simultaneously.

India neither need wait nor can afford another Comptroller and Auditor General (CAG) report indicating irregularities in another of its nationwide flagship health scheme.

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