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Challenges in Implementing Pradhan Mantri Jan Arogya Yojana (PMJAY): Empirical Findings from RSBY Study

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Introduction

Universal health coverage (UHC) is one of the important objectives of the Sustainable Development Goals (SDGs). UHC emphasises the importance of access to quality health care for everybody without risking financial hardship. As such, financial protection is at the core of the universal health coverage (WHO, 1948). In India, health care financing is dominated by out-of-pocket spending (OOP). It is estimated that around two-third of the total health care spending of an average Indian is out-of-pocket spending (Government of India, 2018). The high OOP spending in the country is because of low level of public spending on health care which still remains at around 1.2 percent of the GDP (Government of India, 2018). It is estimated that because of high OOP, about 2-3 per cent of the Indian population is pushed below the poverty line (Van Doorsaler et al, 2007). More recent estimates suggest that about 5 crore Indians were pushed below the poverty line in 2015 because of OOP spending on health (World Bank and WHO, 2017).

In order to address the problem of very high OOP spending on health, the Government of India had launched the Rashtriya Swasthya Bima Yojana (RSBY) in 2008 with the objective of providing much-needed financial protection to households below the poverty line (BPL households). RSBY provides free health insurance cover of Rs 30,000 per annum for all BPL households up to a maximum of five members per household on a floater basis. The five members of the household include the husband, the wife and up to three dependents and there is no age limit. The benefits under RSBY include hospitalisation, day care treatment and related tests, consultation and medicines and pre and post hospitalisation expenses for more than 700 medical and surgical procedures. There is a fixed package rate for different diseases. In addition, RSBY also provides for a transport allowance of Rs 100 for each case of hospitalisation up to a maximum of Rs 1000 per annum. Another important feature of RSBY is that the transaction is fully cash less and no document is required at the time of hospitalisation except the RSBY smart card. The

scheme requires enrolment of eligible households after paying a registration fee of Rs 30 after which a biometric smart card is issued in the name of the head of the household. The smart card also contains details of all beneficiaries including name, age, gender, thumb impression and photograph. A beneficiary can avail inpatient care from any of the empanelled hospitals across the country using the RSBY smart card. There is also a provision of splitting the smart card for one migrant member of the beneficiary household so that he or she can also avail the benefits under the scheme from any empanelled hospital in his or her place of work. The empanelled hospitals include both private and public hospitals and beneficiaries have a choice of either of the two. The scheme has since been extended to a number of categories of unorganised sector workers belonging to the above poverty line households such as MNREGA workers, bidi workers, domestic workers, sanitation workers, street vendors, postman, rickshaw pullers, auto-rickshaw and taxi drivers, rag pickers and miners, mine workers and registered construction workers, etc. The scheme had the target of covering entire BPL households in the country by the end of 2013 and, by March 2016, the scheme had covered about 4.1 million households. In September 2018, the scheme was upgraded with the wider coverage and increased coverage amount and was renamed as "Pradhan Mantri Jan Arogya Yojana" (PMJAY) which provides for annual health insurance cover of Rs 5 lakh per family for 10 crore poor and vulnerable households in the country.

The present paper highlights the challenges that can be faced while implementing PMJAY on the basis of the experiences gained from the implementation of RSBY. The paper is based on a primary study on RSBY that was conducted in 2014 in one of the districts of Odisha and the review of a number of studies on RSBY. Specific objectives of the paper include: 1) to estimate the coverage of health insurance in India and across states; 2) to study the level of enrolment and awareness about the RSBY scheme; and 3) to study the level of utilisation of the RSBY scheme in the study population.

Data Source and Methodology

The paper is based on both primary and secondary data. The secondary data come from the 71st round of the National Sample Survey which covered health insurance in India and states (Government of India, 2014). On the other hand, the primary data come from a survey of 432 households in 14 villages in two blocks of district Jajpur in the state of Odisha in 2014 - one having higher percentage of BPL households and other having low percentage of BPL households. Within the selected blocks, households were selected following a two-stage sampling procedure. In the first stage, villages were stratified into four groups by population size (0-500; 500-1000; 1000-2000; 2000 and above). In the second stage, required number of BPL households from each selected village was determined by PPS sampling. Seven villages were selected from each block. While selecting villages, adequate representation was also given to Scheduled Castes (SC) and Scheduled Tribes (ST) population. Systematic sampling method was used to select BPL households from the village-wise sampling frame of BPL households. Using the expected proportion of RSBY enrolment in the study district at 67 per cent and the desired precision level at 5 percent, the required number of BPL households to study the level of

enrolment, awareness and utilisation of the scheme among BPL households was determined by using statistical formula for sample size calculation. The required number of BPL households was 362 after adjusting the non response error. Data were also collected from 70 non-BPL households (selected randomly) to study the possession of health insurance among non-BPL households in the study area. The method of analysis included comparison of the proportionate distribution of households and bivariate analysis.

Coverage of Health Insurance

The data available through the National Sample Survey reveal that, at all India level, only about 15 per cent population was covered by any health insurance scheme (including RSBY) in 2014. The coverage was marginally higher in the urban (18 per cent) as compared to the rural areas (14.1 per cent). Among the major states of the country, the coverage of health insurance was the highest in Andhra Pradesh (63.8 per cent) followed by Telangana (61.2 per cent), Kerala (39.5 per cent), Chhattisgarh (39.3 per cent), Rajasthan (22.6 per cent), and Tamil Nadu (21.8 per cent). On the other hand, the low coverage states were Madhya Pradesh (1.7 per cent), Assam (2.6 per cent), Jharkhand (3.8 per cent), Uttar Pradesh (4.2 per cent), Punjab (5.6 per cent) and Bihar (6.2 per cent). Among the smaller states, the coverage was the highest in Mizoram (73.9 per cent), followed by Nagaland (27.4 per cent) and Meghalaya (20.5 per cent) but the lowest in Uttarakhand (0.3 per cent), Manipur (0.5 per cent), Sikkim (2.9 per cent) and Arunachal Pradesh (5.4 per cent). Among the Union Territories, Dadra and Nagar Haveli had the highest coverage (17.0 per cent), followed by Daman & Diu (14.2 per cent), and Chandigarh (12.0 per cent), while the coverage was the lowest in AN Islands (0.3 per cent), Lakshadweep (0.8 per cent) and Puducherry (5.8 per cent). Among the three types of health insurance schemes (government-funded, employer-supported, and arranged by household with insurance companies and others), it was the government-funded health insurance whose share was the maximum. At the national level, 85 per cent of the insurance was funded by the government and in the high coverage states of Andhra Pradesh, Telangana, Chhattisgarh and Rajasthan, this proportion was almost 100 per cent (Table 1).

In order to understand the implementation of RSBY in the context of PMJAY, a primary survey was carried out in district Jajpur, Odisha. The findings of the survey with regard to the implementation of RSBY are described in the following pages.

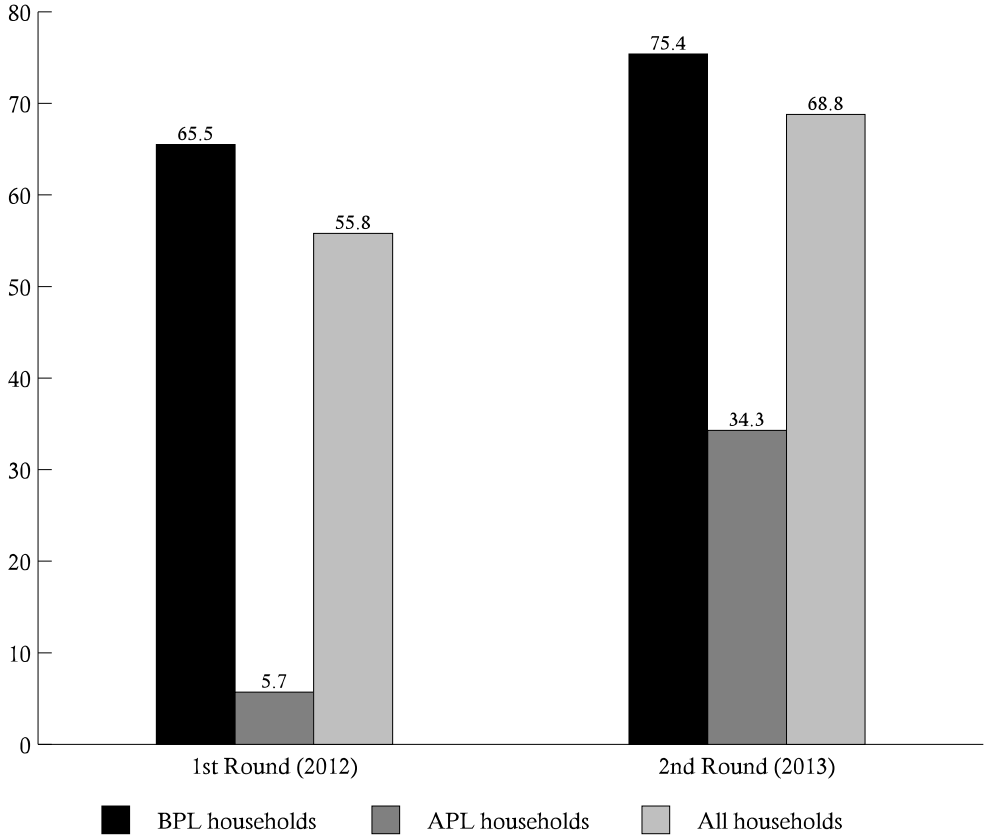
Enrolment Status of Households under RSBY. The first requirement to avail the benefits of RSBY is enrolment. In the study district, two rounds of enrolment were completed by the time the survey was carried out. The first round of enrolment was carried out in May 2012 while the second in October 2013. It was found that, in the first round of the enrolment drive, 65.5 per cent of the BPL households were enrolled while the enrolment increased to 75.4 per cent after the second round. The enrolment of all households, however, was 55.8 per cent after the first round and 68.8 per cent after the second round in the 14 villages in which the survey was carried out (Figure 1). The proportion of households enrolled under the scheme, however, varied by socioeconomic groups as may be seen from table 2.

Enrolment Status of Out-migrant Workers. A unique feature of RSBY is the provision of free hospitalisation to those who are out of their usual place of residence for work or out-migrant workers at their place of work. In order to avail benefits, out-migrant workers need to be enrolled at their usual place of residence and they must have a separate smart card. Since the scheme covers the whole country, anybody enrolled under the scheme can avail benefits of the scheme at any empanelled hospital throughout the country. It was reported that, although, one third of the out-migrant workers were enrolled in the second round, yet none of them had a separate smart card. Therefore, they could not avail the benefit of free hospitalisation at their place of work.

Awareness about the RSBY Scheme. For successful implementation of any government programme, the role of awareness campaign is very important. The level of awareness influences the level of enrolment and the level of utilisation of the benefits available under the programme. During the survey, a number of questions were asked related to the awareness of the community about different aspects of the RSBY including knowledge about RSBY, benefits available through RSBY, knowledge regarding different types of medical care available under the scheme, knowledge about the eligibility under the scheme, knowledge regarding the maximum annual amount of medical coverage, and knowledge regarding the transport allowances and the cost of joining the scheme, etc. Results are presented in table 3 which suggest that the awareness about the scheme was poor to very poor in the study population.

Utilisation and Financial Risk Protection under RSBY. In the 14 villages covered under the survey, 184 cases of hospitalisation were reported during the period 2012 through 2014 out of which 166 cases were from BPL households and the remaining 18 were from APL households. Similarly, 120 cases were from those households which were enrolled under RSBY. Out of these 120 households, 114 cases were from BPL households while only 6 cases were from APL households and all of them had smart cards. However, in only 10 cases, the smart card was used and beneficiaries got free hospitalisation, although, even these beneficiaries had to spend some money from their pocket. In three other cases of hospitalisation, the benefit was sought under the scheme, but it was denied by the RSBY help desk because of such reasons as the patient's name was not included in the smart card and the card was invalid. This shows that despite large number of hospitalisations under RSBY from the enrolled households, utilisation of the scheme remained poor. A study in Maharashtra about the utilisation of RSBY scheme also shows that only 16 households had actually utilised the scheme out of 6000 sample households with an enrolment level of 21.6 per cent and an awareness level of 29.7 per cent (Thakur, 2016). In another study in Shimla and Kangra districts of Himachal Pradesh, more than 90 per cent of the eligible households sought hospitalisation by using their RSBY smart card because of high degree of awareness (Government of India, *no date*). In our study, the single most important reason of low utilisation was poor level of awareness about the scheme among the beneficiaries. Only about 28.5 per cent of the BPL households in the 14 villages covered under the study had ever heard the term 'RSBY' and majority of them did not know the type of medical facilities available under the scheme. Only 10 beneficiaries were partially protected

Figure 1
Proportion (Per cent) of different categories of households registered under RSBY in the surveyed population



from the risk of hospitalisation and their median and mean out-of-pocket spending was Rs 8500 and Rs 15150 respectively which was incurred mainly for purchasing medicines and other non medical items. When all the 184 cases of hospitalisation were taken into account, the average out-of-pocket spending associated with hospitalisation was estimated to be Rs 17361 which was quite substantial.

The major source of financing the out-of-pocket spending related to hospitalisation was borrowing (60.3 per cent) followed by household income or savings (32.6 per cent), sale of physical assets (3.85 per cent) and contribution and support from friends and relatives (3.3 per cent). A study in Gujarat has also observed that RSBY scheme provided only partial financial coverage for hospitalisation and around 44 per cent of the patients who had enrolled and used the smart card, still had to incur a median out-of-pocket expenditure of Rs 4000 mostly for medicines and diagnosis (Devadasan et al, 2013). The present study also shows that RSBY scheme could not be able to provide protection to all the BPL households from catastrophic health expenditure resulting from hospitalisation in the surveyed population.

Conclusions

In the study area, although, an impressive 75 per cent BPL household were enrolled under the RSBY scheme, yet, the level of utilisation of the scheme was very low and people were still spending from their pocket. Main factors behind the non utilisation of the scheme were lack of proper awareness about the scheme; people were not interested in getting benefits under the scheme; and the indifference on the part of the RSBY help desk. One third of the out migrants were found to be enrolled under the scheme but none of them had separate smart card which affected utilisation of the benefits of the scheme. It may, therefore, be concluded that the scheme was not able to achieve the desired objective of protecting all the target beneficiaries. The parliamentary standing committee, after reviewing various studies on RSBY, also found that the enrolment in the RSBY scheme was quite low with only 57 per cent eligible households enrolled and less than 12 per cent of the eligible persons getting their hospitalisation covered under the scheme. In majority of the states (eight out of 14), there was an increase in OOP expenditure related to RSBY while only two states showed a reduction in the expenditure" (Government of India, 2018a). The committee had urged that the government should form a committee to analyse the failure of RSBY and ensure that inadequacies plaguing the operation and implementation of RSBY are not repeated (Government of India, 2018a). In the light of these observations, the PMJAY scheme must focus on increasing the awareness level of the potential beneficiaries by properly conducting awareness programme so that it can ensure better utilisation of the scheme. The scheme should be implemented effectively with constant monitoring of the empanelled hospitals and a robust grievance redressal mechanism must be established to ensure that the insured persons get due benefits at the time of hospitalisation. At the same time, the health infrastructure in the empanelled hospitals must be strengthened to meet the growing demand for health care.

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Table 1
Coverage of health insurance in India and States/Union Territories, 2014

States/UTs	Government funded insurance scheme	Employer (other than government) supported health protection	Arranged by household with insurance company and others	Total insurance coverage	Share of public funded insurance scheme (Per cent)
Andhra Pradesh	62.6	0.6	0.6	63.8	98.1
Telangana	58.2	2.3	0.6	61.2	95.1
Kerala	34.6	2.2	2.8	39.5	87.6
Chhattisgarh	38.8	0.5	0	39.3	98.7
Rajasthan	22.4	0.2	0.1	22.6	99.1
Tamil Nadu	17.8	1.9	2.1	21.8	81.7
Orissa	19.2	0.9	0.5	20.7	92.8
West Bengal	13.5	1.3	2.0	16.8	80.4
Delhi	8.6	1.9	6.1	16.6	51.8
Gujarat	7.1	0.7	6.4	14.2	50.0
Karnataka	5.2	3.5	1.9	10.5	49.5
Jammu & Kashmir	3.8	3.2	1.1	8.1	46.9
Maharashtra	2.8	1.3	3.1	7.2	38.9
Haryana	3.8	0.5	2.6	6.9	55.1
Bihar	5.3	0.8	0.1	6.2	85.5
Punjab	3.3	2	0.3	5.6	58.9
Uttar Pradesh	3.3	0.7	0.1	4.2	78.6
Jharkhand	2.4	1.3	0.0	3.8	63.2
Assam	1.2	1.2	0.2	2.6	46.2
Madhya Pradesh	1.2	0.2	0.2	1.7	70.6
Mizoram	72.0	1.8	0.2	73.9	97.4
Nagaland	27.1	0.3	0.0	27.4	98.9
Meghalaya	14.6	5.7	0.2	20.5	71.2
Dadra & Nagar Haveli	11.1	5.4	0.4	17.0	65.3
Daman & Diu	1.5	0	12.7	14.2	10.6
Goa	13.2	0.1	0.0	13.3	99.2
Tripura	11.4	0.7	0.7	12.8	89.1
Chandigarh	8.4	2.2	1.5	12.0	70.0
Himachal Pradesh	7.6	0.7	0.9	9.3	81.7

States/UTs	Government funded insurance scheme	Employer (other than government) supported health protection	Arranged by household with insurance company and others	Total insurance coverage	Share of public funded insurance scheme (Per cent)
Puducherry	4.8	0.3	0.6	5.8	82.8
Arunachal Pradesh	3.1	0.9	1.3	5.4	57.4
Sikkim	2.2	0.7	0.0	2.9	75.9
Lakshadweep	0.8	0.0	0.0	0.8	100.0
Manipur	0.4	0	0.1	0.5	80.0
Uttarakhand	0.2	0	0.1	0.3	66.7
AN Islands	0.3	0	0.0	0.3	100
India	12.8	1.2	1.3	15.2	84.2

Source: Author's estimation from the unit level data from NSS 71st round survey, 2014
Note: Government-funded insurance schemes include RSBY, Arogyasri, CGHS, ESIS, etc.

Table 2
Enrolment status of household by background characteristics

Characteristics	Category	Enrolment among BPL Households (Per cent)		Enrolment among All Households (Per cent)	
		Round-I	Round-II	Round-I	Round-II
Household size	<5	67.2(78)	77.6(90)	55.2(79)	68.5(98)
	=5	56.3(49)	72.4(63)	50.0(51)	68.6(70)
	>5	69.2(110)	75.5(120)	59.4(76)	69.0(129)
Type of House	Kuchha	58.3 (63)	71.3(77)	50.4(64)	66.1(84)
	Semi-pucca	60.0(45)	73.3(55)	55.6(45)	70.4(57)
	Pucca	72.1(129)	78.8(141)	58.9(132)	69.6(156)
Social group	SC	75.3(134)	82.0(146)	71.8(135)	79.8(150)
	ST	14.3(6)	23.8(10)	13.3(6)	24.4(11)
	OBC	57.4(31)	70.4(38)	44.9(31)	63.8(44)
	Others	75.0(66)	89.8(79)	53.1(69)	70.8(92)
Education of Household Head	Illiterate	63.5(80)	76.2(96)	61.4(81)	74.2(98)
	Primary(1-5)	62.8(59)	72.3(68)	58.8(60)	73.5(75)
	Secondary(6-10)	69.3(79)	78.1(89)	52.3(80)	64.7(99)
	Higher Secondary and above	67.9(19)	71.4(20)	44.4(20)	5.5.6(25)
Means of livelihoods	Agriculture	72.9(62)	81.1(74)	59.5(65)	78.9(86)
	Wage/ agricultural labour	61.6(122)	70.2(139)	56.2(122)	66.8(145)
	Self-employed in non agriculture	70.7(41)	77.6(45)	58.6(41)	67.1(47)
	Salaried job	57.1(12)	71.4(15)	36.1(13)	52.8(19)
Total		65.5(237)	75.4(273)	55.8(241)	68.8(297)

Source: Author's calculations
Note: Figures in the bracket are frequency

Table 3
Awareness about the RSBY Scheme

SN	Type of awareness	Response (Per cent)
1	Respondent ever heard the word 'RSBY or Rashtriya Swasthya Bima Yojana'	30.0
2	Some knowledge regarding the benefits of RSBY	69.9
3	knowledge regarding medical benefits of RSBY	55.0
4	Knowledge regarding the source of availability of medical facility under RSBY	24.1
5	Medical facility is available only in government hospitals	17.0
6	Knowledge regarding the eligibility household to enroll in the RSBY scheme	30.7
7	Knowledge regarding number of family members can be enrolled in the RSBY scheme	45.2
8	Knowledge regarding the cost of enrolment	80.0
10	Knowledge regarding the annual insurance coverage	27.5
11	Knowledge regarding how to use the smart card	5.0
12	Knowledge regarding transport allowance	0.0

Source: Author's calculations.

Assessing fertility with anthropometric measures

India 2019

Country/State/