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Rashtriya Swasthya Bima Yojana (RSBY): Analysis of Utilization and Performance in Context of Social Marketing

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ABSTRACT

Out-of-pocket expenditure (OOPE) largely finances healthcare expenditures in India, especially of the marginal, vulnerable sections of the society and those living in rural areas. This has increasingly led to impoverishment and poor health-seeking behaviour. In the year 2008, the Government of India launched its flagship health insurance scheme called Rashtriya Swasthiya Bima Yojana (RSBY), which aimed to provide insurance cover to around 65 million families from below poverty line strata. The present paper uses secondary data from published literature in reputed journals to analyze the performance of the scheme draw comparisons with a recently launched more robust scheme for health insurance, namely, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY), which aims to bring health insurance cover to 10.74 million poor and vulnerable families. The social marketing of RSBY was studied to understand resultant behavioural change among the poor population in terms of decrease in OOPE and non-health seeking behaviour, improvement of women's health and overall health insurance utilization. The study shows that RSBY is not generating the required results. RSBY effect on reduction in catastrophic OOPE was not found for both inpatient and outpatient spending. Over time no major behaviour change in terms of utilization and adoption of health-seeking behaviour was found. Social Marketing can help policymakers to design planned interventions and schemes for the long term success of health insurance in India.

***Keywords**: RSBY, Health insurance, Ayushman Bharat, PMJAY, Modicare, Universal Health care, Below Poverty Line, Social Marketing,*

I. INTRODUCTION

Health insurance is important for growth, more so in developing nations. India, even after 72 years of independence, still lacks provision of even basic healthcare for its huge population of poor, vulnerable and those belonging to the unorganized sector. The Government has taken the baton of Universal Health Coverage (UHC) to provide health for all and to widely increase

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health insurance adoption among the poorest of the poor. Two important schemes of health insurance, namely RSBY (2008) and PMJAY (2018), aimed at the below poverty line (BPL) population, will be discussed in the scheme. RSBY is an older scheme as compared to PMJAY but has not reached any substantial positive results in terms of UHC or health insurance adoption among the poor population, which suffers daunting financial risks and out-of-pocket health-related. Should people even opt for the RSBY scheme or go with PMJAY? Can redesigning RSBY on Social Marketing Principles save the scheme and increase its reach?

India has made huge strides in its economic and social development in the 75 years of its independence. The journey has been brilliant and one that has inspired nations across the world. Technology advancement, rational and progressive policies have knit a landscape of growth and positivity across various sectors. Healthcare is one sector that has seen great strides too in terms of health tourism, world-class hospitals, medical colleges, etc. From the outward, the picture does look quite rosy, but sadly, health and healthcare access in India does not match the economic growth of the country. Inequality and poor health mainly result in out-of-pocket (OOP) expenses for medical treatments and wellbeing. OOP, which finances 75 per cent of health care, leads to impoverishment as mounting medical expenses push more than 63.2 million Indians into poverty every year[2].

Another trend that increases OOP expenditure is the alarming rise in the number of non-communicable disease (NCD) cases in India. Therefore, OOP expenses related to hospital care and chronic diseases (cardiovascular, cancer, diabetes, etc..) continue to rise.

II. HEALTH SCENARIO AND HEALTH POLICY IN INDIA

Healthcare services in India have improved dramatically over the past decades. The promotion of health has seen progress, and many diseases like smallpox have been eliminated. India has been on the frontline in the fight against diseases like polio, cholera, measles, tuberculosis, etc., resulting in a marked decrease in their occurrences or mortalities. Despite the huge leaps, ground realities have remained worrisome, and healthcare has remained a challenge despite so many years of independence. The issues of affordability and accessibility to quality healthcare are large and need serious prioritization by the Government. In India, even after more than 70 years of independence, a large number of the population still lives in rural areas or in below the poverty line (BPL) and, unfortunately, have minimal access to even basic, good and cheap healthcare. This fact needs to be addressed and not just an ever-eluding goal for the

[2] Nandi, A., Laxminarayan, R., Holtzman, E., & Malani, A. (2015). The need for better evidence to evaluate the health & economic benefits of India′s Rashtriya Swasthya Bima Yojana. *Indian Journal of Medical Research, 142*(4), 383. doi:10.4103/0971-5916.169194

policymakers.

There is an asymmetry between the economic development of India and its health status. There is also vast asymmetry in healthcare status by states, urban and rural, ethnic groups, gender, religion, etc. The perception of people towards health was also not positive, and the government policies also lacked proper planning. Since independence, the Government has launched many health schemes and programs to address health availability and affordability, but a lot needs to be done. The National Health Policy guided a well-coordinated and planned approach for the health sector in the Five-Year Plans. Currently, though, healthcare issues are changing. Health priorities are shifting focus from maternal and child mortality (which has seen rapid decline) to an increase in occurrences of non-communicable and infectious diseases. More importantly, is the issue of the growing incidence of catastrophic expenditure due to medical and health care costs which are major contributors to poverty and poor health. The National Health Policy (2017) of India also consistently aims to achieve affordable healthcare for all in the context of universal health coverage and to counter the above-mentioned issues. In terms of healthcare financing, the Policy aims that by the year 2025:

- to increase the health expenditure of the central Government from 1.25% to 2.5% of the GDP.
- To decrease the number of households that face imminent catastrophic health expenditure by 25% from current levels.

In the context of accessibility, affordability, availability, and acceptability, all these issues must be addressed to increase the equitable healthcare reach of the larger population. The Government has taken many initiatives in this direction. One of the most important initiatives was the Rashtriya Swasthya Bima Yojna (RSBY) which was launched in 2008 with the aim to increase the reach and coverage of health insurance in India and bring affordable healthcare to the poorest sections of society. Over the years, RSBY coverage also included workers from the unorganized sector in its umbrella. Under the scheme, an annual registration fee of Rs.30 has to be paid by the beneficiaries, while the insurance premium is publicly financed. Cost of hospitalization for up to Rs. 30,000 is covered by insurance for a comprehensive list of diseases. The scheme has many attractive features for the benefit of the financially weakest strata of the society, and no exclusion, whether on the basis of age or due to any pre-existing conditions, is allowed. The program has many private hospitals empanelled with the scheme, and beneficiaries are provided biometric-enabled smart cards and cash- and paperless transactions.

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III. RSBY EVALUATION

It is clear now that catastrophic health expenditure is one of the major reasons for the impoverishment of many households in India. In view of this, the Government of India, in 2008, launched Rashtriya Swasthya Bima Yojna or RSBY. It is one of the largest social protection health insurance schemes in the world and is specifically targeted at economically vulnerable households. It aims to improve affordability and access to better healthcare services and minimize the financial loss and even impoverishment as a result of healthcare expenditures. BPL households were covered under the scheme and were provided financial protection and healthcare access.

The BPL households, state and central governments and the Third-Party Administrators (TPAs) are the major stakeholders of the scheme. In the initial days of its launch, the scheme presented a great impression for its design and its inherent vision of benefit to all its stakeholders in its ecosystem. It was considered more efficient in comparison to other state-specific health insurance schemes due to its usage portability. Many recent studies evaluate RSBY; however, they present contradictory findings that are inconsistent with the aims and objectives of the scheme.

Since its inception in 2008, from the very beginning, it was claimed that it covered a large percentage of the targeted population—however, substantial variations through many studies conducted across and within states[3][4][5]. Not much is known about why many did not enrol and whether awareness about the program in the community was sufficient. The actual impact of RSBY was also a matter of concern. A lot of evidence from various studies on the overall effectiveness and total of RSBY is not very encouraging with regards to OOP expenditure. Studies showed that hardly 12.7% of the poorest households were covered under the program, and also, 36.52% of households that were enrolled across 18 Indian states were from the richest households (40% of the sample)[6]. The program has suffered for a long due to mismanagement, low enrolment, the inadequacy of the insurance cover for outpatient costs and several medical procedures. At the same time, public healthcare facilities involved in the implementation of the

[3]Palacios, R., Das, J., & Sun, C. (2011). *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana*. Centre for Policy Research.

[4] Dror, D., & Vellakkal, S. (2012). Is RSBY India′s platform to implementing universal hospital insurance? *The Indian Journal of Medical Research, 135*(1), 56. doi:10.4103/0971-5916.93425

[5] Nandi, A., Ashok, A., & Laxminarayan, R. (2013). The Socioeconomic and Institutional Determinants of Participation in India's Health Insurance Scheme for the Poor. *PLoS ONE, 8*(6). doi:10.1371/journal.pone.0066296

[6] Ghosh, S and N Datta Gupta (2017): "Targeting and Effects of Rashtriya Swasthya Bima Yojana on Access to Care and Financial Protection," Economic & Political Weekly, Vol 52, No 4, pp 61–70

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scheme are nagged with problems such as lack of medicines, diagnostic facilities, and even non-availability/absenteeism of doctors. It was seen in a study conducted in the state of Gujarat that RSBY provided only partial financial coverage. The OOP payments in about 60% of insured and admitted patients were still high[7]. Another study conducted in the state of Maharashtra showed that the awareness and enrolment rate was lower than the national average. About 11% to 55% of utilization of RSBY was found in the Amravati district in Maharashtra[8]. Data procured from secondary sources also indicated that in many districts of the state, the RSBY program was poorly implemented[9].

In most households in the state of Himachal Pradesh, awareness was found about the inclusions and eligibility of the scheme, but people lacked clear information about the utilization of the scheme. Enrolling agencies provided any written literature about the scheme to only 49% of respondents, and knowledge of empanelled hospitals was also very little (the list of the hospitals was provided to only 15% of respondents). Awareness amongst the enrolled population in Uttar Pradesh was found to be below, and only 42% of respondents were aware, of which 37% were women, and 44% were men[10]. Karnataka, another major Indian state, 71 % of households reported being familiar with the name and RSBY insurance cared[11]. In another study in Karnataka in 2010 showed that after RSBY was implemented in the state, awareness of RSBY increased[12]. Utilization was virtually zero in the state of Karnataka. In a study from Chattisgarh's Durg district, the scheme awareness in the majority of BPL households was (84%), and awareness of scheme benefits was 90%. 27% of respondents complained about their lack of understanding of the eligibility criteria for availing of the scheme, 25% were unclear about their RSBY smart card validity, and 31% were doubtful about the number of members allowed for coverage under the scheme[13].

Most of the studies analyzed regarding the interstate performance of RSBY showed that huge

[7] 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*, 29. https://doi.org/10.1186/1478-4505-11-29

[8] Rathi P, Mukherji A, Sen G: Rashtriya Swasthya Bima Yojana: evaluating utilisation, roll-out and perceptions in Amravati district, Maharashtra. Econ Polit Weekly 2012, 47:57–64

[9] Nandi, A., Ashok, A., & Laxminarayan, R. (2013). The Socioeconomic and Institutional Determinants of Participation in India's Health Insurance Scheme for the Poor. *PLoS ONE, 8*(6). doi:10.1371/journal.pone.0066296

[10] Amicus Advisory Report (2011)

[11] Aiyar, A., Sharma, V., Narayanan, K., Jain, N., Bhat, P., & Mahendiran, S. (2013). Rashtriya Swasthya Bima Yojana: a study in Karnataka. Centre for Budget and Policy Studies (CBPS), Bangalore, India

[12] Rajasekhar, D., Berg, E., Ghatak, M., Manjula, R., & Roy, S. (2011). Implementing health insurance: The rollout of Rashtriya Swasthya Bima Yojana in Karnataka. Economic & Political Weekly, 46(20), 56–63

[13] Nandi, S., Nundy, M., Prasad, V., Kanungo, K., Khan, H., Haripriya, S., . . . Garg, S. (2012). The Implementation of RSBY in Chhattisgarh, India: A study of the Durg district. *Health, Culture and Society, 2*(1), 40-70. doi:10.5195/hcs.2012.61

deficiencies remain in the way RSBY has been propagated and implemented. The awareness of the target population regarding the functioning of the scheme may have resulted in its low enrolment and low rate of utilization. It is clear from the studies that even the enrolled households lacked awareness about the 'how what, and why' of the scheme. Recent studies have again reiterated that the introduction of RSBY has, by and large, not led to a significant reduction in OOP bills and expenditures. Poorer sections of households in districts where RSBY intervention was conducted also experienced a rise in healthcare expenditures, especially on hospitalization.

IV. SOCIAL MARKETING OF RSBY

RSBY program suffers from mismanaged planning and implementation. It suffers from low enrolment rates and insurance cover that is inadequate for several medical procedures and outpatient costs. Making things worse, public health facilities implementing the program are ill-equipped to provide what the scheme promised and suffer from their own discrepancies in providing a stock of essential medicines, absenteeism in doctors, and also non-availability of diagnostic facilities and doctor absenteeism. The medical infrastructure to support RSBY is not robust and needs better provision and preparedness.

The enrolment agencies communicated insufficiently with the target households. It appears from the various studies evaluating the performance of RSBY. It appears that the lack of effective IEC (Information, Education, and Communication) both from the agencies entrusted with it and the Government led to fewer enrolments for the scheme and overall poor awareness, understanding, and utilization.

It is obvious from the above studies that there is an imminent need for healthcare reforms on a large scale across public and private providers of healthcare so as to meet the goal of health for all. The whole scenario of RSBY implementation and evaluation entails strategic handling of the scheme to save it from ending into oblivion. It needs a concerted marketing effort from planning, designing, promoting, implementing and evaluating the entire process end-to-end. The success of the RSBY program will largely depend on many things, including a well-resourced public sector for its proper implementation, delivery, and monitoring. Backing this recommendation is the theory of social marketing which will help understand the entire social protection scene and will also benefit RSBY in making serious headway after more than a decade of its launch.

Social marketing theory is a collection of theories that focus on the promotion of social good and socially valuable information. The theory, which is administrative in nature, advocates and

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assists social and welfare organizations to promote good behaviours by stressing the importance of a framework to be used to design, implement, and evaluate information campaigns. Social marketing draws upon techniques from commercial marketing to influence social behaviours that befit the target audience/community. The target audience is identified based on the information need, and then programs and packages of information are designed and distributed for that audience accordingly.

Meyer et al. (2004)[14] researched the effectiveness of outreach programs aimed to spread awareness about the Child Health Insurance Protection Programme (CHIP) in 88 Ohio counties. Funds were made available to all the counties by the state for the design and implementation of their outreach strategies to approach families regarding insurance and enrolment. The scheme was proposed under landmark federal legislation that intended to offer health insurance to low-income families. Despite CHIP, the number of uninsured families remained high, which could result in repercussions such as adverse health (with likelihood not reaching out to a paediatrician or not receiving immunizations) and impoverishment. The author stresses the framework provided by Social marketing theory to better conceptualize interventions and outreach for programs such as CHIP. There is very little research on the effectiveness of the interventions. Studies had revealed that enrolments increased post-outreach, which included interventions like student volunteers assisting enrolment, public health nurses approaching families in rural areas, targeted and customized approach to specific communities such as ethnic minorities, supporting community-based organizations with mini-grants to carry out initiatives for enrolment in the insurance program, etc. The social marketing themes emerging in these studies showed successful outreach strategies were of the nature that included one-to-one outreach, collaboration among various entities like schools, social services, health agencies, etc. Also, the promotional campaigns with the help of media raised awareness of child health insurance.

Lesch &Byars (2008)[15] conducted a study on the management of the consumer insurance fraud in the property-casualty market in the US and analyzed the fraud prevalence, insurer and regulatory responses, and outcomes. A social marketing campaign was offered by the authors as a partial but long-term solution. An example of the Safeco Insurance "FireFree" campaign was presented, which targeted reducing the "combustibles" around the home exteriors and

[14] Meyer, C. L., Brun, C., Yung, B., Clasen, C., Cauley, K., & Mase, W. A. (2004). Evaluation of Social Marketing Efforts Designed to Increase Enrollment in the Children's Health Insurance Program (CHIP). *Journal of Nonprofit & Public Sector Marketing, 12*(2), 87-104. doi:10.1300/j054v12n02_05

[15] Lesch, W. C., & Byars, B. (2008). Consumer insurance fraud in the US property-casualty industry. *Journal of Financial Crime, 15*(4), 411-431. doi:10.1108/13590790810907245

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thereby reducing the dangers from wildfires. Safeco has a brand positioning with home safety, and therefore, with regards to the problem of wildfires, it proved beneficial for it due to the lower numbers of claims associated with it (Kotler and Lee, 2007). The authors reiterated that strategies and tactics of Social marketing strategies should be well-conceived and well-funded so that it unites the social actors towards a common moral goal. Social marketing can help reduce the prevalence of problematic behaviours and help adopt positive and progressive behaviours. It would be helpful if there was a social marketing campaign relevant to the industry and in everyone's interest, which would aim in social re-orientation and brand positioning with a communication strategy that is effective to counter the moral hazard. Shared responsibility, which is a prime objective of social marketing, will help set superior frameworks and standards of performance and accountability at each step of the program.

Icard, Bourjolly, & Siddiqui (2003)[16], in a qualitative study, attempted to analyze four key factors to link at-risk Americans with their accessibility to health promotion programs. The study involved many focus group discussions in designing strategies that would improve access to better health promotion programs for African Americans. The results revealed that certain strategies such as involvement of the church in health promotion programs or using high profile person to deliver the message also proved a barrier rather than a motivator to people for a health program. Results showed that people would prefer a person who is known to them, is credible and trustworthy and from their community, as a source of information about the health programs and who also had experienced problems like them. People desired involvement, respect, empowerment, concern, and familiarity in the social marketing message of a health program. Participants desired to design social marketing strategies around sports to recruit African American men for health promotion programs. It was also suggested to encourage word-of-mouth for the dissemination of messages and include interaction places like social clubs, barbershops, and neighbourhood bars as propagation channels. It was also strongly expressed to target African American men in social marketing campaigns as it was felt that they were frequently neglected. The findings advocated designing better social marketing interventions to bring inclusivity and progress for marginalized African American adults.

Swaminathan & Vishwanathan (2015)[17] analyzed in the context of social marketing a health insurance scheme in the state of Tamil Nadu, called the Chief Minister's Comprehensive Health

[16] Icard, L. D., Bourjolly, J. N., & Siddiqui, N. (2003). Designing Social Marketing Strategies to Increase African Americans' Access to Health Promotion Programs. *Health & Social Work, 28*(3), 214-223. doi:10.1093/hsw/28.3.214

[17] Swaminathan, T. N., & Viswanathan, P. K. (2015). Social Marketing - Awareness and Satisfaction Levels of Government Aided Health Insurance Project in Rural Tamil Nadu. *Indian Journal of Marketing, 45*(6), 7. doi:10.17010/ijom/2015/v45/i6/79930

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Insurance Scheme. This scheme, introduced by the Tamil Nadu government, is one of the innovative and attractive health insurance initiatives/schemes for people belonging below poverty line (BPL) families, covering about 14 million people who earned less than INR. 72000 (USD 1000) annually. The scheme gave coverage for 51 types of various diseases and was implemented through a network of 663 hospitals that included both private and public sector hospitals. The study attempted to assess the awareness and satisfaction levels. It was found that the overall awareness was low, and better social marketing strategies were needed to help awareness and adoption of the scheme.

Reza & Meisam (2018)[18] studied developing strategies of social marketing for insurance companies. The model used traffic police behavioural interventions to boost traffic culture in the city of Guilan. Traffic police and insurance experts were the samples for the research. The study results showed insurance companies could change the behaviour of people through strategies that used persuasion, awareness, coercion, and warning in response to high-risk behaviours of insured people.

Aydin & KOC (2016)[19], in their study, aimed to explore and analyze the Compulsory Earthquake Insurance policies in Turkey and the reasons for its low purchase rates. Many large catastrophic events in the country have raised awareness about public policy and helped trigger strategies to develop disaster coverage programs. For this study, the authors took a sample size of 667 people. The research results revealed that besides demographic variables, the personality characteristics of people influenced their attitudes towards purchasing the policies and led to cognitive failure to underestimate or ignore risk. The study highlighted a major communications gap as people had not been properly informed on the insurance scheme benefits and coverage, nor had they been enlightened on the various dangers of any strong earthquake. Risk communication, as a social marketing tool, was also suggested by the authors to be implemented in the form of marketing communications, which would strategically aim to change an individual's behaviours towards risk recognition and adoption to insurance and address the prevalent communication gap.

All these studies show the implications of social marketing theory and practices for RSBY also. And possibly, the practitioners of the scheme would do well to adopt building more focused

[18] Reza, E., Meisam, G., (2018), Developing a Social Marketing for Insurance Companies. *Journal of Business Management (Management Knowledge), 10(1), Pg: 31-38*

[19] Aydin, G., & Koç, E. (2016). Social Marketing Analysis of Attitude Toward Compulsory Earthquake Insurance in Turkey(Türkiye'de Zorunlu Deprem Sigortasına Yönelik Tutumun Sosyal Pazarlama Kapsamında Analizi). *Yönetim Ve Ekonomi Celal Bayar Üniversitesi İktisadi Ve İdari Bilimler Fakültesi Dergisi, 23*(2), 389. doi:10.18657/yecbu.81769

social marketing campaigns for the target consumer of the scheme and address the issues of lack of awareness and adoption. In the face of such robust new schemes for below poverty line strata such as Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY), it is to be seen if redesign and implementation of RSBY program with more community focus, larger reach, and accountability at every stage of its implementation will help save the scheme.

V. AYUSHMAN BHARAT-PRADHAN MANTRI JAN AROGYA YOJANA (PMJAY)

PMJAY, also known as Modicare, was launched by the Government of India on 23rd September 2018 as an ambitious health insurance scheme providing social and financial protection for over 500 million economically weak and vulnerable people belonging mostly to the below poverty line (BPL) population. The Government has allocated about US$1.5 billion to the PMJAY program for the years 2018– 2019 and 2019–2020. The scheme seeks to halt the curse of impoverishment due to medical-related expenditure that hits 50–60 million Indians every year. It aims to enhance and build on already schemes to provide a health insurance cover which was publicly funded up to 500,000 Indian rupees (over US$7,000) per family per year. The scheme offers broader coverage than the prevailing schemes.

AB-PMJAY gives importance to a system-wide reform and promises to tackle long-term and deep-rooted shortcomings in quality control, governance and accountability in the campaign. More importantly, it helps give a much-needed fillip to India's progress towards achieving the goal of Universal Health Coverage (UHC).

The scheme does not have a limit to the total number of family members that can be covered, and it also offers pan-India reach and benefits. State governments are free to lead the implementation of AB-PMJAY and have the independence to choose their operating model for the scheme and integrate it alongside their existing programs. All expenditures under the program are shared between the central and state governments share all expenditures of the program in a prespecified ratio, with 60%–100% of insurance expenses usually covered by the Indian Government.

VI. CONCLUSION

Owing to the robust framework and implementation of PMJAY, it seems to be getting very difficult for RSBY to reach its intended potential of Universal Health Coverage (UHC) in India. The RSBY scheme needed serious re-thinking by the Government and administrators to implement it better and increase its visibility. Following social marketing is a recommendation to bring more rigour and focus in the social health insurance schemes and make it attractive to

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the target audience. This would again entail a complete understanding of both schemes through strategic planning. Literature highlights that there are lessons from RSBY for the policymakers, and social marketing can help policymakers in making health insurance schemes such as Ayushman Bharat PMJAY achieve the aim of optimal utilization, health care access and long-term success.

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