A study of RGJAY Scheme in Maharashtra: Key Findings

Introduction

The state of Maharashtra launched 'Rajiv Gandhi Jeevandayee Arogya Yojana' (RGJAY) on 2 July 2012 in a phased manner by discontinuing the already functioning RSBY scheme. The first phase was introduced in eight districts of Maharashtra. The second phase was, launched after more than a year, in November 2013, in rest of the state. The stated objective of the scheme is to improve access to quality medical care for identified specialty services requiring hospitalisation by providing an insurance cover. The scheme promises to provide access to healthcare to the vulnerable population with annual income below INR One lakh as well as those with Anthyodaya and Annapurna cards.Coverage under the scheme is up to INR One lakh fifty thousand per family per year and it provides 971medical procedures through the empanelled network hospitals. Smart cards with photographs of the insured persons are issued to the beneficiaries. Unlike the general health insurance schemes, there is no age limit for enrolments in RGJAY and all pre-existing illnesses are covered from day one onwards.

The present study by CEHAT, critically examined the scheme in order to understand the functioning of the scheme in terms of service provisioning, coverage, inequities in access. The study also analysed various aspects of the scheme including hospital empanelment, the bottlenecks and barriers for patients while accessing the scheme.

Methodology

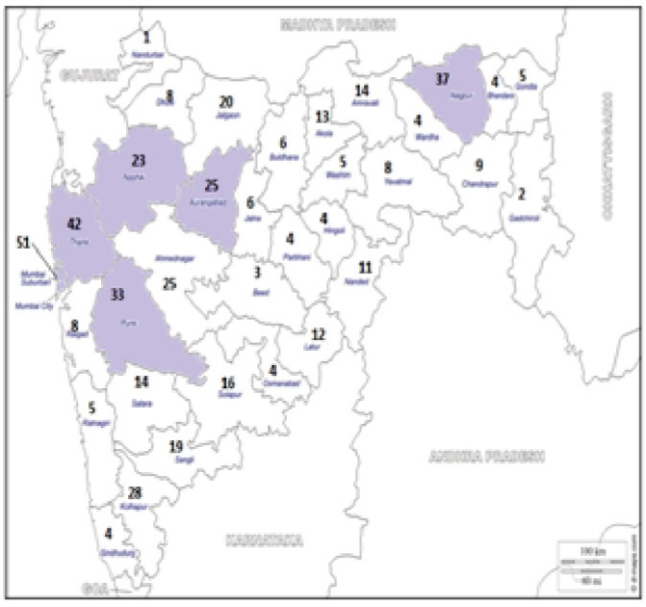
The study employed a mixed methods approach for research and analysis. Secondary analysis of quantitative data (such as data on preatuthorisation, claims, and so on) shared by the RGJAY society, was done for a period of two years (July2012 to August 2014). Data on the network of empanelled hospitals was obtained from the RGJAY website. This was supported by primary qualitative research data obtained from interviews conducted with key stakeholders such as RGJAY society officials, third party association (TPA) doctors and beneficiaries. Two empanelled hospitals, one public and one private, were included in the study in order to understand the implementation of the scheme.

Key Findings of the Study

Service Availability

Scheme has empanelled 473 network hospitals, of which 84% are in the private sector. Though the scheme intends to increase healthcare access to the marginalised population, the presence of empaneled hospitals in the 12 least urbanised districts of Maharashtra including Beed, Bhandara, Gadchiroli, Gondia, Hingoli, Jalna, Nandurbar, Osmanabad, Ratnagiri, Satara, Sindhudurg and Washim is merely 12%. The gap of availability of network hospitals worsen in districts with significant tribal population, further highlighting the inability of the scheme to make available health insurance and health services to the marginalised. The district Nandurbar which has more than 65% ST (Schedule Tribe) population, has only one network hospital, which is a public hospital. Similarly, rural Thane has about 47% ST population and

Figure 1 : Concentration of Private Hospitals

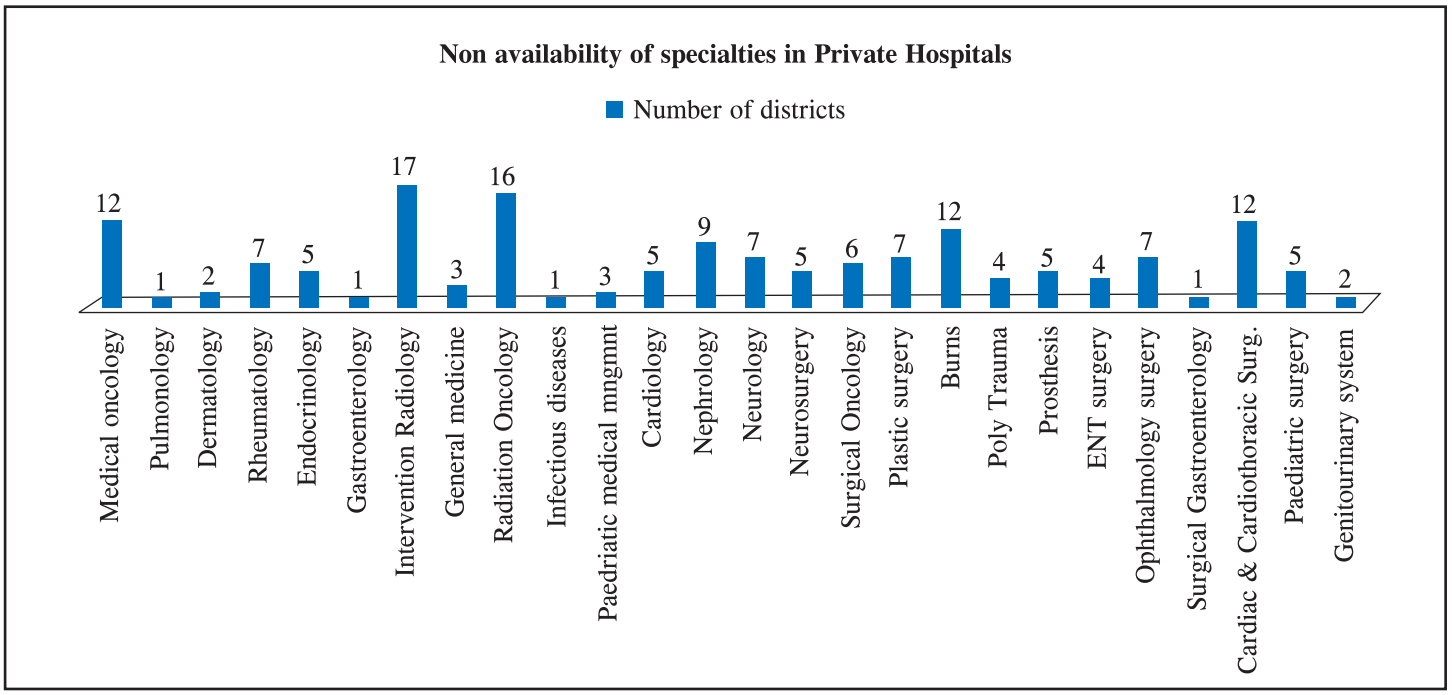


there is not a single privately empanelled network hospital. On the other hand, 44% of the private hospitals are concentrated in six urban centers across the state. Thus, the scheme does little to address the existing rural urban disparity in terms of health service availability. The public private partnership, which was supposed to help bridge this gap, has clearly not been able to address the existing inequities across regions.

Table 1: Non-availability ofspecialties in Private Hospitals

Specialties	Number of districts
Intervention Radiology	17 districts
Radiation Oncology	16 districts
Medical Oncology	12 districts
Cardiothoracic	12 districts
Burns	12 districts

Figure 2 : Non availability of specialties in Private Hospitals



The disparity is not only in terms of availability but also in terms of specialties provided by the hospitals. In general, Maharashtra has a huge private sector presence. However, this does not translate into better availability and range of medical specialties in empanelled hospitals. In order to make use of the large private sector presence, the norms of empanelment under the scheme were relaxed. This has in fact resulted in making available a large number of single specialty private empanelled hospitals(10%). The huge gap in availability of specialties in the private hospitals is evidentas some specialties are completely unavailable in the private sector across entire districts. (Table 1).Moreover, what makes matters worse is that some of the specialties that are highly accessed are also completely absent in the private network hospitals in many tribal and least urbanised districts (Table 1). Thus, for instance, Radiation oncology, (which we found is a highly accessed specialty from the quantitative data), is not available in any private empanelled facility across 16 districts. It raises questions about how best to use the private sector to increase accessibility and the role of private sector in general. Such discrepancy results in extremely poor access to specialties despite the schemes intentions to bridge this gap through public private partnerships due to the existing limitations in the public sector.

Utilisation of the Scheme

- Total eligible families across Maharashtra, as per the PDS data, were 20,794,294during 2015. At the time of the study, merely 2.45% of the families had been enrolled under the scheme in the state. The coverage therefore is insignificant. However, under the scheme, enrollment is independent of the utilisation and the beneficiary family can avail the treatment without enrollment. Considering this, one would expect high utilisation. This is not the case as seen from the number of preauthorisations raised over two years (Table 3).
- The extent of utilisation is dependent on the level of awareness about it. The qualitative interviews with key informants clearly brought out the lack of awareness amongst the beneficiary population about various stakeholders aspects including the scheme's presence across the state, validity of the health card in all districts, the benefits of the scheme as well as the procedures to be undertaken. Additionally, phase I districts including Amravati, Dhule, Gadchiroli, Solapur, Nanded show almost 50% fall in the preauthorisations in the second phase. This can be attributed to the subsequent neglect of the phase I districts. In general, the low uptake of the scheme can be clearly being a result of poor IEC activities undertaken through the scheme.
- The RGJAY MOU identifies health camps as a tool for popularising the scheme as well as identifying and referring potential beneficiaries to network hospitals. From the qualitative research, we found that for the empanelled public hospital, conducting even a single health camp was an additional burden whereas for the empanelled private hospital, it seemed to been used as an opportunity for self-promotion and widening awareness of their presence in other parts of the state to attract paying patients. This highlights the inadequate attention given to IEC activities and the lack of interest of TPA/ Insurer who stand to benefit from limited IEC as it would control utilisation of the scheme. This would in turn maximise their profit from premiums received.
- Moreover, Aarogyamitras posted at PHCs in phase I, were removed as a cost cutting measure. This further compromises the scheme.

Table 2: Preauthorisations for Patients - Within District and in Other Districts

Patient District	Pre-authorisations within district	Pre-authorisations raised in other districts*	Total
Gadchiroli	596 (30.8%)	1340 (69.2%)	1936
Chandrapur	162 (9.3%)	1589 (90.7%)	1751
Beed	446 (11.1 %)	3561 (88.9%)	4007
Bhandara	605 (43.7%)	778 (56.3%)	1383
Buldhana	523 (13.1%)	3457 (86.9%)	3980
Osmanabad	378 (14.4%)	2252 (85.6%)	2630
Sindhudurg	366 (26.3%)	1023 (73.7%)	1389
Washim	309 (14.7%)	1793 (85.3%)	2102
Jalna	457 (17.4%)	2176 (82.6%)	2633

* The beneficiary can register in any of the network hospitals across the state irrespective of his/her own district.

- The scheme promises to provide healthcare access to patients close to their homes. However, the inadequate public sector and insufficiently empanelled private hospitals force patients in rural areas to travel to hospitals empanelled at a great distance or to urban areas or even to neighboring districts. This adds to their financial burden (Table 2). Thus while huge sums of money are being spent through the scheme, the benefits are not reaching to the target population. As critiqued in other state level schemes, such humongous

spending by the state, directed towards the 'for profit' sector, can have serious implications in terms of fuelling the already dominant private health sector.

Figure 3 : Preauthorisation Raised Across Regions

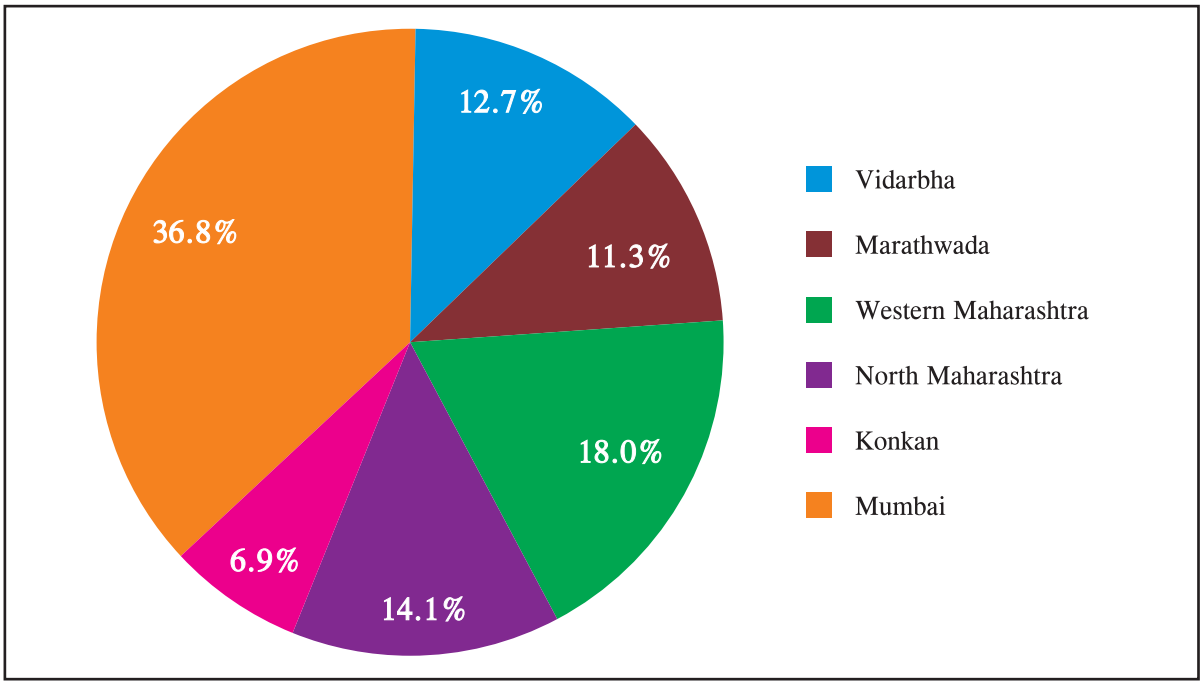
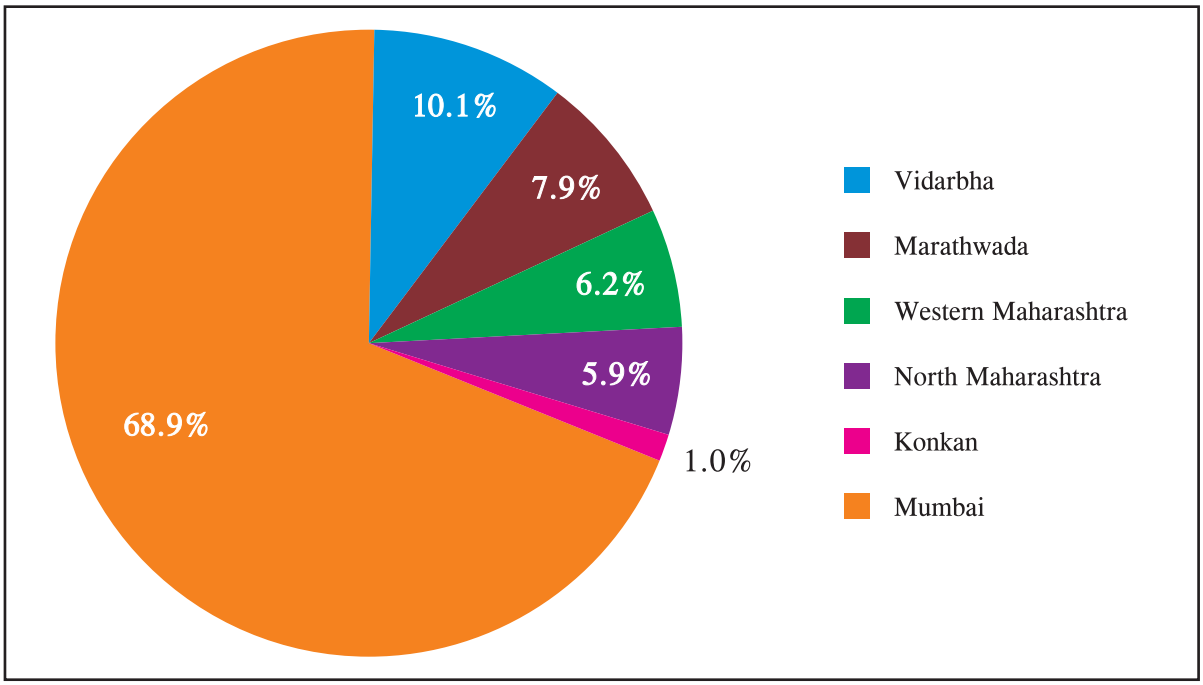


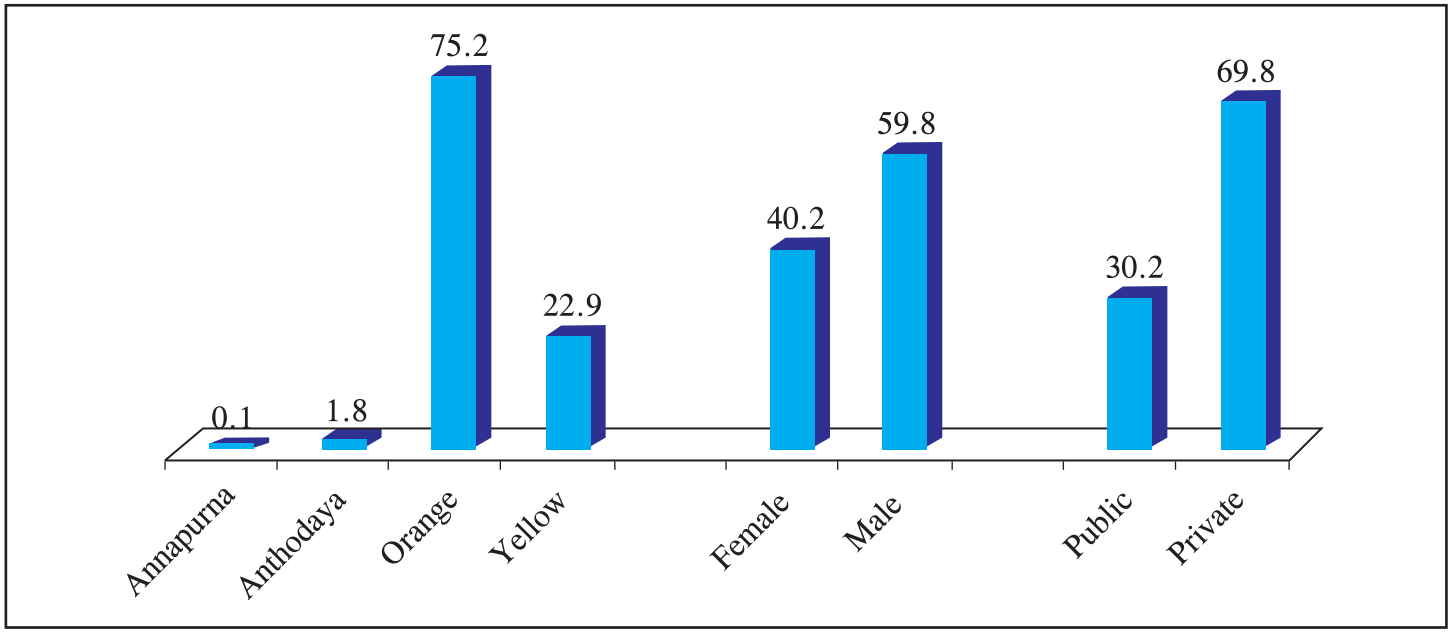
Figure 4 : Preauthorisation Raised in Public Hospitals across Regions



- Mumbai has only 11% (51/473) of the network hospitalsin the state among which nearly 63% are private hospitals, yet proportion of pre-authorisations in Mumbaiis more than other regions.Utilisation of the scheme has been largely limited to Mumbai with 36.8% of the total preauthorisation raised(Figure 3). Moreover, 68.9% of the total preauthorisation in public hospitals isalso from Mumbai (Figure 4). Higher utilisation in Mumbai can be associated with the migration of patients from rural districts. Such a situation

can burden the public hospitals in Mumbai, which are already struggling to cater to the needs of patients.Other areas that have shown higher utilisation, as was evident even earlier, are the urban areas of Thane, Nashik, Solapur, Nanded, Aurangabad.

Figure 5 : Profile of the Beneficiary Population



- Beneficiaries of the scheme ranged from newborn children to senior citizens. Maximum pre-authorisations were between the age group of 26-50 yrs (41%) and 51-75 years (41%). Almost 70% of the preauthorisation were in the private sector. While the orange cardholders[1] raised the highest preauthorization, male beneficiaries raised 60% of the pre-authorizations (Figure 5).
- There was a stark difference in terms of availability of specialties and their utilisation (Figure6). Five specialties extensively available in the network hospitals were, general surgery (75%), infectious diseases (70%), critical care (74%), orthopedic (69%), pulmonology (63%), however the top five specialties which raised maximum preauthorisation include medical oncology (17%), nephrology(15%), cardiology (13.7%), genitourinary system (8.1%), polytrauma (7.2%), cardiac and cardiothoracic surgery (6.7%). This mismatch raises questions on how hospital empanelment was carried out. The higher utilisation clearly documents that the scheme is skewed towards the tertiary specialties that require hospitalisation and high-tech medical expertise. The already existing inadequacy of the public hospitals in terms of meeting with these requirements makes them automatically incapable of providing this expertise.
- Despitethe reserved procedures in the public hospital, it is evident that the private hospitals have the biggest share of cases under the scheme (Figure 7). A clear difference in utilisation could be seen across specialties such as nephrology, ENT surgery, radiation oncology, genitourinary, cardiology, cardio and cardiothoracic surgery, critical care which have more than 75% of cases approved in the private sector. Higher proportion of preauthorisation were approved in public hospitals for specialties such as burns, infectious diseases, pulmonology, which do not have any procedures reserved in public hospitals.

[1]The Maharashtra Govt. introduced Tricolor ration card scheme w. e. f. 1st May, 1999. Accordingly, as per following criteria 3 different colored ration cards are issued in the State. Yellow ration cards signify the BPL families, Orange the APL familieshavingtotal annual income of more than Rs. 15,000 and less than 1 lakh and the White are for the families having annual income above 1akh. http://mahafood.gov.in/website/english/PDS.aspx

Figure 6 : Availability and Utilization of Medical Specialties

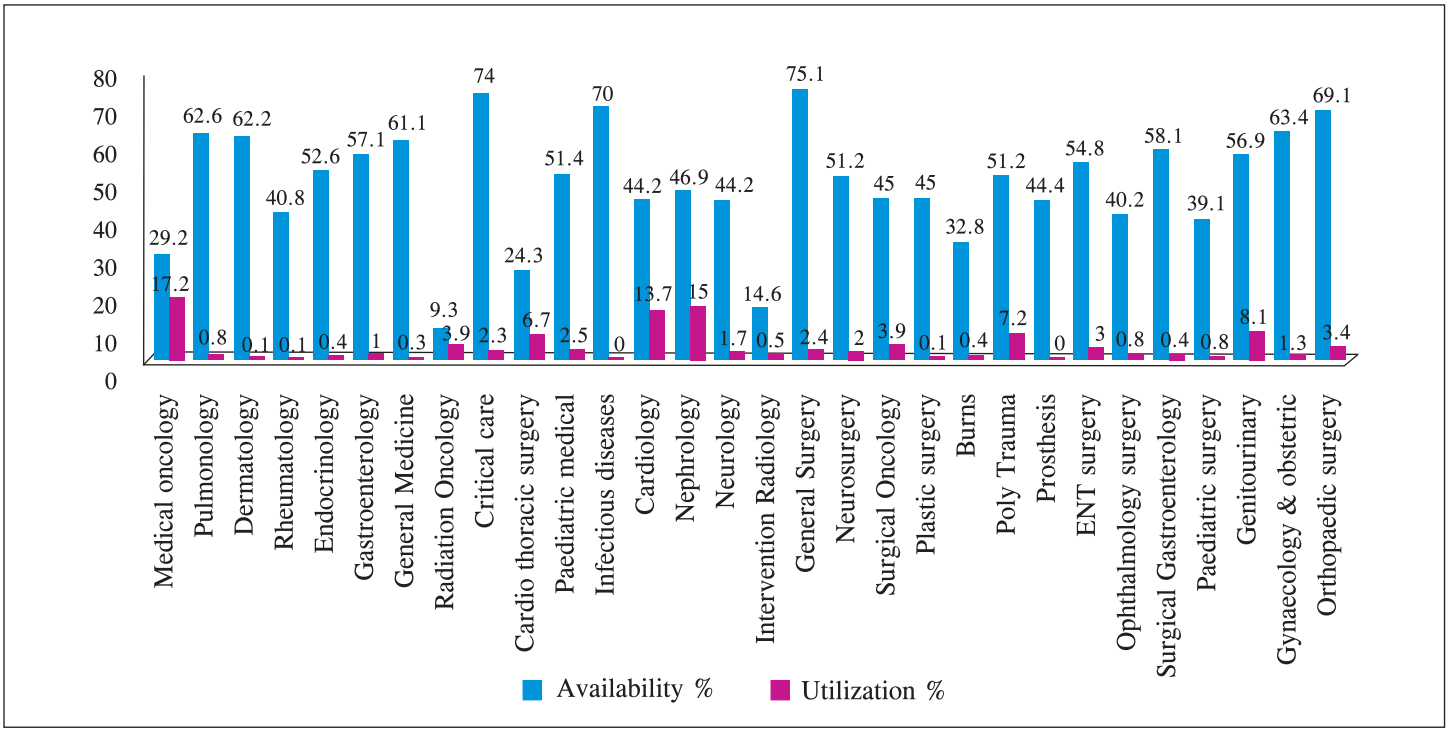


Figure 7 : Approved Preauthorization across Specialties and Type of Provider

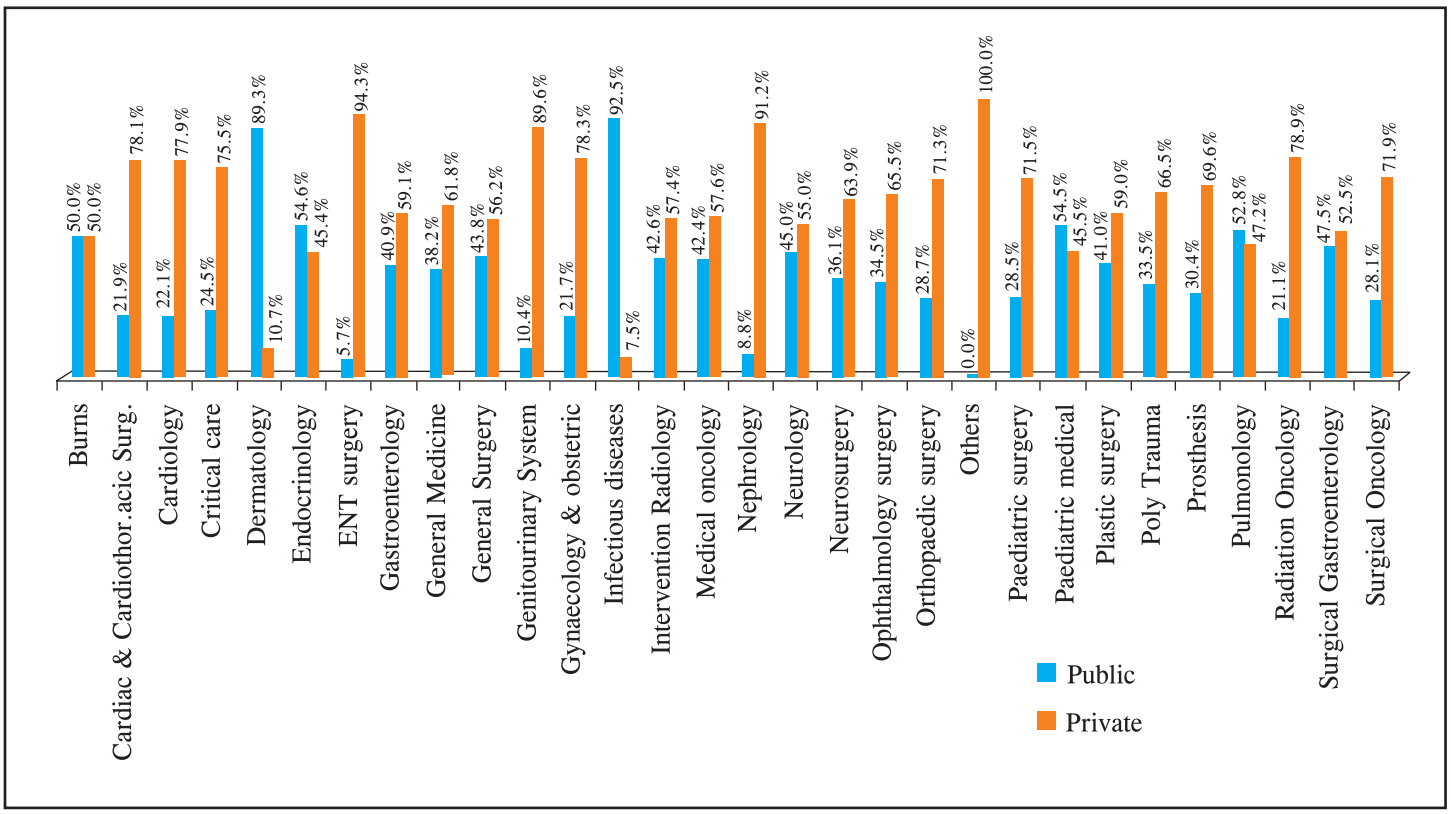


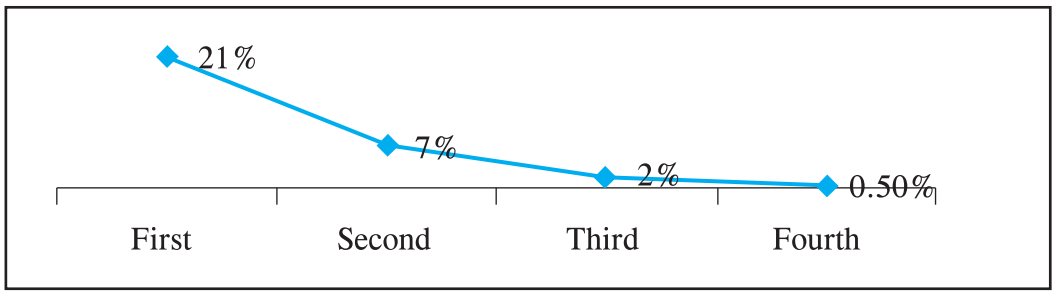
Table 3: Scheme Performance at a Glance

	July 2012-August 2014		
	Public	**Private**	**Total**
Enrolled families		509,971	
Preauthorisations raised	93664	216638	310302
Surgeries /therapies approved	76524	193410	269934
Preauthorisation amount approved	INR 202 crores (N* = 68656)	INR 503crores (N* = 179783)	INR 706 crores
Claims raised		54044	152679 206723
Claims paid Number	43107 (24.43%)	133369	176479
Claims amount paid	INR 118 crores	INR 348 crores	INR 466 crores

*N= total number of cases for which preauthorisation amount approved is known was arrived by removing the missing values and the zero from the data file

- Preauthorisation for about 2.69 lakh surgeries and procedures were approved till August 2014, which majorly included Medical oncology 19% (50585), Nephrology 16% (43755), Cardiology 14% (37097). These three specialties incorporate almost half of all the cases (48%) approved. While 87% of the total preauthorisation raised were approved, 85% of the total claims raised were approved until August 2014 (Table 3).
- The patients' journey in the RGJAY scheme was not as effortless as laid down in the MOUs. We were able to identify systemic access barriers at various levels delaying the entire process right from the time of registration to seeking treatment. In practice, Health cards are redundant, as personal documentation has to be submitted all over again at the time of accessing the scheme. Hospitals are required to do detailed and elaborate documentation of each case. Minor omissions have led to delays and rejections of requests. Out of 971 procedures, about 192 procedures raised less than 10 preauthorizations in between July 2012 until August 2014. In a scheme which offers a range of procedures, this poor utilization of one-fifth of the procedures is a cause of concern
- In the context of the upcoming restructuring of the scheme with procedures going up to 1100, there is a need to understand the reasons for the underutilised procedures. Even the government hospital reserved procedures were not available in all the public hospitals. Thus, there were few preauthorisations raised for such procedures indicating underutilisation due to unavailability. This makes us question the rationale of reserving these procedures under public hospitals and lack of options available to the beneficiaries under the scheme.
- About 214019 claims had been raised by hospitals in Maharashtra out of which 74% of claims raised were from private hospitals while 26% were from public hospitals. The study puts forth that, compliance to medical documentation becomes a necessity for Claims reimbursement as it becomes the most common reason for rejecting the claims.
- Out of the total population eligible for follow-up, only 21% availed the first follow-up, 7% availed the second follow-up, 2% availed the third follow-up and less than one percent of the patients came for the fourth follow-up (Figure 8).
- The study clearly documents the Out of Pocket (OOP) expenditures where, more than half of the grievances registered with the RGJAY Society were related to it. Other common grievances were delay in treatment, denial in admission etc. Most patientsare referred to the scheme post admission from either OPD or IPD where the patient has already incurred some cost. Further, the qualitative data shows that the patients seem to overlook the OOP expenditure as they were receiving rest of their treatment free.

Figure 8 : Follow-up Availed



Discussion & Conclusion

- The present study clearly documented the lacunae in the RGJAY scheme, with continued high OOP expenditure; inter-district travelling to avail health care and poor accountability. The dependency on private sector players for service delivery and for management can hamper the sustainability of the scheme, as it is dependent on the willingness of the private players. The objective of the scheme is to improve the access to quality health care of the economically weaker sections through a public private partnership. However, as seen from the findings, the scheme has failed to achieve the same. The scheme has also not been able to address the persistent issues with the health care system such as the rural-urban disparity. It is known that BNHRA (Bombay Nursing Home Registration Act) is superficially implemented with hospitals openly flouting norms especially in terms of qualified staff (Deosthali & Khatri, 2011). In face of this, though RGJAY has its own eligibility criteria and grading for single specialty hospitals, one wonders if their monitoring and supervisory checks are strong enough to make sure the standards of care are maintained. It may happen that for achieving greater access, quality of services is compromised for poor patients who utilise these services.
- The MOU mentions different committees including the district level and state level monitoring committees formed by the TPA and the Society who are responsible to supervise various processes in the scheme. It also mentions capacity-building workshops for the empanelled hospital staff and medical practitioners. However, hardly any of these mechanisms seem to be functional and the way these are executed needs to be looked into. As implied by the scheme's tagline, the scheme promises to provide quality health care to poor patients. However, apart from the application of NABH (National Accreditation Board for Hospitals and Healthcare providers) guidelines for hospital empanelment, no clear guidelines exist to monitor the utilisation of specialties in public or private hospitals. The need to set up a mechanism for monitoring and audit of private sector is what is required. By reserving a procedure like hysterectomy under public sector, the state recognises the malpractice of private sector. However, reserving the procedures is not a measure to restrict malpractice but it might impede the accessibility of the beneficiaries. It calls for strict rules, audit and monitoring.
- Stringent regulation, transparency and accountability are needed along with strategies that make their participation more amicable and positive. A continued assessment of the scheme would be recommended to understand the effects across years. Indeed, in a system where Universal Health Coverage is yet to be achieved, giving preference to tertiary services against primary and secondary healthcare is not only a step backwards but also unfair to those who have limited access to these services.

This Key Findings document has been prepared by Suchitra Wagle and Nehal Shah for CEHAT. Mumbai.

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