Government Funded Health Insurance Scheme in Maharashtra: Study of Rajiv Gandhi Jeevandayee Aarogya Yojana

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Centre for Enquiry into Health and Allied Themes

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Abbreviations

APL	Above Poverty Line
BPL	Below Poverty Line
BSI	Balance Sum Insured
CBHI	Community Based Health Insurance
CEO	Chief Executive Officer
CGHS	Central Government Health Scheme
CHC	Community Health Center
DAMA	Discharge Against Medical Advice
DCO	District Co-ordinator
DGM	Deputy General Manager
DH	District Hospital
DHO	District Health Officer
DMER	Directorate of Medical Education and Research
DMO	District Medical Officer
DNB	Diplomate of National Board
ENT	Ear Nose Throat
ESIS	Employees' State Insurance Scheme
ETI	Emergency Telephonic Intimation
GR	Government Resolution
ICU	Intensive Care Unit
IEC	Information, Education and Communication
INR	Indian National Rupee
IPD	Inpatient Department
IRDA	Insurance Regulatory and Development Authority
LMIC	Low and Middle Income Countries
MCCO	Medical Camp Co-ordinator
MCGM	Municipal Corporation of Greater Mumbai
MCO	Medical Co-ordinator
MIS	Management Information System

MLC	Medico-Legal Case
MOA	Memorandum of Association
MOU	Memorandum of Understanding
MRI	Magnetic Resonance Imaging
NABH	National Accreditation Board of Hospitals
NIC	National Insurance Company
NRHM	National Rural Health Mission
NWH/NH	Network Hospital
OECD	Organization for Economic Co-operation and Development
OOP	Out of Pocket
OPD	Outpatient Department
PHC	Primary Health Center
PPP	Public Private Partnership
RGJAY	Rajiv Gandhi Jeevandayee Aarogya Yojana
RGJAYS	Rajiv Gandhi Jeevandayee Aarogya Yojana Society
RSBY	Rashtriya Swathya Bima Yojana
SHG	Self Help Group
SOP	Standard Operating Procedures
TAT	Turn Around Time
TPA	Third Party Administrator

Documents Referred from RGJAY Website

1. RGJAY Empanelment Process and NABH Scoring and Grading Criteria
2. RGJAYS. User Manual for e -Empanelment Module. Government of Maharashtra.
3. Memorandum of Understanding - Rajiv Gandhi Jeevandayee Arogya Yojana Phase I
4. Memorandum of Understanding - Rajiv Gandhi Jeevandayee Arogya Yojana Phase II
5. NATIONAL INSURANCE COMPANY LTD "Rajiv Gandhi Jeevandayee Aarogya Yojana" Scheme PHASE II - Revised Guidelines for Preauth Approval & Claims Settlement - Adjudication guidelines 14 Nov 2013
6. Enrolment guidelines for Orange/Yellow/Annapurna /Antyodaya Cards holders under RGJAY
7. Rajiv Gandhi Jeevandayee Aarogya Yojana phase II - draft memorandum of understanding amongst National Insurance Company Limited/ TPA and Hospital
8. Training Program on Empanelment Criteria Under Rajiv Gandhi Jeevandayee Arogya Yojana Course Material
9. RGJAY Document on Package costs

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Preface

The report titled "The study of the government funded health insurance scheme in Maharashtra: Rajiv Gandhi Jeevandayee Aarogya Yojana" presents much required evidence on this state funded health insurance scheme in Maharashtra.

The initiatives for improving health service provisioning have been dominated with several government funded health insurance schemes across the country. Apart from the Rashtriya Swasthya Bima Yojana (RSBY), many states have introduced their own schemes. As precious public funds are diverted to these schemes, an assessment of their effectiveness is necessary.

This report analyses two years of implementation of RGJAY scheme and raises several concerns as well as loopholes in the scheme. The study is grounded in literature review on various insurance schemes in India with a special focus on state level insurance schemes. A mixed -methods approach was taken for a holistic understanding of the scheme implementation. Qualitative method was used to study one empanelled public hospital study and one empanelled private hospital and the RGJAY staff, TPA doctors, patients to get a multiple stakeholder perspective on the scheme functioning. Quantitative analysis of secondary data obtained from the RGJAY society database was used to understand the scheme utilization.

Despite such a large presence of the private sector, the scheme has not been able to reach rural population and remote districts which was a crucial goal of the scheme, to cover majority of the state population, besides increasing the sum insured per family. The disparity in terms of the service availability across districts continues to exist, forcing patients to travel to other districts to avail health care. Besides lack of awareness about the scheme, the beneficiaries accessing the scheme faced barriers like problems with medical documentation, unavailability of services, etc. Out-of-pocket expenditure was one of the major grievances even as many a times it went unreported. Many patients were satisfied even though they had incurred some out-of-pocket expenses. Poor accountability and overall lack of adequate monitoring mechanisms prevent efficient execution of the scheme.

While the National Health Policy (2017) relies on the private health sector to fill gaps in public health services, including primary health care services, the present report comes at a critical juncture as it raises pertinent concerns about the functioning of RGJAY scheme, public - private partnerships and huge spending by the state government on the scheme without stringent monitoring and regulation. We hope that cognizance of these findings will be taken by the policy makers and government actors and review of the scheme will be done in the light of its performance.

Sangeeta Rege, Coordinator, CEHAT

Executive Summary

Since the past decade, the Indian healthcare system has witnessed an upsurge of the government funded health insurance schemes. The schemes launched both at the central and state level, brought a substantial population under the insurance cover and changed the equations of health care delivery considerably. Maharashtra also has seen the passage of various insurance schemes. The government of Maharashtra launched the 'Rajiv Gandhi Jeevandayee Arogya Yojana' (RGJAY) on 2nd July 2012 in a phased manner by discontinuing the RSBY scheme. The scheme provides coverage up to INR one lakh fifty thousand per family per year. 971 medical procedures are covered under empanelled hospitals.

CEHAT carried out the present study with the aim of understanding the overall functioning of the scheme in terms of service provisioning, coverage and inequities in access to health care. The study provides analysis of various aspects of the scheme including the process of hospital empanelment, the bottlenecks and barriers while accessing the scheme vis-a-vis government guidelines.

The study engages in a mixed methods approach. Quantitative analysis of secondary data is done for the period of two years (July 2012 to August 2014). The empanelled hospital data is obtained from the RGJAY website. One public hospital and one private hospital empanelled under the scheme, were included in the study in order to gain insights about the nature of implementation of the scheme.

The study presents a profile of the hospitals empanelled under the scheme. About 473 hospitals have been empanelled through the scheme of which 84% (396) belonged to the private sector. The data shows that about 44% of the private hospitals have been empanelled from six urban centers. Merely 12% of the hospitals are empanelled from the 12 least urbanized districts, creating a gap in terms of availability of the network hospitals. The gap worsens in the tribal districts including Nandurbar and rural Thane. The huge private sector empanelment is not able to gurantee the availability of hospitals across the districts.

The study provides a detailed analysis of the scheme utilization, from the preauthorizations raised, approved till claims raised and approved. About 69.8% of the preauthorizations have been raised in the private sector. With 36.8% of preauthorization raised, the utilization of the scheme has been largely limited to Mumbai. Of the total preauthorizations in public hospitals, 68.9% belonged to the public hospitals in Mumbai.

Profile of the beneficiary population shows that half of the population accessing the scheme belong to the age group of 41-65 years (50.8%), 75% of the total beneficiaries were orange card holders and 60% of the beneficiaries were males. Gender differential could be seen in preauthorizations of certain medical procedures including rheumatology, surgical oncology, medical oncology, dermatology, and burns where preauthorizations were more in females. The top five specialties under which maximum pre-authorizations were raised include medical oncology (17%), nephrology (15%), cardiology (13.7%), genitourinary system (8.1%), poly trauma (7.2%), cardiac and cardiothoracic surgery (6.7%), however the top five

specialties extensively available in the empanelled hospitals are general surgery (75%), infectious diseases (70%), critical care (74%), orthopaedic (69%), pulmonology (63%). Such a gap in terms of available specialties can affect the accessibility of the scheme.

The extent of utilization of the scheme depends on the level of awareness about it. The qualitative data documents the lack of awareness amongst the beneficiary population about various 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 medical procedures covered under the scheme. This can be linked to the inadequate Information, Education and Communication (IEC) activities carried out through the scheme. The study reveals that systemic issues including medical and personal documentation requirements acting as barriers while raising the preauthorization request, which is the basic requisite for availing the treatment under the scheme. While, the non-availability of specialists and medical equipments act as barriers in the public hospitals, preference given to paying patients is the hurdle for the patients accessing scheme from the private hospital.

The data shows that, a total of 2.69 lakh surgeries and procedures were approved till August 2014, which majorly included Medical oncology 19% (50585), Nephrology 16% (43755), Cardiology 14% (37097) etc. About 1,94,823 surgeries and procedures were approved in the private hospitals and 75,111 in the public hospitals. The Emergency data of the scheme show sthat ETIs (Emergency Telephonic Intimation) were raised in 313 empanelled hospitals, out of which 48 were Public and 265 were Private. 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. However, the qualitative data shows that the patients seem to overlook the OOP expenditure as they were receiving rest of their treatment free.

About 74% of claims raised were from private hospitals while only 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. The scheme also provided follow up for 121 procedures. From the 45014 cases for follow-up only 9397 (21%) cases availed the first follow-up, 3284 (7%) cases availed the second follow-up, 1086 (2%) availed the third follow-up and only 328 cases had the fourth follow-up (0.7%). Follow-up treatments have to be sought from the same hospital where surgery was performed, and this can act as an impediment in accessing the follow-up services.

The present study is able document the discrepancies in terms of distribution and availability of services. The service provisioning and the utilization is urban centric forcing the beneficiaries to travel to urban areas for accessing the scheme. The analysis documents the gaps in the process of implementation of the scheme vis-à-vis the MOUs. The scheme is skewed towards the tertiary specialties that require hospitalization and high-tech medical expertise. The study further puts forth the gaps in collaborating with the private sector in terms of the lack of stringent mechanisms in assessment and monitoring of the partnerships. The findings reiterate the increasing reliance of government on the private sector. The findings are significant in the current healthcare scenario where government is spending large sums of money on such schemes, which is benefitting the private sector, at the same time ignoring the primary and secondary public healthcare sector.

The report provides recommendations for better implementation of the scheme including suggestions regarding changing the focus of the monitoring process, improving the IEC activities. In the background of the study findings, it can be concluded that there is a need for stringent mechanisms to evaluate such schemes vis-a-vis their benefits to the population.

Chapter 1

Introduction and Context Development

Introduction

The health insurance sector in India has evolved in a big way since the launch of its first ever-insurance scheme, the Employee State Insurance Scheme in 1948. Since then, there have been reforms in the health insurance sector in India, which have witnessed introduction of many different insurance models in both public and private sectors. In 2005, restructuring of the public health care system began with the launch of the National Rural Health Mission (NRHM). These two developments changed the nature of health provision in India (Prasad & Raghavendra, 2012). The public sector too saw launch of several insurance schemes at the central and state level, thereby increasing the coverage of population. State level schemes include Rajiv Aarogyashri in Andhra Pradesh, Yesashwini in Karnataka and Kalaignar in Tamil Nadu; that managed to cover the majority of the state's population (Reddy et al., 2011). In fact, according to projections made by a World Bank report (La Forgia & Nagpal, 2012), it was estimated that by 2015 about half of India's population would be covered by some form of health insurance through the government as well as commercial schemes.

The key objective of public health insurance schemes was to decrease the financial burden on the poor particularly due to increasing health care costs. However, several reports and studies have pointed to serious issues such as continued OOP expenditures and poor implementation of insurance schemes (Shijith & Sekher, 2013).

Maharashtra has seen the passage of various insurance schemes such as the Jeevandayee Aarogya Yojana and the pan India scheme, Rashtriya Swasthya Bima Yojana (RSBY). The former was introduced in 1997 for Below Poverty Line (BPL) families and children less than 6 years of age. It was limited in scope as it covered only the super-specialty services including heart, kidney, brain and spinal cord related procedures. The RSBY, launched in 2008, was one of the largest government-sponsored health insurance schemes in the world. The scheme's purpose was to provide protection to BPL households from financial liabilities arising due to hospitalization. It also brought private hospitals under its ambit. However, in 2012, the scheme was withdrawn abruptly and replaced by a new state level scheme 'Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY), which was claimed to have rectified all issues pertaining to previous schemes. Moreover, the Maharashtra government is investing a large amount of state funds in it. Concerns have been raised around the budget of the scheme, as it would be completely dependent on the state health budgets, which might jeopardize the funds kept for primary and secondary healthcare and further deteriorate it (Kurian, 2012). It is therefore worthwhile to study the scheme in some detail.

Organization of the Report

The report is divided across six chapters. The first chapter looks briefly at health care financing internationally as well as in India. It then, with the help of literature review, presents an assessment of the existing public health insurance schemes at the national and state levels. The second chapter states the objectives and describes the methodology incorporated in the study. The third chapter discusses the findings of the study

in the light of the literature surveyed. This chapter is further divided into sub sections, which describe the process of the insurance scheme, right from the registration into the scheme until the discharge and follow up, with the help of qualitative as well as the quantitative data and the fifth chapter presents the discussion and conclusion. This chapter also provides recommendations for the better implementation of the RGJAY scheme. The last section of the report contains the annexure including the details of RGJAY data files and the additional tables used for analysis.

Healthcare Financing and Various Health Insurance Models: Literature Review

Healthcare Financing: Some International Observations

Since the introduction of Alma Ata's declaration of 'Health for All' in 1978 and subsequent international emphasis on Universal Health Coverage, countries and organizations all over the world have tried to achieve a viable and sustainable system of universalizing health services. Health financing plays a key role in establishing such an equitable system of healthcare.

Bennett and Gilson (2001) have identified four basic health-financing mechanisms implemented across the world. These are; tax based financing, social insurance financing, private health insurance and community based health insurance. Most of the countries that are part of the Organization for Economic Co-operation and Development (OECD) have health-financing models that rely on taxes, social or public health insurance to fund their health provisioning. The Consumer Sovereignty Model is also common and is based on individual or employer contribution centered on private insurance model and private health care provisioning. However, these are not watertight distinctions. More often than not, most health systems have pluralistic models of health care financing with varied levels of control, funding and provisioning (Burau & Blank, 2006). More importantly, the governments of these countries take a stewardship role in steering the health system towards a sustainable, equitable and responsive system (World Health Organization, 2000).

Following the lead of many OECD countries, health insurance through government has emerged as a preferred method of health financing in many low and middle-income countries including India. There are different models of risk pooling through the contribution of various stakeholders and financial protection at various levels of healthcare. Some common patterns are nevertheless evident such as cross-subsidisation through complete or partial tax-based funding, gradually moving towards more inclusive risk pools and relying on demand-side financing mechanisms to fuel purchase of services. Being a relatively new trend in these countries, there has been a mixed impact as seen in terms of parameters such as coverage and cost-reduction (Lagomarsino, Garabrant, Adyas, Muga & Otoo, 2012).

Models of Health Insurance and Financing: India

There are several models of health insurance and financing in India. This section is a brief description of some of these models.

As mentioned earlier, the Employees' State Insurance Scheme (ESIS) was the first ever-insurance scheme, which was launched in 1948 and is still active. It catered to the lower rung workers in the formal sector and their families. Funding was through contributions from the government along with a percentage of employer's and employee's share from the wages payable to the employee. The least paid workers are exempted from employee contribution. The scheme provides a comprehensive package at all levels of

health care along with cash benefits compensating for the loss of earning capacity due to illness, disability or death. Health provisioning is mainly through its own hospitals and dispensaries with some additional empanelled private hospitals. However, India has a large working population in the unorganized sector. This seriously limits the schemes coverage amongst the neediest worker.

The Central Government Health Scheme (CGHS) was introduced in 1954 to provide health benefits exclusively to the central government employees, their families, pensioners, Members of Parliament and Supreme Court judges. It is financed through central government funds and employee contributions. The service packages are quite comprehensive. Health services are provided through its own dispensaries in select cities. Some public hospitals and private hospitals are also empanelled to provide services. The narrow scope of the scheme in terms of its target population especially since there is a stable and secure source of income is a serious limitation (Devadasan & Nandaraj, 2006). Obviously, it is not a scheme for the masses.

Community Based Health Insurance Schemes (CBHI), are run by NGOs and hospitals for communities. These schemes have been around in India for many decades. These schemes are essentially voluntary and cater to the poor households in the informal sector who are unable to afford the high premiums of private health insurance (Devadasan, Ranson, Van Damme & Criel, 2004). However, low premiums mean that the benefit packages are also lower. As these schemes have been limited to poor communities, there is no cross subsidizing between the rich and the poor. This also means that they are not amenable to expansion on a larger scale (Devadasan & Nandaraj, 2006).

There is a multiplicity of various social insurance schemes at both state and central level including the Maharashtra Mathadi, Hamal and other Manual Workers (Regulation of Employment and Welfare) Act, 1969 schemes for railway employees, and so on; that cover some amount of health benefits.

In 1986, public sector health insurance companies launched the first voluntary health insurance scheme called Mediclaim. It covered all those healthy individuals who were willing to pay premiums based on age, foreseeable health risks and corresponding benefits package for future hospitalisation expenses along with tax benefits. Policyholders are reimbursed the cost of hospitalisation and home care on submission of bills and other documents. This scheme catered mainly to the upper and middle-class population.

A number of similar voluntary health insurance schemes by private companies were introduced (Devadasan & Nandaraj, 2006) from 1999 onwards when liberalisation of the economy led to the insurance sector being thrown open to the private sector. Simultaneously, development of private health sector gained momentum; leading to sprouting of small and large hospitals and private nursing homes. This, along with the decline of the public health sector, the household health expenditures increased. The expensive private health insurance schemes offered thus far were unaffordable to the poor who continued to be impoverished under the burden of health care (Xu et al., 2003). There was a need to protect the poor. Following international experiences in other developing countries, many community-based as well as government, health insurance schemes were introduced across the country.

The Government of India launched universal Health Insurance Scheme (UHIS) in 2003 in order to reach out to the poorest households. The premiums were heavily subsidized and the annual cover ranged from INR 15,000 - INR 30,000 for hospitalisations. Premiums were further lowered in 2004 following poor

response from the target BPL population. Despite this, the scheme failed to take off (Devadasan & Nandaraj, 2006).

The year 2003 also saw the launch of the Yeshaswini Scheme in Karnataka by the state government for the rural co-operative societies. The government to provide financial and technical aid to farmers, artisans, weavers, fishermen etc. and other workers in the informal sectors has formed these societies. This scheme worked much on the lines of community based health insurance. Participation was voluntary and the premiums highly subsidized. This was the first ever structured scheme with a pre-decided list of medical procedures covered, set package of services, fixed package rates and annual package limits. The scheme brought considerable number of informal workers in rural areas under a health insurance cover. This pioneering and very successful scheme became a popular model for several government health insurance schemes across the country. Thus emerged a spate of government sponsored health insurance schemes like the central government's Rashtriya Swasthya Bima Yojana (2008) followed by state level Aarogyasri (2007), Kalaignagar (2009), Vajpayee Aarogyasri (2010) to name a few (La Forgia & Nagpal, 2012). States that did not have state health insurance schemes adopted the central scheme RSBY. Target population of BPL and poor households, free of cost or subsidized premiums, benefit packages for secondary and/or tertiary healthcare, cashless services, health provisioning through empanelled public and private hospitals and involvement of Third Party Administrators (TPAs), were some of the common features across the schemes. Thus, the new government funded insurance schemes for the poor, were significantly different from the existing schemes such as the ESIS and CGHS.

Government Sponsored Health Insurance Schemes

Introduction of several government subsidized insurance schemes was a welcome development. These schemes, however, had some significant shortcomings. Thus, none of these schemes served the purpose of universal coverage as each scheme had a specific target population making them limited in scope. The present section attempts to highlight some of the key problem areas with various schemes as through a literature review of studies done on these.

Reddy et al. (2011) critically reviewed various health insurance schemes including private voluntary and publicly financed schemes through secondary data and interviews with scheme officials. The study shows that the introduction of publicly financed schemes has increased the insurance coverage to about one-fourth of the population; with RSBY, Rajeev Aarogyasri and Kalaignagar together making up for one-fifth of the insured population. Packages offered by most schemes focus largely on covering hospitalization expenses (with the exception of ESIS and CGHS). RSBY focuses on high-frequency secondary care and has a modest benefit package while schemes such as Aarogyasri and Kalaignagar have higher benefit packages that focus on low-frequency tertiary care. An important consequence of this is that the hospitalization rates seem to vary, predictably, according to the scheme. They were highest in private voluntary schemes followed by RSBY, which is little less than the national average and finally still lower in Aarogyasri and Kalaignagar. Although risk pooling and pre-payment is there in most of these publicly financed schemes, due to their focus on particular level of care, there is still a significant burden of healthcare costs on households The authors found that the average medical expenses for hospitalization were higher in the insured as against the uninsured. There is a wide variation in claims ratio across districts. Moreover, government spending on private sector tertiary care increased as majority chose private hospitals. Consequently, sustainability of these schemes was an issue highlighted by the authors. Reddy and Mary (2013) in their review of the Aarogyasri scheme based on secondary data analysis have

also raised the issue of sustainability. The scheme, as mentioned earlier, focuses on tertiary health care; and covers nearly 80% of the population of Andhra Pradesh. Again, it was the private sector that benefitted more as it was used more extensively for treatment, than the public sector. There were also reports of fake claims and unnecessary surgeries by hospitals under the scheme. As a result, more than 100 hospitals had been de-empanelled for malpractice or disobeying norms. With the increase in healthcare costs, the premium amount has also been rising gradually, further straining the government finances. By 2009, the state government was spending a quarter of its health budget on the scheme.

Some positive impact was seen by Fan, Karan and Mahal (2012) in their study on the Aarogyasri scheme (Phase I and II) based on NSSO data. They found that there was indeed some positive impact on the OOP expenditure. There was a significant reduction in out-of-pocket expenditure for inpatients and to a lesser extent for out-patients in Phase I districts. There was no noticeable impact in Phase II districts (implemented at the time of the survey). Further, they also found that the impact on Scheduled Castes and Scheduled Tribes was not significant despite them being specifically identified as key beneficiaries. The authors opine that the gains to the household are underestimates and the utility gains from the scheme outweigh the costs to the government.

Later, in a similar study, based on National Sample Survey data (NSS) Hooda (2015) found that although the access to health care increased in general for insured households, the impact on the poor insured households was limited as rate of hospitalization, was relatively higher among rich insured as compared to poor insured. The insured were more likely to access expensive tertiary care rather than focus on preventive and primary care. There was an increase in the use of inpatient services accompanied by an increase in its average cost. Health insurance, therefore, also increases supply side and demand side moral hazard[1]. As the health insurance packages are limited to hospitalizations, the policyholders are driven to utilize more of inpatient services for treatments that could easily be dealt with in outpatient settings. Moreover, moral hazard is more apparent among the rich and urban residents with little effect among poor and rural insured people. The reimbursement per case received by the rich and the urban residents was also much higher than that received by the poor and rural insured. This could be attributed to the lack of knowledge about the benefits provided by the insurance packages among the poor and the rural insured people. The impact of health insurance was also limited by the inequities in the presence of health infrastructure. Health insurance promoted the growth of the private providers, but this did not much benefit the poor segments of the Society.

An evaluation study of the Aarogyasri scheme by Rao et al. (2011) revealed that though the scheme is targeting the informal sector, many vulnerable groups like migrant workers, destitutes, and street-dwellers are excluded from the scheme for the lack of residential address and proof. Scheduled castes and scheduled tribes also had a low enrollment rate. The study, based on the database of the scheme and primary data from interviews of various stakeholders like beneficiaries, coordinators etc.; found that utilization rate of the scheme was highest for cardiac diseases, cancer, and neurological diseases. Moreover, the utilization rate for the scheme decreased with distance from the major cities with empanelled hospitals. High out of pocket expenses continued and were mainly for transport, medicine, pre-diagnostic tests, etc. Primary healthcare providers welcomed the scheme as it allowed them to refer patients for high-cost healthcare

[1] Moral hazard is associated with the change in the behaviour of the users where they tend to over utilize the healthcare services as they have coverage.

regardless of their ability to pay. However, lack of awareness among providers, lack of clarity among beneficiaries and lack of feedback mechanisms were some of the issues pointed out.

Prasad and Raghavendra (2012) also critically analyzed the Aarogyasri scheme in Andhra Pradesh. This scheme, covering the poor, focuses on costly medical procedures, which constitute less than 2% of total disease burden. It mainly benefits the 80% empanelled private corporate hospitals that are situated in urban areas. Of the 938 listed procedures, 352 are reimbursable by insurance companies and 586 by Aarogyasri Trust itself. Analysis of claims showed that a considerable part of reimbursements through insurance companies went to private hospitals and majority of those through Aarogyasri Trust went to government hospitals. The authors suggest that most high cost, high profit procedures are under the list governed by insurance companies; while the low cost procedures are managed by Aarogyasri trust. Additionally, it was reported that the corporate hospitals selectively captured not just the high cost procedures, but also those that were low-risk, and referred the high-risk low-profit surgeries like neurology to the government hospitals. There are also several media reports of malpractice like charging beneficiaries for investigations, medicines and food, claiming higher reimbursements, performing unnecessary surgeries by private hospitals in order to gain profits from the scheme. Moreover, nearly a quarter of the state health budget is allotted to the scheme, leading to shrinking of the budget meant for primary and secondary healthcare.

Selvaraj and Karan (2012) studied the impact of various publicly financed health insurance schemes and found that there was no decrease in out-of-pocket expenditures of people. On the contrary, the headcount of catastrophic payment[2] increased, mainly due to hospitalization expenses. The authors argue that these schemes are driven by demand-side financing in a supplier-influenced market, which not only increased costs, but also failed to provide any real financial protection to the targeted population. Additionally, the most vulnerable population often do not have proper documentation and identification proof and thus are unable to gain any help from the scheme that is supposedly meant to benefit them.

Devadasan, Seshadri, Trivedi and Criel (2013), in their survey of BPL households enrolled under RSBY in Patan, Gujarat; found that 58% households nevertheless incurred expenditure during hospitalization. Hospitalization rates were greater among those who were within 30 km of the city, of women and scheduled castes; but lowest among scheduled tribes. The scheme was found to be riddled with implementation flaws such as enrolled population not having smart cards, approaching an unempanelled hospital, errors on the smart card and smart card reader not working. A lot of this, it was found, was due to poor Information, Education and Communication (IEC) amongst the beneficiary population. This led to OOP expenditures despite being insured. It was also found that many hospitals demanded advance payments from patients. Though they were being reimbursed, it defeated the purpose of a cashless scheme for the poor. Providers justified such demands by citing the delays or refusals of claims payment by the insurance companies on flimsy grounds. There was also little supervision by the government or the insurance company to prevent this.

A study by Shahrawat and Rao (2012) based on NSSO data on consumer expenditure shows that out-of-pocket expenditure for health results in 3.5% of the population to fall below the poverty line, while 5% population incurs catastrophic expenditure. The major components of out of pocket expenditure were

[2] Households with out-of-pocket expenditure more than 10% of their total household expenditure.

medicines and outpatient care. Significantly, they found that removal of OOP expenditure due to inpatient care did not lead to any significant reduction in the poverty headcount. The authors argue that in such a scenario, a scheme like RSBY that focuses mainly on hospitalization costs does not provide adequate financial protection to majority of poor households. Further, schemes that target BPL populations do not have proper identification mechanisms. They also exclude households that are barely above the poverty line and just as vulnerable to impoverishment.

An interesting qualitative study of the RSBY by Cerceau (2012) through a gender perspective found that the RSBY as a cashless scheme has had limited success in making health services accessible to women. Though women were found to have benefited to some extent, pertinent issues related to mobility and affordability persist. Moreover, those enrolled were unable to use the smart cards independently and the situation was compounded by lack of information on the scheme and inability to communicate properly with providers. The women thus sometimes ended up succumbing to supplier induced demand and abuse by providers including the discrimination and rude attitudes towards women. Nevertheless, RSBY being a cashless service has benefited many women, as they do not have to rely on husbands for cash. However, the decision to enroll in the scheme is not in the hands of women

Trivedi and Saxena (2013) did another study on RSBY in the Patan district of Gujarat using secondary data and primary qualitative data from interviews with service providers in empanelled hospitals. According to the providers, low awareness and information on RSBY were mainly due to low literacy, poor IEC and weak efforts in providing RSBY cards. IEC was mainly the responsibility of the insurance company and peripheral health staff. Hence, from the providers' perspective, insurance companies would not be greatly interested in promoting the use of cards as it would harm their profits and the peripheral health staff was already overburdened with other target driven programmes. In addition, as the premium was paid on each card issued, there was no incentive to make certain that other members of the family are enrolled (maximum five per family are permissible). The scheme is supposed to be a paperless and cashless service, but in reality, reimbursements are made against physical submission of documents. Providers also faced delay in payments, as there were multiple insurance companies for different districts and people often travelled across districts to avail services. Empanelled hospitals avoided taking on such patients and even insurance companies encouraged patients to use services from within the district. This makes 'national portability' benefit redundant for the beneficiaries. Providers also faced the threat of de-empanelment as hospitals generating greater claims would be investigated by the insurance company and state authorities. The hospitals, in turn, could only appeal to the district authorities. Whenever insurance companies in a district changed, the outgoing company would negotiate for lower reimbursements, which the hospitals had to accept in the fear of losing the entire claim amount.

A sample survey of 303 BPL households in Gulbarga district of Karnataka by Rajasekhar and Manjula (2012) to assess the implementation of Vajpayee Arogyasri, found that nearly 86% of households had never heard of the scheme. Arogyamitras, who are responsible for creating awareness, had played a negligible role. Moreover, the Arogyasri Trust and empanelled hospitals are supposed to be organizing health camps for awareness about the scheme and to identify beneficiaries and patients. It was found that most households surveyed were not aware of the health camps being held at all. Among those few who attended them and were referred to hospitals under the scheme, majority had utilized the scheme eventually. Those who utilized the scheme in empanelled hospitals had mixed experiences. While the treatment was free, out of pocket expenses for transport and medicines were incurred. It was also found that sometimes

if one family member has used the card, the balance left in the card was not sufficient to cover another member's treatment. It was also found that 6.3% of the enrolled households were also members of Yeshasvini scheme.

Das and Leino (2011) present an evaluation of RSBY based on an experimental information campaign including IEC intervention and household survey of randomly selected eligible households in Delhi. The sample consisted of four blocks as follows - receiving either IEC or household survey, receiving both and receiving neither. They found that IEC by itself did not have any significant impact on increasing enrollment. In fact, the household surveys, which were conducted just before the enrollment period began, lead to an overall increase in enrollment in the scheme. However, despite enrollment, the actual utilization of scheme was low for those households that received IEC or IEC/household surveys. Households that received IEC followed by the survey after a gap were more likely to enroll as they had been exposed to information more than once. Nevertheless, Das and Leino suggest that the timing of IEC when implementing the scheme and reinforcement of information through multiple contacts can have a positive effect on enrollment.

An evaluation of RSBY by GIZ (2012) through a survey of eligible households in the states of Karnataka, Bihar and Uttarakhand found that detailed information about the scheme was poor even among the enrollled members. Distance traveled to get the smart cards, was less than 2 km for the majority of the enrollees in Bihar and Uttarakhand while it was more in Karnataka because of hilly terrain of the studied district. The study found that majority of those who utilized RSBY benefits did not incur any out of pocket expenditure as treatment costs and the package of INR 30,000 was adequate in 90% of the cases. On the other hand, those who had not enrolled in the scheme incurred an expenditure of more than INR17, 000/- on average per year on hospitalization. However, the stipulated travel costs were not reimbursed for nearly 50% of the beneficiaries and many were not informed about the cost of the procedure. Majority of those who had utilized the RSBY scheme were very satisfied and all those enrolled in the scheme expressed willingness to re-enroll. The major reasons for satisfaction were cashless nature of the scheme, polite staff of the empanelled hospital and shorter waiting time for procedures. In a study by Sun (2010) on the enrollment pattern in the RSBY scheme, it was found that there were wide variations in the enrollment levels across villages with as many as 10% villages having no household enrolllled and 2.5% villages having all the BPL households enrollled. To identify the eligible population for enrollment in the scheme in 2008, the list generated from BPL 2002 census was used. This list did not include the changes in household composition between 2002-2008 due to deaths, births, marriage or migration and there were several data entry errors. This may affect enrollment rates negatively, along with other issues such as frequent power cuts. Insurance companies are responsible for enrollment of households and are paid per household enrolled. Hence, insurers have an incentive in targeting villages with large number of BPL households, healthier population and small sized households to reduce risk of hospitalization claims. No significant evidence was found, however, to indicate such a bias. The conversion rates i.e. the number of members enrolled versus those eligible were likely to be affected negatively by the distance of the village from the nearest town and positively by the number of BPL families in the village and immunization rates as a proxy of local government capacity. Significant gender patterns in enrollment were evident only when there was an enrollment limit per family in which case sons were given preference. There was also no significant age bias towards younger populations, which could indicate 'cream skimming' on the part of the insurer.

In a World Bank study, La Forgia and Nagpal (2012) examined various Government Sponsored Health Insurance Schemes (GSHIS) to identify successes, challenges, and opportunities in becoming a sustainable health-financing model. Schemes like Rajiv Arogyasri (Andhra Pradesh), Yeshasvini and Vajpayee Arogyasri (Karnataka), Kalaignar (Tamil Nadu), etc., have introduced demand-side financing in public sector allowing the poor patients to choose the type of provider, public or private. The study found that schemes have not only rapidly increased the number of poor people covered by insurance, but have also received considerable political support and increased the visibility of health in the political agenda and public policy. By introducing fee-for-service based payments, the schemes have improved the accountability in the public health system in relation to scheme beneficiaries. The schemes have standard rates for a package of services, which make cost containment easier as the prices for procedures are fixed, not subjective as against the private insurers who use open-ended itemized fee-for-service payments. Under these schemes, the entire process of pre-authorization to claims payments is computerized while one third of the private health insurers still use paper-based reimbursements. Among the challenges in implementing, the schemes are weak targeting mechanisms based on faulty BPL lists that have led to many poor households being excluded and many above the poverty line getting included. In most of these schemes, the government pays the premium to the insurers for all the BPL households in the list hence, automatically enrolling them. Thus, authors conclude that adverse selection is not much evident in the schemes as they are at no cost to the beneficiaries. However, even with cost containment with fixed packages, moral hazard i.e. overutilization of insured health services and unnecessary care were a problem that needed to be addressed. Package rates set by the GSHISs are usually lower than the market prices and have a 'one-size-fits-all' approach. They do not consider the differences in price grade among the various regions or cities where the hospitals may be located and consequently, overpay the providers in some parts or underpay in others. This leads to the providers resorting to providing unnecessary care to recover their costs and garner profits. It has been also pointed out that the schemes usually lack their own capacity to govern and manage, hence, rely on TPAs and insurers for execution. Furthermore, they do not have adequate monitoring over all the operations carried out by TPA and insurers.

A study on RSBY by Dror and Vellakkal (2012) based on various sources of secondary data found that the number of households enrolled in the scheme were around 27.8% of the eligible BPL households by March end 2011 according to the Tendulkar committee estimates. Moreover, they found that the budget allocated for RSBY by the Union Government in FY 2010-11 was 0.032% of the total union budget and could only suffice to pay for the premiums of 34% of the eligible population. The allocations for FY 2011-12 were even lower than the previous year and were not enough to even maintain the already enrolled households. This low contribution would make it difficult to expand and sustain the scheme in the long run. Evidently, the literature on health insurance schemes in India is replete with studies using different sources of information like some relying on the official database, some on primary data from surveys, some on consumer expenditure surveys and secondary data from various sources. There is also considerable variance in methodologies used and results of the studies. Nevertheless, some common issues and positive developments are evident. It is evident that impact of the government-sponsored insurance schemes on financial protection and health status of the poor has yet to be strongly established. In terms of access, utilization rate of the scheme across geographical regions and socio-economic groups varies significantly. In some cases, utilization improved while in other, there was no significant change found. This is also because ultimately utilization depends on various factors like level of awareness, ease of access to services and proper implementation of the scheme. On the other hand, inherent problems of the insurance schemes like demand-side or supply-side overutilization of services, frauds by hospitals,

unnecessary rejection of claims by insurance companies to control costs; persist. As is expected in a system where multiple stakeholders with conflicting interests are in a partnership. This leads to questions on the long-term sustainability of the schemes. It is evident that many important challenges in the system need to be tackled for the schemes to sustain and to beneficially affect its target population.

Context and Rationale of the Study

Insurance Schemes in Maharashtra

In Maharashtra, the Jeevandayee Aarogya Yojana was launched in 1997 for providing financial aid upto INR 1,50,000 to BPL patients for surgeries related to heart, brain, kidney diseases, and cancer. This scheme was not truly an insurance scheme as there were no premiums or insurance agencies involved. The state government allocated funds for the scheme that were used to directly reimburse the designated public and private hospitals that performed these surgeries on a case-by-case basis. Although all grants were fully utilized, many eligible patients incurred heavy OOP expenditure for surgeries, diagnostics, travel, etc., because of the very low awareness about the scheme (Jaswal & Goyal, 2011).

In 2008, the central scheme RSBY was also implemented in Maharashtra as in other parts of the country. The scheme was available in 32 out of the 35 districts of the state. A study by Thakur and Ghosh (2013) on RSBY in Maharashtra found that only one district had an empanelled public hospital. The rest of the empanelled hospitals were private. Based on a survey of BPL households, the study also found that there was very low awareness about the scheme with only 30% of the respondents having heard about the scheme while even lower having ever enrolled in the scheme. Not all enrolled had valid smart cards. Although nearly one third of smart card holders had a hospitalization episode in last 1 year, only 13% of them had used the scheme to access healthcare.

Another paper based on the same survey by Ghosh (2014) points out that using BPL lists to identify poor households in a targeted approach is problematic. It was found that more than 50% the BPL households were actually non-poor based on their household consumption expenditures. Predictably, lack of awareness about the scheme has led to a skewed enrollment where, surprisingly, enrollment was lower in urban areas as compared to rural areas. One of the reasons for low enrollment was lack of awareness activities. Hospitalization was less likely in very poor households, STs and Muslim households; this was due to the continued access issues, which this population is facing despite of the RSBY coverage hence, authors point out that RSBY has not been effective in enhancing access to hospitalization or utilization of inpatient care. In addition, RSBY coverage had no significant effect on catastrophic hospitalization expenditure. Moreover, about half the households formerly enrolled did not renew enrollment. The author has suggested that instead of the annual renewal, long-term coverage might help decreasing the attrition rate. Moreover, there was a lack of accountability of insurance companies and third party agencies responsible for awareness campaigns. The TPAs get remuneration according to the number of families enrolled, thus there is no motivation to go back and enroll those family members present during the original registration. Family members could also be excluded as the scheme allows maximum of five people per family to be enrolled.

Another study based in Amravati found that the overall enrollment ratio was only 39%, and was worse in remote and backward tribal areas. The fact that the empanelled hospitals were located in district headquarters and larger towns, making them difficult to access, added significantly to the OOP expenditures for those

enrolled and living in remote areas. Even though the scheme was largely used for simple procedures, than for emergency care, yet those who utilized the scheme were only moderately satisfied (Rathi, Mukherji & Sen, 2012).

In 2012, when the Jeevandayee Aarogya Yojana was converted into Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAY) and implemented in Maharashtra, the RSBY was withdrawn across the whole state. The rationale was to avoid duplication as both schemes catered to BPL population, were heavily sponsored by the government and had provision of services by empanelled public and private hospitals. Both schemes were cashless services with use of third party administrators and use of technology for smooth implementation. The RGJAY had the added advantage of a greater package of INR 1.5 lakh per family per annum. However, it is important to point out that both schemes have different focus areas for service provision and different ways of implementation. RSBY covered a wider range of services including secondary level heath care and primary level like normal deliveries, which is not included in RGJAY, a tertiary healthcare oriented scheme. Primary and secondary level health services are more commonly required and withdrawal of RSBY has led to loss of this crucial benefit (Gothoskar, 2014).

RGJAY has adopted its structure from the Aarogyasri of Andhra Pradesh. According to Maharashtra government, RGJAY is an improvement over all other similar schemes. However, there have been some studies that have highlighted crucial flaws in the scheme. A study on out-of-pocket expenditures of households covered under RGJAY, Rent and Ghosh (2015) found that nearly 63% of all studied beneficiaries and 88% of BPL beneficiaries incurred OOP expenditure while availing the scheme. Despite availing the scheme for their treatment, nearly 15% of beneficiary households suffered catastrophic health expenditure due to direct out-of-pocket payments. Out-of-pocket expenditure was two times higher when the scheme was used in private hospitals than public hospitals. This observation is crucial as most enrollees preferred private hospitals. Diagnostics and medicines accounted for maximum OOP expenditure in private hospitals. Overall, the most commonly accessed specialties of cardiac and cardiothoracic surgery, cardiology and nephrology, entailed high out-of-pocket payments. Interestingly, the study also found that orange ration cardholders more commonly used services of private hospitals, while yellow cardholders seem to use the scheme more through public hospitals.

Rationale of the Study

The RGJAY scheme has been functioning in Maharashtra for more than four years now and it is necessary to study it in some detail at this stage particularly as there is not much documented evidence about it. The present study is an attempt to understand the functioning of the scheme on the ground. It looks at its positives and negatives across the board right from key components to implementation, both in the private and public sector. RGJAY has an ambitious objective of catering to the needs of both the BPL and the above poverty line (APL) families, and how far it has able to achieve this target needs to be understood. Additionally, RGJAY has been promoted as a Public Private Partnership (PPP) model. It would be interesting to understand roles of various stakeholders involved and its success as a PPP model. The study also analyzes various aspects of the scheme including hospital empanelment, the bottlenecks and barriers while accessing the scheme. We hope that our objective study of the scheme will prove

[3] This percentage is arrived at by only considering the direct expenditure while taking treatment under RGJAY; however, the expenditure incidence rises if indirect expenditure is considered.

helpful for policies on healthcare financing and provisioning, and provide a critical outlook on the government insurance schemes and their effectiveness in fulfilling their aims and goals.

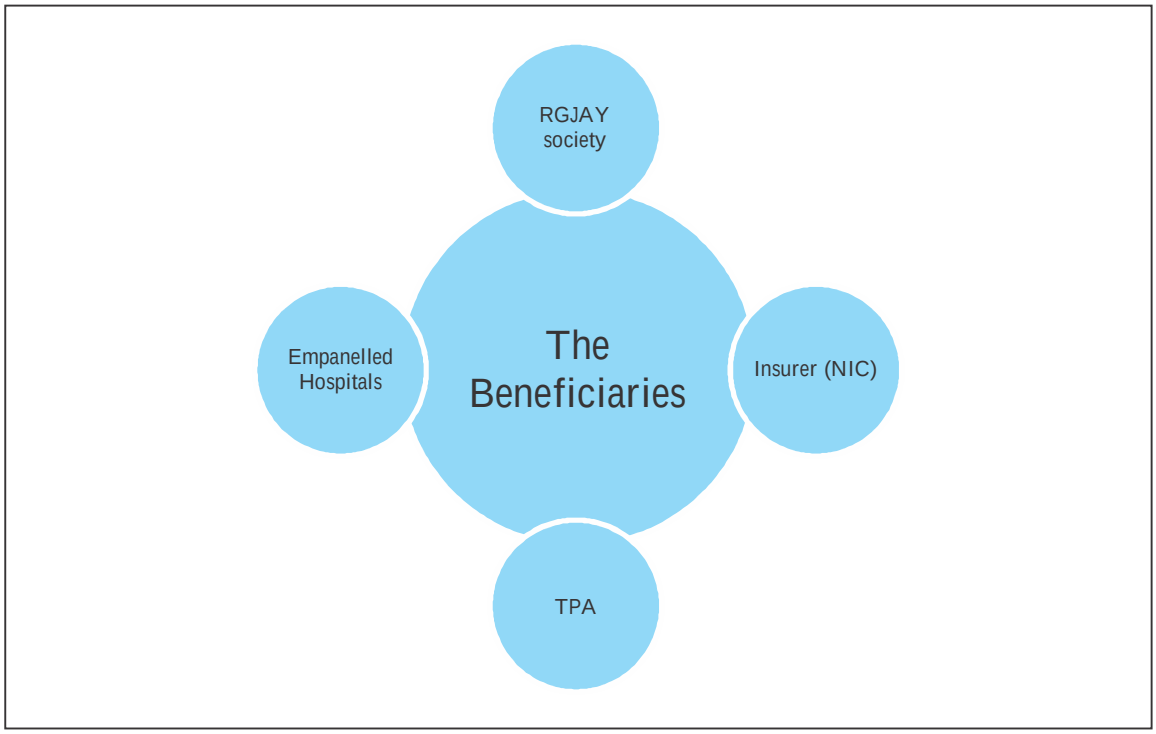
Overview of Rajiv Gandhi Jeevandayee Aarogya Yojana

The State of Maharashtra launched the RGJAY on 2 July 2012 in a phased manner starting with eight districts and after a span of a year; the second phase was launched on 21st November 2013 in rest of the districts.

There were some changes made while rolling out the second phase. There was a change in the total number of medical procedures from 972 to 971. Minimum number of beds required for hospital empanelment was relaxed from 50 to 30. Additionally, minimum beds required for seven specialties was only ten and less than ten. A hospital grading tool based on NABH was introduced as a standard for quality control and package rate decision. In addition, the turn-around-time (TAT), time allowed for completion of preauthorization and claims clearances was increased from 12 hours to 24 hours. The TAT for the claim settlement process was increased from 7 days to 15 days.

The scheme intends to provide assistance to the population with annual income below INR 1lakh. Eligible families are those in the BPL and APL list as per the criteria of the food, civil supplies and consumer protection department[4] (Government of Maharashtra, n.d.). Anthyodaya and Annapurna cardholders are

Figure 1: Important Stakeholders in RGJAY



[4] The targeted public distribution system in Maharashtra follows a tricolour ration card scheme, Yellow card denotes families having annual income up to INR 15,000, AAY card-selected BPL families including agriculture labourers, marginal farmers, rural artisans/ craftsmen such as potters, tanners etc. Orange/ Saffron card denotes families having total annual income of more than INR 15,000 and less than 1 lakh White card denotes the families having annual income of INR 1 lakh or above

also eligible to avail services under the scheme. Smart cards with the photographs of the insured persons are issued to the beneficiaries. Unlike the general health insurance schemes, there is no age limit for enrollments in RGJAY and all pre-existing illnesses are covered from day one onwards.

The RGJAY Society is a government body formed in order to facilitate and implement the scheme. It is headed by the Chief Executive Officer (CEO) who is responsible for conceptualizing, implementing, establishing and monitoring the scheme in accordance with the rules and guidelines. The National Insurance Company (NIC) is the insurance provider and has to ensure that the beneficiaries are enrolled based on the eligibility criteria specified in the scheme. The body which manages the Society is the governing council headed by the Chief Minister. Third Party Administrator (TPA) is the agency to which the insurance company outsource many of its activities. Medical services are delivered through a network of hospitals empanelled under the scheme. The empanelment is done based on prescribed criteria by the empanelment committee. As soon as the insurer gets the contract and they can begin with the enrollment of the beneficiaries in the scheme. NIC also has the responsibility to ensure that enough hospitals are empanelled in the district so that beneficiaries need not travel very far to get the health care services.

A patient can be referred to the scheme through health camps, Primary Health Centers (PHCs) or by the empanelled hospital. At the empanelled hospital, the aarogyamitra[5] (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., a) enrols the patient and once the doctor identifies the patient's eligibility for availing scheme packages, a pre-authorization request is sent to the TPAs. This request is scrutinized along with the documents and approval given in case everything is in order. As soon as the approval is given, patient's treatment takes place. After the treatment, patient can be discharged and a patient satisfaction letter is obtained from the patient. The hospital sends the all documents including personal identification cards and clinical documents to the TPA for reimbursement of claims. An annual premium of Rs 333 per family per year is borne by Government of Maharashtra, along with any administrative and other scheme related cost, is borne by State Government.

Salient Features of RGJAY

a) Total sum insured is INR 1,50,000 per family per annum on a floater basis. An exception for renal transplant has been made where the maximum ceiling is INR 2,50,000.
b) Pre-existing health conditions too are covered. If the beneficiary is suffering from any disease or medical condition prior to the scheme inception are also included in the scheme. Cashless coverage of the pre-decided 971 procedures/surgeries is provided across 30 specialties. Also, 131 out of 971 of these procedures can only be carried out in public hospitals.
c) Provision for a health card, post enrolment, for the purpose of beneficiary identification.
d) The scheme provides for reasonable pre and post-hospitalization expenses for one day prior and five days after hospitalization.
e) Provision for one-way transport allowance.
f) Provision of free medicines and food during the treatment.
g) Patients can avail follow-up services up to 10 days after discharge. In case of procedures where follow-up packages are available, these can be availed by the patients later as per the treatment schedule.

[5] Aarogyamitras are the facilitators recruited by the TPA in the empanelled hospitals in order to ensure performance efficiency and acceptability among local communities.

h) Cashless coverage of 121 listed follow up procedures.
i) The NIC has outsourced services to three IRDA certified TPAS (Third Party Administrators) - MD India, Medi assist, and Paramount.
j) There is a separate space for the RGJAY aarogyamitras allocated in the form of RGJAY counter/ kiosk, which should be located at the entrance of the hospital or besides registration counter.
k) RGJAY kiosk is equipped with a computer with networking, printer, scanner, bar code reader and digital camera in order to carry out all the activities associated with registration, preauthorization and claim settlement.
l) Free Outpatient Department (OPD) consultation for patient seeking RGJAY package.

Chapter 2

Objectives and Methodology

Objectives

As mentioned earlier, the objective of the study is to build evidence on the functionality of a publicly funded health insurance scheme in Maharashtra. It looks at the equity concerns in access, along with understanding the nature of private sector participation in the scheme since it is a PPP model.

Specific Objectives of the Study

1. To understand the service availability and access to medical specialties across Maharashtra under the RGJAY scheme.
2. To understand the process of enrollment & registration and identify access barriers at each level of the scheme.
3. To understand the profile of the beneficiary population as well as their utilization of the scheme.
4. To understand the nature of private sector participation in the scheme.

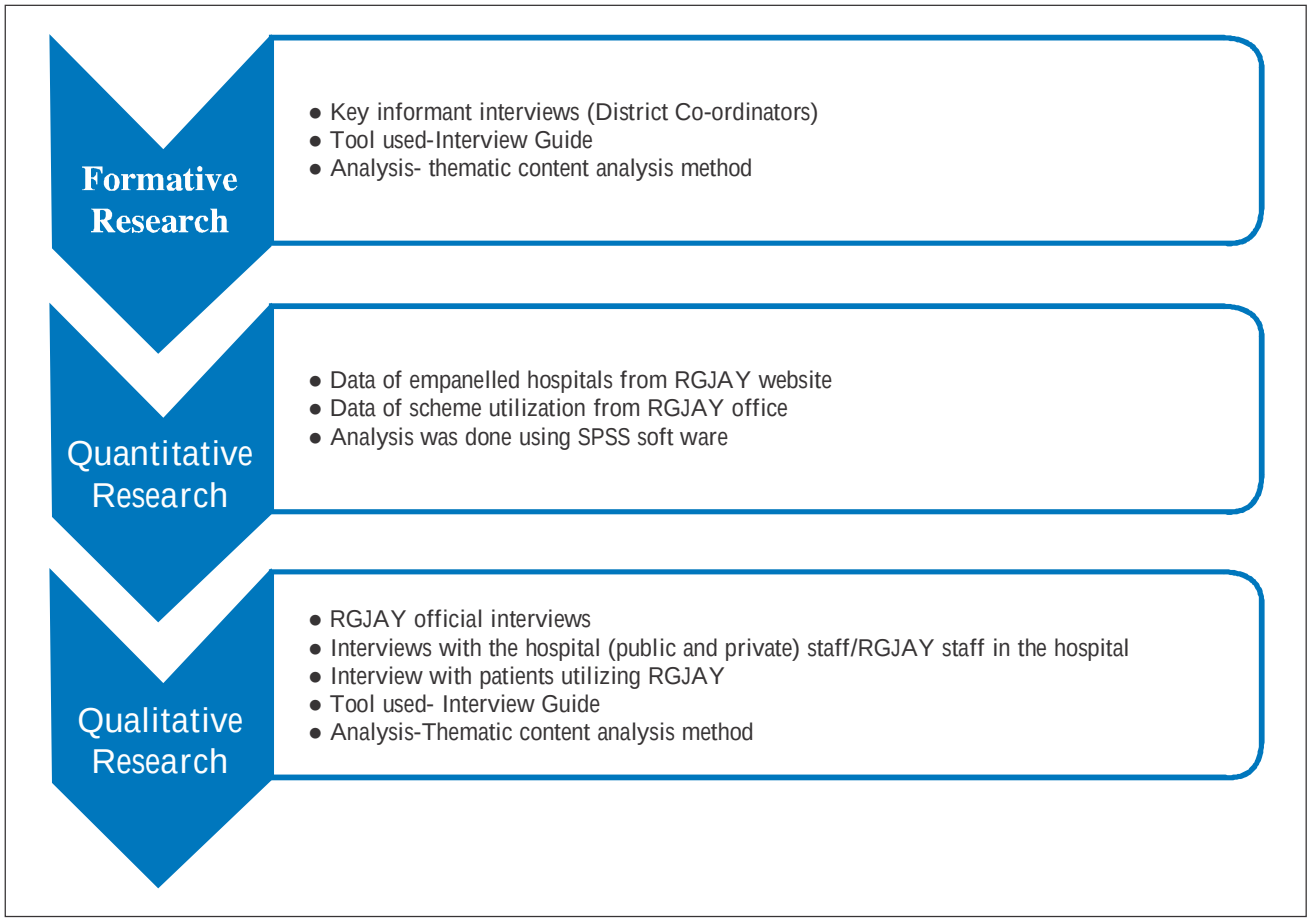
Methodology

We began by doing an extensive literature review (covered under Chapter 1), around the public health insurance schemes in India. This not only provided a background for the study but also helped in formulating the objectives for the present study.

We decided to formulate an exploratory study to understand the RGJAY, its key components, issues and its positives. Using a mix method approach, we tried to obtain a holistic picture of the scheme. The following diagram gives a representation of the methodological aspects incorporated in the study.

The following section describes the application of each of the component of research through the study.

Figure 2: Methodology of the study



Formative Research

Formative research helped us identify the areas of exploration and design a better strategy to study the scheme. It also helped in identifying the relevant stakeholders for interviews. As a part of a formative research strategy, District Coordinators (DCO) were identified as the key informants and in-depth interviews were conducted with three of them from across Maharashtra (urban and rural) in order to understand the ground realities and the intricacies of the scheme.

Qualitative Research

The scheme had four important stakeholders that were a part of the formal structure of the scheme. These are the RGJAY Society, NIC, TPAs and the empanelled hospital. Our interviews with DCOs at the time of formative research helped us short-list the officials to be interviewed from the RGJAY Society and TPAs. It also helped in developing the interview tool for the staff. Interviews thus conducted yielded important information about their systems, mechanism of the processing of preauthorization requests and claims. One public hospital and one private hospital empanelled under the scheme were included from one of the urban districts in the study in order to understand the implementation of the scheme at that end. It also helped to better know the difference in processes in private and public. In both the hospitals, informal interactions were carried out with patients to get some insights.

Accordingly, interviews were conducted over a span of 6 months from June 2014 to December 2014. In all, eight members of RGJAY Society, 4 members of staff of the TPAs, 8 staff members (including

doctors) of empanelled hospitals (public and private) and 8 patients were interviewed.

Quantitative Research

Quantitative data was collected from two sources. The RGJAY website had data on empanelled hospitals and the same was entered into SPSS software for further analysis. The data comprised of variables including the districts, geographical location, type of hospital, the phase of enrollment, the number of specialties etc.

The RGJAY Society also shared files with CEHAT researchers from their database updated until August 2014. This data was in Excel sheets and compiled in different formats. Data files for analysis were then shortlisted and 13 were selected for detailed analysis[6] (refer Annexure I, Table 1).

Data Analysis

Qualitative Analysis

All the interviews were first documented manually, and later on the computer. Thematic content analysis technique was used to arrange the responses according to various themes.

Identification and documentation of various processes from enrollment to claims settlement was done. The roles and responsibilities of various stakeholders were identified and documented, along with barriers, the nature of the PPP, disparities (if any) across the private and public sector, etc. The analysis also documented the nature of implementation of scheme, perception of the hospital staff, scheme staff about the scheme and the implementation process. The content analysis of the data was carried out manually.

Quantitative Data Analysis

The quantitative data was converted from Excel to SPSS format and analysis was carried out.

Ethical Considerations

Informed consent was been obtained from the RGJAY officials, the scheme officials at the empanelled hospitals as well as the patients seeking the treatment through the scheme. The letter of consent included the information about the study with the objectives. Additionally, it also included the right to refusal and confidentiality of the respondents. The names and other identifiers in the research are avoided. The names of the hospitals or officials working with the scheme at various levels are not revealed.

Limitations of the Study

Some of the key senior officials associated with the scheme did not respond to our repeated requests for interviews. We were thus unable to present their perspective. The data obtained from RGJAY was voluminous. However not all of it could be utilized as it lacked many socio-economic indicators necessary for thorough analysis. Analysis of the social class differentials could not be carried out as the secondary

[6] A total of 71 files were shared with the research team by the Society staff. Each file was gauged for its relevance for analysis. The inclusion of different determinants such as age, gender, district, specialty, procedure etc. was checked in each file before it was shortlisted for further analysis. The main file had government as well as private hospitals preauthorization data and therefore no other file subsets needed to be selected. A similar procedure was followed for files having data on claims rejection. In the initial screening about 22 files were selected from the 71 excel files. These 22 files were checked again in order to further filter the most relevant files. Thus, 13 files have been selected which are used in the analysis along with the file of the empanelled hospitals as mentioned above.

data received, did not have the information about caste, which is an important indicator. Further, the raw data related to an actual number of surgeries and procedures done under the scheme and their claim amounts paid was not available.

Additionally, the claims pending and rejection data lacked information about the TPAs and hence the analysis of rejected and pending claims across the TPAs could not be captured. There was no segregated information regarding the amount of premium paid every year and surgeries done and claims paid amount. This made it difficult to calculate the incurred claims ratio according to districts, which is an important indicator in an insurance scheme. The information on human resources, which is based on our interviews on the field and therefore not exhaustive and cannot be considered representative. Despite limitations of data and our own shortcomings, we have made a sincere effort to present a report based on our research to the best of our abilities.

Chapter 3

Findings of the Study: The Empanelled Hospitals

This chapter presents outcomes of the quantitative and qualitative data analysis. The key processes taking place under the RGJAY have been analysed, beginning with empanelment of hospitals.

Empanelment of Hospitals

In order to understand the process of empanelment on the ground, it might first be helpful to understand the process as laid down under the scheme. Empanelment is a process through which hospitals willing to provide medical services under the RGJAY scheme are included in its network of hospitals. The definition of hospital or nursing home under the scheme is, "Any specialty hospital in Maharashtra established for indoor medical care and treatment of disease and injuries and should be registered under Bombay Nursing Home Registration Amendment (2005) Act and Public Hospital" (RGJAY MOU Phase II). The data collected through interviews also covered the process of empanelment of the hospitals, de-empanelment and the monitoring mechanisms.

The Process of Empanelment of the Hospitals

Empanelment of a hospital is a multistage process with scrutiny at various levels and by the officials at Third Party Administrator (TPA), Insurance Company and RGJAY Society. Once the hospital submits a complete online application with all the details, there is Level 1 Non-medical scrutiny of the application by TPA. This is followed by Level 2 technical verification of the application by Insurer/TPA doctors Level 3 technical verification is done by RGJAY Society doctors. This is followed by an audit and a rating is given based on the audit.

It is relevant to understand certain aspects of the NABH Audit. The process mainly looks at quality of the services provided by the hospital. The criteria such as HR quality, facilities management, infection control measures, monitoring medication, maintenance of patient medical records, patient satisfaction indices etc. For reassessment of already empanelled hospitals, quality patient care and performance of scheme indicators are used. There are general criteria for all hospitals and specific criteria for certain specialties like cancer, poly trauma, etc (Annexure I, Table 2).

1. NABH audit (National Accreditation Board for Hospitals) done by Officials from Directorate of Health services & Society
2. Infrastructure Audit by TPA and DCO
3. Grading and scoring by TPA, Society & NIC representative
4. Presenting the hospitals in Empanelment committee (EC)
5. Empanelment committee (EC) decision based on all the reports by field team and application form
6. If hospital is cleared, then Communication to hospital regarding score and grades and a rate list based on the grades.

Once the rate list is accepted by the hospital, a Memorandum of Understanding (MOU) is generated and signed by the Insurer and Hospital. Thereby, the hospital agrees to provide the prescribed services at pre-decided rates under the scheme (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., b). Public Health Facilities and Government Hospitals are automatically empanelled under RGJAY.

RGJAY Phase II MOU prescribes general minimum criteria for the empanelment of hospitals by the Insurer/TPA summarized as below -

1. A general criterion for the minimum bed strength was 50 during the first phase of the scheme. However, it was changed to 30 in the second phase. Exception is given for single specialty hospitals (for seven specialties including ENT, eye, orthopaedic, oncology, prosthesis, paediatric medical management and nephrology) with 10 or less than 10 beds can be empanelled. Out of the total bed strength, 25% beds should be reserved for RGJAY patients.
2. Hospital should be equipped to provide medical and surgical facilities along with round the clock diagnostic services (in-house or outsourced) for inpatients.
3. Additionally the hospital should have a functional Operation Theatre of its own wherever surgical operations are carried out, Intensive Care Unit (ICU) facilities, casualty, Post-operation ward with ventilator, separate Male and Female general wards.
4. Hospital should have round the clock availability of qualified doctors and nursing staff.
5. Hospital should maintain complete records as required under the scheme on day-to-day basis.
6. Hospital should facilitate round the clock Blood Bank and Ambulance services either in-house or outsourced.

There are further criteria laid down for grading the hospital. These include aspects such as location, type of hospital (training or non - training), doctor - patient ratio, nurse to patient ratio, bio - medical waste disposal system, accreditation (NABH, ISO certification, Indian Public Health Standard), etc (Annexure I, Table 3).

The second phase MOU does not clearly mention the TPA's role in the hospital audits for empanelment. However, the MOU puts audit as a joint responsibility of the Empanelment and Disciplinary Committee consisting of the Society and the Insurance Company (NIC) representatives. Therefore, legally, there are no existing guidelines for TPA responsibilities yet. There might be separate contracts between NIC and TPA for the same as many activities are outsourced by NIC to TPAs. Moreover, a training for NABH auditing is conducted which is attended by the DCO as a representative of the Society, DMO (district medical officer) as a representative of the TPA, one from NIC (insurer). Additionally there are representatives from private hospitals, Directorate of Medical Education and Research (DMER) and Municipal Corporation of Greater Mumbai (MCGM). A booster training is conducted for DCO and DMO after which they can undertake audit.

Interviews with various stakeholders i.e. TPA doctors and RGJAY officials about empanelment process not only helped us understand the process better, but it also gave us information about the challenges faced by them while implementing the scheme. These ground realities gave an insight into the gaps in process.

As informed by the officials, at the state level, an empanelment officer is appointed by the RGJAY Society who works with the district coordinators for all empanelment related activities. District coordinators

visit hospitals in their respective districts and ascertain their eligibility for empanelment under the scheme. A database of hospitals is prepared based on this format. They approach the eligible hospitals for empanelment. The hospitals are trained for online application process by district coordinators. The technical issues in the online system are resolved; guidance related to the required documents to be uploaded is also given. Out of the eligible hospitals, a list of priority hospitals is also prepared and presented in front of the empanelment and the disciplinary committee (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., c). A priority hospital as implied by the district coordinators (as it is not official terminology), is a hospital with large bed capacity, offering multispecialty care, providing high-end procedures, etc. As the officer informed, priority hospitals are approached for empanelment with the intention that most of the patients can be accommodated in these hospitals.

In general, the DCOs were of the opinion that the applying the NABH accreditation criteria for audit of posed different challenges for different sectors and regions. As mentioned earlier, accreditation has been introduced so that hospitals can be graded. The grades determine the package rates for the hospitals. Hospitals from rural areas face many problems as they do not have the required number of staff, resources or equipment. Therefore, they end up having lesser package rates that may prove to be a disadvantage for the poor in rural areas.

There was also difficulty faced by hospitals when it came to other aspects of accreditation as well. Thus for instance, we were informed that,

"In the private hospital, you know how much it is difficult to get the qualified nurses. Government hospitals have all qualified nurses so obviously when you use the grading sheet, these hospitals would score more" (District Coordinator).

According to a DCO, most of the private hospitals got low scores due to this type of grading. In such situations, inputs/suggestions are given to the hospitals to work on their weakness to continue being under the scheme. A time span of 6 months is given to them to upgrade. Moreover, one of the DCOs opined, that NABH emphasizes more on the record maintenance, which is not up to date in case of the private hospitals. Government hospitals, on the other hand, generally maintain all the records. This might not only affect the grading of private hospitals, but also give public hospitals an advantage over the private sector. It is important to note here that there is a perception amongst the staff about higher importance given to maintenance of records on the grading scale, which could very well be due to lack of clarity. Thus, a more strategically implemented training could go a long way in simplifying this aspect.

Moreover, there is also a process of addition of specialties. As informed by the RGJAY officials, the empanelled hospitals are encouraged to develop their facilities, such as hospital infrastructure, in such a way to get them in to align with the accreditation norms or to improve the grade. They can also add more specialties, and submit an application for the same. In this process, as in empanelment, is tedious and take long. There are multiple authorities involved. The application goes to the TPA and then to the NIC, causing delays. According to the staff, most of the delay is from the insurance company as there is no uniform mechanism to facilitate the process. As a result, a process that should not take more than 3-4 days actually gets prolonged for months together. This has two important consequences. This can give rise to

[7] The committee is composed of four doctors, two from the Society and two from the Insurance Company.

disinterest amongst service providers. Secondly, it could result in and reflect lack of clarity in general amongst staff across various processes.

Additionally, RGJAY officials shared that there were issues associated with quality of audit and transparency between the TPA and the Society that affected the empanelment process during Phase I. TPAs were involved in the process of hospital empanelment and as pointed out by a scheme officer,

"Some of the hospitals did not have key infrastructure such as functional operation theatres intensive care units (ICU), ventilators, etc; as per the requirement of the scheme. However, this only came to light when the district coordinators did an infrastructure audit. However, when the TPAs had done the infrastructure audit initially, their report showed all these things as available".

Consequently, in phase II, online system of empanelment was introduced. This improved the transparency as details and documents of each hospital could be monitored online by RGJAY and all other stakeholders. There was also a uniform allocation of responsibilities between the RGJAY officials, the TPA and the NIC.

Challenges in Empanelment: Private Hospitals' Resistance to Participate

RGJAY MOU II has set targets for certain districts where minimum 5 or 15 or 20 hospitals have to be empanelled. In many districts, DCOs find it difficult to have hospitals enlisted in the scheme and are unable to meet this target due to the resistance of private hospitals in participating in the scheme.

On the ground, a few of the private hospitals themselves had put in requests for withdrawal from the scheme, leading to their de-empanelment. Most private hospitals are dissatisfied with the package rates offered, thus explaining their resistance to join the scheme and also justifying their withdrawal from the scheme.

As the Medical Coordinator (MCO) of the private hospital under study opined, "We are not satisfied with the package rate. For example, if a normal (non-accredited) hospital does a surgery and 7 star NABH accredited hospital does the same surgery, the rates are bound to be different and this difference should be accepted. If a surgery is rated for INR 40,000/- in a non-accredited hospital then in NABH it will be around INR 47,000/-. There is a difference of about 7 - 8 thousand INR. It is a significant difference. There definitely should be a revision in the package rate. Sometimes the differences can be vast." He added, "Also, if you are asked to do an operation in INR 1.5 lakhs which are actually costing INR 5-6 lakhs, there will be a compromise. Don't you think so?"

The junior MCO at the private hospital added, "The Chemo package under the scheme is INR 5000. However, the latest chemotherapy costs INR 25,000. Doctor says medicines listed under the scheme were ones that used to be given 10 years ago. We do not give these anymore. They are now old medicines".

We were also informed by a DCO, that two empanelled hospitals from one of the districts had voluntarily withdrawn from the scheme, stating that they were not able to fulfil the NABH criteria. While low package rates were not the stated reason for withdrawal of these hospitals, the DCO nevertheless believes it to be so.

Hospitals were also found to be actively avoiding patients that required medical management and therefore longer hospital stay. They preferred cases with surgical intervention as they had a comparatively much shorter hospital stay. Longer hospital stay meant that the patients occupied the hospital bed for longer periods and had to be provided all services free of cost, while package rates offered were not as profitable.

As one of the DCOs shared, "The package covers everything right from the hospital stay to food; specifically in the case of the medical management of patients, it becomes difficult in terms of costs, also as they don't get discharged quickly".

The DCOs reported that they had to convince the private hospitals by trying to entice them with the publicity their hospital would get if they were to be associated with the scheme. They also appealed to the benefits their empanelment would bring to the common man, "Tyana sangitala, ithe empanel vha tumchya hospital chi publicity honar, patient cha fayda honar" (We had to tell these hospitals, get empanelled in the scheme, your hospital will get the publicity, patient will get benefitted) (District Coordinator).

Further, it was observed that, patients from the neighbouring states come for treatment to the larger empanelled private hospitals in Maharashtra. Thus, empanelment for these hospitals meant losing out on paying patients. This aspect too was an important for resistance to empanelment under the scheme. Another consequence experienced on the ground is sourced in the fact that not just BPL families, even APL families are eligible for the scheme. This seriously compromises the income pool for the private doctors. As one of the DCOs shared, "APL, BPL ekatra thevalaa ahe, ithe 90% population poor ahe, and uralele APL madhe ahet, tyamule doctors takrar kartat ki tumhi aamcha source kadhun ghetala mhanun" (Both APL and BPL criteria are covered under the scheme. In villages, more than 90% of the population is poor and remaining is APL so the doctors complain that the scheme has removed our source of income).

Even with respect to large cities like Mumbai, where there are large charitable hospitals, scheme officials shared that they were in talks with charitable hospitals that have been reluctant in participating in the scheme. The hospitals not only find the scheme unsustainable as the package rates offered are lower than rate of treatment; they also assert that under the Bombay Public Trusts Act (1950), charitable hospitals are already required to spend 2% of their profits on treatment for the poor (Banerjee, 2013). However, it has been pointed out that this comes across as a well thought move by the charitable hospitals who want to avoid empanelment (Kurian, 2012). Evidently, it is a challenging task for the DCOs to convince the reluctant private hospitals for empanelment and ensure availability of services.

Monitoring of the Hospitals and Disciplinary Action

RGJAY MOU has specified monitoring mechanisms for the performance of the scheme and for hospitals. Members of the Government of Maharashtra, RGJAY Society and insurance company do review of the scheme implementation and performance. There are monitoring committees at the State level and District level which are supposed to conduct regular review meetings. The district level monitoring committee is chaired by the District Collector and is constituted by various district level officials of the government, RGJAY and insurance companies. Additional Chief Secretary Public Health and Family Welfare and

various state level officials from the government, RGJAY and insurance companies chair the State level monitoring committee. Another form of monitoring mentioned in the MOU is medical audit of the hospitals, which is to be done on periodic basis. During the second phase, 50 aspects were identified as indicators to help with the audit such as human resources, facility management, and infection control, standard operating procedures (SOPs) for various aspects of health services, transparency in pricing, which all the empanelled hospitals should report. This data has to be submitted every month.

Our interviews with RGJAY officials revealed that medical audit includes surprise visits to the hospital by the Society and the insurer representatives. They study the functioning by examining various aspects such as patient grievances reported, or by checking the death rates of the hospital for increase or decrease in trends. The audit is joint responsibility of the Society and NIC. During this audit, the officials talk to the patients and do a random check of the death records. Obtaining data from the private hospitals has been challenging, as submission of data to government is not a part of their routine activity. In the public sector, on the other hand, there are standard data collection and submission formats that have been maintained on a regular basis for the same. Thus, the DCO of RGJAY is now responsible for training private empanelled hospitals in data maintenance and they are required to submit the data in time on a regular basis. From the perspective of RGJAY officials, this was not a great trend. As one RGJAY official said in the interview regarding the ongoing monitoring of empanelled hospitals,

"The problem is, private hospital data is not captured anywhere, it is never reported... that is why this compulsion . Government hospitals usually have to maintain all the data".

As per the RGJAY MOU, when disciplinary action is to be taken against empanelled hospitals including "de-listing" the empanelled hospital in case the RGJAY guidelines are not followed and services or infrastructure are not satisfactory or are below the prescribed standards. The MOU also mentions that if hospitals engage in activities like fraudulent claims, etc; they will be de-listed. These prescribed standards have not been detailed anywhere. However, through our interviews we did manage to get a sense of how the monitoring might be done. After the hospitals are empanelled, the RGJAY Society monitors activities of the hospital. The officials keep track of the number of pre-authorizations sent by the hospitals, number of medical and surgical procedures conducted by them under the scheme, etc. If a hospital does not send enough number of pre-authorizations as per the number of specialties offered, it is termed as 'inactive hospital'[8] by the Society. A show cause notice is sent to such hospitals and district monitoring committee and district grievance redressal committee are informed.

As one of the DCOs explained, "samja jar tumchyakade 1 specialty ahe ani tumhi mahinyache 10 ch patients kele tar te thik ahe, pan jar tumchyakade 20 speciality ahe and tumhi mahinyache 5 patients kelet tar tyana show cause notice deto, nahitar reason dya asa sangato" (Suppose, if the hospital has only one speciality and you bring only 10 patients in a month then it is alright, however if you have 20 specialties and you have only 5 patients in a month then we send show cause notice in such cases).

District coordinators follow up with the respective hospitals and submit a report to the Society. Based on the report, Society decides whether to continue with the hospital or not, whether to send active show cause notice, suspend the hospital, or de-empanel it. The empanelment department in the RGJAY Society

[8] This is the term used by District Coordinators

initiates the process and then forwards it to the District Monitoring committee who takes the final decision. Such a targeted approach towards monitoring could be problematic as it defeats the purpose of monitoring.

Distribution of Empanelled Hospitals across Maharashtra

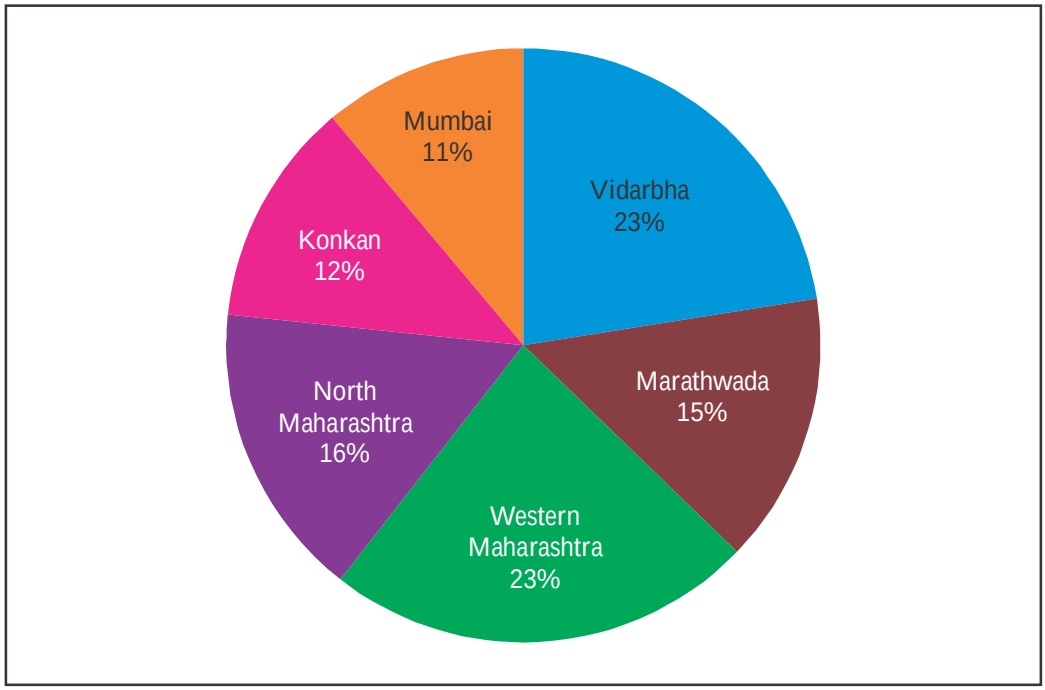
At the time of data entry, there were 473 empanelled hospitals in Maharashtra under the RGJAY scheme, of which 396 were private and 77 were public hospitals (Table 1). A region-wise distribution of the empanelled hospitals shows that 23% (110) of the empanelled hospitals were in western Maharashtra, 23% (107) in Vidharbha and 11% in Mumbai city (51) (Figure 3). Private sector presence of empanelled hospitals is lowest in Mumbai as compared to other regions. This is despite the fact that Mumbai is a hub for medical care and has 79 large multispeciality charitable hospitals.

Table 1: Distribution of Empanelled Hospitals across Regions and Type of Hospital

Region	Public	Private (%)	Total (%)
Vidarbha	19 (17.8%)	88 (82.2%)	107 (100.0%)
Marathwada	11 (15.9%)	58 (84.1%)	69 (100.0%)
Western Maharashtra	10 (9.1%)	100 (90.9%)	110 (100.0%)
North Maharshtra	9 (11.7%)	68 (88.3%)	77 (100.0%)
Konkan	9 (15.3%)	50 (84.7%)	59 (100.0%)
Mumbai	19 (37.3%)	32 (62.7%)	51 (100.0%)
Total	77 (16.3%)	396 (83.7%)	473 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Figure 3: Region wise Distribution of Empanelled Hospitals



(Source: Tables prepared using data obtained from RGJAY Society)

As per the 2011 census, about 55% population in Maharashtra resides in rural areas, so data was analyzed from the perspective of understanding the equitable distribution of health facilities. It was seen that merely 12% of the total empanelled hospitals belonged to the 12 least urbanized districts of Maharashtra including Beed, Bhandara, Gadchiroli, Gondia, Hingoli, Jalna, Nandurbar, Osmanabad, Ratnagiri, Satara, Sindhudurg and Washim put together (Annexure II, Table 1). On the other hand, about 44% of the total empanelled hospitals were concentrated in six urban centers, including Mumbai, Thane, Pune, Nagpur, Nashik, and Aurangabad. Availability of empanelled hospitals was worse in districts with significant tribal population. Thus, for instance, Nandurbar, which has more than 65% ST population, has only one empanelled hospital, which is a public hospital, and no private empanelled hospital. Similarly, Thane rural has about 47% ST population; there is not a single privately empanelled hospital.

This presents a clear picture of the skewed distribution of empanelled hospitals across Maharashtra despite including private hospitals in the scheme. The rural- urban disparity in terms of healthcare infrastructure and services is long-standing. This has to be contextualised to the burgeoning privatization and corporatization of the health care sector in Maharashtra, which has deepened the rural urban gap in terms of concentration of health services in urban areas. In addition, the scheme does not do much in terms on ensuring equitable access to services, especially in favour of the marginalised and difficult to reach areas. Such a sparse distribution of empanelled private services in the rural areas has left the people no choice but to avail services from the insufficiently supported public facilities, or travel long distances to avail these services.

This is the situation despite the fact that the phase II MOU clearly lays down the minimum number of hospitals required to be empanelled in each district. The table below (Table 2.) shows the minimum number of hospitals to be empanelled and those presently empanelled. As eight districts are from Phase I, there were no criteria set for minimum number of hospitals to be empanelled in each of these districts in either of the MOUs.

Table 2: District-wise Distribution of Hospitals against Minimum Criteria and Proportion of Public and Private Hospitals

District	No. of empanelled hospitals	Number of empanelled public hospitals	Number of empanelled private hospitals
Minimum 5 hospitals to be empanelled			
Nandurbar	1	1	0
Beed	3	2	1
Bhandara	4	1	3
Hingoli	4	1	3
Osmanabad	4	1	3
Sindhudurg	4	1	3
Wardha	4	1	3
Gondia	5	2	3
Ratnagiri	5	1	4
Washim	5	1	4

District	No. of empanelled hospitals	Number of empanelled public hospitals	Number of empanelled private hospitals
Buldhana	6	3	3
Jalna	6	1	5
Satara	14	1	13
Yavatmal	8	1	7
Minimum 15 hospitals to be empanelled			
Parbhani	4	1	3
Latur	12	1	11
Chandrapur	9	1	8
Jalgaon	20	1	19
Akola	13	1	12
Sangli	19	1	18
Ahmednagar	25	1	24
Kolhapur	28	1	27
Minimum 20 hospitals to be empanelled			
Aurangabad	25	2	23
Nashik	23	3	20
Pune	33	5	28
Nagpur	37	3	34
Thane	42	5	37
No minimum criteria for hospitals to be empanelled			
Mumbai	51	19	32
Nanded	11	2	9
Amravati	14	4	10
Solapur	16	2	14
Gadchiroli	2	1	1
Dhule	8	3	5
Raigad	8	2	6
Total	473	77	396

(Source: Tables prepared using data obtained from RGJAY Society)

Evidently, from the table above, we find that most districts have fulfilled the set minimum criteria for number of empanelled hospitals in the district. However, when we look closely, it is also evident that the skewed distribution of available empanelled services persists. The idea to make available health services to the most backward districts by collaborating with the private sector does not seem to have worked. Nandurbar, for instance, has only one empanelled hospital. Some of the most backward districts, in fact, are falling short of the minimum criteria. These include Gadchiroli, Nandurbar, Beed, Parbhani, Chandrapur etc. On the other hand, the traditionally well performing districts predictably fare well.

Interestingly through, when we look at the districts that have fulfilled the set minimum criteria, we find that a large majority of the empanelled hospitals are in fact in the private sector. This is despite the reported difficulties faced in empanelling them. Thus, for instance, Jalna (minimum set criteria of 5), has six empanelled hospitals, of which five are in the private sector. Even in case of districts such as Parbhani, Dhule, Raigad, Chandarpur and Nanded; that have a significant shortfall of empanelled services based on the set criteria, it is interesting to note that even here there is a dominant presence of empanelled private hospitals. Thus, Parbhani (minimum criteria of 15) has four empanelled hospitals, of which 3 are in the private sector. Chandrapur with a minimum criterion of 15 has nine empanelled hospitals, of which eight are in the private sector.

Thus, the distribution and availability of services continues to remain skewed despite the RGJAY with the backward districts continuing to be at a disadvantage. Nevertheless, it can be said that the RGJAY scheme seems to have made some inroads into getting on board the private sector to overcome to some extent the shortfall of services in the public sector.

Hospital Empanelment across Phases

Data showed that 363 of 473 hospitals were empanelled in the second phase of the scheme. A phase wise differentiation showed that the proportion of private hospitals empanelled in the second phase was more compared to phase I (Table 3).

Table 3: Type of Hospital According to Phases

	Public (%)	Private (%)	Total (%)
Phase I	33 (30.0%)	77 (70.0%)	110 (100.0%)
Phase II	44 (12.1%)	319 (87.9%)	363 (100.0%)
Total	77(16.3%)	396 (83.7%)	473(100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Of the 110 hospitals from phase I, 51 were empanelled from Mumbai alone. During the second phase, when the number of beds criteria was relaxed from 50 beds to 30 beds and less than 10 beds for single speciality hospitals. This added 189 private hospitals (nearly 43%) to the total empanelled hospitals, which were less than 50 bedded (Annexure II, Table, 2). What the relaxation of norms has led to is making available a large number of single specialty private empanelled hospitals (9.9%) (Annexure II, Table, 3).

Availability of the Hospitals as per the Number of Specialties Provided

As per the MOU, the medical procedures under RGJAY are categorized across 30 different specialties. It is crucial to understand the presence of these specialties across public and private hospitals as well as across the geographical regions. Data was analyzed for the number of specialties the hospitals provided. Data across regions showed that a little over 40% of all empanelled hospitals were providing 11-20 specialties and 29.3% of them were offering 21-30 specialties. It is interesting to note that only three empanelled hospitals offered all 30 specialties (Table 4).

Table 4 : Regionwise Number of Specialties

Number of Specialties	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Single speciality	8 (7.5%)	6 (8.7%)	10 (9.1%)	5 (6.5%)	4 (6.8%)	14 (27.5%)	47 (9.9%)
2-10 specialties	36 (33.6%)	12 (17.4%)	20 (18.2%)	13 (16.9%)	8 (13.6%)	6 (11.8%)	95 (20.1%)
11-20 specialties	39 (36.4%)	37 (53.6%)	48 (43.6%)	45 (58.4%)	15 (25.4%)	6 (11.8%)	190 (40.2%)
21-30 specialties	24 (22.4%)	14 (20.3%)	32 (29.1%)	14 (18.2%)	32 (54.2%)	25 (49.0%)	141 (29.8%)
Total	107 (100.0%)	69 (100.0%)	110 (100.0%)	77 (100.0%)	59 (100.0%)	51 (100.0%)	473 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Moreover, the public hospitals empanelled are largely medical colleges and district hospitals. This analysis helps us to understand that there is a huge gap in terms of availability of a wider range of specialties that both the public empanelled hospitals and private empanelled hospitals, put together, cannot presently address. This highlights the inequitable availability of these services.

Availability of the Hospitals as per the Medical Specialty

Going into further details, the top five specialties (Table 5) extensively available in the empanelled hospitals were general surgery (75%), infectious diseases (70%), critical care (74%), orthopaedic (69%), and pulmonology (62.6%). Public sector share of super specialties like medical oncology, cardiology, cardiothoracic surgery was 5.9%, 7.2% and 4.7% respectively while their share in private sector was 23.3%, 37% and 19.7% respectively. Specialties such as radiation oncology were available only in 9% of the hospitals & interventional oncology in 15% of all the empanelled hospitals. It is interesting to note that Burns as a specialty is available more commonly in the public sector empanelled hospitals. Thus, 66 of the 77 publicly empanelled hospitals offer burns as a specialty as against only 89 of the 396 hospitals in the private sector. Other specialties such as radiation oncology and intervention oncology are in general sparsely available across all empanelled hospitals. Interestingly, all three of these require long term or repeated hospitalization. In general, it can be said that due to the random availability of specialties across sectors and hospitals, accessibility of insured services to become random.

Table 5: Availability of Specialty across the Providers

	Specialty	Availability empanelled hospitals (N = 473)	Availability in Public hospitals (N = 473)	Availability in Private hospitals (N = 473)
1	Medical oncology	138 (29.2%)	28 (5.9%)	110 (23.3%)
2	Pulmonology	296 (62.6%)	62 (13.1%)	234 (49.5%)
3	Dermatology	294 (62.2%)	61 (12.9%)	233 (49.3%)
4	Rheumatology	193 (40.8%)	53 (11.2%)	140 (29.6%)
5	Endocrinology	249 (52.6%)	38 (8.0%)	211 (44.6%)
6	Gastroenterology	270 (57.1%)	53 (11.2%)	217 (45.9%)
7	General Medicine	289 (61.1%)	70 (14.8%)	219 (46.3%)
8	Radiation Oncology	44 (9.3%)	10 (2.1%)	34 (7.2%)
9	Critical care	350 (74.0%)	71 (15.0%)	279 (59.0%)
10	Cardiac and Cardio thoracic surgery	115 (24.3%)	22 (4.7%)	93 (19.7%)
11	Paediatric medical management	243 (51.4%)	64 (13.5%)	179 (37.8%)
12	Infectious diseases	331 (70.0%)	66 (14.0%)	265 (56.0%)
13	Cardiology	209 (44.2%)	34 (7.2%)	175 (37.0%)
14	Nephrology	222 (46.9%)	60 (12.7%)	162 (34.2%)
15	Neurology	209 (44.2%)	42 (8.9%)	167 (35.3%)
16	Intervention Radiology	69 (14.6%)	21 (4.4%)	48 (10.1%)
17	General Surgery	355 (75.1%)	69 (14.6%)	286 (60.5%)
18	Neurosurgery	242 (51.2%)	38 (8.0%)	204 (43.1%)
19	Surgical Oncology	213 (45.0%)	44 (9.3%)	169 (35.7%)
20	Plastic surgery	213 (45.0%)	36 (7.6%)	177 (37.4%)
21	Burns	155 (32.8%)	66 (14.0%)	89 (18.8%)
22	Poly Trauma	242 (51.2%)	42 (8.9%)	200 (42.3%)
23	Prosthesis	210 (44.4%)	44 (9.3%)	166 (35.1%)
24	ENT surgery	259 (54.8%)	63 (13.3%)	196 (41.4%)
25	Ophthalmology surgery	190 (40.2%)	57 (12.1%)	133 (28.1%)
26	Surgical Gastroenterology	275 (58.1%)	54 (11.4%)	221 (46.7%)
27	Paediatric surgery	185 (39.1%)	36 (7.6%)	149 (31.5%)
28	Genitourinary	269 (56.9%)	43 (9.1%)	226 (47.8%)
29	Gynaecology & Obstetric surgery	300 (63.4%)	67 (14.2%)	233 (49.3%)
30	Orthopaedic surgery & procedures	327 (69.1%)	66 (14.0%)	261 (55.2%)
	Total	473 (100.0%)	77 (16.3%)	396 (83.7%)

(Source: Tables prepared using data obtained from RGJAY Society)

Moreover, with a dismal non-availability of critical specialties in the public sector, we looked at their distribution across districts in the private sector. Apart from the four specialties, including critical care, general surgery, obstetric surgery, orthopaedic surgery, rest of 26 specialties showed a consistent non-availability in one or more districts (Table 6). The super specialties such as medical oncology, radiation oncology, and intervention radiology show huge disparity across the tribal and least urbanized districts. Other important specialties such as nephrology, burns, and cardiothoracic surgery were absent in almost one-third of the districts of Maharashtra. Thus, making available high cost specialties as insured services despite collaborating with the private sector has thus far not proved very successful.

Table 6: Non-availability of Specialties in the Private Hospitals across Districts

	Speciality	Not available in the empanelled private hospitals	Number
1	Medical oncology	Beed, Buldhana, Chandrapur, Gadchiroli, Gondia, Hingoli, Nanded, Osmanabad, Parbhani, Sindhudurg, Washim, Yavatmal.	12
2	Pulmonology	Gadchiroli	1
3	Dermatology	Gadchiroli, Sindhudurg	2
4	Rheumatology	Amravati, Buldhana, Dhule, Gadchiroli, Jalna, Osmanabad, Raigad	7
5	Endocrinology	Amravati, Dhule, Gadchiroli, Raigad, Sindhudurg	5
6	Gastroenterology	Gadchiroli	1
7	Intervention radiology	Beed, Bhandara, Buldhana, Chandrapur, Gadchiroli, Gondia, Hingoli, Jalna, Latur, Nashik, Osmanabad, Parbhani, Ratnagiri, Satara, Sindhudurg, Washim, Yavatmal	17
8	General medicine	Amravati, Dhule, Gadchiroli	3
9	Radiation Oncology	Beed, Bhandara, Buldhana, Dhule, Chandrapur, Gadchiroli, Gondia, Hingoli, Jalgaon, Jalna, Nanded, Osmanabad, Parbhani, Raigad , sindhudurg, Washim	16
10	Infectious diseases	Beed	1
11	Paediatric medical management	Beed, Gadchiroli, Osmanabad	3
12	Cardiology	Beed, Bhandara, Gadchiroli, Sindhudurg, Washim	5
13	Nephrology	Beed, Bhandara, Buldhana, Chandrapur, Gadchiroli, Jalna, Osmanabad, Sindhudurg, Washim	9
14	Neurology	Beed, Jalna, Gadchiroli, Osmanabad, Ratnagiri, Sindhudurg, Yavatmal	7
15	Neurosurgery	Beed, Gadchiroli, Parbhani, Sindhudurg, Washim	5
16	Surgical oncology	Beed, Buldhana, Gadchiroli, Hingoli, Washim, Yavatmal	6
17	Plastic surgery	Beed, Gadchiroli, Osmanabad, Parbhani, Sindhudurg, Washim, Yavatmal	7

	Speciality	Not available in the empanelled private hospitals	Number
18	Burns	Beed, Buldhana, Gadchiroli, Jalna, Latur, Osmanabad, Parbhani, Ratnagiri, Satara, Sindhudurg, Washim, Yavatmal	12
19	Poly trauma	Beed, Parbhani, Sindhudurg, Washim	4
20	Prosthesis	Beed, Buldhana, Gadchiroli, Sindhudurg, Washim	5
21	ENT surgery	Beed, Osmanabad, Sindhudurg, Washim	4
22	Opthalmology surgery	Bhandara, Buldhana, Osmanabad, Parbhani, Sindhudurg, Washim, Yavatmal	7
23	Surgical Gastroenterology	Gadchiroli	1
24	Cardiac and Cardiothoracic surgery	Beed, Buldhana, Chandrapur, Gadchiroli, Gondia, Hingoli, Jalna, Osmanabad, Parbhani, Sindhudurg, Washim, Yavatmal	12
25	Paediatric surgery	Beed, Gadchiroli, Osmananbad, Ratnagiri, Washim	5
26	Genitourinary system	Gadchiroli, Washim	2

(Source: Tables prepared using data obtained from RGJAY Society)

In most districts, there are very few public hospitals with the capacity to provide tertiary medical care. Additionally, these public hospitals themselves may not by capable providing certain super-specialties like medical oncology, etc. Hence, private hospitals are empanelled to fill this gap in access to hospitalization. However, as seen from the above table and discussion, many common specialties are not available even in private sector in certain districts like Beed, Gadchiroli, etc. In such a situation, the patients have to migrate to higher urban centers such as Mumbai, Nagpur or Pune for treatment under the scheme. If such patients go to public hospitals in these urban centers, the public hospitals get considerably overburdened, leading to further delay in treatment for beneficiaries and public at large. Moreover, it needs to be stated here that the public health infrastructure being anyways limited, what the RGJAY has done is that it has ended up further reducing the options available for the poor (as they would want to choose to go only to an empanelled facility) and overburdening the tertiary level public sector in general. For such a policy to be successful and serve the purpose, it was meant for, improving public health facilities and reigning in the private sector is a critical first step.

Availability of Beds under Empanelled Hospitals

The RGJAY Society officials shared data on bed strength. For 30 hospitals, data was missing; therefore, analysis was done for 443 hospitals.

Bed strength of empanelled hospitals under the RGJAY ranged from single bedded hospital up to hospitals with 1800 beds. About 31% of the hospitals had bed strength in the range of 100 -500 + and about 2% were 1-10 bedded.

It is interesting to note that private sector presence in terms of empanelled hospitals actually decreases with increase in bed strength, a space that is then taken over by the public hospitals. Thus maximum private sector participation is in the 30 - 50 bed category while in the 100 - 500 bed category it falls to less than 20%. This clearly supports the argument presented earlier that larger corporate hospitals are

reluctant to participate in the scheme. In the public sector, 87% of hospitals were 100-500+ bedded and remaining are 70-100 bedded category. More than 50% (246/443) hospitals had beds strength ranging from 1-70 and all belonged to the private sector (Annexure II, Table, 2).

Table 7: Availability of Beds across Regions

Number of beds	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
less than 10 beds	1 (1.0%)	1 (1.5%)	1 (0.9%)	2 (2.8%)	1 (1.8%)	4 (8.9%)	10 (2.3%)
10-30 beds	21 (21.2%)	10 (15.2%)	9 (8.4%)	11 (15.5%)	9 (16.4%)	7 (15.6%)	67 (15.1%)
> 30-50 beds	29 (29.3%)	17 (25.8%)	29 (27.1%)	16 (22.5%)	18 (32.7%)	3 (6.7%)	112 (25.3%)
> 50-70 beds	11 (11.1%)	13 (19.7%)	19 (17.8%)	8 (11.3%)	2 (3.6%)	4 (8.9%)	57 (12.9%)
> 70-100 beds	13 (13.1%)	9 (13.6%)	15 (14.0%)	15 (21.1%)	6 (10.9%)	4 (8.9%)	62 (14.0%)
> 100 to 500 beds	24 (24.2%)	16 (24.2%)	34 (31.8%)	19 (26.8%)	19 (34.5%)	23 (51.1%)	135 (30.5%)
Total	99 (100.0%)	66 (100.0%)	107 (100.0%)	71 (100.0%)	55 (100.0%)	45 (100.0%)	443 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Region wise bed strength showed that Vidharbha, Marathwada had most hospitals with 30-50 beds, however, maximum hospitals in Western Maharashtra, North Maharashtra, Mumbai and Konkan had 100 -500+ bed strength (Table 7). More than 50% (246/443) hospitals had beds strength ranging from 1-70 and all belonged to the private sector (Annexure II, Table 2).

Availability of Human Resources

A hospital implementing the RGJAY scheme has to assign staff to cater to eligible patients and carry out the procedures as laid down. Our interviews with both public and private hospital staff revealed significant differences in their approaches and implementation when it comes to staff assignment for the scheme.

"We have around 150 (for RGJAY) data entry operators as clerks for admission, billing, in ward, technicians, etc.; and camp coordinators, organizers and other executives" (MCO, private hospital).

The private hospital had about 150 personnel to run and manage the scheme. This is over and above the RGJAY Society staff itself. There are staffs such as an assistant MCO, assistant Medical Camp Coordinator (MCCO); that are independently employed by the hospital for the purpose of implementation of the scheme. It is possible that private hospitals see profit in numbers (as we had found earlier that they do not

find package rates under the scheme adequate), and therefore employ additional staff in order to enrol and get more patients. This theory is reinforced by the fact they also conduct many health camps as described in the following section.

The public hospital, on the other hand had just three people the data entry operator, the aarogyamitra and a MCO looking after RGJAY. Doctors from public hospitals reported that they are overburdened, as they have to now additionally handle RGJAY work such as preauthorizations and paper work for every procedure done under RGJAY, along with their regular OPD duties.

As MCO from a public hospital shared, "Yes, the pressure is too much. Time is a major constraint; I am not able to devote enough time for RGJAY. It has been 5 days that our kiosk is non-functional and there is a lot of work. I give first priority to the hospital as I am their employee and then RGJAY".

Moreover, we were informed that senior doctors were not keen to be a part of the scheme. They feel this is additional responsibility and have a general aversion towards the additional paper work and procedures to be followed. They shared, "Amhala ya scheme cha kay fayda ahe, scheme che paise government la milnar pan tras amhala" (We have no benefit from the scheme, money (reimbursement) from the scheme will go to the government but trouble (workload and responsibility) will come to us).

Lack of available and specialized dedicated staff for RGJAY duties obviously adds to the work pressures in an already overburdened public hospital. This can directly impact enrollment of patients and using the benefits under the scheme.

TPA Existence

There are three TPAs appointed by the RGJAY Society, MD India, Mediassist and Paramount, of which MD India has most of the patient coverage (77.8%) (Table 8).

Table 8: Preauthorizations raised across the three TPAs

TPA	Frequency
MDIndia	241440 (77.8%)
Mediassist	39570 (12.8%)
Paramount	29292 (9.4%)
Total	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

A region-wide data shows that (Annexure II, Table 4) MD India spans across Mumbai, Western Maharashtra, and Marathwada, Whereas Mediassist has a stronger presence in North Maharashtra (70%) and Paramount in Konkan (59%).

Chapter 4

Findings of the Study: The Beneficiary Population

The RGJAY MOU lays down a very streamlined process of patient registration under the scheme. However, fieldwork showed several departures from what is laid down along with several lapses. Before we begin this section, it is important to highlight here that the total number of eligible families in Maharashtra as on 2013 were 2, 07, 94,294 [9]. However, as per the information on the RGJAY website on August 2014, number of families enrolled under the scheme was merely 5, 09,971 (RGJAY, 2014). Thus only 2.45% of eligible families had until then been enrolled under the scheme. Based on our field interviews and quantitative analysis, it is evident that the various lapses or departures in the implementation of the scheme could have significantly contributed to the dismal enrollment.

Awareness Activities under the Scheme

Awareness becomes an important determinant of utilization of any scheme. The present section lays down various ways in which the beneficiary population becomes aware of the scheme. The responsibility of publicity of the scheme is with the insurer and TPAs in consultation with RGJAY Society. The RGJAY MOU states that publicity should be done through electronic and print media, distribution of brochures to potential beneficiaries, display boards etc.; in public places. Further, it states that the insurer should effectively use the services of aarogyamitras and District Co-ordinators. It outlines the beneficiary patient flow through four ways - referrals from public hospitals like PHCs, rural hospitals, etc.; health camps; accident sites and patients coming directly to hospitals.

When beneficiary families approach public facilities like PHCs or sub district hospitals, etc. Aarogyamitras appointed by RGJAY Society play an important role, as they are the first point of contact for beneficiaries in the empanelled hospital. They are responsible for facilitating admission, treatment, follow-up and cashless transaction of the beneficiary (RGJAY MOU). If the facility is non-network government health facility, then the patient is given a referral card with preliminary diagnosis to a empanelled hospital. The patients may also be referred from health camps being conducted by the empanelled hospital in villages. The information on outpatient and referred cases from these public health centers and the health camps has to be collected from all aarogyamitras/hospitals on regular basis. This data has to be captured in the dedicated database through a well-established call center as per the RGJAY User manual.

PHCs and Community Health Center (CHCs) were important contributors for awareness generation and referrals to higher centers in the first phase. All PHCs were required to have RGJAY Help Desk (which was given away with in the second phase) with aarogyamitras posted there and Health camps would be conducted there periodically. In the second phase, IEC activities were expanded to include advertisements on radio and TV as well as on government transport.

[9] The figure was arrived at by adding the number of district wise eligible families put in the RGJAY MOU I and MOU II.

The present study showed that there were no specific IEC activities planned apart from the weekly health camps conducted during the first phase, banners and print media activities. From our interviews, we ascertained that the role of PHCs in IEC had diminished. There were no aarogyamitras at PHCs anymore. On probing, we found that this was a cost cutting measure and that there was not much work for aarogyamitras at these centers except for helping in camps and follow-up of patients. Banners in the hospital premises, were the only source of information inside the hospital apart from the kiosk and the scheme staff.

Role of Health Camps in Awareness Activities

Organizing health camps was one of the obvious strategies for awareness generation. According to what has been prescribed, these are to be organized in each district for identifying beneficiaries and for generating awareness about the scheme and its procedures. The RGJAY, Insurer and TPAs coordinate to set up health camps. Insurer or TPA is responsible for ensuring that minimum one free camp per 15 days per empanelled hospital. District officials of the government and officials of the insurance company decide the venue. Empanelled hospitals are the ones that actually conduct the camp. Publicity of the camp is to be done through pamphlet distribution, public address system, advertisements in newspapers, in village meetings etc. Staffs are trained to identify beneficiaries under RGJAY. Along with identifying cases, the medical camp will also provide consultation and treatment for common ailments not covered under the scheme. Identified patients are given a referral card to a specific empanelled hospital. The RGJAY Society is required to provide guidelines, technical and financial assistance for the camps and monitor their activities. Role of TPAs is to co-ordinate with all the stakeholders, organize the health camps and monitor IEC activities. TPAs also have to conduct training sessions with medical officers and paramedical staff for screening of patients as per the RGJAY Health Camp Policy.

In this context, qualitative interviews gave important insights into the process of organizing health camps and its regularity. As told by the RGJAY officials, all the hospitals have to give tentative dates for health camps for the upcoming months to the DCO. The DCO then checks and assigns venues to each hospital based on specific criteria. We also found that the determinants for conducting a camp included aspects such population covered in the past camps, potential beneficiaries in that area etc. This information package is forwarded to the District Health Officer (DHO), who takes the final decision. In case of unavailability of the venue, lack of infrastructure camp is conducted in the PHC.

As per the Phase II policy document, only two health camps should be conducted in a month (instead of the earlier stipulated four camps). The RGJAY Society pays INR 5000 per camp to the empanelled hospital. TPA/Insurer is the responsible body for arranging the camps as mentioned in the MOU, which means the IEC responsibility associated with the health camps etc. lies with the TPA. The health camp policy document (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., d) available on the scheme's website, mentions a comprehensive list of responsibilities of the TPAs which include meeting with NGOs, civil surgeons etc to arrange the camps, mechanism to ensure the camps etc. Now, the cost of any form of publicity should be borne by the insurer. The interest of TPAs and insurers usually lies in lowering costs and pay-outs in claims to achieve maximum profit from the premium received. The lower level of awareness activities might be associated with this cost factor and lack of interest, hence, TPAs may want to lessen the expenditure by lowering the IEC activities.

One of the TPAs shared,
"Abhi kahin pe intense heat, ya kahin bhari barish ho to boss health camp mein koi nahi aayega" (Where there is intense heat or somewhere there may be heavy rains, so no one will come for the camp). He also shared that as conducting health camps was mandatory for the empanelled hospitals, the hospitals which cannot conduct the camps have to submit a justification letter.

When probed further he said,
"There is no consequence for (disciplinary action against) the empanelled hospital. We can't do anything or impose any restriction. Many hospitals haven't conducted health camps. No action was taken. Warning kind of thing, so vaisa hai…going on…shayad we are coming up with some restrictions. We have shared data with Society, but Society overnight toh decision nahi de sakti" (Warning kind of thing, it is like that…going on…maybe we are coming up with some restrictions. We have shared data with Society, but Society cannot give decision overnight).

Additionally, an aarogyamitra from an empanelled public hospital informed, "Till now (i.e. in two years) we have not conducted a single health camp, some time back there was a discussion about arranging one, but it did not happen".

Awareness Campaigns and the Role of the Empanelled Hospitals

There are no clear guidelines in the MOU to ensure that health camps are regularly conducted. Besides being completely unaware about the scheme, poor awareness efforts also mean that the beneficiaries do not have complete information about the scheme. This is true even for cities like Mumbai, which besides having a number of hospitals that are empanelled also was part of the phase I of the project, thus in that sense has it has had more time for awareness activities and one would expect the beneficiaries to be better informed. However, as the below case depicts, the patient was unaware of the presence of the scheme in his vicinity and travelled all the way from his place of residence to a hospital which he thought was the only hospital one providing the speciality relevant to his needs.

Poor Awareness Even in the City of Mumbai

Case Study 1: KD was a 65-year-old male from the central Mumbai who was waiting for the OPD check-up under the RGJAY scheme. The hospital's health camp was conducted in his area. He was then told to visit the hospital to consult with a specialist. KD was accompanied by his wife and was sitting in the overcrowded OPD since morning. He shared that as there was no fixed timing for the consultant, they were asked to come in the morning. We probed for his particular selection of the hospital, as there were other large empanelled multi - speciality hospitals closer to home. He looked surprised and said "hame to pata nahi hai kaunse hospital main ye service milati hai, hume laga ke heart problem ke liye isi hospital main aana padega." (We had no idea/clue that which hospitals in our area provide the services related to health specialty, we thought since it is related to hearty speciality; it is only provided by this hospital).

Source: Patient interview, Private hospital

Mumbai being the phase I district the level of awareness amongst the people was expected to be more, which as seen above, is not the case. Beneficiaries are not adequately informed about what they are entitled under the scheme, the facilities that they can access within their districts and across the state. One

wonders if such is the state in Mumbai what might be the level of awareness in other places particularly in the rural or difficult to access areas. Moreover, we also found people coming from other districts whilst we were at this hospital for our study. Some had even brought their luggage with them to the hospital. The fact that they had nowhere to stay in the city complicated the matter further besides increasing their out of pocket expenses.

This narration, throws light on the quality of health camps conducted by the hospital under the scheme. Furthermore, one cannot help but question the clearly biased information shared during the health camp conducted by the private hospital. The patient was directed to come to that particular hospital as against being given a list of hospitals that he could choose to access under the scheme. This reinforces our observation earlier, that private hospitals see profit in numbers and have a large staff recruited for the specific purpose of undertaking the scheme activities that obviously include awareness and enrollment. Interestingly, we also found that the private hospital under study was conducting about 70-80 camps in a month. The MCCO employed by the private hospital revealed,

"We on our expenses (as in the private hospitals) conduct 70-80 camps. From these camps, we (private hospitals) do not gain anything. It's like marketing for the hospital. That becomes a part of the marketing, conducting camps, TV advertisement, paper advertisement and we have some political contacts, we have tie-ups with social workers, we know NGOs. They know that such and such (some key) people work here so they tie us up with them. Social workers, political leaders, MLAs, MPs, NGOs, different political parties".

During the course of our study, we also observed that in advertisements and promotion activities on radio by private hospitals, what is predominantly highlighted is the fact that the patients can avail free services at the private hospital. The information that these services are available free as a result of the said hospital being empanelled under the RGJAY scheme and other aspects of the scheme seems to be overshadowed or sidelined. Thus, for instance, we observed that in hoardings, RGJAY appeared in small letters that too towards the end.

Thus, it is clear from the above discussion that the approach and attitude towards conducting awareness camps is strikingly different in the public sector and private sector. The private hospitals modify the mechanisms and use them for their own benefit. Some of the private hospitals used health camps as an instrument to advertise their hospital using the scheme benefits to attract more patients. Health camps seem to have become an important mode of self-promotion through advertising and marketing for private hospital under the garb of the scheme. In contrast, the apparent lack of interest of public hospital in conducting health camps suggests their avoidance of such tasks on the grounds of overburdening and avoiding additional responsibilities.

On probing, we found that not only was there poor reporting about health camp activities, but also where there has been reporting, no action was taken. Thus, indicating poor monitoring by the RGJAY Society and TPA/Insurer. Barriers created by lack of correct and relevant information accompanied by poor monitoring can be crippling for the entire RGJAY scheme, defeating its very purpose of reaching out to the poor and inaccessible in order to reduce their financial burden due to health expenses.

The Inpatient Ward as Point of Referral to the Scheme

In our effort to understand the poor enrollment under the scheme and the implementation of the scheme in general, we decided to look at referrals to the scheme from within a hospital. Through our interviews with doctors and the program officers, we found that many patients come to know about the scheme once in the in-patient ward after being admitted in the hospital (both in public and private hospitals).

"Doctors tell them. Or other patients in the ward tell them" (Aarogyamitra, Public hospital).

"What I see here in the district is that after the patients are admitted by the doctor, aarogyamitra's go for ward visits and then identify the patients for the scheme" (Ex Program officer, RGJAY).

A patient may also be informed about the scheme by a fellow patient in the ward or a treating doctor. Even at private hospitals we found that the treating doctor when he/she realizes that the patient does not have capacity to pay, informs them about the scheme. The patient cases below depict that patient becomes aware about the presence of the RGJAY after getting admitted in the hospital from the treating doctor or other admitted patients.

Referrals from the Inpatient Deparment

Case Study 2: BC was a male admitted in the IPD of the hospital. While he was making some wooden toy for his kid, he cut his hand with a saw. After he was admitted, the doctor informed his relatives about the scheme. He was then enrolled. When we had met him, his preauthorization had also been approved and he was then waiting for the doctor to schedule his surgery.

Case study 3: MA was a 50-year-old male from a slum near a public hospital. He met with an accident with a rickshaw and had to be admitted. They learned about the scheme from a fellow patient's relative who informed them about the scheme and the registration process. The doctor had told MA's wife that the total cost of the treatment would be around 5000 INR. The cost made her think that it would be better to enroll in the scheme. They had a yellow ration card. We had met her when she had come to register her husband at the kiosk. The details of the documents were given to her on the previous day by the aarogyamitra, who also gave her the form for enrollment.

She shared that she had found it difficult to locate the kiosk in the hospital, as she exclaimed,

"Kitna dundha maine, ye hospital main, kaha hai pata nahi chalata, to inko maine bola aap mere saath aao aur muze dikhao". [How much I looked in the hospital, could not find where it was. So I told her (another patient) to come with me and show me].

Case study 4: PD was a 48-year-old lady from Mumbai admitted in the female IPD. She worked as a maid in several households and lived with her 22-year-old son. PD's son was mentally challenged and was working as a peon with a small company. PD fell down while climbing onto a bus. Her neighbours brought her to the hospital. She had a head injury and a hipbone fracture. She had to get some investigations done such as X-rays and CT scan. PD's brother came later after PD was admitted and was not aware of the exact number of tests done or the cost for the same. Two days after PD's admission, the treating doctor informed them about the scheme after confirming about the yellow

ration card. Doctor had not given any prior intimation of the cost of the operation, nor of medicines or tests. Her brother did the paperwork necessary for the scheme. He had all the necessary documents as informed to him by the aarogyamitra; it took about 15-20 minutes for the enrollment of the patient.

Source: Patient interview, Public hospital

Interestingly, our interviews in the field revealed that referrals to the scheme varied by medical specialties. The public hospital we had included in our study offered 21 specialties under the scheme. However, we found that more than 80% preauthorization requests were raised from just from the orthopaedic department. The reason being that most of these cases referred from orthopaedic department undergo procedures that require surgical implants and patients have to pay a large sum for the same. The staffs therefore find it wise to enroll the patient under the scheme and offer the service. The MCO reported that indeed the doctors do not refer patients uniformly to avail the scheme, as they feel that treatment for most procedures is already provided at a low-price in public facilities[10].

Another reason could also be the lack of comprehensive information and training amongst doctors in general is made worse by their high turnover. As per the RGJAY MOU training of the hospital staff comes under the section of capacity building which is yet again the responsibility of the insurer. However, as an MCO shared, RGJAY is not on any hospitals list of priorities. It is evident from the MCO interview, that the efforts taken by the TPA in order to sustain the interest and spread awareness amongst these doctors are insufficient which adds on to the doctors' apathy towards the scheme. The situation gets worse when RGJAY does not get prioritized for discussion even in meetings.

As explained by the Medical officer,
"The problem is doctors get changed every 6 months to 1 year. It is not possible to train every now & then. So usually, it happens that the old doctors (the ones who have continued service in the public hospital) train the new ones. Rarely does it happen that there is any meeting and we talk on RGJAY for 5-10 minutes".

Doctors also reported that there was enormous paperwork associated with the scheme. Thus, for instance, as the MCO shared, small surgeries anyways do not cost much in a public hospital. Therefore, oftentimes the patients choose not to avail the scheme, as they want to avoid the paperwork and documentation.

"Operations like herniotomy and hernioplasty are also performed at such low rates and hence, te tevdhi katkat karayla magat nahit...patient hi nahi ani doctor pan mhantat chala thik ahe. Rajiv Gandhi madhe kasa ahe...discharge kara, photo kadha, saglav yavastit lava...and that is time consuming. Ani patient la kasa asta...jo kamavta asto toch jar operate honar asel tar to mhanto ki mala kamavarti jayacha ahe, mala lagech resume vyacha ahe tyamule me chottich procedure karto ani Rajiv Gandhi madhe jaat nahi". (Some of the operations are performed at such low rates (cost in a public hospital), so patients do not like to take that much trouble (of waiting for completion of RGJAY approvals) patients and doctors say that it is fine. How it is in Rajiv Gandhi. Do the discharge, then take a photo, and everything should be appropriate, which is time-consuming. Generally, the patient who is working and is admitted, then decides that he needs immediate treatment, therefore, decides to do it from the public (as a non-RGJAY

[10] This particular hospital did not offer cardiac surgery or other bigger surgeries and therefore we were unable to explore these referrals.

patient) and they don't go for (benefits under) Rajiv Gandhi (scheme)) (MCO, Public hospital).

While this was the case with public hospitals, in the case of private empanelled hospitals, we found that the referral process is selective and pre-determined by their priority specialties and profit interests. The hospital under study, which was registered to provide 17 specialties, in reality, the preauthorization requests were raised in not more than 3-4 specialties, as these were the specialties that they wanted to focus on and promote. As explained by the chief MCO of the private hospital,

"We have Cardiology, Cardiovascular Surgery, Urology, Orthopedics, Oncology both medical and surgical, Neurosurgery, ENT, Neurophysician, General medicine, General Surgery. Around 60 % (of RGJAY patients are) on Cardiology, 20% (RGJAY patients in) cancer and remaining in other specialties". As explained by the assistant MCO from the private hospital,

"Cardiac surgery, Cancer patients are the ones which we are targeting (under RGJAY) as these are not common diseases. Fractures also come. Monthly, around 2-3 patients come for fractures".

Another MCCO shared,
"Our specialty is cardiology and oncology. The amount of cases we do, nobody does it. Even (XX Hospital, for cancer) patients come to us for Oncology. We do radiation, oncosurgery, chemo everything. In Cardiology, we have for 5 months to 80 years old people. We have a super specialty. We have all doctors. Eight each in Cardiology, CDA surgeon, paediatric surgeon, oncosurgeon, radiosurgeon, everything, chemotherapy, we have everything. Therefore, it is full-fledged. We also do other procedures but what happens is that our wards are full by this only".

Thus, both the public and private hospitals seem to choose to refer/offer selective specialties under the schemes and therefore refer accordingly.

Location of the Kiosk
It is mandatory for all the empanelled hospitals to have the RGJAY kiosk where the aarogyamitra and the data entry operator are required to be present. After the referral, the next task for the patients is to locate the RGJAY kiosk. It was found that in the public hospital where we conducted our study, the kiosk was located outside of the main building making it extremely difficult for patients to locate it. There were also no banners or other informative material related to the scheme inside the hospital that could help not just inform patients about the existence of such a scheme, but also share other key information such as the position of the kiosk. As evidenced from case 3, patients keep searching for the kiosk and most of the times they have to rely on other patients for locating it. While, in case of the private hospital, the entrance for RGJAY scheme department was at the extreme corner of the main building indicated by a large display board.

Once the patient approaches the kiosk, process of registration (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., e) of the patient as the beneficiary of the scheme begins. We also found that, all the family members as per the ration card are registered in the scheme (as potential beneficiaries). The preauthorization request is raised only for the person who has come to seek treatment.

Process of Registration and Delays in Registration of RGJAY Beneficiaries

The first step to avail the scheme is the registration of the beneficiary. As per the MOU, initially valid Annapurna/Antyodaya/Orange/Yellow Ration card with Aadhar card or if Aadhar card is not available then any government issued photo identity card of the patient could be used for identification of the beneficiary. In case of a newborn child, birth certificate along with photo of either child with any of the two parents and health card or valid ration card is required. Once the scheme was implemented in all districts, Rajiv Gandhi Jeevandayee Health Cards were to be issued by the Government of Maharashtra to all the eligible families across the districts. This health card carried the beneficiaries' ration card and Aadhar card number and could then be used to avail benefits of the scheme. However, non - availability of health cards cannot prevent a legitimate beneficiary from accessing the scheme.

Personal Identification Documents

We found that even though the process of registration and enrollment is laid down meticulously, in the scheme MOU, ground reality is very different. Despite having made a health card based on several identification proofs, it has not been able to do away with requiring these same proofs all over again, along with the healthcard. This process has in fact become an integral part the system, so much so that when analyzed the data, we found that "Issue with ration card/health card/Photo ID proof" is an actual official category listed as possible cause for pending or rejecting preauthorization (Table 27).

The staff at the kiosk at the public hospital shared,

"Actually donhi compulsory ahe...mag tyamule nahi hou shakat. Ekahi document nasel tar amhi kahihi nahi karu shakat" (Actually, both the documents are compulsory, one ID proof plus a ration card or health card are compulsory. Therefore, enrollment cannot happen. Even if any one of the document is missing we are not able to do anything) (Data entry operator, public hospital).

As reported by the aarogyamitra, the patient has to submit at least two ID proofs one of which should be a photo ID. The justification given by the data entry operator for such requirement was to avoid unnecessary delay/issues afterwards. The doctors and the TPA rationalized it by saying that a personal photo ID proof is important to identify the patient in order to prevent any fraudulent activity.

"See, in ration card there a number of persons covered. But how will you get to know ki who is the particular beneficiary. Agar dus log uske is me hain, ration card mein, aur usmese patient ek hi hai aur kuch fraudulency hoti hai toh hum humare team ko agar instruct karte hain district team, toh humare district team kaise usko follow karega? Kaise usko identify karegi ki this is the particular patient? For that purpose, we require photo ID" (If there are ten people in that ration card and among these, there is only one patient and if some fraud happens then if we instruct our team, district team, then how will our district team follow him (patient)? How will they identify that this is the particular patient) (TPA doctor).

Based on information shared with us through interviews, there were about two denials in a month in the public hospital linked to identification proofs. In such cases, the preauthorization request could not be raised. As informed by the aarogyamitra and data entry operator, this problem was more common for patients from rural areas. As often times they do not have / carry the necessary documents, which results in the delay as evident in the case below.

In addition, data form is filled online by the data entry operator, while referring to the ration card. There could be an error in entering the information. This can also contribute to a delay in approval. Hence, in addition to the lack of identification documents, other ground level difficulties contribute to delays in preauthorization approval.

Another issue that causes delays is the cut off set by the scheme to identify yellow and orange cardholders. While not clearly stated in the MOU, RGJAY Society has used the list of ration cardholders from Civil Supplies Department as on March 2013 to pay premium per eligible family to the insurance company. Consequently, premium paid would not include any new eligible family added after this date until the list is updated again. So the date of issue on ration card is checked. If the date of issue is not mentioned on the ration card, the family is sent to the Civil Supplies Department. A letter is issued to the beneficiaries in order to facilitate the process of getting the required date. This leads to some serious delay.

"Ration card numbers on these (health) cards have been printed wrongly in certain cases and these cannot be accepted. So, we have to check the ration card. Then again if we face problems during the claims, claims are not passed. We match the numbers, whether the number on the health card is matching with the ration card, at the time of enrollment" (Data entry operator, Public hospital).

Delay Due to Lack of Identification Documents and Lack of Awareness about Scheme's Presence

Case study 5: CR was a 38-year-old female from a village in Jalgaon admitted in the female IPD. Her sister was based in Mumbai and accompanied her to the hospital along with her mother. CR had a slipped disc (mankyachi gadi sarakali ahe). As explained by her sister, she was taking her for treatment from various doctors from Jalgaon for past few years. The treatment included mostly physiotherapy sessions and other medications, massage etc. However, lately her condition had worsened, as she could not even walk or move now.

Eventually, a doctor from Jalgaon asked her family to take CR to a hospital in Mumbai at the earliest, as there was a risk that she could lose the strength in her legs. CR had the RGJAY health card prepared at her village, but she and her sister were not aware whether the same card is valid in Mumbai as well. CR and her relatives had approached a private doctor for the operation who gave them an estimate of Rupees 4 to 4.5 lakhs. Therefore, they decided to shift her to a government hospital.

The doctors at the government hospital informed CR's sister that the cost of the treatment would be around INR 60,000. The doctor also informed her about the scheme. CR had a yellow ration card but they did not have her photo ID card that was needed as a proof of enrollment. Though she had a health card, CR's sister had to arrange for getting her ID card from the village along with the ration card, which was then verified at the RGJAY kiosk. This entire process led a delay in her treatment and added to the anxiety and agitation of the relatives.

Source: Patient interview, Public hospital

The case described above flags various issues associated with the delay in the registration process. It not only documents the problems with the incomplete identification, it also shows patient's unawareness about the documents needed for registration. Additionally, patient's unawareness regarding the validity of

health card across the state is also important from the point of gap in the awareness amongst the beneficiary population. In addition, non-awareness between the private providers about the scheme's presence should be noted.

Thus, the enrollment process has several pitfalls making the process lengthy and cumbersome. If the field level staffs rely only on health card then they face technical difficulties at a later stage, which may lead to rejection of case eventually. Hence, to overcome such a possibility, they seem to have established their own way by insisting on additional identification proof at the time of enrollment itself.

The scheme relies on information technology for its implementation right from the registration stage. Infrastructural issues related to these can also cause delays as evident from the case below.

Delay in Enrollment of Patient Due to Technological Difficulties

Case study 6: A young married man met with an accident at his workplace. He resided in a slum. He was admitted to the hospital for four days. The doctor told them that the patient would need a CT scan and a surgery to fit a screw in order to fix the tibia-fibula fracture. The estimated cost given by him was around INR 10-15 thousand. The family then asked if some aid could be made available by the hospital. The doctor then informed them about the scheme.

At around 10.30 am his wife was standing outside the office in the OPD area, waiting for the form for enrollment into the scheme. When she reached the desk, she was told that she should wait in the IPD and she would be informed when to come. The woman was carrying all the necessary documents as informed by the aarogyamitra. She was asked to bring the ration card as well as a photo identity card of the patient. At around 2.30 pm she again went to the office to inquire about the form and then she was told that it will not be done on that day, and she should come again the next day.

Source: Patient and staff interviews, Public hospital

In the above case, we also found that the preauthorizations and the registration of the patients were not taking place for the last seven days, as there was a problem with the scanner and the printer. We found that in fact it was the laid-back attitude of the concerned staff because of which the problem had stretched on for several days and not addressed till the time of the interview. The hospital staff could have very well attempted to solve the problem on their own. This had not happened. Moreover, though they had registered a complaint with the TPA, the responsible party in such events, they too had not responded effectively.

The staff also reported that they faced frequent problems with the internet connection.
"We were given a dongle, so once its pack (internet data package) was over then we faced problems in getting it recharged and sometimes this was not done in time" (Data entry operator, Public hospital).

A medical officer from the private hospital under study also complained,
"As it (the scheme) is all over Maharashtra, it is bound that the server will be down sometimes. Only in the evening times the server is fast because in the evening, people don't work...especially if we want to attach the videos, it is possible only in the evening. Daytime it is very difficult".

Thus the repeated requirement of identity proofs despite having health cards, along with other barriers such as poor IEC leading to poor awareness amongst beneficiaries, infrastructural issues, etc.; can lead to serious setbacks in the implementation of the scheme and avoidable delays right from registration of beneficiaries.

Preauthorizations

As per the phase II MOU, the patient presenting at an empanelled hospital with a RGJAY referral card and valid health card or ration card and ID proof is registered by aarogyamitra in the scheme. Preauthorization process starts only after registration of the patient, and the requests are scrutinized by the insurer/TPA. Based on the details provided, a preauthorization request can be approved, delayed, rejected or cancelled. Once approved, the beneficiary undergoes further specialist consultation, preliminary diagnosis, basic tests and admission process. The Medical Coordinator of empanelled hospital as per the format feeds all the information like admission notes, tests done, in the RGJAY database. Following this, based on the diagnosis, the empanelled hospital admits the patient and e-preauthorization request is sent to the insurer/TPA, which can also be reviewed by the RGJAY Society. Doctors appointed by Insurer/TPA examine the request and approve pre-authorization if all the conditions are satisfied. Response to request has to be done in 24 working hours and in case of emergency, immediately. In case of a query, insurer/ TPA has to communicate with hospital within 11 hours. The preauthorization is valid for up to 30 days for private hospitals and 60 days for government hospitals, once approved. In case the patient is referred to another hospital before the surgery is performed, the referring hospital is not paid while the referral hospital gets 100% payment of the package.

From the interviews with RGJAY authorities, it was found that RGJAY has no direct role in approval or rejection of pre-authorization requests. Earlier, in Phase I, if any preauthorization was rejected by TPA then it could still be approved by RGJAY Society. Now, RGJAY Society only monitors the rejected and pending requests. The cases, which have been rejected by the TPA, is presented before a committee, appointed for the purpose, which discusses these cases and the reasons for rejections, following which RGJAYS' response to these is given to the TPA. The purpose of monitoring rejected and pending requests is to understand the reason for the same and if there any scope for RGJAY Society to intervene and help the beneficiary.

The scheme does not provide information about all the enrolled families across different socioeconomic categories such as age, gender etc. Therefore, no analysis in terms of the profile of those enrolled was possible. However, scheme data was obtained from the RGJAY Society of the period from beginning of the scheme up to August 2014. In this data, what was available was detailed information of the total number cases of pre-authorizations raised, approved, claims accepted, or rejected etc. Quantitative analysis of this data is presented in the following sections.

Table 9: Preauthorizations at a glance (July 2012-August 2014)

	Public	Private	Total
Preauthorizations raised	93664	216638	310302
Surgeries /therapies approved	76524	193410	269934
Preauthorization amount approved	INR 202 crores (N* = 68656)	INR 503crores (N* = 179783)	

(Source: Tables prepared using data obtained from RGJAY Society)

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

Profile of the Beneficiaries

RGJAY Data for 3,10,302 pre-authorizations raised were obtained from the RGJAY Society. In the absence of data on registered patients and their profile, data on pre-authorization requests can give important clues to the kind of patients who are able to access the scheme. Although in some cases, same patient may have accessed the scheme more than once, hence multiple pre-authorization requests under one registered beneficiary maybe made. Keeping this in mind, only a brief analysis is presented here.

Analysis showed that males raised almost 60% of the pre-authorizations. Maximum pre-authorizations were raised for beneficiaries between the age group of 26-50 years (41%) and 50-75 years (41%) (Table 10). Further, it shows that maximum patients who accessed the scheme were orange cardholders (75.2%), followed by yellow cardholders (22.9%), Anthyodaya (1.8%) and Annapurna cardholders (0.1%).

Table 10: Profile of Beneficiaries[11]

Card Type	Frequency (Percent)
Annapurna	304 (0.1%)
Anthodaya	5543 (1.8%)
Orange	233328 (75.2%)
Yellow	71127 (22.9%)
Total	310302 (100.0%)
Gender	
Female	124886 (40.2%)
Male	185416 (59.8%)
Total	310302 (100.0%)

[11] Cases whose preauthorization was raised

Type of provider	
Public	93664 (30.2%)
Private	216638 (69.8%)
Total	310302 (100.0%)
Age group	
0-5	11959 (3.9%)
6-10	5335 (1.7%)
11-15	6711 (2.2%)
16-20	9797 (3.2%)
21-25	14386 (4.6%)
26-30	17678 (5.7%)
31-35	20950 (6.8%)
36-40	26344 (8.5%)
41-45	30755 (9.9%)
46-50	31840 (10.3%)
51-55	31124 (10.0%)
56-60	31527 (10.2%)
61-65	32407 (10.4%)
66-70	21206 (6.8%)
71-75	11415 (3.7%)
76-80	4641 (1.5%)
81-85	1697 (0.5%)
86-90	417 (0.1%)
91-95	94 (0.0%)
96-100	19 (0.0%)
Total	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Preauthorization was raised across 30 predetermined specialties (Table 11). The top five specialties, which raised maximum cases, include medical oncology (17.2%), nephrology (15%), cardiology (13.7%), genitourinary system (8.1%), polytrauma (7.2%), cardiac and cardiothoracic surgery (6.7%).

Table 11: Pre-authorizations Raised across 30 Specialties

Specialty	Frequency
Burns	1368 (0.4%)
Cardiac And Cardiothoracic Surgery	20814 (6.7%)
Cardiology	42440 (13.7%)
Critical Care	7197 (2.3%)
Dermatology	166 (0.1%)
Endocrinology	1095 (0.4%)
ENT Surgery	9444 (3.0%)
Gastroenterology	3239 (1.0%)
General Medicine	861 (0.3%)
General Surgery	7381 (2.4%)
Genitourinary System	25142 (8.1%)
Gynaecology And Obstetrics Surgery	4166 (1.3%)
Infectious Diseases	67 (0.0%)
Interventional Radiology	1542 (0.5%)
Medical Oncology	53327 (17.2%)
Nephrology	46537 (15.0%)
Neurology	5290 (1.7%)
Neurosurgery	6104 (2.0%)
Ophthalmology Surgery	2333 (0.8%)
Orthopedic Surgery And Procedures	10641 (3.4%)
Other	4 (0.0%)
Pediatric Surgery	2413 (0.8%)
Pediatrics Medical Management	7741 (2.5%)
Plastic Surgery	423 (0.1%)
Poly Trauma	22483 (7.2%)
Prostheses	26 (0.0%)
Pulmonology	2334 (0.8%)
Radiation Oncology	12095 (3.9%)
Rheumatology	356 (0.1%)
Surgical Gastro Enterology	1264 (0.4%)
Surgical Oncology	12009 (3.9%)
Total	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Preauthorizations across Gender

Analysis of pre-authoruzation data across gender saw a general domination of the male patients. There was not much gender differentiale in accessing public & private facilities by male and female patients, apart from slightly more percentage of utilization of public facilities by women as compared to men (Table 12). Higher utilization of public facilities by women can be also due to the many gynaecological procedures falling in the reserved category to be provided only in the public facilities.

Table 12: Preauthorizations Raised across Type of Provider and Gender

Gender	Public	Private	Total
Female	41318 (33.1%)	83568 (66.9%)	124886 (100.0%)
Male	52346 (28.2%)	133070 (71.8%)	185416 (100.0%)
Total	93664 (30.2%)	216638 (69.8%)	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

A significant gender differential could be seen when we look at the preauthorizations raised in different specialties. In rheumatology, quite predictably, female patients raised 88.5% of the preauthorizations. Surgical oncology, medical oncology, dermatology, and burns had more pre-authorizations raised by female patients in comparison to male patients. In specialties such as paediatrics, genitourinary, cardiology, orthopaedic, male patients (Table 13) raised more than 70% of the preauthorizations.

Highly accessed specialties discussed above are completely absent in the privately empanelled hospitals in many districts (Table 6). Thus, for instance, Radiation oncology is not available in any private empanelled hospital across 16 districts. Similar is the case for cardiothoracic surgery, burns, etc. This implies that there is probably an over burdening of the public sector, especially empanelled facilities; accompanied with extensive travelling to access empanelled services. It also raises questions about how best to use the private sector to increase accessibility and the role of the private sector in general.

Further analysis of the pre-authorizations raised between the reproductive age group of 15-49 years was calculated however, no significant findings were noted (Annexure II, Table 5).

Table 13: Gender Differentials in Preauthorizations Raised

Specialty	Female	Male	Total
Burns	799 (58.4%)	569 (41.6%)	1368
Cardiac & Cardiothoracic Surgery	8621 (41.4%)	12193 (58.6%)	20814
Cardiology	11813 (27.8%)	30627 (72.2%)	42440
Critical Care	2758 (38.3%)	4439 (61.7%)	7197
Dermatology	105 (63.3%)	61 (36.7%)	166
Endocrinology	509 (46.5%)	586 (53.5%)	1095
ENT Surgery	3137 (33.2%)	6307 (66.8%)	9444
Gastroenterology	743 (22.9%)	2496 (77.1%)	3239
General Medicine	333 (38.7%)	528 (61.3%)	861
General Surgery	3812 (51.6%)	3569 (48.4%)	7381
Genitourinary System	6641 (26.4%)	18501 (73.6%)	25142
Gynaecology And Obstetrics Surgery	4142 (99.4%)	24 (0.6%)	4166
Infectious Diseases	11 (16.4%)	56 (83.6%)	67
Interventional Radiology	532 (34.5%)	1010 (65.5%)	1542
Medical Oncology	30919 (58.0%)	22408 (42.0%)	53327
Nephrology	16123 (34.6%)	30414 (65.4%)	46537
Neurology	1825 (34.5%)	3465 (65.5%)	5290
Neurosurgery	2444 (40.0%)	3660 (60.0%)	6104
Ophthalmology Surgery	856 (36.7%)	1477 (63.3%)	2333
Orthopedic Surgery And Procedures	3105 (29.2%)	7536 (70.8%)	10641
Others	0 (0.0%)	4 (100.0%)	4
Pediatric Surgery	597 (24.7%)	1816 (75.3%)	2413
Pediatric Medical Management	3059 (39.5%)	4682 (60.5%)	7741
Plastic Surgery	170 (40.2%)	253 (59.8%)	423
Poly Trauma	6032 (26.8%)	16451 (73.2%)	22483
Prostheses	7 (26.9%)	19 (73.1%)	26
Pulmonology	966 (41.4%)	1368 (58.6%)	2334
Radiation Oncology	6963 (57.6%)	5132 (42.4%)	12095
Rheumatology	315 (88.5%)	41 (11.5%)	356
Surgical Gastroenterology	607 (48.0%)	657 (52.0%)	1264
Surgical Oncology	6942 (57.8%)	5067 (42.2%)	12009
Total	124886 (40.2%)	185416 (59.8%)	310302

(Source: Tables prepared using data obtained from RGJAY Society)

Preauthorizations as per Age Group

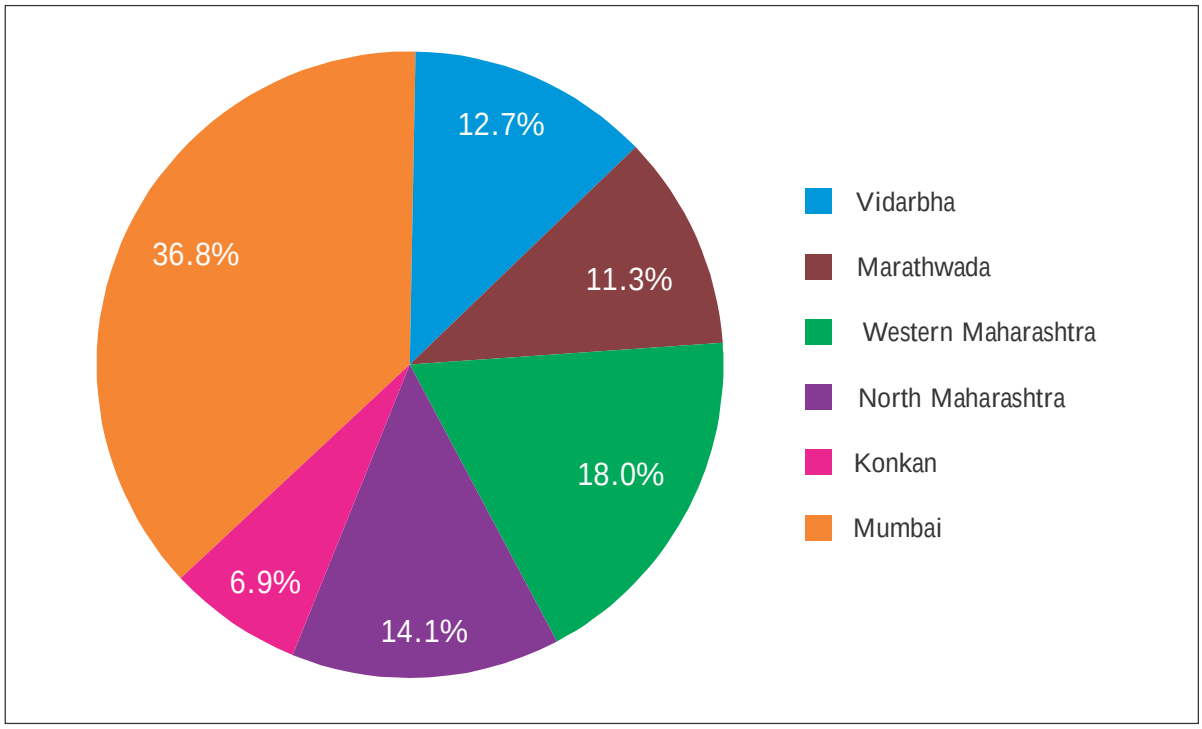
The preauthorizations raised across different medical specialties showed that, many of them were predictably age specific. Thus, more than half of the pre-authorizations for burns cases were raised in the younger age group of 16 - 35 years (56.4%). About 47% of the plastic surgery cases were seen amongst 16-40 years group (Annexure II, Table 6),while, 81.8% pre-authorizations were raised between the ages of 41-70 years for cardiology. About 45% of the requests for ENT speciality were from the age group of 56-75 years. Similarly, ophthalmology requests were more from the older age group of 46-70 years (45%). Maximum orthopaedic surgery requests were from 21-55 years age group (66.8%). About 74% of the Nephrology cases were in the age group of 31-65 years group. Percentage of pre-authorizations related to infectious diseases was more common in 36-50 years group (44.8%) followed by 0-10 year (28%). About 56% requests were raised of Neurosurgery amongst 31-60 years of age group.

Causes of these gender and age differences are multi-factorial and are directly linked to the actual prevalence of particular disease in the population. Further research in this area will be useful in evolving the scheme packages rather than having a carpet scheme with limited procedures covered.

Preauthorizations Raised across the Region

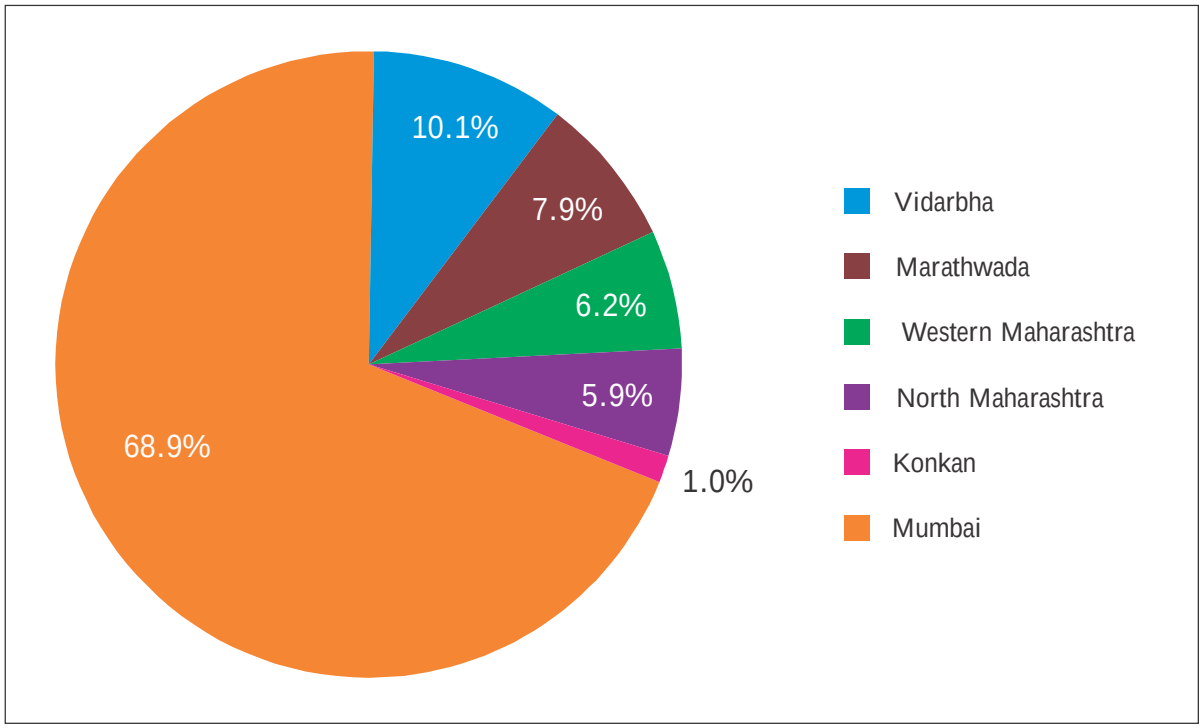
While 69.8% of the preauthorization requests were raised from the private hospitals (Table 12), a region wise comparison (Figure 4) showed that maximum preauthorizations were raised from Mumbai (36.8%), and minimum in Konkan (7%). Although the preauthorizations raised were more in the private hospital across the regions, Mumbai had more than half of its requests raised in the public hospitals (Figure 5, Annexure II, Table 7). Western Maharashtra, which has a maximum number of empanelled hospitals, raised only 18% of the preuthorisation requests in the public sector. Mumbai has the lowest percentage of

Figure 4: Preauthorizations across Geographical Regions



(Source: Data obtained from RGJAY Society)

Figure 5: Region wise preauthorization in Public hospitals



(Source: Data obtained from RGJAY Society)

the empanelled hospitals (11%) of which nearly 63% are private hospitals, yet the proportion of pre-authorizations raised from Mumbai is highest compared to other regions. Despite more number of hospitals empanelled in many other regions, the utilization of RGJAY is more in Mumbai as a well established hub for tertiary medical care in the public sector. This suggests that many of the public hospitals in Mumbai would be overburdened due to the scheme.

There is a clear mismatch between the percentage of preauthorizations raised and empanelled services available. Moreover, as established in the previous section, with several of the districts ill equipped to handle the most commonly occurring problems, we are going to have lopsidedly (some specialties more than the others) overburdened empanelled health care services. The most affected by this issue would evidently be Mumbai as seen above.

A region-wise utilization of the scheme across the ration card types showed that (Table 14), Annapurna cardholders raised maximum preauthorization request from the Marathwada region (0.3%), whereas Anthodaya cardholders raised more requests from Vidharbha region (5.5%), Mumbai showed the highest requests by Orange cardholder population (93.6%), while Yellow cardholders were maximum in the North Maharashtra as well as Vidharbha region.

Table 14: Pre-authorization as per Card Type across Regions

Type of Ration Card	Region Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Annapurna	42 (0.1%)	102 (0.3%)	45 (0.1%)	47 (0.1%)	20 (0.1%)	48 (0.0%)	304 (0.1%)
Anthodaya	2166 (5.5%)	675 (1.9%)	831 (1.5%)	1213 (2.8%)	232 (1.1%)	426 (0.4%)	5543 (1.8%)
Orange	21858 (55.4%)	22600 (64.2%)	38584 (68.9%)	25501 (58.1%)	17825 (83.1%)	10690 (93.6%)	233328 (75.2%)
Yellow	15414 (39.0%)	11837 (33.6%)	16517 (29.5%)	17113 (39.0%)	3371 (15.7%)	6875 (6.0%)	71127 (22.9%)
	39480 (100.0%)	35214 (100.0%)	55977 (100.0%)	43874 (100.0%)	21448 (100.0%)	114309 (100.0%)	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

The preauthorization data included information about the patient districts and the empanelled hospital district. It was interesting to look at the preauthorizations raised in the hospitals from various regions. The data for the preauthorization raised in the hospitals were analyzed for the districts where number of empanelled hospitals was low (Table 15) and large number of specialties were unavailable in the private sector (refer to Table 6). This was specifically with an intention to understand the repercussions on the access of the beneficiary population. If the beneficiary population is registering themselves in the neighbouring districts or developed districts, other than their own district then, this suggests migration of the beneficiaries in order to avail health facilities under the scheme. Table 15 shows that in the 14 districts which have very few empanelled hospitals and not having availability of all the medical specialties, the beneficiaries are migrating to other districts and registering under the scheme. Large number of preauthorizations has been raised by the beneficiaries from Beed, Buldhana, Gadchiroli and Chandrapur in the hospitals of other districts.

Table 15: Preauthorizations (within District and in other Districts) Raised for Patients Belonging to theD with Few Empanelled Hospitals and Poor Availability of the Medical Specialties

Patient District	Number of empanelled hospitals	Preauthorizations raised within district	Preauthorizations raised in other districts*	Total
Minimum 5 hospitals to be empanelled				
Nandurbar	1	71 (7.5%)	877 (92.5%)	948
Beed	3	446 (11.1%)	3561 (88.9%)	4007
Bhandara	4	605 (43.7%)	778 (56.3%)	1383
Hingoli	4	299 (16.8%)	1476 (83.2%)	1775

Patient District	Number of empanelled hospitals	Preauthorizations raised within district	Preauthorizations raised in other districts*	Total
Osmanabad	4	378 (14.4%)	2252 (85.6%)	2630
Sindhudurg	4	366 (26.3%)	1023 (73.7%)	1389
Wardha	4	1814 (78.6%)	495 (21.4%)	2309
Gondia	5	355 (34.7%)	668 (65.3%)	1023
Ratnagiri	5	1052 (39.1%)	1638 (60.9%)	2690
Washim	5	309 (14.7%)	1793 (85.3%)	2102
Buldhana	6	523 (13.1%)	3457 (86.9%)	3980
Jalna	6	457 (17.4%)	2176 (82.6%)	2633
Yavatmal	8	1022 (27.2%)	2738 (72.8%)	3760
Satara	14	2186 (52.0%)	2016 (48.0%)	4202
Minimum 5 hospitals to be empanelled				
Parbhani	4	262 (10.7%)	2196 (89.3%)	2458
Chandrapur	9	162 (9.3%)	1589 (90.7%)	1751
Latur	12	1731 (49.5%)	1767 (50.5%)	3498
Akola	13	1245 (57.1%)	934 (42.9%)	2179
Sangli	19	3826 (70.3%)	1619 (29.7%)	5445
Jalgaon	20	4999 (58.0%)	3616 (42.0%)	8615
Ahmednagar	25	7087 (80.4%)	1727 (19.6%)	8814
Kolhapur	28	7830 (83.7%)	1528 (16.3%)	9358
Minimum 5 hospitals to be empanelled				
Nashik	23	7324 (79.9%)	1848 (20.1%)	9172
Aurangabad	25	4607 (83.4%)	918 (16.6%)	5525
Pune	33	4773 (77.9%)	1355 (22.1%)	6128
Nagpur	37	5334 (94.5%)	313 (5.5%)	5647
Thane	42	4700 (35.9%)	8400 (64.1%)	13100
No criteria for hospitals to be empanelled				
Gadchiroli	2	596 (30.8%)	1340 (69.2%)	1936
Dhule	8	13698 (73.9%)	4834 (26.1%)	18532
Raigad	8	8083 (50.8%)	7816 (49.2%)	15899
Nanded	11	14140 (62.5%)	8466 (37.5%)	22606
Amravati	14	13391 (70.6%)	5564 (29.4%)	18955
Solapur	16	24251 (91.8%)	2180 (8.2%)	26431
Mumbai	51	85347 (95.4%)	4071 (4.6%)	89418
Total	473	223269 (72.0%)	87029 (28.0%)	310298

(Source: Tables prepared using data obtained from RGJAY Society)

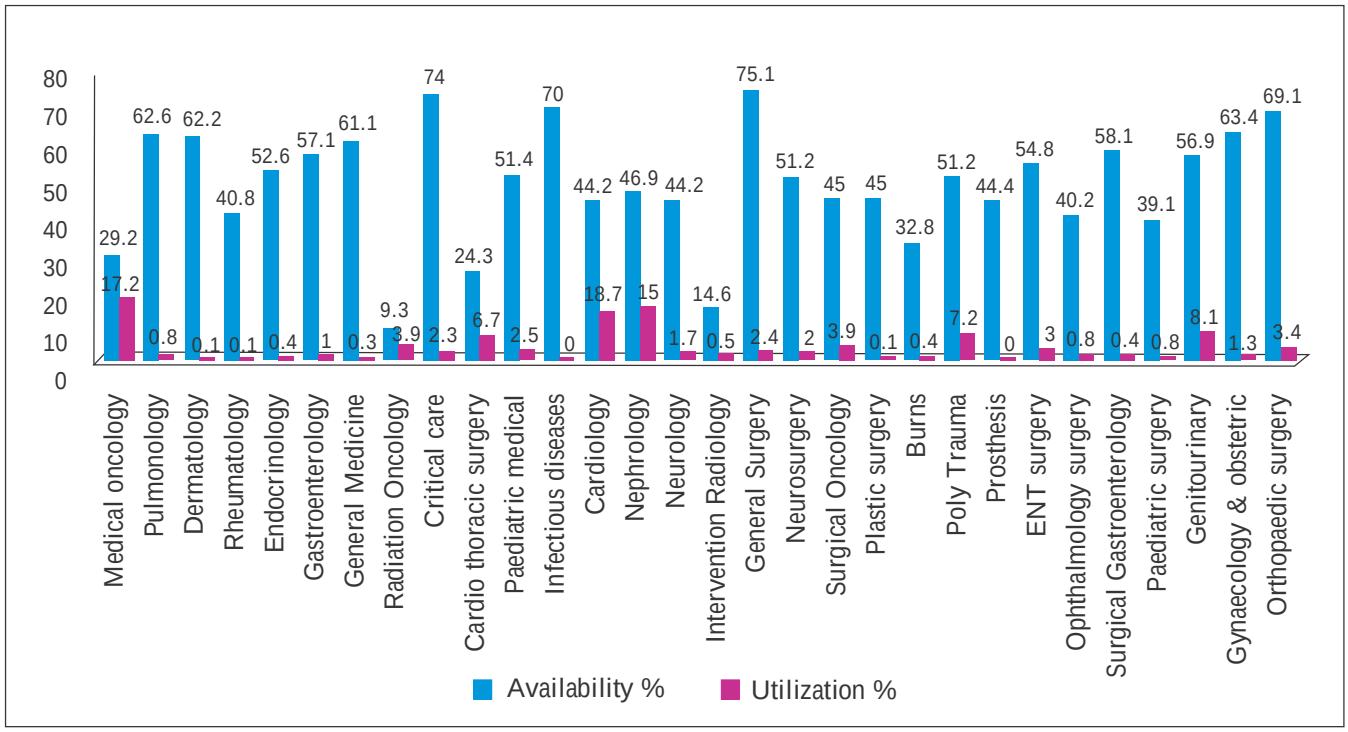
* The beneficiary can register in any of the empanelled hospitals across the state irrespective of his/her own district.

Preauthorization across Medical Specialties and Type of Provider

Five specialties extensively available in the empanelled hospitals were, general surgery (75%), infectious diseases (70%), critical care (74%), orthopaedic (69%), pulmonology (63%), however the top five specialties which raised maximum preauthorization include medical oncology (17.2%), nephrology (15%), cardiology (13.7%), genitourinary system (8.1%), polytrauma (7.2%), cardiac and cardiothoracic surgery (6.7%). Stark difference can be found in terms of availability of specialties and their utilization (Figure 6). Certain specialties such as radiation and interventional oncology have high demand but low availability across empanelled hospitals. This could be because these are highly specialized require super specialists and sophisticated expensive equipment hence, these are not available in rural areas and therefore low empanelment. On the other hand, despite of having high availability of specialties including infectious diseases, critical care and general surgery, preauthorization requests raised are lesser. However, the mismatch indicates a possible lacuna in empanelment process wherein the required specialties are not being empanelled. The manner in which hospital empanelment has been carried out can be questioned in the context of the mismatch between the provision and utilization.

The higher utilization clearly documents that the scheme is skewed towards the tertiary specialties that require hospitalization 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.

Figure 6: Availability and utilization of medical procedures



(Source: Graphs prepared using data obtained from RGJAY Society)

Data was further analyzed for the preauthorizations raised in public and private hospitals across specialties. Because there are 131 procedures reserved only for public hospitals, the utilization of some of the specialties is greater in public hospitals. Thus, all requests for Rheumatology had been raised only from the public hospitals as all the procedures under this specialty are reserved for government hospitals. Similarly, higher preauthorization percentages of dermatology, gynaecology and general surgery in the public hospitals are also related to the fact that many procedures in these specialties fall in category of reserved procedures.

Nevertheless, if we consider specialties without any reserved procedures and available in both public and private, we see a pattern where certain specialties show greater utilization in public and others in private hospitals. If preauthorization raised is compared with the speciality availability across type of hospital, it shows that, certain specialties such as infectious diseases, endocrinology, pulmonology, paediatric medical management, neurology have raised more number of preauthorizations in the public hospitals. This is inspite of the fact that none these specialties have any government reserved procedures and greater numbers of private hospitals providing these specialties.

Additionally, despite relatively lower availability in the public sector, more than half of preauthorizations for burns are raised in public. This can be because private hospitals may want to escape the medico-legal procedures involved in most burn cases. It was seen that the specialties that are in general heavily demanded in the scheme such as medical oncology, cardiology and nephrology were available only in 23.3%, 37%, and 34.2% of the private hospitals respectively (Table 16). Similarly, a region wise analysis showed that except for ENT, general medicine and genitourinary all other specialties maximum preauthorizations were raised from Mumbai (Annexure II, Table 8).

Table 16: Availability and Preauthorizations Raised across Specialties and Type of Providers

Specialty	Availability in Public hospital No. (%)	Preauthori-zation in Public	Availability in private No. (%)	Preauthorization in Private hospital
Burns	66 (14.0%)	697 (51.0%)	89 (18.8%)	671 (49.0%)
Cardio thoracic surgery	22 (4.7%)	5238 (25.2%)	93 (19.7%)	15576 (74.8%)
Cardiology	34 (7.2%)	10172 (24.0%)	175 (37.0%)	32268 (76.0%)
Critical care	71 (15.0%)	1958 (27.2%)	279 (59.0%)	5239 (72.8%)
Dermatology	61 (12.9%)	159 (95.8%)	233 (49.3%)	7 (4.2%)
Endocrinology	38 (8.0%)	611 (55.8%)	211 (44.6%)	484 (44.2%)
ENT surgery	63 (13.3%)	2226 (23.6%)	196 (41.4%)	7218 (76.4%)
Gastroenterology	53 (11.2%)	1555 (48.0%)	217 (45.9%)	1684 (52.0%)
General Medicine	70 (14.8%)	366 (42.5%)	219 (46.3%)	495 (57.5%)
General Surgery	69 (14.6%)	5235 (70.9%)	286 (60.5%)	2146 (29.1%)
Genitourinary	43 (9.1%)	3249 (12.9%)	226 (47.8%)	21893 (87.1%)
Gynaecology& Obstetric surgery	67 (14.2%)	2831 (68.0%)	233 (49.3%)	1335 (32.0%)
Infectious diseases	66 (14.0%)	63 (94.0%)	265 (56.0%)	4 (6.0%)

Specialty	Availability in Public hospital No. (%)	Preauthori-zation in Public	Availability in private No. (%)	Preauthorization in Private hospital
Intervention Radiology	21 (4.4%)	704 (45.7%)	48 (10.1%)	838 (54.3%)
Medical oncology	28 (5.9%)	22598 (42.4%)	110 (23.3%)	30729 (57.6%)
Nephrology	60 (12.7%)	4656 (10.0%)	162 (34.2%)	41881 (90.0%)
Neurology	42 (8.9%)	2659 (50.3%)	167 (35.3%)	2631 (49.7%)
Neurosurgery	38 (8.0%)	2644 (43.3%)	204 (43.1%)	3460 (56.7%)
Ophthalmology surgery	57 (12.1%)	870 (37.3%)	133 (28.1%)	1463 (62.7%)
Orthopaedic surgery	66 (14.0%)	3241 (30.5%)	261 (55.2%)	7400 (69.5%)
Paediatric medical management	64 (13.5%)	4499 (58.1%)	179 (37.8%)	3242 (41.9%)
Paediatric surgery	36 (7.6%)	902 (37.4%)	149 (31.5%)	1511 (62.6%)
Plastic surgery	36 (7.6%)	221 (52.2%)	177 (37.4%)	202 (47.8%)
Poly Trauma	42 (8.9%)	8015 (35.6%)	200 (42.3%)	14468 (64.4%)
Prosthesis	44 (9.3%)	8 (30.8%)	166 (35.1%)	18 (69.2%)
Pulmonology	62 (13.1%)	1264 (54.2%)	234 (49.5%)	1070 (45.8%)
Radiation Oncology	10 (2.1%)	2535 (21.0%)	34 (7.2%)	9560 (79.0%)
Rheumatology	53 (11.2%)	356 (100.0%)	140 (29.6%)	0 (0.0%)
Surgical Gastroenterology	54 (11.4%)	638 (50.5%)	221 (46.7%)	626 (49.5%)
Surgical Oncology	44 (9.3%)	3494 (29.1%)	169 (35.7%)	8515 (70.9%)
Total	77 (16.3%)	93664 (30.2%)	396 (83.7%)	216634 (69.8%)

(Source: Tables prepared using data obtained from RGJAY Society)

A phase wise analysis of preauthorizations raised showed a reduction from 34.3% in public hospitals in phase I to 27.4% in Phase II. At the same time, preauthorizations increased in the private hospitals from 65.7% in Phase I to 72.6% in phase II (Table 17). One obvious explanation for this is the increased empanelment in the private sector in the second phase. As was seen in table 5, from phase I to phase II, while the number of empanelled public hospitals more than doubled, the number of empanelled private hospitals increased more than 4 times.

Table 17: Preauthorizations Raised across Phases and Type of Provider and Regions

Type of hospital	Phases		Total
	Phase 1	Phase 2	
Public	42845 (34.3%)	50819 (27.4%)	93664 (30.2%)
Private	82007 (65.7%)	134631 (72.6%)	216638 (69.8%)
Total	124852 (100.0%)	185450 (100.0%)	310302 (100.0%)
Region	Phase 1	Phase 2	Total
Vidharbha	12819 (10.3%)	26661 (14.4%)	39480 (12.7%)
Marathwada	11547 (9.2%)	23667 (12.8%)	35214 (11.3%)
Western Maharashtra	16722 (13.4%)	39255 (21.2%)	55977 (18.0%)
North Maharashtra	11138 (8.9%)	32736 (17.7%)	43874 (14.1%)
Konkan	8953 (7.2%)	12495 (6.7%)	21448 (6.9%)
Mumbai	63673 (51.0%)	50636 (27.3%)	114309 (36.8%)
Total	124852 (100.0%)	185450 (100.0%)	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Futhermore, analysis of preauthorizations raised according to procedure done shows that that out of 971 procedures about 192 procedures raised less than 10 preauthorizations in between July 2012 until August 2014. In a scheme which offers limited number of procedures, this poor utilization of one-fifth of the procedures is a cause of concern. The reasons for this low utilization should be further explored and measures taken accordingly to improve the scheme and make it more demand driven. In the light of such finding, there is a need to take an account of the procedures reserved under the scheme and utilization of each and whether those can be replaced by treatments of general illnesses, which have higher proportion amongst the population.

Reserved Procedures in Public Hospital

As per the RGJAY MOU, 131 procedures out of 971 are reserved specifically for the public hospitals. Though no specific reason is mentioned on the website or in the scheme documents, the Society officials informed that it is done with the purpose of preventing 'procedure abuse', i.e. medically unnecessary procedures done on insured patients by hospitals to get more profit. The program officer from the Society informed,

"(During medical audit of hospitals) NIC also looks at the frequency of certain procedures, and (in these audits) there were some issues (related to procedures) that we noted. Some specific procedures are frequently conducted which are noted down. During the phase II we have sent show cause notice to 34 hospitals (for carrying out unnecessary procedures) after the audit".

Table 18: Preauthorizations Raised Under the Reserved Procedures in Public Hospitals

	Preauthorizations under the reserved procedure
Yes	9624 (10.3%)
No	84040 (89.7%)
Total	93664 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

There were about 93,664 preauthorizations raised in the public hospitals. This data was further analyzed in order to understand how many of the 131 procedures were actually used by the people. Of the total preauthorizations raised in a public hospital, reserved procedures constitute merely 10.3% (9624) (Table 18). These 131 procedures are spread across 13 medical specialties (Table 19). The top most specialties utilized were general surgery, gynaecology, and ENT surgery, followed by rheumatology and dermatology.

Table 19: Preauthorizations Raised for Reserved Procedures Across Specialties

Specialty	Preauthorization raised - Reserved procedure		
	Yes (%)	No (%)	Total (%)
Burns	0 (0.0%)	697 (100.0%)	697 (100.0%)
Cardiac and Cardiothoracic Surgery	0 (0.0%)	5238 (100.0%)	5238 (100.0%)
Cardiology	0 (0.0%)	10172 (100.0%)	10172 (100.0%)
Critical Care	0 (0.0%)	1958 (100.0%)	1958 (100.0%)
Dermatology	129 (81.1%)	30 (18.9%)	159 (100.0%)
Endocrinology	0 (0.0%)	611 (100.0%)	611 (100.0%)
ENT Surgery	1730 (77.7%)	496 (22.3%)	2226 (100.0%)
Gastroenterology	21 (1.4%)	1534 (98.6%)	1555 (100.0%)
General Medicine	0 (0.0%)	366 (100.0%)	366 (100.0%)
General Surgery	3478 (66.4%)	1757 (33.6%)	5235 (100.0%)
Genitourinary System	395 (12.2%)	2854 (87.8%)	3249 (100.0%)
Gynaecology And Obstetrics Surgery	2431 (85.9%)	400 (14.1%)	2831 (100.0%)
Infectious Diseases	0 (0.0%)	63 (100.0%)	63 (100.0%)
Interventional Radiology	0 (0.0%)	704 (100.0%)	704 (100.0%)
Medical Oncology	0 (0.0%)	22598 (100.0%)	22598 (100.0%)
Nephrology	0 (0.0%)	4656 (100.0%)	4656 (100.0%)
Neurology	0 (0.0%)	2659 (100.0%)	2659 (100.0%)
Neurosurgery	625 (23.6%)	2019 (76.4%)	2644 (100.0%)
Ophthalmology Surgery	2 (0.2%)	868 (99.8%)	870 (100.0%)
Orthopedic Surgery and Procedures	66 (2.0%)	3175 (98.0%)	3241 (100.0%)
Pediatric Surgery	239 (26.5%)	663 (73.5%)	902 (100.0%)
Pediatrics Medical Management	0 (0.0%)	4499 (100.0%)	4499 (100.0%)
Plastic Surgery	66 (29.9%)	155 (70.1%)	221 (100.0%)

Specialty	Preauthorization raised - Reserved procedure		
	Yes (%)	No (%)	Total (%)
Poly Trauma	0 (0.0%)	8015 (100.0%)	8015 (100.0%)
Prostheses	0 (0.0%)	8 (100.0%)	8 (100.0%)
Pulmonology	0 (0.0%)	1264 (100.0%)	1264 (100.0%)
Radiation Oncology	0 (0.0%)	2535 (100.0%)	2535 (100.0%)
Rheumatology	356 (100.0%)	0 (0.0%)	356 (100.0%)
Surgical Gastro Enterology	86 (13.5%)	552 (86.5%)	638 (100.0%)
Surgical Oncology	0 (0.0%)	3494 (100.0%)	3494 (100.0%)
Total	9624 (10.3%)	84040 (89.7%)	93664 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Apart from general surgery, gynaecology and ENT, rest of the medical specialties with many procedures reserved for public hospitals were barely utilized. The underutilization of these reserved procedures needs to be understood in the context of the information given by the RGJAY official who commented, "In 35 districts, 75 (empanelled) government hospitals are there and out of 131(reserved) procedures, (government) medical colleges offer 60-70% of procedures and district hospitals offer only 20-30% procedures".

Even though these are estimates, it does give us a fair idea of the reality. Thus, reserved procedures were simply not available in all the government hospitals and low preauthorizations raised indicate underutilization 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.

Reserving procedures for public hospitals is causing a lot of problems for RGJAY officials and for patients as well. In instances where facilities are not readily available in the government sector, the patients end up going to a private hospital and incur large out of pocket expenditures or they have to travel across districts to avail RGJAY scheme. This is true even for diagnostics, as we observed in case of a public hospital where there was no MRI machine. One of the patients we met had come from a different district for a procedure not available in his. Having done that, he found that an MRI scan, which he needed, was not available in the public hospital for which he had travelled across districts to avail treatment. This makes it not just expensive, but also tedious and impractical with a sick relative and in an unfamiliar place.

"The procedures government la hot nasale tar patient ni kay karayacha? Mag private la allow karava lagata" (What should the patients do if these procedures could not be conducted at the public hospitals? We have to allow them to (go for) these procedures at private hospitals) (RGJAY official).

Table 5, which shows 140 private hospitals providing rheumatology, needs to be looked at in the context where all the procedures under rheumatology specialty are reserved for public hospitals. This could be because while empanelling the hospitals, these aspects do not seem to be taken into account. Making these procedures exclusive to the public sector implies that the scheme is actually restricting access. Thus, the

analysis of the reserved procedures in the present section yet again documents the inconsistency in terms of the policy, practice and need. Although the rationale behind keeping certain medical procedures reserved in the public sector was to keep a check on the irrational practice of the private sector, however, in reality such a decision has resulted into increasing the difficulties of the beneficiary population to avail the necessary medical specialty in their vicinity. Thus, procedures such as hysterectomies have been kept in public sector as a 'precautionary measure', however, this can be looked at as an easy escape of the government by pushing all responsibilities on the government hospitals when there are no significant efforts made to regulate the private sector in general.

Status of Preauthorization

As mentioned earlier, preauthorization requests are reviewed and can be approved, delayed, rejected or cancelled. Only beneficiaries whose preauthorization requests are approved can avail the benefit of the scheme. Some requests may be delayed due to pending formalities such as submission of all documents or test reports. Analysis of preauthorizations raised from the data obtained for a two-year period was done for status of requests.

Table 20: Preauthorization Status Under RGJAY (for a two-year period)

	Number of preauthorization requests (%)
Approved	269934 (87.0%)
Cancelled	23296 (7.5%)
In process	282 (0.1%)
Pending	2133 (0.7%)
Rejected	14657 (4.7%)
Total	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

As the table above depicts, 87% of the preauthorization requests were approved, 7.5 % were cancelled and 4.7 were rejected. Less than one percent of the cases were pending for preauthorization.

The preauthorization status across the providers showed that 89.3% of total preauthorizations raised in private and 81.7% of total preauthorizations raised in public sector were approved. However, 11% of the preauthorizations raised in public were cancelled (Table 21). This rate was more than the cancellations and rejections in the private sector. Thus, in general, private sector had higher approvals and lower cancellations.

Table 21: Preauthorization Status across Type of Provider

Type of Hospital	Status of Preauthorization request					Total
	Approved	Cancelled	In process	Pending	Rejected	
Public	76524	10273	120	1347	5400	93664
	(81.7%)	(11.0%)	(0.1%)	(1.4%)	(5.8%)	(100.0%)
Private	193410	13023	162	786	9257	216638
	(89.3%)	(6.0%)	(0.1%)	(0.4%)	(4.3%)	(100.0%)
Total	269934	23296	282	2133	14657	310302
	(87.0%)	(7.5%)	(0.1%)	(0.7%)	(4.7%)	(100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Approved Preauthorizations

A district wise statistics of preauthorization show that from across Maharashtra, Mumbai not only had the highest preauthorizations raised, but also the highest approved. More than half of the preauthorization requests (66.1%) were approved from merely six districts including Mumbai, Solapur, Nanded, Aurangabad, Amravati and Dhule. while 27% of the preauthorization have been approved from the remaining 24 districts (Table 22).

This further highlights the complete lack of uniformity across the states in terms of service availability under the scheme, with few districts with better service figures than the others under the scheme.

Table 22: District wise preauthorisations Approved

Districts	Preauthorization Approved (%)
Akola	2602 (1.0%)
Amravati	12444 (4.6%)
Bhandara	554 (0.2%)
Buldhana	547 (0.2%)
Chandrapur	250 (0.1%)
Gadchiroli	461 (0.2%)
Gondiya	290 (0.1%)
Nagpur	10207 (3.8%)
Wardha	5175 (1.9%)
Washim	278 (0.1%)
Yavatmal	1034 (0.4%)
Aurangabad	13502 (5.0%)
Beed	500 (0.2%)
Hingoli	258 (0.1%)
Jalna	512 (0.2%)
Latur	2087 (0.8%)

Districts	Preauthorization Approved (%)
Nanded	13804 (5.1%)
Osmanabad	344 (0.1%)
Parbhani	251 (0.1%)
Kolhapur	8081 (3.0%)
Pune	6155 (2.3%)
Sangli	4594 (1.7%)
Satara	2531(0.9%)
Solapur	27843 (10.3%)
Ahmadnagar	10969 (4.1%)
Dhule	12756 (4.7%)
Jalgaon	5028 (1.9%)
Nandurbar	45 (0.0%)
Nashik	10109 (3.7%)
Raigad	8026 (3.0%)
Ratnagiri	1124 (0.4%)
Sindhudurg	298 (0.1%)
Thane	8930 (3.3%)
Mumbai	98345 (36.4%)
Total	269934 (100%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 23: Approved Preauthorizations across Districts and Type of Providers

Hospital District	Hospital Type		Total
	Public	Private	
Akola	68 (2.6%)	2534 (97.4%)	2602 (100.0%)
Amravati	2144 (17.2%)	10300 (82.8%)	12444 (100.0%)
Bhandara	137 (24.7%)	417 (75.3%)	554 (100.0%)
Buldhana	207 (37.8%)	340 (62.2%)	547 (100.0%)
Chandrapur	23 (9.2%)	227 (90.8%)	250 (100.0%)
Gadchiroli	460 (99.8%)	1 (0.2%)	461 (100.0%)
Gondiya	104 (35.9%)	186 (64.1%)	290 (100.0%)
Nagpur	4369 (42.8%)	5838 (57.2%)	10207 (100.0%)
Wardha	65 (1.3%)	5110 (98.7%)	5175 (100.0%)
Washim	20 (7.2%)	258 (92.8%)	278 (100.0%)
Yavatmal	0 (0.0%)	1034 (100.0%)	1034 (100.0%)
Aurangabad	3495 (25.9%)	10007 (74.1%)	13502 (100.0%)
Beed	486 (97.2%)	14 (2.8%)	500 (100.0%)

Hospital District	Hospital Type		Total
	Public	Private	
Hingoli	13 (5.0%)	245 (95.0%)	258 (100.0%)
Jalna	10 (2.0%)	502 (98.0%)	512 (100.0%)
Latur	122 (5.8%)	1965 (94.2%)	2087 (100.0%)
Nanded	1990 (14.4%)	11814 (85.6%)	13804 (100.0%)
Osmanabad	93 (27.0%)	251 (73.0%)	344 (100.0%)
Parbhani	79 (31.5%)	172 (68.5%)	251 (100.0%)
Kolhapur	129 (1.6%)	7952 (98.4%)	8081 (100.0%)
Pune	1421 (23.1%)	4734 (76.9%)	6155 (100.0%)
Sangli	492 (10.7%)	4102 (89.3%)	4594 (100.0%)
Satara	389 (15.4%)	2142 (84.6%)	2531 (100.0%)
Solapur	2041 (7.3%)	25802 (92.7%)	27843 (100.0%)
Ahmadnagar	42 (0.4%)	10927 (99.6%)	10969 (100.0%)
Dhule	2242 (17.6%)	10514 (82.4%)	12756 (100.0%)
Jalgaon	67 (1.3%)	4961 (98.7%)	5028 (100.0%)
Nandurbar	27 (60.0%)	18 (40.0%)	45 (100.0%)
Nashik	2454 (24.3%)	7655 (75.7%)	10109 (100.0%)
Raigad	466 (5.8%)	7560 (94.2%)	8026 (100.0%)
Ratnagiri	51 (4.5%)	1073 (95.5%)	1124 (100.0%)
Sindhudurg	141 (47.3%)	157 (52.7%)	298 (100.0%)
Thane	144 (1.6%)	8786 (98.4%)	8930 (100.0%)
Mumbai	52533 (53.4%)	45812 (46.6%)	98345 (100.0%)
Total	76524 (28.3%)	193410 (71.7%)	269934 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Further analysis of approved cases with the type of provider showed that in the districts including Beed, Gadchiroli, Nandurbar, Sindhudurg and Mumbai, more than half the preauthorization requests were raised in public hospitals. Higher approval in Mumbai can be associated with more number of publically empanelled hospitals as compared to other districts. However, in terms of the other districts the non availability of the private empanelled hospitals could be the reason for more utilization of the public hospital. While in district such as Yavatmal, not a single pre-authorization request was raised or approved from public sector and in districts including Ahmadnagar, Akola, Jalgaon, Jalna, Kolhapur, Thane and Wardha less than 5% pre-authorizations raised from public sector (Table 23). This is surprising in case of Thane as it has five empanelled public hospitals. In case of Yavatmal, there is one public empanelled hospital and seven private empanelled hospitals. Thus, the predominant presence of the private sector seems to have some effect on the use of the single public empanelled hospital. Additionally, Shirdi city from Ahmednagar district, Barshi and Akluj from Solapur have all preauthorization raised in the private sector. This can be because there was not a single publically empanelled hospital in those areas.

Approved Preauthorization across Specialty

The approved preauthorizations data was further analyzed across the medical specialties. Table 24 shows a compilation of the top 10 specialties and their approval and rejection statuses. The specialties in which higher percentages of the preauthorization requests were accepted were medical oncology, ENT, nephrology, radiation oncology etc. The top 10-rejected preauthorization specialty includes orthopaedic, plastic surgery, infectious diseases which had higher rejections of the preauthorization requests as compared to other specialties (Table 25).

Table 24: Top Ten Specialties with Preauthorization Approved in Public and Private Sector Against Their Availability

Top ten specialties accepted for preauthorizations	Total (% of preauthorizations requests approved within specialty)	Public (% of approved preauthorizations in public)	%Availability of specialty in public	Private (% of approved preauthorizations in private)	%Availability of specialty in private
Medical Oncology	50585 (95%)	21454 (42.40%)	5.9%	29131 (57.60%)	23.3%
ENT Surgery	8863 (94%)	1918 (21.60%)	13.3%	69475(78.40%)	41.4%
Nephrology	43755 (94%)	3856 (8.80%)	12.7%	39899 (91.20%)	34.3%
Radiation Oncology	11217 (93%)	2362 (21.10%)	2.1%	8855 (78.90%)	7.2%
Pediatric Surgery	2082 (86%)	737 (35.40%)	7.6%	1345 (64.60%)	31.5%
Prostheses	23 (89%)	7 (30.40%)	9.3%	16 (69.60%)	35.1%
Dermatology	145 (87%)	140 (96.60%)	12.9%	5 (3.40%)	49.3%
Cardiology	37097 (87%)	8202 (22.10%)	7.2%	28895 (77.90%)	37.0%
Endocrinology	934 (85%)	510 (54.60%)	8.0%	424 (45.40%)	44.6%
Ophthalmology Surgery	1991 (85%)	687 (34.50%)	12.1%	1304 (65.50%)	28.1%
Genitourinary System	21402 (85%)	2494 (11.70%)	9.1%	18908 (88.30%)	47.8%

(Source: Tables prepared using data obtained from RGJAY Society)

Table 25: Top Ten Specialties with Preauthorizations Rejected and Across the Type of Provider

Top ten specialties rejected the preauthorizations	Total(% of preauthorizations requests rejected within specialty)	Public (% of rejected preauthorizations in public)	Private (% of rejected preauthorizations in private)
Orthopaedic	1732 (16.3%)	565 (32.60%)	1167 (67.40%)
plastic surgery	57 (13.5%)	31 (54.40%)	26 (45.60%)
Infectious diseases	7 (10.4%)	7 (100.00%)	0 (0.00%)
Surgical Gastroenterology	123 (9.7%)	35 (28.50%)	88 (71.50%)
Burns	119 (8.7%)	47 (39.50%)	72 (60.50%)
Critical care	631 (8.8%)	167 (26.50%)	464 (73.50%)
Pulmonology	201 (8.6%)	92 (45.80%)	109 (54.20%)
Gastroenterology cases	275 (8.5%)	168 (61.10%)	107 (38.90%)
General medicine	71 (8.2%)	36 (50.70%)	35 (49.30%)
General surgery	590 (8.0%)	410 (69.50%)	180 (30.50%)

(Source: Tables prepared using data obtained from RGJAY Society)

The data was analyzed to look at the most commonly utilized medical procedures across the 30 specialties (Annexure II, Table 9). It was seen that, haemodialysis was the most utilized procedure amongst both male and females (90% each). In case of nephrology, dialysis was the most common therapy. Most common procedure for cardiology was coronary balloon angioplasty (47%) followed by Percutaneous Transluminal Coronary Angioplasty (PTCA) (27.6%) and acute Myocardial Infarction (MI) (10%). More than 60% of the Gynaecological procedures approved were hysterectomies.

Additional Barriers in Availing Treatment

After the approval of the preauthorization request, the patient undergoes the approved treatment under RGJAY cover in the empanelled hospital where the pre-authorization request was raised and approved. However, the study found that there were several barriers that add to the delay.

Unavailability of Specialists & Facilities in the Public Hospital

One of the main causes for delay to avail treatment at the public hospital was due to the unavailability of specialists, which is a chronic problem of all public health services in general. As told by an aarogyamitra in a public hospital, specialist doctors such as anaesthetists may not be available. The patients are informed about the delay, and surgery is postponed. This delay can extend from one week to one month and in case of prolonged delay, there is no other option for the patient but to go to another public empanelled hospital or get the procedure done in a private hospital with or without the RGJAY insurance cover.

"In this district, only one private and 2 government hospitals are present and hence patients from here are mobilized to neighbouring district" (Program officer, RGJAY).

Unavailability of certain facilities such as diagnostics was another cause for delay. Patients were referred to private hospitals or neighbouring districts, leading to an increase in the OOP expenditures and adding to the inconvenience of getting it done from elsewhere that may even involve travelling and loss of working days.

Preference to Paying Patients in Private Hospitals

From our interviews, we got a sense about the priorities of private hospitals. That they tend to give preference to patients who pay as against the ones who seek services under the RGJAY scheme. According to a senior officer in a private hospital, they had about 6 months waiting period for paediatrics and one month for cardiology; for patients seeking treatment under the scheme. This was not the case for paying patients.

"We do not have a waiting list for private patients, as they are paying patients. They will not like to wait. We also operate immediately, if there is an emergency case under the RGJAY. But not always. We do not perform everytime based on high-risk patients because if one patient is put in ICU, what we will get, just 1.5 lakhs. However, at the same time if we operate a private patient then the package goes to 6-7 lakhs" (Senior staff, Private).

He added,
"In private you don't need a ration card; we do not need any approvals. So for them if they are admitted today they can be operated tomorrow morning".

During the course of our interviews, we were told that there were about 32 admitted RGJAY patients waiting for Coronary Artery Bypass Grafting (CABG) as Operation Theatre (OT) slots were not available. Under these circumstances and given the above context, one wonders if the patients were waiting for the hospital to wrap up surgeries for the paying patients and then accommodate the free patients as and when possible. This is the situation despite the fact that there is 25% bed reservation under the RGJAY scheme in the private empanelled hospitals. Besides the financial motivation, what makes matters worse, as evident from the previous sections is the fact that there are more patients anyways accessing the scheme through the private sector. This reiterates the fact that there is a thorough overhaul required, first in terms of services and infrastructure available in the public sector, followed by adding private empanelled hospitals into the scheme and by stricter monitoring of the scheme per se. All of these steps should be done on the basis the needs of the people on the ground and kind of services needed and unavailable. It requires a detailed and systematic mapping and planning for the entire scheme.

Pending Preauthorizations

It was seen that from the 310302 total preauthorization requests about 2133 (0.7%) were pending (Table 20). After receiving a preauthorization request, the TPA has to take a decision within 24 hours. This turnaround time (TAT) was 12 hours during phase I.

"Suppose today, right now I have received one pre-auth in my system, at 11:10. From 11:10 it is TAT started. I have to process within twenty-four hours. But we are not waiting twenty-four hours. We are trying to clear that pre-auth within three hours" (TPA doctor).

Data on pending preauthorizations with reason for pending status was available separately. However, the number of cases in this file (2063 cases) does not match exactly with that in the preauthorization files (2133 cases). In order to further analyze the pending cases in detail, the pending preauthorizations file was used with information on 2063 cases available.

Public hospitals had the majority (63%) of the pending preauthorizations in comparison to private hospitals (37%) (Table 26). This is an important finding when we look at the extensive private sector participation in the scheme where the preauthorization raised data shows majority of requests are from private (69.8%) as compared to public (30.2%) sector. From our interviews, incorrect selection of a package by a hospital; or wrong or incomplete documents are a couple of reasons that led to a delay in clearing preauthorization requests. Moreover, a phase wise analysis showed that during phase I, 82% of the preauthorizations were pending in the public, which reduced to 61% in phase II. On the other hand, for the same period, there has been an increase in the number and proportion of pending cases in the private sector in phase II (Table 26). This increase can be due to 4-fold increase in the number of empanelled private hospitals added into the scheme in the second phase.

Table 26: Pending Preauthorizations across Phases and across Providers

Phase	Hospital type		Total
	Public	Private	
Phase 1	169 (82.4%)	36 (17.6%)	205 (100.0%)
Phase 2	1130 (60.8%)	728 (39.2%)	1858 (100.0%)
Total	1299 (63.0%)	764 (37.0%)	2063 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Reasons for Pending preauthorizations

As per the MOU with the empanelled hospitals, the hospital is supposed to provide OPD consultation along with diagnostic tests free of charge to the beneficiary, irrespective of surgery or treatment under RGJAY ultimately taking place. Hence, all the diagnostic tests are to be carried out by the empanelled hospital through in-house or outsourced facilities without any cash transaction. Each of the medical procedure under the scheme has a list of medical documents and tests like X-rays, biopsy reports, MRI films etc., that are required to be submitted online for the purpose of clearance of preauthorization requests. Along with these, a signed copy of consent of the patient and digital photo of the patient taken in the hospital is to be uploaded. The responsibility of meeting with the needs of the scheme related documents lies with the hospital. Further, it is mentioned that in case of any deficiency in documentation, the process may lead to pending of pre-authorization approval, the responsibility for such delay leading to delay in treatment and outcome is the responsibility of the hospital.

As the aarogyamitra of the public hospital explained,
"If there is a fracture patient, and his X-ray is attached (to the preauthorization request). If the name is not mentioned or it is changed, or if the fracture is not seen properly, then the TPA keeps it as pending".

Analysis of the data shared with us by the RGJAY, reveals that the most common reason of pending requests are related to incomplete medical documentation (63%) such as diagnostics tests, clinical documents

etc. The other large share is associated with the procedural issues (23.7%) including wrong selection of package, referral to another empanelled hospital and so on. Additionally six percent cases are kept pending because of the issue with personal identification documents. These make for 93% of the total pending cases.

"Suppose if it is a case of MI (Myocardial Infarction) you can write myocardial infarction as a footnote then the mandatory document for it is ECG. If the hospital has not sent ECG then the pre-authorization is kept pending" (Ex Program officer).

Other reasons for pending cases were that hospital had not provided clarification on remarks sent by the TPA doctors on the requests (3.6%). There were some cases for which, no clear proper reason was mentioned and therefore we were unable to code it (Table 27).

Table 27: Reasons for Pending Preauthorizations

Reasons	Public	Private	Total
Pending because of procedure related issues (explanation or clarification required/wrong selection/repeat request/referral to other hospital)**	300 (23.2%)	187 (24.5%)	487 (23.7%)
Pending as no clarification on TPA doctors' remarks on submitted preauthorization requests was provided	46 (3.6%)	11 (1.4%)	57 (2.8%)
Procedure/package is not covered under RGJAY	6 (0.5%)	6 (0.8%)	12 (0.6%)
Pending due to issue with identity proof/ration card/ anthyodaya card/ health card of the patient	60 (4.6%)	63 (8.3%)	123 (6.0%)
Cancellation of not required preauthorizations advised by TPA***	22 (1.7%)	12 (1.6%)	34 (1.7%)
Pending due to incomplete, inappropriate documentation (laboratory & radiology reports, clinical notes, other clinical documents, on bed photographs, etc)	834 (64.4%)	462 (60.6%)	1296 (63.0%)
Already approved preauthorization request for same or another package for the same patient diagnosis plus incomplete documentation	10 (0.8%)	9 (1.2%)	19 (0.9%)
Other	17 (1.3%)	13 (1.7%)	30 (1.5%)
Total	1295 (100.0%)	763 (100.0%)	2058* (100.0%)
Data not available			5
Total			2063

* N varies as the reasons for pending are analyzed from a separate file, which is not updated as the dump file.
** variety of issues related to procedures like explanation or clarification or justification about the diagnosis or package selected or for delay in updation or repeat preauthorization request for same package already approved/requested
***Cancellation of not required preauthorizations was advised by the TPA for eg. in many cases multiple requests may have been generated and if any of the preauthorization request is approved for the same patient then other preauthorizations not required have to be cancelled
(Source: Tables prepared using data obtained from RGJAY Society)

Across providers, as observed earlier, the reasons for pending preauthorization requests show that, issue of incomplete documentation was more in public hospitals. However, pending preauthorizations due to procedural issues including explanation of procedure /wrong selection of procedure were more common in private hospital (24.5%). Similarly, more preauthorizations were kept pending in private sector giving the reasons of lack of ID proof documentation (8.3%). Importantly, the hospital is obligated to prevent and clear any delays for the sake of the patients.

Rejected Preauthorizations

About 4.7% (14657) of total preauthorization requests got rejected (Table 20), of which most of them were from the private empanelled hospitals (63.8%) (Table 28). Due to limitations of data, for further analysis, the separate file on rejected preauthorizations made available to us by the RGJAY Society was used. The Pending queries if not solved would go as rejected and fresh preauthorization request needs to be raised. If pending preauthorization queries are not resolved, then they could be grounds for rejection. Most common reason for rejection was associated with issues of medical documentation (25%). Other common reasons were a wrong selection of the package (20%), prior approval (13%), rejected as the cancellation was requested by hospital (12%) and no evidence of mentioned pathology was found in 7% of the cases (Annexure II, Table 10).

Table 28: Reasons for Preauthorization Rejection across Type of Provider

Reasons for preauthorization rejection	Hospital Type		Total
	Public	Private	
Issue with medical documentation	1143 (34.9%)	2134 (65.1%)	3277 (100.0%)
Issue with ration card/health card/ Photo ID proof	178 (30.7%)	402 (69.3%)	580 (100.0%)
Rejection of preauthorization on request/ cancellation requested by hospital	793 (50.3%)	785 (49.7%)	1578 (100.0%)
Unjustified selection/wrong selection of treatment package	849 (32.1%)	1792 (67.9%)	2641 (100.0%)
Prior approval/previous package covers the amount/cannot be approved within 1 month of previous approval/due date for future preauthorizations	481 (27.4%)	1277 (72.6%)	1758 (100.0%)
RGJAY amount is exhausted/insufficient to cover the procedure	14 (53.8%)	12 (46.2%)	26 (100.0%)
Rejection due to issue with Emergency Telephonic Intimation (ETI)	68 (55.3%)	55 (44.7%)	123 (100.0%)
Rejected as wrong amount is quoted/ amount not as per RGJAY package	11 (39.3%)	17 (60.7%)	28 (100.0%)
The procedure selected is reserved for Government hospital	4 (2.3%)	173 (97.7%)	177 (100.0%)

Reasons for preauthorization rejection	Hospital Type		Total
	Public	Private	
No evidence of the mentioned pathology found in medical reports by TPA doctors	341 (37.2%)	575 (62.8%)	916 (100.0%)
The procedure is not covered under RGJAY	198 (54.5%)	165 (45.5%)	363 (100.0%)
No reason mentioned	329 (35.5%)	599 (64.5%)	928 (100.0%)
Rejected due to older pending requests/ duplications	30 (42.3%)	41 (57.7%)	71 (100.0%)
Issue with ration card and documentation	4 (44.4%)	5 (55.6%)	9 (100.0%)
Due to prior approval and issue with documentation	1 (50.0%)	1 (50.0%)	2 (100.0%)
Diagnosis and treatment do not match	9 (23.7%)	29 (76.3%)	38 (100.0%)
Patient is discharged/ absconded/ referred to another hospital/ Expired	152 (61.3%)	96 (38.7%)	248 (100.0%)
Procedure done before preauthorization	88 (50.3%)	87 (49.7%)	175 (100.0%)
Other	57 (32.2%)	120 (67.8%)	177 (100.0%)
Total	4750 (36.2%)	8365 (63.8%)	13115* (100.0%)

* N varies as the reasons for rejection are analyzed from a separate file, which is not updated as the dump file
(Source: Tables prepared using data obtained from RGJAY Society)

Referring to the previous section, it can be inferred that if the reasons for pending preauthorizations are rectified, then the same cases would not come up for rejection. It is clear from the above discussion that most of the reasons cited for rejection of preauthorization requests are easily rectifiable.

Issues with medical documentation (25%), the problem of wrong package selection (20.1%), missing or incorrect identity proofs (4.4%) or (Annexure II, Table 10) can be overcome with some help and guidance from the relevant authorities. This raises a doubt about the entire mechanism that has been set up for the submission and scrutiny of documents. Most of the issues associated with these rejections are at the level of institutions i.e. hospitals. Rejections not only add to the delays in accessing the scheme, but also add to the hardships faced by the patients and their families already reeling under a medical need or an emergency. Moreover, as the data suggests, the preauthorization approval is hospital specific and in case of referral to another empanelled hospital after approval, the new hospital has to send a fresh preauthorization request. This further adds to the delay in treatment of the patient.

As mentioned earlier, in phase I, RGJAY Society was part of the preauthorization process as after approval or rejection of any request by TPA, the Society officials would assess the request and had the power to approve the request if it deemed appropriate. But as per the phase II MOU, the role of RGJAY Society has been reduced to doing committee based monitoring of preauthorization rejections and pending cases, reviewing them and intervening when deemed necessary.

"The cases, which have been rejected by the TPA, a committee is appointed which discusses these cases and the reasons for the rejections, then we revert back to the TPA validating the reasons with our reply.

The purpose of monitoring rejected and pending requests are to understand the reason for the same and is there any scope for RGJAY Society to intervene and help the beneficiary" (Officer, RGJAY Society).

Thus, based on our qualitative study and the MOU, it is clear that the TPA is an important agency in terms of regulating patients' access to the scheme. It is the first authority to receive the requests and decide whether they need to be kept approved, pending or rejected based on set criteria.

"In the case of wrong selection of package by hospitals, TPAs guide the hospitals for selection of right package (package of treatment and services for a particular disease pre-defined under the scheme). TPAs can give two chances to the hospital for correction of package or document issue by keeping it pending only 2 times [12]. The third time they have to either 'Approve' or 'Reject' as the system is designed in such manner" (TPA, doctor).

When a preauthorization request is kept pending, two chances are given by the TPA to the hospital for producing mandatory documents. Once these are made available, the pre-authorization request is cleared. Sometimes the pre-authorization requests are rejected due to the non-eligibility of the patient in the scheme, as the procedure does not fit the predefined list of procedures. Another reason is that all the pre-authorization requests have to be cleared within 24 hours or else it directly gets auto-rejected. In the case of rejection of a preauthorization request, a fresh request needs to be sent with all the necessary documents. Following approval, the patient is considered eligible for the surgery or treatment.

A cross tabulation of the reasons across the type of providers show that the rejections due to issues with medical documents (65.1%) as well as issues with ID proofs (69.3%) and wrong or unjustified selection of the package (67.9%) were more common in private hospitals. The reason for rejection as the patient is absconding or has taken discharge is more in the public sector (61.3%) (Table 28).

Cancelled Cases

Cancelled cases are those cases of the beneficiaries whose preauthorization has been approved however; the request was eventually cancelled because of various reasons. As per the MOU, preauthorization approved also is automatically cancelled on RGJAY portal, if the surgery or therapy is not updated within 30 days after the approval. In such cases, hospital can obtain fresh approval for cancelled cases by furnishing valid reasons. This fresh request too can be approved or rejected. The preauthorization approved may also be cancelled if during routine checks at hospital by RGJAY/Insurer/TPA officials, the hospital cannot present the patient undergoing treatment under the scheme at that time.

Of the 9466 cancelled cases about 40.4% were in public hospitals while the rest in the private hospitals. The region wise classification (Table 29) shows that Mumbai by far had the highest number of cancellations with 42% cases and there were relatively fewer cancellations in Northern Maharashtra (15.5%), Western Maharashtra (14.1%), Marathwada (11.3%), Vidarbha (10.8%) and Konkan (6.3%).

[12] Different sources of information gave different information. For pending preauthorizations, for correcting any issues from the hospital side, the hospital is given 2 chances as per the TPA official while as per RGJAY official 3 chances are given. The RGJAY website FAQs mentions that three chances are given. Thus, this seems an issue of poor communication and poor implementation understanding.

Table 29: Cancelled Cases across Hospital Region and Type of Provider

Hospital region	Hospital type		Total
	Public	Private	
Vidarbha	287 (3.0%)	738 (7.8%)	1025 (10.8%)
Marathwada	232 (2.5%)	837 (8.8%)	1069 (11.3%)
Western Maharashtra	98 (1.0%)	1232 (13.0%)	1330 (14.1%)
Northern Maharashtra	218 (2.3%)	1250 (13.2%)	1468 (15.5%)
Konkan	24 (0.3%)	575 (6.1%)	599 (6.3%)
Mumbai	2964 (31.3%)	1011 (10.7%)	3975 (42.0%)
Total	3823 (40.4%)	5643 (59.6%)	9466 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

The public hospitals in Mumbai region have the highest number (31.3%). Interestingly, as discussed earlier, Mumbai also has the maximum preauthorizations raised (36.8%) (Table 19). Considering the fact that there is a dearth of specialists and diagnostics in the public sector and the private sector giving preference to paying patients, there is, as acknowledged earlier, delay in getting treatment and waiting lists. This delay could be a possible cause for cancellation. Thus, for instance, "Surgery/ treatment not done/ postponed" (Table 31) may have been one of the contributing factors. Moreover, the high demand on Mumbai's health infrastructure for RGJAY, particularly in the public sector due to the concentration of large tertiary level public hospitals, possibly leads to patient overload thereby further causing cancellations. Interestingly, the public hospitals in the rest of the regions have small number of cancellations ranging from 0.2-2.9% of total cancelled cases. The above theory holds true when we have a look at other regions in Maharashtra. Thus, least amount of preauthorizations (6.9%) were raised in Konkan (Table 17). Correspondingly, Konkan had the least cancellations (6.3%). Thus, caseload may indeed have something to do with cancellations being further aggravated by the state of public health infrastructure and by waiting lists at private hospitals.

Table 30: Top Ten Cancelled Medical Specialties across the Type of Provider

Procedure	Hospital type		Total
	Public	Private	
Cardiac And Cardiothoracic Surgery	550 (14.4%)	1062 (18.8%)	1612 (17.0%)
Cardiology	619 (16.2%)	1141 (20.2%)	1760 (18.6%)
General Surgery	275 (7.2%)	116 (2.1%)	391 (4.1%)
Genitourinary System	135 (3.5%)	855 (15.2%)	990 (10.5%)
Medical Oncology	217 (5.7%)	312 (5.5%)	529 (5.6%)
Nephrology	80 (2.1%)	207 (3.7%)	287 (3.0%)
Neurosurgery	124 (3.2%)	208 (3.7%)	332 (3.5%)
Orthopedic Surgery A	123 (3.2%)	242 (4.3%)	365 (3.9%)
Poly Trauma	483 (12.6%)	451 (8.0%)	934 (9.9%)
Surgical Oncology	313 (8.2%)	428 (7.6%)	740 (7.8%)

(Source: Tables prepared using data obtained from RGJAY Society)

Cross-tabulation of procedure category with hospital type gives us information on the pattern of cancellations in public and private hospitals by Specialty (Table 30). The table above shows top 10 specialties with highest cancellations. Cardiology and cardiac & cardiothoracic surgery have highest cancellations in both public and private hospitals. After these, poly trauma, surgical oncology, general surgery, and medical oncology in that order show more than 5% cancellations in public hospitals. The pattern changes slightly in private hospitals with the genitourinary system, poly trauma, surgical oncology, and medical oncology having more than 5% cancellations.

The reason for cancellations of cases as given in the data files will give us information on the issues encountered in implementing the scheme (Table 31).

Table 31: Reasons for Cancellation

Reasons for cancellation	Frequency
No reason specified	2008 (21.2%)
Change of procedure/package	1490 (15.7%)
Unfit for treatment/surgery	1106 (11.7%)
Surgery/ treatment not done/ postponed	986 (10.4%)
Wrong selection of package/ code/ procedure	677 (7.2%)
Patient/relatives unwilling for procedure	648 (6.8%)
DAMA/patient absconded/patient is not in hospital/patient didn't come for treatment	508 (5.4%)
Procedure changed on table/failed	388 (4.1%)
Patient did not take or want any benefit of RGJAY/ patient paid the bill	329 (3.5%)
Patient is referred to another hospital/ patient preferred another hospital	326 (3.4%)
Patient death	181 (1.9%)
Others	216 (2.3%)
Equipment under repair/diagnostic/blood/medicines not available	154 (1.6%)
No need for surgery/procedure/problem resolved	138 (1.5%)
Pre-auth rejected/ new sent	108 (1.1%)
Patient is discharged/ want discharge	81 (0.9%)
Documents related issues	65 (0.7%)
Doctor/staff not available	57 (0.6%)
Total	9466 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

In the data sheets shared with us, the reasons for cancellation were not all mentioned completely which were then classified according to broad themes that emerged. While in the majority of cases, a reason could be identified, there were about 21.2% cases in which no specific explanation emerged, and hence, they are labelled as 'No reason specified'. This was the single largest category as compared to others with specific reasons.

Among other major categories, about 15.7% cases were cancelled due to 'change in procedure or package or code', 11.7% due to the patient being 'unfit for treatment/surgery', and 10.4% due to 'treatment/surgery not being done or postponed'.

Since RGJAY requires pre-authorization or prior telephonic intimation and packages are predefined, whenever there is a change in the line of treatment due to medical complications, change in the condition of disease, second opinion from other doctors or even co-morbid conditions; the hospitals have to cancel the initial package and apply for a new one if it fits in the scheme. In cases where patients were unfit to undergo a procedure or take treatment, they were cancelled or postponed or referred to a higher center or the line of treatment was changed. In many cases, the treatment was postponed due to various reasons like a patient having personal problems or technical problems or simply to let the current treatment show results. In many cases, the treatment was not done because of specific reasons as the treatment had poor prognosis or no effect; or for unspecified reasons. In about 4.1% cases, cancellations were because 'procedure was changed on table/failed' due to complications or discovery of some new pathology during operation or attempts at surgery failed or patient underwent emergency procedures before the date of elective surgery.

Apart from these, cases were cancelled because of 'wrong selection of package/code/procedure' (7.2%), 'patient or relatives unwilling for the procedure' (6.8%), 'patient took discharge against medical advice or absconded or did not come for treatment' (5.4%), 'patient did not take or want any benefits from RGJAY' (3.5%) and 'patient referred to or preferred to access another hospital (3.4%). Other reasons include 'patient death' (1.9%), 'equipment under repair/diagnostic or medicines or blood unavailable' (1.6%), 'no longer need the procedure/problem resolved' (1.5%), 'document related issues' (0.7%) and 'doctor or staff not available' (0.6%). Nearly 2.3% of cases were classed in 'others' category which included cases cancelled due rejection by Society or TPA, package amount not sufficient, surgery done before approval or cases where the reason was simply mentioned to be "patient is HIV positive or HBsAg positive" [13].

[13] We do not have any further explanation on this category of cancellation, as, these reasons have been filled by the scheme officials and there might be gaps in terms of explanation provided. Eg this is case there is no further explanation apart from this sentence.

Table 32: Reason for Cancellation across the Type of Provider

Reason for cancellation	Hospital type		Total
	Public	Private	
Unfit for treatment/surgery	197 (5.2%)	909 (16.1%)	1106 (11.7%)
Change of procedure/package	398 (10.5%)	1092 (19.3%)	1490 (15.7%)
Procedure changed on table/failed	61 (1.6%)	327 (5.8%)	388 (4.1%)
Patient/relatives unwilling for procedure	143 (3.8%)	505 (8.9%)	648 (6.8%)
No reason specified	1315 (34.5%)	693 (12.2%)	2008 (21.2%)
Wrong selection of package/ code/ procedure	227 (6.0%)	450 (8.0%)	677 (7.2%)
Pre-auth rejected/ new sent	16 (0.4%)	92 (1.6%)	108 (1.1%)
Surgery/ treatment not done/ postponed	485 (12.7%)	501 (8.9%)	986 (10.4%)
Doctor/staff not available	6 (0.2%)	51 (0.9%)	57 (0.6%)
Patient death	82 (2.2%)	99 (1.7%)	181 (1.9%)
Equipment under repair/diagnostic/blood/ medicines not available	43 (1.1%)	111 (2.0%)	154 (1.6%)
Others	77 (2.0%)	139 (2.5%)	216 (2.3%)
DAMA/ patient absconded/ patient is not in hospital/ patient didn't come for treatment	229 (6.0%)	279 (4.0%)	508 (5.0%)
Patient is discharged/ want discharge	29 (0.8%)	52 (0.9%)	81 (0.9%)
Patient did not take or want any benefit of RGJAY/ patient paid the bill	286 (7.5%)	43 (0.8%)	329 (3.5%)
Patient is referred to another hospital/ patient preferred another hospital	140 (3.7%)	186 (3.3%)	326 (3.4%)
Documents related issues	18(0.5%)	47 (0.8%)	65 (0.7%)
No need for surgery/procedure/problem resolved	56 (1.5%)	82 (1.4%)	138 (1.5%)
Total			
	3808 (100.0%)	5658 (100.0%)	9466 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

The top six reasons for cancellations in public hospitals (Table 32) include 'no reason specified' (34.5%), surgery/treatment not done or postponed (12.7%), Change in procedure/package (10.5%), patient did not want or take any RGJAY benefits (7.5%), wrong selection of package (6.0%) and patient took discharge against medical advice/absconded/didn't come for treatment' (6.0%). Among private hospitals, the top reasons were 'Change in procedure/package' (19.3%), unfit for treatment (16.1%), no reasons specified (12.2%), patient/ relatives not willing for procedure (8.9%), surgery/treatment not done or postponed (8.9%) and wrong selection of package (8.0%). Some of the differences in the reason for cancellation according to hospital type were as anticipated based on our qualitative study. Patients foregoing RGJAY benefits in public hospitals because they already receive subsidized care and rather not go through the cumbersome procedures of the RGJAY scheme. More patients taking discharge against medical advice or not turning up for treatment in public hospitals could be because of a multitude of reasons; that there is

distrust and dissatisfaction against them among the patients, or because of procedural delays leading to loss of daily wages, or they might have not been explained the procedure clearly. On the other hand, there are a greater percentage of cases cancelled under the reason 'unfit for surgery/treatment' in private empanelled hospitals. This may suggest that there may be a general unwillingness to take high-risk patients or it may also imply that few private hospitals have all the relevant specialties that can cover co-morbidities and complications.

Emergency Telephonic Intimation

Rajiv Gandhi Jeevandayee Aarogya Yojana made a provision in the scheme to ensure timely preauthorization in cases of emergencies through emergency telephonic approvals. Provisional approval is given by collecting minimal essential data of the patient through call conference facility available round the clock between treating doctor, MCO, DMO, Executive, Pre-Auth Doctor (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., f).

The empanelled hospital provides the details of the patient to the 'Executive' and discusses the patient condition and diagnosis with the Specialist doctor appointed by the TPA who is responsible for giving the approval. The preauthorization executive will then generate a Telephonic Approval ID. This Telephonic approval ID is then used to register the patient. After the approval, hospital can perform the surgery and then raise the preauthorization within 72 hours. If preauthorization is not raised, then automatically the telephonic approval is cancelled.

"In the case of emergency, Emergency Telephonic Intimation (ETI) is done. If there is an emergency case, (like) heart attack patient and Angioplasty is to be done/ operation is done, if preauthorization has to be raised it would take 24 hours and patient cannot wait until that time. (In such a case), a call on the call center number is made through which ETI number is issued. (In most such cases) Patient does not bring ration card, forgets, heart attack aala tar ration card tar barobar anayacha lakshat yet nahi, samja dusrya gavala gela asel tithe kay zala... then pre authorization can be raised in 72 hours and to which the ETI number should be linked (preauthorization generated is connected to emergency telephonic approval)" (Official, RGJAY Society).

Data was available on emergency telephonic intimations (ETI) for the period of July 2012 to August 2014 from RGJAY Society. There were 8610 ETIs raised over a period of two years, of which 6076 cases were registered (Table 33).

Table 33: Distribution of Hospitals with ETIs, Number of ETIs Raised, Registrations Done, Inpatients and Outpatients According to Type of Hospital and Region

	No. of hospitals	ETIs	Registrations	Inpatient	Outpatient
	(% of all hospitals)	raised	done	cases	cases
Public	48 (15.3%)	4115	2494	2152	191
Private	265 (84.7%)	4495	3582	3300	80
Total	313 (100.0%)	8610	6076	5452	271
Hospital Region	No. of hospitals	ETIs	Registrations	Inpatient	Outpatient
	(% of all hospitals)	raised	done	cases	cases
Vidarbha	61 (19.5%)	907	684	633	27
Marathwada	54 (17.3%)	1376	678	623	45
Western Maharashtra	73 (23.3%)	1793	1240	1134	17
Northern Maharashtra	56 (17.9%)	1249	936	847	16
Konkan	37 (11.8%)	540	394	359	16
Mumbai	32 (10.2%)	2745	2144	1856	150
Total	313 (100.0%)	8610	6076	5452	271

(Source: Tables prepared using data obtained from RGJAY Society)

ETIs were raised in 313 empanelled hospitals, out of which 48 were Public and 265 were Private. Of total empanelled hospitals, ETIs were raised from 73 hospitals in Western Maharashtra, 61 in Vidarbha, 56 in Northern Maharashtra, 54 in Marathwada, 37 in Konkan and 32 in Mumbai. Despite the fact that relatively fewer hospitals had been found to be raising ETIs in Mumbai, the actual number of ETIs raised here was actually the highest. Mumbai was followed by Western Maharashtra, Marathwada, Northern Maharashtra, Vidarbha, and Konkan. Even though there is a large difference in the number of private and public hospitals raising ETIs, there is not much difference in number of ETIs raised between private and public sector. Moreover, it should be noted that not all ETIs raised are actually registered and not all registered cases actually get treatment under the scheme.

Table 34: Drop-outs Between ETIs and Registration and Between ETIs and Actual Cases Define "Drop Out" and "Actual Cases"

Type of Hospitals	Difference between ETIs raised and Registrations	% drop out	Total actual cases (Inpatient + Outpatient)	Difference between ETIs and Actual cases	Total % drop-out
Public	1621	39.4%	2343	1772	43.1%
Private	913	20.3%	3380	1115	24.8%
Total	2534	29.4%	5723	2887	33.5%
Hospital Region	Difference between ETIs raised and Registrations	% drop out	Total actual cases (Inpatient + Outpatient)	Difference between ETIs and Actual cases	Total % drop-out
Vidarbha	223	24.6%	660	247	27.2%
Marathwada	698	50.7%	668	708	51.5%
Western Maharashtra	553	30.8%	1151	642	35.8%
Northern Maharashtra	313	25.1%	863	386	30.9%
Konkan	146	27.0%	375	165	30.6%
Mumbai	601	21.9%	2006	739	26.9%
Total	2534	29.4%	5723	2887	33.5%

(Source: Tables prepared using data obtained from RGJAY Society)

According to the RGJAY process, once an ETI is approved, it has to be registered and preauthorized within 72 hours. Majority of dropouts[14] occur between duration of ETI approval and registration, while dropouts between registration and total actual cases[15] including inpatient and outpatient cases are quite less. The reason for dropouts post - preauthorization could be rejection or maybe even the death of a patient. As seen in the table above, nearly 29.4% ETI cases are not registered, out of which 39.4% are in public hospitals and 20.3% are in private hospitals. This suggests that ETIs raised in public are less successfully registered as compared to those raised in private sector. In terms of regional variation, nearly 50.7% of ETIs raised in Marathwada did not get registered and 30.8% in Western Maharashtra. On the other hand, 21.9% ETIs raised in Mumbai did not get registered.

If we consider the total drop-out i.e. the difference between ETIs approved and actual cases, the gap between public and private then becomes evident. The percentage drop out in the public sector is 43.1% while in the private sector it is 24.8%. Within regions, the total drop-out is highest in Marathwada with 51.5% and lowest in Mumbai with 26.9%. Thus, despite that fact that least number of hospitals in Mumbai raised ETIs, the total number of ETIs raised is highest in Mumbai and the total dropout of ETIs is lowest.

[14] Drop-outs here mean the cases which do not successfully move from one stage to another in the Emergency telephonic intimation process
[15] Actual cases are those cases which have moved beyond the registration stage and been given services under the scheme as per the emergency telephonic intimation process

Claims

Once the preauthorization request is approved, the treatment starts, and soon after its completion the claims process is initiated. The process of claim settlement starts after the patient is discharged from the hospital. The process, as shared by a RGJAY official, is as follows:

- After the surgery the data operator has to fill the OT notes (operation theatre notes), then the hospital has to initiate the discharge procedure.
- Post discharge, after 10 days, "claims" tab opens on the website to upload the details. Discharge card, name and kind of procedure performed along with OT notes and other required documents are to be uploaded. All the documents are sent to the TPA for approval.

Till the 1st week of August 2014, when the RGJAY data was collected, 214019 claims had been raised by hospitals in Maharashtra. Nearly 74% of claims raised were from private hospitals while only 26% were from public hospitals empanelled in RGJAY (Table 35). Information about the region wise and specialty wise claims raised was unavailable.

Table 35: Claims Raised across Type of Provider

Type of Provider	Frequency (Percent)
Public	53034 (24.8%)
Private	160985 (75.2%)
Total	214019 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Pending Claims

The claims sent by hospitals have to be complete with all the required documents, or else the TPA sends it back to the hospital within 7 days and gives reason for the same. This is called as claims pending. It is the empanelled hospital's responsibility, where the procedure has been done to then fulfil the requirements and send it back to the TPA for processing the claim.

Claims Pending Analysis[16]

As the process of claims payment undergoes scrutiny more than once, the data file from RGJAY Society contained multiple entries for most of the cases, sometimes stating the same reason for the claim being kept pending. In order to prevent unnecessary inflation of the numerator N we clubbed all the multiple entries into one case containing various reasons for which they had been kept pending. After this process of data cleaning, 7860 cases remained and further analysis was carried out.

[16] The file on pending claims cases originally contained 9979 cases in which after removing incomplete data only 8960 cases remained.

Table 36: Reasons for Claim Pending

Reasons for pending cases	Frequency Percent of total cases (N = 7860)
Issues with medical documents*	5005 (63.7%)
Issues with non-medical documents**	1754 (22.3%)
Issues with photos***	2479 (31.5%)
Issues with photos taken at the time of discharge	1088 (13.8%)
Issue with late submission of claims	27 (0.3%)
Explanation/clarification sought regarding the package or the procedure	413 (5.3%)
Attaching death certificate****	128 (1.6%)
Issue regarding billing amount	319 (4.1%)
Other	44 (0.6%)
Data not available	1 (0.0%)
	11258*****

* Includes X-rays, HP reports, Fundus photos & reports, USG films/ reports, OT notes, discharge summary, induction reports, endoscopy photographs, ECG
** Includes valve sticker, satisfaction letter, RGJAY invoice bill, transportation cost letter, pre-auth form
*** Includes intra-operative photo i.e. photo taken during the operation, photo of patient on dialysis
**** Includes all remarks about death certificate, and death certificate plus other document/explanation to be included
***** Multiple reasons taken separately in a single case, hence, the total here is more than all the cases

(Source: Tables prepared using data obtained from RGJAY Society)

The processing of claims requires submission of extensive documentation and evidence by the concerned hospital. These include medical documents like case sheets, diagnostic reports etc.; and non-medical documents like identification cards, photos taken during the procedures, bills and so on. Missing any of these documents leads to claim remaining pending until the said documents or evidence is not produced and submitted. From the RGJAY data files, pending claims were analyzed for the reasons for pending status. It was found that in many cases, there was more than one reason for pending status; hence, each reason was treated separately. Data was not available for one case.

Accordingly, the major reasons for pending cases were issues with medical documents like pre-operative and post-operative diagnostic reports (X-ray, USG, blood reports etc.), case sheets, drug charts, OT notes, discharge summary etc. There were also issues with non-medical documents like ration cards, RGJAY invoice bill, medical device stickers[17], pre-authorization forms etc. We found that photographs are also required to be submitted. Thus non sub-mission of photos taken during operative procedures, photos of patient while taking treatment, scar photos etc.; can also contribute to claims being delayed. Even photos of the beneficiary at the time of discharge with specific elements like RGJAY poster in background, alongside MCO etc. have to be taken and submitted. In many cases, there were issues with these 'Discharge' photos which were not submitted or MCO/aarogyamitra was not visible or RGJAY poster was not seen etc. in the picture. Issues with late submission of claims; explanations or clarifications sought for a particular package selected or procedure done other than approved can also lead to pending of claims. A claim, in case of deaths, also requires attaching death certificates in a particular format like

[17] Here device stickers are important in certain medical procedures like orthopaedic implants etc. where medical devices are used. The stickers on them give information on the company name, quality, model, etc.

"form 4" with specific details like date and time of death etc. There could also be issues associated with billing. The patient might have multiple case registrations. Claims might also have been submitted before completing procedure, and so on. Missing details or face was not seen properly in photos or documents not corresponding to proper dates or asking to provide evidence of money refunded, a procedure done, conflicting evidence, evidence of post-treatment improvement etc., could all contribute to delays.

The medical officer from the private hospital explained the pending claims by giving example of a bypass procedure,

"See I will explain with a simple case. I hope you understand the Bypass procedure. While doing this operation we need a pump called IBP. The surgeons always want case approval with this IBP. The patient may require it post intra-operative (during the operation). As we cannot judge at that time (of pre-operative procedure). Maybe 60% because of the diffused vessel disease that patient may require this pump or not at all. No one can predict. So one pre-auth (preauthorization) was rejected saying that we do not depend on possibilities (of treatment). A Consultant or a surgeon will not be able to predict whether the patient needs IBP pump or not. It all depends on how severe it is. He will see in the ER and decide that it is not required but if patient's blood pressure falls then he has to put the IBP in any case. Therefore, there are such cases, where the pump was not used. Such cases were also rejected citing a reason that why was not it intimated to them earlier. Why did you not change the preauth accordingly? These cases are put in pending".

Here, the decision made to use the IBP pump was made during the course of the surgery. Thus, quite obviously, its use was not included in the preauthorization request and therefore not cleared at that stage. This led to problems during the claims process. In fact, as was pointed out earlier, even at the stage of cancellations of preauthorization requests, "Change of procedure/package" was noted as one of the reasons for cancellation in nearly 15.7% of all requests (Table 32).

Table 36 shows the major reasons for pending claims, which were listed and coded while those that could not be categorized among them were put in 'Other'. Thus, each reason is counted separately, as a single case may have multiple reasons for pending status. It was found that issue with medical documents was found in the majority (63.7%) of the cases followed by issues with photos of the procedure (31.5%). Issues with non-medical documents were seen in 22.3% cases while discharge photo related issues were reported in 13.8% cases. Explanation or clarification of the package or procedure was sought in 5.3% cases while there were issues regarding billing in 4.1% cases. Around 1.6% cases had issues with death certificate and 0.3% cases were a late submission for claims. Besides, there were 0.6% of cases with other issues.

We analyzed each reason for its proportion within the public and private sector. In general, the number of pending claims cases is higher in public sector (57.7%) as compared to private sector (42.3%). Within the claims cases, we see a slightly different pattern of reasons for pending cases in private and public sectors as shown in table 50 (Annexure II, Table 11). From this analysis, some specific trends emerged. The public sector had greater issues with late submission of claims than the private sector. Issues with incomplete or missing documents or photos persisted in the public sector as seen in the earlier section on pending preauthorizations. Interestingly, in the private sector, there were issues with billing where patients had been charged by the hospital; these were nearly twice that in the public sector.

Claims Rejection

As informed by an RGJAY official, majority of the cases of rejections are because of incomplete submission of documents, which can be easily rectified with resubmission of the completed documents. The reasons for rejection seem frivolous and minor, eg post-operative x-ray not clear or discharge papers are not proper etc. Such claims are kept pending and then if they are not cleared in time they get rejected.

One of the reasons for rejection was associated with the problems in the identity proofs. As told by the assistant medical officer from a private hospital,

"There are some claims where ID proof is not attached. ID proof and ration card is not the issue of the hospital, and during enrollments if you approve the documents then it should not be rejected later".
He further complained,

"When we send the claim after 10 days of the surgery then they say that the photo is not clear in the ID proof. My question is then why did you approve during the enrollment and registration. There are many claims like these. Yesterday, around 10 such rejected claims cases I have updated and have put the same question asked above as my remarks on them".

Yet another instance of claims rejection was shared a doctor in the private sector who was associated with public to private referral of the patient. As per his narration, the patient was registered in a tertiary level public hospital for doing an angiography and was referred to a private hospital for surgery post angiography due to the long waiting list. However, after the treatment, claim was rejected, citing the reason that the angiography video was not submitted. The government hospital had given a letter and the film too.

When the TPA doctors were asked about reasons for claims rejection one of them replied,
"If there is treatment prior to preauthorization, check karne par maloom padta hai ki surgery pehle kar diya. If there is deviation from preauthorization – approval kisi aur cheez ke liye liya tha aur woh kar kuch aur raha hai (Claim is rejected)." (Rejection of claim can happen also if the treatment is done prior to preauthorization. When we check, we come to know that surgery has already been done. Or if there is deviation from what was approved under preauthorization. Approval was taken for some procedure and they have done some other procedure).

He also added,
"If mandatory documents are missing; hospital has 2 chances to rectify. 2nd time my doctor has to either accept or reject claim. If claim is rejected, the hospital has right to appeal to the CMO in the TPA. If CMO rejects appeal then matter goes to the CCM, which consists of members from TPA, Society and NIC".

As per a RGJAY official, RGJAY Society also monitors rejected claims and reasons for rejection. The claims, which are rejected by the TPA can be reviewed by the Society which again verifies the claims against the reasons for rejections. As mentioned in the phase II MOU, the empanelled hospitals also have the right to appeal if they are not satisfied with the Insurer's decision to reject the case. In such a case, a Central Committee consisting of members from Insurance company and RGJAY Society hear the case and give a recommendation to the Deputy General Manager (DGM) of the Insurer for final decision. As per a senior RGJAY official, convincing TPA doctors in case of rejected claims and making them

understand issues with processing was very challenging. In some cases, after the intervention of the Society, claims get accepted.

Claims Rejection Analysis

Analysis of the rejected cases was done in order to understand the patterns of claims rejection across phases and type of hospital. It was seen that, more than half of the rejected claims were from phase I and most were in the private sector. This is in contrast to pending claims where the number of pending cases was higher in public sector. As such, the distribution (35:65) of rejected cases among public and private sector is closer to that of pre-authorizations raised (30:70). From the rejected claims cases, about 13.6% were from cardiology, followed by 11.1% from nephrology, 9.3% from genitourinary system, 8.8% from medical oncology and 8.4% from poly trauma categories of specialties. Other specialty categories had 5% or less number of cases. With respect to regions where the hospitals were located, nearly 36.2% of cases rejected were from Mumbai, 16.6% of cases were from Western Maharashtra, 16% percent cases from Vidarbha and around 10-11% cases each from the rest three regions.

Table 37: Rejected Claims Cases according to Phases, Hospital Categories, Specialty categories and Hospital regions

RGJAY Phases	Rejected Claims cases
Phase 1	3544 (56.0%)
Phase 2	2785 (44.0%)
Total	6329 (100.0%)
Hospital Category	Frequency
Public	2226 (35.2%)
Private	4103 (64.8%)
Total	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 38: Rejected Claims Cases according to Specialty Categories

Specialty Category	Frequency
Burns	30 (0.5%)
Cardiac And Cardiothoracic Surgery	292 (4.6%)
Cardiology	858 (13.6%)
Critical Care	345 (5.5%)
Endocrinology	27 (0.4%)
ENT Surgery	268 (4.2%)
Gastroenterology	99 (1.6%)
General medicine	9 (0.1%)
General Surgery	319 (5.0%)
Genitourinary System	587 (9.3%)
Gynaecology And Obstetrics Surgery	225 (3.6%)
Infectious Diseases	6 (0.1%)
Interventional Radiology	70 (1.1%)
Medical Oncology	557 (8.8%)
Nephrology	703 (11.1%)
Neurology	147 (2.3%)
Neurosurgery	170 (2.7%)
Ophthalmology Surgery	24 (0.4%)
Orthopedic Surgery And Procedures	277 (4.4%)
Pediatric Surgery	67 (1.1%)
Pediatrics Medical Management	190 (3.0%)
Plastic Surgery	14 (0.2%)
Poly Trauma	529 (8.4%)
Prostheses	2 (0.0%)
Pulmonology	111 (1.8%)
Radiation Oncology	111 (1.8%)
Rheumatology	5 (0.1%)
Surgical Gastro Enterology	65 (1.0%)
Surgical Oncology	222 (3.5%)
Total	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 39: Rejected Claims Cases according to Hospital Regions

Hospital Regions	Frequency
Vidarbha	1013 (16.0%)
Marathwada	642 (10.1%)
Western Maharashtra	1049 (16.6%)
Northern Maharashtra	676 (10.7%)
Konkan	657 (10.4%)
Mumbai	2292 (36.2%)
Total	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

A cross-tabulation of hospital regions and hospital types for claims rejection shows that in most regions, the proportion of cases rejected from private are more than public hospitals, which is similar to the preauthorization distribution where number of cases in private hospitals is more than in public hospitals (Table 40). Mumbai region has greater percent of cases rejected in public hospitals due to the high percentage of publically empanelled hospitals.

Table 40: Hospital Region against Hospital Type for Claims Rejection

Hospital region	Rejected Claims across the type of provider		Total
	Public	Private	
Vidarbha	203 (9.1%)	810 (19.7%)	1013 (16.0%)
Marathwada	149 (6.7%)	493 (12.0%)	642 (10.1%)
Western Maharashtra	146 (6.6%)	903 (22.0%)	1049 (16.6%)
Northern Maharashtra	87 (3.9%)	589 (14.4%)	676 (10.7%)
Konkan	12 (0.5%)	645 (15.7%)	657 (10.4%)
Mumbai	1629 (73.2%)	663 (16.2%)	2292 (36.2%)
Total	2226 (100.0%)	4103 (100.0%)	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

When analysis for various reasons for rejection was done, it was found that in many cases there was more than one reason for rejection. Therefore, the frequency of each reason in all cases was taken separately to simplify the understanding of various reasons of rejection and their occurrence. Frequency analysis found that issues with medical documents were found in nearly one-third of cases (Table 41).

This was supported by what a TPA shared on rejection of claims,
"Document deficiency is the highest reason for rejection of claims. In the Government hospitals the MCOs (Medical coordinators) keep getting transferred. People not equipped in trying to handle the system and upload documents, this is a major cause for document deficiency. We even had a cluster meeting to inform all hospitals that such a list exists. Now if they won't read it, then what can we do?"

Evidently, therefore, understanding the system can be a task and in a scenario where the relevant authority keeps changing, it only works negatively for the patients.

Further, he added,
"Except OPD, every procedure requires photo. Clinical photo and post procedure/surgery are mandatory as is discharge photo. Many times discharge photos are clicked with the patient lying in bed and holding money. That makes no sense, how will patient go home like that. Discharge photo is to be clicked at the time the patient is actually leaving the hospital" (TPA).

Table 41: Major Reasons for Rejection of Claims

Reasons for Rejection of cases	Frequency (Percent of total cases, N = 6329)
Medical documents were not satisfactory or documents were not attached	2262 (35.7%)
Procedure was done prior to preauthorization	578 (9.1%)
Issue with patient ID proof/ name, etc	229 (3.6%)
Already approved the claim previously	560 (8.8%)
Issues with bills	107 (1.7%)
Procedure not covered under the scheme/ wrong selection of package	1570 (24.8%)
Other issues with the procedure - stent etc	166 (2.6%)
Rejected due to death of the patient	45 (0.7%)
Approved procedure not performed[18]	394 (6.2%)
Discharge and/or dialysis photos were not attached or not satisfactory	223 (3.5%)
Procedure not covered under private hospital as reserved for government hospital	101 (1.6%)
Surgery done more than one month after preauthorization	4 (0.1%)
Reason not mentioned	204 (3.2%)
Others	28 (0.4%)
Operated in other hospital	16 (0.3%)
The case was rejected by TPA & approved by Society	64 (1.0%)
The patient was not physically present during the visit of RGJAY/TPA officer	18 (0.3%)
Claim raised after run-off period	45 (0.7%)
Surgery not done and/ or postponed	33 (0.5%)
Discrepancy found in documents given online as against the documents or treatment being given at the time of field visit or in the report.	42 (0.7%)
Total	6689*

* Multiple reasons taken separately in a single case, hence, the total here is more than all the cases
(Source: Tables prepared using data obtained from RGJAY Society)

[18]Eg cholesysectomy is the approved procedure, however procedure done is different.

Annexure II, Table 12 shows that within public and private sector, some reasons, are more significantly seen in each category. In private hospitals, such reasons are issues with bills, approved procedure not performed, discrepancy found at the time of field visit or in the report and dialysis photo not attached or not proper. The reason 'procedure not covered under private hospital' is of course completely under the private hospital category. In public hospitals, the significant reasons are claims rejected due to death of the patient, issues with discharge related photos, case rejected by TPA and approved by Society at the time of pre-auth and patient not physically present during the visit. The less significant reasons are claims raised after run-off period and surgery not done or postponed.

Analysis of rejected claims across phases and type of provider showed that the percentage of claims rejected from public hospitals has significantly decreased in Phase II. While for Private hospital claims, the proportion is nearly the same (Table 42). The reason for such a decrease might be due to the expansion of scheme across the remaining districts, which resulted in empanelment of large number of private hospitals in the scheme.

Table 42: Rejection of Claims across Phases and Type of Provider

Phases	Hospital type		Total
	Public	Private	
Phase 1	1518 (68.2%)	2026 (49.4%)	3544 (56.0%)
Phase 2	708 (31.8%)	2077 (50.6%)	2785 (44.0%)
Total	2226 (100.0%)	4103 (100.0%)	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

The specialty categories are cross-tabulated against type of providers to examine if any changes in the pattern of claims rejection (Table 43). In public hospitals, top specialties in claims rejection are cardiology (14.7%), medical oncology (11.7%), poly trauma (10%) and general surgery (9.3%). In private hospitals, the top specialties in claims rejection are nephrology (14.5%), cardiology (12.9%), genitourinary system (12.3%), poly trauma (7.5%) and medical oncology (7.2%) Among these as mentioned earlier, medical oncology, nephrology, cardiology, genitourinary system and poly trauma are also the specialties where most preauthorization requests are made.

Table 43: Medical Specialties against Type of Hospital for Claim Rejection

Specialty Category	Type of Hospital		Total
	Public	Private	
Burns	22 (1.0%)	8 (0.2%)	30 (0.5%)
Cardiac And Cardiothoracic Surgery	122 (5.5%)	170 (4.1%)	292 (4.6%)
Cardiology	327 (14.7%)	531 (12.9%)	858 (13.6%)
Critical Care	80 (3.6%)	265 (6.5%)	345 (5.5%)
ENT Surgery	35 (1.6%)	233 (5.7%)	268 (4.2%)
Endocrinology	13 (0.6%)	14 (0.3%)	27 (0.4%)
General Medicine	4 (0.2%)	5 (0.1%)	9 (0.1%)
Gastroenterology	44 (2.0%)	55 (1.3%)	99 (1.6%)
General Surgery	207 (9.3%)	112 (2.7%)	319 (5.0%)
Genitourinary System	83 (3.7%)	504 (12.3%)	587 (9.3%)
Gynaecology And Obstetrics Surgery	89 (4.0%)	136 (3.3%)	225 (3.6%)
Infectious Diseases	6 (0.3%)	0 (0.0%)	6 (0.1%)
Interventional Radiology	30 (1.3%)	40 (1.0%)	70 (1.1%)
Medical Oncology	260 (11.7%)	297 (7.2%)	557 (8.8%)
Nephrology	108 (4.9%)	595 (14.5%)	703 (11.1%)
Neurology	82 (3.7%)	65 (1.6%)	147 (2.3%)
Neurosurgery	73 (3.3%)	97 (2.4%)	170 (2.7%)
Ophthalmology Surgery	11 (0.5%)	13 (0.3%)	24 (0.4%)
Orthopedic Surgery And Procedures	85 (3.8%)	192 (4.7%)	277 (4.4%)
Pediatric Surgery	28 (1.3%)	39 (1.0%)	67 (1.1%)
Pediatrics Medical Management	98 (4.4%)	92 (2.2%)	190 (3.0%)
Plastic Surgery	7 (0.3%)	7 (0.2%)	14 (0.2%)
Poly Trauma	223 (10.0%)	306 (7.5%)	529 (8.4%)
Prostheses	2 (0.1%)	0 (0.0%)	2 (0.0%)
Pulmonology	58 (2.6%)	53 (1.3%)	111 (1.8%)
Radiation Oncology	14 (0.6%)	97 (2.4%)	111 (1.8%)
Rheumatology	5 (0.2%)	0 (0.0%)	5 (0.1%)
Surgical Gastro-Enterology	30 (1.3%)	35 (0.9%)	65 (1.0%)
Surgical Oncology	80 (3.6%)	142 (3.5%)	222 (3.5%)
Total	2226 (100.0%)	4103 (100.0%)	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Claims Paid

Table 44: Compiled Claims Information As Per Type of Hospital

	Claims raised	Claims rejected	Claims rejection rate**	Claims paid	Claims paid amount (INR)
Public hospital	54044 (26.17%)	1633	3.02	43107 (24.42%)	1,18,25,57,787
Private hospital	152679 (73.85%)	1983	1.29	133369 (75.57%)	3,48,71,34,314
Total	206723	3616	1.74	176479	4,66,96,92,101

*The table is for 206723 claims raised. Since it is an ongoing process the rejected claims get resubmitted by the empanelled hospital and might get accepted. therefore, the denominator in the claims rejection file and in the table differ.
**Claims rejection rate = claims rejected/claims raised*100

(Source: Tables prepared using data obtained from RGJAY Society)

It is evident from the above table that the proportion of the claims raised from the private hospitals was more than those in public hospitals. However, the claims rejection rate was more than double in public hospitals than private. The amount paid to the public hospitals was INR 118 crores and that to the private hospital it was INR 348 crores. The section presented a detailed analysis of the claims rejection data as well as the realities on the ground which we ascertained through key informant interviews. Most of the reasons, we found, are the systemic associated with cumbersome, often even impractical, procedures under the scheme.

Follow-up

Follow-up packages are restricted to 121 procedures. As per the protocol (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d.-g) on the RGJAY website, the process starts from the 11th day after discharge. We analyzed the data files on follow-up received from RGJAY for the period July 2012-August 2014. There were 45014 cases for follow-up out of which only 9397 (21%) cases availed the first follow-up, 3284 (7.3%) cases availed the second follow-up, 1086 (2.4%) availed the third follow-up and only 328 cases had the fourth follow-up (0.7%) (Table 45).

Table 45: Status of Eligible Follow-up Cases

Follow-up status	First follow-up	Second follow-up	Third follow-up	Fourth follow-up
Availed	9397 (20.9%)	3284 (7.3%)	1086 (2.4%)	328 (0.7%)
Not Availed	35617 (79.1%)	41730 (92.7%)	43928 (97.6%)	44686 (99.3%)
Total	45014 (100.0%)	45014 (100.0%)	45014 (100.0%)	45014 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Thus, only about 21% cases came for the first follow-up, which falls drastically to 7.3% in the second follow-up, 2.4 in the third and only 0.7% in the fourth. The follow-up turnouts may be dismal because of migration for availing the RGJAY scheme. As the follow-up has to be availed from the same hospital, it may not be possible for migrating patients to avail these services from their hometown.

Table 46: First Follow-up against Type of Hospital

First follow-up	Type of hospital		Total
	Public	Private	
Availed	20 (0.2%)	9377 (99.8%)	9397 (100.0%)
Not Availed	10582 (29.7%)	25035 (70.3%)	35617 (100.0%)
Total	10602 (23.6%)	34412 (76.4%)	45014 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

If we look at the public and private distribution against the first follow-up status, it shows a sharp contrast. Only 0.2% cases availed the first follow up in the public hospital as against 99.79% of the cases in private hospitals. The number of cases in public hospitals for further follow-ups is either negligible to zero.

As seen from the data, less than one fourth of the eligible patients availed the first follow up, and the percentage further decreased with the second, third and fourth follow-ups. The schemes cover significant number of medical procedures for follow up. However, as seen from the narration above, not all the eligible patients have been able to take the benefit. This is also because of the condition that the follow up has to be done from the same hospital where the original treatment / surgery was done. We also anticipate that since for the follow up there are cumbersome procedures and obviously package amount being much less, patients may not find it worthwhile to travel and incur loss of working days. It might therefore, also be possible, that these same patients may either be skipping follow ups or may be going to the local providers providing relevant follow ups thereby incurring out of pocket expenditures. This is a serious limitation of the scheme as it defeats the purpose of the scheme and clearly restricts patients from completing their treatment comprehensively under the RGJAY.

Cross-tabulation in table 47 follow-up rate for cases was highest in hospitals in Marathwada (38.7%) and lowest in Konkan (1.4%). Marathwada was followed by Northern Maharashtra (28.2%), Mumbai (22.2%), Western Maharashtra (21.1%) and Vidarbha (6.1%).

Table 47: First Follow-up of Patients across the Patient Regions

First follow-up	Patient Regions - where patient originally belongs						
	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Availed	316 (6.4%)	1180 (30.7%)	1453 (20.3%)	2033 (29.2%)	345 (7.0%)	4070 (23.7%)	9397 (20.9%)
Not Availed	4645 (93.6%)	2659 (69.3%)	5692 (79.7%)	4919 (70.8%)	4585 (93.0%)	13117 (76.3%)	35617 (79.1%)
Total	4961	3839	7145	6952	4930	17187	45014

(Source: Tables prepared using data obtained from RGJAY Society)

As we know many patients migrate to other districts to avail the RGJAY scheme, it is important to see the trend of follow-ups across regions from where the patients belong to get the true picture of geographical barriers in utilization.

"kasa aahe, mumbait hospital madhe Maharashtrachya koparyatun patients yetat…samajaek patient Nagpur hun heart surgery sathi ala, ani tyala sangitala ki parat teen mahinyani yava lagel tar to yenarach nahi…" (Usually what happens is patient is from distant village who has come for a surgery to a hospital in Mumbai , then if it is told to him that please come after 3 months (for follow-up) then he won't come) (RGJAY Official).

The cross-tabulation of follow-up availed is presented in table 47 for patient's region of origin above shows a similar pattern as that for region in which hospital is located. The first follow-up rate was higher in Marathwada (30.7%), followed by Northern Maharashtra (29.2%), Mumbai (23.7%) and Western Maharashtra (20.3%). Follow-up rates were considerably lower in Konkan (7%) and Vidarbha (6.4%).

Grievance Redressal

RGJAY scheme includes a grievance redressal mechanism whereby patients can share their grievances about any issue related to the scheme with the authorities. According to the MOU between RGJAY Society and the Insurance Company, both district level and the state level authorities are a part of the grievance redressal Committee. The grievance department manned by doctors and other staff also look after the grievances received from Empanelled Hospitals and not just beneficiaries. The responsibility of making patients aware about such a system lays mainly with the scheme providers, and the information is shared as soon as he/she is enrolled.

The MOU mentions a 24-hour call center with toll free helpline to be set-up by the Insurer, which would also receive complaints or grievances from patients, as well as Empanelled Hospitals. A record of grievances received in oral, written or any other form of communication has to be maintained. Action Taken Report (ATR) has to be made within 7 working days or immediately in case of emergencies.

In our interviews with the DCOs, we found that most of the grievances were associated with out of pocket spending (this was supported by our quantitative analysis given later). This can happen due to various reasons such as non – availability of diagnostics or scans in public hospitals leaving no choice to the beneficiaries, but to access the private sector for the same. We found that some public hospitals reimburse this cost under RGJAY against a valid a receipt that has to be submitted in the public hospital. This defeats the purpose of a cashless scheme. Many of these diagnostic tests, for instance an MRI, are very expensive in the private sector. It would be very difficult for the poor people to come up with that kind of money in the first place. Moreover, reimbursements will take time, until then the beneficiaries have to carry the burden despite availing the scheme.

Another important source of grievances, revealed through our interviews, was the low costs set for procedures under the scheme. Accordingly, as shared by a DCO that the cost of the procedure can in fact be more than the package rate. This contributes to an increased OOP spending by patients. This is more likely to happen in Grade C and D of hospitals (Rajiv Gandhi Jeevandayee Aarogya Yojana, n.d., h) as their packages are marked lower. Patients were in fact asked by hospitals to deposit the balance money.

A doctor from the private sector narrated another source of grievance,

"Just recently there was a case…an uncle whose son had soiled the bed sheet. He had asked the nurse to change it. The nurse had some other work and she could not do it even after agreeing to do it for the next 30 minutes. So the uncle said that his one complaint can bring down the hospital's reputation. Hospital ki waat lag jayegi (The hospital's reputation would be ruined - Uncle)".

"I also told him in sweet way that if he wants to call anybody, other than the CMD, he can call and jiski waat lagani hai, laga do. Dekhte hum bhi. You have come under RGJAY for treatment and not for sleeping on the bed. Your discharge is in a day or so. They still complained that they received bad treatment. We could not do anything in this" (Doctor, private hospital).

This incident clearly points to poor quality of care and poor responsiveness towards a grievance. Importantly, it also clearly displays the attitude of the private sector towards patients availing the scheme.

The grievance dump file contains 4006 cases of grievances where a single complainant may have registered multiple complaints about the same grievance. However, since each complaint is registered separately and evaluated, we have kept these cases as it is.

Table 48: Grievance Cases Registered Through Various Channels

Channel through which grievance was registered	Frequency
Chief Minister's[19] Feedback Letters	363 (9.1%)
CTS(Communication To Society)	879 (21.9%)
District level reported Grievance	823 (20.5%)
Government Programs	215 (5.4%)
News	4 (0.1%)
Phone Calls to Call centre	1625 (40.6%)
Walk-In RGJAY office	97 (2.4%)
Total	4006 (100%)

(Source: Tables prepared using data obtained from RGJAY Society)

The most common means of communication for reporting a grievance were 'Phone calls' (40.6%); followed by direct Communication to RGJAY Society (21.9%) followed by registration of complaints with District level grievance committee (20.5%).

[19] Letter from the chief minister given to each beneficiary at the time of discharge, which have the information about grievance registration.

Table 49: Grievance Issues as Per Hospital Category

Grievance as per hospital type	Frequency
Public	771 (23.8%)
Private	2466 (76.2%)
Total	3237 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

From the cases where type of hospital is known, 23.8% of cases of grievances are sourced from a government hospital and 76.2% of the cases are from private hospitals.

Through our quantitative analysis of the data shared by the RGJAY Society, we were able to develop a clear profile of the grievances. The grievance redressal process in RGJAY entails, as discussed above, registration of a grievance through various modes. Three variables in the grievance files give us key information about each case. The first variable is the grievance brought by the patient and in many cases, there was more than one complaint. These were coded separately. The second variable is the 'actual issue' found by the grievance cell after an investigation of the case and the third variable is the outcome of grievance resolution. Although grievances vary case by case and may be complicated, we have tried to identify a central problem in each case and give it a code, which conveys the general idea.

Grievance Issues as Registered by Complainants

These are complaints or grievances as registered by the complainants. Not just beneficiaries, but also empanelled hospitals can register complaints. As grievances registered from the patient were coded in two variables, we calculated the frequency of each complaint in the file. The frequency analysis shows that in more than half cases, there was a complaint of collection of money or demand for money by the hospital over and above the cost of the package or for investigations, blood transfusions or surgical gear etc.

The second major complaint was a delay in receiving treatment (20.5%) which was followed by denial of hospital admission (8.1%). About 4.4% of the cases were complains against the hospital, its staff or aarogyamitras, 4.2% had complaints against the empanelled hospital not providing free follow-up services, 3.5% had a grievance of not receiving medicines, food or travel services from the hospital and 3.2% complained that they were not being registered under RGJAY scheme to avail the benefits. Other grievances include unavailability of staff/ aarogyamitra (2.0%), incomplete treatment (0.9%), postoperative complications/ surgery failure (0.9%), blood/investigation/service not available in empanelled hospital (0.6%), negligence by hospital (0.6%), pending pre-auth approval (0.5%), discharge without treatment (0.4%), not clear/ others (0.4%), problem with documents (0.3%) and patient not given discharge (0.2%).

Table 50: Grievance Issues as Registered By the Patients

Patient Grievance issue	Frequency (Percent of all cases, N = 4006)
Collection of money/ demand for money	2042 (51.0%)
Denial of Admission	324 (8.1%)
Blood/Investigation test/service not available in empanelled hospital	26 (0.6%)
Unavailability of staff	79 (2.0%)
Incomplete treatment	38 (0.9%)
Empanelled hospital not providing food/travel/medicines	140 (3.5%)
Empanelled hospital not providing free follow-up services	170 (4.2%)
Delay in treatment	821 (20.5%)
Discharge without treatment	18 (0.4%)
Pending preauth approval	19 (0.5%)
Complaint on Hospital Staff/Management	178 (4.4%)
Patient not registered under RGJAY	127 (3.2%)
Problem with documents	12 (0.3%)
Patient not given discharge	10 (0.2%)
Negligence case	24 (0.6%)
Post operative complication/ surgery failure	38 (0.9%)
Not clear/ others	17 (0.4%)
Total	4083*

(Source: Tables prepared using data obtained from RGJAY Society)

For grievances, information of the type of hospital was available only for 3237 cases and only those cases were cross-tabulated with grievance issue. It is interesting to note that, both the private and public sectors fared close for the same grievances. Thus, the top category of grievance in both public and private hospitals was collection of / demands for money with 65.4% and 61.1% cases respectively (Table 51). In the government sector, other major grievances were denial of admission (7.0%), delay in treatment (6.1%), complaint against hospital/staff/aarogyamitra (5.2%), Empanelled hospital not providing free follow-up services (3.4%) and food/travel medicine (3.1%). Denial of admission (7.1%), Empanelled hospital not providing free follow-up services (5.7%), complaint against hospital/staff/ARM (4.7%), Empanelled hospital not providing food/travel medicine (4.6%), delay in treatment (4.5%) and patient was not registered under RGJAY (4.2%); is how the private sector fared on this.

Table 51: Grievance Issues across Hospital Type

Patient grievance issue	Hospital type		Total
	Public	Private	
Collection of money	504 (65.4%)	1506 (61.1%)	2010 (62.1%)
Denial of Admission	54 (7.0%)	176 (7.1%)	230 (7.1%)
Blood/Investigation test/service not available in Empanelled Hospital	2 (0.3%)	22 (0.9%)	24 (0.7%)
Unavailability of staff	20 (2.6%)	41 (1.7%)	61 (1.9%)
Incomplete treatment	5 (0.6%)	33 (1.3%)	38 (1.2%)
Empanelled hospital not providing food/ travel/medicines	24 (3.1%)	113 (4.6%)	137 (4.2%)
Empanelled hospital not providing free follow-up services	26 (3.4%)	141 (5.7%)	167 (5.2%)
Delay in treatment	47 (6.1%)	112 (4.5%)	159 (4.9%)
Discharge without treatment	3 (0.4%)	15 (0.6%)	18 (0.6%)
Pending preauthorization approval	4 (0.5%)	12 (0.5%)	16 (0.5%)
Complaint on Hospital Staff/Mgmt	40 (5.2%)	117 (4.7%)	157 (4.9%)
Patient not registered under RGJAY	20 (2.6%)	104 (4.2%)	124 (3.8%)
Problem with documents	3 (0.4%)	9 (0.4%)	12 (0.4%)
Patient not given discharge	3 (0.4%)	4 (0.2%)	7 (0.2%)
Negligence case	6 (0.8%)	18 (0.7%)	24 (0.7%)
Post op complication	5 (0.6%)	33 (1.3%)	38 (1.2%)
Not clear/ others	5 (0.6%)	10 (0.4%)	15 (0.5%)
Total	771 (100.0%)	2466 (100.0%)	3237 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Significant Cases from the Grievance Data File

Though there were some general complaints registered by the patients, there were certain cases, which the researchers identified from the file to be presented as case studies for a better understanding. Each complaint went through a chain of staff who investigated the complaint at the Grievance Department. It was found that for every complaint, there are comments under the Executive Grievance procedure, Project head, Manager Project Office Operations, Assistant Manager Grievance and finally the Executive Grievance gives the conclusion of the case.[20] The cases below will also provide an insight into the nature of the complaints, how the grievance was addressed, and the entire approach of the officials towards handling patient grievances.

[20] This is the verbatim format found in every grievance registered.

Grievance Case 1: Emergency Admission, Unavailability of Aarogyamitra and Out of Pocket Expenditure

"Complaint: Caller complained aarogyamitra is not available in the hospital. He told number of time visit kiosk but ARM (Aarogyamitra) is not present that time. Patient comes on 6 Jan at 7.30pm and patient death on 10.30pm. So hospital charge (for treatment done) INR 13000 because patient was not enrolled and registered (under RGJAY.)

Executive Grievance procedure: Information given we will escalate this issue to supervisor and ARM., Project Head: Resolved,

Manager Project Office Operations: The 2nd shift ARM was available at the NWH (Empanelled hospital) but he was on routine round from 7:00pm till 7:30pm. He was available till 8:30pm. The Night shift ARM was also available in his duty hours. Though if the ARM were not available for any reason the ETI facility is provided to the NWH MCO (Hospital Medical Coordinator) and his staff, it could have been used but it has not happened so. As the patient is neither enrolled nor ETI is taken we have no evidence to help the patient. The attender could have called the ARM on the CUG (Phone number) displayed at the Kiosk or the Toll Free Number to get the guidance. Thus, the attender himself is responsible for not enrolling the patient in the scheme.

Asst. Manager Grievance: The 2nd shift ARM was available at the NWH but he was on routine round from 7:00pm till 7:30pm. He was available till 8:30pm. The Night shift ARM was also available in his duty hours. Though if the ARM were not available for any reason The ETI facility is provided to the NWH MCO and his staff, it could have been used but it has not happened so. As the patient is neither enrolled nor ETI is taken we have no evidence to help the patient. The attender could have called the ARM on the CUG displayed at the Kiosk or the Toll Free Number to get the guidance. Thus, the attender himself is responsible for not enrolling the patient in the scheme.

Executive Grievance: as per DVO instruction we closed the case because of DVO cross verify all the situation".

In the case mentioned above, the patient was not able to register under RGJAY and get the scheme benefit in an emergency, as the aarogyamitra was not present at his RGJAY kiosk in the hospital. While the patient ultimately died while taking treatment privately, the family had to bear hospital charges of INR13,000. The case demonstrates how the complaint of absence of aarogyamitra from the RGJAY kiosk is justified in the investigation by the authorities as part of his routine schedule. Meanwhile patient expires before being registered and the blame of not being registered under the scheme is entirely shifted on to the patient attendant, as he/she did not call the aarogyamitra on the phone number displayed on the board and did not register through an ETI. It raises questions such as,

1. Should not the hospital authorities be aware that ward rounds are a part of aarogyamitra's schedule and hence, knowing the schedule, the hospital should have a back-up system during such a time? Are they not accountable to the patients or at the very least guide the patient?

2. There seems to be complete lack of co-ordination between the aarogyamitra and hospital staff wherein the ARM is treated as an external entity by the Hospital.

Grievance Case 2: Cashless Treatment?

"Complaint: We have received grievance of X hospital. Patient have paid money for treatment. Patient was admitted in the hospital on 13.10.2012 for treatment and he spent money for medicines. Dr. I has assured to returned money in due course.

Executive Grievance: We told them that we are discussing with NWH(Empanelled hospital) management about the refund issue we have escalated this issue to seniors ARM told that MCO have told that on one day hospital will refunding patients refund amnt

Project Head: Cross Verified and resolved,

Manager Project Office Operations: After Several reminders Patient is unable to submit the bills hence grievance can be considered as closed.

Asst. Manager Grievance: After Several reminders Patient is unable to submit the bills hence grievance can be considered as closed.

Executive Grievance: We had tried to call patient many times but this contact no 9XXXXXXXXX is not reachable and patient could not submitted the bills till date so we have closed this grievance"[21].

In both the above cases, we find that in a scheme that is supposed to be 'cashless', patients are made to pay money for treatment with assurance of a refund later. But when patient registers grievance for a refund that was never received, the case is closed with the patient / caretaker being projected as the guilty party. It is interesting to point out that in the cases above, officials have recorded identical statements mentioning that the "reminders" were sent to the patient "several times". This implies that these were sent in writing to the patient. However, according to the Executive Grievance, the patients' phone was not reachable. Thus, the case is presented differently by different officials. At the very least, it can be said that it was not a comprehensive investigation into the case. Moreover, the fact different officials have cited identical reasons, as seen in case 1, one also wonders whether any independent investigation was done by the respective officers.

The RGJAY Society/Insurer/TPA needs to take proactive remedial measures to improve the access and accountability under the scheme. The patients' families end up paying cash under the scheme which is supposedly cashless. Even reimbursement of this cash seems to be a cumbersome affair, riddled with issues that could be easily rectifiable.

The Systems' Perspective

Often it was found that actual issue discovered after investigation by the staff was different from the original as stated by the complainant. This section is on the system's perspective of the problem. Hence,

[21] while the exact verbatim has been reproduced as it is from the data file, the phone number has been camouflaged to protect patient identity

the data was coded separately. There may nevertheless be an overlap with the complainant's grievance. The code 'not clear' was given to explanations which were unclear or incomplete or conflicting.[22] This was in 22.5% of the cases.

The most common reason for complaint was 'incurring out of pocket expenditure' (20%) followed by 'unavailability of bed/ long waiting list' (13.7%). In about 11.4% cases, patient contact was not found and hence the grievance issue could not be verified. Other issues found are that patient did not have bills to prove out of pocket expenditure or collection of money by hospital (refer to table 52 for more issues).

Table 52: Actual Issue Found After Investigation of the Grievance by the Grievance Cell

Actual issue found after investigation	Frequency
Out of pocket expenditure	620 (20.0%)
Unavailability of bed/ Long waiting list	425 (13.7%)
Patient contact not available	355 (11.4%)
Patient does not have bills as proof/ waiting for bills	170 (5.5%)
Others*	159 (5.1%)
Patient treatment/diagnosis not covered under RGJAY	135 (4.4%)
Issues related to Follow - up treatment or medicines	126 (4.1%)
unavailability on Hospital staff	101 (3.3%)
Patient paid money before RGJAY registration	97 (3.1%)
RGJAY package does not cover all patient conditions/medicines/travel expenses	93 (3.0%)
Pending preauthorization approval/preauthorization rejected	88 (2.0%)
Patient not getting free services under RGJAY (food/medicines/travel fare etc.)	79 (2.5%)
Complaint on Hospital Staff/Mgmt	64 (2.1%)
Package insufficient to cover patient treatment	62 (2.0%)
Problem with documents/health card invalid	62 (2.0%)
Duplicate entry/wrongly updated	57 (1.8%)
Unavailability of treatment/diagnostic/equipment in the hospital	47 (1.5%)
Related RGJAY Guidelines not finalized	47 (1.5%)
Patient has not registered under RGJAY	45 (1.5%)
Empanelled hospital not covering the procedure/specialty	39 (1.3%)
Hospital not under RGJAY	30 (1.0%)
Patient expired	26 (0.8%)
Procedure covered only in govt hospital	25 (0.8%)
Balance Sum Insured (BSI) exhausted	20 (0.6%)

[22] For example, the issue may be still under investigation or after the initial complaint, when contacted again to get information regarding the matter, the patient reports not having any problem. In many cases, the explanation simply mentions that they co-ordinated with the hospital and resolved the issue. In all these cases, it was difficult to identify the actual issue and hence, the cases coded 'not clear' are removed from further analysis.

Actual issue found after investigation	Frequency
Delay in treatment/problems in admission	20 (0.6%)
Patient got diagnostic privately not suggested by Empanelled hospital / patient bought medicines on own	21 (0.7%)
Empanelled hospital not admitting RGJAY patient	19 (0.6%)
Internet not available/system problem	21 (0.7%)
DTRS not submitted/surgery not updated/missing reports	15 (0.5%)
Misunderstanding between patient and Empanelled hospital /staff	14 (0.5%)
No discrepancy found	8 (0.3%)
Patient not eligible for follow-up	9 (0.3%)
Emergency procedure not registered	4 (0.1%)
Total	3103 (100%)

(Source: Tables prepared using data obtained from RGJAY Society)

*'Others' category includes cases where patient is not interested in taking treatment under RGJAY, had been managed conservatively, post operative complications had arisen, patient got financial aid from some trust, hospital temporarily inactive under RGJAY, hospital not ready to provide blood or certain injections, post discharge further treatment expenses, confusion about the coverage of treatment under the scheme, patient went to hospital billing center instead of RGJAY kiosk, preauthorization was not updated, hospital received package amount less than approved, patient took special ward, patient is not eligible under RGJAY, district is not yet covered under the scheme, patient getting benefit from another health insurance scheme, hospital was demanding money because previous claim was rejected, patient surgery was done before registration, patient not fit for surgery, patient spent money privately, etc.

When we look at the patients' complaints versus the hospital perspective (presented as actual complaints on investigation), we find a large gap between patient expectations and perspective and hospitals perspective and reality. "Collection of money" is topmost in the list of patient complaints making up for more than 60% of all complaints. It appears as an actual complaint in just about 26% of the cases ("n" maybe different in both the cases, however, one is definitely able to get an idea of the proportion). What we do find in the hospitals' perspective, which is obviously not there in the list of patient complaints, are heads such as "RGJAY package does not cover all patient conditions/medicines/travel expenses", "Patient does not have bills as proof/ waiting for bills", "Package insufficient to cover patient treatment" and so on. All of these situations could lead to the patient incurring out of pocket expenses. While we cannot say for certain the reason for such a mismatch, what we can say based as we have ascertained earlier in the report, that the project suffers from poor IEC as well as poor guidance and referrals within the hospitals. This possibly implies that a poor patient, who comes in a harried state, is most likely not to be aware of various requirements and aspects of the scheme.

Cross-tabulation of actual issue found on investigation against type of hospital was done to look for issues specific to government and private hospitals. In government hospitals, the most common issues were out of pocket expenditure (23.4%), patient does not have bills as proof (12.3%), RGJAY guidelines related to the issue not finalized (8.1%) and unavailability of staff (5.4%). The most common private sector issues were out of pocket expenditure (27.0%), patient diagnosis or treatment not covered under RGJAY (6.4%), issues related to follow up treatment or medicines (5.9%) and patient does not have bills as proof (5.5%).

Table 53: Actual Issue against Type of Hospital

Actual Issue found	Hospital type		Total
	Govt	Pvt	
Empanelled hospital not covering the procedure/ specialty	4 (0.7%)	35 (1.9%)	39 (1.6%)
unavailability on Hospital staff	31 (5.4%)	61 (3.4%)	92 (3.9%)
RGJAY package does not cover all patient conditions/medicines/travel expenses	15 (2.6%)	78 (4.3%)	93 (3.9%)
BSI exhausted	2 (0.3%)	18 (1.0%)	20 (0.8%)
Delay in treatment/problems in admission	9 (1.6%)	11 (0.6%)	20 (0.8%)
Patient not getting free services under RGJAY (food/medicines/travel fare etc.)	15 (2.6%)	64 (3.6%)	79 (3.3%)
Issues related to Follow-up treatment or medicines	17 (2.9%)	107 (5.9%)	124 (5.2%)
Patient does not have bills as proof/ waiting for bills	71 (12.3%)	99 (5.5%)	170 (7.2%)
Pending preauthorization approval/ preauthorization rejected	18 (3.1%)	70 (3.9%)	88 (3.7%)
Patient paid money before RGJAY registration	12 (2.1%)	85 (4.7%)	97 (4.1%)
Patient got diagnostic privately not suggested by empanelled hospital / patient bought medicines on own	7 (1.2%)	14 (0.8%)	21 (0.9%)
Patient expired	4 (0.7%)	20 (1.1%)	24 (1.0%)
Unavailability of bed/ Long waiting list	9 (1.6%)	38 (2.1%)	47 (2.0%)
Complaint on Hospital Staff/Mgmt/ unavailability of staff	16 (2.8%)	46 (2.6%)	62 (2.6%)
Procedure covered only in govt hospital	1 (0.2%)	24 (1.3%)	25 (1.1%)
Package insufficient to cover patient treatment	12 (2.1%)	50 (2.8%)	62 (2.6%)
Unavailability of treatment/diagnostic/equipment in the hospital	19 (3.3%)	28 (1.6%)	47 (2.0%)
Out of pocket expenditure	135 (23.4%)	485 (27.0%)	620 (26.1%)
Misunderstanding between patient and empanelled hospital /staff	2 (0.3%)	12 (0.7%)	14 (0.6%)
Patient treatment/diagnosis not covered under RGJAY	19 (3.3%)	116 (6.4%)	135 (5.7%)
Empanelled hospital not admitting RGJAY patient	3 (0.5%)	16 (0.9%)	19 (0.8%)
DTRS not submitted/surgery not updated/ missing reports	3 (0.5%)	12 (0.7%)	15 (0.6%)
Internet not available/system problem	4 (0.7%)	17 (0.9%)	21 (0.9%)
Emergency procedure not registered	0 (0.0%)	4 (0.2%)	4 (0.2%)

Actual Issue found	Hospital type		Total
	Govt	Pvt	
Hospital not under RGJAY	2 (0.3%)	16 (0.9%)	18 (0.8%)
Problem with documents/health card invalid	16 (2.8%)	29 (1.6%)	45 (1.9%)
No discrepancy found	1 (0.2%)	7 (0.4%)	8 (0.3%)
patient has not registered under RGJAY	17 (2.9%)	28 (1.6%)	45 (1.9%)
Others	37 (6.4%)	114 (6.3%)	151 (6.4%)
related RGJAY Guidelines not finalized	47 (8.1%)	0 (0.0%)	47 (2.0%)
Patient not eligible for follow-up	3 (0.5%)	6 (0.3%)	9 (0.4%)
Patient contact not available	18 (3.1%)	50 (2.8%)	68 (2.9%)
Duplicate entry/ wrongly updated	8 (1.4%)	39 (2.2%)	47 (2.0%)
Total	577 (100.0%)	1799 (100.0%)	2376 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Grievance Outcome

Once the grievance is investigated, the outcome is explained to the patient. In 16.2% of the cases, it was found that the patient paid or has to pay money or pay extra money for treatment. Some of the positive outcomes were seen in the form of refunding patient's money by hospital (14.1%). In about 7.5% cases, patient was eventually treated under RGJAY following initial problems like delay in treatment, waiting list, non-availability of beds. In 6.1% cases patient was referred to another hospital under RGJAY, in 5.3% cases patient had no issue after the initial complaint and in 5% cases, patient had got cashless treatment and given the satisfaction letter. In less than 3% of cases, grievance issue was resolved (in ways other than already described above), patient got free follow-up treatment and medicine, patient got free services under RGJAY like medicine/food/travel, etc.

Table 54: Action Taken or the Outcome of the Grievance Case*

Action taken on grievance	Frequency
Patient paid / has to pay money/extra money	648 (16.2%)
Grievance action is not clear/ in progress	634 (15.8%)
Patient money refunded by Hospital	563 (14.1%)
Grievance closed as issue cannot be resolved	417 (10.4%)
Patient treated under RGJAY	299 (7.5%)
Patient got private treatment in same or another hospital	290 (7.2%)
Patient referred to another hospital under RGJAY	243 (6.1%)
Patient has no issue	212 (5.3%)
Patient got cashless treatment/gave satisfaction letter	201 (5.0%)
Issue resolved	110 (2.7%)
Patient got free follow-up treatment/medicine	83 (2.1%)
Patient got free services under RGJAY (medicine/food/travel)	69 (1.7%)
Duplicate entry/ wrongly updated	57 (1.4%)
Patient expired	52 (1.3%)
Treatment/test demanded is not required	52 (1.3%)
Patient was explained about the problem/issue	48 (1.2%)
Patient did not get admitted	8 (0.2%)
Empanelled hospital asked to give services under package/ accepted demand of cashless treatment	8 (0.2%)
Patient not eligible for refund of OOP incurred	5 (0.1%)
Patient did not incur OOP	6 (0.1%)
Empanelled hospital requesting de-empanelment from scheme	1 (0.0%)
Total	4006 (100%)

(Source: Tables prepared using data obtained from RGJAY Society)
*case here implies the grievance as registered in the data file as there were not many cases with separate outcomes for cases with multiple grievances.

Patient Satisfaction with the Scheme

From the various quantitative and qualitative analysis presented so far, it is evident patients under the scheme do end up having to pay out of their pockets. It is also one of the common grievances. However, there were also instances where the patient was satisfied with the scheme and wished that it should not be discontinued. It was also noted that few of the patients reported that they are satisfied despite of the OOPs incurred.

When asked, the RGJAY officials and the DCOs conceded that patients have to bear some costs while seeking care. However, they also mentioned these are not “large amounts”. For staff, it seemed normal and acceptable for the patients to spend a few thousand rupees on the treatment when he mentioned,

"2-4 hajar lagale tar patient na kay watat nahi, te detat, pan jar 40-50 hajar lagale tar te complaint kartat" (Patients do not mind if it they have to give 2-4 thousand rupees. But if it takes 40-50 thousand then they complain).

In fact this small amount is reported as "no OOP" when asked as a direct question. In case of larger amount of OOPs the DCO calls the patient and the TPA and discusses the matter in front of both. This is done only when it is reported by the patient then action is taken on the hospital.

"Patient mhanato paise ghetalet, hospital records mhantat nahi ghetale" (Patient says that money has been taken but hospital records do not show that any money was taken).

Both the parties are called patient and concerned people from the hospital and everything is done transparently. If the hospital is found guilty then they are issued show cause notice. Suspensions/de-empanelment of the hospital can take place. There is a District Monitoring Committee and District Grievance Redressal Committee involved in this process.

While most of the OOP expenditure is for medicines, OOP expenditure was also found to be a result of spending money on implants and stents used in the surgery. For example, In case of cardiac surgery, the stent is of two types; medicated which is medicine coated and costs around INR Sixty to Seventy thousand and non-medicated which is bare metal, not coated with medicine and costs INR Four to Five thousand. The non-medicated stent is used in surgeries done under the scheme. Therefore, if the patient chooses to get the medicated stent, they have to bear the additional cost. Patients do come seeking treatment for procedures that are not covered under the scheme. In that case, the DCOs forward the case to the District Grievance Redressal Committee. They take the decision whether it can be covered under the scheme or not.

As an example given by one of the DCOs,
"There are 971 ailments covered in the scheme, suppose a patient is suffering from a psychological disorder and goes to the hospital. It won't get covered under the scheme and then the patient comes to us with a complaint".

We also came across patients who were happy with the scheme and did not mind bearing some costs as the major expenses were covered by the scheme.

Patient Satisfied with the Scheme, Ignores Minor OOPs

Case Study 7: BD was a young boy from a village situated about 12 km inside Mangalvedha district in Solapur. He was accompanied by his uncle who stayed in Mumbai. He had undergone an operation under RGJAY. He had come for his follow up which was a month after his operation. BD and his uncle were on their way to the pharmacy to fetch some medicines. About the history of BD's ailment, his uncle shared with us that last year the boy met with an accident at his village, he underwent an operation (humerous bone) where a screw was fitted to his bone, however within a year the screw was bent and he had to again approach a doctor for treatment.

BD said that he decided to come to Mumbai instead of going to any other doctor nearby since his first operation was a failure. "Motha doctor ithe aahe" (the better qualified "big" doctor is in Mumbai). BD's uncle stayed near the hospital was added advantage.

When BD came to the hospital, he or his uncle were not aware about the scheme, and only after the doctor gave an intimation of the total cost of the operation which was told to be between INR 10-15,000 (including the implant), they asked about any aid and were informed by the RGJAY. When asked about any out of pocket expenditures they had incurred; initially uncle said no, "We did not even spend anything for this, through the scheme operations are done completely free of cost" (both looked very happy and smiled at us). There was only a one day delay when the doctor had to attend some emergency, and BDs operation was postponed to the next day.

It was only after some probing it became apparent that the patient had to take 2-3 X-rays for which they had to pay. Both felt this was absolutely normal to pay INR 100-200 out of pocket if the treatment worth INR 15,000 is made available free of cost. BD's uncle also shared that medicines worth INR 3000 had to be bought from a Bandra hospital and though going there was a little cumbersome. He was happy that when the doctor signed on the case paper and they got all the medicines free of charge.

The next case showcases how the scheme was helping a poor patient avail hospitalization services free of cost. For many patients, this scheme comes as a relief from burden of expensive medical treatment and they are satisfied with the scheme.

Patient Satisfaction with the Scheme

Case study 8: MP was a 20-year-old male, who was admitted in the male IPD of the hospital. MP stayed in a slum close to the empanelled hospital. He was staying along with his mother, in their maternal grandparents' house. He fractured his hand as he fell down from the roof of his house.

"Main apne ma baap pe boz hoon, aur mera beta aisa hain, toh sochake ye scheme se thodi toh madat milegi" (I am a burden on my parents, and my son is like this, thinking that this scheme will give us at least some help).

MP's mother was separated from her husband and had no source of income. As her son was mentally challenged, she worked from home making jute/nylon baskets and did some embroidery work to make a living. The doctors about the scheme informed her after her son's admission. MP's preauthorization was done and they were waiting for the operation. She wished that the scheme should not close down with the coming of a new government as it is proving to be helpful for needy people like her.

Source: Patient interviews, Public hospital

The scheme comes as a kind of relief to many beneficiaries who are accustomed to paying out of their pockets even free services in the public sector. Under these circumstances, even if they have to pay some amount as OOP expenditure, it is not an issue for them. They are satisfied with the scheme as significant amount of the expenses is covered by the scheme.

Chapter 5

Discussion, **Recommendations** and Conclusion

As mentioned earlier, this study is based on secondary data from RGJAY website and other sources, quantitative data shared by the RGJAY Society and interviews with key stakeholders and patients. The study tries to understand the RGJAY scheme holistically, with a focus on service availability and utilization of the scheme. The functionality of the scheme was also gauged against the scheme MOUs and guidelines to understand the issues and gaps in implementing the scheme. Processes in the scheme are explored in depth including empanelment of hospitals, IEC, health camps, preauthorization, claims, ETI, follow-up and grievances.

The present section discusses the key findings and observations that have emerged from the analysis as well as suggests recommendations relevant for better functioning of the scheme.

Service Availability and Hospital Empanelment

The scheme allows the beneficiary to access tertiary healthcare services free of cost anywhere in the state. However, there exist some challenges in recruitment of private hospitals in the scheme and bringing tertiary healthcare services closer to home in rural areas. Wider coverage in service provisioning in the scheme is largely dependent on the availability of empanelled hospitals across all districts and the range of specialties they provide. Overall, the issues with hospital empanelment are found to be twofold and are3 associated with the rural - urban health care economics. While the unwillingness of the multi-specialty private hospitals to participate in the scheme has affected the availability of services, the infrastructural lacunae in the rural government hospitals continue to remain unaddressed.

Out of the 473 empanelled hospitals, 83.7% are in the private sector. There is a disparity in terms of the service availability across districts. While Nandurbar has only one empanelled hospital for the entire district, Mumbai has 51 empanelled hospitals. The discrepancy is emerging from the already existing disparity in the health services in Maharashtra. As revealed from the analysis of the data, several districts did not meet the criterion for minimum required empanelled hospitals as specified in the MOU. This was more pronounced in the backward districts and least urbanized districts. The districts that were found to meet the criteria of the minimum required empanelled hospitals were mostly better-developed ones. A clear rural urban divide in terms of hospital empanelment could also be seen with the private hospitals concentrated in urban areas as expected. Those districts with lesser level of urbanization also had fewer empanelled hospitals. Merely 12% (of all empanelled hospitals belong to the 12 least urbanized districts of Maharashtra including Beed, Bhandara, Gadchiroli, Gondia, Hingoli, Jalna, Nandurbar, Osmanabad, Ratnagiri, Satara, Sindhudurg and Washim.

9.9% of the empanelled hospitals are single specialty, private hospitals; most of them in Mumbai. Merely three empanelled hospitals in entire Maharashtra provide all 30 specialties. Huge disparity in availability of key specialties in the private hospitals can be clearly seen where intervention radiology (17 districts), radiation oncology (16 districts), medical oncology (12 districts), cardiac and cardiothoracic (12 districts)

and burns (11 districts) are absent in most of the tribal and least urbanized districts. While it was found that the public sector share of the availability of medical oncology as a specialty in total empanelled hospitals was found to be only 5.9%. This reflects the stark reality of the extremely poor access to specialties for those living in rural areas as public sector is extremely lacking and private sector is concentrated more in urbanized areas. The quantitative data analysis was supported by our findings through interviews of stakeholders. Thus, accessibility and availability of health services continue to remain an issue despite the PPP under the RGJAY scheme.

Further, the lack of infrastructural facilities, such as lack of equipment or non - functional equipment, in the rural public hospitals can also hinder the patient's access by causing unnecessary delays. Such gaps in service availability can also mean that the patient has no choice but to either seek care from a non-empanelled private hospital within their district or to travel long distances to a higher graded hospital to seek care under the scheme. Both the situations would add on to the illness expenditure defeating the scheme's objective.

Awareness about the Scheme and IEC

The extent of utilization of the scheme depends on the level of awareness about it. This is not a voluntary scheme where the beneficiaries actively enroll themselves in the scheme. Here, the beneficiary is passively enrolled as the Maharashtra government pays the premium for eligible households, and the beneficiaries do not have to contribute. We found that a beneficiary either comes to know about the scheme beforehand through awareness campaigns or when he/she visits the hospital and is told about the scheme by the doctor/other staff/other patients. In this context, the study looked at how the scheme reached the beneficiaries and the challenges in the process.

The qualitative data documented the lack of awareness amongst the beneficiary population about various 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 covered. The districts, which have been empanelled from phase I showed almost 50%, fall in the preauthorizations in the second phase. This suggests that, during the second phase stakeholder's focus was only on remaining 27 districts while the 8 districts from the first phase were neglected. Thus the huge gap in the utilization across phases can be associated with sheer neglect of phase I districts in terms of continued IEC activities, as IEC cannot be a one-time activity.

Conducting health camps has been adopted by RGJAY as a strategy for popularizing the scheme as well as identifying and referring potential beneficiaries to empanelled hospitals. The MOU obligates the empanelled hospital to conduct at least one free camp per fortnight. From the qualitative research, we found that one of the empanelled public hospitals had not conducted any health camp since the inception of the scheme. On the other hand, the concerned private hospital conducted 70-80 camps a month, on a regular basis. We found that for the empanelled public hospital, this was an additional burden whereas for the empanelled private hospital, this was used as an opportunity for self-promotion and widening their presence in other parts of the state to attract paying patients. TPAs have failed their responsibility of organizing and monitoring health camps and have neglected it completely. It was also found that aarogyamitras posted at PHCs in phase I, were removed as a cost cutting measure. This highlights the poor attention given to IEC activities and the lack of interest of TPA/Insurer who stand to benefit from limited IEC, as it would control utilization of the scheme. This would in turn maximize their profit from premiums received.

Patients were often found to have referred to the scheme through indirect ways. From the interviews and patient case studies, both in private and public hospitals, it was found that many patients came to know about the scheme only after admission in the hospital. This information was given to them either by doctors or by other patients in the ward. But this information often comes late in the stage of treatment, as a consequence, patient may have already spent considerable amount in investigation and consultations. Moreover, they may still not have access to detailed information about what they are entitled to and the procedures therein. This can also result in out of pocket expenditures. Further implication of such referrals, particularly by doctors, is that it is the doctor who makes the choice about which patient is to be informed about the scheme rather than it being treated as an entitlement for the patient. This was brought to light by case studies presented based on interviews. The studied public hospital provided many specialties under the scheme yet most cases (80%) under the scheme came from orthopaedic department. The reason offered was that most other specialties were already being provided at subsidized cost in the public hospital. However, orthopaedic surgeries required costly surgical implants not subsidized by the government and hence, doctors chose to refer a large majority of orthopaedic patients to the scheme. In case of the private hospital, amongst the numerous specialties offered under the scheme, certain specialties like cardiology and cancer were actively promoted under the scheme as these were in alignment with their priorities of being seen as a specialist in these specialties. It was thus a business decision. Another challenge with referral of patients was the lack of awareness about the scheme and training among doctors themselves, especially in public hospitals. Trainings and workshops to sensitize the doctors about the schemes by TPAs was not taking place regularly as envisioned and when meetings were held, RGJAY was not considered a priority. The temporary postings of post-graduate doctors and frequent transfers of other doctors further accentuate the problem.

Issues with Documentation Process & Cumbersome Patient Journey

Access barriers were identified at various levels of the scheme delaying the entire process from registration to seeking treatment. The study revealed that systemic issues including medical and personal documentation requirements act as initial barriers while raising the preauthorization request, which is the basic requisite for availing the treatment under the scheme. The scheme officials face functional difficulty while verification of the identification documents. Ideally, the RGJAY health card should mark the entry of the person into the scheme, as stipulated. However, as mentioned earlier, other verification documents (the same ones that have in fact been used to make the health card in the first place), are again required to be produced for the purpose of registration when admitted in order to avail the scheme. However, this makes the health card redundant. Moreover, it seems rather unfair and impractical to have people (especially daily wage earners) go through a highly cumbersome procedure, of getting health cards made only to find them not useful in the time of need; and then having to go through the whole process again. It also leads to a huge wastage of precious public health resources as considerable money has been spent in both phases for printing and distribution of the health cards. While the officials, from our interviews, rationalized this on the grounds that it is more practical as it not only prevents fraudulent behaviour by people who are not true beneficiaries, but it also prevents rejection of claims later.

The next barrier is the non-availability of specialists such as anaesthetists and equipment such as MRI machines in the public hospital; that add to the delay. Often times, the patients are referred to private facilities for diagnostic tests, the cost of which is to be reimbursed on production of bills. The patients have to then pay for these tests to start with, under a cashless scheme. This not only adds hurdles in accessing the scheme, also reimbursement for this is another minefield in the claims process.

Documentation requirements also act as obstacles during claims reimbursement. It was also found that absence of medical documentation was a key reason for their delay/rejection. Provision of documents, such as reports and pictures (like pictures of patients taking discharge with RGJAY board in the background); is the responsibility of the empanelled hospitals and should therefore not be the cause of any delays. Cumbersome procedures and delays may act as deterrents. We found that patients in public hospitals opted out of the scheme for low cost surgeries to avoid the delays and a cumbersome system. This finding from our qualitative study was supported by our analysis of the quantitative data. The doctors in public hospitals complained about the lengthy documentation and procedural maze under the scheme. Moreover, when genuine cases are rejected for frivolous reasons or for lack of the most basic documentation; it takes away from the ethos of the scheme, the benefit for the poor.

In the earlier phases, RGJAY played a role in approval of pre-authorizations. However, as per our key informant interviews, this is not the case anymore and the RGJAY Society only monitors rejected preauthorization and claims; and in genuine cases, tries to convince TPA to approve the case.

Our study also revealed lack of communication between the top authorities who are the decision makers and the ground level staff when it comes to actual implementation of the scheme's components. The lack of clarity in terms of operationalization of various processes in the scheme results in a gap in its functionality. Moreover, some of the above mentioned gaps are between the guidelines and the MOU and how the scheme is implemented on the ground. Whether the problems faced by the stakeholders are addressed is unclear.

Actual Utilization of the Scheme

Total beneficiary families across Maharashtra as per the PDS data were 2,07,94,294 of which only 5,09,971 families were enrolled that is merely 2.45% of the eligible families in the state. Around 3,10,302 preauthorizations were raised in the period between July 2012 to August 2014.

The utilization rate for the scheme was proportional to the urbanization level. It decreased with distance from the major cities with empanelled hospitals. Five specialties extensively available in the empanelled hospitals were general surgery (75.1%), infectious diseases (70%), critical care (74%), orthopedic surger & procedure (69.1%), pulmonology (62.6%). However the top five specialties under which maximum pre-authorizations were raised include medical oncology (17%), nephrology(15%), cardiology (13.7%), genitourinary system (8.1%), poly trauma (7.2%), cardiac and cardiothoracic surgery (6.7%). Questions can be raised about whether any prior attention was given to the specialty availability at the time of empanelment of hospitals. This again can have implications in terms of access, as there is a mismatch between what is provided by the scheme and what is utilized.

Of the approximately 3.1 lakh preauthorizations raised, approvals were given for about 2.69 lakh surgeries and procedures till August 2014, which majorly included medical oncology 18.7%, nephrology15.2%, cardiology 13.7% etc. About 193410 surgeries and procedures were approved in the private hospitals and 76524 in the public. Merely 2.9% of the cases were from the 131 procedures reserved for the public hospital. In spite of the reserved procedures, it is evident that the private hospitals have the biggest share of cases under the scheme. The present study showed that the preauthorizations raised as well as approved showed a clear difference across type of providers. Specialties such as nephrology, ENT surgery, radiation oncology, genitourinary, cardiology, cardio and cardiothoracic surgery and critical care had

more than 75% of cases approved in the private sector. Higher proportion of preauthorization were approved in public hospitals for specialties such as burns, infectious diseases, pulmonology, which do not have any procedures reserved in public hospitals.

Utilization of the scheme has been extensively limited, with Mumbai contributing 36.8 % of total preauthorization. About 68.9% of the cases in the public hospitals were registered only from Mumbai. Even after the state-wide launch, it is clearly evident that the scheme has been profoundly catering to beneficiaries from Mumbai or traveling to Mumbai for treatment, in addition to certain urban centers including Thane, Nashik, Solapur, Nanded, Aurangabad. Such a situation can burden the public hospitals in Mumbai, which are already struggling to cater to the needs of existing resident population. It also reflects the failure of the scheme to reach out to the rural and backward areas despite collaborating with the private sector.

Data for follow-up shows that out of the population eligible for follow-up, only 21% cases 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. This can be associated with the patient migration from rural areas to urban centers for treatment under the scheme, which results into fewer patients turning up for a follow up. Moreover, the follow ups have to be done in the same hospital where the original surgery was performed. This becomes a very difficult and practical issue for the patients who might have travelled the distance for the original surgery or treatment due to a dearth of options in their area, but may not be able to do so for a check-up.

Previous insurance schemes including RSBY and Aarogyasri have been critiqued for various reasons, including their narrow focus. The same is also true in the case of RGJAY which focuses only on tertiary level hospitalization. The NSSO data from 1988 to 2004 clearly indicates an increasing trend towards hospitalization. At the same time, however, there continues to be a much larger population that seeks out patient care. Thus, inpatient care is sought by only 2.3% and 3.1% of rural and urban population respectively on an average; while 8.8% and 9.9% of the population access outpatient care (Selvaraj & Karan, 2009; 2012). Thus rather than learning from experiences on the ground and the fallacies of other schemes, RGJAY seems to have been simply started without taking these into account. Strangely, the policymakers fail to understand that RSBY, one of the previous schemes, covered a much wider range of services including secondary and primary level health care like normal deliveries, besides tertiary health care. Indeed, in a system where Universal Health Coverage is yet to be achieved, giving preference to just tertiary services and neglecting to have a holistic needs based approach, is not only a step backward but also unfair to those who have limited access to these services.

Financial Protection

More than half of the grievances registered with the RGJAY Society were related to OOP expenditures. Most patients are referred to the scheme post admission from either OPD or IPD where the patient has already incurred some cost. However, the qualitative data showed that the patients seem to probably overlook the OOP expenditure as they were receiving rest of their treatment free. This is enough to raise concerns about RGJAY scheme and the financial protection promises made under it.

Private Sector Participation

In the context of RGJAY, private sector involvement is not only in the form of commercial TPA companies but also in the form of health care provisioning where more than 80% of the empanelled hospitals belong to the private sector.

The RGJAY scheme is an example of complex partnerships between public and private stakeholders for providing tertiary level services. As evident, sustainability of the program is dependent on the willingness of the private players to provide the healthcare services under the schemes rules and regulations. The scheme portrays an example of a PPP where the state is delegating responsibilities to the private players in terms of administration as well as service delivery. This is where TPAs come in. TPAs play a very important role of an intermediary between the hospital, Society and NIC. This multiple stakeholder partnership is influenced by the vested interests of each party. Private hospitals prefer to not enroll or maybe withdraw from the scheme, as they are not offered competitive packages. On the other hand, TPAs and insurers reject claims for frivolous reasons like photo taken at the time of discharge of the patient was not proper. Insurers had an incentive to increase awareness and enrollment, which were profitable for them; but not utilization of services under the scheme where they would stand to lose profits if it increased. The governments' perspective was that, by entering into a PPP, they would be increasing accessibility and decreasing financial burden on the poor due to health costs. However, the scheme, as it comes across, was not well planned and therefore not always successful in its purpose, sometimes even adding to the patients woes.

Empanelment of the hospital in initial phase was difficult as private hospitals were not able to meet the standard requirements of the scheme like a requirement of minimum 50 beds or minimum criteria for qualified staff, etc. These norms were relaxed subsequently with hospitals requiring minimum 30 beds to qualify for empanelment. The hospitals were also trained by district level officials in NABH standards for hospitals. We found certain issues with hospitals audits against these set standards. There was a lack of transparency with TPA authority in infrastructure audits. For instance, it was found that in many cases hospitals were supposed have ventilators did not have these, but were marked as present in these audits. However, with digitalization of the empanelment process, the RGJAY Society could monitor the process online and this eventually improved transparency.

As mentioned earlier, private hospitals are in general reluctant to participate in the scheme or even withdraw from the scheme since the package rates offered by the scheme are lower as compared to the market price. In certain border districts, there were patients who would migrate across and come to the private hospitals for services and pay the regular price. However, with the scheme, a large majority of population is eligible for benefits, which the private hospitals felt were restricting their flow of private patients depriving them of their profits. The struggle of the district level RGJAY officials to empanel the private hospitals points towards the challenges of such a partnership as the 'for profit' private sector functions on the market forces. Another issue that our study revealed was the fact that despite empanelment, the private sector selectively prioritized paying clients rather than those under the scheme. This was detrimental to the scheme as it resulted in waiting lists for surgeries and procedures for RGJAY patients, amongst other issues.

There was purposive selection of certain specialties and procedures by the private sector. The qualitative study revealed how the private hospitals 'targeted' certain specialties like cardiology among the scheme eligible patients. The intention seems obviously to cater to high-end packages in the scheme, gain more profit and be projected as specialists for the same, despite offering other specialties. The alliance with the private sector is to improve access and provide quality care; however, the scheme has failed to achieve both. The scheme has not been able to address the persistent issues with the health care system such as the rural urban disparity; however, the disparity continues despite the scheme and its partnerships.

Aligning the interests of the public and private sector, therefore, is always a difficult task. Such partnerships bring the public sector's role in the forefront and its continued relevance to increase accessibility to the poor; and point towards the private sectors' uncompromising nature. It raises the old and yet pertinent argument of the role of private sector through PPPs with a view to increase accessibility of health care to the masses.

Attempts at regulation, incentives and subsidies do not seem to have met with significant success in the past when it comes to private hospitals. Previous studies conducted by CEHAT comment on the standards of care provided by the private sector in Maharashtra (Bhate-Deosthali, Khatri & Wagle, 2011). It is clear that Bombay Nursing Home Registration Act (BNHRA), 1949 is poorly implemented with hospitals openly flouting norms especially in terms of qualified staff, 24 hours availability of doctors etc. Under these circumstances, to expect standardized care available at subsidized rates under RGJAY is a rather difficult prospect.

However, in the light of the public sector showing no signs of an overhaul, sustainable private sector participation seems indispensible. Stringent regulation, transparency and accountability are needed along with strategies that make it their participation more amicable and positive. A stakeholders' grievance review along with meetings with the private sector partners can probably help evolve such a strategy.

Monitoring Mechanisms

Our study came across lacunae in the monitoring mechanisms at various levels of the scheme. Though MOU has guidelines for the monitoring of hospitals; in practice, no such monitoring seems to be taking place. The MOU mentions different committees e.g. district-level monitoring committees and state level monitoring committees formed by the insurer/TPA and the Society who are responsible for supervising the 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 seems to be functional and the way they are executed is not clear. However, there have been surprise visits in the empanelled hospitals the mechanism should be much more stringent for ensuring eligible population's access. As seen from the MOU, majority of the tasks associated with implementation of the scheme are residing with the TPA, however there is absence of a mechanism, which will ensure that the work is done. As seen in the case of keeping a check on the number of health camps by the empanelled hospitals, if the TPAs are not doing their tasks, there are no strict guidelines, which will enforce them to do so. In addition, there is a lack of clarity about who will ensure the same.

Recommendations

The present study has highlighted gaps in the Maharashtra government financed health insurance scheme RGJAY and its implementation. Recommendations have been put forward to improve the scheme implementation and the overall perspective of health insurance schemes in the context of Universal Health Coverage.

There has to be modification in the present mechanism of monitoring. The de-empanelment of empanelled hospitals is focused on their performance in terms of number of beneficiary registrations per hospital. Instead, the focus of the monitoring body should be on the access related issues and the quality of care provided by these empanelled hospitals. Hospital grading for MOU renewal includes parameters on patient satisfaction but these are superficial measures. Not enough focus is given to access; quality of care and no such mechanism seems to function in this regard.

One important way to create awareness and register beneficiaries in the scheme is through the network of peripheral public health centers including PHCs, CHCs, Rural hospitals, etc. Although laid out in the MOU that facilities like PHCs would screen the eligible patients and refer them to the empanelled hospitals for treatment under the scheme, this does not really seemed to have been the case. There is a need to strengthen and implement the referral mechanism. The referral from within the public hospital is also associated with the lack regular training/ monitoring by the higher authorities, which needs more attention. The PHCs, CHCs, NGOs should be actively made a part of the IEC activities, which at presently is not happening.

The IEC activities should include the private doctors who are not a part of the scheme, as they might not be aware of the scheme's benefit. They can prove to be crucial in the referral mechanism. IEC activities need to be repetitive and complete information should be provided to patients so that they can choose their provider under the scheme and know about the services they can avail under the scheme. Health camps under the scheme can be merged with the health camps conducted by the public health sector for other purposes. This will negate the need for special health camps for the purpose of the IEC of the scheme. Other public health infrastructure, such as the village health committees, can be involved to increase awareness about the scheme.

Even though RGJAY scheme has laid out a flow of processes in its system, there is a need to understand and address the ground level complexities of operationalizing the scheme. The problems and difficulties of the scheme staff at various levels of the scheme including enrollment, preauthorization to claim settlement should be taken into account. While involving the personnel from the public health system, the existing workload should be taken into consideration. Mechanisms should be formed to address the overburdening of these staff members due to the scheme related activities.

It is important that processes should be thorough but they should not be cumbersome. Beneficiaries and providers should not shy away from utilizing the scheme. These can be simplified and the process should be made faster.

The scheme criteria of availing follow-up at the same hospital should be changed to allowing the patient to access follow-up services from any empanelled hospital in Maharashtra. This can considerable improve utilization of follow-up services.

Nearly 20% of the 971 procedures show less than 10 preauthorization requests were raised. The reason for poor utilization of these procedures should be further explored. This necessitates a need to re-examine the 971 procedures in terms of their utilization and the procedures, which are redundant, should be removed or replaced with more relevant ones. RGJAY mainly provides tertiary level surgeries free of cost under the scheme. However, these services are needed by a smaller fraction of population as compared to outpatient, primary and secondary level services. The scheme should consider widening the scope of health care services under the scheme and including those procedures, which are needed by more number of people like inclusion of normal delivery. This would be an important step towards Universal Health Coverage.

Considering that the structure of the scheme is dependent on the private sector, which is both the implementer and service provider, there needs to be strong monitoring oversight by the public sector. The Society's role should be clearly carved out which should also include strengthening the roles of the RGJAY officials. There should be clearly defined guidelines for each stakeholder and it should be ensured by the RGJAY Society as an administrative body, that all the stakeholders are doing their given duties.

It should also be acknowledged that in a PPP such as this, where the guidelines are prepared by the public sector and the private sector is expected to act on it, adequate monitoring mechanisms should be in place. It is apparent that there is a gap in what is stated in the guidelines and what happens in practice. In order to bridge the gap, the ground level difficulties faced by the scheme staff who is directly involved in implementing the scheme need to be acknowledged by the government who is drafting the rules. Additionally, there has to be a clear communication about the guidelines for registration and preauthorization in order to avoid confusion.

Stringent regulation, transparency and accountability are needed along with strategies that make it their participation more amicable and positive. A stakeholders' grievance review along with meetings with the private sector partners can help evolve such a strategy.

Conclusion

The core finding of the present study clearly indicates that the RGJAY scheme in Maharashtra has some serious shortcomings with continued OOP expenditure, inter district travelling to avail health care and poor accountability and overall lack of adequate monitoring mechanisms There are nevertheless some bright sparks and satisfied and grateful patients. With the public sector still showing little scope for a revamp, it is but a foregone conclusion that a PPP could promote accessibility and reduce impoverishment due to health care. It is therefore worth researching whether the scheme has able to bring down the catastrophic expenditure due to tertiary hospitalization or it is continuing to put poor people in indebtedness. A continued assessment of the program can be suggested to understand the effects over the years. The monitoring mechanisms should be more dynamic in order to take care of various issues highlighted

through the present study. The government should therefore use the huge private sector and its resources in the form of technically proficient specialists and infrastructure wisely and effectively.

This study was able to point out the gaps in the process of implementation of the scheme vis-à-vis the MOUs. However, additional insights are necessary for terms of addressing the individual beneficiary issues such as awareness of the scheme, satisfaction, reduced OOP expenditures, improved access through the scheme, making available most needed specialties, etc. The findings of the present study are significant in the current political economy of health, where government plays a significant role in promoting these partnerships. Despite spending huge amount of money, the scheme in reality is not able to reach out to economically weaker section. As critiqued in other state level schemes, such humongous spending by the state, which is directed towards the 'for profit' sector, can have serious implications in terms of fuelling the already dominant private health sector. Such insurance schemes rely on purchasing health services as the delivery mechanism, but can simply end-up being inefficient and expensive. While there is a need for strengthening the primary and secondary public health structures, the state is spending its resources on such schemes, which have a limited focus. 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.

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Annexure I : **RGJAY Data Files & NABH Criteria**

Table 1: Details of the Files Selected for Analysis

Sr. No.	File Name	Number of cases	Information included Preauthorization related files
1	Preauthorization Dump[23]	310000	Total number of preauthorization raised since the initiation of the scheme. District, age group, specialty, gender card type and provider type.
2	preauthorization pending	2000	Reasons for pending preauthorization, District, age group, specialty, gender card type and provider type.
3	Preauthorization rejected	13118	Reasons for rejection of the preauthorization, District, age group, specialty, gender card type and provider type.
4	Cancelled cases		Reasons for cancellation, type of provider Claims related files
5	Claims pending	9900	Reasons for pending claims
6	Claims rejections	48000	Reasons for rejection
7	Claims ageing report	213990	Type of providers
8	Grievance dump	3978	Type of grievance, status of the complaint, action was taken, delay in taking action, provider type
9	ETI (Emergency telephonic Intimation)	281	Type of providers, districts, type of procedure
10	Follow-up	66375	Type of providers, districts, type of procedure
	Empanelled hospital file		
11	Hospital information	473	30 specialties across regions, type of providers , number of beds

[23] The preauthorization dump file was split on the basis of type of hospital, in order to analyze the utilization of the 131 reserved procedures in public hospitals.

Table 2: Parameters for Hospital Gradation

Sr No	Category of Standard	% weightage doesn't add up to 100
1	HR Quality	18
2	Facilities Management	15
3	Infection Control Measures	12
4	Monitoring Medication	8
5	Maintenance of Patient Medical Records	7
6	Patient Satisfaction Indices	8
7	Standard Operating Protocols	5
8	Transparency In pricing	7
9	Quality Patient Care	20
10	Performance of Scheme Indicator	10
	Total Weightages	110

(Source: RGJAY NABH Criteria)

Table 3: Criteria for Hospital Gradation

1	Location – District based score
2	Category – Number of specialties
3	Type of Hospital – Training or non training hospital
4	No. of Beds (excluding Intensive Care) – minimum 30
5	Span of Control - Duty Doctor to patient Ratio - Nurse to patient Ratio(non ICU)
6	Availability of in-house doctors (full time) with regards to the occupied inpatient beds.
7	Availability of Nurses for occupied inpatient Beds
8	Infrastructure / Facilities – Intensive care beds, Operation Theatre, Equipment, Pharmacy, Medical Audit etc.
9	Diagnostic Services – Type, In house or outsourced
10	Availability of Ambulance facilities – Type, in house or outsourced
11	Hospital Infection Control measures
12	Hospital Information System and Medical Records Dept
13	Accreditation – NABH, ISO certification, IPHS
14	Bio Medical Waste Disposal System

(Source : RGJAY User manual)

Annexure II : Tables Used for Analysis

Table 1: Hospital Availability across Districts

Districts	Public	Private	Total
Ahmednagar	1(1.3%)	24 (6.1%)	25 (5.3%)
Akola	1 (1.3%)	12 (3.0%)	13 (2.7%)
Amravati	4 (5.2%)	10 (2.5%)	14 (3.0%)
Aurangabad	2 (2.6%)	23 (5.8%)	25 (5.3%)
Beed	2 (2.6%)	1 (0.3%)	3 (0.6%)
Bhandara	1 (1.3%)	3 (0.8%)	4 (0.8%)
Buldhana	3 (3.9%)	3 (0.8%)	6 (1.3%)
Chandrapur	1 (1.3%)	8 (2.0%)	9 (1.9%)
Dhule	3 (3.9%)	5 (1.3%)	8 (1.7%)
Gadchiroli	1 (1.3%)	1 (0.3%)	2 (0.4%)
Gondia	2 (2.6%)	3 (0.8%)	5 (1.1%)
Hingoli	1 (1.3%)	3 (0.8%)	4 (0.8%)
Jalgaon	1 (1.3%)	19 (4.8%)	20 (4.2%)
Jalna	1 (1.3%)	5 (1.3%)	6 (1.3%)
Kolhapur	1 (1.3%)	27 (6.8%)	28 (5.9%)
Latur	1 (1.3%)	11 (2.8%)	12 (2.5%)
Mumbai	19 (24.7%)	32 (8.1%)	51 (10.8%)
Nagpur	3 (3.9%)	34 (8.6%)	37 (7.8%)
Nanded	2 (2.6%)	9 (2.3%)	11 (2.3%)
Nandurbar	1 (1.3%)	0 (0.0%)	1 (0.2%)
Nashik	3 (3.9%)	20 (5.1%)	23 (4.9%)
Osmanabad	1 (1.3%)	3 (0.8%)	4 (0.8%)
Parbhani	1 (1.3%)	3 (0.8%)	4 (0.8%)
Pune	5 (6.5%)	28 (7.1%)	33 (7.0%)
Raigad	2 (2.6%)	6 (1.5%)	8 (1.7%)
Ratnagiri	1 (1.3%)	4 (1.0%)	5 (1.1%)
Sangli	1 (1.3%)	18 (4.5%)	19 (4.0%)
Satara	1 (1.3%)	13 (3.3%)	14 (3.0%)
Sindhudurg	1 (1.3%)	3 (0.8%)	4 (0.8%)
Solapur	2 (2.6%)	14 (3.5%)	16 (3.4%)
Thane	5 (6.5%)	37 (9.3%)	42 (8.9%)
Wardha	1 (1.3%)	3 (0.8%)	4 (0.8%)
Washim	1 (1.3%)	4 (1.0%)	5 (1.1%)
Yavatmal	1 (1.3%)	7 (1.8%)	8 (1.7%)
Total	77 (100.0%)	396 (100.0%)	473 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 2: Bed Strength across Type of Hospital

Beds	Public	Private	Total
less than 10 beds	0 (0.0%)	10 (2.7%)	10 (2.3%)
10-30 beds	0 (0.0%)	67 (18.2%)	67 (15.1%)
> 30-50 beds	0 (0.0%)	112 (30.4%)	112 (25.3%)
> 50-70 beds	0 (0.0%)	57 (15.4%)	57 (12.9%)
> 70-100 beds	10 (13.5%)	52 (14.1%)	62 (14.0%)
> 100 to 500 + beds	64 (86.5%)	71 (19.2%)	135 (30.5%)
Total	74 (100.0%)	369 (100.0%)	443 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 3: Number of Specialties across Provider

Number of specialties	Public	Private	Total
Single specialty	0 (0.0%)	47 (11.9%)	47 (9.9%)
2-10 specialties	11 (14.3%)	84 (21.2%)	95 (20.1%)
11-20 specialties	30 (39.0%)	160 (40.4%)	190 (40.2%)
21-30specialties	36 (46.8%)	105 (26.5%)	141 (29.8%)
Total	77 (100.0%)	396 (100.0%)	473 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 4: Presence of TPAs across Regions

	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
MD India Phase I	20891 (8.7%)	45132 (18.7%)	51564 (21.4%)	18532 (7.7%)	15899 (6.6%)	89422 (37.0%)	241440 (100.0%)
Mediassist	12021 (30.4%)	0 (0.0%)	0 (0.0%)	27549 (69.6%)	0 (0.0%)	0 (0.0%)	39570 (100.0%)
Paramount	12113 (41.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	17179 (58.6%)	0 (0.0%)	29292 (100.0%)
Total	45025 (14.5%)	45132 (14.5%)	51564 (16.6%)	46081 (14.9%)	33078 (10.7%)	89422 (28.8%)	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 5: Specialty wise Preauthorization Raised in Reproductive Age Group (15-49yrs)

Specialty	Female	Male	Total
Burns	621 (60.8%)	400 (39.2%)	1021 (100.0%)
Cardiac And Cardiothoracic Surgery	4185 (52.0%)	3870 (48.0%)	8055 (100.0%)
Cardiology	2443 (22.6%)	8367 (77.4%)	10810 (100.0%)
Critical Care	1232 (38.6%)	1959 (61.4%)	3191 (100.0%)
Dermatology	58 (70.7%)	24 (29.3%)	82 (100.0%)
ENT Surgery	1276 (41.6%)	1793 (58.4%)	3069 (100.0%)
Endocrinology	173 (40.1%)	258 (59.9%)	431 (100.0%)
General Medicine	216 (39.3%)	334 (60.7%)	550 (100.0%)
Gastroenterology	399 (19.9%)	1611 (80.1%)	2010 (100.0%)
General Surgery	2493 (55.5%)	1996 (44.5%)	4489 (100.0%)
Genitourinary System	4231 (30.0%)	9869 (70.0%)	14100 (100.0%)
Gynaecology And Obstetrics Surgery	2843 (99.6%)	11 (0.4%)	2854 (100.0%)
Infectious Diseases	4 (13.8%)	25 (86.2%)	29 (100.0%)
Interventional Radiology	318 (40.6%)	466 (59.4%)	784 (100.0%)
Medical Oncology	14886 (60.5%)	9728 (39.5%)	24614 (100.0%)
Nephrology	9473 (36.3%)	16613 (63.7%)	26086 (100.0%)
Neurology	611 (33.4%)	1218 (66.6%)	1829 (100.0%)
Neurosurgery	1256 (38.2%)	2034 (61.8%)	3290 (100.0%)
Others	0 (0.0%)	1 (100.0%)	1 (100.0%)
Ophthalmology Surgery	291 (35.0%)	541 (65.0%)	832 (100.0%)
Orthopedic Surgery and Procedures	1539 (22.4%)	5340 (77.6%)	6879 (100.0%)
Pediatric Surgery	28 (32.9%)	57 (67.1%)	85 (100.0%)
Pediatrics Medical Management	91 (38.2%)	147 (61.8%)	238 (100.0%)
Plastic Surgery	92 (38.2%)	149 (61.8%)	241 (100.0%)
Poly Trauma	1874 (15.7%)	10053 (84.3%)	11927 (100.0%)
Prostheses	3 (17.6%)	14 (82.4%)	17 (100.0%)
Pulmonology	412 (41.1%)	590 (58.9%)	1002 (100.0%)
Radiation Oncology	3035 (59.9%)	2032 (40.1%)	5067 (100.0%)
Rheumatology	272 (90.4%)	29 (9.6%)	301 (100.0%)
Surgical Gastro Enterology	359 (50.7%)	349 (49.3%)	708 (100.0%)
Surgical Oncology	3284 (59.7%)	2221 (40.3%)	5505 (100.0%)
Total	57998 (41.4%)	82099 (58.6%)	140097 (100.0%)

Table 6 : Preauthorisations across Age Group

Specialty	Age group (years)																				Total
	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90	91-95	95 +	
Burns	86	58	125	205	193	212	161	109	80	48	28	20	18	10	7	4	3	1	0	0	1368
	6.3%	4.2%	9.1%	15.0%	14.1%	15.5%	11.8%	8.0%	5.8%	3.5%	2.0%	1.5%	1.3%	.7%	.5%	.3%	.2%	.1%	.0%	.0%	100.0%
Cardiac And Cardiothoracic Surgery	2026	1065	756	757	1015	1091	1202	1360	1544	1674	2036	2059	2198	1220	606	153	41	11	0	0	20814
	9.7%	5.1%	3.6%	3.6%	4.9%	5.2%	5.8%	6.5%	7.4%	8.0%	9.8%	9.9%	10.6%	5.9%	2.9%	.7%	.2%	.1%	.0%	.0%	100.0%
Cardiology	32	38	44	99	166	479	992	2164	3933	5356	6405	6904	7281	4800	2492	897	285	55	18	0	42440
	.1%	.1%	.1%	.2%	.4%	1.1%	2.3%	5.1%	9.3%	12.6%	15.1%	16.3%	17.2%	11.3%	5.9%	2.1%	.7%	.1%	.0%	.0%	100.0%
Critical Care	67	64	196	437	526	426	423	461	565	586	539	684	830	667	393	216	80	29	8	0	7197
	.9%	.9%	2.7%	6.1%	7.3%	5.9%	5.9%	6.4%	7.9%	8.1%	7.5%	9.5%	11.5%	9.3%	5.5%	3.0%	1.1%	.4%	.1%	.0%	100.0%
Dermatology	5	3	4	4	4	15	14	20	9	15	30	12	6	8	9	5	2	1	0	0	166
	3.0%	1.8%	2.4%	2.4%	2.4%	9.0%	8.4%	12.0%	5.4%	9.0%	18.1%	7.2%	3.6%	4.8%	5.4%	3.0%	1.2%	.6%	.0%	.0%	100.0%
ENT Surgery	58	183	362	422	421	400	416	513	535	552	545	900	1290	1279	829	475	210	40	12	2	9444
	.6%	1.9%	3.8%	4.5%	4.5%	4.2%	4.4%	5.4%	5.7%	5.8%	5.8%	9.5%	13.7%	13.5%	8.8%	5.0%	2.2%	.4%	.1%	.0%	100.0%
Endocrinology	17	61	79	69	37	95	31	56	80	92	82	89	133	81	51	27	13	0	2	0	1095
	1.6%	5.6%	7.2%	6.3%	3.4%	8.7%	2.8%	5.1%	7.3%	8.4%	7.5%	8.1%	12.1%	7.4%	4.7%	2.5%	1.2%	.0%	.2%	.0%	100.0%
General Medicine	18	15	61	104	103	83	64	79	62	62	32	39	51	42	25	15	5	1	0	0	861
	2.1%	1.7%	7.1%	12.1%	12.0%	9.6%	7.4%	9.2%	7.2%	7.2%	3.7%	4.5%	5.9%	4.9%	2.9%	1.7%	.6%	.1%	.0%	.0%	100.0%
Gastroenterology	15	19	40	101	164	278	345	425	433	416	255	278	222	128	73	36	8	3	0	0	3239
	.5%	.6%	1.2%	3.1%	5.1%	8.6%	10.7%	13.1%	13.4%	12.8%	7.9%	8.6%	6.9%	4.0%	2.3%	1.1%	.2%	.1%	.0%	.0%	100.0%
General Surgery	97	109	276	541	640	616	729	779	738	640	573	505	543	343	172	60	15	5	0	0	7381
	1.3%	1.5%	3.7%	7.3%	8.7%	8.3%	9.9%	10.6%	10.0%	8.7%	7.8%	6.8%	7.4%	4.6%	2.3%	.8%	.2%	.1%	.0%	.0%	100.0%
Genitourinary System	289	246	314	798	1987	2642	2606	2401	2430	2021	1881	1901	2113	1752	1078	479	159	35	9	1	25142
	1.1%	1.0%	1.2%	3.2%	7.9%	10.5%	10.4%	9.5%	9.7%	8.0%	7.5%	7.6%	8.4%	7.0%	4.3%	1.9%	.6%	.1%	.0%	.0%	100.0%
Gynaecology And Obstetrics Surgery	2	2	4	38	157	281	398	788	877	577	318	284	240	136	46	10	4	2	2	0	4166
	.0%	.0%	.1%	.9%	3.8%	6.7%	9.6%	18.9%	21.1%	13.9%	7.6%	6.8%	5.8%	3.3%	1.1%	.2%	.1%	.0%	.0%	.0%	100.0%
Infectious Diseases	5	14	3	3	0	1	2	4	12	14	3	3	2	1	0	0	0	0	0	0	67
	7.5%	20.9%	4.5%	4.5%	.0%	1.5%	3.0%	6.0%	17.9%	20.9%	4.5%	4.5%	3.0%	1.5%	.0%	.0%	.0%	.0%	.0%	.0%	100.0%
Interventional Radiology	7	17	33	74	97	94	115	147	147	150	146	148	163	115	57	20	11	0	1	0	1542
	.5%	1.1%	2.1%	4.8%	6.3%	6.1%	7.5%	9.5%	9.5%	9.7%	9.5%	9.6%	10.6%	7.5%	3.7%	1.3%	.7%	.0%	.1%	.0%	100.0%
Medical Oncology	781	711	1148	1335	1540	2114	3464	5303	6423	7041	6228	5965	5887	3325	1494	438	118	6	3	3	53327
	1.5%	1.3%	2.2%	2.5%	2.9%	4.0%	6.5%	9.9%	12.0%	13.2%	11.7%	11.2%	11.0%	6.2%	2.8%	.8%	.2%	.0%	.0%	.0%	100.0%
Nephrology	30	37	304	1199	2440	3838	4192	4963	5428	5610	5256	5072	4163	2221	1161	454	132	36	1	0	46537
	.1%	.1%	.7%	2.6%	5.2%	8.2%	9.0%	10.7%	11.7%	12.1%	11.3%	10.9%	8.9%	4.8%	2.5%	1.0%	.3%	.1%	.0%	.0%	100.0%
Neurology	40	31	142	169	201	246	260	303	392	437	464	593	721	579	396	188	101	22	3	2	5290
	.8%	.6%	2.7%	3.2%	3.8%	4.7%	4.9%	5.7%	7.4%	8.3%	8.8%	11.2%	13.6%	10.9%	7.5%	3.6%	1.9%	.4%	.1%	.0%	100.0%

Specialty	Age group (years)																			Total
	0-5	6-10	11-15	16-20	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	71-75	76-80	81-85	86-90	91-95	95 +	
Neurosurgery	319	119	204	338	395	425	524	575	676	577	568	492	472	250	112	47	6	5	0	0	6104
	5.2%	1.9%	3.3%	5.5%	6.5%	7.0%	8.6%	9.4%	11.1%	9.5%	9.3%	8.1%	7.7%	4.1%	1.8%	.8%	.1%	.1%	.0%	.0%	100.0%
OTHERS	0	0	0	0	0	0	1	0	0	0	0	0	0	2	0	0	1	0	0	0	4
	.0%	.0%	.0%	.0%	.0%	.0%	25.0%	.0%	.0%	.0%	.0%	.0%	.0%	50.0%	.0%	.0%	25.0%	.0%	.0%	.0%	100.0%
Ophthalmology	152	168	114	129	121	87	98	115	147	196	218	227	244	173	95	32	15	2	0	0	2333
Surgery	6.5%	7.2%	4.9%	5.5%	5.2%	3.7%	4.2%	4.9%	6.3%	8.4%	9.3%	9.7%	10.5%	7.4%	4.1%	1.4%	.6%	.1%	.0%	.0%	100.0%
Orthopedic Surgery	179	189	355	740	1267	1132	1137	1002	1056	808	714	586	568	495	217	106	71	15	3	1	10641
And Procedures	1.7%	1.8%	3.3%	7.0%	11.9%	10.6%	10.7%	9.4%	9.9%	7.6%	6.7%	5.5%	5.3%	4.7%	2.0%	1.0%	.7%	.1%	.0%	.0%	100.0%
Pediatric Surgery	1692	414	236	24	15	6	6	5	4	4	2	2	1	0	1	0	0	0	0	1	2413
	70.1%	17.2%	9.8%	1.0%	.6%	.2%	.2%	.2%	.2%	.2%	.1%	.1%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	100.0%
Pediatrics Medical	5702	1137	711	94	25	31	11	3	4	4	2	5	8	0	1	1	1	1	0	0	7741
Management	73.7%	14.7%	9.2%	1.2%	.3%	.4%	.1%	.0%	.1%	.1%	.0%	.1%	.1%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	100.0%
Plastic Surgery	52	52	33	54	49	38	31	30	14	27	17	8	9	5	4	0	0	0	0	0	423
	12.3%	12.3%	7.8%	12.8%	11.6%	9.0%	7.3%	7.1%	3.3%	6.4%	4.0%	1.9%	2.1%	1.2%	.9%	.0%	.0%	.0%	.0%	.0%	100.0%
Poly Trauma	164	445	875	1564	2021	1874	1782	1842	1784	1595	1500	1511	1870	1585	1066	580	277	113	29	6	22483
	.7%	2.0%	3.9%	7.0%	9.0%	8.3%	7.9%	8.2%	7.9%	7.1%	6.7%	6.7%	8.3%	7.0%	4.7%	2.6%	1.2%	.5%	.1%	.0%	100.0%
Prostheses	0	0	1	1	0	0	4	6	5	1	1	3	3	0	1	0	0	0	0	0	26
	.0%	.0%	3.8%	3.8%	.0%	.0%	15.4%	23.1%	19.2%	3.8%	3.8%	11.5%	11.5%	.0%	3.8%	.0%	.0%	.0%	.0%	.0%	100.0%
Pulmonology	22	10	55	103	113	128	116	183	194	250	226	244	317	192	126	34	14	5	1	1	2334
	.9%	.4%	2.4%	4.4%	4.8%	5.5%	5.0%	7.8%	8.3%	10.7%	9.7%	10.5%	13.6%	8.2%	5.4%	1.5%	.6%	.2%	.0%	.0%	100.0%
Radiation	49	75	92	99	216	417	767	1233	1505	1489	1532	1558	1488	872	438	187	61	15	1	1	12095
Oncology	.4%	.6%	.8%	.8%	1.8%	3.4%	6.3%	10.2%	12.4%	12.3%	12.7%	12.9%	12.3%	7.2%	3.6%	1.5%	.5%	.1%	.0%	.0%	100.0%
Rheumatology	2	8	19	39	61	46	40	45	52	21	14	7	2	0	0	0	0	0	0	0	356
	.6%	2.2%	5.3%	11.0%	17.1%	12.9%	11.2%	12.6%	14.6%	5.9%	3.9%	2.0%	.6%	.0%	.0%	.0%	.0%	.0%	.0%	.0%	100.0%
Surgical Gastro	19	10	35	56	78	95	110	138	134	140	104	104	127	71	27	13	3	0	0	0	1264
Enterology	1.5%	.8%	2.8%	4.4%	6.2%	7.5%	8.7%	10.9%	10.6%	11.1%	8.2%	8.2%	10.0%	5.6%	2.1%	1.0%	.2%	.0%	.0%	.0%	100.0%
Surgical Oncology	32	35	90	201	334	488	909	1292	1492	1437	1405	1324	1437	854	438	164	61	14	1	1	12009
	.3%	.3%	.7%	1.7%	2.8%	4.1%	7.6%	10.8%	12.4%	12.0%	11.7%	11.0%	12.0%	7.1%	3.6%	1.4%	.5%	.1%	.0%	.0%	100.0%
	11959	5335	6711	9797	14386	17678	20950	26344	30755	31840	31124	31527	32407	21206	11415	4641	1697	417	94	19	310302
	3.9%	1.7%	2.2%	3.2%	4.6%	5.7%	6.8%	8.5%	9.9%	10.3%	10.0%	10.2%	10.4%	6.8%	3.7%	1.5%	.5%	.1%	.0%	.0%	100.0%

(Source: Tables prepared using data obtained from RGJAY Society)

Table 7: Preauthorisations raised across Regions and Type of Provider

Type of hospital	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Public	9495 (24.1%)	7383 (21.0%)	5804 (10.4%)	3986 (9.1%)	945 (4.4%)	64552 (56.5%)	92165 (29.7%)
Private	29985 (75.9%)	27831 (79.0%)	50173 (89.6%)	39888 (90.9%)	20503 (95.6%)	49757 (43.5%)	218137 (70.3%)
	39480 (100.0%)	35214 (100.0%)	55977 (100.0%)	43874 (100.0%)	21448 (100.0%)	114309 (100.0%)	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 8: Preauthorisations Raised across Regions and Speciality

Speciality	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Burns	268 (19.6%)	242 (17.7%)	339 (24.8%)	174 (12.7%)	98 (7.2%)	247 (18.1%)	1368 (100.0%)
Cardiac And Cardiothoracic Surgery	2209 (10.6%)	2142 (10.3%)	2858 (13.7%)	2977 (14.3%)	1410 (6.8%)	9218 (44.3%)	20814 (100.0%)
Cardiology	3781 (8.9%)	3322 (7.8%)	6084 (14.3%)	7924 (18.7%)	2469 (5.8%)	18860 (44.4%)	42440 (100.0%)
Critical Care	1204 (16.7%)	876 (12.2%)	1391 (19.3%)	652 (9.1%)	986 (13.7%)	2088 (29.0%)	7197 (100.0%)
Dermatology	17 (10.2%)	5 (3.0%)	9 (5.4%)	4 (2.4%)	1 (0.6%)	130 (78.3%)	166 (100.0%)
ENT Surgery	1321 (14.0%)	3470 (36.7%)	2369 (25.1%)	878 (9.3%)	218 (2.3%)	1188 (12.6%)	9444 (100.0%)
Endocrinology	97 (8.9%)	35 (3.2%)	216 (19.7%)	120 (11.0%)	11 (1.0%)	616 (56.3%)	1095 (100.0%)
General Medicine	216 (25.1%)	129 (15.0%)	107 (12.4%)	199 (23.1%)	26 (3.0%)	184 (21.4%)	861 (100.0%)
Gastroenterology	455 (14.0%)	175 (5.4%)	437 (13.5%)	263 (8.1%)	278 (8.6%)	1631 (50.4%)	3239 (100.0%)
General Surgery	1058 (14.3%)	945 (12.8%)	1303 (17.7%)	832 (11.3%)	306 (4.1%)	2937 (39.8%)	7381 (100.0%)
Genitourinary System	1803 (7.2%)	2667 (10.6%)	6319 (25.1%)	5610 (22.3%)	2828 (11.2%)	5915 (23.5%)	25142 (100.0%)

Speciality	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Gynaecology And Obstetrics Surgery	727 (17.5%)	583 (14.0%)	592 (14.2%)	1185 (28.4%)	201 (4.8%)	878 (21.1%)	4166 (100.0%)
Infectious Diseases	3 (4.5%)	0 (0.0%)	7 (10.4%)	8 (11.9%)	0 (0.0%)	49 (73.1%)	67 (100.0%)
Interventional Radiology	320 (20.8%)	142 (9.2%)	178 (11.5%)	30 (1.9%)	26 (1.7%)	846 (54.9%)	1542 (100.0%)
Medical Oncology	8784 (16.5%)	6929 (13.0%)	11206 (21.0%)	6090 (11.4%)	1665 (3.1%)	18653 (35.0%)	53327 (100.0%)
Nephrology	2710 (5.8%)	4865 (10.5%)	5327 (11.4%)	2606 (5.6%)	5849 (12.6%)	25180 (54.1%)	46537 (100.0%)
Neurology	833 (15.7%)	298 (5.6%)	842 (15.9%)	584 (11.0%)	279 (5.3%)	2454 (46.4%)	5290 (100.0%)
Neurosurgery	874 (14.3%)	464 (7.6%)	935 (15.3%)	811 (13.3%)	348 (5.7%)	2672 (43.8%)	6104 (100.0%)
Others	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	4 (100.0%)	4 (100.0%)
Ophthalmology Surgery	246 (10.5%)	64 (2.7%)	650 (27.9%)	518 (22.2%)	98 (4.2%)	757 (32.4%)	2333 (100.0%)
Orthopedic Surgery And Procedures	1869 (17.6%)	1017 (9.6%)	1583 (14.9%)	2374 (22.3%)	609 (5.7%)	3189 (30.0%)	10641 (100.0%)
Pediatric Surgery	336 (13.9%)	277 (11.5%)	647 (26.8%)	219 (9.1%)	293 (12.1%)	641 (26.6%)	2413 (100.0%)
Pediatrics Medical Management	1460 (18.9%)	241 (3.1%)	1763 (22.8%)	1047 (13.5%)	584 (7.5%)	2646 (34.2%)	7741 (100.0%)
Plastic Surgery	97 (22.9%)	32 (7.6%)	67 (15.8%)	16 (3.8%)	31 (7.3%)	180 (42.6%)	423 (100.0%)
Poly Trauma	4079 (18.1%)	2833 (12.6%)	4458 (19.8%)	5291 (23.5%)	893 (4.0%)	4929 (21.9%)	22483 (100.0%)
Prostheses	2 (7.7%)	0 (0.0%)	1 (3.8%)	0 (0.0%)	15 (57.7%)	8 (30.8%)	26 (100.0%)
Pulmonology	329 (14.1%)	289 (12.4%)	224 (9.6%)	212 (9.1%)	126 (5.4%)	1154 (49.4%)	2334 (100.0%)
Radiation Oncology	2535 (21.0%)	1612 (13.3%)	3038 (25.1%)	1563 (12.9%)	917 (7.6%)	2430 (20.1%)	12095 (100.0%)
Rheumatology	8 (2.2%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	348 (97.8%)	356 (100.0%)

Speciality	Vidarbha	Marath-wada	Western Mahara-shtra	North Mahara-shtra	Konkan	Mumbai	Total
Surgical Gastro Enterology	165 (13.1%)	56 (4.4%)	156 (12.3%)	134 (10.6%)	153 (12.1%)	600 (47.5%)	1264 (100.0%)
Surgical Oncology	1674 (13.9%)	1504 (12.5%)	2871 (23.9%)	1553 (12.9%)	730 (6.1%)	3677 (30.6%)	12009 (100.0%)
Total	39480 (12.7%)	35214 (11.3%)	55977 (18.0%)	43874 (14.1%)	21448 (6.9%)	114309 (36.8%)	310302 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 9: Specialty wise Preauthorizations Approved and Most Common Procedure

	Speciality	Preauthorization approved	Most common approved procedure
1	Gynaecology	3438	Hysterectomy (LAVH (11.5%), Vaginal hysterectomy (28.8%), Vaginal Hysterectomy With Mesh Repair (3.5%), Vaginal Hysterectomy With pelvic floor repair (17%)
2	Nephrology	43755	Haemodialysis 39371 (90%)
3	Cardiology	37097	Coronary balloon angioplasty (47%)
4	Cardiac and cardiothoracic surgery	17231	Coronary bypass surgery* 22% 3903
5	Medical oncology	50585	Palliative chemotherapy 45%
6	Orthopaedic surgery	7767	Soft tissue reconstruction procedures 25% 1976 and arthroscopy 15% 1170
7	Poly trauma	18457	Open Reduction And Internal Fixation Of Long Bone Fractures 79% 14589
8	General Surgery	5691	Lap. Appendectomy (12%), Lap. Cholecystectomy (11.1%), Appendicular Perforation (10.3%)
9	Genitourinary System	21402	URSL (22.8%), PCNL (22.3%), Transurethral Resection Of Prostate (TURP) (12.8)
10	Radiation Oncology	11217	Radical Treatment With Photons (28.3%), Radical Treatment (13.5), 3DCRT-Up To 30 Fractions In 6 Weeks (13.2), IMRT-Up To 40 Fractions In 8 Weeks (12.9)
11	Surgical Oncology	9307	Mastectomy Any Type (16%), Composite Resection & Reconstruction (10)

	Speciality	Preauthorization approved	Most common approved procedure
12	Critical care	5876	COPD Respiratory Failure (Infective Exacerbation) 14 Days Stay with ventilator support (21.4%), ARDS With Ventilatory Care 14 Days Stay (14.5), Septic Shock (ICU Management) With Ventilatory Assistance (13.9), ARDS With Multi Organ Failure With Ventilatory Care 14 Days Stay (11.4)
13	ENT Surgery	8863	Behind The Ear Analogue Hearing Aid (81.6%), Tympanoplasty (6.3)
14	Pediatric Surgery	2082	Hypospadias Single Stage (11%), Anorectal Malformations Stage 2 (7.6), Hypospadius Stage 1 (6.7)
15	Interventional Radiology	1278	"Subclavian, Iliac, Superficial Femoral Artery Stenting Each With One Stent" (15.7%), Biliary Drainage Procedures - External Drainage And Stent Placement - Single Metallic Stent (7.7), Carotid Stenting Single Stent With Protection Device (7.5)
16	Neurology	4313	"Ischemic Strokes-Management with all necessary investigations including 4- vessel cerebral angio (DSA), & Surgery if necessary" (53.7%)
17	Neurosurgery	4725	Spinal fusion procedure (15%),
18	Pediatrics Medical Management	6107	Severe Bronchopneumonia (Non Ventilated) (11.4%), Thalassemia Major Requiring Chelation Therapy - 7 Days Stay - Payable maximum upto (6.2)
19	Burns	1063	"Severe Contracture Surgeries For Functional Improvement (including splints, pressure garments And Physiotherapy)" (22.2%), "Moderate Contracture Surgeries For Functional Improvement (including splints, pressure garments And Physiotherapy)"(18.3), Up To -40% With Scalds (Conservative) (17.5)
20	Surgical gastro enterology	856	GB + Calculi CBD Stones Or Dilated CBD (17.8%), Hydatid Cyst-Marsupilisation (8.6),

	Speciality	Preauthorization approved	Most common approved procedure
21	Gastroenterology	2517	Acute Pancreatitis (Mild) - 1 Week Stay With Post Treatment Evidence Of - Payable maximum upto (28.8%), Cirrhosis With Hepato Renal Syndrome - 10 Days Stay (19.9), Cirrhosis With Hepatic Encephalopathy -11 Days Stay (14.5), Acute Pancreatitis (Severe) - 3 Weeks Stay - Payable maximum upto (12.3)
22	Opthalmology surgery	1991	"Vitrectomy - Membrane Peeling Endolaser , Silicon Oil Or Gas" (25.1%), Monthly Intravitreal Anti-VEGF For Macular Degeneration - Per Injection (Maximum 6) (12.2), Rectus Muscle Surgery Two/Three (11.6)
23	Pulmonology	1868	Acute Respiratory Failure (Without Ventilator) 10 Days Stay (45.8%), Acute Respiratory Failure (With Ventilator) 10 Days Stay (24.8%)
24	Dermatology	145	Pemphigus / PemphigoidTzanck Clinical Protocol 15 Days Stay (76.6%), Stevens-Johnson Syndrome 15 Days Stay (19.3)
25	Rheumatology	290	SLE (Systemic Lupus Erythematosis) 10 Days Stay (51.7)
26	Endocrinology	934	Lower Respiratory Tract Infection 10 Days Stay (39.5), Pyelonephritis 10 Days Stay (19.5)
27	General Medicine	694	Thrombocytopenia With Bleeding Diathesis (43.1), Snake Bite Requiring Ventilator Support (15.6), TB Meningitis (14)
28	Plastic Surgery	305	Nerve And Tendon Repair + Vascular Repair (22), Flap Cover For Electrical Burns With Vitals Exposed (16.7), Syndactyly Of Hand For Each Hand (13.4)
29	Infectious Diseases	53	Tetanus Severe (67.9)
30	Prostheses	23	Below Knee(BK/PTB) Prostheses Modular(52.2)

(Source: Tables prepared using data obtained from RGJAY Society)

*includes on pump with IABP and off pump with IABP

Table 10: Reasons for Preauthorization Rejection

Reason for preauthorization rejection	Frequency
Issue with medical documentation	3277 (25.0%)
Issue with ration card/health card/Photo ID proof	580 (4.4%)
Rejection of preauthorizationon request/ cancellation requested by hospital	1578 (12.0%)
Unjustified selection/wrong selection of treatment package	2641 (20.1%)
Prior approval/previous package covers the amount/cannot be approved within 1 month of previous approval/due date for future preauthorizations	1758 (13.4%)
RGJAY amount is exhausted/insufficient to cover the procedure	26 (0.2%)
Rejection due to issue with Emergency Telephonic Intimation (ETI)	123 (0.9%)
Rejected as wrong amount is quoted/ amount not as per RGJAY package	28 (0.2%)
The procedure selected is reserved for Government hospital	177 (1.3%)
No evidence of the mentioned pathology found in medical reports by TPA doctors	916 (7.0%)
The procedure is not covered under RGJAY	363 (2.8%)
No reason mentioned	928 (7.1%)
Rejected due to older pending requests/duplications	71 (0.5%)
Issue with ration card and documentation	9 (0.1%)
Due to prior approval and issue with documentation	2 (0.0%)
Diagnosis and treatment do not match	38 (0.3%)
Patient is discharged/absconded/referred to another hospital/Expired	248 (1.9%)
Procedure done before preauthorization	175 (1.3%)
Other	177 (1.3%)
Total	13115 (100.0%)
No information available	2 (0.0%)
Total	13117 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 11: Reasons for Pending Claims across Type of Provider

Reason for pending claims	Type of Provider		Total
	Public	Private	
Issue with medical documents*	1852 (40.9%)	1253 (37.7%)	3105 (39.5%)
Issue with non-medical documents**	334 (7.4%)	270 (8.1%)	604 (7.7%)
Issue with medical and non-medical documents	362 (8.0%)	169 (5.1%)	531 (6.8%)
Issue with photo***	438 (9.7%)	564 (17.0%)	1002 (12.7%)
Issues with photos taken at the time of discharge	434 (9.6%)	154 (4.6%)	588 (7.5%)
Issue with medical documents and photos	480 (10.6%)	393 (11.8%)	873 (11.1%)
Issue with non-medical documents and photos	147 (3.2%)	105 (3.2%)	252 (3.2%)
Issue with medical documents, non-medical documents and photo	176 (3.9%)	57 (1.7%)	233 (3.0%)
Issue with late submission of claims	6 (0.1%)	4 (0.1%)	10 (0.1%)
Issue of late submission along with medical and non-medical documents	7 (0.2%)	0 (0.0%)	7 (0.1%)
Issue of late submission and medical documents	4 (0.1%)	2 (0.1%)	6 (0.1%)
Explanation/clarification sought regarding the package or the procedure	153 (3.4%)	153 (4.6%)	306 (3.9%)
Attaching death certificate****	54 (1.2%)	36 (1.1%)	90 (1.1%)
Other	9 (0.2%)	7 (0.2%)	16 (0.2%)
Issue regarding billing amount	77 (1.7%)	159 (4.8%)	236 (3.0%)
Data not available	0 (0.0%)	1 (0.0%)	1 (0.0%)
Total	4533 (100.0%)	3327 (100.0%)	7860 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Table 12: Reason for Claim Rejection against Hospital Type

Reason for claims rejection	Type of Hospital		Total
	Public	Private	
Medical documents were not satisfactory or documents were not attached	867 (38.9%)	1329 (32.4%)	2196 (34.7%)
Procedure was done prior to preauthorization	216 (9.7%)	360 (8.8%)	576 (9.1%)
Issue with patient ID proof/ name, etc	77 (3.5%)	134 (3.3%)	211 (3.3%)
Already approved the claim previously	168 (7.5%)	383 (9.3%)	551 (8.7%)
Issues with bills	14 (0.6%)	89 (2.2%)	103 (1.6%)
Procedure not covered under the scheme/wrong selection of package	453 (20.4%)	960 (23.4%)	1413 (22.3%)
Other issues with the procedure - stent etc	57 (2.6%)	95 (2.3%)	152 (2.4%)
Rejected due to death of the patient	24 (1.1%)	19 (0.5%)	43 (0.7%)
Approved procedure not performed	106 (4.8%)	284 (6.9%)	390 (6.2%)
Discharge and/or dialysis photos were not attached or not satisfactory	68 (3.1%)	94 (2.3%)	162 (2.6%)
Procedure not covered under private hospital as reserved for government hospital	3 (0.1%)	80 (1.9%)	83 (1.3%)
Surgery done more than one month after preauthorization	1 (0.0%)	2 (0.0%)	3 (0.0%)
Reason not mentioned	75 (3.4%)	129 (3.1%)	204 (3.2%)
Others	7 (0.3%)	20 (0.5%)	27 (0.4%)
Operated in other hospital	5 (0.2%)	9 (0.2%)	14 (0.2%)
The case was rejected by TPA & approved by Society	35 (1.6%)	29 (0.7%)	64 (1.0%)
The patient was not physically present during the visit of RGJAY/TPA officer	17 (0.8%)	1 (0.0%)	18 (0.3%)
Claim raised after run-off period	22 (1.0%)	23 (0.6%)	45 (0.7%)
Surgery not done and/ or postponed	7 (0.3%)	26 (0.6%)	33 (0.5%)
Discrepancy found in documents given online as against the documents or treatment being given at the time of field visit or in the report.	4 (0.2%)	37 (0.9%)	41 (0.6%)
Total	2226 (100.0%)	4103 (100.0%)	6329 (100.0%)

(Source: Tables prepared using data obtained from RGJAY Society)

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.

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