CHAPTER 5: Maharashtra case study summary

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Introduction

Marx postulated that “The history of all hitherto existing society is the history of class struggles” (Marx and Engels, 1848). But many scholars engaged in dalit studies assert, “the history of hitherto existing society in India is the history of caste struggles” (Gait, 1913; Ghurye, 1961; Kancha Illaia, 1993; Omvedt, 2012). Though the debate about the root cause of such social setting in India remains inconclusive, there is little disagreement over the fact that, in Indian society, certain social groups and religious minorities such as Dalits, Adivasis and Muslims have been facing exclusion, discrimination and deprivation for generations. This phenomenon remains unabated even after the Indian constitution prohibited identity based discriminatory practices. Like other states, caste based discrimination is not uncommon in Maharashtra, as is evident from the recent violence against specific castes in the state (Khairilanji incident).

According to some scholars, recent economic reforms have made some impression on the existing caste system in India by dismantling the age-old tradition of not pursuing occupations that are considered to be lowly for those belonging to higher castes. Similarly, those on the lower rungs of the caste hierarchy are now able to participate in occupations that were earlier restricted to higher castes (Prasad, 2008; Kapur et al., 2010). However, these observations cannot be generalized, as the traditional association between caste and occupation continues to persist in India (Beittile, 2012; Omvedt, 2012). As a result, there is still a strong correlation between caste and economic status (Deshpande, 2000; Thorat and Newman, 2009; Chaudhury, 2012), considered to be a cause of exclusion from access to productive resources such as land, education and health (Desai and Dubey, 2012).
Further, a major concern is that the high economic growth achieved during the past two decades also led to higher levels of income inequality in all social groups, including those belonging to the traditionally discriminated groups such as Schedules Caste (SC), Scheduled Tribe (ST) and Muslims (Thorat and Dubey, 2012). These vulnerable groups continue to fare poorly in terms of developmental indicators than the general population (Desai and Dubey, 2012; World Bank, 2011). For example, in 2011-12, the poverty rate among STs was 54%, more than three times the rate for all groups in Maharashtra (Panagariya and More, 2013). Not surprisingly, vulnerable groups have far worse health outcome indicators than others (IHDR, 2011). For instance, the tribal children aged between 1 and 4 years have significantly higher mortality rate than non-tribal children (World Bank, 2011).

Indeed, access to health care for poor and vulnerable groups is constrained by financial reasons: non-availability of public health services, discrimination by the privileged and other barriers (Baru, 2010; Shivakumar, 2011; Thorat, and Sadana 2009; Sabharwal, 2011). In fact, despite being sick, more than a quarter of the poor did not seek health care at all in 2004, citing some of the aforementioned reasons (Ghosh, 2014). Often, a major untreated illness results in losing a job, income source, the indebtedness of household or the death of the earning member in the family. All of these result in a chronically poor status of the family and increase their risk for social exclusion, as they are less likely to receive adequate education, be less aware, less empowered and have low social and political standing (Pathak et al., 2010).

Overview of Maharashtra’s health system

Not much is known internationally about Maharashtra’s health system. With a gross domestic product per capita of $1368, Maharashtra is a lower-middle income state in India. But with a population of 112 million, it is almost equivalent to Mexico, the eleventh most populous country in the world. Maharashtra covers over 308,000 km2. It is the second largest state in terms of population and third largest state by area; it also happens to be the most industrialized state in the country. Table 1 provides some key indicators. The incidence of poverty stands at 25%. As can be seen from the table 1, the population belonging to SC and ST is substantial.

In India, health is the responsibility of the state, local and central governments. Curative health services are provided by both public and private facilities. The private sector plays a dominant role in the provision of outpatient and inpatient services: in 2004, 79% of Maharashtra’s citizens resorted to a private source of outpatient care, while 67% resorted to a private source of inpatient care (Ghosh 2014).

The private sector comprises private hospitals, polyclinics, nursing homes, dispensaries and general physicians. Although the public sector’s contribution in terms of providing health care is diminishing, it still has the largest network of health facilities. Both urban and rural areas of Maharashtra are served by a decentralised public health system operating at three levels of care: primary, secondary, and tertiary.

Table 1. Key indicators of Maharashtra, India

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Maharashtra</th>
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<tbody>
<tr>
<td>Population (2011)</td>
<td>112 million</td>
</tr>
<tr>
<td>% of SC population (2011)</td>
<td>11.8</td>
</tr>
<tr>
<td>% of ST population (2011)</td>
<td>9.3</td>
</tr>
<tr>
<td>% of Muslim population (2011)</td>
<td>13.4</td>
</tr>
<tr>
<td>Annual Population Growth Rate (2001-2011)</td>
<td>1.6%</td>
</tr>
<tr>
<td>Per capita State Domestic Product (2010-11)</td>
<td>$1368</td>
</tr>
<tr>
<td>Poverty headcount 2009-10</td>
<td>24.5</td>
</tr>
<tr>
<td>Doctor-population ratio</td>
<td>1:1382</td>
</tr>
<tr>
<td>Bed-population ratio</td>
<td>1:1200</td>
</tr>
<tr>
<td>Life expectancy at birth (2011)</td>
<td>73.4 years</td>
</tr>
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In its first decades after independence, India had a top-down approach for developmental planning and programme implementation. The first effort to replace this occurred in 1993 in the form of an amendment to the constitution. The 73rd amendment made some fundamental changes in the governance structure of the country. For the first time, it provided legal recognition to the ‘Panchayats’, which had existed for centuries as a traditional local governance body. It defined the Panchayati Raj Institutions (PRIs) as a three-tier system of local government. One of the key provisions of the 73rd amendment was the participation of the SCs and STs in the local administration. However, in Maharashtra, the level of participation of SC, ST and OBCs in PRIs is not proportionate to their percentage of population. The representation in PRIs is even lower than in many states, such as West Bengal and Madhya Pradesh (Ventatesu in 2005). The denial of equal participation of these vulnerable groups at the panchayat (local government) level implies lack of political voice, leading to potential exclusion from access to public resources such as education, health and social welfare programmes.

The act also created a major provision through which the state can devolve as many as 29 subjects, including health, to PRIs. All these measures concerning fiscal decentralisation are being looked at as an attempt to enable the government and the rural community to interact closely, thereby making development more locally sensitive and participatory (Shekhar et al., 2006). In other words, this was an important step towards strengthening the voice of the rural poor.

In accordance with its policy of promoting decentralisation, the central government designed the National Rural Health Mission (NRHM2) in such a manner that many of its activities are intricately linked to PRIs. For example, Village Health, Sanitation and Nutrition Committee (VHSNC), a key element of NRHM, is formed and managed by the ‘Gramsabha’, or village council, which is a part of the PRI. VHSNC has a mandate to monitor health at community level and government health-related initiatives, develop village health plans, and create awareness in the community about health services etc. Thus, the PRIs now have a say in the allocation of resources and the delivery of health services in accordance with the needs of the community.

**Health financing**

Public health investment is very low in India, and Maharashtra is not an exception. The states make the major contribution to public health spending followed by central and local governments. The total per capita public-health spending in Maharashtra turns out to be only US $ 7.7. Hence, out-of-pocket (OOP) payments have been the main source of health financing in Maharashtra. This considerably impedes access to health care. According to one estimate, one-tenth of Maharashtra’s population did not seek care at all due to financial constraints in 2004, thereby exposing themselves to health risks (author’s own estimate from National Sample Survey data). And those who utilize the services face severe financial hardships in terms of experiencing catastrophic expenditure and impoverishment.
due to OOP health payments. The over-reliance on OOP payments for health care increased the poverty ratio by 4.9 percentage points, and almost a fifth of the households in Maharashtra experienced catastrophic health expenditure in 2004-05 (Ghosh, 2011). Clearly, the health system in Maharashtra lacks considerably in terms of providing health service and access to financial risk protection, two important aspects of Universal Health Coverage.

Acknowledging the health insecurity issue of the poor, Government of India (GoI) launched one of the world’s largest social health protection initiatives, called Rashtriya Swasthya Bima Yojana (RSBY), in 2008 to provide them insurance cover. RSBY was not only seen as a potential solution to the issues regarding access to health care for the poor, it was also viewed as a tool to reduce poverty and inequality.

In 2008, the Department of Labour (DoL) of the Government of Maharashtra was given the responsibility of implementing RSBY to remove financial barriers and improve access to health care for the poor.

**Overview of RSBY**

**Key features of RSBY**

RSBY is publicly financed, implying that premiums are paid by the central and state governments with the contribution fixed at 75% and 25% respectively. Its aim is to reach out to the unorganised sector workers, in particular the 32 million below poverty line (BPL) persons in Maharashtra. Under RSBY, a BPL family can enrol a maximum of 5 members by paying a token enrolment fee of ₹30 (50 dollar cents) per year, and the enrolled families are entitled to receive secondary level hospital care for around 750 specific procedures up to an annual sum of ₹30,000 ($500).

Unlike usual private health insurance, in RSBY, pre-existing conditions and maternity care are included. However, the notable exclusion is outpatient care, which is more impoverished than inpatient care (Bhandari, Berman and Ahuja, 2010). In order to enrol under RSBY, it is mandatory that the name of the household features on the BPL list that is prepared by the Ministry of Rural Development in rural areas and the Municipality or Municipal Corporation in urban areas.

The design of RSBY is quite unique. It was conceived to be a public-private-partnership model wherein the government would finance and provide stewardship; private players, namely commercial insurance companies, are chosen in each district by a bidding process. As per the contractual agreement between the Ministry of Labour, Government of Maharashtra and insurance companies, the latter is responsible for carrying out information, education and communication (IEC) activities for generating awareness about RSBY among the target population, identifying and enrolling the BPL households, processing the claims from the hospitals, and monitoring the behaviour of the providers to prevent unnecessary utilisation of insured services. In practice, most of these activities are carried out by private firms known as third party administrators (TPAs) and smart card vendors contracted in by the insurance companies. They act as a service integrator between the insurer, the insured and the health service provider (Gupta, Roy and Trivedi, 2004).

The insurance company and TPAs are supposed to carry out Information Education Campaigns (IEC) through various means, like distribution of pamphlets and handbills; and secondly, by displaying the list of beneficiaries at the Panchayat office or by contacting them directly. In many instances, TPAs in turn contract a number of NGOs to generate awareness among BPL households and smart card vendors to carry out the actual enrolment operations. For service provision in Maharashtra, RSBY has established a network of hospitals with only private providers, and those enrolled can seek cash-less inpatient care from this identified network of hospitals.
Current status of the scheme in Maharashtra

Based on programme data provided by the DoL, in 2008, the scheme was implemented in seven districts of Maharashtra in the first phase. By 2011, two years after the program launch, a total of 28 districts completed the first round of enrolment under RSBY. In 2013, the scheme was at various stages of implementation across districts with the duration of the programme varying from 2 to 4 years. In 2012, the Government of Maharashtra started a new state-specific scheme, namely Rajiv Gandhi Jeevandayee Aarogya Yojana (RGJAYS), in 8 districts of Maharashtra that provided coverage for tertiary care expenses up to ₹1.5 lakh (US$2,459) for eligible families, i.e. BPL families as well as above poverty line (APL) families with income up to ₹100,000 (US$1667). The scheme covers 971 surgeries, therapies and procedures under 30 specialties with 121 follow up packages. The RGJAYS pays a premium of ₹333 per eligible family to a commercial insurance company depending on the number of orange ration cards (for APL families), yellow ration cards (for BPL families), and Antyodaya and Annapurna cardholders in the state based on data provided by the Food and Civil Supplies department. Both public and private hospitals are empanelled for providing services. Consequently, the RSBY scheme was withdrawn from 6 districts. In Mumbai and Mumbai Sub-urban region, RSBY was never implemented due to the non-availability of BPL data. In 2013, RGJAY was extended to cover the whole state, and RSBY has been temporarily withdrawn from Maharashtra since October 2013.

The evidence on RSBY enrolment levels and patterns of utilization emerging from various studies paint a disturbing picture of RSBY’s implementation in Maharashtra. From Narayana’s (2010) study, it appears that after the end of the first year of implementation in 2010, only 39% of BPL families were enrolled according to the programme data in eleven districts of Maharashtra, the lowest across seven states; more worrying, Rathi et al. (2012) found that within the Amravati district, Maharashtra ST-dominated blocks recorded the lowest enrolment. Studies conducted in other Indian states found that a large number of poor households still lack access to RSBY; and among those covered by RSBY, utilization of needed health care has remained limited (Rathi et al., 2012; Rajasekhar, 2011; Devadasan, 2013).

However, the majority of these studies focusing on enrolment and other issues either relied on the programme data, or they are based on small, localised geographical areas. Hence, the extent to which their findings can be generalised is questionable.

Aim of the study

Our literature review further reveals that although many studies have looked at different implementation aspects of RSBY to date, there has been no in-depth assessment of RSBY’s impact on access to health care. The current study therefore aims to understand why eligible BPL households are not able to enrol in RSBY, and access its benefits and to explore the extent to which social exclusion could explain this.

Methods

We used a social exclusion framework to study the above objectives. In order to apply the concept of ‘social exclusion’, we adapted the SPEC analytical framework (for details on social exclusion and on SPEC, see previous sections by Williams et al. and Soors et al.) to identify possible reasons for the limited success of RSBY in Maharashtra. With the help of survey data, the SPEC-by-step tool was applied to break down RSBY coverage into a cascade of steps with each step determining the proportion of households excluded and non-excluded by the programme. While the survey data allowed for quantification of excluded population at each step of RSBY implementation, qualitative data were used to answer the research questions, such as how and why exclusion takes place.
Quantitative arm

The quantitative data for this study came from a large scale survey conducted in Maharashtra from November 2012 to February 2013 across 22 districts that met the inclusion criterion of having experienced at least 2 years of RSBY implementation. The remaining 6 districts were excluded, as they hadn’t completed 2 years of RSBY implementation. The household survey used a multi-stage stratified sampling design for the rural and urban sampling domains. The rural sample was typically selected in two stages: the selection of Primary Sampling Units (PSUs), which are villages or groups of villages (in the case of small linked villages), with probability proportional to population size (PPS) in the first stage, followed by the selection of below-poverty-line (BPL) households using systematic sampling within each selected PSU in the second stage.

In the urban domain, a three-stage sampling procedure was followed. The reason for adopting a three-stage sampling design is that urban areas are quite large; therefore, it is difficult to list all the households directly from the resulting list. In the first stage, wards were selected with PPS. From each selected ward, one or two segments were selected with PPS in the second stage followed by selection of BPL households using systematic sampling within each selected segment in the third stage. A total of 6000 households were included, giving a final sample of 29,585 individuals.

Figure 1. Selected districts in Maharashtra, India (the quantitative survey was carried out in the 22 coloured districts and the qualitative survey was carried out in 4 districts with * sign and bold font)
Qualitative arm

To capture the experiences of eligible beneficiaries in relation to RSBY and to identify the barriers that prevent them from the programme, we conducted a total of 17 FGDs, 34 in-depth interviews (IDI) with the members of BPL households, and 3 in-depth interviews with individuals involved in the management of RSBY at different levels, including DoL officials, insurance company representatives and Third Party Administrators (TPAs). A purposive sampling technique was used for selection of sites as well as participants for FGD and IDIs. Initially, 22 districts were grouped into four major regions. Then from each of these zones we chose one district purposively, totalling 4 districts for inclusion. Within each district, PSUs were visited based on the information of the household list prepared for the survey. The PSUs were broadly categorised into two groups based on high and low enrolment rates. Each PSU was then randomly selected from each category. In districts identified as ’Tribal Districts’, we selected PSUs with tribal population. A total of 15 PSUs were visited.

Within the PSU, for FGDs and IDIs, potential participants from BPL households were identified. We ensured representation from all genders, different castes and tribes, religious groups and elderly groups. The topic guide for the FGDs consisted of five sections of probes: resources and problems, concepts of social exclusion, social institutions in their community, presence of collective action and, lastly, RSBY. For IDIs, respondents were interviewed using semi-structured probing guides that included: social exclusion, process of becoming a member in RSBY, perceptions, knowledge and utilization of RSBY, access to health services in the locality and details of the hospitalization.

The discussions and interviews were conducted and transcribed in the native language, which were then translated to English and transcribed verbatim. We examined the verbatim transcripts for consistency and completeness. NVivo 7 was used for managing the texts from FGDs and IDIs. The coding was completed in two stages: first, the text was coded with an inductive approach using principles of grounded theory; second, we used probing guides and research questions to prepare a ‘framework of hierarchical’ codes that are related with the SPEC-by-step tool.

Results and discussion

Descriptive summary statistics of the sample

This section provides a profile of the socio-demographic characteristics of the household population in the survey sample. The sample population of 29,858 individuals is relatively young: the average age is 30 years with approximately 25% below 14 years of age, 63% aged between 15 and 59 years and 12% aged 60 and above (Table1).

Table1. Descriptive characteristics at household and individual level, Maharashtra, 2012-13

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Total</td>
</tr>
<tr>
<td>Sex ratio (%)</td>
<td>50.8</td>
</tr>
<tr>
<td>Male</td>
<td>49.2</td>
</tr>
<tr>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>Age group (%)</td>
<td></td>
</tr>
<tr>
<td>0-14</td>
<td>24.8</td>
</tr>
<tr>
<td>15-59</td>
<td>62.9</td>
</tr>
<tr>
<td>60+</td>
<td>12.3</td>
</tr>
<tr>
<td>Age</td>
<td>30.2 (20.1)</td>
</tr>
<tr>
<td>Marital status1 (%)</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>23.8</td>
</tr>
<tr>
<td>Currently married</td>
<td>66.0</td>
</tr>
<tr>
<td>Widowed/Divorced/Separated</td>
<td>10.20</td>
</tr>
<tr>
<td>Poor health status3</td>
<td>4.1</td>
</tr>
</tbody>
</table>
The mean household size is 4.9; 49% are female and 51% are male. About a quarter of the population is unmarried (24%) and two-thirds of them are currently married. However, almost one-tenth of the population is widowed, divorced or separated. Only 4% of the sample population is perceived to have poor health.

The distribution of households by religion reveals that about 79% of them are Hindus, 9% are Muslims and 12% are others, comprising Buddhists, Christians, Jains and Sikhs. The majority of BPL households belong to marginalized social groups, such as Scheduled Castes (33%), Scheduled Tribes (19%) and Other Backward Castes (29%). The remaining 19% are ‘others’. Males head about 79% of households. Education measured by highest education level achieved by any member in the household is low at a mean of 9 years. The average monthly household consumption expenditure is US$101. More than 6% of household heads reported to have been suffering from chronic health problems.

**SPEC-by-step Results**

Using the SPEC-by-step tool, we tried to quantify the extent of non-coverage at various steps of RSBY implementation on the basis of quantitative data. The quantitative data was also employed to identify the characteristics of excluded households and individuals at each step. The qualitative data contributed to understanding the social, political, economic and cultural processes that led to exclusions of households from accessing RSBY in Maharashtra.
Step 1. Awareness of RSBY

Figure 2 shows that of the 6000 BPL households interviewed, only 30% reported that they knew about the scheme, with rural households having a considerably higher level of knowledge than their urban counterparts. Besides, the level of knowledge about the programme's features was found to be very limited by even those who were enrolled in RSBY. Using their responses regarding the composition of the benefit package in the survey, we classified them into three categories: ‘fully aware’– those who could tell about all the components; ‘partially aware’ – those who had knowledge about any of the components; and ‘not aware’– those not able to provide any correct answer. Only 4% were found to be fully aware. We have provided a detailed analysis on awareness in chapter 7.
As explained earlier, the insurance companies and TPAs are primarily responsible for awareness generation in the community. The in-depth interviews with beneficiaries and implementing officials reveal that, in practice, they greatly relied on Panchayat members, Block Development Officers and ‘Anganwadi’ workers for contacting them directly despite little or sometimes inadequate incentive. The enrolling agencies often approached the PRI members for making arrangements for enrolment in their villages. Peons of the gram panchayat, Anganwadi workers, ASHA workers and personnel of the Revenue Department were the key actors in reaching these BPL households. Hence, the role of PRI was very vital in making the eligible beneficiaries aware about RSBY.
Such over-reliance on PRIs for IEC as found in Maharashtra left enormous scope for the exclusion of BPL households from knowing about RSBY in two ways. First, local officials at Panchayat office were found to be reluctant to do the RSBY related work, as this was not their department’s work; therefore, least priority was given to those activities. Second, it has been generally observed in previous studies that access to public resources largely depends on the political affiliation of person/households/groups; hence, the chances of getting information are less for those not associated with the political party locally in power (Besley et al., 2005, Bardhan et al., 2008, Markussen, 2011). The analysis of the survey data also confirmed the same households that are active in local politics and have political contacts had significantly higher chances of getting information about RSBY (OR=1.9; CI: 1.7-2.1) from the local authorities and vice-versa.

Apart from institutional and political factors, certain characteristics of households seemed to have influenced the access to information related to RSBY. For example, female-headed households and households with uneducated heads were less likely to receive information about RSBY; more worryingly, across all social categories, the tribals were clearly at a disadvantage in terms of having knowledge about RSBY compared to other social groups. Notably, the level of awareness among ST households was lowest (25%) across social groups. This was also reflected in the FGD’s wherein a participant residing in the tribal area narrated their experience regarding the process of information exchange about the scheme.

“... we were told that... this booklet consists of the names of hospitals and services) which can be used for the hospitalization related services); we were not told in face about the card except that the facilities are covered in the booklet and one can read and understand them from it.” (Source: Nandurbar rural tribal FGD)

The above narrative clearly reveals the reasons as to why the level of knowledge about the scheme is very low among the beneficiaries. The TPAs and insurance companies did not take into account the socio-economic context of the beneficiaries at all while designing the IEC activities and disseminating information about RSBY. It is a well-known fact that majority of STs either do not have formal education or have very limited educational achievements and therefore to expect them to go through the RSBY booklet to know about the scheme is very unrealistic. In short, the IEC materials and dissemination strategies worked to the disadvantage of people with low educational achievements or groups like Tribals.

**Step 2. Ever enrolment in RSBY**

Upon enquiring about the insurance status of the BPL households, it was found that 22% were ever enrolled under RSBY. The ever enrolment rate of BPL households was considerably higher in rural areas (27%) than in urban areas (13%). Ever enrolled are those who became a member of RSBY at some point since the beginning of the scheme but may not necessarily remain enrolled in the scheme.

The qualitative evidence points to several reasons for a low-enrolment rate. Flawed BPL list, death of the head of the household, seasonal migration, lack of administrative support on the ground, cost of enrolment, no compulsive mandate on the insurance company to achieve higher enrolment rates, limited and inflexible time span of enrolment and ineffective oversight by the DoL, appeared to be important design and implementation related factors that affected enrolment activity on the ground. Besides, wider contextual factors such as corruption and nepotism were reported by participants as prime mechanisms of exclusion from any social-protection programme.

As per the narratives of the respondents and focus groups, enrolment in general was conducted in a haphazard and shoddy manner.

“We asked them that our photos were not taken yet, so they replied that their duty was only of 8 days but they spent 15 days. Still our photo was not taken, though we have yellow card.” (Male participant from FGD in Nandurbar)
“The problem was, they had not informed before coming. So, when they came, we were not there. Then they came again, too, on another day. But they had not informed. So, we couldn’t make it again... (Male participant from FGD in Nandurbar)”

“They (people of enrollment agency) informed in the village (through village head–sarpanch) that there will be a card distribution and everyone whose name features in the list are requested to stay back for getting the card (enrollment). Some households did not listen to it (or were not able to understand it) and went on to work (to various places out of the village) thus they were not able to get the cards” (In-depth interview, rural areas, Bhandara)

Except for one PSU in Nandurbar, none of the other participants reported that they were provided with a note or saw their names on the list. In most cases, they were informed through the network of PRI members in rural areas and ward members in urban areas. As explained earlier, this strategy was not successful. Findings from the qualitative data analysis suggest that it led to the exclusion of households with no political clout or any proximity to the main village area or close to politically active households.

“Family member: yes they do not share valuable information. They feel that if we are getting benefits of welfare programmes then why to bother about the rest of the households. Why should we even pay attention to these people? They will realize the benefits of welfare programme when they get to know about it from other sources. “(FGD, Jalana urban 1)

We also examined the RSBY coverage across social groups at the village level. Given the history of social discrimination, it was not surprising to find that tribal households were excluded from accessing RSBY. For instance, we noticed that a household from a tribal settlement was not enrolled in subsequent rounds, though a villager under the same Gram Panchayat (GP) but from a non-tribal village was enrolled consecutively. On asking the female head of a tribal household what may possibly explain the reason for her exclusion from RSBY, she replied that she was not aware of such a scheme. When it was pointed out that others got the information from the GP, she made the following remark:

“They received wells, land. They provide employment to those who already have enough and let the poor die”

“Yes! That is it! They will come there (in the Gram Panchayat) and leave from there. They will not come here.” (Woman whose husband is hospitalized and who is not enrolled)

Hence, the qualitative results showed that apart from administrative and design-related issues, spatial isolation, social stratification as well as political neglect were some of the mechanisms that explain the reasons for exclusion of eligible households from enrolment.

Another issue is the ‘intra-household’ exclusion that occurs due to the following reasons. Firstly, RSBY imposes a five-member limit on the enrolment of a household. However, 34% of the households had more than five members, implying that because of the five-member limit in the scheme, some vulnerable members, like women and children, may have been excluded from the coverage of RSBY. Second, almost 40% of the enrolled households reported that not all five members were included in RSBY, as there was no clarity on who can be enrolled from a family. Our qualitative data revealed that at a later stage when people went on to use the card, many people found that the name of a particular family member was not included on the card.

“Yes, we had taken this card to the hospital. But they said that his name is not there on this card. His son and his family were travelling to other place for sugarcane cutting, so he was not able to enrol his name in this card and the hospital said that his name is not there on this card; so won’t get any benefits of the scheme. He gave his photo but his family left” (tribal woman in Nandurbar)
Step 3. Current enrolment in RSBY

The analysis of the survey data revealed that only 12% of the BPL Maharashtra households were currently enrolled in the scheme. As observed in cases of ever enrolment, the current RSBY enrolment rate of the BPL population was higher in rural areas (14%) compared to urban areas (8%). A large number of households (90% and 77% in rural and urban areas respectively) said that they had neither any information saying that the card could be renewed, nor that there was any camp held for reenrolment. Further, the qualitative results suggest that the empanelled hospital’s refusal to treat patients under RSBY, the non-availability of empanelled hospitals in the vicinity and the lack of knowledge about the listed hospitals have reduced the scheme’s acceptance in some areas. Many BPL households refused to be re-enrolled in RSBY: they thought it was not worth spending 50 cents to obtain the RSBY smart cards and perceived this to be a waste of money because they were unable to utilize the services to which they were entitled.

Analysing the quantitative data, we identified the determinants of current enrolment of RSBY (details are provided in chapter 9). The results suggest that male-headed, non-labourer households, households belonging to a majority religion and those residing in urban areas and from Vidharbha region were less likely to be included in RSBY. The odds of reporting enrolment was also found to be significantly lower among single-member households than joint and extended families (OR=0.47). With regard to social dimension indicators, households that did not know any influential person were less likely to be enrolled (OR=0.81) in RSBY than those with wider social networks. Those who expressed a lack of trust in institutions such as local government, national government, judicial system, press etc. were significantly less likely to be enrolled in RSBY. In other words, the above findings indicate that a low level of social capital was associated with lower levels of enrolment in RSBY. Such within group cohesion may lead to inclusion of some households while excluding single member households or households from other castes or religions. Interactions within a certain group were stronger but interactions between two groups, for instance Muslims and Hindus, or scheduled tribes and others, were very poor. Also, factors such as migration or lack of interaction in the community led to poor information exchange and exclusion from enrollment. In addition, community ties are much stronger in rural areas compared to urban areas. This social isolation along with implementation problems such as the delay in launching the scheme in urban areas and an incomplete BPL list are responsible for lower participation in RSBY in urban areas. Besides, the analysis of the quantitative data suggests that households which were vulnerable in all dimensions of social exclusion were less likely to be enrolled into RSBY.

Step 4. Possession of RSBY cards

For utilizing the services covered under RSBY, it is essential to have an RSBY smart card. However, of the currently enrolled households, 5% did not possess smart cards. Analysis of the survey data reveals that technical problems were reported as a reason for not getting the smart card by 37% of the currently enrolled respondents who did not have smart cards. A third of them also said that they did not know why they had not received the card. Delay in the distribution of smart cards was consistently reported in almost all focus-group discussions. Further, in one of our field visits, we noticed that cards were kept with the Gram Panchayat and were not distributed to households.

Step 5. Utilisation of RSBY services

Finally, the utilisation of RSBY services was very low in Maharashtra. It was found that among the households with valid RSBY cards with at least one hospitalisation case in the year prior to the survey date, only 12% of them had used the cash-less services from the listed hospitals of RSBY. The qualitative interviews help to explain the reasons for non-utilization of services. Lack of information regarding the listed hospitals, inability to recognise the use of the smart card, non-availability of listed hospitals in their neighbourhood and invalid smart cards were the leading causes of non-utilisation. One beneficiary narrated his experiences relating to RSBY:
“Oh...these are hospitals located in Bhandara. We go to Bramhapuri which is close to us and we know the doctors, and list of hospitals in Bramhapuri (nearby town) are not given here, then what’s the use of it...? Every year these people come and take thirty rupees from us and yet the card is useless at any (in the respondent’s town) hospitals here” (IDI-1, enrolled male 1)

Conclusion

Our research has demonstrated that the design and implementation-related issues only partly explain the reasons for the limited success of RSBY in Maharashtra. The evidence shows that access to RSBY is also shaped by social, political, economic and cultural processes that have significantly impacted the performance of RSBY in terms of achieving universal population and service coverage within the target population. As the implementation of the scheme was embedded in existing social, economic, political and cultural structures, the inequalities in these structures further deepened the inequalities in access to RSBY. The analysis unravelled ways in which the exclusionary processes reinforce and reproduce inequalities in access to RSBY. For instance, households that did not know any influential person were significantly less likely to be enrolled in RSBY than those with wider social networks. Unless these exclusionary processes are recognised and addressed while designing and implementing social welfare programmes, inequities in access to these programmes, including RSBY, will persist.

Low awareness and enrolment are the major concerns; hence, these issues have been explored in detail in chapter 7 and 9 respectively. The BPL list is very problematic, as it significantly excluded eligible households and persons thereby depriving them from obtaining the benefits of RSBY. Such findings strongly suggest that instead of relying on the BPL list, it will be better to have wider criteria for enrolment in the scheme. In order to improve the access of RSBY, there should be more emphasis on educating BPL families about the programme. More importantly, the IEC activities should be carried out in such a manner that information about RSBY and its benefits reaches the vulnerable population and, if necessary, a clear policy bias in terms of allocation of resources should be introduced in order to provide access to RSBY to the unreached vulnerable population groups.

Urban households were found to be more disadvantaged than rural households in terms of RSBY coverage. Hence, the nodal agency needs to monitor the enrolment activities more closely to improve the awareness level and enrolment in urban areas. The utilisation of services was poor, particularly in rural areas. Given these findings, the role of commercial insurance companies and TPAs should be critically reviewed and, a public agency should instead be given the responsibility for awareness generation and enrollment of workers. Efforts should also be made to empanel public hospitals so that access to RSBY translates into access to care for vulnerable households. If RSBY is reintroduced, DoL should focus on improving it by abandoning its current target based approach and instead adopt a ‘universal’ approach for enrollment (covering all workers engaged in the unorganised sector), providing more control to the nodal agency, scrapping the ‘compulsory annual renewal policy’ and expanding the benefit package. Finally, the findings of our study clearly suggest that any social health protection programme such as RSBY would be more successful at reaching the unreached vulnerable population if it was implemented by a public agency with a pro-social inclusiveness approach embedded in its policy framework.

References


Endnotes

1  Recognising the socio-economic differences among the various population groups, the Government of India classified its population on the basis of their social and economic conditions as Scheduled Tribe (ST), Scheduled Caste (SC), Other Backward Class (OBC) and Others. ST is the most socio-economically disadvantaged followed by the SC and OBC and together they comprise 67% of India’s population, with SC at 16.6%, ST at 8.6% and OBC over 42%.

2  National Rural Health Mission, started in 2005 represents an important initiative by the central government to address the health care needs of the rural population by strengthening the public health system in rural areas.
The acronym BPL is used for below-poverty-line households in India. A BPL census is periodically conducted by Ministry of Rural Development, Government of India in all the states for identifying the poor households for social support. The identification of BPL household is not based on the poverty line defined by the Planning Commission GOI, but is determined by using various parameters that score the households in a range of 0 to 52. This method was used in 2002 BPL Census to rank all the households on the basis of these scores in a typical village and the BPL households were chosen using a cut-off.

In chapter 9, we have provided a detailed description of how an index of ‘social exclusion’ is constructed using indicators of SPEC dimensions.