



AWARNESS OF RSBY SCHEME AMONG DOCTORS IN A TERTIARY CARE TEACHING INSTITUTION -A CROSS SECTIONAL SURVEY

Community Medicine

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ABSTRACT

Rashtriya swasthya bima yojana (RSBY) is a government sponsored health insurance scheme for the unorganised sector labours in the country. Aim of the study was to assess the awareness of RSBY scheme among clinicians in the tertiary care teaching institution in central kerala.

Methods: With approval of IEC after getting written informed consent a cross sectional study was conducted among 121 clinicians using a self administered structured questionnaire consisting of 20 questions. Scores were assigned to each questions and score more than 60% were considered as good and less than 40% were considered as poor awareness. Data was entered in excel and analysed using SPSS version 21 done. Mean and percentage were used for describing the data, while chi square was done to find out association between variables.

Result: 57(47.1%) out of 121 doctors were from medicine and medical speciality, while the rest from surgery and surgical speciality. 14 (11.3%) doctors were having good awareness and 82(66.1%) were having average awareness. Mean awareness score for males (12.29) was greater than females (10.54) and statistically significant ($p=0.003$). There was association between awareness and designation ($p=0.04$) and gender ($p=0.02$).

Conclusion : The study revealed that majority of the clinician have adequate knowledge on RSBY

KEYWORDS

RSBY, Awareness Health insurance

BACKGROUND

Rashtriya Swasthya Bima Yojana (RSBY) is a government-run health insurance programme for the Indian poor. The scheme aims to provide health insurance coverage to the unrecognised sector workers belonging to the BPL category and their family members shall be beneficiaries under this scheme. The government of India provides financial assistance of 75% of the premium for insured families. Under RSBY, a maximum of five members in a family can avail in-patient treatment benefit upto Rs. 30,000/- for a year through empanelled Government, Private and Cooperative hospitals. Transportation charges are also provided limited to Rs. 100/- per visit. The beneficiary needs to pay only Rs. 30/- as registration fee which will be used to meet the administrative expenditure for scheme implementation.

Beneficiaries under RSBY are entitled to hospital coverage upto Rs. 30,000/- per year for most of the diseases that require hospitalization. Government has also fixed the package rates for the hospitals for a large number of interventions. Preexisting conditions are covered from day one and there is no age limit. Coverage extends to five members of the family which includes head of the household, spouse and upto three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee, while central and state Government pays the premium to the insurer selected by the state government, on the basis of a competitive bidding.

This scheme differs from other health insurance schemes of the government in several important ways.

1. Empowering the beneficiary with freedom of choice between public and private hospitals and makes him a potential client worth attracting, on account of the significant revenues that hospitals stand to earn through the scheme.
2. The scheme has been designed as a business model for a social sector scheme with incentives built for each stakeholder. The business model design is conducted both in terms of expansion of the scheme as well as for its long run sustainability.
3. The insurer is paid premium for each household enrolled for RSBY. Therefore the insurer has the motivation to enroll as many households as possible from the BPL list. This will result in better coverage of targeted beneficiaries.
4. A hospital has the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. It is a source of income for public hospitals which they can use for their own purpose. Insurers in contrast will monitor participating hospitals in order to prevent unnecessary procedures or fraud, resulting in excessive claims.
5. Inclusion of intermediaries such as NGO's, who will be paid for

the services they render in reaching out to the beneficiaries.

6. By paying only a maximum sum upto Rs. 750/- per family per year, the government is able to provide access to quality health care to the below poverty line population. It will also lead to a healthy competition between public and private providers which in turn will improve the functioning of the public health care provider.
7. For the first time Information Technology (IT) applications are being used for social sector scheme on such a large scale. Every beneficiary family is issued a biometric enabled smart card containing their finger prints and photographs. All hospitals under RSBY are IT enabled and connected to the server at the district level. This will ensure a smooth data flow regarding service utilization periodically.
8. Biometric enabled smart card and a key management system makes this scheme safe and fool proof. The card reaches the correct beneficiary and there remains accountability in terms of issuance of the smart card and its usage. Only the real beneficiary can use the smart card.
9. The smart card is unique in that it can be used in any RSBY empanelled hospital across India. This portability is beneficial to poor families, that migrate from one place to the other.
10. The transactions are cashless and paperless.

A good understanding of the RSBY by the stakeholders may be a precursor of successful implementation of the scheme. But unfortunately not much studies have been conducted on the awareness of doctors regarding RSBY. Hence the present study is conducted to assess the awareness of RSBY among doctors and to identify the association between awareness and gender in a tertiary teaching hospital of central Kerala.

MATERIALS AND METHODS

2.1. Study Area and Design

A hospital based cross-sectional survey was conducted among doctors working at the tertiary care teaching hospital. The study was conducted from September 2017 to February 2018.

2.2. Study Population and Sampling

All clinicians attached to both Medical and surgical specialities were included in the study. Compulsory Rotating Resident Internees and non academic residents were excluded.

Sampling method used was universal sampling technique. Total study subjects obtained for the study was 121. Repeated attempts were done to pick up the absentees as well as those who were availing off duty.

2.3. Study Instrument

The structured questionnaire consisted of 20 items on RSBY. These questions were categorized based on the study objectives into the following sections: demographic profile, awareness of information, understanding and perception of RSBY. The questionnaire was piloted among 10 healthcare professionals and adjustment was made using the feedback from the respondents. Data from the pilot study was not included in the final analysis. One mark was allotted for each correct responses in the questionnaire and the total score was calculated. Based on total score awareness was categorised. More than 60% (score 16-20) were considered as good awareness while 40 – 60 % (score 8-15) as average and less than 40 % (score < 8) as poor awareness.

2.4. Data Collection

The investigators hand-delivered the questionnaire to all the clinicians . Questionnaires were collected within a week of distribution. A total of 135 questionnaires were administered of which 121 were received (Response rate=89.6%). Overall, 14 participants did not return the questionnaire.

2.5. Ethical Consideration

Ethical approval was obtained from the Institutional Ethics Committee. Written informed consent was obtained from each participant for the voluntary participation in the study.

2.6. Statistical Analysis

Data was coded and entered in Microsoft excel and analysed using SPSS software version 21. Qualitative data was summarised using frequencies and percentages while quantitative data using mean and standard deviation. For inferential statistics, chi square test was used to find out association between variables. Significance level was kept at 5 % level.

3. RESULTS

Table :1 – Distribution of study subjects according to speciality and gender

Speciality	Male	Female	Total
Medical	25(43.9%)	32(56.1%)	57(100%)
Surgical	31(48.4%)	33(51.6%)	64(100%)
Total	56(46.3%)	65(53.7%)	121(100%)

Table :2 – Distribution of awareness according to gender

Gender	Good	Average	Poor	Total
Male	9(16.1%)	41(73.2%)	6(10.7%)	56(100%)
Female	5(7.7%)	41(63.1%)	19(29.2%)	65(100%)
Total	14(11.6%)	82(67.8%)	25(20.7%)	121(100%)

Figure :1 – Descriptives of awareness score according to gender

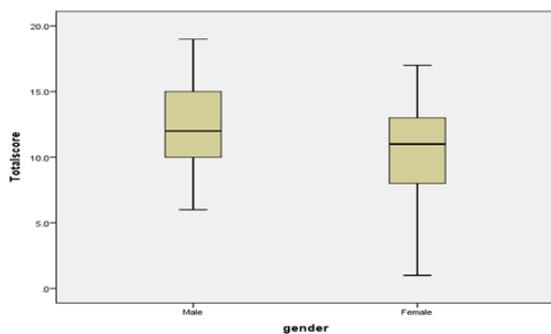


Table :3 – Comparison of awareness score according to gender

Gender	Mean	SD	P value
Male	12.29	3.04	0.003
Female	10.54	3.19	

Table :4 – Distribution of awareness according to designation

Designation	Good	Average	Poor	Total
Professor	4(23.5%)	11(64.7%)	2(11.8%)	17(100%)
Asso.Professor	0(0%)	13(100%)	0(0%)	13(100%)
Assistant Professor	4(11.1%)	22(61.1%)	10(27.8%)	36(100%)
Lecturer	4(18.2%)	13(59.1%)	5(22.7%)	22(100%)
Senior Resident	2(13.3%)	7(46.7%)	6(40%)	15(100%)
Junior Resident	0(0%)	16(88.9%)	2(11.1%)	18(100%)
Total	14(11.6%)	82(67.8%)	25(20.7%)	121(100%)

77.4 % of the clinicians have adequate knowledge on RSBY with statistically significant greater mean awareness score for males and designation wise , professors had relatively better awareness

4.DISCUSSION

In a similar health professional's awareness study² in Africa , majority (81.3 %) showed good understanding of the National insurance scheme , the study not being confined to doctors alone but also nurses and other paramedical staff. This is similar to previous reports from Ethekwini Metro and Ugu districts in Kwazulu – Natal province ² of Africa, which documented 91 % awareness among health professionals ie private doctors alone . Here age variable was also analysed and doctors less than 40 years displayed the highest awareness. (100%). Age variable was avoided in our study. Purpose and challenges of implementation of the scheme was also studied for successful implementation in the above two studies.

Present study was confined to doctors alone as their awareness was more important ,since decision taking is being done by doctors in RSBY and a good understanding will prevent insurance company rejections , thus benefitting the patient and institutional income.

In a Jaipur , descriptive cross sectional study (Rajasthan state , India) on RSBY perception among Medical practitioners ³, the main concern was to analyse problems faced by doctors in RSBY implementation , know their satisfaction level and doctor's perception from the beneficiary point of view. Here beneficiary awareness was studied through the doctors and suggestions for better implementation given. This study was also confined to doctors alone , but doctor's awareness not studied.

Awareness and Perception of Resident doctors towards National Health insurance scheme in a tertiary hospital ⁴ in Nigeria, more than 80% of respondents had adequate basic knowledge about the scheme. Here performance scale of the scheme was also studied through the doctors.

Gender awareness and awareness according to designation were also analysed in the present study.

Acknowledgements

The author would like to thank Dr. Manjula V.D. & Dept. Of Community Medicine for encouragement & contribution in statistical analysis. Study funded by SBMR.

Disclosures : No conflict of interest.

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