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CONTENTS

Sr. No.	TITLE & NAME OF THE AUTHOR (S)	Page No.
1.	**ANALYSIS OF TOMATO MARKETING IN UASIN- GISHU COUNTY, KENYA** *YEGOH KENNETH KIMELI KOSGEY*	1
2.	**INDIAN DISINVESTMENT PERFORMANCE EVALUATION BETWEEN NDA & UPA GOVERNMENTS** *DR V S PURANIK & VIRUPAKSHA GOUD G*	11
3.	**DEVELOPMENT OF SUSTAINABILITY REPORTING: CASE STUDY IN PT TIMAH (PERSERO) TBK** *IA. BUDHANANDA MUNIDEWI, EKO GANIS SUKOHARSONO & DR. ARI KAMAYANTI*	15
4.	**TRENDS IN ECONOMIC CONTRIBUTION OF TOURISM INDUSTRY TO INDIAN ECONOMY** *HARINI K.V & INDIRA M*	21
5.	**TOWARDS ENHANCING EFFICIENCY IN THE TRANSPORT INDUSTRY IN KENYA: A STUDY OF THE ROAD AND RAIL TRANSPORT** *ERIC LEWA KATANA & ABDULKARIM ABDULRAHMAN ABDULKARIM*	25
6.	**EMERGING TRENDS IN THE MARKET OF EVENT MANAGEMENT: A LITERATURE REVIEW** *ANTRIKSHA NEGI & RAVINDER PANT*	30
7.	**A STUDY ON INVESTORS' PERCEPTION TOWARDS DERIVATIVE INSTRUMENTS AND MARKETS** *DR. Y. NAGARAJU & SUMAN REDDY S*	33
8.	**RASHTRIYA SWASTHYA BHIMA YOJANA - COMPREHENSIVE HEALTH INSURANCE SCHEME (RSBY-CHIS) IN KERALA : A STUDY ON THE EFFECTIVENESS AND UTILIZATION OF THE SCHEME WITH SPECIAL REFERENCE TO ERNAKULAM AND WAYANAD DISTRICTS** *DR. P. P. MINI*	41
9.	**TIME USE STUDIES TO EVALUATE UNPAID CARE WORK IN KERALA** *ANILA SKARIAH*	47
10.	**BOARD STRUCTURE AND BANK PERFORMANCE: AN ETHIOPIAN SURVEY** *ARON HAILESELLASIE*	53
11.	**FINANCIAL DISCLOSURE IN THE ANNUAL REPORTS OF LIBYAN BANKS: FROM PREPARERS' PERSPECTIVES** *DR. MUSA M. KRIBAT*	59
12.	**APPRAISAL OF INFLUENCE OF MAJOR EXOGENOUS FACTORS ON VOLUME OF LENDING BY DEPOSIT MONEY BANKS IN NIGERIA (1990 -2011)** *ABDULLAHI SHEHU ARAGA*	65
13.	**DOMESTIC ROOF WATER HARVESTING PRACTICES: AN EMPIRICAL INVESTIGATION IN MEKELLE, ETHIOPIA** *ARAYA ABREHA*	73
14.	**PRICE DISCOVERY AND INFORMATION TRANSMISSION IN SPOT AND FUTURE SEGMENTS FOR NSE 50: AN EMPIRICAL STUDY** *PIYUSH PANDEY*	80
15.	**EFFECTIVE GOVERNANCE FOR SUSTAINABLE GROWTH OF INDUSTRIAL UNDERTAKINGS AND MSME's IN INDIA** *AMARENDRA BHUYAN*	83
	REQUEST FOR FEEDBACK & DISCLAIMER	87

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   RESEARCH METHODOLOGY

   RESULTS & DISCUSSION

   FINDINGS

   RECOMMENDATIONS/SUGGESTIONS

   CONCLUSIONS

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RASHTRIYA SWASTHYA BHIMA YOJANA - COMPREHENSIVE HEALTH INSURANCE SCHEME (RSBY-CHIS) IN KERALA : A STUDY ON THE EFFECTIVENESS AND UTILIZATION OF THE SCHEME WITH SPECIAL REFERENCE TO ERNAKULAM AND WAYANAD DISTRICTS

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ABSTRACT

Health insurance is an urgent necessity and universal coverage is the need of the hour. Rashtriya Swasthya Bhima Yojana-Comprehensive Health Insurance Scheme is a move towards this end and it is being successfully implemented in all the 14 districts of the Kerala state from the 1st year of introduction in the country. This study is an attempt to understand the effectiveness of the scheme in Kerala, with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses with special reference to Ernakulam and Wayanad districts, as these two districts are having the highest and lowest utilization of the scheme respectively. The main source of data for this study is the sample survey conducted among the hospitalized beneficiaries under the scheme. The study found out that even though the scheme has a positive role in reducing the hospitalization expenditure among the beneficiaries, low awareness level, limited number of private empanelled hospitals, poor implementation of the scheme, absence of effective monitoring mechanism and redressal of grievances, timely reimbursement to hospitals, ambiguities in the benefits of the scheme, etc., are some of the pertinent issues still persisting as constraints in achieving the desired objectives of the scheme. The program designers and policy planners may take effective steps to address the issues concerned, while making future plans in implementing the scheme more effectively or in improved forms.

KEYWORDS

Comprehensive Health Insurance Scheme, Health Financing, Health Insurance, Rashtriya Swasthya Bhima Yojana.

INTRODUCTION

The level of health care spending in India is currently over 6% of its GDP. In a break up of this 6%, as much as 4.7% is accounted for by the private sector. Out of this 4.7%, 4.5% comprises out-of-pocket expenditures of households and 0.2% includes contributions from private employers and other non government organizations. Health spending averaged 11% of non food expenditures and almost 5% of the total annual expenditures of households. The NSSO 60th Round Report (2004) on "Morbidity, Health Care and the Condition of the Aged", shows two worrying developments: an increase by nearly 50% in health expenditures as compared to the last survey conducted in 1994-95; and a near stagnation in the utilization of public facilities. Without health insurance, and under the existing paradigm of a very low share of public expenditure and a very high share of unpooled expenditure, poor households are exposed to risk of impoverishment due to the cost of healthcare, and enjoy low access to healthcare due to its high cost. This conclusion has been corroborated by the World Bank; it estimated that one quarter of all hospitalized Indians fell below the poverty line as a direct result of the related medical expenses of this single event.

Among the states in India, Kerala surpasses all the other states in the levels of human development. But, now has the problem of high morbidity. State facilities exist, but due to lack of funding and shortcomings, people are forced to rely on private providers for their health care needs. Studies show that about 80% of all outpatients and about 50% of all inpatients seek health care from the private sector. But the cost of care in private sector is expensive and unaffordable to large segment of population. 'Good health at low cost in Kerala' faces serious challenges due to increased privatization.

Thus both the Indian and Kerala health financing scenes raise number of challenges and healthcare costs are the single most serious cause of impoverishment among those whose income is close to the poverty line and therefore exploring health financing options become critical. Health insurance is therefore an urgent antipoverty measure.

HEALTH INSURANCE SECTOR

The existing health insurance schemes in India can be broadly divided into categories such as :

1. Employer based schemes (limited to concerned employees only).
2. Insurance offered by NGOs/CBHIs (limited to some specific geographical locations)
3. Mandatory health insurance schemes like ESIS, CGHS, ECHS, etc. (ESIS only cover workers in the organized sector, CGHS cover only central government employees, and ECHS cover only retired army personnel and their eligible dependants)
4. Voluntary health insurance schemes (an important viable option for all segments of society, but in spite of liberalization in 2000, these have covered only less than 2% of the population until now, the reason is its un affordability by the masses. There are also problems and negative unintended consequences of private health insurance. All these effects will tend to increase the prices of private health care, thus hurting the uninsured).
   As a result, to address such issues, governments in India have introduced,
5. Social insurance or government sponsored schemes like UHIS (Universal Health Insurance Scheme), RSBY (Rashtriya Swasthya Bhima Yojana) etc.

UNIVERSAL HEALTH INSURANCE SCHEME (UHIS) started in 2003, but it had problems due to poor policy design, lack of clear accountability, weak monitoring and evaluation and poor awareness among beneficiaries about the schemes.

Learning from the experiences of UHIS, another scheme known as:

RASHTRIYA SWASTHYA BIMA YOJANA (RSBY*)* was started in 2008. The scheme as originally envisaged was to cover the entire country in stages by the end of 2012-13. But government of India gave sanction for the implementation of the scheme in all the 14 districts of Kerala during 2008-09 itself. Accordingly the State Government has formulated a Comprehensive Health Insurance Scheme on the same lines of RSBY in the name RSBY-CHIS.

RASHTRIYA SWASTHYA BHIMA YOJANA – COMPREHENSIVE HEALTH IINSURANCE SCHEME (RSBY-CHIS)

The scheme was started on 02-10-2008 in Alappuzha. Insurer is United India Insurance Company. Premium per family quoted now is Rs.1274/-. BPL families need to pay only Rs 30/- towards registration fees per family. APL families need to pay premium amount of Rs.1274/- as well as registration fees.

FEATURES OF RSBY-CHIS

SMART CARD: All eligible families, enrolled in to the scheme, are issued a smart Card for identification.

COVERAGE: Hospitalization coverage for up to Rs. 30,000 for a family of five. There is no age limit. In addition to the coverage of Rs. 30,000 available under the Central Scheme, the state government has decided to give additional coverage of Rs. 70,000 to the BPL beneficiaries for the treatment of serious diseases affecting kidney, heart etc and for cancer treatment. It has been implemented from 1st Dec, 2010, in the name of CHIS-PLUS.

CASHLESS TREATMENT: OP treatment is not available. Only for allopathic treatment and for treatment in general ward.

NETWORK HOSPITALS: These are the hospitals empanelled by insurance company in consultation with the State Government to provide cashless treatment to RSBY-CHIS beneficiaries. In Kerala as a whole, 130 public and 110 private hospitals empanelled under the scheme during the year 2011. In Wayanad and Ernakulam, the study area, 5 public and 1 private hospital and 10 public and 12 private hospitals respectively.

PACKAGE RATES: The charges for medical/ surgical procedures/ interventions have been pre-determined. For non surgical admission, Rs.500/day can be deducted by the hospital, for admission in I C U, Rs.1000/day can be deducted and there are different rates for surgery in accordance with its category.

PRE-EXISTING DISEASES: All Pre-existing diseases, unless specifically excluded, are covered under RSBY-CHIS from the day one itself.

MATERNITY BENEFITS: All expenses related to the delivery of the baby in the hospital are covered. For normal delivery, Rs.2500 is deducted from the smart card and it is Rs.4500 for caesarian delivery.

EXCLUSIONS: The scheme is not available for usual exclusions.

TRANSPORTATION ALLOWANCE: of Rs. 100 per hospitalization subject to an annual ceiling of Rs. 1,000. This will be paid by hospitals to the beneficiary at the time of discharge.

PRE AND POST HOSPITALIZATION: Expenses up to 1 day prior to hospitalization and up to 5 days from the date of discharge are available from the hospital.

FOOD CHARGES: Food only for the person who is hospitalized is covered in the package rate.

ACCIDENT INSURANCE: of Rs. 2 lakh.

STATEMENT OF THE PROBLEM

Health insurance is an urgent necessity and universal coverage is the need of the hour. RSBY-CHIS is a move towards this end and it is being successfully implemented in all the 14 districts of the state from the 1st year of introduction in the country. Now 4 years has been completed since the launch of the scheme and there are only a few studies available about the effectiveness and utilization of this health security measure for the poor. In these contexts, it is felt necessary to make an attempt to understand the effectiveness of the scheme in Kerala, with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses with special reference to Ernakulam and Wayanad districts, as these two districts are having the highest and lowest utilization of the scheme respectively. Therefore, performance of RSBY-CHIS in terms of its effectiveness on the beneficiaries, the impact thereof and the factors, if any, affecting the proper utilization are considered as the research problem of this study.

OBJECTIVES OF THE STUDY

The research is undertaken with the following specific objectives.

1. To study the socio-economic profile of the beneficiaries of the scheme.
2. To study the awareness level of the beneficiaries regarding the features of the scheme.
3. To evaluate the effectiveness of the scheme with regard to its main aim of protecting low-income households from the financial burden of hospitalization expenses.
4. To study the satisfaction level of the beneficiaries in the utilization of the scheme.
5. To suggest suitable measures to make the scheme more effective and useful to the beneficiaries.

HYPOTHESES

1. There is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.
2. There is no significant difference between BPL and APL beneficiaries as far as the level of awareness on the feature of the scheme is concerned.
3. There is no significant difference in the effectiveness of the scheme in between Ernakulam and Wayanad beneficiaries.
4. There is no significant difference in the effectiveness of the scheme in between BPL and APL beneficiaries.

METHODOLOGY

PRIMARY DATA: The main source of data for this study is the sample survey conducted among the hospitalized beneficiaries under the scheme.

SAMPLING: By using stratified sampling method, all the districts in Kerala are classified into two stratums based on their hospitalization rate under the scheme. One stratum consisting of all those districts in which hospitalization rate is above the all kerala hospitalization rate of 9.34 and from this group, Ernakulam, which is having the highest rate (13.26) is taken for study and another stratum consisting of all those districts in which hospitalization rate is below the all kerala hospitalization rate and from this group, Wayanad, which is having the lowest rate (1.54) is taken for study. In the year 2010-11, there are 21,624 hospitalized beneficiaries in Ernakulam district and 885 hospitalized beneficiaries in Wayanad district and thus a total of 22509 hospitalized beneficiaries constitute the population for the study. Then, a sample of 765 BPL and 100 APL beneficiaries from Ernakulam district and 30 BPL and 5 APL beneficiaries from Wayanad district, are selected at random. There are 5 public and 1 private hospital empanelled under the scheme in Wayanad district, whereas 10 public and 12 private hospitals empanelled under the scheme in Ernakulam district. So care has been taken to see that the samples include the hospitalized beneficiaries of all network hospitals in Ernakulam and Wayanad districts. The total sample size is 900 hospitalized beneficiaries.

SECONDARY DATA: From official websites of RSBY, CHIAK, IRDA, United India Insurance company, etc., from officers of United India insurance company, PROs of various hospitals, Kudumbasree workers and also from different journals and periodicals published from time to time. The researcher also made discussions with officials of United India Insurance Company, TPAs, and RSBY-CHIS staff at the hospitals to gather their views.

TOOLS OF ANALYSIS: Analysis of data was done with the help of tools like tables, bar charts, pie diagrams etc. Mathematical tools like percentage and weighted average were also used and testing of hypotheses was done with the help of statistical tools like Chi-square test, Mann-Whitney U test and Repeated Measures Analysis.

FINDINGS

SOCIO-ECONOMIC PROFILE: It has been found that the socio-economic profile of the sample beneficiaries under RSBY-CHIS were of a very low status in terms of education, occupation, income, ownership of house, its structure, type of latrines, type of drainage and the source of drinking water and light. The details in this regard re-emphasize the low economic status and poor condition of the beneficiaries. Moreover, it is also revealed that majority of the beneficiaries had only average health and they are spending a good percentage of their income on medical care and it throws light on the inevitability of a well defined health insurance scheme like RSBY-CHIS.

AWARENESS: It has been found that the awareness level about the scheme related details among the beneficiaries was low. Even the staffs at RSBY-CHIS help desk of the hospitals are not well educated about the scheme for which they fail to meet the queries raised by the patients. Thus there is a wide gap between project strategy and implementation level.

Awareness has been analyzed with the help of 16 features of the scheme arranged under 3 headings:

1. General awareness (5 features)
2. Awareness on procedures during admission (5 features)
3. Awareness on procedures during discharge (6 features)

The details are given in table 1.

TABLE 1: DETAILS ON AWARENESS

Sl No.	Awareness	Ernakulam beneficiaries (in %)	Wayanad beneficiaries(in %)	APL beneficiaries(in %)	BPL beneficiaries(in %)	Total beneficiaries (in %)
I.	**General awareness**					
1.	Awareness on amount of coverage in CHIS	74.5	65.7	79.0	73.5	74.1
2.	Awareness about CHIS-PLUS	49.9	57.1	54.3	49.7	50.2
3.	Awareness on amount of coverage in CHIS-PLUS	16.2	17.1	14.3	16.5	16.2
4.	Awareness on empanelled hospitals in CHIS	34.8	34.3	25.7	36.0	34.8
5.	Awareness on empanelled hospitals in CHIS-PLUS	37.0	22.9	28.6	37.5	36.4
II.	**Awareness on procedures during admission as an in-patient**					
6.	Awareness on giving smartcard at the counter during admission	47.1	51.4	46.7	47.3	47.2
7.	Awareness on knowing available balance in the card during admission	35.1	62.9	54.3	33.8	36.2
8.	Awareness on fingerprint verification during admission	53.5	28.6	44.8	53.6	52.6
9.	Awareness on free medicines and tests even from outside	44.6	54.3	55.2	43.6	45.0
10.	Awareness on free food to the patient	35.7	42.9	41.0	35.3	36.0
III.	**Awareness on procedures during discharge**					
11.	Awareness on receiving discharge summary	37.0	22.9	28.6	37.5	36.4
12.	Awareness on fingerprint verification during discharge	47.1	51.4	46.7	47.3	47.2
13.	Awareness on receiving smartcard back	35.1	62.9	54.3	33.8	36.2
14.	Awareness on money left in the card during discharge	53.5	28.6	44.8	53.6	52.6
15.	Awareness on 5 days post hospitalization expenses	44.6	54.3	55.2	43.6	45.0
16.	Awareness on travelling allowance of Rs.100/.	35.7	42.9	41.0	35.3	36.0

Source: Primary data

Chi-square test has been done on each of the 16 features to analyze whether the economic category or the regional category of the sample is influencing level of awareness or not. It has been done on each of the categories of sample (Ernakulam, Wayanad, APL and BPL).
The details are given in table 2.

TABLE 2: CHI SQUARE ANALYSIS ON AWARENESS

Sl No.	Awareness	P-value					
		in between Ernakulam APL and Ernakulam BPL beneficiaries	in between Wayanad APL and Wayanad BPL beneficiaries	in between Ernakulam APL and Wayanad APL beneficiaries	in between Ernakulam BPL and Wayanad BPL beneficiaries	In between Total APL and BPL beneficiaries	in between Total Ernakulam and Wayanad beneficiaries
I	**General awareness**						
	Awareness on amount of coverage in CHIS	0.176	0.999	0.581	0.390	0.219	0.247
	Awareness about CHIS-PLUS	0.282	0.631	0.658	0.249	0.376	0.404
	Awareness on amount of coverage in CHIS-PLUS	0.732	0.561	0.603	0.596	0.567	0.880
	Awareness on empanelled hospitals in CHIS	0.029	0.999	0.601	0.759	0.038	0.950
	Awareness on empanelled hospitals in CHIS-PLUS	0.123	0.315	0.318	0.212	0.074	0.088
II	**Awareness on procedures during admission as an in-patient**						
	Awareness on giving smartcard at the counter during admission	0.662	0.338	0.182	0.944	0.903	0.611
	Awareness on knowing available balance in the card during admission	0.000	0.337	0.658	0.000	0.000	0.001
	Awareness on fingerprint verification during admission	0.069	0.610	0.999	0.003	0.089	0.004
	Awareness on free medicines and tests even from outside	0.026	0.999	0.999	0.276	0.025	0.260
	Awareness on free food to the patient	0.343	0.631	0.646	0.587	0.261	0.389
III	**Awareness on procedures during discharge**						
	Awareness on receiving discharge summary	0.123	0.315	0.318	0.212	0.074	0.088
	Awareness on fingerprint verification during discharge	0.662	0.338	0.182	0.944	0.903	0.730
	Awareness on receiving smartcard back	0.000	0.337	0.658	0.000	0.000	0.001
	Awareness on money left in the card during discharge	0.069	0.610	0.999	0.003	0.089	0.004
	Awareness on 5 days post hospitalization expenses	0.026	0.999	0.999	0.276	0.025	0.260
	Awareness on travelling allowance of Rs.100/.	0.343	0.631	0.646	0.587	0.261	0.473

Source: Primary data

Chi-square analysis revealed that the difference in awareness is significant in the following cases:

Awareness on empanelled hospitals in CHIS: in between Ernakulam APL and Ernakulam BPL beneficiaries and also in between total APL and total BPL beneficiaries.

Awareness on knowing the available balance in the card during admission: in between Ernakulam APL and Ernakulam BPL beneficiaries, in between Ernakulam BPL and Wayanad BPL beneficiaries, in between total Ernakulam and total Wayanad beneficiaries and in between total APL and total BPL beneficiaries.

Awareness on finger print verification during admission: in between Ernakulam BPL and Wayanad BPL beneficiaries, and also in between total Ernakulam and total Wayanad beneficiaries.

Awareness on free medicines and tests even from outside: in between Ernakulam APL and Ernakulam BPL beneficiaries and also in between total APL and total BPL beneficiaries.

Awareness on receiving smart card back during discharge: in between Ernakulam APL and Ernakulam BPL beneficiaries in between Ernakulam BPL and Wayanad BPL beneficiaries, in between total Ernakulam and total Wayanad beneficiaries and in between total APL and total BPL beneficiaries.

Awareness on receiving information on money left in the smart card during discharge: in between Ernakulam BPL and Wayanad BPL beneficiaries and also in between total Ernakulam and total Wayanad beneficiaries.

Awareness on coverage of 5 days post hospitalization expenses: in between Ernakulam APL and Ernakulam BPL beneficiaries and also in between total APL and total BPL beneficiaries.

For having a better understanding of overall awareness level of the beneficiaries, Mann-Whitney U test has been performed on the above 3 groups of features of the scheme.

The details are given in table 3.

TABLE 3: MANN-WHITNEY U TEST ON AWARENESS

Awareness	P-value					
	in between Ernakulam APL and Ernakulam BPL beneficiaries	in between Wayanad APL and Wayanad BPL beneficiaries	in between Ernakulam APL and Wayanad APL beneficiaries	in between Ernakulam BPL and Wayanad BPL beneficiaries	in between Total Ernakulam and Wayanad beneficiaries	In between Total APL and BPL beneficiaries
I. General awareness	0.550	0.299	0.430	0.911	0.664	0.421
II. Awareness on procedures during admission as an in-patient	0.080	0.185	0.393	0.437	0.256	0.051
III. Awareness on procedures during discharge	0.068	0.448	0.843	0.721	0.649	0.053
Total	0.064	0.873	0.820	0.618	0.611	0.062

Source: Primary data

Thus none of the differences in awareness level on the features of the scheme is significant and so there is no significant difference in the level of awareness among different categories of beneficiaries.

HYPOTHESIS H1

There is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.

P- value for Mann-Whitney U test done on Ernakulam and Wayanad beneficiaries on total awareness is 0.611, indicating that the Hypothesis can be accepted. It is concluded that there is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.

HYPOTHESIS H2

There is no significant difference between BPL and APL beneficiaries as far as the level of awareness on the feature of the scheme is concerned.

P- value for Mann-Whitney U test done on BPL and APL beneficiaries on total awareness is 0.062, indicating that the Hypothesis can be accepted. It is concluded that there is no significant difference between Ernakulam and Wayanad beneficiaries as far as the level of awareness on the features of the scheme is concerned.

EFFECTIVENESS OF THE SCHEME

It depends on the fact that whether the scheme has helped the beneficiaries to mitigate their hospitalization expenditure or not. For this, expenditure for non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization incurred by the sample beneficiaries are compared. The details of average expenditure for hospitalization, both for non-RSBY and RSBY hospitalization are given in table 4.

TABLE 4: DETAILS ON AVERAGE EXPENDITURE FOR HOSPITALIZATION

Category	Average expenditure for hospitalization	APL	BPL	Total
Ernakulam	Average expenditure for non RSBY-CHIS hospitalization	5543	3362	3602
	Average expenditure for RSBY-CHIS hospitalization	594.5	565.3	568.7
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4948.5	2796.7	3033.3
Wayanad	Average expenditure for non RSBY-CHIS hospitalization	4500	3718	3863
	Average expenditure for RSBY-CHIS hospitalization	428.0	616.7	589.7
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4072	3101.3	3273.3
Combined	Average expenditure for non RSBY-CHIS hospitalization	5478	3375	3612
	Average expenditure for RSBY-CHIS hospitalization	586.6	567.3	569.5
	Difference in expenditure in between non RSBY-CHIS and RSBY-CHIS hospitalization	4891.4	2807.7	3042.5

Source: Primary data

The scheme helped all categories of beneficiaries to mitigate their hospitalization expenditure. In between APL and BPL beneficiaries, it is comparatively higher in the case of APL beneficiaries. In between Ernakulam and Wayanad beneficiaries, it is comparatively higher in the case of Wayanad beneficiaries. It is revealed that the intervention of RSBY-CHIS has protected significant section of poor households from the financial burden of hospitalization expenses.

For statistically verifying it, Repeated Measures Analysis has been applied. The results are given in table 5.

TABLE 5: REPEATED MEASURES ANALYSIS

Category		F- value	p-value
Ernakulam	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	1461.876	0.000
	Difference in effectiveness in between Ernakulam APL and BPL beneficiaries	39.485	0.000
Wayanad	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	164.125	0.000
	Difference in effectiveness in between Wayanad APL and BPL beneficiaries	0.037	0.849
Combined	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	1583.702	0.000
	Difference in effectiveness in between total APL and BPL beneficiaries	36.171	0.000
APL	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	202.478	0.000
	Difference in effectiveness in between Ernakulam APL and Wayanad APL beneficiaries	2.874	0.094
BPL	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	325.131	0.000
	Difference in effectiveness in between Ernakulam BPL and Wayanad BPL beneficiaries 1.115 0.291	1.115	0.291
Combined	Effectiveness in terms of difference in expenditure in between non RSBY-CHIS hospitalization and RSBY-CHIS hospitalization	433.044	0.000
	Difference in effectiveness in between total Ernakulam and Wayanad beneficiaries	0.409	0.523

Source: Primary data

The result showed that the scheme is effective in terms of reduction in hospitalization expenditure of the beneficiaries. It is effective in the case of all categories of beneficiaries, as the p- value is 0.000 in the case of all categories of beneficiaries. An analysis is also performed to find out whether this effectiveness is significantly different in between different categories of beneficiaries. The concerned p-value indicates that the difference is significant in between:

a) Ernakulam APL and BPL beneficiaries (effectiveness higher in APL).
b) Total APL and BPL beneficiaries (effectiveness higher in APL).

HYPOTHESIS H3

There is no significant difference in the effectiveness of the scheme in between Ernakulam and Wayanad beneficiaries.

By applying Repeated Measure Analysis, p-value for difference in effectiveness in between Ernakulam and Wayanad beneficiaries is found to be 0.523, indicating that the Hypothesis can be accepted. It can be concluded that there is no significant difference in the effectiveness of the scheme in between Ernakulam and Wayanad beneficiaries.

HYPOTHESIS H4

There is no significant difference in the effectiveness of the scheme in between BPL and APL beneficiaries.

By applying Repeated Measure Analysis, p-value for difference in effectiveness in between BPL and APL beneficiaries is found to be 0.000, indicating that the Hypothesis cannot be accepted. It can be concluded that there is significant difference in the effectiveness of the scheme in between BPL and APL beneficiaries.

SATISFACTION

It has been revealed that majority beneficiaries were having average satisfaction with the scheme and only a minority i.e. around 15% were dissatisfied. Among this 15% dissatisfied beneficiaries, majority have stated that inaccessibility to health services as the reason for dissatisfaction, which throws light on the urgent necessity of including more hospitals under the network of the scheme.

SUGGESTIONS

The main suggestions are:

1. Reducing the high premium for the APL beneficiaries,
2. Empanelling more hospitals,
3. Increasing the awareness level of the beneficiaries,
4. The concerned authority should organize seminars/classes for the hospital authorities about the various elements of the scheme and the roles they are expected to perform with respect to the scheme,
5. Rectifying the ambiguities in the implementation of the scheme,
6. Including OPD coverage,
7. Timely reimbursement to hospitals, and
8. Establishing a good monitoring mechanism and effective grievance redressal of the beneficiaries.

CONCLUSION

It is thus clear from the study that majority of the beneficiaries were having average satisfaction with the services provided through the RSBY-CHIS. It has really assisted them to reduce their hospitalization expenses and utilize better hospital facilities. Even though RSBY-CHIS has a positive role in reducing the hospitalization expenditure among the beneficiaries, low awareness level, limited number of private empanelled hospitals, poor implementation of the scheme, absence of effective monitoring mechanism and redressal of grievances, timely reimbursement to hospitals, ambiguities in the benefits of the scheme, etc., are some of the pertinent issues still persisting as constraints in achieving the desired objectives of RSBY-CHIS. The program designers and policy planners may take effective steps to address the issues concerned, while making future plans in implementing the RSBY-CHIS more effectively or in improved forms.

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