ISSN (online): 2320-9836
ISSN (Print): 2320-9828

Extent of use of the government sponsored health insurance schemes: evidence from rural Odisha

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Abstract

Objectives: The National Health Insurance Scheme of India, i.e., *Rashtriya Swasthya Bima Yojana*, and the Odisha State health insurance scheme, i.e., *Biju Krushak Kalayan Yojana*aim to provide financial protection to target population against catastrophic health expenditure by reducing out-of-pocket spending and improve access to quality healthcare. The study estimates healthcare expenditure of beneficiaries, the extent of use of the scheme and to point out obstacles that the beneficiaries face.
Methodology: The study was based on both secondary and primary data. Multi-stage random sampling method is used to select 200 beneficiaries of both the scheme. Data were collected through direct personal interviews by using structured schedules. Descriptive statistics are used to substantiate the objectives. Qualitative data were also analysed briefly to supplement quantitative analysis.
Results: The average amount of expenditure on Medicine, Diagnostic and Food and accommodation incurred by beneficiaries for their treatment were quiet high. The overall spending on medicine in proportion of total healthcare payment was 60.01%.47.5% beneficiaries spend from own pocket for their treatment. Only 5.7% beneficiaries fully access the facilities of the scheme. The average claimed amount and received amount was only `6246 and `3632.70 respectively. Only 58.15% of the claimed amount was only realized. The obstacles faced by the beneficiaries in the reimbursement of the claimed amount are bureaucratic official procedures, mismatch of the fingerprint of beneficiaries, failure of networking of installed software, more amounts of money deducted than released amount and exploitation involved in the delivery of facilities.
Conclusions: This paper contributes to the current debate on financial protection provided by the health insurance scheme which is burning issue in the healthcare sector. The finding of the study may help the policymaker to create awareness among insured, the behaviour of healthcare providers may be turned friendly, immediate attention may be provided by help desk counters to the beneficiaries, the sum assured amount may be increased and the detailed receipt of hospital expenditure may be supplied to the insured at the time of discharge.
Keywords**:** *Rashtriya Swasthya Bima Yojana*, *Biju Krushak Kalayan Yojana,* Health insurance, Out of pocket payment, Odisha.

1. Introduction

Illness may occur to anybody at any place and in any time even if the people take adequate care of their health and therefore they need proper treatment to be cured. For treatment of illness, now-a-days several government and private hospitals have been set up in India. The treatment may be done either in a government hospital or in a private hospital. Whereas the treatment expenditure is partly borne by the government in the government hospital, the same is not true in case of a private hospital. A person receiving treatments in a private hospital has to bear the entire treatment related expenditure. This may be very hard for many people. Specifically in many developing countries like India household's expenditure is a chief source of healthcare financing. The Indians bear around 75% for their healthcare from own pocket. By bearing healthcare expenditure from own pocket, in every second minutes three people are pushed in to poverty [1].

ISSN (online): 2320-9836
ISSN (Print): 2320-9828

The monthly households healthcare expenditure was increased day by day [2] which reflected that rural households are hit hard financing in term of high out of pocket expenditure on health. Due to this high spending, the number of below poverty line families were increasing and also dragging them towards the depth of poverty in one month [3]. This, in turn, aggregates their health related sufferings. Health insurance has therefore become an unavoidable need for the people. To tackle the above challenges, at present both central and state government is provided health insurance facilities to take care of national health which improving the quality of life and well-being of the citizen. The Central Government has launched a health insurance scheme, named as "*Rashtriya Swasthaya Bima Yojana*", for the below poverty line (BPL) families with the objective of financial protection. The scheme covers the entire country including Odisha State. It covers households cashless hospitalization facilities of up to `30,000 (Rupees thirty thousand) only per annum including pre-existing conditions. Five members of eligible household are covered under the scheme including head of the households, spouse and three dependents by paying `30 (Rupees thirty) only as registration fee at enrolment. Both central and state government are funded for the scheme. Both public and private insurance companies are enrolling the beneficiaries at enrolment camp. Both public and private empanelled hospitals are delivered the facilities to beneficiaries. The insured may also avail transport allowance of `100 (Rupees one hundred) only per household per hospitalization up to `1000 (Rupees one thousand) only.

Besides RSBY, Government of Odisha lunched another health insurance scheme called as "*Biju Krushak Kalyan Yojana*" (BKKY) in 2013. It is trying to cover more than 60 lakh farmers. Its objective is to improve the access of identified farmers' families to quality medical care for treatment of diseases, involving hospitalization, through an identified network of healthcare providers. The scheme has two streams, i.e., Stream I and Stream II. The enrolled farmer families are entitled to cashless healthcare facilities for maternity benefit and new-born care up to `30000 per family per year, in any of the empanelled healthcare providers across Odisha under Stream I. Under Stream II, the same farmer families can also avail cashless medical expenses of hospitalization (except maternity benefit and new-born care) up to `70000 per family from the empanelled hospitals. In this connection, this piece of research work attempted to study the disease profile of the beneficiaries of rural Odisha and estimates their healthcare expenditure and to assess the extent of use of availing government sponsored health insurance scheme and finally identify difficulties they faced in availing the facilities under the two schemes.

2. Literature survey

In [4] examined about whether the RSBY scheme protected particularly marginalized community in underserved area in Chhattisgarh. Data were collected from 1200 families belonging to these groups through household questionnaire. The study finds that the scheme is far away from its objectives. There is no guarantee of healthcare services for the poor people. Majority of vulnerable sections are uncovered from the financial protection of the scheme. This study concludes that "There is need for strong monitoring and grievance redressal mechanism including transparency during empanelment. Time bound settlement of claims needs to be ensured through penalties for delays. System for referral and complications need to be evolved and cost for high and packages needs to be revised and made more realistic". In [5] studied the height of coverage (the proportion of the total costs to be met) of RSBY enrolled households from Gujarat. The study is a cross-sectional study and data were collected from 3120 BPL households in Patna district through household survey. After the analysis the study find that only 15% insured who were hospitalized have cashless experience and others spend form own out of pocket. The median expenditure among insured was around `7,000 which was quiet similar with the person who did not use the scheme or not enrolled. It clearly indicated that there was near absence of financial protection that objective of the scheme. The study concluded that at level of utilisation, strict monitoring should be needed.

In [6] studied about out of pocket expenditure of RSBY beneficiaries in civil hospital, Ahmadabad. Data were collected from 198 registered patients between the periods 1/11/2012 to 28/2/2012 by using telephonically interviewed. In this study, they find that the beneficiaries had spent from own pocket for pre hospitalization and post hospitalization due to lack of awareness about the benefit package.

ISSN (online): 2320-9836
ISSN (Print): 2320-9828

Hence they recommended the awareness among beneficiaries should be improved through Information, Education and Communication activities for which they can access better services for them and their families. In [7] examined the design issues in RSBY in Chhattisgarh. The qualitative study on the RSBY scheme was conducted by covering three districts in Chhattisgarh including private, public and not for profit institutions. This study finds that the RSBY beneficiaries represented a tiny proportion among total patient in large multispecialty hospitals and institutions which are skilled for providing treatment for serious illness. They suggest that the healthcare providers should need to be rethinking on the critical design issue. In [8] analysed about "the extent to which RSBY contribute to universal health coverage by protecting families from making OOP payments". Data were collected from 2920 enrolled households who were belonging from poor section of the society in Patna district of Gujarat through structured questionnaire. This study reveals that the beneficiaries still made out of pocket payment at hospitalization after using the smart card. Around 60% admitted patients insured faced OOP. The purchase of medicine and diagnostic test were two important components which incurred OOP for patients. This result indicated that better monitoring of the scheme can improve the financial coverage among insured. In [9] studied on impact of RSBY in rural India revealed that health insurance had contributed to improvement in access to hospital care, reduction in out-of-pocket expenditure, and improvement in availability of health infrastructure. In [10] took up a study with main objective to study the current status of *Rashtriya Swasthya Bima Yojana* and its implementation and impact in various states of India. The result shows that health expenses related impoverishment is moderately high among Indians. There are significant variations across the implemented states. Few states marked as high impoverished state due to most of health spending. Rural states occupied higher rank than urban. Out-patient care imposed much large portion of the financial burden on insured than in-patient care.

The study finally concluded that RSBY has been cable to enhance the access to health care and reduce out of pocket expenditure by involving the extensive information, education and communication in all implemented states to maximize utilization and regular review should be needed by state government on service utilization. In [11] studied about the current status of RSBY in Maharashtra at each step of utilization. Data were collected from both rural and urban areas covered 6000 households across 22 districts through focus group discussion and in depth interview. The study finds that the insured who utilized the facilities at hospitalization faced out of pocket expenditure for additional payment to purchase drugs. The result was quiet similar with other studies that done in recent past. The study recommends that it is necessary to monitor the scheme at level of insurers and insured. The proper utilisation should ensure among the vulnerable sections by proactively educating. In [12] studied about impact of *Rashtriya Swastya Bima Yojana* from efficiency perspectives. The study is conducted with the aim to examine whether the scheme has enhanced the utilization among poor families. Data were collected from National sample survey office- Consumer Expenditure Survey of the years 2007-08 and 2009-10 of government of India. The study highlights that there were innumerable issue involved with design and implementation of the scheme. These were become major hurdles to achieving its objective i.e. financial protection to beneficiaries from catastrophic health expenses. So this study recommended that the scheme need to review which will make more accessible to the target population.

In [13] examined about impact of RSBY as a measure to reduce the burden of healthcare expenditure among beneficiaries. Data were collected from 298 BPL households through baseline study in Shimoga district of Karnataka. In this study, they highlight that "The median monthly expenditure has also increased to `6539.33. The mean monthly expenditure on medical cost was 8.9%, which is a substantial strain on expenditure per month, especially on the studied households which fall below the poverty line". The result indicates that health services benefit package need to be maintained at competitive market price to enhance the quality. The above review of research works indicate that the researchers have covered different aspects of healthcare protection, yet there are many questions which have not been answered in those studies. Further, it has been found that a significant proportion of health insurance researches have been conducted in only a few key states in India - Gujarat, Tamil Nadu and Karnataka, thus paying less attention to others which might have provided a different pictures of health insurance because of both inter-state and intra- state variations in socio-economic, demographic and cultural characteristics. Finally, many problems that faced by insured of Odisha especially have not been addressed by other researchers. This study significantly addresses these research gaps.

ISSN (online): 2320-9836
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3. Data and Methods

The study was based on both secondary and primary data. The secondary data was collected from record that maintained by community hospital of study area. The primary data were collected from beneficiaries (who accessed benefit from empanelled hospital by using smart card). The multi-stage random sampling was applied for selecting the sample size. Out of thirty districts of Odisha, the sample rural district (Jajpur) selected on simple random sampling technique from among the top ten districts based on rural population as per 2011 census. From Jajpur district, by following the same sampling procedure one Block, i.e., Barchana was selected. Barachana block occupies top one position of the rural block in Jajpur district which contains 100% rural populations.

Table 1. Socio economic profile of respondent

	Group	Percentage of respondents
Sex	Male	54.63
	Female	45.37
	Total	100.0
Age	1-20	31.94
	20-40	35.72
	40-60	24.77
	60 above	7.57
	Total	100.0
Education	0-5	41.46
	5-10	40.03
	10-15	18.25
	15 above	0.26
	Total	100.0
Occupation	Working on own farm	37.8
	Business/Trade	10.4
	Farm Labourers/ Daily wage	13.7
	Other (Working in private sector, industrial worker, domestic servant and private tutor)	38.1
	Total	100.0
Monthly income	Less than `1000	64.0
	`1000-`2000	6.2
	`2000-`3000	7.8
	`3000-`4000	8.0
	`4000-`5000	6.0
	`5000 above	8.0
	Total	100.0
Marital Status	Married	52.7
	Widow(er)	3.5
	Divorced	0.9
	Separated	0.1
	Unmarried	42.8
	Total	100.0
Economic categories	Above Poverty Line	53.2
	Below Poverty Line	46.8
	Total	100.0
Average Monthly Income		`5915.29

Source: Calculated and compiled from field survey

ISSN (online): 2320-9836
ISSN (Print): 2320-9828

A list of 5461 beneficiary households (until 31 December 2016) under RSBY and BKKY in Barachana Block was collected from community health centre. Out of the list, 200 beneficiary households were selected randomly through random Table method for data collection. Data collected through direct personal interviews by using structured schedules. Due to some data inconsistency, the study can take 188 sample households for analysis. The data analysis was carried out through descriptive statistics using SPSS software. The socio economic profiles of respondents were analysed applying simple percentage.

4. Socio-economic profile of beneficiaries

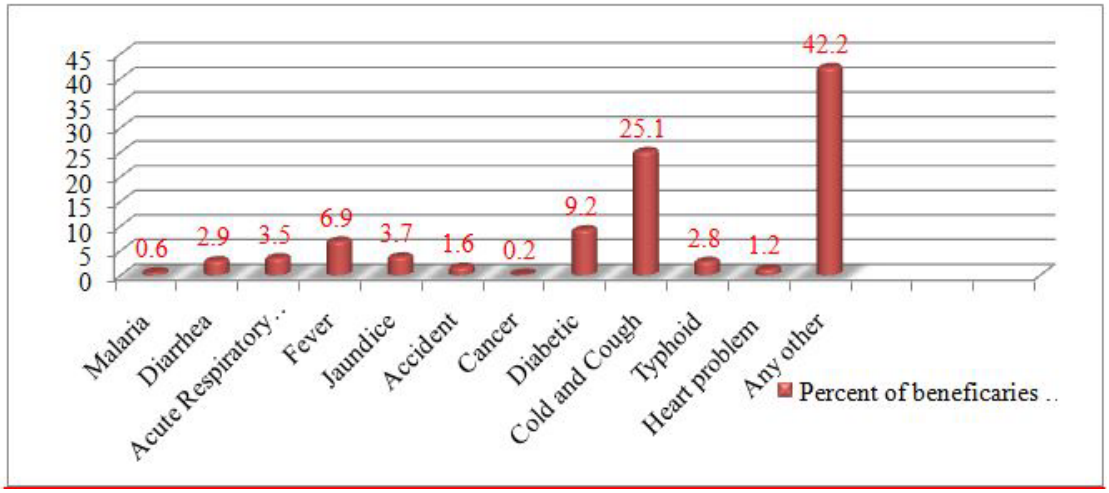
The socio-economic profile of sample households which show the general standard of living of study area. This demographic profile includes classification on the basis of Sex, Age, Marital status, Education, Occupation, Monthly income, Caste category and Economic category. The socio-economic profile of sample households show general standard of living in the study area. This socio-economic profile includes classification on the basis of sex, age, education, occupation, monthly income, marital status, economic categories and average monthly income. There are 54.63 and 45.37% male and female beneficiaries in the study area. The beneficiaries come under the 1-20 age group (31.94%), 20-40 age group (35.72), 40-60 age group (24.77) and 60 above (7.57). Coming to educational classification, a majority, i.e., 41.16 have studied up to class 1 to 5, 40.03% up to 5 to 10, 18.25% up to 10 to 15 and only 0.26% up to 15 years education. On the basis of monthly income, the majority, i.e., 64% fall in the income category less than `1000. As per marital status, it was found that 52.7% were married beneficiaries. Among rural beneficiaries; the average monthly income was `5915.29. The socioeconomic picture of the sample insured illustrates that majority sample beneficiaries of sample rural district were of very low status regarding education classification, occupation, monthly income and average monthly income. These overall pictures indicate the beneficiaries have low financial status and poor conditions in the study area.

5. Result and Discussion

1. Disease profile of the beneficiaries of rural area and estimate their healthcare expenditure

The aim of the government sponsored health insurance scheme to provide financial protection to insured against catastrophic healthcare expenditure by reducing their out of pocket expenditure at hospitalization. The present study investigated if the government sponsored health insurance scheme achieved its objective in the rural area. That's why the study is an attempt to estimate the disease profile of the beneficiaries of rural area and try to estimate their healthcare expenditure even if they have sum assured which is stated in Figure1 and 2.The way of life of rural population is related with illiterate, poverty, heavy physical work burden, poor sanitation, lack of awareness, no safe drinking water with unhygienic surrounding.

Figure 1. Innumerable diseases faced by sample households



Source: Calculated and Compiled from Field Survey

ISSN (online): 2320-9836
ISSN (Print): 2320-9828

Due this unhealthy surrounding, the beneficiaries go through from number of diseases in the study area which indicate in Figure 1. It illustrates that among the sample rural households, the majority of beneficiaries i.e. 42.2% suffer from Gastrological problem, Asthma, Weakness, Injury and skin infection, Cold and Cough and Diabetic are accounted for 25.1% and 9.2% respectively. The other beneficiaries are counted for other diseases burden like Heart problem, Cancer, Jaundice, Diarrhoea. The beneficiaries are taking their treatment from different sources for recovery from their unhealthy situation. The majority of beneficiaries i.e. 93% accessed their treatments from allopathic source which is costly for present healthcare system and 5% availed homeopathic and rest availed ayurvedic treatments which may be comparatively beneficial in terms of expenditure.

For recovering from their disease burden, there was moderately a higher incidence of out of pocket expenses for beneficiaries which are stated in Table 2.

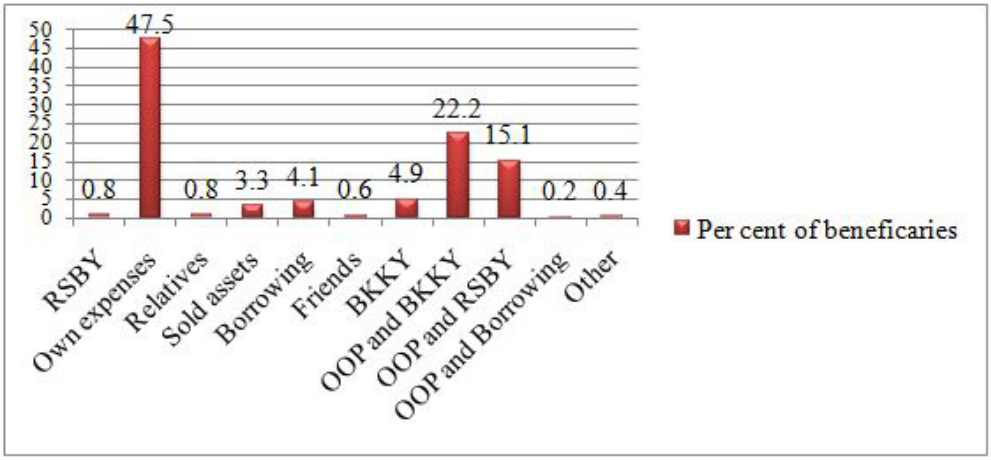
Table 2. Healthcare expenses incurred by sample households by different healthcare providers

Components	Mean amount in (`)	Median amount in (`)
Total	`8856.47	`4350
Medicine	`5926.38	`3100
Diagnostic	`2713.44	`1500
Food and accommodation	`2291.86	`1500
Travel	`1809.07	`1000

Source: Compiled and calculated from field survey

It reveals that the mean and median amount of healthcare expenses spend by beneficiaries on various elements while they accessing health services under the government sponsored health insurance scheme. Here the mean of expenditure on Medicine, Diagnostic and Food and Accommodation incurred by beneficiaries for their treatment was quiet high.

Figure 2. Sample households cover their healthcare expenses from the various healthcare providers



Source: Calculated and compiled from field survey

Notably, the overall spending on medicine in proportion of total healthcare payment was 60.01%which imposed a huge amount of financial hardship upon beneficiaries at their treatment. It highlights a question regarding the objective of the government sponsored scheme i.e. whether the schemes afford financial support to beneficiaries at their treatment. To highlighting the issue, the study points out the beneficiary's healthcare expenses coverage pattern. These are described in Figure 2. It points out that majority of rural beneficiaries, i.e. 47.5% bound to spend from own pocket for their treatment even if accessing their healthcare services from the schemes. 22.2% and 15.1% cover their expenses by using sum assured of BKKY and RSBY respectively with addition from own pocket.

ISSN (online): 2320-9836
ISSN (Print): 2320-9828

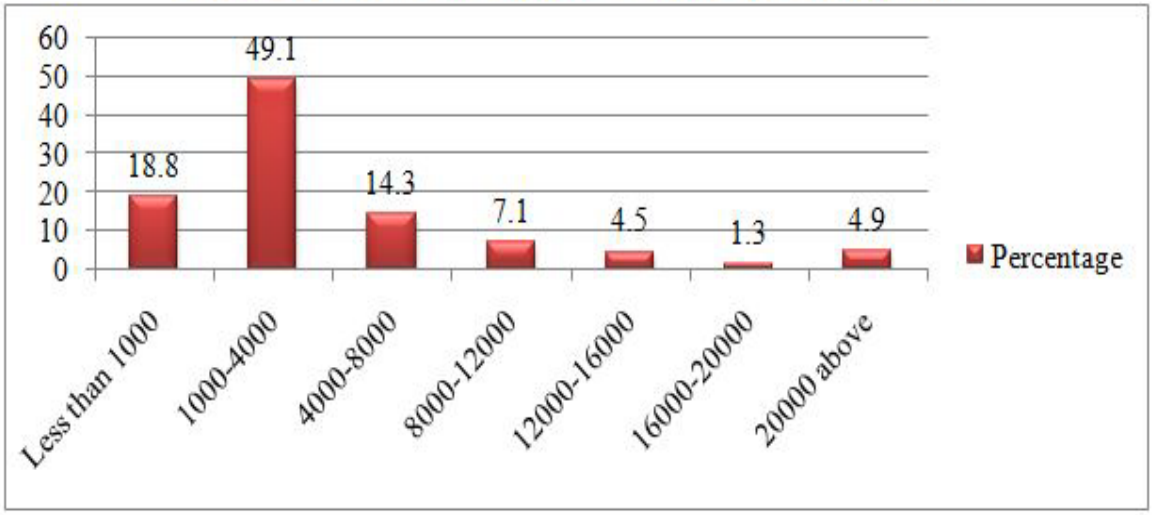
Only 4.9 and 0.8% rural beneficiaries fully accesses the facilities of the scheme using sum assured at their treatment. By selling the assets, borrowing from friends and relatives and borrowing with high rate of interest are chief sources of healthcare financing even if they have sum assured. The study found that the availing government sponsored health insurance schemes do not protect from high healthcare expenses that incurred by beneficiaries at their treatment in the study area. Thus still it performs behind its objective after seven year implementation of central government sponsored health insurance scheme (RSBY) and state sponsored health insurance scheme (BKKY) in Odisha.

2. To assess the extent of use of availing government sponsored health insurance scheme by beneficiaries

The efficacy of health insurance is not just limited either to provision of need-based healthcare services or providing financial protection to the insured at hospitalisation. The extent of efficacy rather greatly depends upon the extent of use the services by insured. In view of this, the study investigated the extent of use of availing government sponsored health insurance scheme by beneficiaries in the study area by taking in to consideration of claimed and received amount details of beneficiaries, accessing empanelled hospital, number times using smart card at treatment and purpose of healthcare payment. It is stated in following Figure 3**.**

The claim detail of sample rural households is depicted in Figure 3. The amount claimed by the most of rural beneficiaries out of total sample households range from `1000 to `4000 for Gastrological problem, Asthma, Diarrhoea, Malaria, Diabetic and Injury. In the similar manner, 18.8% beneficiaries received medicine for Fever, Diabetic and Cold and Cough up to `1000 without accessing inpatient care. They claimed that medicinal cost take huge share on out of pocket expenditure and even if some time they forced to borrow the amount with high rate of interest, friends and relatives to substitute the deficit amount. Only 1.3%, 4.5% and 4.9% claimed the amount from `12000 to `20000 for Accident, Typhoid, Jaundice, Gynaecology operation and Heart problem. The average claimed amount was only `6246 among rural sample beneficiaries which is quiet low. They claimed that their treatment cost only partly covered with their sum assured. It imposed huge financial hardship on rural beneficiaries at time of treatment even if they have sum assured and pushed them towards to touch the poverty line. To point out this issue after considering the claimed amount by rural beneficiaries, it essential to examine the benefit received by beneficiaries. These are as discussed.

Figure 3. Insurance claim details of sample rural households



Source: Compiled and calculated from field survey

The benefit detail of sample rural households is stated in Figure 4. Among rural beneficiaries, majority received the benefit amount from `1000 to `4000. 31.3% and 12.5% accessed the benefit below `1000 and `4000-8000 respectively. Only 1.2% received the amount `16000 to `20000 for their treatment by using smart card which is counted as highest amount that received among sample rural beneficiaries.

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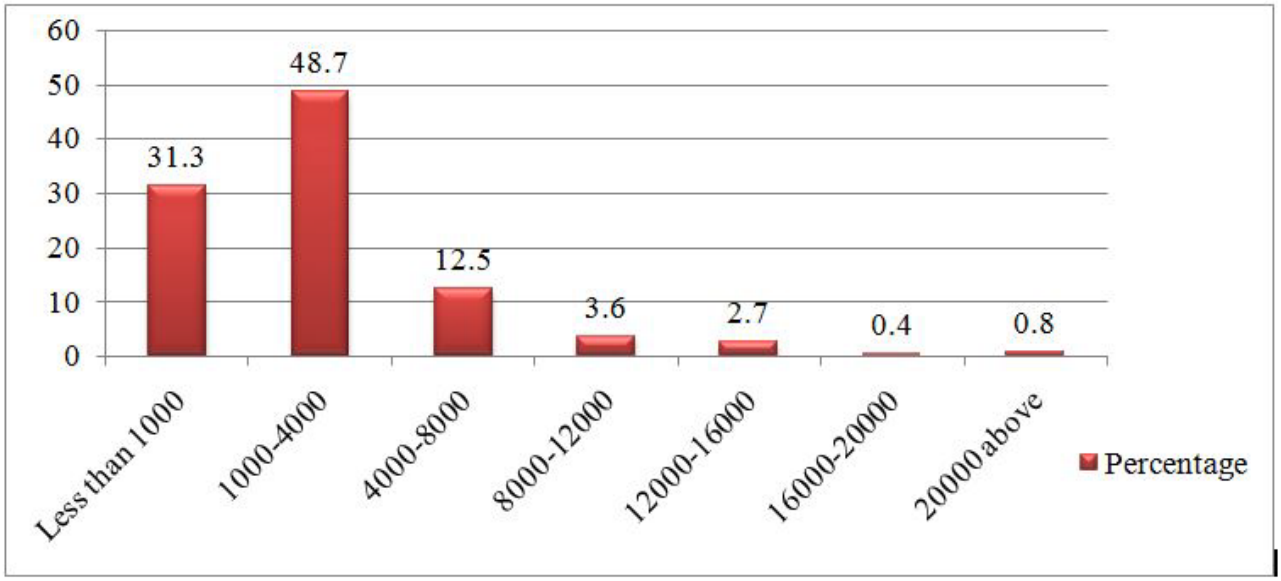
ISSN (Print): 2320-9828

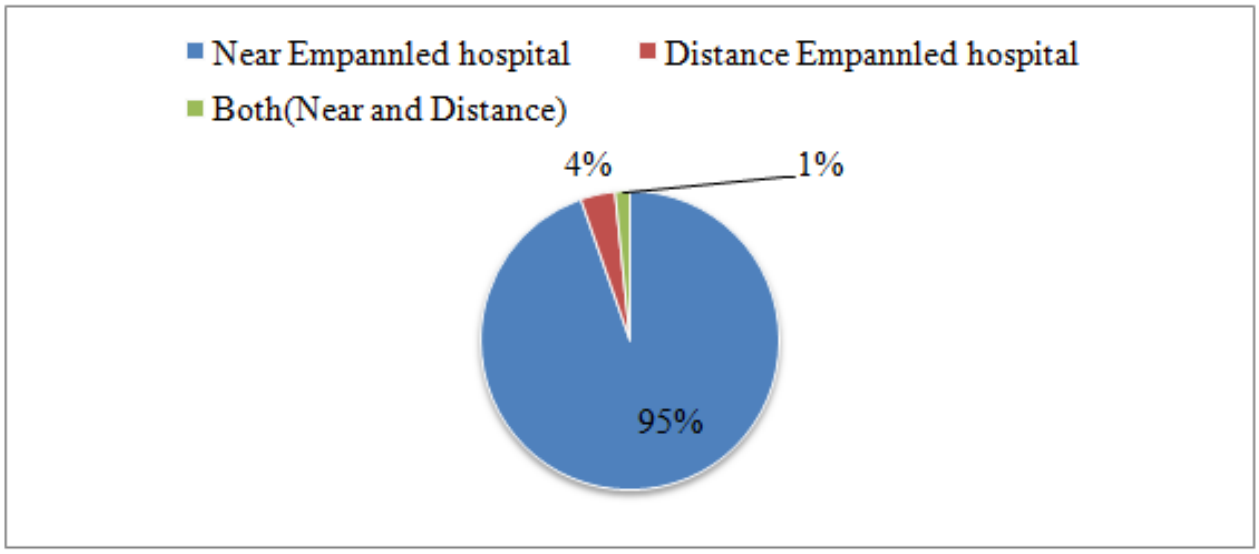
Figure 4.Benefit received details of sample rural households



Source: Compiled and calculated from field survey

The average received amount among sample rural beneficiaries was `3632.70.Notably, only 58.15% of the claimed amount was only realized. The sample rural beneficiaries an accessed different type of empanelled hospital is highlighted in Figure 5. Here majority of rural beneficiaries i.e. 95% received their benefit from near empanelled community health centre because they are closer to it. Only 4% preferred for distance empanelled hospital for availing improves and quality healthcare facilities rather than community hospital. The number of times sample rural households using smart card for their treatment is explained by Figure 6. Here majority of households (85) were using the smart card more than twice only.

Figure 5. Types of empanelled hospital accessed by sample rural households

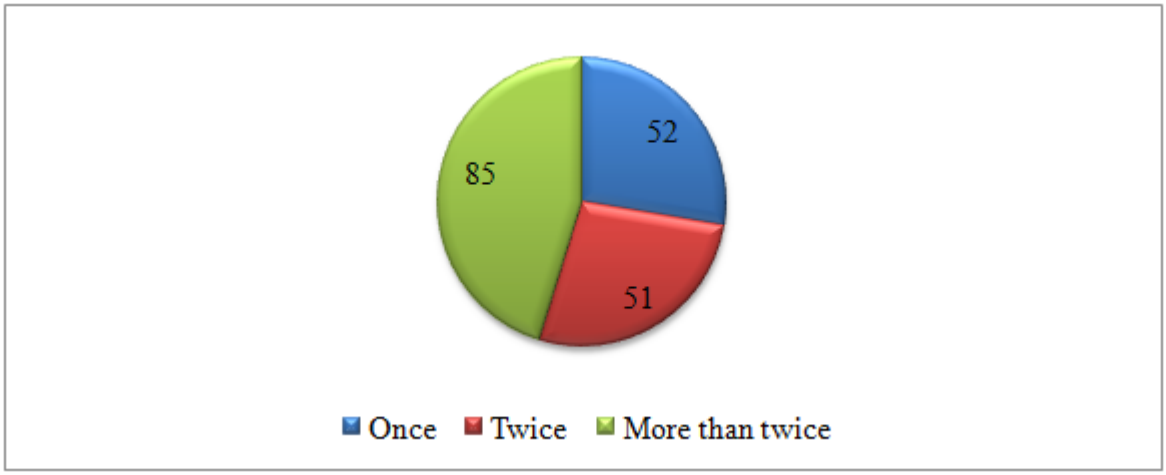


Source: Compiled and calculated from field survey

The rest of others households i.e. 52 and 51 used only once and twice respectively. It can be questionable in term of accessibility because now implementation of both the scheme crossed more than five years. The purpose of payment made by sample rural households at their treatment was studied. Here majority rural beneficiaries (74%) accessed their benefit during hospitalization and rest of others through pre hospitalization as per provision mentioned in the guidelines.

ISSN (online): 2320-9836
ISSN (Print): 2320-9828

Figure 6. Sample rural households using smart card



Source: Compiled and calculated from field survey

Notably that all sample beneficiaries have lack of knowledge regarding post hospitalization facilities that provide by scheme. So they forced to spend from own pocket for post hospitalization even if schemes has provision to provide these facilities. All sample households cover their healthcare expenses both cash based and cashless mode. It reveals that the beneficiaries add amount from own pocket with their sum assured at treatment. All rural beneficiaries claimed that they faced financial hardship at healthcare financing even if they have sum assured of availing government health insurance schemes. It becomes a major reason to deteriorate their standard living and push them towards poverty.

3. Identify the reasons for incurring OOP spending by beneficiaries even if they have sum assured

The study finds that the beneficiaries experienced high OOP for their healthcare treatment which significantly impose greater financial burden and increase the vulnerability status. It also highlightsa question of why average claim and received amount was quiet low among rural beneficiaries and why the government sponsored health insurance scheme was far away from its objective. The study found that there exist major obstacles which are discussed as below. Delay in official procedure is a major obstacle at utilization that claimed by 132 sample rural households. The beneficiaries do not access their released amount from help desk counter at time of need. 111 households returned from near empanelled community health centre repeatedly before hospitalization. Most of time, beneficiaries were not only come back from hospital repeatedly but also put them on the waiting list for accessing benefit. It creates major problem at the time of emergency. The beneficiaries were unable to utilize the services due to this delay in official procedure and suffered a lot. 107 households forced to bear healthcare expenses from own pocket due to this reason. 48 households had to claim at help desk before 15 days, they could get the chance to receive the benefit once. It is one of major reason for beneficiaries utilizing their facilities at irregular manner.

Finger print mismatch of beneficiaries is one more barrier. 148 sample households suffered a lot for the reason. Their fingerprint was mismatched at utilization, that they registered the same at enrolment. The healthcare provider (insurance company and empanelled hospital) was not organized any camp even if the beneficiaries frequently face the problem. The help desk counter advised them to go for rectification at district health quarter which situated far away from their residence. The long distance was not reasonable for them and bound to spend from own pocket even if they have sum assured. The beneficiaries were also faced exploited for correction at District head quarter through the third party by paying `500per beneficiaries. It is due to inadequate information about rectification procedure. It shows exploitation in delivery of services of the scheme. Failure of installed software is also another hurdle. 92 sample rural beneficiaries did not access the benefit due to the same at time of treatment. The local leaders received their services without complications due to political supremacy rather than common man. In spite of this 113 sample households stated that the help desk counter was deduced twice amount from sum assured than the released amount without their knowledge. The beneficiaries did not receipt the detail expenditure receipt claimed by all sample households.

ISSN (online): 2320-9836
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So they have lack of information about the remaining sum assured after deduced the released amount which creates problem for further use of the smart card at emergency. Last but not the least lots of exploitation also involved in delivery of services of the schemes. 98 sample households claimed that sometime the help desk counter closed to supply the services due to local political disturbances.

Low quality medicine supplied to beneficiaries at treatment by near empanelled community health centre was claimed by 108 households. 78 households unable to access their transport cost from healthcare providers as prescribed by the guidelines of the scheme. 32 households revealed that food services of near empanelled community health centre to beneficiaries who hospitalized were not distributed fairly. It means exploitation involves in distribution process. 52 households got a chance to access their services with the help of intermediary person. 140 households got medicine facilities without taking inpatient care for which the scheme is meant for.

4. Conclusion and Policy implication

The government has lunched the health insurance scheme to provide financial protection to insured against high out of pocket expenditure at hospitalization. These government sponsored health insurance scheme are very valuable for rural population. This paper contributes to the current debates on financial protection provided by the health insurance scheme which is burning issue in health sector. The study investigated the disease profile of the beneficiaries of rural area and estimates their healthcare expenditure. This study also presents the extent of use of availing government sponsored health insurance scheme by beneficiaries and also identify the reasons for incurring OOP spending of beneficiaries even if they have sum-assured. After conducting the household survey, the study revealed that sample rural beneficiaries suffer from innumerable diseases like heart problem, cancer, Jaundice, Diarrhoea, Gastrological problem etc. Here majority of beneficiaries i.e. 93% accessed their treatments from allopathic source which is costly consume for present healthcare treatment system. For recovering from their disease burden, there was moderately a higher incidence of out of pocket expenses among sample rural beneficiaries.

The mean amount of medicine, Diagnostic and Food and accommodation incurred by beneficiaries for their treatment was quiet high. Notably, the overall spending on medicine in proportion of total healthcare payment was 60.01% which imposed a huge amount of financial hardship upon beneficiaries at their treatment. 47.5% beneficiaries bound to spend from own pocket for their treatment even if accessing their healthcare services from the schemes. Only 5.7% rural beneficiaries fully accesses the facilities of the scheme using sum assured at their treatment. By selling the assets, borrowing from friends and relatives and borrowing with high rate of interest are chief sources of healthcare financing of rural beneficiaries. The average claimed amount and received amount was only `6246 and `3632.70 respectively. Remarkably, only 58.15% of the claimed amount was only realized to delay in an official procedure, mismatch of the fingerprint of beneficiaries, failure of networking of installed software, more amounts of money deducted than released amount and exploitation involved in the delivery of facilities. 95% beneficiaries received their benefit from near empanelled community health centre because they are closer to it. They were using the smart card more than twice only. It can be questionable in term of accessibility of the scheme. All sample beneficiaries have lack of knowledge regarding post hospitalization facilities that provide by scheme.

The study also highlights that the beneficiaries add amount from own pocket with their sum assured at treatment. The finding from this study stated that the availing government sponsored health insurance schemes in the rural area do not protect from high healthcare expenses that incurred by beneficiaries at their treatment after seven year implementation of central government sponsored health insurance scheme (RSBY) and state sponsored health insurance scheme (BKKY) in Odisha. They claimed that their treatment cost only partly covered with their sum assured. It imposed huge financial hardship on rural beneficiaries at health care treatment even if they have sum assured and pushed them towards to touch the poverty line.

The study recommended that government may create awareness among beneficiaries regarding the use of the scheme, i.e., about how, where and when to use this scheme by healthcare providers. The supportive and friendly behaviour may provide by healthcare providers to enhance the motivation among rural population. Quality healthcare may supply by emplaned hospital for better healthcare services.

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ISSN (Print): 2320-9828

The health services benefit package may include the medicinal cost to reduce out of pocket spending. Delay in official procedure may be reduced which may avail the facilities quickly. Detail expenditure may supply to beneficiaries to check exploitation among healthcare providers. The mismatched fingerprints may be corrected by healthcare providers in near empanelled hospital. The services may be supplied to beneficiaries in to 24*7 hour services to deal with the emergency situation. The assured amount of government sponsored insurance scheme may be hike against high out of pocket expenditure prevailing in present healthcare system.

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The Publication fee is defrayed by Indian Society for Education and Environment (www.iseeadyar.org)
Cite this article as:
Babita Panda, Himanshu Sekhar Rout. Extent of use of the government sponsored health insurance schemes: evidence from rural Odisha. *Indian Journal of Economics and Development.* Vol 6 (10), October 2018.