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Evaluation of Mukhya Mantri Chiranjeevi Swasthya Bima Yojana

Government of Rajasthan

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Evaluation of Mukhya Mantri Chiranjeevi Swasthya Bima Yojana- Government of Rajasthan

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Foreword

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The Bhore Committee, entrusted with the task of preparing a blueprint for health care in post-independent India, recommended that India build a health scheme similar to the National Health Service of the United Kingdom. Under this, health care would be financed entirely by the state from tax revenues and provided by the government through health personnel employed by the state. A necessary condition for the success of such a system was that government budgetary provision would be adequate to provide quality, universal health care and that health personnel employed by the government would be willing to work in all parts of the country. Both the conditions were not met in full. This resulted in many parts of the country not having adequate health care services. The demand-supply gap was met by the private sector which provided services to persons who could pay. Soon, the majority of services in most states were provided by the private sector, keeping them out of the reach of the poor who could not pay.

Governments responded to this situation, not by increasing allocation to health and improving government health services, but by creating government-funded health insurance schemes (GFHIS). Under these schemes, governments would pool the money they pay as premiums and use it to purchase services from the government or private providers of health care. Providers were provided with a pre-determined package rate for each service they delivered. Initially, they were started by many state governments such as Rajiv Arogyashri in Andhra and Vajpayee Arogyashri in Karnataka. In 2008, the Government of India started the Rashtriya Swasthya Bima Yojana and the Pradhan Mantri Jan Arogya Yojana in 2018 as centrally sponsored schemes. Subject to a few constraints, states could redesign PMJAY to suit their requirements. Many states did so. The Mukhyamantri Chiranjeevi Swasthya Bima Yojana was launched by the government of Rajasthan with more liberal coverage and benefits than the national programme. As this evaluation shows, the implementation of the scheme in Rajasthan ranks above that in many other states.

Health insurance started growing in India recently. Therefore the expertise available on health insurance is also limited and on GHIS it is even less. Therefore studies such as the present one contribute to a better understanding of the challenges of implementing the scheme. This study has been undertaken in partnership with the local officials and it carries the virtues and failings of such a methodology. There is scope for improving areas of the study by greater examination of the implementation officials embedded in the sysytem. This is an area where other researchers can contribute to enriching this study. It is our hope that this study will lead to a better understanding of the current state of the scheme and promote further research on this topic in future.

Study Team

The study titled 'Evaluation of Mukhya Mantri Chiranjeevi Swasthya Bima Yojana' was executed by the Centre for Research in Schemes and Policies (CRISP), in partnership with RSHAA, Government of Rajasthan. The main objective of this study was to understand the effectiveness of the scheme in terms of the reduction of OOPE. The study team consisted of Ms. Neha Dhingra, Senior Manager of programmes at CRISP, along with Mr. Daksh Baheti, Mr. Sandesh Reddy and Ms. Akanksha R. This research was supported by the State and Central CRISP office teams, including Mr. Khemraj and Dr. Vijay Raghavan.

The study team extends its gratitude to Dr. Sudha Chandrasekhar, HSTP, and CRISP mentor Mr. R.S. Julania and Mr. R. Subrahmanyam for their valuable inputs.

Contents

List of Abbreviations

AB PM-JAY	Ayushman Bharath Pradhan Mantri Jan Arogya Yojana
BPL	Below Poverty Line
CHC	Community Health Centres
CHE	Catastrophic Health Expenditure
CMCHIS	Chief Minister's Comprehensive Health Insurance Scheme
KASP	Karunya Arogya Suraksha Padhathi
ESIC	Employee State Insurance Scheme
GFHIS	Government-Funded Health Insurance Schemes
CGHS	Government Health Scheme
MMCSBY	Mukhya Mantri Chiranjeevi Swasthya Bima Yojana
NFHS	National Family Health Survey
NFSA	National Food Security Act
RSBY	Rashtriya Swasthya Bima Yojana
RSHAA	Rajasthan State Health Assurance Agency
SECC	Socio-Economic Census
UHC	Universal Health Coverage
OOPP	Out-of-Pocket Payments
OOPE	Out of Pocket Expenditure

Executive Summary

The Mukhya Mantri Chiranjeevi Swasthya Bima Yojana (MMCSBY) was launched in April 2021 by the Government of Rajasthan. The scheme's objective was to cover every family in the state with health insurance covering up to ₹5 lakh for cashless treatment in case of hospitalization. According to the scheme, the state government will pay the entire insurance premium for families, small and marginal farmers, and contract workers eligible under the National Food Security Act (NFSA) and Socio-Economic Census (SECC 2011).

Families outside the ambit of the SECC are encouraged to register under the scheme by paying a premium of ₹850 per annum. Under the scheme, 1798 packages for various diseases were included. Beneficiary families can receive free treatment in private and government hospitals associated with the scheme. Medical expenses for 5 days before the patient's hospitalization and 15 days after discharge are included in the free package.

Research Objective

The key objectives of this study are to assess the impact of the scheme on beneficiaries in terms of key parameters such as out-of-pocket expenditure. An analysis of the data provided by the State has been conducted to identify trends and patterns in claims. Furthermore, it understands the status of the scheme, identifies gaps, and provides recommendations to enhance scheme implementation in the State. The study was conducted between August and November 2023.

Major Findings

The study covered a total of 525 scheme beneficiaries and 100 Swasthya margadarshaks (front–line health workers). As per the scheme enrolment and claims data only 17 per cent of the enrolled beneficiaries, claimed benefits under the scheme. Out of the total scheme beneficiaries, only 500 families crossed the annual expenditure ceiling of INR 5 Lakhs. The scheme provides the highest health insurance coverage in India at 88%. Out of the total claims presented to the state, 88.5% were paid to the patients.

In terms of coverage - the scheme has been able to cover large segments of the population at 1.39 Cr families. With regards to enrolment under the scheme – more than 1.11 Cr families were identified through the NFSA and SECC reflective of appropriate beneficiary identification. 96% of the beneficiaries reported no challenges registering under the scheme.
Awareness about the scheme directly influences the out-of-pocket expenses, only 32% of the beneficiaries were aware of the insurance packages, while about 38% knew their claim amount. Lack of awareness of packages and claims is often directly linked to out-of-pocket expenses. Challenges experienced by frontline health personnel reveal a lack of awareness among beneficiaries about documentation issues.

In terms of access to healthcare districts with high populations have a higher number of private empanelled facilities, and in districts with low populations, more public hospitals are empanelled. The ratio of patients in the state treated under the Chiranjeevi scheme – the ratio of Government to Private hospitals is 68:32. It was also found that 68% of the beneficiaries used the scheme only once and 88% of beneficiaries utilised the facilities for short-term medical interventions and acute illnesses (0-5 days).

While both private and government hospitals extensively utilize general medicine packages, there are some key differences in their top 10 packages. Private hospitals cater to many

patients for haemodialysis, whereas government hospitals have an influx of patients with febrile illness and acute gastroenteritis. Furthermore, private hospitals offer several specialized services, as evidenced by the presence of cardiology and surgery packages. On the other hand, government hospitals use a large number of birth-related and neonatal care packages, reflecting their role in providing accessible maternity care.

From the data, it can be inferred that Government hospitals play a critical role in the provision of maternal health; however, several packages under obstetrics and gynaecology are not covered under the Chiranjeevi Scheme. In addition, a few packages (anal fistula, diagnostic laparoscopy and cataract) are found only in Government facilities, leaving the patient with no choice. Costs associated with conservative management before surgery, palliative care, and coverage of follow-up costs, in addition to flexibility in packages, are reported as gaps in the current scheme.

With respect to out-of-pocket expenses, it was found that 90% of the beneficiaries reported no out-of-pocket expenses to cover treatment costs. 61% of beneficiaries incurred expenses associated with transportation, nonmedical expenses, treatment-related costs, diagnostic tests, and medicines. Treatment was the most expensive category, with a mean expenditure of ₹ 3996 among 54 beneficiaries, followed by Bed Charges (₹ 8668) and Transportation (₹ 979). Medicines and diagnostic tests were also expensive, with mean expenditures of ₹ 2025 and ₹ 2039, respectively. Other medical expenses, doctor or surgeon fees, and other nonmedical expenses were less expensive, with mean expenditures of less than ₹1500. Outlier data reveal cases of excessive OOPE related to haemodialysis and admission to private facilities, before taking admission under Chiranjeevi empanelled hospitals.

Recommendations

Increasing scheme coverage:

Documentation requirements can be reduced, leading to a shortening of the time needed to register the scheme. Further modalities can be introduced to register patients both online and offline. This will help the majority of the population to be enrolled under the scheme and be aware of the details of packages, eligibility and benefits associated with the scheme.

Awareness about the scheme and access can be improved:

Models such as Vajpayee Aarogyashree could be adapted to the context of Rajasthan. Linkages between Jan Aadhar and mobiles can be strengthened for this purpose. Public programming can be strengthened to improve the uptake of the scheme. A scheme hotline can be set up to provide targeted advice to patients. Further, recommendations from the Right to Health Bill Rajasthan (2023) can be adopted.

Improving the coverage of packages:

Packages for general treatment should be included to ensure comprehensive coverage. Revision of package rates to meet actual expenses should be conducted. Flexibility in packages should be introduced to accommodate treatments that are not categorized under any package. In addition, additional cover for treatment, medicines, and diagnostics-related expenses should be covered under the scheme to address OOP expenses. Empanelment of more hospitals under the scheme and increasing the number of doctors based on the packages offered

Administration-related recommendations:

Include the delivery of quality services by encouraging NABH accreditation of facilities empanelled under the scheme. Strengthen monitoring mechanisms for scheme implementation, strengthen IT-enabled infrastructure, and address manpower issues such

as tenure and regular training. Further, incentive structures for healthcare providers can be developed.

IT Infrastructure Strengthening:

Enhance MIS for better insight into scheme operations and regional disease trends can be developed. Software can be made more user-friendly and training for staff on updates can be facilitated. A patient interface mobile app for easier hospital selection and feedback can be developed.

Monitoring and feedback:

Regular quality checks need to be implemented and feedback sessions with Private hospitals need to be facilitated. Appointment of nodal officers for better support and communication can be considered. A dedicated helpline for hospitals and fixing nodal persons to address claims-related issues could be considered.

Introduction

Universal Health Coverage

The World Health Organization (WHO; 2023) defines Universal Health Coverage (UHC) with the goal that "all people have access to the full range of health services they need, when and where they need them, without financial hardship." UHC is a key indicator of the Sustainable Development Goal (SDG) 3 – ensure healthy lives and promote well-being for all at all ages (United Nations Department of Economic and Social Affairs). The attainment of UHC is both a means to achieve better health outcomes and a desirable goal in its own right, with potential implications for poverty reduction and the promotion of a stable and secure society (World Health Organization Secretariat, 2013).

UHC subsumes universal access, which is defined as the "opportunity or ability" to obtain health services and benefit from financial risk protection (Evans et al., 2013). UHC can be attained only when the presence of physically accessible and financially affordable health services interacts with the willingness to use these services. While there is some debate on whether the goal should be universal access to health services or universal health coverage, the latter cannot be achieved without the former, making them complementary.

History of UHC

For a large part of recorded history, universal health care was 'meaningless' because: a) health care had very little to offer and b) health systems were virtually non-existent to provide such services (McKee et al., 2013). Advances in science in the late 19th century, along with the potential of health care to affect the odds of whether a person would live or die (Nolte and McKee, 2004), kickstarted the systems for organized health care emergence in Western Europe. Access to healthcare—as a part of the demand for social protection by labour unions in Germany in the late 19th century—was initially limited to those in industrial employment and was financed mostly through wage-related contributions. This model of financing healthcare has now been adopted—as one of the many parallel systems—by Belgium, Japan, Switzerland, France, and several other countries.

The advent of industrialization also brought with it some social problems such as alcoholism, tuberculosis, and overcrowding. Tackling these issues required the government to play a more active role in the provision of health services, often through forging political alliances and the redistribution of resources from those who had it to those who needed it most (McKee et al., 2013). In some countries, such as Scandinavia, local governments took on the complete responsibility of providing health services. Countries such as Australia and Canada provide such services through partnerships between the federal and provincial, state, and territorial governments. Some countries relied on a composite mix of government and employer-based systems operating in parallel to provide health services (Greece and Ireland).

Medcalf et al. (2015) documented the development of UHC in various countries—from Sri Lanka to Mexico to China to South Africa—and highlighted political and economic trends that affected the design and implementation of the respective health coverage schemes in these countries. Despite the different methods or provision of healthcare services across these countries, McKee et al. (2013) argue that the pursuit of such provision has historically been an 'explicitly political process'.

The pursuit of Universal Health Coverage is as much a global pursuit as it is a national or regional pursuit. Some major (chronological) milestones in this global journey—as organized by the Civil Society Engagement Mechanism for UHC2030 (CSEM, 2021) – have been as follows:

1. Recognition of the 'right to health' irrespective of "race, religion, political belief, economic or social condition" by the World Health Organization in 1946.
2. Reaffirmation of the need to achieve health for all by 134 WHO member states in Kazakhstan in 1978.
3. Launch of the International Health Partnership to meet the Millennial Development Goals by improving "effective development cooperation in health" in 2007.
4. The publication of the World Health Report on Health System Financing: Path to UHC by the World Health Organization in 2010.
5. Endorsement of the first resolution by the United Nations General Assembly endorsing UHC in 2012.
6. Launch of the Sustainable Development Goals as part of the 2030 Agenda for Sustainable Development in 2015.
7. Launch of the first WHO-World Bank global monitoring report on Tracking Universal Health Coverage in 2015.
8. Establishment of the "Group of friends of UHC and Global Health" as an informal platform for UN member states to build momentum toward UHC by 2030 in 2018.
9. The first congregation of the finance and health ministers of the G20 countries on health financing for UHC in Japan in 2019.
10. Launch of the United Nations Secretary General's policy brief on UHC and COVID-19, release of the first State of UHC Commitment Review, and launch of the Global Action Plan to bring together United Nations entities to make progress on all SDG 3 targets in 2020.
11. The G7 declaration of Health recommits the seven nations to focus on UHC during the COVID-19 crisis in 2021.

▶ Financing models for UHC

Healthcare financing can be categorized into four major models. Table 1 below, based on Ranabhat et al. (2023), describes each of these four models and lays out its advantages and disadvantages. It is critical to note that very few, if any, countries explicitly rely on one of these models; most countries use a combination of two or more models to fulfil the healthcare financing needs of their populations.

Model	Description	Advantage	Disadvantage
Beveridge model	Centralized provision with a single-payer government system funded by public taxes	Low costs, standard benefits, eliminates out-of-pocket expenditure	Risk of overutilization (moral hazard), higher taxation to fund increasing demand, and potential exclusion for non-taxpayers
Bismarck	Decentralized system with the onus of payment on employees and employers, private healthcare providers, and public insurers	Usually has wide coverage (including pre-existing conditions); competing insurers ensure the best price for the consumer	Potential exclusion of informal and unemployed workers, issues with sustainability, and competition dynamics
National health insurance model	Private providers with the government as an insurer	Better affordability for consumers, cheaper to administer, more freedom for providers	Characterized by delays in treatment for consumers and delays in payments for providers
Out-of-pocket model	Consumers directly pay for services utilized	Free-market solution, pay-what-you-use model	Equity concerns (healthcare driven by income)

Table 1: Models of Healthcare Financing

▶ Current progress in UHC

The world made substantial progress on Universal Health Coverage, as measured by the UHC service coverage index (SDG 3.8.1), between 2000 and 2015. However, as Figure 1 below depicts, the index has plateaued since then, indicating that even incremental improvements

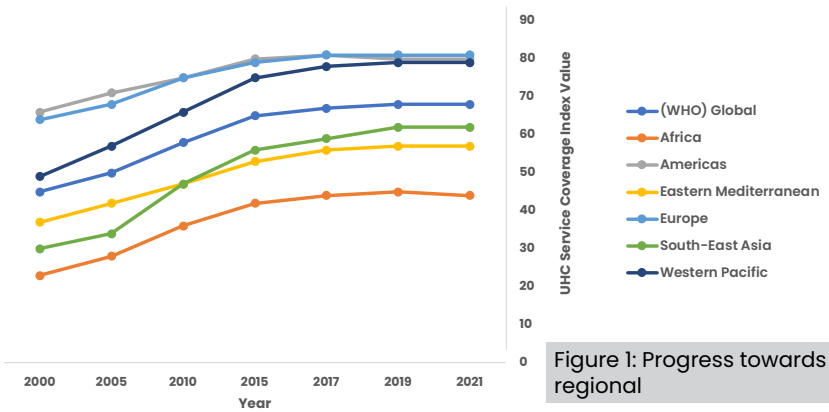


Figure 1: Progress towards UHC (2000-2021) – global and regional

worldwide have been hard to come by. It is critical to note here that these averages mask within-region and within-country inequalities in UHC attainment, which have been documented to have a disproportionate impact on those who are poor, less educated, and live in rural areas (World Health Organization, 2023). The absence of physical and affordable access to health services forces out-of-pocket expenditure (OOPE) on health by individuals and households. This OOPE was noted to push 344 million people into extreme poverty and 1.3 billion people into relative poverty in 2019 (World Health Organization), even before the onset of the COVID-19 pandemic. There is evidence of a strong inverse relationship between government spending on health services and the share of healthcare expenditure funded from OOP payments, and follow-on implications for the burden of catastrophic payments on the population (Xu et al., 2003)

India and Universal Health Care

India's ambition to attain Universal Health Care can be traced as early as pre-independence with the Bhore Committee report in 1946, which noted that "... the present medical services should be free to all without distinction..." The early establishment of this ideal led to the setup of one of the first health insurance schemes in India as early as 1948, and has subsequently led to the country experiencing a "remarkable proliferation" of 48 Government Funded Health Insurance Schemes [1] (GFHIS) between 1997 and 2018 (Patnaik, Roy, and Shah, 2018). We highlight a selection of the various GFHIS schemes in the country since independence.

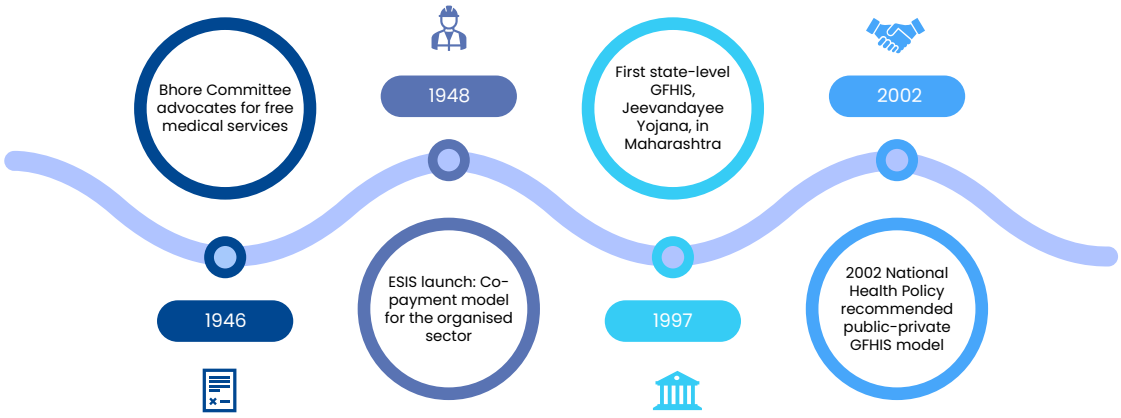


Figure 2: Evolution of health insurance in india

History of Government-Funded Health Insurance Schemes in India

The Employee State Insurance Scheme (ESIS), which was launched in 1948, provided health insurance to workers in the organized sector. The idea behind limiting the benefits to the organized sector was that as India grew economically, more workers would be employed in the organized/formal sector and would therefore come under the ambit of this scheme (Patnaik, Roy, and Shah, 2018). The ESIS used a co-payment model of funding, with contributions from the employee, employer, and state to fund health insurance (ibid). A similar model was adopted for the selection of central government employees under the Central Government Health Scheme of 1954. For women workers, the Maternity Benefit Act of 1961—the funding of which was the responsibility of the employers—mandated the provision of maternity leave and financial benefits for the first time in India (ibid).

1 *The authors also provide a useful classification of the 48 schemes based on four salient features: regulatory body, funding, maximum benefit amount, and empanelling authority.*

Despite the recommendation of the National Health Policy of 1983, which argued for the state-wise adoption of GFHIS, the next decade saw the adoption of multiple national health insurance schemes for organized workers.

Given that a large majority of the Indian workforce was employed in the unorganized sector, these individuals remained outside the ambit of the above-mentioned national-level schemes (ibid). The Rashtriya Aarogya Nidhi Scheme of 1997 was the country's first attempt at providing insurance to individuals who were poor and worked in the unorganized sector at the national level (Dubey et al., 2023).

The same year, 1997, witnessed the launch of the first state-level GFHIS in Maharashtra, called Jeevandayee Yojana, which covered health services in public and select private facilities for individuals belonging to the below poverty line (BPL) category. This model of government-funded targeted provision of health insurance, pioneered by Maharashtra, was adopted and used by several other states as well as the central government (Dubey et al., 2023).

Karnataka witnessed the adoption of yet another distinct form of health insurance known as community-based health insurance. The Yeshasvini Scheme—a joint cooperative health care scheme by farmers and the state government—was launched in 2002-03 with the beneficiaries paying the yearly insurance premiums and the government supplementing them with co-pay models. It is worth noting that the state-level take-up of health insurance schemes "followed the wave of privatization in the healthcare sector in the 1990s" (ibid), with the former acting as a protective mechanism against financial shocks to individuals and households from the latter.

The National Health Policy of 2002—as opposed to its 1983 and subsequent versions—proposed a joint public-private delivery of a national GFHIS for the poor (ibid). Following this, the Ministry of Finance announced the Universal Health Insurance Scheme (UHIS), India's first national GFHIS, in 2003. Although the initial beneficiary group was not restrictive, the scheme was restructured for BPL families along with self-help groups within a year of its original launch to increase targeted coverage. Despite this change, coverage remained insufficient (Patnaik, Roy, and Shah, 2018), and the scheme "failed to take off". The government's next attempt at securing health security was through the Unorganized Sector Workers' Social Security Scheme of 2004. However, this too was met the same fate as UHIS and was discontinued at the pilot stage.

Taking its cue from the state GFHIS in Maharashtra and Karnataka, Andhra Pradesh launched the Rajiv Aarogyasri Scheme in 2007, targeting the free provision of secondary and tertiary care to the poor residents of the state across a network of public and private empanelled facilities. Among the state-run GFHIS schemes, the Rajiv Aarogyasri is noted to have the highest coverage (Yellaiah, 2013) in terms of families covered under the scheme.

Patnaik, Roy, and Shah (2018), Hooda [2](2020) , and Dubey et al. (2023), provide similar chronological timelines of various central and state-level GFHIS in India. Prinja et al. (2017) provided a systematic review of the impact of some of these schemes. We now shift our focus to the two major central health insurance schemes that the country has implemented in recent years, highlighting their design, impacts, and shortcomings.

2 *The author provides another classification of health insurance systems into one of four kinds: "employer-mandated social health insurance (SHI) like CGHS and ESIS, commercial/voluntary health insurance (VHI), community-based health insurance, and target oriented government-funded health insurance (GFHI)".*

Rashtriya Swasthya Bima Yojana (RSBY)

Among the largest health insurance schemes in the world (Shroff, Roberts, and Reich, 2015), the RSBY was launched in 2007-08 by the Ministry of Labour and Employment, Government of India. The scheme had two objectives: a) to reduce health expenditure and increase health-seeking behaviour among the population and b) to "overcome supply side shortages" (Dubey et al., 2023), through the involvement of private health service providers. The scheme was initially meant to cover only BPL families but was expanded to include other unorganized workers[3] as well (Hooda, 2020). In terms of coverage, the scheme covered pre-existing conditions but excluded outpatient and drug costs for a total cover of ₹ 30,000 per family per annum.

The scheme was funded by the central and state governments, with the former paying around three-quarters of the ₹ 750 annual premium and the latter paying the remaining (National Informatics Centre, Ministry of Electronics & Information Technology, 2016). An annual registration fee of ₹ 30 was levied per household to maintain active status in the scheme.

The implementation of electronic enrolment records and usage of smart cards has been noted to be a key factor in propelling the RSBY to achieve high levels of enrolment in comparison with similar schemes in Georgia, Mexico, and Vietnam (Dubey et el., 2023). Johnson and Krishnaswamy (2012) estimated that RSBY on an average, with regional variation, increased hospital utilization rates by nearly 20% and reduced total medical expenses by 8%. An internal evaluation survey also highlights that every 9 in 10 beneficiaries who received treatment under the scheme were satisfied with the treatment and the services provided in the hospitals.

In terms of reducing out-of-pocket expenditure, RSBY have either fallen short or had the reverse effect of what would be expected. Devadasan et al. (2013) highlight that in Gujarat, "nearly 60% of insured patients had to spend about 10% of their annual income on hospital expenses, despite being enrolled." The authors prescribe this to the low level of coverage under the scheme (₹ 30,000 per family per annum), which, they argue, is "too little" for major surgeries. On a national level, Karan, Yip, and Mahal (2017) found a 30% increase—as opposed to a decrease that would be expected—in the likelihood of incurring any out-of-pocket spending due to RSBY. Reshmi et al. (2021) provided a meta-review of the impact of RSBY on financial risk protection and healthcare utilization, noting that nearly all the results were not statistically significant

Apart from these impacts, various shortcomings of the scheme have also been documented in the literature. Some of these are:

a. The disconnect of RSBY from existing state-level GFHI schemes leads to fragmented risk pools (Giedion, Alfonso, and Díaz, 2013);
b. Incomplete enrolment due to the inability of beneficiaries to present required documentation, lack of district participation, and inadequate outreach by agencies (Karan et al., 2017 Prinja et al., 2017);
c. Inequitable enrolment with lower representation from remote rural areas, tribal communities, and female-headed households (Devadasan et al., 2013);
d. The skew of private empanelled hospitals toward urban and richer districts (Nandi et al., 2018) &
e. Lack of access to data and lack of transparency regarding grievance redressal mechanisms (Thakur, 2016 and Narayana, 2017).

3 As Hooda (2020) notes, these categories include "building and other construction workers, street vendors, MGNREGA workers (those who worked for more than 15 days), beedi workers, domestic workers, railways porters, sanitation workers, rickshaw drivers/pullers, mine workers, rag pickers, auto/taxi drivers, and weavers and textile workers."

▶ Ayushman Bharath Pradhan Mantri Jan Arogya Yojana (AB PM-JAY)

As the successor to RBSY, the AB PM-JAY, was launched by the Ministry of Health and Family Welfare (MoHFW), Government of India, in 2018. The AB PM-JAY is the second component of Ayushman Bharat—a Government of India flagship scheme to achieve the vision of UHC in India—in addition to the creation of 1,50,000 Health and Wellness Centres (HWCs) aimed at delivering comprehensive primary healthcare. The AB PM-JAY aims to cover nearly 55 crore beneficiaries based on the "deprivation and occupational criteria of Socio-Economic Caste Census 2011 for rural and urban areas, respectively," (National Health Authority, 2019). Those under RBSY who did not fall into this category were also subsumed under AB PM-JAY. Learning from the shortcomings of the RBSY, the AB PM-JAY provides cashless cover of up to ₹ 5,00,000 (revised upwards from ₹ 30,000 for RBSY) for secondary and tertiary level services to eligible families per annum, with the key distinction being the removal of the cap on the number of members in a family. In addition to covering all pre-existing conditions, AB PM-JAY covers up to 3 days of pre-hospitalization and 15 days of post-hospitalization expenses. The PM-JAY also covers the cost of drugs and many outpatient services (unlike the RBSY), and beneficiaries can utilize services from both public and empanelled private hospitals across the country. Dubey et al. (2023) provided an overview of the hierarchical implementation model of AB PM-JAY.

Given the recency of the scheme, there are not many impact assessments for PM-JAY. Parmar et al. (2023) conducted a household survey and highlighted that while PM-JAY was not associated with an increase in hospitalizations, it increased the chances of visiting a private facility by 4.6 percentage points. The authors also note that the scheme was associated with a 13% relative reduction in out-of-pocket expenditure and a 21% reduction in catastrophic health expenditure, both driven primarily by private facilities.

Within the state of Chhattisgarh, Garg, Bebarta, and Tripathi (2020) found that enrolment under PM-JAY did not increase utilization of hospital care and that the incidence of OOPE and CHE did not decrease with enrolment under the scheme. Results from Meerut in Uttar Pradesh (Verma et al., 2022) highlight that nearly three-quarters of providers considered PM-JAY to be inferior to private insurance due to poor grievance reprisal and delays in claims processing. Non-payment of claims was documented (Bhasin, 2021) to have forced private hospitals in Punjab to suspend the intake of new patients under Ayushman Bharat. Dubey et al. (2023) provided additional details regarding financing, beneficiary enrolment and awareness, monitoring and evaluation, and results on geographical, gender, age, caste, and religion equity under the AB PM-JAY.

A 2021 report by NITI Aayog highlights that nearly a third of the Indian population (amounting to nearly 40 crore individuals) is devoid of any financial protection for health and that these individuals are spread across rural and urban areas and between formal and informal occupations. The same report also outlines various state-level GFHIS, with a particular focus on those covering the "non-poor" population.

▶ Status of health-related expenditures and health insurance in India

Despite the rich history and massive scale of health insurance in the country, public health spending in India is among the lowest when compared with other big economies, both as a percentage of gross domestic product and in per capita terms (Organization for Economic Co-operation and Development, 2019). This underinvestment in health has been noted by both governments (for example the Economic Survey of India 2020-21) and nongovernmental actors (such as The Elders, 2018) across the years.

Indian Government's (Centre and states), spending on education and health (including

Expenditure	2000	2005	2010	2018
Current health expenditure per capita PPP (in current international $)	88.55	117.16	145.47	275.13
Current health expenditure as % of GDP	4.04	3.79	3.27	3.54
Domestic general government health expenditure as % of general government expenditure	3.29	3.03	3.11	3.39
Domestic general government health expenditure as % of current health expenditure	20.68	20.13	26.20	26.95
Domestic private expenditure on health as % of current health expenditure	76.67	78.34	72.82	72.35
Voluntary health insurance (VHI) as % of total health expenditure [1]	NA	1.6	3.4 (2013–2014)	4.7 (2016–2017)

Source: World Bank Data Bank (World Bank, 2021) for all, apart for 1: (NHSRC, 2019)

Table 2: Health Spending in India

nutrition programmes) is currently 3.8% of GDP and 1.4% of GDP, respectively, which is significantly lower than the corresponding world averages of 4.4% and 6.0%, respectively (as cited in Selvaraj et al, 2022).

Such low levels of public investment in healthcare spending have traditionally resulted in consumers of healthcare having to pay for health service out-of-pocket. The out-of-pocket expenditure (OOPE) on healthcare (as a percentage of total healthcare expenditure) in India has historically been nearly 70% (World Health Organization, 2019), which is much higher than that in middle-income countries, Sub-Saharan Africa, and the rest of the world (as shown in the figure below). While OOPE has begun to decline in recent years, more than half of the healthcare spending burden in the country still falls on consumers. In 2018, nearly 16% of the population faced catastrophic health expenses (Sriram and Albadrani, 2022), and approximately 3.3% were pushed into poverty due to out-of-pocket expenditures on health (Mohanty and Dwivedi, 2021).

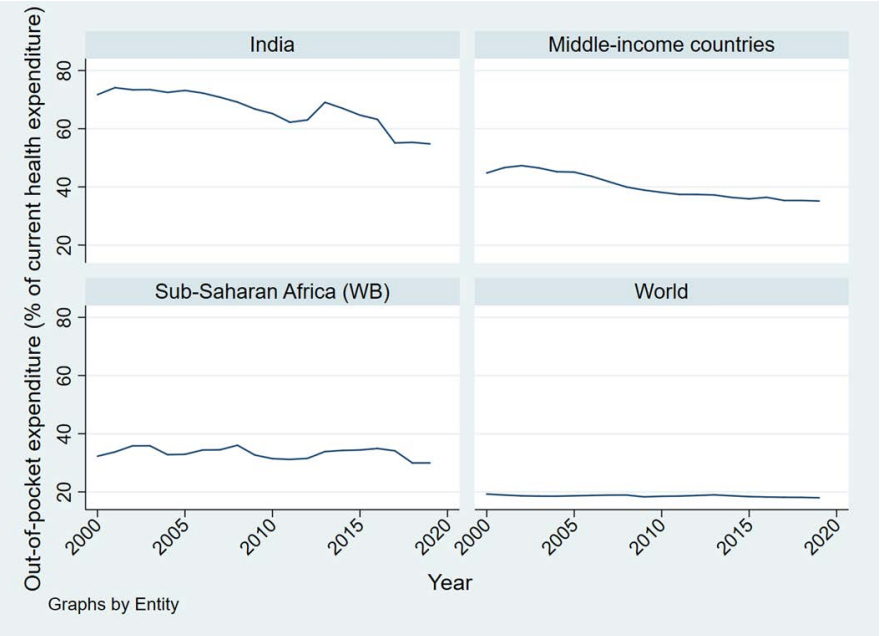


Figure 3: OOPE on healthcare (as a percentage of total health expenditure)

Nationally, the National Family Health Survey (NFHS-5) highlights that only 38% and 42% of urban and rural households, respectively, have any usual member within the household covered under a health insurance/financing scheme[4] . However, there is substantial variation in health insurance coverage across states and districts in India, ranging from less than 10% (in districts in Maharashtra, Uttar Pradesh, and Bihar) to more than 80% (in districts in Rajasthan and Chhattisgarh). The map below, produced by the Geographic Insights Lab (2021) based on NFHS-5 data, highlights district-level health insurance coverage in India.

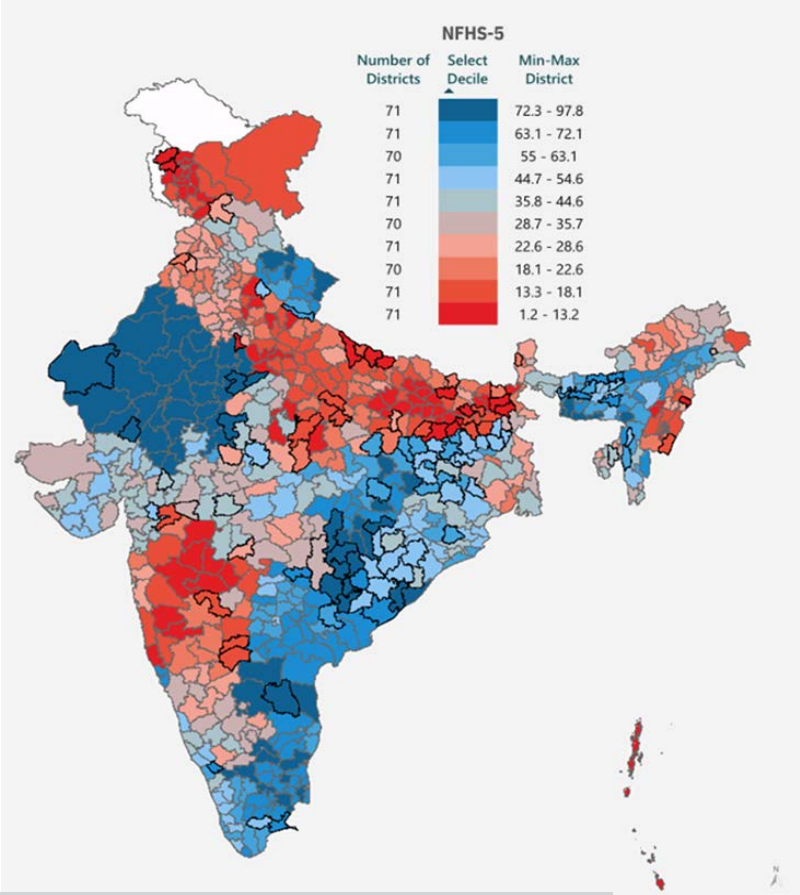
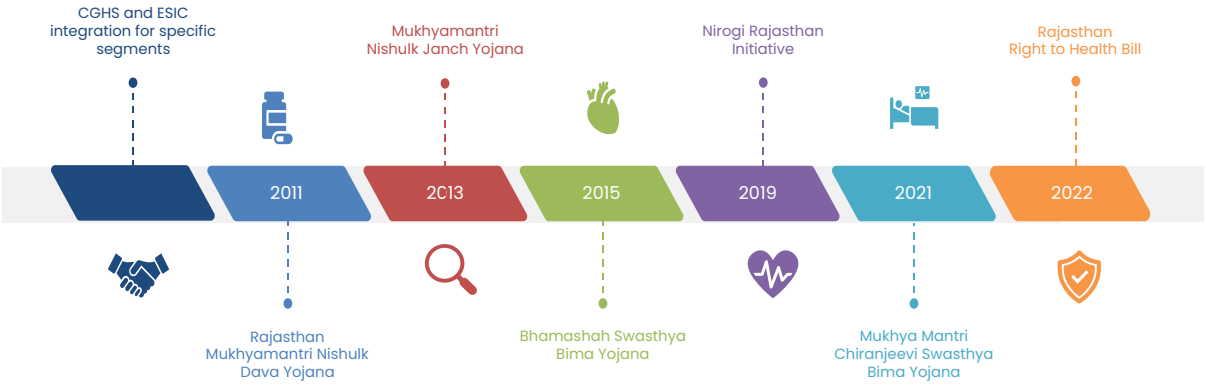


Figure 4: District level Health Insurance Coverage in India

4 It is worth noting that these statistics are valid for a household even if only one of the members of the household is covered under a health insurance scheme. This implies that the actual individual-level figures might be lower than the average of 41 percent.

Health Insurance in Rajasthan

Historically, the state of Rajasthan has relied on deploying central schemes to cater to the health insurance needs of its citizens. This began with the integration of the Central Government Health Scheme (CGHS) and Employees' State Insurance Scheme (ESIC) into the state, providing healthcare benefits to specific segments of the population (Dubey et al., 2023 and Hooda, 2020).



In 2011, the state government introduced the Rajasthan Mukhyamantri Nishulk Dava Yojana to provide commonly used essential medicines free of cost to patients visiting government healthcare institutions (Khan, 2019). In 2013, this was extended to include free medical tests under the Mukhyamantri Nishulk Janch Yojana, benefiting more than 170 million individuals across the state (Rajasthan Medical Services Corporation Limited, 2016).

The state then introduced the Bhamashah Swasthya Bima Yojana in 2015 to provide cashless health services benefits of up to ₹ 30,000 for illnesses and ₹ 3,00,000 for critical illnesses. The scheme covered families under the National Food Security Act (NFSA) and Rashtriya Swasthya Bima Yojana (RSBY). Jain (2019) documents "substantial rates and levels" of out-of-pocket payments (OOPP) at private hospitals under the scheme, and that 70% of the variation in OOPP is explained by differences within hospitals. Joseph (2020) finds that the scheme in the capital city of Jaipur resulted in increased use of hospital services, but that nearly 80% of individuals insured under the scheme had to incur out-of-pocket expenses.

The state government also introduced several instruments adjacent to its health insurance offerings. Examples include the Nirogi Rajasthan initiative launched in 2019, which aims to promote better health and wellness among citizens by focusing on preventative healthcare measures, early diagnosis, and treatment (Times of India, 2019). This initiative has nearly 43 million individuals registered under its aegis (Medical, Health and Family Welfare Department, Government of Rajasthan). Others include e-health initiatives such as the Arogya Online Health Management and Information System, e-Upkaran, and the Integrated Ambulance Services Payment Monitoring System (Joshi et al., 2021).

In 2022, the Government of Rajasthan introduced the Rajasthan Right to Health Bill, which provides the right to health and access to healthcare for people in the state, including free healthcare services at any clinical establishment to residents of the state. PRS Legislative Research (2023) provides an analysis of the bill and highlights its key challenges.

In recent years, in part because of the presence of the many schemes outlined above, Rajasthan has emerged as a leader in health insurance coverage among all states in India. According to the National Family Health Survey (NFHS; 2019-2021), nearly 9 of 10 households in Rajasthan had at least one member covered under a health insurance scheme, the

highest in India. Between the two rounds of the NFHS – 2015-16 and 2019-21 – all districts in Rajasthan have seen substantial improvements in health insurance coverage, with the average increase between the two years being 70 percentage points. This increase is among the largest across all states in the country.

▶ Rajasthan's Mukhya Mantri Chiranjeevi Swasthya Bima Yojana (MMCSBY)

In 2021, the state government launched the Mukhyamantri Chiranjeevi Swasthya Bima Yojana—an instrument to implement Universal Health Coverage across the state by a) reducing out-of-pocket expenditure on health for eligible families, b) providing quality treatment from public and private facilities, and c) providing free-of-cost treatment for nearly 1800 treatments.

The scheme provides a cover of up to ₹ 25 lakhs per family to all families in Rajasthan under two brackets:

1. Eligible beneficiary families registered in the free category under the State Food Security Act (NFSA), eligible families of the Socio-Economic Census (SECC) 2011, contractual workers working in all the departments/boards/corporations/ government companies of the state, small and marginal farmers, and former destitute and helpless families who received the COVID-19 ex gratia amount are included in the scheme by default and do not have to pay to maintain coverage.
2. All other families of the state who are not government employees/pensioners can join the scheme by paying a prescribed premium of ₹ 800 per family per year.

▶ Best Practices observed in other states

i. Dr. YSR Aarogyasri Health Insurance Scheme (Andhra Pradesh)

Transparent online system: The entire process from the time of health camp conduct to screening, diagnosis, treatment, follow-up, and claim payment is made transparent through online web-based processing to prevent any misuse and fraud. Enhances accountability and minimizes fraud through real-time tracking of claims.

Disease mapping and identification of morbidity pools: As the entire patient data of people attending health camps, network hospital OP, in-patient treatment details, and treatment details of the beneficiaries approved under the scheme are captured online, it creates huge morbidity data of the population. Patient data are used to identify disease trends and inform public health interventions.

ii. Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) (Tamil Nadu)

IEC activities: Raise awareness about the scheme and encourage beneficiaries to use its benefits.

iii. Karunya Arogya Suraksha Padhathi (KASP) (Kerala)

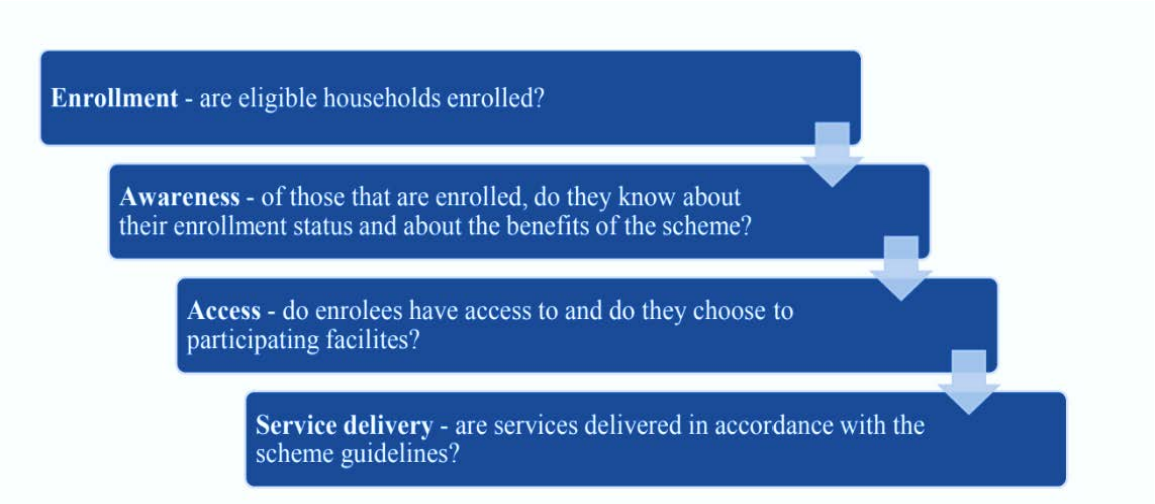
1. Universal coverage for the bottom 40%: Offers healthcare access to a large segment of the population regardless of income level.
2. Coverage of pre-existing conditions: Eliminates concerns about exclusion due to existing medical conditions.
3. Portability across India: Ensures uninterrupted coverage even when beneficiaries

travel outside Kerala.

4. Follow-up care for specific procedures: Enhances treatment outcomes and promotes long-term patient well-being

Methodology

The study implements systematic 'insurance cascade' framework developed by Bauhoff and Sudharsanan (2021).



Research objectives

1. Assess the impact of the scheme on beneficiaries in terms of key parameters such as out-of-pocket expenditure.
2. Understand the current status of the scheme, identify gaps, provide recommendations to enhance scheme implementation, and improve the provision of Universal Health Coverage (UHC).
3. Analyze the data made available by the State to identify trends and patterns in claims.

Research design and setting

To assess the scheme's status and identify impediments to Universal Health Coverage, mixed methods were deployed, including quantitative and qualitative methods. The key stakeholders engaged in the study included beneficiaries availing benefits under the scheme (survey), Swasthya Margadarshak's (survey), and hospital administrators (IDIs).

Sampling

Identification of hospitals/health care facilities: There are 1788 empanelled health facilities under the Chiranjeevi Swasthya Beema Yojana. A standard sampling calculation with 1788 as the population parameter, 95% confidence level, and 10% margin of error yields a sample size of around 92 facilities. To include other institutions such as medical colleges etc., 102 facilities were selected based on a stratified random sampling strategy with margins as listed in the framework. All 33 districts in Rajasthan were covered under the study with 52 Government and 50 Private facilities.

Stakeholders covered under the study

a. Beneficiaries under the study:

From each facility, 5-6 patients were covered through structured questionnaires deployed through Google Forms. Thus, the number of beneficiaries covered under the study totalled 525. During the field visits, some beneficiaries were discharged from the facility. Hence, their surveys were conducted at their homes after contacting them through the records made available by the hospitals/CHCs.

b. Swasthya Margdarshaks:

In addition to the beneficiaries, interviews were conducted through structured questionnaires with 100 Swasthya Margdarshaks in the same hospitals/facilities as the patients.

c. Hospital Administrators:

Ten hospital administrators were included in the study.

Through the tools developed, the following aspects of the scheme implementation and benefits were explored:

With the scheme beneficiaries, those availing in addition to those who have already availed the scheme benefits were covered. Aspects on ease of enrolment, awareness about the scheme, access to services, and out-of-pocket expenses were covered in addition to any challenges faced by them with regard to enrolment, availing benefits under the scheme, and reimbursements associated with hospital admission. Under OOPE, the category of direct medical costs included both package and non-package components, consisting of doctor's fees, diagnostic tests, medication costs, bed charges, and other similar expenses. Direct nonmedical expenditures, including transportation for patients or others involved in their care, and lodging accommodations for escorts or food expenses, have been covered.

The Swasthya Margdarshaks tool covers the following aspects: their understanding of roles and responsibilities, whether they received training to deliver their services, and how they deliver their duties and help the patients. Documentation associated with the scheme and general questions patients have about availing benefits under the scheme, challenges associated with availing benefits under the scheme, how they support patients who are not registered, and lastly, how can the benefit/outcome of the scheme be improved to reach out to more beneficiaries.

With the Hospital administrators, it attempts to understand the effectiveness of the scheme and their experience working with multiple stakeholders. It understands their inputs on scheme coverage, compensation received by hospitals, claim submission process and associated challenges, if any, processing of payments, and any challenges, and recommendations they have to improve scheme delivery. Questions about incentives being given to private and Government hospitals were discussed. The impact on service delivery by doctors owing to increased patient load is also covered.

The tools were first developed in English, aligned to the objectives of the study, upon finalization they were translated into Hindi. Google Forms were used to capture responses from beneficiaries and Swasthya Margdarshaks, and interviews with hospital administrators were conducted.

Data collection process

To address the objectives of the study, several data requests were made to the State Health Department anchoring the Chiranjeevi Swasthya Beema Yojana. The key data requests are shared below:

State MIS data was requested for the following parameters:

- List of hospitals registered under the scheme
- Number of packages offered
- Gender-wise breakdown of male and female beneficiaries
- 3 most utilized packages (package code)
- Claims data-total claims under Chiranjeevi - Submitted, Approved, paid, and rejections data
- Allocated budget under the scheme and budget spent

Limitations in the data available:

As part of the study, hospital and scheme level data were requested-these included-patients utilizing Chiranjeevi scheme per month, beneficiaries with/without premium, category of incentives and visits per patient for treatment.

Scheme-level data were requested for the following: details of the total number of beneficiaries registered (district-wise), category-wise details of the registered beneficiaries, total beneficiaries availed benefits under the scheme (district-wise), and total number of beneficiaries availed benefits under the scheme under Government and Private categories. Payments are made under the same categories. Grievance-related data covering the total number of grievances received and addressed, month-wise data. District wise and caste wise enrolment and claim data was requested from the Government for this study. However, due to software issues and a prolonged data retrieval period, data points such as those listed above were not retrieved from the database. Hence, especially with regard to the scheme data, there are limitations.

Data collection for the study was spread throughout August - mid-November 2023. As a part of the data collection process, training of enumerators was conducted at the beginning of the study. The context of the study was given to all participants and their oral consent was obtained. Quality checks were conducted on an ongoing basis to ensure the quality of data, and replacement was suggested in case of issues identified with the responses.

Data Analysis

The first step during the analysis process was to clean the data. MS Excel is used for the analysis and visualization of quantitative data. The qualitative data from the interviews were analyzed, and key themes were identified from the responses to each question.

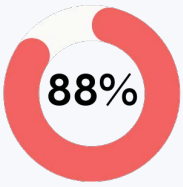
The OOPE was divided into different categories such as treatment, doctor or surgeon fees, medicines, diagnostic tests, bed charges, other medical expenses, transportation, and other non-medical expenses. We calculated the 5% trimmed mean by removing outliers and the median OOPE with interquartile range (IQR) for different components of OOPE.

Data Analysis and Discussion

The data has been organized into seven sections. The first section gives an overview of the **current status of the scheme** in terms of coverage, packages offered, trends in utilization of packages, and the top illnesses covered under the scheme. The second section covers the **demographic details** of beneficiaries covered under the CRISP study. The third section, covers the **enrolment under the scheme**, and the fourth section deals **with awareness of the scheme.** The fifth section highlights aspects around the **accessibility of the scheme**, if the beneficiaries faced any difficulties while availing the scheme benefits, and attempts to understand from the perspective of administrators and frontline health workers how accessibility of the scheme can be improved. The sixth section covers **service delivery under the scheme**, analysis of out-of-pocket expenditure incurred by beneficiaries, sources of financing, and challenges experienced by stakeholders in the effective delivery of the scheme. Finally, the last section outlines the **impact of the scheme on beneficiaries.**

The sections of the report have been divided into two sub-parts. The first sub-section (wherever possible) highlights data received from the State Government (MIS), and the second section covers data analysis of the field-level data gathered from the beneficiary survey conducted by CRISP, in addition to the survey responses from Swasthya Margdarshaks and the Hospital Administrators' responses. The third sub-section discusses the trends observed through the State data, primary level data, and literature mapped with other states/insurance schemes/literature in the Indian context. With the above-mentioned flow, each section of the report provides insights into the functioning of the s cheme and how it fares with respect to the Insurance schemes spread over India.

Section I :Current Status and Spread of the Scheme



Rajasthan

Highest health insurance coverage in India, with 80% urban and 90.4% rural coverage

1798 packages

1761 under insurance mode and 37 under trust mode. Insurance mode is responsible for more than 95 % of the total MMCSBY spending.

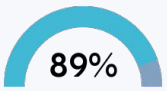
80%

URBAN

90.4%

RURAL

of claims Approved



of claims Paid

As per the enrolment and claims data available, ~ 17% of enrolled beneficiaries have claimed benefits under the scheme.

The state allocated

₹ 1,463 Crore in FY 21-22
₹ 2228 Crore in FY 22-23

State-level data

1. 1) NFHS-related data in terms of insurance coverage in the state-As per the latest report of NFHS 2019-21, in Rajasthan, approximately 88% of the households (HH) are covered under any health insurance scheme, which is the highest in the country[5]. This includes 80% of urban HH and 90.4% of rural HH.
2. 2) Fund allocated under the scheme—Year-wise fund utilized (available in primary level claims data)
   a. FY 21-22 – ₹ 1463 crore has been allocated for the Public Health Insurance scheme. [6]
   b. FY 22-23 – ₹ 2,228 crore has been allocated to Mukhya Mantri Chiranjeevi Swasthya Bima Yojana[7]
3. In terms of the packages available in the State: 1798 packages are offered as part of the Insurance scheme. Out of these, the insurance mode offers 1761 packages and the trust mode covers 37 packages.

It can be inferred that the majority of the packages provided by the state are under the insurance mode.
Year-wise - Spend under insurance and trust:

Year	Insurance (In Cr)	Trust (In Cr)
2020-2021	997.41	67.57
2021-2022	2389.27	136.82
2022-2023	2117.48	44.38
Total	**5504.16**	**248.77**

Year-wise expenditure: Table No. 3

The year-wise spend under the respective modes also highlights more claims and spending under the Insurance mode of spending.

4. Analysis of Scheme claim data
   a. The Submitted, Approved, Paid, and Rejected data summary (between the period of May 2021-November 2023) highlights that ~92% of the claims under the scheme have been approved, whereas ~89% claims associated with the scheme have been paid.

	No. of Persons	Amount	Amount (%)	No. of Persons (%)
Submitted	37,76,202	6548,85,30,675		
Approved	34,37,809	6021,56,55,491	91.95	91.04
Paid	33,43,169	5807,69,04,122	88.68	88.53
Rejected	4,84,712	370,48,09,259	5.66	12.84

Claims summary : Table No. 4

5 *https://main.mohfw.gov.in/sites/default/files/NFHS-5_Phase-II_0.pdf - pg 51*
6 *https://prsindia.org/budgets/states/rajasthan-budget-analysis-2021-22#:~:text=Total%20expenditure%20in%202021%2D22,borrowings%20of%20Rs%2061%2C904%20crore.*
7 *https://prsindia.org/files/budget/budget_state/rajasthan/2022/Rajasthan%20Budget%20Analysis%202022-23.pdf)*

As per the State data, 1.39 Cr households are enrolled under the scheme, out of which33.43 lakh have been paid claims under the scheme. The scheme has been able to reach out to 5.56 Cr individuals (assumption of 4 member households) out of the total enrolled beneficiaries ~ 16.6% have been paid claims through the scheme.

b. Package count volume-wise data

Volume -wise data of the top 10 diseases availed in Pvt. Empanelled hospitals

Sl.no.	Disease Name	Package count/ No. of claims
1	Haemodialysis Dialysis (ARF / CRF) (General medicine)	3,74,694
2	Febrile illness (General medicine)	83,571
3	Respiratory failure	56,937
4	Haemodialysis Dialysis (ARF / CRF) (Nephrology)	35,733
5	Acute gastroenteritis with dehydration/Recurrent vomiting with dehydration/Chronic diarrhoea/Dysentery	35,568
6	Dengue fever	33,591
7	Intensive Neonatal Care Package	32,700
8	Blood transfusion	21,041
9	PTCA, inclusive of diagnostic angiogram	20,823
10	Cholecystectomy	13,402

Volume- wise top 10 diseases- Private hospitals: Table No. 5

After analysis of the data provided by RSHAA, the top 10 packages used in private hospitals under the MMCSBY are: **Haemodialysis Dialysis** (ARF / CRF), being the most used package, followed by **Febrile illness and Respiratory failure.** It is observed that the Haemodialysis package was availed in both the General Medicine and Nephrology procedures. Other packages include Febrile Illness, Respiratory Failure, Acute Gastro-enteritis, Dengue Fever, and Blood Transfusion, highlighting the focus on common medical conditions. Interestingly, packages related to cardiology and surgery are also present, indicating the availability of a wider range of specialized services at the empanelled private hospitals.

Package count: volume-wise of Top 10 diseases availed in Govt. hospitals

Sl.no.	Disease Name	Package count availed
1	Febrile Illness (General Medicine)	3,82,909
2	Acute Gastroenteritis with dehydration/Recurrent vomiting with dehydration/chronic diarrhoea/dysentery	2,71,165
3	Severe Anaemia	1,21,234
4	Special Neonatal Care Package	81,368
5	Enteric Fever	64,509
6	High Risk Delivery	49,453
7	Haemodialysis Dialysis (ARF / CRF) (Nephrology)	49,286
8	Hospitalization for antenatal complications	44,094
9	Febrile Illness (Paediatric medical management)	42,042
10	Haemodialysis Dialysis (ARF / CRF) (General medicine)	38,131

Volume -wise top 10 diseases- Government hospitals: Table No. 5

The top 10 packages used in government hospitals under this scheme are also dominated by general medicine, with **Febrile illness** being the most used package followed by **Acute Gastroenteritis and Severe Anaemia.** Similar to private hospitals, Haemodialysis appears in both the General Medicine and Nephrology categories, indicating its importance in both settings. However, government hospitals cater to critical maternal health and birth-related packages, with High-Risk Delivery and Hospitalisation for Antenatal Complications recording a high number of registrations.

While both private and government hospitals extensively utilize general medicine packages, there are some key differences in their top 10 packages. Private hospitals cater to a large number of patients for haemodialysis, whereas government hospitals have an influx of patients with Febrile Illness and Acute Gastroenteritis. Furthermore, private hospitals offer a wider range of specialized services, as evidenced by the presence of cardiology and surgery packages. On the other hand, government hospitals show large usage of birth-related and neonatal care packages extensively, reflecting their role in providing accessible maternity care. The presence of Haemodialysis in both settings and across different categories underscores its overall importance in the healthcare system.

c. Value-wise data for Private and Government hospitals

Top 10 packages utilized in Pvt. empanelled hospitals in the State

Sl.no.	Disease Name	Amount spent. (₹ in Crores)
1	PTCA, including diagnostic angiogram	53.25
2	Haemodialysis Dialysis (ARF / CRF) (General medicine)	41.69
3	Cholecystectomy	26.80
4	Intensive Neonatal Care Package	19.62
5	Respiratory failure	17.41
6	Febrile illness (General medicine)	15.04
7	Ureteroscopy + Stone removal with lithotripsy	11.81
8	Total Knee Replacement	10.87
9	Appendicectomy	9.90
10	Dengue fever	8.53

Value -wise top 10 packages Private Hospitals: Table No. 6

The analysis of the top 10 packages used based on the value in private empanelled hospitals under the MMCSBY revealed that **cardiology procedures** dominate the list, with PTCA (including diagnostic angiogram) accounting for the highest expenditure (₹ 53.25 crores). This is followed by other expensive treatments like **haemodialysis, cholecystectomy, and neonatal care packages.** Interestingly, even common conditions like **febrile illness and appendicectomy** were among the top 10 packages availed by beneficiaries.

Value-wise - top 10 packages utilized in Govt. hospitals in the State:

Sl.no.	Disease Name	Amount spent (₹ in Crores)
1	Febrile Illness (General medicine)	68.92
2	High Risk Delivery	56.87
3	Acute Gastroenteritis with dehydration/Recurrent vomiting with dehydration/Chronic diarrhoea/Dysentery	48.81
4	Special Neonatal Care Package	24.41
5	Caesarean Delivery	24.11
6	Severe Anaemia	21.98
7	Enteric Fever	11.61
8	CT for CA Breast/Head & Neck/Ovary/Endometrium/Cervix/Vulvar/Urinary Bladder/Anal Cancer	8.12
9	Hospitalization for antenatal complications	7.94
10	Febrile illness (Paediatric medical management)	7.57

Value-wise top 10 packages in Government Hospitals: Table No. 7

Analysis of the top 10 packages used in Government hospitals under the Rajasthan Health Insurance Scheme shows a different scenario. **Obstetrics & gynaecology procedures like high-risk deliveries and caesarean deliveries rank highest,** reflecting the sizeable influx of patients needing urgent medical attention. General medicine conditions like **febrile illness, gastroenteritis, and severe anaemia are prominent**, indicating the burden of these common ailments. Notably, cardiology procedures are less prevalent compared to private hospitals.

Comparing the top packages availed in private and government hospitals revealed distinct patterns. Expensive cardiology procedures were availed in private hospitals, while in government hospitals, obstetrics & gynaecology and general medicine treatments were predominantly availed. This difference quite likely reflects the varying demographics and healthcare needs of each sector. Additionally, febrile illness availed in both lists highlights its widespread impact across both settings.

Section II: Beneficiary demographics

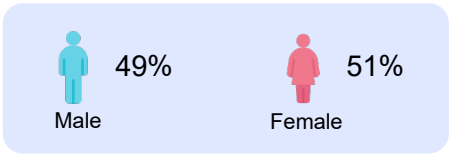
A total of 525 beneficiary responses were collected from 255 (49%) male and 270 (51%)

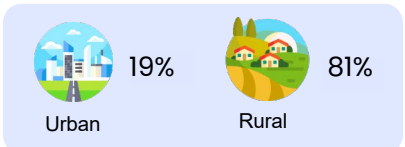
female respondents. Approximately 80% of the beneficiaries hailed from rural areas (427), while the remaining 20% (98) were from urban areas. The beneficiaries of the scheme come from diverse age groups, with young adults (17-30 years old) forming the largest group at 36%. Older adults, both middle-aged (31-45 years old) and those above 45 years old, also represent a significant portion at 22% and 34%, respectively. Children (0-16 years old) constitute the smallest group at 8%. This suggests that the scheme caters to various individuals, with a particular focus on young and older adults.

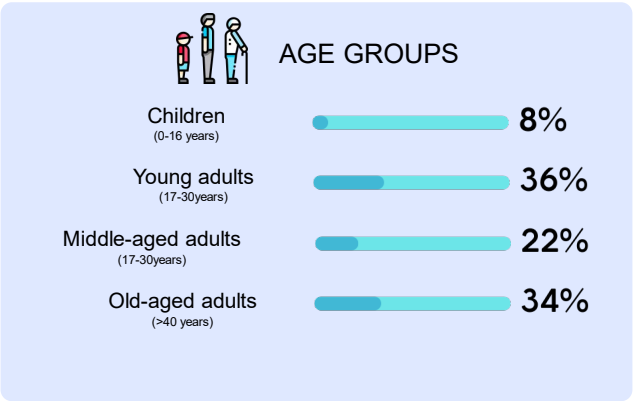
Beneficiary Demographics

Variables	Frequency (n)	Percentage (%)
Type of Hospital		
Private	252	48
Government	273	52
Patient type		
In-patient	405	77.14
Discharged	120	22.86
Gender of the Patient		
Male	255	48.57
Female	270	51.43
Area of Residence		
Rural	427	81.33
Urban	98	18.67
Age group of the patient		
Children (0-16)	43	8%
Young Adults (17-30)	189	36%
Middle-aged Adults (31-45)	116	22%
Old-aged adults (>45)	177	34%

Beneficiary demographics: Table No. 8







525 Analysis based on 525 beneficiary responses, reflecting a near-even gender distribution and a significant rural representation.

Section III - Enrolment under the scheme

As per the data shared by the Government of Rajasthan, 1.39 Crore families have been enrolled under the Chiranjeevi Swasthya Bima Yojana. [8]

Category-wise distribution is as follows:

a. NFSA and SECC: 111.08 lakh

b. Small and marginal farmers: 11.10 lakh

c. Contractual workers: 0.40 lakh

d. Beneficiaries of the COVID-19 ex gratia scheme: 3.18 lakh

e. Other families: 13.9 lakh

As per the survey: Majority of the sample beneficiaries 283 (53.9%) who availed the benefits of the scheme were registered in the year 2023-24, followed by 119 beneficiaries (22.67%) in the year 2021-2022. It was also observed that 30 beneficiaries (5.71%) who availed the benefits of Chiranjeevi Yojana were enrolled as beneficiaries under "Bhamashah Swasthya Bima Yojana" (BSBY). Highlighting that despite enrolment in previous schemes, beneficiaries are still able to enrol access to health services.

Year	Frequency (%)
Before 2021	30 (5.71%)
2021-22	119 (22.67%)
2022-23	93 (17.71%)
2023-24	283 (53.90%)

Year of registration: Table No.9

In terms of difficulties faced while registering for the scheme: Out of the 525 beneficiaries, the majority of the beneficiaries 504 (96%) did not face any difficulties while registration, and only 21 (4%) of the respondents faced difficulties. This highlights the ease of access for availing scheme benefits, where the majority of beneficiaries did not report any issues.

Difficulties faced during Registration	Frequency	Percentage
Yes	21	4.00
No	504	96.00
Total	**525**	**100**

Difficulties faced during registration: Table No. 10

Some of the challenges faced by the beneficiaries are mentioned below, not knowing where or when to register topped the list (17 and 9 instances, respectively). Feeling unassisted during the process (7 instances), having to travel to a distant registration location (5 instances), and lack of proper documentation (2 instances) further hindered their attempts to enrol. The challenges highlighted by the beneficiaries underline the gaps in terms of awareness of the possible camp dates, location of camps, and documentation needed for a registration process. This reflects the need to improve the registration process to ensure the accessibility of scheme benefits.

8 Data available in RSHAA report - March 2, 2023

https://drive.google.com/drive/folders/1L73pAvsq-tocyqqr-jhcp3yJstf4xUjd

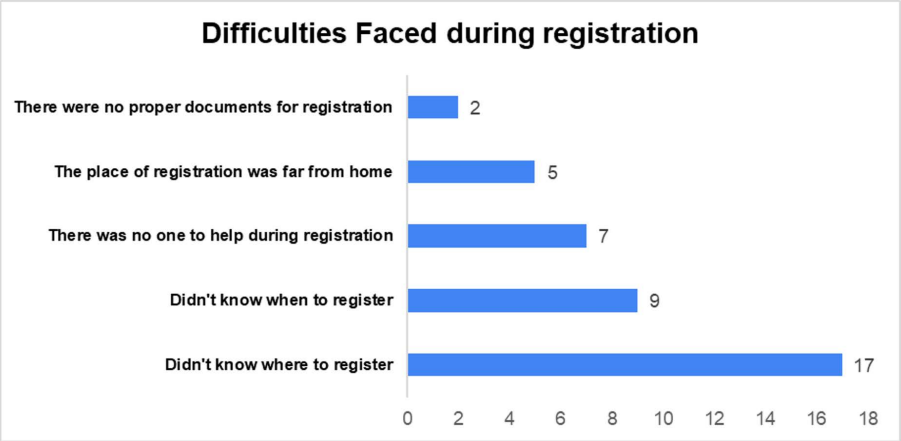


Figure 5: Difficulties faced during Registration

A significant portion of the surveyed beneficiaries (83%) availed the benefits of the scheme without paying a premium, owing to its wide coverage under different social or economic categories.

Number of beneficiaries without premium	436
Number of beneficiaries with premium	89
Total	**525**

Enrolment with/without premium: Table No.11

Discussion

From the above section, we can infer that, despite holding older registration scheme cards, beneficiaries have availed benefits under the Chiranjeevi scheme, thus making it a pro-poor scheme. Second, 96% of the beneficiaries reported that they did not face issues during registration, again highlighting the ease with which the Government has operationalized the functioning of the scheme till the last mile. Third, the fact that beneficiaries without premiums outnumber those with premiums also highlights the ease of access to the scheme. Section IV: Awareness of the Scheme Section IV: Awareness of the Scheme

Section IV: Awareness of the Scheme

Knowledge of the scheme benefits, aspects of insurance packages, and claims are critical to ensuring that the scheme can deliver its mandate and that the target audience does not incur additional costs. There needs to be investment by the State in awareness generation about the scheme so that beneficiaries can avail benefits.

As part of the study, beneficiaries' knowledge of insurance was assessed on two parameters: their knowledge of insurance packages and the claim amount associated with packages.

Awareness of the insurance packages yielded the following response: the beneficiary survey showed that 32.38% of beneficiaries were aware of the insurance packages under the scheme, whereas 67.62% were not. This suggests a significant gap in awareness about the packages under which patient illnesses can be booked. Thus, even if they are eligible to be booked under a certain package, their lack of knowledge prevents them from availing complete benefits under the scheme.

Awareness of different insurances under the scheme	**Frequency**	**Percentage**
Yes	170	32.38
No	355	67.62
Total	**525**	**100**

Awareness of insurance schemes- Table No.12

Beneficiaries' knowledge of claims yielded the following responses. 37.9% of beneficiaries were aware of their claim amount under the scheme, whereas 62.1% were not. This indicates a significant knowledge gap in terms of the scheme benefits of beneficiaries.

Knowledge of claim	**Frequency**	**Percentage**
Yes	199	37.90
No	326	62.10
Total	525	100

Knowledge of claim - Table No.13

Interactions with the Swasthya Margdarshaks on their awareness of the scheme and whether they received training to deliver their role effectively were conducted. Survey responses of Swasthya Margdarshaks showed that 83.33% (85) received training related to the scheme, while 16.67% did not. This suggests that a large majority of healthcare workers are equipped with the knowledge and skills necessary to effectively guide beneficiaries through the programme. It is also noted that previous schemes in the state have delivered similar capacity-building initiatives to equip frontline workers with basic prerequisite skills to effectively deliver their roles.

Formal Training	Frequency	Percentage
Yes	85	83.33
No	17	16.67
Total	**102**	**100**

Training received by SM's - Table No.14

It is important to note that even with a high training rate, there is a small percentage of Swasthya Margdarshaks who did not receive any training support. It could be helpful to investigate the reasons behind the lack of training for the remaining 16.67% and ensure that all helpline workers are equipped to effectively support beneficiaries.

The preceding health insurance in Rajasthan (BSBY) lists in detail the role played by the Swasthya Margdarshaks as an integral component of the functioning of the scheme[9]. With their front-ending role in the scheme including enrolments, registrations, claim process, and patient documentation, they must be trained regularly in the case of upgradation of packages/software.

Discussion

Studies across the country reveal how lack of awareness contributes to out-of-pocket costs

during treatments and availing benefits. "For the PM-JAY in Bihar and Haryana, even among those who received their beneficiary cards, less than 40% received any information on what the scheme covers and where the benefits can be accessed, and more than half were not aware that the scheme is cashless. A 2018 survey in Rajasthan found that only about half of the patients who received dialysis treatments under the state scheme (BSBY) knew that the scheme covered all costs and knew a nearby empanelled hospital. Similarly, evidence from small-scale studies on RSBY in several states reveal consistently low awareness of what is covered and which facilities participate in the schemes: One study in Gujarat found that roughly 25% of households knew which hospitals were empanelled and none were aware that the scheme covered transportation, post-procedure, and food costs" (as cited in Bauhoff and Sudharsanan)[10] .

Barik et al. studied the awareness of the Bhamashah Swasthya Bima Yojana (BSBY) and revealed that beneficiaries often lack awareness about their entitlements and how to claim benefits. More than one-third of the BSBY beneficiaries were unaware that the scheme covered pregnancy and delivery expenses. Age, education level, and experience with chronic illness directly influence awareness, with younger, educated individuals with exposure to chronic illness demonstrating better knowledge. Low awareness translates to low utilization, with only 17.8% of beneficiaries with high knowledge claiming cashless benefits or reimbursement compared with 8.7% with low knowledge.

Thus, from the above study findings, it can be concluded that utilisation of the scheme is directly linked to awareness and UHC. It is extremely important for the Government to make appropriate investments towards awareness generation.

9 *BSBY*

10 *The Insurance Cascade Framework to Diagnose Bottlenecks and Improve the Effectiveness of Health Insurance Programs: An Application to India-Sebastian Bauhoff and Nikkil Sudharsanan*

Section V: Access to Health Insurance

Access to the scheme has been mapped below in terms of the geographic spread of Private and Government healthcare facilities (list shared by the RSHAA) and the population status as per 2011 census data.

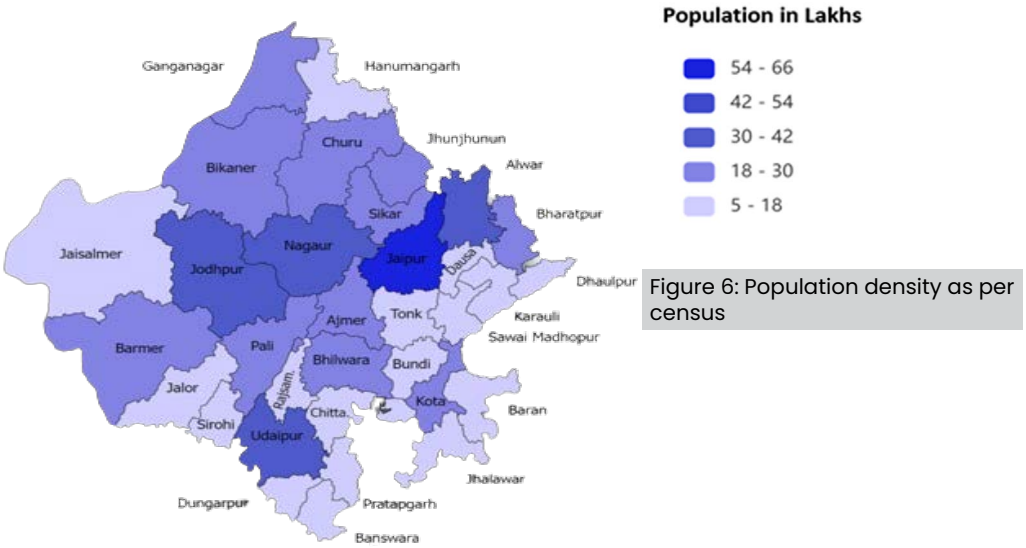


Figure 6: Population density as per census

With a population of 6.85 crores, Rajasthan's districts vary in density and healthcare access. Jaipur (66.3 lakhs), Jodhpur (36.9 lakh), Alwar (36.7 lakhs), Nagaur (33.1 lakhs), and Udaipur (30.7 lakhs) boast the highest populations. Districts like Jaipur (69 govt hospitals), Jodhpur (45 govt hospitals), Nagaur (40 govt hospitals), Sikar (39 govt hospitals), and Jhunjhunun (33 govt hospitals) have the most empanelled government facilities under Chiranjeevi.

Conversely, Baran (12.2 lakhs), Dhaulpur (12.1 lakhs), Pratapgarh (8.7 lakhs), and Jaisalmer (6.7 lakhs) have lower populations and even fewer empanelled government hospitals (17, 11, 10, and 12, respectively). Similar disparities exist in empanelled private hospitals. Jaisalmer, Baran, Dhaulpur, and Pratapgarh have minimal private options (2, 4, 3, and 1, respectively), whereas Jaipur (280), Jodhpur (66), Sikar (54), Alwar (52), and Jhunjhunun (45) have significantly more empanelled private hospitals.

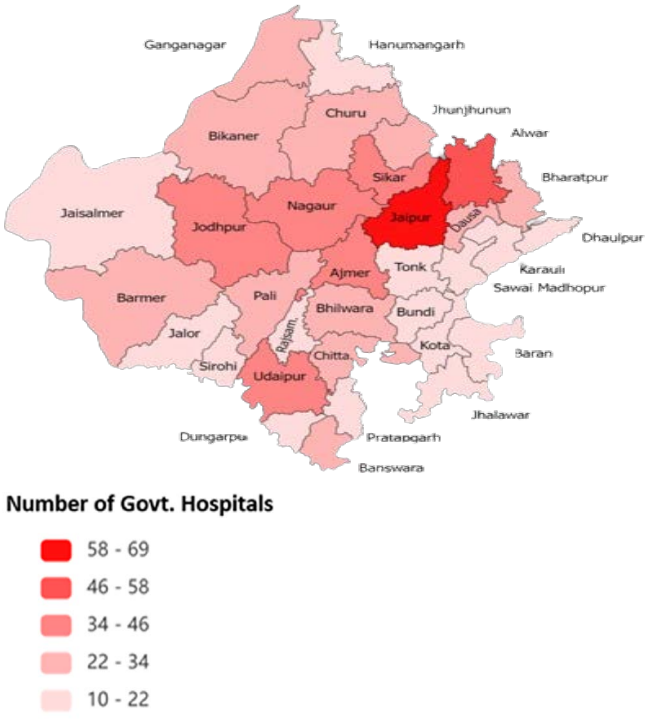


Figure 7: Density of Government hospitals empanelled under Chiranjeevi

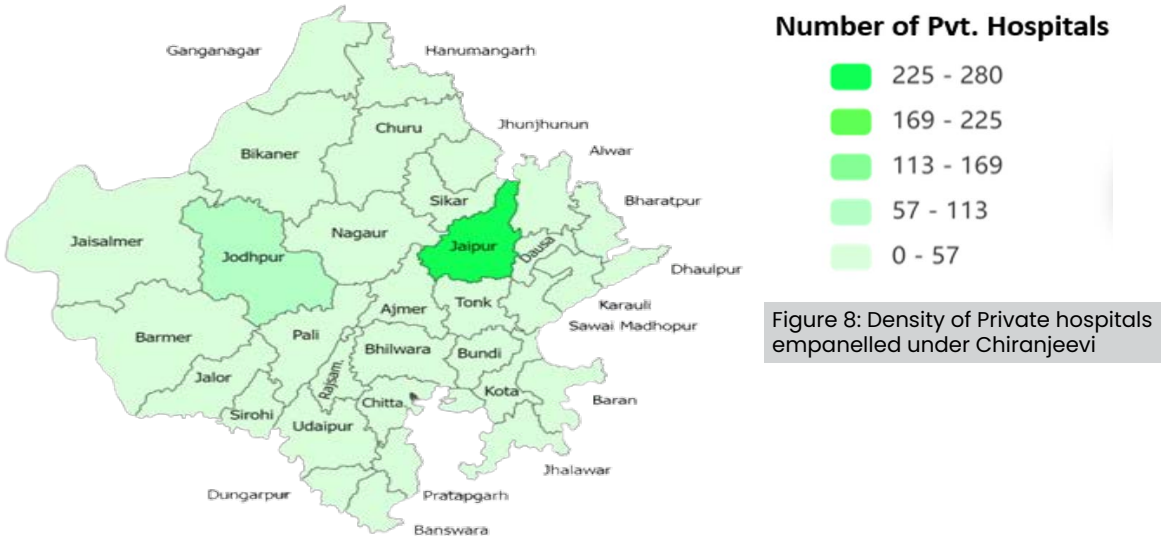


Figure 8: Density of Private hospitals empanelled under Chiranjeevi

Access to the scheme was also understood in terms of beneficiaries access to health care facilities, usage of Health insurance, length of hospital stay and challenges faced while availing the scheme.

From the beneficiary survey usage of health Insurance revealed that the majority of beneficiaries, 68.38%, availed benefits only once. This is followed by **19.05% who availed it twice** and 4.57% who availed it three times. A smaller group, 8.00%, availed of the benefits more than four times. This suggests that most beneficiaries utilized the scheme on a limited number of occasions, potentially indicating that it served their immediate needs or addressed specific short-term situations. However, a small but notable portion relied on the benefits more frequently, highlighting their potential dependence on the scheme for ongoing support.

No. of times benefits availed	Frequency
1	359
2	100
3	24
More than 4	42
Grand Total	**525**

Frequency of Usage: Table No.15

Length of hospital stay	Frequency	Percentage
Short stay 0-5 days	464	88.38%
Medium stays 6-10 days	43	8.19%
Long stays >10 days	18	3.43%

Length of Hospital Stay: Table No.16

The data show that the vast majority of beneficiaries, 88.38%, had short hospital stays of 0-5 days. This was followed by a much smaller group experiencing medium stays of 6-10 days (8.19%) and an even smaller group with long stays exceeding 10 days (3.43%).

This suggests that the scheme primarily caters to individuals requiring short-term medical interventions or treatment for acute illnesses. The low percentage of longer stays indicates that the scheme may not be the main source of support for beneficiaries with chronic conditions or those needing extensive hospitalization.

Faced any difficulty while availing Benefits	Frequency	Percentage
Yes	16	3.05
No	509	96.95
Total	**525**	**100**

Difficulty in availing the Scheme Benefit: Table No.17

Difficulties in availing scheme benefits - The majority of beneficiaries did not face any difficulty (96.95%) while availing of the scheme benefits. Among the surveyed beneficiaries, only 16 (3.05%) faced some challenges while availing the benefits.

Nature of Challenges Experienced by Beneficiaries	Frequency
No guidance from the hospital authorities on how to avail the benefits	8
No benefits received without out-of-pocket expenses	7
Special packages not available at the facility	5
Complete information not provided at the time of hospital admission	5
Late approvals from the Government	1

Nature of Challenges Experienced: Table No. 18

Swasthya Margadarshak's challenges	Frequency
Documentation Issues	24
Scheme Coverage and Awareness Challenges	19
Identity and Verification Challenges	11
Logistical and Operational Challenges	9
Enrolment and Registration Challenges	5
Financial Aspects and Benefit Disbursement	3

Ensuring Scheme Benefits: Table No. 19

The nature of challenges in availing scheme benefits by the beneficiaries include lack of clear guidance from hospital authorities on how to navigate the process (8 instances). This was closely followed by beneficiaries having to incur out-of-pocket expenses despite the scheme's promise of financial coverage (7 instances). The absence of special packages tailored for the scheme at the facility was also a notable challenge (5 instances), as was the incomplete information provided to beneficiaries at the outset (5 instances). Although encountered less frequently, late government approvals also posed a barrier to accessing benefits (1 instance). These challenges collectively highlight the challenges faced by beneficiaries in accessing the scheme's promised healthcare benefits.

Challenges experienced by the Swasthya Margdarshaks in ensuring scheme delivery include difficulties associated with documentation proofs of beneficiaries, lack of

knowledge of the scheme among beneficiaries, challenges associated with identification and verification of beneficiaries, and problems associated with enrolment and registration and disbursement of benefits.

The hospital administrator's responses in terms of accessibility of the scheme cover aspects related to scheme coverage, provision of flexible packages, and issues of accessibility at the hospital level.

Packages under Obstetrics and Gynaecology, such as normal delivery and related packages, are removed from the Chiranjeevi Scheme MMCSBY. In case packages like Anal Fistula, Diagnostic Laparoscopy, and Cataract are covered exclusively in Government facilities in the current scheme and not in private hospitals, a similar demarcation is not found under BSBY. Suggestions for additional coverage include a general package for a combination of treatments, maternity-related treatments for private hospitals, and the inclusion of neurology and pulmonology. The inclusion of packages related to conservative management before surgery, gynaecology-related treatments, palliative care, and coverage for follow-up costs to enhance patient satisfaction is also shared as suggestions. The need for flexible packages is highlighted, particularly for patients with comorbidities or conditions not covered by existing packages. The scheme is acknowledged to be helpful at the CHC level.

Observations and discussion

Access to health insurance in India remains a complex and multifaceted challenge, despite various initiatives like state-sponsored schemes and Government Health Insurance Schemes (GHIS). Studies by Ambade et al. (2023), Garg et al. (2020), and Goyal et al. (2021) highlight significant disparities in coverage across rural/urban areas, socioeconomic groups, and regions. Hooda (2020) points to potential gaps in government schemes, with actual coverage falling below official claims, particularly in rural areas. Rajasthan, however, boasts of commendable progress in terms of insurance coverage.

However, insurance coverage does not translate into access to health care, service availability, affordability, and associated OOPE expenses, as highlighted by Harish et al. (2020), in the case of Kerala, which boasts of high insurance coverage (74%). Prinja et al. (2019) highlight the need for investigation as existing health insurance schemes, including RSBY, have not demonstrably improved access to healthcare across India. However, schemes like Vajpayee Arogyashree in Karnataka (Sood and Wagner, 2018) offer valuable lessons in targeting expensive conditions, simplifying enrolment, and providing cashless treatment to enhance access for the poor.

Studies have also highlighted gender disparities in terms of access and utilization of free care programmes like Rajiv Aarogyasri along with the challenges faced by the poor (Phalswal et al. (2023), and Shaikh et al. (2018). Kamath et al. (2023), further emphasize the need to address weaknesses like fraud and low awareness within schemes to ensure equitable access.

From the above literature and the beneficiary survey, it can be inferred that the insurance scheme was availed once, indicating that the scheme is used to address only short-term illnesses, rather than chronic conditions that might be difficult to treat. Second, many beneficiaries shared that they did not face any challenges while availing of scheme benefits, which also highlights the systems put in place to ensure smooth delivery of scheme benefits. Inputs from frontline health workers are noteworthy, and they reflect challenges they experience while executing the scheme, and these need to be addressed. This brings us back to the previous section highlighting the need to invest in increasing awareness of

the scheme. Furthermore, discussions with hospital administrators reveal critical aspects around packages that need to be addressed to ensure the effectiveness of the scheme. Overall, improving access to health insurance in India requires a multi-pronged approach that addresses disparities, strengthens existing schemes, and explores alternative strategies to ensure equitable healthcare for all.

Section VI: Service delivery under the scheme

This section of the report covers aspects of service delivery under the scheme, especially those related to out-of-pocket expenditures. Among the beneficiaries, it explores the nature of OOPE, highlighting the outliers in terms of OOPE. With the Swasthya Margdarshaks, it attempts to understand the challenges experienced by them in the effective delivery of the scheme and their impressions on how the scheme can be improved. It further understands from the Hospital Administrator's impressions on the scheme, challenges associated with the scheme, claims, reimbursement process, package rate disparities, and incentives under the scheme:

1. **From the beneficiary survey, it was observed that out of 525 beneficiaries, 320 incurred OOPE expenditures as medical and non-medical expenses.**

Variables	Frequency (n)	Trimmed mean ± Standard deviation (₹)	Median (₹)	Range (₹)
Treatment	54	3996 ± 5196	3000	500 – 15000
Doctor or surgeon fees	22	2485 ± 7400	500	10 – 20000
Medicines	43	2025 ± 3409	1200	400 – 10000
Diagnostic tests	49	2039 ± 2610	1400	300 – 8000
Bed Charges	7	8668 ± 18657	1000	10 – 50000
Other Medical Expenses	20	1052 ± 682	800	500 – 2000
Transportation	281	979 ± 769	1000	100 – 2000
Other nonmedical expenses	196	653 ± 412	800	100 – 1000

Mean and Median Costs Associated with OOPE–Table No.20

OOPE expenditures vary considerably across different categories. Treatment was the most expensive category, with a mean expenditure of ₹ 3996 among 54 beneficiaries, followed by Bed Charges (₹ 8668) and Transportation (₹ 979). Medicines and Diagnostic tests are also relatively expensive, with mean expenditures of ₹ 2025 and ₹ 2039, respectively. Other Medical Expenses, Doctor or surgeon fees, and other nonmedical expenses are all less expensive, with mean expenditures of less than ₹1500. It is also observed that there is a considerable variation in expenditures within each category. Overall, the data in this table suggest that OOPE expenditures are incurred among beneficiaries. The high cost of treatment, bed charges, and transportation is particularly concerning.

The highest OOPE expenses associated with hospitalization in the beneficiary pool are shared below:

The table highlights several outliers with significantly higher out-of-pocket

Variable (OOPE)	Disease Name	Amount (₹)	Hospital/Facility type
Treatment Cost	Viral Encephalitis	150000	Private
	Haemodialysis Dialysis (ARF / CRF)	400000	Private
	Haemodialysis Dialysis (ARF / CRF)	60000	Private
	Back Bone Problem	50000	Government
Doctor or Surgeon fees	Haemodialysis Dialysis (ARF / CRF)	100000	Private
	Total Knee Replacement	20000	Government
	Haemodialysis Dialysis (ARF / CRF)	10000	Private
Medicines	Haemodialysis Dialysis (ARF / CRF)	200000	Private
Diagnostic tests	Haemodialysis Dialysis (ARF / CRF)	50000	Private
Bed charges	Haemodialysis Dialysis (ARF / CRF)	50000	Private
	Haemodialysis Dialysis (ARF / CRF)	18000	Private

OOPE Outliers: Table No. 21

expenditures than others. Notably, for treatment costs, two cases of Haemodialysis in private hospitals stand out, with expenditures reaching up to ₹4,00,000 and ₹60,000 (in both cases beneficiaries took treatment from non-empanelled hospitals and later they enrolled at an empanelled facility free of cost). In case of doctor/surgeon fees in one instance, private hospital Haemodialysis procedures show significantly higher fees at ₹100,000, compared to other entries under surgeon fees. Among other OOP expenditures in Medicines, Diagnostic tests, and bed charges in case of Haemodialysis in private hospitals, higher costs are incurred. The OOPE treatment, medicines, diagnostic tests, and bed charges reveal a concerning trend: significantly higher out-of-pocket expenditures for Haemodialysis in private hospitals. These expenditures stand out compared with other treatments and facilities.

Discussion

Despite the promise of public-funded health insurance (PFHI) in India, studies in Rajasthan (Kumar et al., 2023) and Chhattisgarh (Nandi et al., 2017) show mixed results for out-of-pocket expenditure (OOPE) reduction. While PFHI lowered OOPE in both private and government hospitals, catastrophic health expenditure (CHE) remained significant, particularly in private settings. Even in rural areas like West Bengal (Dalui et al., 2020), OOPE remains high (median ₹ 3870) and CHE affects 16.2% of families. Surprisingly, having insurance increased CHE risk in West Bengal, suggesting coverage limitations or ineffective utilization. These findings highlight the need for improved accessibility and quality of public healthcare alongside PFHI to truly address OOPE and CHE burdens across India.

The median OOP expenditure for the treatment was ₹ 3000 which is similar to that of the observations in the study conducted by Dalui et al. (2020) in West Bengal among the rural population, which reduced the financial burden on beneficiaries. One study in Gujarat found that only roughly 25% of households knew which hospitals were empanelled and none were

aware that the scheme covered transportation, post-procedure, and food costs (as cited in Bauhoff, 2021). Another study of the BSBY scheme by Roselent, J. (2020) reveals findings contrary to the current study, where OOPE associated with medicines, transportation, and non-medical expenses is considerably higher, as compared to the treatment charges.

Even though there are government programs and subsidies for haemodialysis in India, out-of-pocket expenses (OOPE) remain a significant burden. Studies like Kaur et al. (2018) in Punjab and Bradshaw et al. (2018) in Kerala found high OOPE in haemodialysis, averaging ₹ 2838 per session and leading to catastrophic health expenditure (CHE) in 91% of households in Kerala.

Even with public insurance like Bhamshah Swasthya Bheema Yojana, studied by Dupas and Jain (2022) in Rajasthan, unfair hospital practices and limited coverage resulted in high OOPE, highlighting the need for improved insurance coverage, transparent cost communication, and strategies to empower patients to navigate the healthcare system and access the intended benefits.

A study conducted by Kaur et al. (2018) on public sector tertiary hospitals revealed that the majority of the Out-of-Pocket Expenses apart from treatment are incurred mainly on medicines and consumables, followed by transportation and boarding costs.

2. **Swasthya Margadarshak's survey responses on the improvement of the scheme have been shared below:**

Suggestions	Frequency
Increase awareness and publicity	29
Improve scheme coverage and accessibility	18
Reduce documentation and delays	15
Improve package offerings	15
Improve service quality	7
Other suggestions	12

Improvement of the scheme (SM responses): Table No. 22

In addition to the above, their suggestions can be classified into the following categories:

a. Increasing **awareness** of the scheme
b. Improving **scheme coverage and access**
c. Improving the **registration process**
    - Prioritizing and shortening the registration process for BPL/vulnerable households - Prioritizing registration of BPL families was proposed, especially

those who are not enrolled under the scheme, along with reducing the time it takes for the registration process.

d. Improving service delivery including
   - **Improving the existing cover through packages**
   - **Additional cover for diagnostics and medicine expenditures:** Addressing these would help in the reduction of financial burdens and improve overall health outcomes.
   - Addressing the delays associated with claims

e. Administration related-
   - **Formalizing the employment of SMs** - The SM survey revealed that despite their workload, SMs continue to be contractual employees, formalizing their employment would address issues around their motivation.
   - **Increasing manpower allocation at the hospital and administrative levels** to improve grievance redressal and enhance patient-friendly experience.
   - Provision of a **helpline to address** patient queries.
   - **User friendly software** to expedite registration and claims-related processes.
   - **Quality assurance in treatment and patient care** in registered hospitals: Regular inspections of affiliated hospitals and addition of hospitals to the existing pool of service providers would build trust and ensure quality care.

3. Responses from hospital administrators covering aspects around the compensation of packages, reimbursement, and claims process are discussed below:

a. Compensation and reimbursement
   - Low compensation vis a vis the actual treatment cost: Hospital administrators raise concerns about low compensation costs under several packages (oncology packages, plastic surgery), excluding ophthalmology. This warrants that regular revisions of packages are needed to align with current rates and avoid unnecessary financial burdens on patients, as observed in the example of dog bite treatments.
   - **Inadequacy in compensation for Private hospitals:** Concerns are highlighted when patients are referred to private hospitals for treatment because some illnesses are not covered through packages.
   - **At the CHC level,** the funds received are considered additional and satisfactory, as the treatments were already free.

b. Payment delays: Responses regarding delays in payment release under the Chiranjeevi scheme vary, with some reporting:
   - Delays in payments experienced when queries or objections are raised. However, there is overall consensus on the smooth functioning of the scheme, in case there are no queries raised.
   - **Irregular release of reimbursements,** occasionally experiencing gaps of up to 2 months in a few cases.

These insights highlight the need for greater consistency and efficiency in the reimbursement process under the Chiranjeevi scheme.

c. **Claim submission and payment process**

- **Reducing the documentation for the scheme:** Reducing the need for documentation would reduce the time needed for filing the claim process.
- **Clarity on the standard procedure for verification:** Lack of clarity on the claim process, including query, approval, and rejection, leads to unnecessary complications for staff and patients. Problems arise when claims are rejected despite proper documentation, leading to the need for multiple submissions of the same documents. Patients dropping out between treatments also contributes toward rejection of claims.
- **Lack of clarity in the compensation breakdown per claim:** Since one illness can include multiple packages, there is no clarity on the compensation associated with each claim. Multiple queries for the same claim, even after providing responses with supporting documents, further compound challenges in the claim process. There is a consensus that improvement is needed to streamline the process, enhance objectivity in reviews, and reduce unnecessary queries for a more efficient reimbursement system.

d. **Additional Incentives:** Hospital administrators were asked how incentives are received under the scheme and how these incentives are utilized by the hospital administration.

- The majority of the hospitals surveyed did not receive additional incentives. However, two hospitals noted that they are **receiving incentives under the category of NABH (National Accreditation Board for Hospitals & Healthcare Providers)** accreditation . This implies that, in the context of the Chiranjeevi Scheme, some hospitals may be eligible for additional incentives if they have achieved NABH accreditation, which emphasizes the importance of quality standards in healthcare delivery.
- **Lack of clarity on incentives due to lumpsum payments to hospitals:**

  As only two responses were received under incentives, this aspect could be explored in detail. However, interactions revealed a lack of clarity on whether they are receiving the incentive, and if so, the amount, due to a lump sum payment system made by RSHAA.

Furthermore, it was also shared that incentives help them cover the difference in actual costs borne by the hospital and the compensation provided. This indicates that the incentives play a role in supporting the financial aspects of healthcare service delivery, particularly in addressing any shortfall between the actual costs incurred by the hospital and the compensation received.

- **Incentives based on patient volume:** Lack of clarity amongst the HA's exist for this response, and disparity in responses highlights variability in the financial arrangements or incentives associated with patient volume under the Chiranjeevi Scheme for the hospitals surveyed.

Clarity and consistency in the distribution of additional funds linked to patient numbers could contribute to a more transparent and equitable implementation of the scheme. Aspects around incentives can be examined in detail to understand if they can help meet additional costs incurred, especially by both Government and private facilities.

e. **Package Rate Disparities:** Interaction with the HAs also explored package rate disparities, whether there were differences in charges between the package rates paid by non-scheme beneficiaries and the reimbursement received from the scheme.

- **Substantial variations between non-scheme beneficiaries and those covered under Chiranjeevi:** In one instance, the charge for non-beneficiaries was close to double the amount reimbursed under the scheme (₹1800 under Chiranjeevi compared to ₹ 3500 for other patients). Another example highlights a significant difference, such as Laparotomy costing ₹ 35000 for non-beneficiaries but only ₹18000 under Chiranjeevi, leading to concerns about adherence to the treatment package and potential omissions in essential processes. Similarly, for lipoma abscess treatment, non-beneficiaries pay ₹8000, while the Chiranjeevi package is only ₹500. The variations are described as case-specific, with different rates for government-funded appendix operations compared with hospital charges.

Overall, the responses highlight considerable differences, with rates paid by non-Chiranjeevi patients being cited as 2-3 times higher or even three times the rates paid under the Chiranjeevi scheme. These differences in charges underscore the complex landscape of pricing structures and the impact of the scheme on healthcare affordability for different patient groups.

f. Scheme impact on Government hospitals was discussed.

- **Increase in patient load and workload post-Chiranjeevi launch,** particularly in Super Specialty Hospitals, but deems it not significant enough to have a major impact on the hospitals.
- **Similar patient load at the Community Health Centre (CHC) level:** another respondent indicated a decrease in patient load at the CHC level.
- **Increased beneficiary choice** if they want to avail services from a private service provider, meaning that patients now have the option to seek treatment in private hospitals covered by the scheme.
- **Positive impact on fund availability:** The availability of additional funds under Chiranjeevi has had a positive impact on Government service providers. However, this has added an additional burden on private hospitals. As Government hospitals have received additional funds, there are limited mechanisms to track the deployment/tracking usage of additional funds. Despite the availability of additional funds, this has not been reflected in the coverage of medicine availability or other associated costs.

Overall, the responses highlight potential shifts in patient preferences and varying impacts on workload and resources at government hospitals, emphasizing the need for ongoing monitoring and adjustment in response to evolving healthcare dynamics.

Section VII : Scheme Impact

The scheme impact through the survey was understood in terms of the affordability of treatment for beneficiaries and how they usually arrange finances for treatment in case of emergencies. Responses from the beneficiary survey are discussed below.

It was observed that the majority of the respondents (63%) would have been unable to afford the treatment without the scheme. This highlights the critical need that the scheme is addressing in terms of patient treatment.

Ability to Afford Treatment without the Scheme	Frequency	Percentage
Yes	196	37.33
No	329	62.67
Total	525	100

Affordability of Treatment in the Absence of an Insurance Scheme - Table No. 23

How the respondents would have paid for the treatment in the absence of the scheme was also discussed. The responses highlight that most of them either used their household savings, borrowed from relatives, or took a consumption loan. Alarmingly, 23 of them shared that it would have led them to sell their physical assets.

In the absence of the scheme, the beneficiary would have paid for the treatment through	Frequency
Loans from family members or friends	96
Loans from outside	92
Sale of physical assets	23
Personal/household savings	103

In case of absence of the scheme, beneficiaries would have paid for the treatment through Table No.24

Responses from Hospital Administrators indicate a widespread consensus that the Chiranjeevi Scheme has significantly benefited patients, particularly the most vulnerable sections of society. However, some respondents noted challenges arising from conflicting guidelines with other health schemes, leading to occasional confusion about the appropriate course of action. The scheme's impact is particularly noteworthy in private hospitals, where beneficiaries can access healthcare with minimal out-of-pocket expenses, eliminating financial barriers and allowing for more extensive options in private healthcare. Despite challenges in government medical facilities, such as scheme information not being readily available in hospitals, shortage of medical staff and specialists, delays in treatment and claim processing, and limited availability of necessary tests and equipment, the scheme has led to an increase in the number of poor patients seeking treatment at these hospitals.

Discussion

This section highlights how the scheme has been able to cater to vulnerable populations and make treatment accessible. Overall, the Chiranjeevi Scheme is described as extremely helpful, facilitating access to critical healthcare services for financially disadvantaged individuals across multiple districts.

Recommendations

1. **Increasing scheme coverage and awareness:**
   - Enrolment and awareness of the benefits of the scheme need to be improved. As per the findings of the survey, beneficiaries did not know details about the packages, their eligibility, and the benefits that can be claimed under the scheme.
2. **Improving the coverage of packages**
   - Inclusion of packages for general treatment, ensuring comprehensive coverage.
   - Revision of package rates to meet actual expenses should be conducted
   - Flexibility in packages to be introduced to accommodate treatments that are not categorized under any package.
   - Additional cover for medicines and diagnostics related expenses as treatment and medicine related costs top OOP expenses.
   - Empanelment of more hospitals under the scheme and increasing the number of doctors based on the packages offered are suggested to improve patient access to health services.
3. **Administration related**
   a. **Delivery of quality services**
      - NABH accreditation should be encouraged with empanelled facilities, so they can meet basic quality standards of healthcare delivery and avail scheme-related incentives.
      - Comprehensive incentive structures to be developed to clarify volume-based incentives for private and Government sector hospitals.

   b. **Strengthening the monitoring mechanisms for scheme implementation:**
      - Regular Quality checks of the empanelled facilities should be conducted.
      - Regular feedback from private hospitals for refining processes and addressing concerns specific to private facilities should be taken up.
      - A nodal officer for private hospitals should be appointed to support the private hospitals empanelled under the scheme. The officer would communicate software updates in advance, perform website maintenance during non-working hours, and extend support in case of excessive or repetitive queries.

   c. **Strengthening IT- enabled infrastructure**
      - The current format of MIS data recorded as part of the scheme does not create fortnightly or monthly insights into the operations and challenges associated with the scheme. This makes it difficult to monitor the scheme's progress.
      - The data should provide information regarding diseases in various regions, spread of disease-wise treatment in various hospitals, etc. This would help augment government hospital facilities in addition to preventive health care.
      - Software should be made more user-friendly, the query process should be streamlined, and refresher training for staff should be conducted in case of software upgrade.
      - A nodal officer for private hospitals should be appointed to support the private

hospitals empanelled under the scheme. The officer would communicate software updates in advance, perform website maintenance during non-working hours, and extend support in case of excessive or repetitive queries.

- A mobile application should be developed for the patient interface where all papers are made available at all stages on a real-time basis relating to the diagnosis and treatment of the patient. When the user opens the app and enters their ID and health issue, the mobile app can provide the names of various empanelled hospitals located in their vicinity (like the Google map for restaurants and petrol pumps). Furthermore, a hospital rating system could be developed based on beneficiary feedback.

d. Manpower related: Formalizing employment of the Swasthya Margdarshaks under the scheme.

- Regular training of staff members and hospital administrators so that they can guide the beneficiaries as per scheme guidelines. These become especially important in the case of software upgrades.

4. Beneficiary grievance redressal

- A dedicated helpline for hospitals enrolled under the scheme.
- Fixed nodal persons for the Chiranjeevi Scheme should be appointed to address all challenges associated with claims and coordinate between agencies and hospitals.
- Reduce documentation under the scheme and delays associated with payment processing.
- Streamlining approval of the discharge process, providing reimbursement reports per claim, and expanding coverage to include follow-up visits, palliative care, and conservative management before surgery, among other aspects, are also proposed for a more comprehensive and efficient implementation of the Chiranjeevi Scheme.
- Delay in payments should be reduced.

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▶ Annexures

Annexures:

Beneficiary survey tool:

चिरंजीवी मूल्यांकन - योजना लाभार्थी

साक्षात्कारकर्ताओं (Interviewers) के लिए:

1. कोशिश करें और सुनिश्चित करें कि मरीजों का साक्षात्कार लेते समय कोई अस्पताल अधिकारी या अन्य आधिकारिक कर्मचारी मौजूद न हों। यदि ऐसे व्यक्ति मौजूद हैं, तो कृपया विनम्रतापूर्वक उन्हें साक्षात्कार की अवधि के लिए कमरे से बाहर जाने के लिए कहें।
2. कोशिश करें और सुनिश्चित करें कि जिन रोगियों का साक्षात्कार लिया जा रहा है वे एक-दूसरे के उत्तर न सुन सकें। यह प्रतिवादी की गोपनीयता सुनिश्चित करने और यह सुनिश्चित करने के लिए है कि उत्तरदाता किसी अन्य उत्तरदाता द्वारा दिए गए उत्तरों से प्रभावित न हों।
3. यदि संभव हो, तो कृपया डेटा को सीधे Google फॉर्म में भरें, उत्तरों को कागज पर लिखने और बाद में उन्हें फॉर्म में डालने से बचें। यदि संभव नहीं है, तो कृपया उत्तरों को यथाशीघ्र फ़ॉर्म में अपलोड करें ताकि यह सुनिश्चित हो सके कि उत्तर यथासंभव सटीक हों।
4. किसी भी परिस्थिति में साक्षात्कारकर्ताओं को मरीज की सहमति के बिना मरीज की ओर से जानकारी भरने की अनुमति नहीं है। यह न केवल फॉर्म शुरू करने के लिए, बल्कि फॉर्म के अंदर किसी अन्य फ़ील्ड के लिए भी लागू होता है।
5. आपके द्वारा भरे गए फॉर्म की संख्या आपके नाम और फोन नंबर के जरिए ट्रैक की जाएगी। कृपया सुनिश्चित करें कि आप पूरे सर्वेक्षण के दौरान अपने नाम की सही स्पेलिंग दर्ज करें और केवल एक फ़ोन नंबर दर्ज करें।
6. किसी भी प्रश्न या विवाद के मामले में, कृपया तत्काल सहायता के लिए सुश्री आकांक्षा (+91 9940236829) या श्री दक्ष (+91 9772260555) को कॉल करें।

*Indicates required question.

सर्वेक्षक का विवरण

निर्देश - साक्षात्कार के लिए लाभार्थी के साथ बैठने से पहले भरें

1. सर्वे करने वाले का नाम *

   _____

2. सर्वे करने वाले का फोन नंबर *

   _____

3. संभाग * Mark only one oval.

   ☐ अजमेर ☐ जोधपुर

   ☐ भरतपुर ☐ कोटा

   ☐ बीकानेर ☐ उदयपुर

   ☐ जयपुर

4. ज़िला * Tick only one box.

   ☐ अजमेर ☐ सीकर

☐ कोटा
☐ उदयपुर
☐ जयपुर
☐ जैसलमेर
☐ भीलवाड़ा
☐ राजसमंद
☐ सिरोही
☐ डूंगरपुर
☐ जालौर
☐ बांसवाड़ा
☐ पाली
☐ श्रीगंगानगर
☐ प्रतापगढ़
☐ सवाई माधोपुर
☐ बाड़मेर
☐ चित्तौड़गढ़
☐ झालावाड़
☐ बूंदी
☐ दौसा
☐ करौली
☐ नागौर
☐ चुरू
☐ धौलपुर
☐ झुंझुनूं
☐ हनुमानगढ़
☐ बीकानेर
☐ जोधपुर
☐ अलवर
☐ टोंक
☐ भरतपुर
☐ बारां

5. यह साक्षात्कार कहाँ लिया जा रहा है?* Tick only one box.

☐ अस्पताल में भर्ती लाभार्थी (मरीज़) के साथ

☐ लाभार्थी (मरीज़) को अस्पताल से छुट्टी मिलने के बाद, उनके घर पर

अनुमति

निर्देश - नीचे दिए गए परिचय को लाभार्थी के सामने इसकी संपूर्णता में पढ़ें।

नमस्कार। मेरा नाम XXX है और मैं चिरंजीवी योजना के साथ आपके अनुभव को समझने के लिए सेंटर फॉर रिसर्च इन स्कीम्स एंड पॉलिसीज (CRISP) के साथ काम कर रहा हूं। यह इंटरव्यू करीब 15-20 मिनट तक चलेगा। यदि आप प्रश्नों का उत्तर देना जारी नहीं रखना चाहते हैं तो हम साक्षात्कार के दौरान किसी भी बिंदु पर रुक सकते हैं। इस साक्षात्कार के दौरान एकत्र की गई किसी भी व्यक्तिगत जानकारी को कभी भी अनाम नहीं किया जाएगा। इस साक्षात्कार में एकत्र की गई जानकारी का उपयोग केवल अनुसंधान उद्देश्यों के लिए किया जाएगा। CRISP, आज या भविष्य में, आज आपकी भागीदारी के लिए किसी भी पारिश्रमिक का भुगतान करने का वादा नहीं करता है। किसी भी अन्य प्रश्न के मामले में, आप सुश्री आकांक्षा (+91 9940236829) या श्री दक्ष (+91 9772260555) से CRISP पर संपर्क कर सकते हैं।

निर्देश - प्रयास करें की रोगी को यह सब पूरी तरह समझ में आए। अगर जरूरत पड़े तो दुबारा पढ़ें। फिर रोगी से निम्नलिखित प्रश्न पूछें:

6. क्या आप इस अभ्यास के उद्देश्य और आपकी प्रतिक्रियाओं का उपयोग कैसे किया जाएगा को समझते हैं? Tick only one box.

☐ हाँ

☐ नहीं

7. क्या आप सर्वेक्षण शुरू करने के लिए अपनी सहमति देते है?* Tick only one box.

☐ हाँ (Skip to question 8)

☐ नहीं

लाभार्थी का विवरण

निर्देश - नीचे दिए गए सभी सवाल लाभार्थी के लिए हैं और उन्ही से पूछ कर भरें जाने चाहिए। अगर ऐसा संभव नहीं है और कोई और लाभार्थी की जगह उत्तर दे रहा है, तो ध्यान रखें की सारे सवाल लाभार्थी के लिए हैं और उन्ही के नजरिए से भरे जाने चाहिए।

8. लाभार्थी का नाम और फ़ोन नंबर *

यह प्रश्न पूछते समय कृपया स्पष्ट करें कि इसे किसी के साथ साझा नहीं किया जाएगा

_____

9. आपकी (लाभार्थी की) आयु कितनी है? *

_____

10. आप (लाभार्थी) किस लिंग से पहचान रखते हैं? * *Tick only one box.*

☐ पुरुष

☐ महिला

☐ अन्य

11. आपकी (लाभार्थी की) वैवाहिक स्थिति क्या है * *Tick only one box.*

☐ कभी शादी नहीं की ☐ अभी शादीशुदा हैं

☐ विधवा ☐ तलाकशुदा/अलग

12. आपकी (लाभार्थी की) शिक्षा का उच्चतम स्तर क्या है? * *Tick only one box.*

☐ साक्षर नहीं ☐ डिप्लोमा

☐ प्राथमिक से नीचे ☐ स्नातक

☐ प्राथमिक ☐ स्नातकोत्तर और उससे ऊपर

☐ उच्च प्राथमिक/माध्यमिक ☐ औपचारिक स्कूली शिक्षा के बिना साक्षर

☐ उच्चतर माध्यमिक

13. आपका (लाभार्थी का) निवास का क्षेत्र कहाँ है? * *Tick only one box.*

☐ ग्रामीण इलाके में

☐ शहरी इलाके में

14. आपने (लाभार्थी ने) योजना में पंजीकरण कब करवाया था? * (निर्देश - अगर लाभार्थी को तारीख याद न हो तो पंजीकरण के महीने की पहली तारीख भर दें)

_____

Example: January 7, 2019

15. आपने (लाभार्थी ने) पंजीकरण के बाद से कितनी बार योजना का लाभ उठाया है? *

_____

16. पिछले 365 दिनों के दौरान आपने सभी घरेलू सदस्यों के लिए चिकित्सा बीमा प्रीमियम की कितनी राशि का भुगतान किया है?

_____

योजना में उठाए जाने वाले लाभ की जानकारी (1)

निर्देश - नीचे दिए गए सभी सवाल लाभार्थी के लिए हैं और उन्ही से पूछ कर भरें जाने चाहिए। अगर ऐसा संभव नहीं है और कोई और लाभार्थी की जगह उत्तर दे रहा है, तो ध्यान रखें की सारे सवाल लाभार्थी के लिए हैं और उन्ही के नजरिए से भरे जाने चाहिए।

17. क्या आपको योजना के लिए पंजीकरण करते समय किसी कठिनाई का सामना करना पड़ा? * Tick only one box.

☐ हाँ Skip to question 18

☐ नहीं Skip to question 19

पंजीकरण करते समय कठिनाई

18. योजना के लिए पंजीकरण करते समय आपको किन कठिनाइयों का सामना करना पड़ा? *

Check all that apply.

☐ पता नहीं था कि कहां रजिस्ट्रेशन कराना था

☐ पता नहीं था कि कब रजिस्ट्रेशन कराना था

☐ रजिस्ट्रेशन का स्थान घर से बहुत दूर था

☐ रजिस्ट्रेशन के दौरान कोई मदद करने वाला नहीं था

☐ रजिस्ट्रेशन के लिए उचित दस्तावेज नहीं थे

☐ Other: _____

योजना में उठाए जाने वाले लाभ की जानकारी (2)

निर्देश - नीचे दिए गए सभी सवाल लाभार्थी के लिए हैं और उन्ही से पूछ कर भरें जाने चाहिए। अगर ऐसा संभव नहीं है और कोई और लाभार्थी की जगह उत्तर दे रहा है, तो ध्यान रखें की सारे सवाल लाभार्थी के लिए हैं और उन्ही के नजरिए से भरे जाने चाहिए।

19. क्या आपने अस्पताल में भर्ती होने से पहले किसी डॉक्टर से सलाह ली थी? *

Tick only one box.

☐ हाँ

☐ नहीं

20. आप इलाज के लिए कितने दिनों से अस्पताल में भर्ती हैं/थे?*

_____

21. क्या इलाज सरकारी या निजी सूचीबद्ध अस्पताल में लिया जा रहा है/था ? *

Tick only one box.

☐ सरकारी अस्पताल/सुविधा

☐ निजी अस्पताल/सुविधा

22. हॉस्पिटल का नाम क्या है/था? *

_____

23. क्या आपको इलाज का खर्च उठाने के लिए अपनी जेब से कोई पैसा देना पड़ा? *

Mark only one oval.

☐ हाँ Skip to question 24

☐ नहीं Skip to question 25

इलाज के खर्च की जानकारी

24. इलाज के लिए आपको अपनी जेब से कितने पैसे देने पड़े? *

_____

इलाज के अलावा खर्च की जानकारी

25. डॉक्टर या सर्जन शुल्क (अस्पताल के कर्मचारी / अन्य विशेषज्ञ) के रूप में आपको (या परिवार वालों को) अपनी जेब से कितना भुगतान करना पड़ा है/था? *

_____

26. दवाइयों के रूप में आपको अपनी (या परिवार वालों की) जेब से कितना भुगतान करना पड़ा है। था? *

_____

27. नैदानिक जांच (Diagnostic test) स्कैन, ब्लड टेस्ट, इत्यादि के रूप में आपको (या परिवार वालों को) अपनी जेब से कितना भुगतान करना पड़ा है/था?

_____

28. बिस्तर शुल्क (Bed charges) के रूप में आपको अपनी (या परिवार वालों की) जेब से कितना भुगतान करना पड़ा है/था?

_____

29. अन्य चिकित्सा खर्चों के लिए (परिचर शुल्क, फिजियोथेरेपी, व्यक्तिगत चिकित्सा उपकरण, रक्त, ऑक्सीजन, आदि) के रूप में आपको (या परिवार वालों को) अपनी जेब से कितना भुगतान करना पड़ा है/था?

_____

30. आपके लिए परिवहन के रूप में आपको (या परिवार वालों को) अपनी जेब से कितना भुगतान करना पड़ा है/था?

_____

31. घर द्वारा किए गए अन्य गैर-चिकित्सा ख़र्च (पंजीकरण शुल्क, भोजन, दूसरों के लिए परिवहन, एस्कॉर्ट पर खर्च, आवास शुल्क यदि कोई हो, आदि) के रूप में आपको (या परिवार वालों को) अपनी जेब से कितना भुगतान करना पड़ा है/था?

_____

योजना में उठाए जाने वाले लाभ की जानकारी (3)

32. योजना का लाभ प्राप्त करने की प्रक्रिया का विस्तार में वर्णन कीजिए। * कम से कम 2-3 वाक्यों (लाइन) में

_____

_____

_____

33. क्या आपको योजना के तहत लाभ प्राप्त करने में किसी कठिनाई का सामना करना पड़ा? *

Tick only one boxl.

☐ हाँ Skip to question 34

☐ नहीं Skip to question 35

योजना के तहत लाभ प्राप्त करने में कठिनाई

34. योजना के तहत लाभ प्राप्त करते समय आपको किन कठिनाइयों का सामना करना पड़ा? *
Check all that apply.

☐ सुविधा पर विशेष पैकेज उपलब्ध नहीं था

☐ बिना जेब से खर्च के लाभ नहीं मिला

☐ अस्पताल अधिकारियों द्वारा लाभ कैसे उठाया जाए, इस पर कोई मार्गदर्शन नहीं था

☐ अस्पताल में आने के समय पूरी जानकारी नहीं दी गई

☐ अस्पताल में बुरा व्यवहार किया गया

☐ Other: _____

योजना में उठाए जाने वाले लाभ की जानकारी (4)

35. क्या आप जानते हैं कि इस योजना में आपके इलाज के लिए कितना पैसा कवर किया जा रहा है। था? *
Tick only one box.

☐ हाँ Skip to question 36

☐ नहीं Skip to question 37

योजना में इलाज के लिए कवरेज

36. आपके इलाज के लिए योजना ने कितना पैसा कवर किया जा रहा है/थे? *

_____

योजना में उठाए जाने वाले लाभ की जानकारी (5)

37. यदि चिरंजीवी योजना न होती तो क्या आप यह इलाज करा पाते? *

Tick only one box.

☐ हाँ Skip to question 38

☐ नहीं Skip to question 39

योजना के अलावा इलाज खर्च का ज़रिया

38. यदि योजना के माध्यम से नहीं, तो आप इलाज के लिए भुगतान किस प्रकार से करते/किया ? *

Check all that apply.

☐ व्यक्तिगत घर की बचत

☐ परिवार के सदस्यों से या दोस्तों से उधार लिया होता

☐ बाहर से कर्ज लिया होता

☐ भौतिक संपत्ति की बिक्री

☐ Other: _____

सामान्य प्रश्न

39. आपके नजरिए में योजना को लाभार्थियों के लिए और अधिक सुलभ कैसे बनाया जा सकता है? *

_____
_

_____
_

_____
_

40. क्या आप योजना के अंतर्गत विभिन्न बीमा पैकेजों के बारे में जानते हैं? * Tick only one box.

☐ हाँ

☐ नहीं

41. क्या आप योजना के संबंध में कोई अन्य प्रतिक्रिया देना चाहते हैं? *

_____

_____

_____

42. इस योजना का उपयोग किस बीमारी/उपचार के लिए किया गया है/था? * पैकेज कोड लिखें

_____

धन्यवाद

मुझसे अपने चिरंजीवी योजना के अनुभव को बताने के लिए धन्यवाद। यह इंटरव्यू यहीं खतम होता है। किसी भी अन्य प्रश्न के मामले में, आप CRISP में सुश्री आकांक्षा (+91 9940236829) या श्री दक्ष (+91 9772260555) से संपर्क कर सकते हैं। नमस्कार।

Survey tool: Swasthya Margadarshak

चिरंजीवी मूल्यांकन - स्वास्थ्य मार्गदर्शक

साक्षात्कारकर्ताओं (Interviewers) के लिए:

1. कोशिश करें और सुनिश्चित करें कि स्वास्थ्य मार्गदर्शक का साक्षात्कार लेते समय कोई अस्पताल प्रशासक या अन्य आधिकारिक कर्मचारी मौजूद न हो। यदि ऐसे व्यक्ति मौजूद हैं, तो कृपया विनम्रतापूर्वक उन्हें साक्षात्कार की अवधि के लिए कमरे से बाहर जाने के लिए कहें।
2. यदि संभव हो, तो कृपया डेटा को सीधे Google फॉर्म में भरें, उत्तरों को कागज पर लिखने और बाद में उन्हें फॉर्म में डालने से बचें। यदि संभव नहीं है, तो कृपया उत्तरों को यथाशीघ्र फ़ॉर्म में अपलोड करें ताकि यह सुनिश्चित हो सके कि उत्तर यथासंभव सटीक हों।
3. किसी भी परिस्थिति में साक्षात्कारकर्ताओं को स्वास्थ्य मार्गदर्शक की सहमति के बिना स्वास्थ्य मार्गदर्शक की ओर से जानकारी भरने की अनुमति नहीं है। यह न केवल फॉर्म शुरू करने के लिए, बल्कि फॉर्म के अंदर किसी अन्य फ़ील्ड के लिए भी लागू होता है।
4. आपके द्वारा भरे गए फॉर्म की संख्या आपके नाम और फोन नंबर के जरिए ट्रैक की जाएगी। कृपया सुनिश्चित करें कि आप पूरे सर्वेक्षण के दौरान अपने नाम की सही स्पेलिंग दर्ज करें और केवल एक फ़ोन नंबर दर्ज करें।
5. किसी भी प्रश्न या विवाद के मामले में, कृपया तत्काल सहायता के लिए सुश्री आकांक्षा (+91 9940236829) या श्री दक्ष (+91 9772260555) को कॉल करें।

परिचय एवं सहमति प्रपत्रः

नमस्ते। मेरा नाम XXX है और मैं चिरंजीवी योजना के साथ आपके अनुभव को समझने के लिए सेंटर फॉर रिसर्च इन स्कीम्स एंड पॉलिसीज (CRISP) के साथ काम कर रहा हूं। यह साक्षात्कार लगभग 15-20 मिनट तक चलेगा और मैं आपके बारे में कोई भी व्यक्तिगत या पहचान संबंधी जानकारी दर्ज नहीं करूंगा। यदि आप चाहते हैं कि प्रश्नों का उत्तर देना जारी न रखें तो हम साक्षात्कार के दौरान किसी भी समय रुक सकते हैं। इस साक्षात्कार में एकत्र की गई जानकारी का उपयोग केवल शोध उद्देश्यों के लिए किया जाएगा। CRISP आपकी आज की भागीदारी के लिए आज या भविष्य में कोई पारिश्रमिक देने का वादा नहीं करता है। किसी भी अन्य प्रश्न के मामले में, आप CRISP से जुड़े हुए सुश्री आकांक्षा (+91 9940236829) या श्री दक्ष (+91 9772260555) से संपर्क कर सकते हैं।

*Indicates required question.

सर्वेक्षक का विवरण

1. सर्वे करने वाले का नाम *

_____

2. सर्वे करने वाले का फोन नंबर *

_____

3. संभाग * *Tick only one box.*

☐ अजमेर ☐ जोधपुर

☐ भरतपुर ☐ कोटा

☐ बीकानेर ☐ उदयपुर

☐ जयपुर

4. ज़िला * *Tick only one box.*

☐ अजमेर
☐ कोटा
☐ उदयपुर
☐ जयपुर
☐ जैसलमेर
☐ भीलवाड़ा
☐ राजसमंद
☐ सिरोही
☐ डूंगरपुर
☐ जालौर
☐ बांसवाड़ा
☐ पाली
☐ श्रीगंगानगर
☐ प्रतापगढ़
☐ सवाई माधोपुर
☐ बाड़मेर
☐ चित्तौड़गढ़
☐ सीकर
☐ झालावाड़
☐ बूंदी
☐ दौसा
☐ करौली
☐ नागौर
☐ चुरू
☐ धौलपुर
☐ झुंझुनूं
☐ हनुमानगढ़
☐ बीकानेर
☐ जोधपुर
☐ अलवर
☐ टोंक
☐ भरतपुर
☐ बारां

5. हॉस्पिटल का नाम *

_____

6. क्या उत्तरदाता ने सर्वेक्षण शुरू करने के लिए अपनी सहमति दे दी है?* *Tick only one box.*

☐ हाँ

☐ नहीं

लाभार्थी का विवरण

7. उत्तरदाता का नाम और फ़ोन नंबर *

_____

8. कृपया योजना के अंतर्गत एक स्वास्थ्य मार्गदर्शक के रूप में अपनी भूमिका का वर्णन करें? *

_____

_____

_____

9. क्या आपको इस भूमिका के लिए कोई औपचारिक प्रशिक्षण प्रदान किया गया है? *

Tick only one box.

☐ हाँ

☐ नहीं

10. मरीज़ आपसे कैसे संपर्क करते हैं? हमें बताएं कि आप मरीजों को योजना का लाभ दिलाने में कैसे मदद करते हैं? *

_____

_____

_____

11. क्या योजना का लाभ उठाने के लिए मरीजों को आपको दस्तावेज दिखाने होंगे? *

Tick only one boxl.

☐ हाँ

☐ नहीं Skip to question 13

12. योजना का लाभ उठाने के लिए मरीजों को आपको कौन से दस्तावेज दिखाने होंगे? *

Tick only one box.

☐ आधार कार्ड

☐ भामाशाह कार्ड

☐ अन्य (कृपया निर्दिष्ट करें)

☐ Other: _____

13. क्या योजना का लाभ लेने से पहले मरीजों को किसी दस्तावेज़ पर हस्ताक्षर करने होंगे? *

Tick only one box.

☐ हाँ

☐ नहीं

14. योजना के लाभार्थियों के मन में योजना के संबंध में सबसे आम प्रश्न क्या हैं? *

_____

_____

_____

15. योजना के संबंध में लाभार्थियों को आमतौर पर किन चुनौतियों का सामना करना पड़ता है? *

_____

_____

_____

16. जब कोई गैर-लाभार्थी योजना का लाभ लेने के लिए आपसे संपर्क करता है तो आप क्या करते हैं?

*Tick only one box. **

☐ उन्हें बताते हैं कि वे पंजीकृत नहीं हैं और उन्हें वापस भेज देते हैं

☐ उन्हें बताते हैं कि वे पंजीकृत नहीं हैं और उन्हें पंजीकरण करने के तरीके के बारे में जानकारी प्रदान करते हैं

☐ उन्हें बताते हैं कि वे पंजीकृत नहीं हैं और उन्हें मौके पर ही पंजीकृत करते हैं।

☐ अन्य (कृपया निर्दिष्ट करें)

☐ Other:

17. इस योजना का लाभ उठाने में नागरिकों की बेहतर सहायता के लिए आपको किस प्रकार की तैयारी की आवश्यकता है? *

_____

_____

_____

18. योजना को और कैसे बेहतर बनाया जा सकता है? *

_____

_____

_____

धन्यवाद

मुझसे अपने चिरंजीवी योजना के अनुभव को बताने के लिए धन्यवाद। यह इंटरव्यू यहीं खतम होता है। किसी भी अन्य प्रश्न के मामले में, आप CRISP में सुश्री आकांक्षा (+91 9940236829) या श्री दक्ष (+91 9772260555) से संपर्क कर सकते हैं। नमस्कार।

Chiranjeevi Hospital Administrator Interviews

Please record all observations in detail. Contact the respective team for any queries or clarifications.

*Indicates required question.

1. Email *

_____

2. District*

_____

3. Name of the hospital (with address)*

_____

_____

4. Bed capacity of the hospital*

_____

5. Since when has the hospital been empanelled in Chiranjeevi? *

Mention Month and Year

_____

6. Name of the respondent *

_____

7. Designation of the respondent *

_____

Detailed questions regarding the scheme

8. Describe your interactions with stakeholders of the scheme? *

(other stakeholders in the scheme are beneficiaries, Swasthya Margadarshak, insurance group, district and state government administration, NHA, NGOs)

_____

_____

9. According to you, is the scheme helping patients? If so, how? If not, why not? *

_____

_____

10. What are your thoughts about the coverage of the scheme in terms of the treatments under its ambit? Are these helpful to the patients? *

_____

_____

11. What are your thoughts about the compensation received by the hospital for treatments under this scheme? *

(Aim of the question is to understand if the compensation/rates are too low for procedures)

_____

_____

12. How is the claims submission process for reimbursement? *

_____

_____

13. Are there delays in payment release? *

_____

_____

Challenges and Recommendations

14. Are there specific pain points or challenges in the scheme that you want to see resolved? *

_____

_____

15. How can the scheme be better integrated/streamlined to ensure smooth functioning? *

_____

_____

Additional Incentive

16. Is the hospital receiving any additional incentive? If yes, under which category? *

Tick only one box.

☐ Not receiving any incentive

☐ NABH Accreditation

☐ NQAS Certification

☐ Running PG/ DNB courses

☐ Aspirational district

17. How is the additional incentive being utilised by the hospital administration?

_____

_____

Type of facility

18. Type of facility* *Tick only one box.*

☐ Government facility in a Rural Area Skip to question 22

☐ Government facility in an Urban Area Skip to question 22

☐ Private facility in a Rural Area Skip to question 19

☐ Private facility in an Urban Area Skip to question 19

For Private Hospitals

19. For the same package, is there any difference in charges between the package rate paid by non-scheme beneficiaries and that reimbursed to you by Chiranjeevi? How large is the difference? *

_____

_____

20. What has been the impact of Chiranjeevi on hospital charges - whether the rates have increased or decreased? *

_____

_____

21. Are you satisfied with the processing of the claims? Elaborate. *

_____

_____

Skip to question 26

For Government Hospitals

22. Do you get any additional funds linked to the number of patients treated under Chiranjeevi?

Tick only one boxl. *

☐ Yes

☐ No

23. If yes, is there flexibility or discretion in expenditure with the hospital? Elaborate on how the expenditure is made.

_____

24. Given that many private hospitals have been enrolled into the scheme, what has been the effect on following: (pre and post Chiranjeevi in government hospitals) *

1. Patient load

2. Fund availability in the case that designated funds are provided for Chiranjeevi

3. Medicine availability

4. Workload and staff availability

Record observations for each point separately.

_____

_____

25. Has the introduction of the scheme affected the commitment or quality of service of doctors in the govt hospitals? *

(applicable if the same doctors also work with private hospitals which are empanelled under the scheme)*

_____

_____

Comments of the respondents and surveyors

26. Any additional comments by the Respondent Not otherwise covered in the questions asked

_____

_____

27. Any additional comments or observations by the Surveyor Not otherwise covered in the questions asked

Annexure 4

राजस्थान सरकार

राजस्थान स्टेट हैल्थ एश्योरेन्स एजेन्सी

(चिकित्सा, स्वास्थ्य एवं परिवार कल्याण सेवाएं)

आर.टी,डी.सी. मुख्यालय (स्वागतम होटल परिसर) रेल्वे स्टेशन, जयपुर

क्रमांक एफ.04(05)/आर.एस.एच.ए.ए./पॉलिसी/अध्ययन/2023/3357 दिनांक: 24.08.23

नोडल अधिकारी,
सम्बद्ध निजी एवं राजकीय अस्पताल,
मुख्यमंत्री चिरंजीवी स्वास्थ्य बीमा योजना,
राजस्थान।

विषयः CRISP संस्था द्वारा मुख्यमंत्री चिरंजीवी स्वास्थ्य बीमा योजना के मूल्यांकन/सर्वे के कम में।

Centre for Research in Schemes and Policies (CRISP) संस्था द्वारा मुख्यमंत्री चिरंजीवी स्वास्थ्य बीमा योजना के मूल्यांकन का कार्य किया जाना है, जिसके लिए उनके प्रतिनिधियों द्वारा योजना से सम्बद्ध अस्पतालों से (संलग्न सूची अनुसार) आवश्यक जानकारी एकत्र की जायेगी। उक्त संदर्भ में संस्था के प्रतिनिधियों को आवश्यक सहयोग प्रदान करना सुनिश्चित करें।

संलग्नः उपरोक्तानुसार।

(डॉ. गौरव सैनी)
संयुक्त मुख्य कार्यकारी अधिकारी
राजस्थान स्टेट हैल्थ एश्योरेंस एजेंसी

क्रमांक एफ.04(05)/आर.एस.एच.ए.ए./पॉलिसी/अध्ययन/2023/3357 दिनांक: 24.08.23

प्रतिलिपी निम्न को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित है–

1. निजी सहायक, मुख्य कार्यकारी अधिकारी, आरएसएचएए, राजस्थान सरकार।
2. मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, समस्त जिलें।
3. जिला कार्यक्रम समन्वयक, एमएमसीएसबीवाई, समस्त जिलें।
4. प्रभारी, सर्वर रूम को संबंधित को ई–मेल कराने हेतु।

संयुक्त मुख्य कार्यकारी अधिकारी
राजस्थान स्टेट हैल्थ एश्योरेंस एजेंसी

Sr.No	District	Hospital Type	Hospital Name	Hospital Address	Name Of Nodal Officer	Nodal Officer Mobile Number
1	Ajmer	GOVERNMENT	CHC HARMADA	CHC HARMADA DIST AJMER RAJASTHAN	SHYAM SUNDAR BANSAL	9414435387
2	Ajmer	PRIVATE	JMD HOSPITAL AND RESERACH CENTER	near mission school , highway colony	Dr.Y.K.KHANNA	9829071475
3	Ajmer	PRIVATE	ST FRANCIS HOSPITAL	ST FRANCISH HOSPITAL BEAWAR ROAD AJMER	Dr. Sr. MALTI BUNDELA	9414017592
4	Alwar	GOVERMENT	GOVT SATELLITE HOSPITAL KHAIRTHAL	AMBEDKAR CIRCLE NEAR HARSOLI ROAD KHAIRTHAL	NARENDRA SINGH	9509508886
5	Alwar	PRIVATE	Global Hospital	103 Scheme No 2 Alwar	Avinash MITTAL	9829258825
6	Alwar	PRIVATE	SRI KRISHNA HOSPITAL	148 149 BHAGAT SINGH COLONY BHIWADI ALWAR RAJASTHAN	DR PRAVEEN	9352156225
7	Banswara	GOVERNMENT	COMMUNITY HEALTH CENTER BADREL	CHC BADREL	DR SARVESH YOGI	8104325865
8	Banswara	GOVERMENT	COMMUNITY HEALTH CENTER KUSHALGARH	CHC KUSHALGARH	DR MAZHAR HUSSAIN	9413625244
9	Banswara	PRIVATE	GYAYAK HOSPITAL PVT LTD	Gyayak Shopping Centre, 40 Industrial Area, Dahod Road	Dr Shrayansh Shah	9672972905
10	Baran	GOVERNMENT	Community Health Centre Chhipabarod	Near Govt Danmal School Chhipabarod	Dr. Hemant Nagar	9610699585
11	Baran	GOVERNMENT	govt chc harnawada shahji	harnawada shahji	Dr Deepesh tiwari	8890617613
12	Baran	PRIVATE	RADHA KISHAN MEMORIAL HOSPITAL	opposite forest department kota road baran	Dr. Jitendra Sharma	7014416205
13	Barmer	GOVERNMENT	COMMUNITY HEALTH CENTER KAWAS	KAWAS	DR. NAVRATAN	9643592322
14	Barmer	PRIVATE	DHANWANTRI HOSPITAL AND MULTISPECIALITY	NEAR ICICI BANK, NEHRU NAGAR BARMER	Dr ROOPA RAM	7023453613
15	Barmer	PRIVATE	HITKARI HOSPITAL	NEAR MTM SCHOOL , BALOTRA	HITKARI HOSPITAL	9828412100
16	Bharatpur	GOVERNMENT	COMMUNITY HEALTH CENTER KUMHER	DEEG ROAD KUMHER	DR.KAUSHAL JOSHI	9694603072
17	Bharatpur	GOVERNMENT	CHC GOPALGARH	GOPALGARH	AMIT CHAUDHARY	9887015589
18	Bharatpur	PRIVATE	R. K. Hospital And Research Center	Civil Lines Damdama Road Bayana	Dr. Manoj Kumar	8769378946
19	Bhilwara	GOVERNMENT	GOVT COMMUNITY HEALTH CENTRE MAHUWA	CHC MAHUA TEH MANDALGARH DIST BHILWARA	DR AVINASH LAKHIWAL	9261152860
20	Bhilwara	PRIVATE	BRIJESH BANGER MEMORIAL HOSPITAL	RC VYAS COLONY BHILWARA	GAYATRI CHOUDHARY	9116743111
21	Bhilwara	PRIVATE	SHREE SIDDHI VINAYAK HOSPITAL	11E 17/18 Kota Road Tilak Nagar		9352340396
22	Bikaner	GOVERNMENT	SUPER SPECIALITY BLOCK SPMC BIKANER	SUPER SPECIALITY BLOCK SARDAR PATEL MEDICAL COLLEGE BIKANER	Tushar Bhatnagar	7023266560
23	Bikaner	PRIVATE	Apex Hospital Bikaner	Rani Bazar, Bikaner, Rajasthan 334001	Dr Shailesh Jhawar	8890538289
24	Bikaner	PRIVATE	Jeevan Raksha Hospital	A 156, SARDUL GANJ	Dr praveen chhimpa	9414504746
25	Bundi	GOVERNMENT	comunity health centre Talera	main road talera	Dr. Brij Mohan Malav	9414489175
26	Bundi	GOVERNMENT	COMMUNITY HEALTH CENTER KARWAR	CHC KARWAR DIST BUNDI RAJ	Dr. RAGHUVEER SINGH	9460944744
27	Bundi	PRIVATE	Anurag Nursing Home	Near Drizzali Resort Chatarpura Road Bundi Rajasthan	Dr Madhusudan Sharma	9829035666
28	Chittaurgarh	GOVERNMENT	SUB DISTRICT HOSPITAL	SDM OFFICE KE SAMNE UDAIPUR ROD NIMBAHERA	DR SURESH VEERWAL	7340060777
29	Chittaurgarh	PRIVATE	Om Multispeciality Hospital	Piplikhera Chittor Road Bengu CHittorgarh	Dr Lakhan Pratap Meena	8955774736
30	Chittaurgarh	PRIVATE	RAJASTHAN HOSPITAL	Opp Panchayat bhavan chittorh road Bassi	Dr prakash chand sahu	8233332510
31	Churu	GOVERNMENT	Community Health Centers SALASAR	VPO SALASAR	DR SANJAY JYANI	7665697545
32	Churu	PRIVATE	SMTSHEELAGOYALMEMORIALHEARTANDGENRALHOS	FRONT OF SHREE RAM MANDIR CHURU RAJASTHAN	DR PAWAN PRAKASH GOYAL	9414254745
33	Churu	PRIVATE	SANJIVANI HOSPITAL	Rajgarh Road Taranagar Churu 331304	Dr Ramesh Kumar	9729956801
34	Dausa	GOVERNMENT	COMMUTITY HEALTH CENTER ABHANERI	CHC ABHANERI	DR KAPIL DEV MEENA	9413066651
35	Dausa	GOVERNMENT	CHC BADAGAONV	BADA GAON	DR RAJESH SINGH NAT	6350091338
36	Dausa	PRIVATE	NAVJEEVAN HOSPITAL	GANGAPUR ROAD	dr bhagirath meena	9414078015
37	Dhaulpur	GOVERNMENT	GENERAL HOSPITAL	BASERI BUS STAND BARI	DR RAJIV GOYAL	7821977815
38	Dhaulpur	GOVERNMENT	SHID RAGHVENDRA SINGH PARIHAR CHC RAJAK	PULISH STATION KE PAS RAJAKHERA DHOLPUR	DR SHIV SINGH MEENA	8107435121
39	Dhaulpur	PRIVATE	ayushman hospital	near ghantaghar gaurav path,	Dr Rajesh Goyal	7014603362
40	Dungarpur	GOVERNMENT	community health center GALIYAKOT	GALIYAKOT DUNGARPUR	DR MAHENDRA SINGH JAKHAR	9829910885
41	Dungarpur	GOVERMENT	SHREE HARIDEV JOSHI GENERAL HOSPITAL	district general hospital dungarpur	DR.AJESH KUMAR DAMOR	9414808041

42	Dungarpur	PRIVATE	SIDDHI VINAYAK MULTISPECIALITY HOSPITAL	OPP POOJA PAINTS MEHTA COLONY ASPUR	DR. SWAMBHU NATH AJAY	8789420764
43	Ganganagar	GOVERNMENT	chc gharsana	Tehsil Road, Government hospital, new mandi gharsana	Dr. bhagirath bajiya	7014431545
44	Ganganagar	GOVERNMENT	Community Health Center Padampur	MAIN MARKET PADAMPUR DIST SRI GANGNAGAR	Dr Virendra Singh	9854800006
45	Ganganagar	PRIVATE	SHREE BALA JI HOSPITAL	ward no1 behind water box raisinghnagar	DR VIJAY N BHATNAGAR	9887812029
46	Hanumangarh	GOVERNMENT	MAHATAMA GANDHI MEMORIAL GOVT DIST HOSPI	Near New Grain Merchant Tibbi Road Hanumangarh town	drvinod saharan	7014162187
47	Hanumangarh	GOVERNMENT	CHC GOGAMERI	MAIN BUS STAND GOGAMERI	DR SANDEEP	9782823582
48	Hanumangarh	PRIVATE	Beniwal ortho and maternity hospital	Adrash enclave 2nd, byepass road, Hanumangarh, town	Dr. Abhineet	8824470001
49	Jaipur1	GOVERNMENT	ZENANA HOSPITAL JAIPUR	CHANDPOL ZENANA HOSPITAL JAIPUR	DR. AJAY KUSHWA	8561999099
50	Jaipur1	GOVERNMENT	COMMUNITY HEALTH CENTRE GOVINDGARH	NATIONAL HIGHWAY 52, OPPOSITE POLICE SATION,GOVINDGARH	DR RAMDHAN JAT	9928957301
51	Jaipur1	PRIVATE	DR CHAUHAN ORTHOPAEDIC CENTRE	behind ambabari petrol pump ashok vihar jhotwara road	DR A S CHAUHAN	9828225270
52	Jaipur2	GOVERNMENT	RUHS HOSPITAL OF MEDICAL SCIENCES	Sec 18 Pratapnagar, Rana sanga marg Jaipur	Dr Shiv Prakash Sharama	9413489172
53	Jaipur2	GOVERNMENT	COMMUNITY HEALTH CENTER PHULERA	JOBNER ROAD PHULERA	DR.RAMBABU GURJAR	9462099902
54	Jaipur2	PRIVATE	ADVANCED NEUROLOGY AND SUPERSPECIALITY	D 357 358 MALVIYA NAGAR	DR SUNIT SHAH	9829059370
55	Jaisalmer	GOVERNMENT	CHC BHANIYANA	VP BHANIYANA TEH BHANIYANA	DR. LONG MOHMAD	8619527386
56	Jaisalmer	PRIVATE	SHRI MAHESHWARI HOSPITAL AND RESEARCH CE	NEAR UNIUN CIRCLE, BARMER ROAD, JAISALMER	DR UMAID SINGH SODHA	9414700537
57	Jaisalmer	PRIVATE	Priya Hospitals And Research Center P Lt	Plot No 116/117, C V Singh Colony, Jaisalmer	Dr. Prakash Chandra Garg	9414243353
58	Jalor	GOVERNMENT	COMMUNITY HEALTH CENTRE AHORE	MAIN ROAD GOVT HOSPITAL CHC AHORE	DR PURAN MAL MUNOT	9799373911
59	Jalor	PRIVATE	SHRI KUSHAL CINIC AND CHOUDHARY BHUPENDR	Raniwara Road, ricco road, near a railway crossing Bhinmal	Bhupendra Choudhary	9829792245
60	Jalor	PRIVATE	KRISHNA HOSPITAL	falna road ahore	DR.S NAINA	9413969774
61	Jhalawar	GOVERNMENT	COMMUNITY HEALTH CENTER RATLAI	COMMUNITY HEALTH CENTER RATLAI BLOCK BAKANI JHALAWAR RAJ	DR. PRIYANKA JAIN	8058608080
62	Jhalawar	GOVERMENT	Govt. Satellite Hospital Jhalrapatan	Satellite Hospital , Near Gindor Get, Jhalrapatan, Jhalawar	Dr Hari Prasad Luckwal	9950308267
63	Jhalawar	PRIVATE	ORTHOPEDIC TROUMA CENTRE	Khandiya chouraha Megh Highway Jhalaward	Dr Suresh	9251965348
64	Jhunjhunun	GOVERNMENT	GOVT. HOSPITAL CHC GUDHA GORJI	BHORKI ROAD, GUDHA GORJI	DR. SANJAY JANU	9269816477
65	Jhunjhunun	PRIVATE	AASTHA HOSPITAL	F 21 INDRA NAGAR JHUNJHUNU	DR ASHOK KUMAR CHAUDHARY	9414491098
66	Jhunjhunun	PRIVATE	BABY CARE AND CURE HOSPITAL	plot no 3 indra nagar	DR RAMRAKH	8094289964
67	Jodhpur	GOVERNMENT	CHC Shergarh	near govt senior sec school shergarh	dr ramprakash khoja	9928126669
68	Jodhpur	PRIVATE	GANGA HOSPITAL AND ORTHOPEDIC CENTER	PLOT NO 5 KHASARA NO 212 PAL BYE PASS	Dr. PREMARAM	8769077717
69	Jodhpur	PRIVATE	JIET Medical College And Hospital	JIET Universe NH 62 Jodhpur Pali Highway Village Mogra	Dr. Yash Mathur	8003933311
70	Karauli	GOVERNMENT	COMMUNITY HEALTH CENTER NADOTI	CHC NADOTI TEH NADOTI DIST KARAULI 322215	DR SHIV CHARAN MEENA	9982613558
71	Karauli	PRIVATE	BHAGWAN MAHAVEER HOSPITAL RESEARCH CENT	NEAR BRAHMAN DARAMSALA BAYANA ROAD HINDAUN CITY	DR. SAVITRI MEENA	9521516198
72	Karauli	PRIVATE	ESSAR MULTISPECIALITY HOSPITAL	Opp Roadways Bus stand, Gulab Bagh, Karauli 322241	Mr Pradeep Singh	9928195569
73	Kota	GOVERMENT	RAMPURA SATELLITE DISTRICT HOSPITAL	Rampura Bazar	Dr Vinit Choudhary	9414055345
74	Kota	GOVERNMENT	CHC RAMGANJMANDI	JULMI ROAD RAMGANJMANDI DIST KOTA RAJASTHAN	DR. GOVIND YADAV	9828489196
75	Kota	PRIVATE	UTKARSH HOSPITAL	5/8/11 MHAVEER NAGAR EXT KOTA	RAMESH CHANDRA DHAKARIYA	9414939287
76	Nagaur	GOVERNMENT	CHC RIYAN BADI	AJMER ROAD VPO RIYAN BADI TEH RIYAN BADI DIST NAGAUR	DR S R INANIYAN	9829953232
77	Nagaur	GOVERNMENT	GOVT COMMUNITY HEALTH CENTER NAWA CITY	MAIN MARKET NEAR SUBJI MANDI NAWA CITY	Dr VAKTA RAM CHOUDHARY	9928213889
78	Nagaur	PRIVATE	MAHADEV JANANA HOSPITAL	ABHINANDAN PLAZA, NEAR KANOI PARK DIDWANA ROAD KUCHAMAN CITY	DR DINESH KUMAR	7297982315
79	Pali	GOVERNMENT	Community Health Center	near Bus Stand, Bera	Jasa Ram	8302724446
80	Pali	PRIVATE	bone and joint spine hospital pali	surya colony pali	dr swai singh	9672980310
81	Pali	PRIVATE	OM HOSPITAL	8/9 NEAR BSNL GODOWN NAYA GAON ROAD PALI	DR MAHIPAL SHARMA	9414244844
82	Pratapgarh	GOVERNMENT	COMMUNITY HEALTH CENTRE MUNGANA	MUNGANA	DR JEEVRAJ MEENA	7726011625
83	Pratapgarh	GOVERNMENT	DISTRICT HOSPITAL PRATAPGARH	BANSWARA ROAD PRATAPGARH	DR. NANDLAL MEENA	7665426502

84	Pratapgarh	PRIVATE	SKY LIFELINE MULTISPECIALITY HOSPITAL	HAT SALAMGARH, ACHALPUR, NEAR BY RTO OFFICE, PRATAPGARH	MANU VERMA	8855907472
85	Rajasamand	GOVERNMENT	COMMUNITY HEALTH CENTER KURAJ	KURAJ	DR PRATEEK TIKKIWAL	9754029886
86	Rajasamand	PRIVATE	ANANTA INS OF MEDI SCI AND RC CENTRE	VILL KALIWAS TEH NATHDWARA DISTT RAJSAMAND	DR. BHAGWAN RAM VISHNOI	9772278633
87	Rajasamand	PRIVATE	BHAGWAN MAHAVEER HOSPITAL	INDRA PRASTH COLONY	BHUVNESH RAWKA	9829084080
88	Sawai Madhopur	GOVERNMENT	COMMUNITY HEALTH CENTER WAZIRPUR	PAREETA ROAD WAZIRPUR	DR RAMKHLADEE MEENA	9982159157
89	Sawai Madhopur	GOVERNMENT	CHC KHIRNI	khirni	Dr. Deepak mangal	9461292934
90	Sawai Madhopur	PRIVATE	RIYA HOSPITAL	saloda mode gangapur city	DR MAHENDRA MEENA	9414806888
91	Sikar	GOVERNMENT	COMMUNITY HEALTH CENTRE JEELO	COMMUNITY HEALTH CENTRE JEELO BLOCK NEEM KA THANA SIKAR	DR VINOD KUMAR	8502098182
92	Sikar	PRIVATE	JEEVAN REKHA HOSPITAL RESEARCH CENTRE	KHATRI MOD NEEM KA THANA SIKAR	DR MAMTA MEENA	9680789545
93	Sikar	PRIVATE	NOBLE CARE HOSPITAL	BUS DEPOT TIRAHA, SIKAR	DR. SANJEEV CHOUDHARY	7014784947
94	Sirohi	GOVERNMENT	Govt Medical College and Hospital Sirohi	PALACE ROAD SIROHI	DR. LITIN KHATRI	9687159233
95	Sirohi	GOVERNMENT	community health center swaroopganj	Near subhash circle swaroopganj tah pindwada dist sirohi raj	Dr Rajeev chauhan	7895883637
96	Sirohi	PRIVATE	SANJEEVANI HOSPITAL SIROHI	NEAR jilla urdhyog kendra sai nagar sirohi	dr sanjeev kumar jain	9887774300
97	Tonk	GOVERNMENT	Community Health Centre	near by bus stand, newai	Dr.shriram katariya	9511588326
98	Tonk	GOVERNMENT	CHC TODARAISINGH	WARD 11,TODARAISINGH	DR.NARENDRA SINGH BHALOT	9461671922
99	Tonk	PRIVATE	CHANDRABHAN HOSPITAL	NEAR MAIN POST OFFICE, SWAI MADHOPUR ROAD, TONK 304001	CHANDRABHAN JATAV	7597665869
100	Udaipur	GOVERMENT	COMMUNITY HEALTH CENTER MAVLI	FATEHNAGAR ROAD, AMLIYA BAG, CHC MAVLI	DR. BABU LAL ACHARYA	9309211292
101	Udaipur	PRIVATE	Geetanjali Medical College and Hospital	Geetanjali Medicity Hiran Magri Extn Manwakhera N H 8	Vinod Sharma	9829040199
102	Udaipur	PRIVATE	SHREE KANAK HOSPITAL MEDICAL RESEARCH	460 sector 3 hiranmagri main road opp reliance fresh UDR	DR AMIT DHING	9929702777

Annexure 5

राजस्थान सरकार

राजस्थान स्टेट हैल्थ एश्योरेन्स एजेन्सी

(चिकित्सा, स्वास्थ्य एवं परिवार कल्याण सेवाएं)

आर.टी.डी.सी. मुख्यालय (स्वागतम होटल परिसर) रेल्वे स्टेशन, जयपुर

क्रमांक एफ.04(05) आर एस एच ए ए / पॉलिसी अध्ययन / 2023 / 4316 दिनांक 13-10-2023

नोडल अधिकारी,
सम्बद्ध निजी एवं राजकीय अस्पताल,
मुख्यमंत्री चिरंजीवी स्वास्थ्य बीमा योजना,
राजस्थान।

विषयः CRISP संस्था द्वारा मुख्यमंत्री चिरंजीवी स्वास्थ्य बीमा योजना के मूल्यांकन सर्वे के कम में।
संदर्भः इस कार्यालय द्वारा पूर्व में जारी पत्र कमांक 3357 दिनांक 24.08.2023 के कम में।

Centre for Research in Schemes and Policies (CRISP) संस्था द्वारा मुख्यमंत्री चिरंजीवी स्वास्थ्य बीमा योजना के मूल्यांकन का कार्य किया जा रहा है, जिसके लिए संस्था के प्रतिनिधियों द्वारा योजना से सम्बद्ध चयनित अस्पतालों से आवश्यक जानकारी एकत्र की जा रही है।

इस कार्यालय द्वारा पूर्व में जारी उपरोक्त संदर्भित पत्र के कम में उल्लेखित अस्पतालो की सूची में से कुछ अस्पतालों के सस्पेंड होने/सर्वेक्षक द्वारा पहुंच में कठिनाई महसूस करने के कारण Centre for Research in Schemes and Policies (CRISP) संस्था द्वारा 13 अस्पतालों की सूची में संशोधन किया गया है।

उक्त 13 अस्पतालों की सूची संलग्न कर लेख है, कि संस्था के प्रतिनिधियों को आवश्यक सहयोग प्रदान करना सुनिश्चित करें।

संलग्नः उपरोक्तानुसार।

(डॉ. गौरव सैनी)
संयुक्त मुख्य कार्यकारी अधिकारी
राजस्थान स्टेट हैल्थ एश्योरेंस एजेंसी

क्रमांक एफ.04(05)/आर.एस.एच.ए.ए./पॉलिसी/अध्ययन/2023/4316 दिनांक: 13-10-2023

प्रतिलिपी निम्न को सूचनार्थ एवं आवश्यक कार्यवाही हेतु प्रेषित है–

1. निजी सहायक, मुख्य कार्यकारी अधिकारी, आरएसएचएए, राजस्थान सरकार।
2. मुख्य चिकित्सा एवं स्वास्थ्य अधिकारी, समस्त जिलें।
3. जिला कार्यक्रम समन्वयक, एमएमसीएसबीवाई, समस्त जिलें।
4. प्रभारी, सर्वर रूम को संबंधित को ई–मेल कराने हेतु।

संयुक्त मुख्य कार्यकारी अधिकारी
राजस्थान स्टेट हैल्थ एश्योरेंस एजेंसी

Sr.No	District	Hospital Type	Hospital Name	Hospital Address	Name Of Nodal Officer	Nodal Officer Mobile Number
1	Barmer	Private	Amar Hospital Advance Urosergical Center	Second Floor Arihant Tower Opposite Railway Station Barmer	Dr Pravin Choudhary	9784520734
2	Jalore	Private	NAVKAR MULTISPECIALITY	JODHPUR ROAD AHORE	DR SONAL KIRAN SONI	7045409075
3	Karauli	Private	BHARAT HOSPITAL AND MATERNITY CENTER	PLOT NO 9 GULAB BAGH KARAULI	VIJAY MALI	9782558051
4	Sirohi	Private	Gujrat Hospital	Near Power House, Bhatkara, Sirohi, Rajsthan	Dr.P.L.Desai	9427303989
5	Bundi	Government	GOVT HOSPITAL BUNDI	PMO OFFICE SAMANYA CHIKTSALYA	DR MAHENDRA CHOHAN	9829622856
6	Bundi	Government	CHC NAINWAN	CHC NAINWAN NAGAR ROAD NAINWAN	Dr.Laxmi Kant Nagar	9828537649
7	Dungarpur	Government	PANDIT DINDYAL UAPADHYAY	OPP MAHIPAL SCHOOL	DR YOGENDRA SAINI	8696440044
8	Dungarpur	Government	COMMUNITY HEALTH CENTRE ASPUR	ASPUR	ALANKAR GUPTA	9414759588
9	Ganganagar	Government	community health canter raisinghnagar	opp mini sec raisinghnagar	Dr kishan dan bithu	7877848966
10	Jaipur1	Government	Institute of Respiratory Disease	Shubhash Nagar sastri nagar jaipur	Dr. Govind Singh Rajawat	9214786952
11	Jodhpur	Government	CHC PIPAR CITY	CHC PIPAR CITY	Dr J.P. songara	8005868410
12	Pali	Government	Government Bangur District Hospital Pali	Govrnment Medical Collage Pali	Dr. Vipul Kumar Nagar	9414425968
13	Rajsamand	Government	chc devgarh	chc devgarh mela ground	Dr shantilal	9001691721

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