Learned preferences of health seeking Behaviour and utilization of RSBY card

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Abstract- Indian health scenario is known for the out of pocket expenditure and resultant poverty trap. Considering these situation, Government of India has launched Rashriya Swasthya Bima Yojana (RSBY) for addressing the health expenditure related with health seeking behaviour of the population especially the vulnerable sections. As the Indians health seeking behaviour is more prone to the private players, the RSBY scheme has included empanelled private players for rendering the health care service under the scheme. The researcher here examines the health seeking behaviour and preferences of the sample population before and after their enrollment to the RSBY scheme.

The Sendiri panchayat selected under the study is inhabited mostly by SC and OBC population. The researcher has taken 50 samples, which represent the BPL households of the panchayat. Interview schedule and observation methods are used to get data from the beneficiaries. Also interview with health professional and allied workers working in the villages and district health officials are conducted.

The findings throws light into the, disease pattern and prevalence in the panchayat, health seeking behaviour this BPL population before and after the health card, and learned preference for private or clinics hospitals etc. the highlight of the study is the prefernctial differences of people in choosing the private health care institutions instead of public health institutions in matters of health care choices and health seeking behaviour.

Index Terms- Learned preferences, health seeking behaviour, health insurance, out of pocket expenditure, health care institutions.

I. INTRODUCTION

WWO defines health as the physical, psychological, social and spiritual wellbeing of a person and not mere the absence of infirmity or diseases.[1] The right to health is an essential component of the quality of life of the citizens in any nations.

A developing nation like India has a major task in offering affordable health to its millions of people who belong to all strata of life. There is an ever-widening gap between 'haves' i.e. the minority population who has access to quality health services and can afford the consequent expenditure and 'have-nots' i.e. the majority population who have limited access to quality health services and often reach in the poverty of poverty through the consequent expenditure. As per the study of Peters, Yazbeck et al in 2002, the poorest people are on an average 2.6 % higher chances to forgo the medical treatment for illness.[2] Considering the dilemma, it is the duty of the welfare state to cater the health needs of the citizens.

In April 2008, GOI has introduced the Rashtriya Swasthya Bima Yojana – an insurance scheme for ensuring cashless treatment for In-patient health care services for the BPL sections of India. These measures are implemented to ensure the reduction of gap between the rich and poor in accessing costly and necessary treatment offered at secondary and tertiary level of health care.

As it is the 6th year of the implementation of the RSBY scheme across India, several reports and studies conducted by GOI, research groups and research scholars have acclaimed the success of the programme across different states. Here the researcher tries to analyze learned preferences of the community over their health seeking bahaviour and choices of treatment providers before and after the RSBY enrollment.

Health seeking behaviour of marginalized group: literature review

Previously government and other health providing agencies were of the hypothesis that the more the individual is informed of the illness and the health care facilities, the more the health seeking behaviour. Later, studies have highlighted the inherent and external components that influence the health seeking behaviour of the individuals as well as population.

Health seeking behaviour means the identification of pathways to the formal health care system.[3] Often it starts from traditional healers or local healers and in course of time, they reach at the formal system. This identification of pathways for health care is

[1] WHO, 1948. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[2] Peters, D H, A S Yazbeck et al (2002). Better Health Systems for India's Poor: Findings, Analysis, and Options, The World Bank, Washington, DC pp. i - 347.

[3] Grundy, J & Annear, P., (2010). Health-seeking behaviour studies: a literature review of study design and methods with a focus on Cambodia. In Health Policy And Health Finance Knowledge Hub, Number 7, October 2010, pp. 1-14

influenced by different components. According to Parson's theory of sick role (1951), the individual seeks to get out of his role of being sick, which is an undesirable state.[4] Andersen's Behavioral Model of Health Services Utilization in 1968[5] has described three categories of determinants such as predisposing characteristics, enabling characteristics and need based characteristics that contribute to the health seeking behaviour. In 1970, health system also added to it as the fourth determinant to health seeking behaviour. Later in 1978, Mechanic in his theory of help seeking behaviour described the psychological approach of individual involved in the health seeking behaviour.[6] The health belief model proposed by Rosenstock, Strecher & Becker in 1994 has described the four central variables in health seeking behaviour such as perceived susceptibility, perceived severity, perceived benefits and perceived cost.[7]

Health seeking bahaviour of the marginalized and utilization of the services within the existing government and private health service providers are always burning topics in academic field as well as among health advocacy groups and activists. The globalization has opened the box of opportunities in accessing and using highly effective and complex health care facilities in India. The rich and ever growing middle class in India has seen it as development and turned their attention to these facilities. On the other hand, the vulnerable population of India, which constitutes more than 60% of the population, has still preferred for quacks and local healers, village clinics etc. They found the new 'developments' in health care were unaffordable and would put them in the poverty trap if they approached it. This chasm between the perceptions and experiences of the vulnerable population and the utilization of available health resources has taken India in lagging position in matters of health scenario.

According to Achary & Ranson,[8] 5.1 percent of India's GDP spends on health care expenditure and its 82 per cent is from out of pocket expenditure. The hither to history shows the burden of health related out of pocket expenditure puts the rural and urban population in the trap of debt or losing all their savings. The recent years' evidence shows an increasing (80%) dependence on the private sector for outpatient care and it is largely due to the weakness in the delivery of public health services.[9]

Different studies on the health seeking behaviour of the marginalized sections of society reveals the factors that influences or hinders their choices, delays and influence the preferences in accessing or not accessing health care services. It includes indirect cost such as expenses on transport, food/stay, tips given to secure access to any person or facility, opportunity cost of lost wages of the sick as well as the accompanying person, etc associate with the illness (Sodani, 1997)[10], cost of services, proximity, convenience of timing and perceived quality of health services (Yesudian, 1999)[11], reputation of the provider, cost and physical accessibility (Ager, A. and Pepper, K., 2005)[12], lack of social space for the marginalized groups in the existing health sector from policy to implementation (Prasad, P. 2000)[13], macro environments such as local areas, districts, states (Gordon, D., Kelly, M., Subramanian, and Nandy, S., 2004)[14], price and distance to a health facility (Borah, B.J., 2006)[15], unequal power relations between systems of medicine and between givers and receivers (Prasad, P., 2007)[16], quality of services, behaviour of the health personnel (Baru ,R., Acharya , A., Acharyua, S., Kumar, S. and Nagraju, K., 2010)[17], acceptability and

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[8] Achary & Ranson, 2005. Health Care Financing for the Poor Community-based Health Insurance Schemes in Gujarat. In Economic and Political Weekly, Vol - XL No. 38, September 17, 2005, pp 4141-4150.

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accessibility of the services provided (Gurung, A., Narayanan, P., Prabhakar, P., et.al, 2011)[18], Micro-health insurance (Savitha,S. and Kiran, K., 2013)[19].

Among these factors, the role of health insurance as a resource in facilitating the health and health seeking behaviour of the marginalized group is worth investing. After the introduction of RSBY scheme, there were several studies which highlights the scheme as well as criticizing the need for strengthening primary health care rather than initiating insurance scheme. The present study is looking more into the changes of the health seeking behaviour of Sendiri group, a population which includes SCs, STs and OBCs, in pre and post enrollment period.

II. Research Methodology

General objective

- To study the health seeking behaviour of marginal sections (BPL sections) of Sendiri Panchayat before and after the RSBY scheme.

Specific Objective

- To study the basic profile of the Sendiri Panchayat
- To understand the major and minor disease pattern and prevalence in the panchayat
- To find out about the health seeking behaviour of the BPL sections of the panchayat before and after RSBY enrollment.
- To explain the learned preferences in the health seeking behaviour of the population for private health care institutions.

Profile of the panchayat

The researcher has selected Sendiri, a Gram Pachayath in Bilaspur with more than 7000 population. The study has conducted among 50 BPL household which represents 527 BPL households in the Panchayat. The SC group includes Satnamis, ST group involves Bhoi, The panchayat has got 1 PHC, 7 local healers and clinics, and 2 medical shops.

Caste, Class and Region. In Economic and Political Weekly, vol xlv no 38, September 18, 2010, pp. 49 – 58.

[18] Gurung, A., Narayanan, P., Prabhakar, P., et.al, (2011). Large-scale STI services in Avahan improve utilization and treatment seeking behaviour amongst high-risk groups in India: an analysis of clinical records from six states. Retrieved the abstract from http://www.biomedcentral.com/1471-2458/11/S6/S10 on 15/02/2014.

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Location of the study

Operational definitions

Learned preferences: the acquisition of the greater liking for private health providers over public health system.

Health seeking behaviour: Preferences and practices of the BPL population of Sendiri population in relation with their health care.

Population and sample

The population of the study includes 527 BPL households in the Sendiri Panchayat and the representative sample size is 50 which covers 10% of the population.

Research Design, tools and methods of data collection

The descriptive design using case study method is applied. Interview schedule is administered and observation technique is used throughout the study. The samples are selected using stratified sampling method i.e. samples selected randomly from different social status such as SCs, STs and OBCs and who belong to different wards in the panchayat.

III. RESULTS

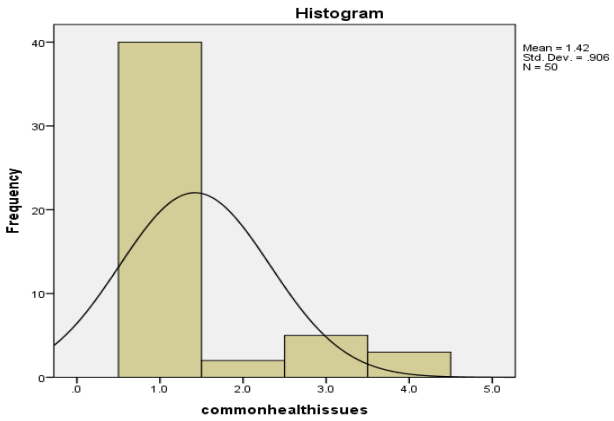
Basic profile of the respondents

Variable		Frequency
Gender	Male	43
	Female	7
Age	20-29 years	6
	30-39 years	11
	40-49 years	15
	50-59	9
	60-69	8
	70-79	1
Education	Illiterate	20
	below 10 the class	27
	plus two and more	3
Religion	Hindu	50
Social status	SC	27
	ST	7
	OBC	16
Occupation	daily wage labourer	21
	self employed	2
	farmer	25
	any other	2

The basic profile shows the vulnerable factors of the population of the panchayat. The education level of the samples was very low and majority is dropouts before completing their matriculation. Their occupation also signifies their economic condition as the 92% of the sample are engaged either in agriculture or daily wage labour. There found a correlation between the education level of the sample population and the occupation they engaged i.e. the illiterate and those who are below the qualification of the SSLC has chosen their occupation either in agriculture or daily wage. Their social status as a SC, ST or OBC further puts them into more socially and economically vulnerable.

The disease pattern and prevalence in the Sendiri panchayat

Common health issues			
	Frequency	Percent	Valid Percent
seasonal disease	40	80.0	80.0
lifestyle disease	2	4.0	4.0
seasonal disease and life style disease	5	10.0	10.0
seasonal disease and accident	3	6.0	6.0
Total	50	100.0	100.0



The table and histogram shows the distribution of disease pattern and prevalence and it points out the higher prevalence of seasonal diseases in the panchayat. The diseases are rather preventable and it requires intensification of the primary health care. The prevalence of other major health events like life style diseases, accidents are reported very few which requires secondary and tertiary level health care. So the strong dissociation between the projected need of health seeking behaviour under the RSBY scheme and actual need of the health seeking behaviour of the population.

Minor Disease and place of treatment

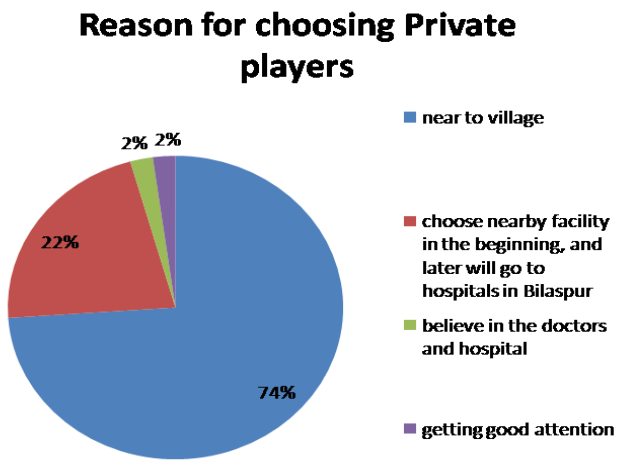
The minor diseases affecting the villagers include fever, body pain, headache, diarrhea, minor injuries with sharp objects, etc. At times of the minor diseases, they depend on the private or public health institutions for the treatment.

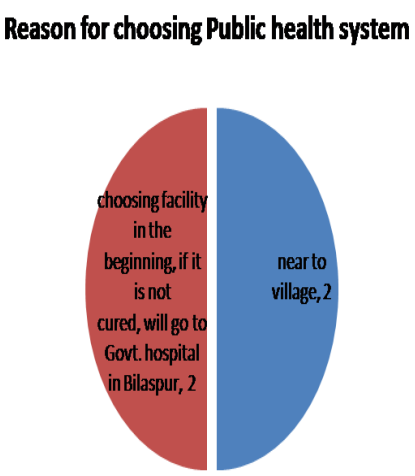
	Place of treatment	**No. of beneficiaries**
Private players, which include local healers, clinics in the village, and private hospitals nearby the Panchayat.		46
Public health system includes PHC at local level and other government hospital nearby the Panchayat		4
Total		50

The table explains the health seeking behaviour of the sample population in relation to the minor and seasonal diseases. The preferences are always made in connection with private players such as local healers (11), clinics in the village (8), private hospitals (6) and its different compositions. PHC is been reportedly utilized by just 2 households!

Dependency on Different Health care institutions and the reasons

Reason for choosing the institution			
		Frequency	Percent
Private players	near to village	36	72.0
	choose nearby facility in the beginning, and later will go to hospitals in Bilaspur	12	24.0
	believe in the doctors and hospital	1	2.0
	getting good attention	1	2.0
Public health system	near to village	2	50.0
	choosing facility in the beginning, if it is not cured, will go to Govt. hospital in Bilaspur	2	50.0





A table and pie diagrams gives answer to the preference of village population towards the private player. The chart shows that people prefer private players because they are nearby village and they believe in the quality of doctor and their treatment. The same village has a PHC nearby. But the utilization is very poor because it was reported and observed irregular in its services and people are not feeling confident with the service of the personnel and the institution namely PHC. However, between these two variables such as proximity and quality, people prefer the former.

Awareness about the RSBY scheme and provision of health card

The researcher asked about the enrollment of the household under the RSBY scheme. 42 out of 50 household responded "yes". Further analysis of the same question by the researcher and field investigator found that majority of these cards belongs to either 2011-12 or 2012-13. These cardholders are not aware that it has to be renewed every year and they will be provided with the new card. In addition, it was found that some are dissatisfied by the health card because they are not benefitted from the card. They approached the hospitals with these expired cards and were denied the services. The current beneficiaries are also not fully aware about the provisions and benefits of the health card and the utilization pattern is also found less effective.

Utilization of RSBY Card at different health care institution

Use of health card in 2013-14

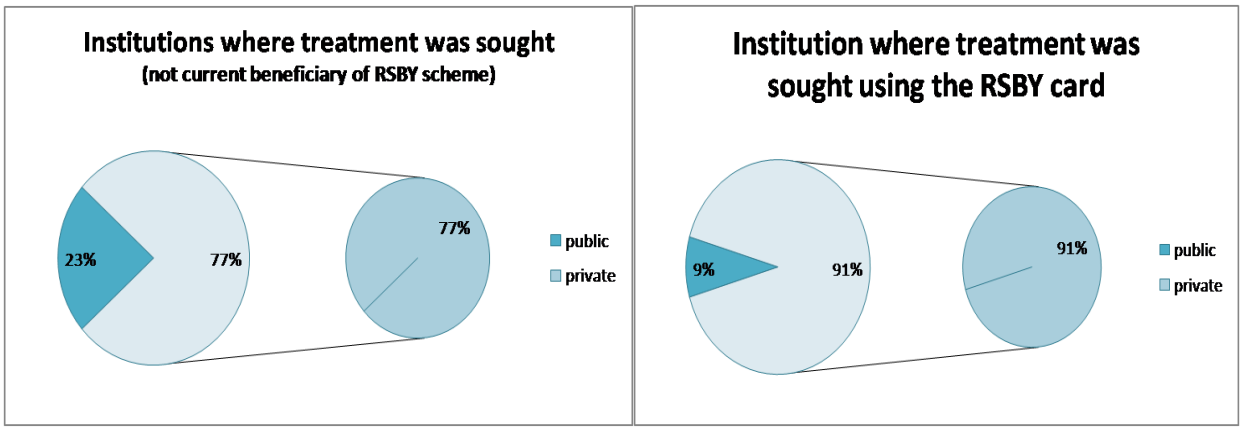
	Frequency	Percent	Valid Percent
Yes	4	8.0	8.0
No	46	92.0	92.0
Total	50	100.0	100.0

Usage of the RSBY card after the first enrollment to 2013-14

	Frequency	Percent	Valid Percent
0	39	78.0	78.0
1-2	9	18.0	18.0
more than 3	2	4.0	4.0
Total	50	100.0	100.0

The tables show the utilization pattern and dependency of the sample population on RSBY scheme. Only a minority (4 persons) has utilized the card in the current year i.e. 2013-14 and the rest were not used the card. Again, the usage of the card from first enrollment of the current year also marks very low. 18% of households has used the card for 1-2 times and 4% households for more than 3 times.

The preference for the health institutions and services used by the beneficiaries also maters. The below charts diagram shows the preferences of enrolled and non enrolled towards private players.



Major health events in the village and usage of the card

The samples from the panchayat have reported with major health events such as health issues of elderly or children, and accidents. These are the rare occasions they have used the card. The number of the health card usage thus ranges from 0, 1-2, more than 3. The no. of people comes in this category is very less.

Another question on the recent use of the RSBY card revealed that only four members has used it. The rest are further asked about the status of their RSBY card and it was found that majority is having expired card which cannot be used in the current year.

IV. Discussion

The health behaviour of individual depends on the beliefs and attitude sufficiently supported with external factors. The minor presence of perceived susceptibility and severity towards the seasonal diseases which is coupled with the absence of regular and decent service from the PHC has influenced the health behaviour of the population under the study. The socioeconomic status of the population is a handicap to their development. According to Amartya Sen, India has an unbalanced growth because the enabling environments are missing.[20] As the educational status of the population is comparable low, the health behaviour also is influenced. The utilization of public health resources is found abysmally low. The misapprehended notion of replacing the use of the service of public health system for private players has contributed little to the health of the population, rather it has its own inflicting burden on the individuals themselves.

Preference for the private players is the highlighting theme of the study. Over the years, the population has transformed their health seeking behaviour in favour the private clinics and private hospitals. The tables and charts show the fatal drop in the use of PHC in the village. Their preference for health institution is primarily influenced by the proximity of the institution. Even then, the nearby PHC never comes into the preferences. On further analysis, the irregularity and unfriendly response from the health system has influenced behaviour. The factor of social space of the population who depend on the existing government health system is a matter of discussion. While conversing, many household members have reported the unfriendly treatment from the government health institutions. Whereas, the same population is satisfied over the private players because they make the patients feel that they are been treated well for the money they spend for.

The profile of the sample denote the socio-economic conditions of the panchayat. The scheduled groups and other backward groups are the major population of the village. Addressing the question of economic access to health care through RSBY scheme for the BPL families is found questionable. The out of pocket expenditure is very high before the RSBY scheme and even after the enrollment. The scheme was there with 'last mile challenges' like lack of sensitization over the provisions, benefits, and related information, inconsistency in enrolling all the beneficiaries to the scheme. The villagers have cards which are not properly utilized because either the cards are expired or they do not know the provisions and the institutions where it is available.

The Alma Ata declaration speaks about the role of primary health care in the health service system. An analysis of the disease pattern and prevalence shows the high need of strengthening primary health care though effectively functioning PHC. The panchayat witnessed a PHC which rarely opens and its services are poor in quality. Over the years, the health seeking behaviour of the villagers too changes to private clinics and hospitals because they are never been offered satisfactory service from the public health system functioning ate panchayat level. The ruling parties in the Gram panchayat also could not effectively address the issue.

If we consider the factors influencing access to curative care (Bajpai, V. and Saraya, A.2012)[21] such as availability of better developed infrastructure, lesser levels of poverty, transportation facilities to reach the hospital facilities, literacy and education to utilize the scheme with prudent choices, demographic composition, political mobilization, the samples and area under

[20] Sen, A, (1994). Beyond the liberalization: Social Opportunity and Human Capability. In Re-imagining India and other essays, (2010), New Delhi, Oriental BlackSwan, pp.1-29.

[21] Bajpai, V. and Saraya, A.,(2012). Rashtriya Swsthya Bima Yojna: A Public Health Perspective. In the Indian Journal of Social Work, 2012 April:73(2):265-286.

study has considerable implications. The population is socially and economically poor. The marginal groups are often victims to the poverty traps through unemployment or failure of the crops. The family structure is also very high that the earning are spent on the daily maintenance of the family. The prevalence of seasonal health issues and consultation at private clinics and hospitals also put them under poverty burden. The distance to the secondary and tertiary level care units are also little far from their village. The illiteracy and low levels of education is the main villain and the majority of the vulnerable population in the panchayat is unable to make optimum utilization of all possible provisions under different schemes.

The case of irregular PHC in the village has given a wrong notion about the public health system in the psyche of the villagers. The health service seekers negative perception and experience in relation with the public health system has influenced their choices. The Panchayat is been witnessing the poor and irregular service pattern by the PHC over the few years. The researcher has a personal experience from the PHC i.e. when the researcher and other fieldwork trainees visited the building, some other person were there who were preparing food and other refreshments for their leisure. The picture depicted by the villagers about the PHC can also summoned as irregular.

Asymmetric power relation between caregivers and beneficiaries is another area. The private health care players are attractive to the villagers because they show courtesy with the customers. The customers are paid for the service and in return they are treated in a dignified way. Whereas in public health system, the villagers reported about the negative experiences from the personnel. If the RSBY card can help them in accessing the private players, they prefer it to expecting the same behaviour from the caregivers.

V. Suggestions and Recommendations

The researcher would like to suggest the following points.

- The need for sensitization about RSBY scheme and its service providing centres
- The need for credibility building of public health system through better health care and service provisions.
- The need for strengthening primary health care at grass root level rather than promoting the curative level.

For these, the following actions are recommended such as

- ✓ Restoring and regularizing the functioning of the PHC and its services.
- ✓ Improved participation of the people in regularizing the services of PHC.
- ✓ Special attention of PRI system on the health aspects of the panchayat.
- ✓ Mass sensitization over the RSBY scheme and its provisions through notices, leaflets and other ICT measures for imparting the relevant information.

VI. Limitations of the Study

The researcher has faced with limitations and challenges such as language barriers, embarrassment of the respondents in spending time for the questionnaire, and lack of awareness of the respondents over the RSBY card and its status and provisions. Also convincing the respondents about the need of conducting a study also was little difficult as they look about its monetary benefits.

VII. Conclusion

The case of Sendiri is copy of lakhs of villages and Panchayats in India and across globe where the health seeking behaviour of the population is moulded through a number of environmental factors. The lagging of public health system has significantly contributing to the profit of private players and loss for the common person who manages his/her life with limited source of money. The out of pocket expenditure puts him/her again into further deteriorating situation, which ultimately affects his/her health. So there need an urgent attention to the infiltrating risk namely learned preference for private health care and denouncing of public health system. To conclude the health seeking behaviour is a learned behaviour which is facilitated by the response of health system

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