BSBY (Bhamasha Swasthya Bhima Yojana)- An Overview of a State Government Sponsored Health Insurance in Rajasthan

By

Pradeep Kamera

Dissertation submitted for the partial fulfillment of the
MBA Hospital and Health Management

Academic year, 2016-2018

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
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IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Pradeep Kamera**student of MBA Health Managementfrom The IIHMR University, Jaipur has undergone internship training at AXA France Vie, Indian Re-Insurance Branch on topic **BSBY (BhamashaSwasthya Bhima Yojana) – An overview of a state government sponsored health insurance in Rajasthan**from 5th Feb 2018 to 4th May 2018.

He has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific, and analytical.
The Internship is in fulfillment of the course requirements.

Iwish him all success in all his future endeavors.

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TO WHOM IT MAY CONCERN

The certificate is awarded to **Pradeep Kamera**, Management Trainee in the Claims and Investigation Department at AXA France Vie – India Reinsurance Branch in recognition of having successfully completed his dissertation from February 5th 2018 to May 5th 2018,

He has successfully completed his Project on "**BSBY (Bhamasha Swasthya Bima Yojana)- An Overview of a State Government Sponsored Health Insurance Scheme in Rajasthan**.

During the period of his dissertation programme, he was found punctual, hardworking and inquisitive.

We wish him good luck for all his future assignments.

For and on behalf of **AXA France Vie – India Reinsurance Branch**

Pankaj Tomar
Chief Underwriting Officer

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **BSBY (Bhamasha Swasthya Bhima Yojana) – An overview of a state government sponsored health insurance in Rajasthan** submitted by Dr. Pradeep Kamera under the supervision of Dr. Sameer Phadnis for award of MBA Health Management of the University carried out during the period from 5th February 2018 to 4th May 2018 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

Signature

Contents

List of Abbreviations

BSBY	**Bhamashah Swasthya Bhima Yojana**
GDP	**Gross Domestic Product**
NGO	**Non-Governmental Organisation**
UIP	**Universal Immunization Programme**
CSSM	**Child Survival & Safe Motherhood**
RCH	**Reproductive & Child Healthcare Programme**
NRHM	**National Rural Health Mission**
AYUSH	**Ayurvedic/Yoga/Unani/Siddha/Homeopathy**
DOTS	**Direct Observed Treatment-Short course**
RNTCP	**Revised National Tuberculosis Plan**
AIDS	**Acquired Immune Deficiency Syndrome**
NVBDC	**National Vector Borne Disease Control Programme**
CVD	**Cardiovascular diseases**
RSBY	**Rashtriya Swasthya Bima Yojna**
WHO	**World Health Organisation**
GIC	**General Insurance Corporation of India**
IRDA	**Insurance Regulatory and Development Authority of India**
TPA	**Third-Party Administrator**
OPD	**Out Patient Department**
UHIS	**Universal Health Insurance Scheme**
OOPE	**Out of Pocket Expenditure**
CBHI	**Community Based Health Insurance**
CHE	**Catastrophic Health Expenditure**
O.T	**Operation Theatre**
NFSS	**National Food Security Scheme**
CEO	**Chief Executive Officer**
SHAA	**Rajasthan State Health Assurance Agency registered under Societies Act, 1958**
CMHO	**Chief Medical Health Officer**
PMO	**Project Management Officer**
MoIC	**Medical Officer In charge**
IPD	**In Patient Department**
BPL	**Below Poverty Line**
NREGA	**National Rural Employment Guarantee**
ICU	**Intensive Care Unit**
FY	**Financial Year**

BSBY (Bhamasha Swasthya Bhima Yojana) – An overview of a state government sponsored health insurance in Rajasthan.

1 Introduction

If one is to compare the health indicators of India from those that are present worldwide, the picture that will emerge is going to be small. The progress in health from the weak starting position in 1947 has been tremendous but still not enough. The government has recognized the need for a reform and has introduced several of these in the eleventh and the twelfth five-year plans. (1)

Both the public and the private sectors have played an important role today in improving access to the quality of the healthcare sector in India, but still the country lags. The presence of inequalities in India further exacerbates this problem. The inequalities are both demographic and geographic in the context of India. The Govt. will have to take bold steps to correct these issues. Health spending, as a proportion of the GDP will have to rise while collaboration between the public and the private sector is the only way by which the said improvements in infrastructure and general healthcare can be addressed.
In the Planning Commission report, the Government of India articulates the need for a universal health care system. This report prepared by Hannover Re Risk Management Services India Pvt. Ltd. aims at providing an articulate vision to the possible roadmap, which the country can follow to achieve its vision. We begin by giving a brief account of the history of the healthcare sector in India to highlight the core changes in the field, which are important in analysing how the country has progressed in the field of healthcare in the past. (1)

(1) Health insurance in narrow sense would be an individual or group purchasing health care coverage in advance by paying a fee called premium. In broader sense it would be any agreement that helps to defer, delay, reduce or avoid payment for health care incurred to individuals or households. The health insurance market in India is very limited covering about 27% of the total population. The existing schemes can be categorised as:

1) Voluntary health insurance schemes
2) Employer based schemes
3) Insurance offered by NGO's (or) community based health insurance schemes
4) Government sponsored health insurance schemes.

2 Background

2.1 Sixty Years of India's Tryst with Healthcare

India started on her unending quest, at the stroke of the midnight hour on 15th August 1947 and her journey since then has been one that has been carefully followed by multitudes of people across the globe. Today India stands as the 3rd largest economy (based on gross domestic product estimation in terms of purchasing power parity) and has come a long way since independence. During this time the country has seen tremendous improvements in it's healthcare sector. An average Indian today, at birth has a life expectancy of 66 years, which is nearly double of that of an individual living in the decade following India's independence. India has successfully eradicated epidemic causing diseases such as smallpox, guinea worm and polio. [1]

In the field of health infrastructure, India has come leaps and bounds, with the country today having nearly 2.5 million primary, secondary and tertiary healthcare institutions compared to the uninspiring number of 10,000 such institutes that we had in 1951. The next few pages will talk about the various schemes which have been started in the country since 1947 leading to this healthcare revolution, table 1 will quickly summaries the various changes in Demographic/Infrastructure/Disease Incidence in the country since Independence.

2.2 Chronological Changes in HealthCare Sector in India [1]

2.2.1 Bhore Commission (1946) [1]

Bhore commission was an important landmark in public health in India. It initiated the concept of integrated development & comprehensive health care. Also, the idea of primary health care owes its inception to this committee. This further led to the three-tier pattern of health care services.

2.2.2 Primary Health Centres (1952) [1]

Following the acceptance of report of Bhore Committee by rulers of newly independent country, in 1952 there was an initiative to setup PHCs to provide integrated promotive, preventive, curative and rehabilitative services to entire rural population, as an integral component of wider Community Development Programme.

National Programme Emphasizing Family Planning

In the same year, India also became the first country to launch a national Programme emphasizing family planning to stabilize the population at a level consistent with the requirement of national economy.

- **Country Implements Vision of Sokhey Committee to have one Community Health Worker per 1000 people (1970s)**

The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision of Sokhey Committee of having one Community Health Worker for

every 1000 people to entrust ‘people health on people's hand'. India has come quite close to Alma Ata (Health for All) Declaration on Primary Health Care made by all countries of the world in 1978.

2.2.3 National Health Policy for Architectural Correction (1982)[1]

In 1982 the government made a major move in health politics by coming up very sharply against the health work done in the country in last 35 years. National Health Policy gave a general exposition of the policies, which required recommendation in the circumstances prevailing at that time in the health sector.

2.2.4 Universal Immunization Programme (UIP) (1985)[1]

This program was to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases.

2.2.5 UIP strengthened becomes Child Survival and Safe Motherhood (CSSM) Project (1992)

The strengthened UIP was to sustain the high immunization coverage level reached by the UIP, and augmenting activities under Oral Rehydration Therapy, prophylaxis for control of blindness in children and control of acute respiratory infections. Under the Safe Motherhood component, training of traditional birth attendants, provision of aseptic delivery kits and strengthening of first referral units to deal with high risk and obstetric emergencies were taken up.[1]

2.2.6 Reproductive and Child Healthcare Program (RCH) (1997)[1]

This program incorporated child health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health.

2.2.7 RCH Phase II (2005)[1]

RCH Phase II aimed as being a sector wide, outcome oriented program with emphasis on decentralization, monitoring and supervision, to bring about a comprehensive integration of family planning into safe motherhood and child health. There was a differential approach for Empowered Action Group (EAG) and non-EAG states with improved ownership among states with dedicated structural arrangements to improve program management.

National Rural Health Mission

The National Rural Health was a program undertaken by the Government to honor it’s political commitment to rural health and access to primary health. NRHM was also a strategic framework to implement the National Health Policy 2002. It adopted key guidelines given in National Health Policy 2002, e.g. equity, decentralization, involving Panchayati Raj Institutions (PRIs) and local bodies in owning primary health care management, strengthening primary health care institutions and suggestions for generating alternate source of financing. The NRHM subsumed key national programmes, namely, Reproductive and Child Health-2 (RCH-2), National Disease Control Programmes and Integrated Disease Surveillance Project. The mission covered the entire country, with special focus on 18 states, which had relatively poor infrastructure. These included all 8 Empowered Action Group (EAG) states viz. Uttar Pradesh, Madhya Pradesh, Rajasthan, Bihar, Orissa, Uttaranchal, Chhattisgarh and Jharkhand; 8 North East States besides Jammu and Kashmir and Himachal Pradesh

2.2.8 Multiple health schemes by India for health sector (Since 2005)[1]

- Setting up for department of AYUSH (Ayurveda/Yoga/Unani/Siddha/Homeopathy) (2003)
- Entire country being covered under DOTS since 2006 (Direct Observed Treatment-Short course) by the RNTCP (revised national tuberculosis plan 1992
- National AIDS Control Programme Department of Aids Control (National AIDS Control Organization)
- National Cancer Control Programme
- National Filaria Control Programme
- National Iodine Deficiency Disorders Control Programme
- National Leprosy Eradication Programme
- National Mental Health Programme
- National Programme for Control of Blindness
- National Programme for Prevention and Control of Deafness
- National Tobacco Control Programme
- National Vector Borne Disease Control Programme (NVBDC)
- Pilot Programme on Prevention and Control of Diabetes, CVD and Stroke

2.2.9 Rashtriya Swasthya Bima Yojna (RSBY) (2008)[1]

RSBY launched by Ministry of Labour and Employment is a health-financing scheme to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to INR 30,000/- for most of the diseases that require hospitalization. Government has fixed the package rates for the hospitals for a large number of procedures. Pre-existing conditions are covered from day on e and there is no age limit. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only INR 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding.

3 Literature review

Evolution of Healthcare Status in India [3]

While statistically India has progressed well on some basic health indicators during the last 60 years since Independence, it lags very much behind other developed and emerging economies like the BRICS countries. In the World Health Organization's rankings of National Healthcare Delivery Systems, India finds itself a very low rank of 112 along with Sub-Saharan countries and even behind Bangladesh that is at position 88.

Table 1 Health & demographic indicators of India [3]

	1951	1981	2000	2012
Demographic Indicators				
Life expectancy [years]	36.7	54.0	64.6	66.0
Crude birth rate [per mille]	40.8	33.9	26.1	19.9
Crude death rate [per mille]	25.0	12.5	8.7	7.9
Infant mortality rate [per mille]	146.0	110.0	70.0	44.0
Maternal mortality rate [per 0.1 million]	_	470.0	390.0	190.0
Epidemiological Shifts				
Malaria [millions]	7.5	2.7	2.2	1.1
Leprosy [millions]	38.1	57.3	3.7	1.1
Smallpox	>44,887	Eradicated	Eradicated	Eradicated
Polio	NA	29,709	265	Eradicated
Infrastructure improvement				
SC/PC/CHC	725	57,363	1,63,181	1,76,820
Dispensaries and Hospitals	9,209	23,555	43,322	66,870
Beds (Pvt. and Public)	1,17,198	5,69,495	8,70,161	13,76,013
Doctors (Allopathic)	61,800	2,68,700	5,03,900	61,20,000

Nursing Personnel	18,054	1,43,887	7,37,000	9,00,000

According to WHO, 35% of the population has no access to essential drugs while 45% of the children below five years of age are malnourished. 3% of the population slides under the below poverty line every year due to the crushing burden of healthcare costs. There are many other indicators that paint a very grim picture of the healthcare in India.

Thus, India has a long way to go in the area of healthcare, and for achieving the millennium development goals and universal health coverage a lot more has to be done in the country. The next few pages will lay a general outlay of the current scenario of the healthcare sector in India; this understanding is essential to help in taking actions for improvement of the sector.

3.1 Reach of Health Insurance [4]

Total penetration has been markedly better since 2000. Life industry penetration level is on the downward path since 2010; 5.10 percent in 2010 to 4.10 percent in 2011. However, throughout 1990 to 2011 non-life insurance has remained remotely stagnant and ranged around 1% for these years.

Approximately 6% of insured households have health insurance with much about 1.3 % difference between urban and rural backdrops. Only 5.27% of insured rural households have health insurance despite the prevalence of government health insurance mass schemes. Amongst the uninsured population, a meager 0.49% has opted for health insurance. Interestingly, motor insurance remains a key preference for both insured and uninsured households with 30.90 % and 6.13 % of the group opting for it, respectively.

Table 2 - Penetration of health insurance in life insured sector and uninsured sector[4]

	Life Insured (those who bought life insurance)			Uninsured (in %)		
Type of insurance	Rural	Urban	All	Rural	Urban	All
No insurance	-	-	-	88.0	89.1	88.7
Life insurance	100.0	100.0	100.0	-	-	0.00
General insurance	2.9	4.8	3.4	0.6	0.7	0.6
Health insurance	**5.2**	**6.6**	**5.9**	**0.6**	**0.4**	**0.5**
Motor insurance	26.4	35.6	30.9	5.1	6.8	6.1
Tractor insurance	2.5	0.9	1.7	0.5	0.2	0.3

The increased penetration with the opening up of the sector in 2000 gives a clear indication that the private and the foreign players & re-insurers have ability to enhance the size, structure and participation in the insurance market worldwide. India has one of the lowest penetrations of non-life insurance when compared internationally, with little to no growth since 2010-11. Sitting at 0.7% penetration rate, such a low and uneven development of insurance implies high risk in economic decisions taken by individuals and firms, therefore, fastening up the insurance sector to make it competitive at global level.

The hallmark of Indian healthcare industry has been the formation of various healthcare delivery services both at state level and national level. Its main objective is to have one central health care organization to deliver a wide range of health services. From the standpoint of integration, major players or participants in health care delivery system are hospitals, insurers and Government.

3.2 Health Insurance Models in India [4]

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity.

Over a period of last few decades health insurance has tremendously evolved in India. In order to gauge the evolution of health insurance in India, important milestones achieved in the sector since its inception are indicated.[1]

Table 3 Evolution of health insurance in India

1938	Insurance act recognizes two categories: life and non-life insurance
1954	Central Government Health Scheme providing health cover to employees of central government employees
1986	General Insurance Corporation of India (GIC) introduced medi-claim insurance policy
1999	Insurance Regulatory and Development Authority (IRDA) Act passed
2001	IRDA introduced provisions for TPA system in health insurance. Nine private general insurance companies get registered with IRDA

1

2003	IRDA sets up a National Health Insurance Working Group to identify existing problems in health insurance industry
2006	First Standalone Health insurance company came into business with a capital requirement of Rs100 crore
2007	The insurance market was de-tariffed. Earlier 70 percent of the General Insurance business was driven by various tariffs. In a tariff driven market, the leverage for taking flexible decisions regarding the pricing based on the merit of individual risk was virtually nil
2010	Offers cashless medical treatment to bring discipline on the pricing of hospital services. The health insurance market continues to be dominated by the four state-owned general insurers, which together accounted for almost 60 percent of the premiums
2011	Portability of health insurance policies by IRDA allowing policyholders to switch providers on the same policy terms, particularly without losing the credit gained for pre-existing conditions in terms of waiting period

Health insurance is protection against the financial damage caused by illness. In India health insurance are broadly of 2 types -

3.3 Retail Health Insurance

Individual or family health product is purchased by an individual on the payment of a premium. The medical risk covered is for self or for family on floater basis. Group health products are purchased by the employer for its employees and/or for their families. It is a broker and client driven market.

To increase the market penetration different insurance companies have come up with different innovative features, some of them are illustrated as below-

3.3.1 Cardiac Care

The product aims at providing protection against the risk of damage caused by any cardiac ailment.

Policy Benefits

- Hospitalization Cover Protects insured for in patient expenses for a minimum of 24 hours.
- These expenses include room rent, nursing and boarding charges, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees, Cost of Medicines and Drugs
- Ambulance charges for emergency transportation to hospital as per specified limits
- Pre-hospitalization expenses up to 30 days prior to admission in the hospital

- Post-hospitalization paid as lump-sum upto the limit specified
- 101 Day-care treatments covered
- Cardiac ailments covered after 90 days.

3.3.2 Senior Citizen Care

The product aims at providing coverage against financial damage caused by diseases specific to old age.

Policy Benefits

- Hospitalization Cover Protects the insured for in patient hospitalization expenses for a minimum of 24 hours.
- These expenses include room rent, nursing and boarding charges, Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialist Fees, Cost of Medicines and Drugs
- Post-hospitalization paid as lump-sum upto the limit specified
- Pre-existing diseases are covered after 12 months
- Co-payment - 30% for other than claims for Pre-Existing Diseases and 50% for Pre-Existing Diseases claims.

3.3.3 Automatic Restore Plan

The policy automatically reinstates the basic Sum Assured, if exhausted. Also, basic sum insured increases by 50% for first, claim free year and if second year also goes claim free, the company doubles the basic sum assured.

Policy benefit

- Pre/Post Hospitalization
- 100% Lifelong renewal
- No sub limits on room rent and no geography based sub-limits
- No claim based loading & health line support for any time medical assistance.
- Pre hospitalisation covered up to 60 days and post hospitalisation covered up to 180 days
- Enlisted 140-day care procedures covered.

3.3.4 Comprehensive Health Product

This is a comprehensive healthcare product.

Policy Benefits

- 101 day-care procedures covered.
- Maternity expenses covered for delivery, treatment of new born and vaccination expenses.
- Covers expenses for outpatient dental and ophthalmic treatment.

- Health check-up benefit becomes payable if the policy is continued for 3 claim free years.
- Cover to HIV positive individuals, provided the CD 4 count at the time of entry is above 350.

Add on covers

- Automatic restoration of sum insured if exhausted, once by 100% for the remaining policy period.
- 20% of co-payment is applicable for the insured above 61 years of age.
- Claim loading clause - If the claim ratio exceeds 100% in two consecutive years, premiums may increase by 20 to 50% in the subsequent years.

3.4 Distribution Channels of health insurance [5]

3.4.1 Agents & Brokers

Among all the distribution channels, to large extent agents take the lion's share and shows a high level of penetration in several countries. Recent trends show a slight decrease in the market share of agents in most markets. This is closely linked to diversification by insurers: onmone hand, there are new distribution channels such as bancassurance and the internet and, on the other hand, insurers have embarked on a multichannel strategy that is eroding the market share of the leading distribution channels. The proportion of tied and multi-tied agents varies widely from country to country according to local practice and national legislation. Brokers remain much less important than agents in most countries.

3.4.2 Bancassurance

The provision of insurance products by banks or lending institutions. The bank or lending institution may act as an insurance agent, bank employee or insurance broker.

Bancassurance is not very well developed in non-life insurance and represented less than 10% in all countries.

However, the development of bancassurance in life insurance does not guarantee the success of this channel in the non-life market

3.4.3 Internet and telemarketing

The development of new channels such as internet and call centers in parallel with the retention of traditional networks such as agents and brokers demonstrates the desire of insurers for multichannel strategies to reach clients. This strategy is made necessary by the growing volatility of purchasing by customers

3.5 Micro health insurance schemes for BPL families sponsored by Government

Micro health insurance schemes are sponsored by government and are for poor population of the country. India currently does not have expertise in OPD coverage under such schemes. Currently, the country lacks the capacity for drug procurement so the cost for OPD cannot be controlled. In United States, OPD coverage was the major reason for the failure of Government insurance scheme. Insurance schemes globally have never been a successful partner to efficiently manage OPD.

Table 4 Evolution of Micro Health Insurance

Year of inception	Micro insurance Policy
2003	• UHIS - Universal Health Insurance Scheme • Yashashvini Health Insurance Scheme (Karnataka)
2006-07	• Weavers and Artisans scheme (Textile Ministry) • Rajiv Aarogyasri Scheme (Andhra Pradesh)
2008	• RSBY (Rashtriya Swasthya Bima Yojana)
2009	• Kalaignar Scheme (Tamil Nadu)
2010	• RSBY Plus (Himachal Pradesh) • Vajpayee Arogyasri Scheme (Karnataka)
2011	• CM's Comprehensive Health Insurance Scheme (Tamilnadu) • Rajiv Gandhi Jeevandayee Arogya Yojana (Maharashtra)
2015	• BSBY (Bhamasha Swasthya Bhima Yojana (Rajasthan)

Yellaiah (J, 2013) in his study concluded that Health insurance as a tool to finance healthcare has very recently gained popularity in India. Government has been putting serious efforts to introduce health insurance for the poor in recent years in order to improve access of poor to quality medical care and for providing financial protection against high medical expenses. There have been several attempts to introduce similar schemes in other states but Andhra Pradesh has been one of the only states to successfully roll out the scheme. The Insurance scheme covered198.25 lac families out of total across 229.11 Lac families (87% families covered) residing in 27138 villages 1128 mandalas of all districts of the State in five Phases. The scheme started with 330 procedures covered and has been gradually extended to 938 procedures. The majority of beneficiaries utilizing the scheme are illiterate and have a rural address. [(6)]

Pugazhenthi et. al. (Pugazhenthi V, 2014) concluded that in case of Government Sponsored Health Insurance Schemes, merely because the insurance premium is subsidized by the Government, the ultimate beneficiaries should not be deprived of the due benefits and their satisfaction should not be taken granted. Because, though the service is free of cost at the receiver's end, full amount of insurance premium is paid by the Government to the insurer and in turn, full amount of the cost of the treatment is paid to the service providing hospitals. If the satisfaction and the expected treatment are ignored, it will be yet another subsidized endeavour to go in vein. So, the researchers take one of the most successful Government Sponsored Health Insurance Scheme, 'Chief Minister's Comprehensive Health Insurance Scheme' of Government of Tamil Nadu to analyse the satisfaction level of the beneficiaries. In the present study from three hundred beneficiaries of the health insurance schemes of Government of

Tamil Nadu document the satisfaction level, the relationship of the same with awareness level and the key determinants of overall satisfaction. [7]

Reddy & Mary (Reddy, 2013) Various models are being tried out under Public–Private Partnerships in health care. Community health insurance is one of the models for providing health security for the people Below Poverty Line (BPL). Various states are experimenting on community health insurance with largely state financing, private provisioning of health care, especially curative care. When the partnership is for profit private/ corporate sector, where the underlining principle is profit making, the core principal of partnerships of beneficence and equity is undermined. The Aarogyasri scheme started in 2007 as a political move is continuing and praised as one of the most effective ways of treating tertiary, curative, largely surgeries and therapies for BPL population and is completely sponsored by the state. This article critically analyses the procedures and the cost incurred in private and public hospitals and finds that Aarogyasri is skewed towards curative tertiary care and is a big drain on the state exchequer with questions of sustainability. Further, this kind of partnership undermines the existence of large public sector, which is underutilised. The way forward for sustainable and comprehensive health care for people of Andhra Pradesh to ensure 'Arogyandhra' is to promote and strengthen public sector. [8]

Gumber & Kulkarni (Gumber A, 2000)This pilot study explores the availability of health insurance coverage for the poor and especially women, their needs and expectations of a health insurance system, and the likely constraints in extending current health insurance benefits to workers in the informal sector. The ESIS has substantial scope for improvement of its services, particularly better utilisation of its facilities. The survey shows that the poor prefer public sector management of health care facilities. [9]

Gill & Shahi (Gill HS, 2012) Government of India announced Rashtriya Swasthya Bima Yojana (RSBY) in October 2007 to provide health insurance to Below Poverty Line (BPL) household, which is being implemented by different states across India, to protect them from major health shocks. There are twenty-six states, which have tendering process of RSBY out of which twenty-three states have signed memorandum of understanding with central government. The enrollment processes have already been started in twenty-six states and twenty-three states have started delivery of RSBY to BPL families. 150 million people who are covered under any kind of health insurance and there are 51.3 million BPL families in twenty-six states/UT and approximately 24.14 million people enrolled with Rashtriya Swasthya Bima Yojana out of which Smart cards have been issued to 24 million people with 2.2 million hospitalization cases. The objectives of the study are two-fold, firstly, to study the current status of Rashtriya Swasthya Bima Yojana in India and second to study the Implementation and impact of Rashtriya Swasthya Bima Yojana in various states of India. The study indicates that health expenditure related impoverishment in India is quite high. There are substantial variations across the states of India, with a few states accounting for most of the health expenditure related impoverishment. Rural states rank higher than urban and outpatient services account for a much larger share of the financial burden on households than inpatient services, even though the latter are typically costlier per service consumed. [10]

Ibrahim & Khan (Ibrahim SMAS, 2014) The Government of Maharashtra has launched the schemes Rajeev Gandhi Jeevandayee Aarogya Yojanaon 2nd July 2012 to improve access of Below Poverty Line (BPL) and Above Poverty Line (APL) families. This paper will attempt to

elaborate that, what is the scheme? And what facilities are getting by the beneficiaries of the scheme? [11]

Purohit (B, 2014) The health inequities remain high in India with government and private health expenditures clearly favouring the rich, urban population and organized sector workers and the Out of Pocket (OOP) spending as high as 80%, afflicting the poor in the worst manner. The focus of the paper is to examine the potential Community Based Health Insurance (CBHI) offers to improve the healthcare access to rural, low income population and the people in unorganized sector. This is done by drawing empirical evidence from various countries on their experiences of implementing CBHI schemes and its potential for applications to India, problems and challenges faced and the policy and management lessons that may be applicable to India. It can be concluded that CBHI schemes have proved to be effective in reducing the Catastrophic Health Expenditure (CHE) of people. But success of such schemes depends on its design, benefit package it offers, its management, economic and non-economic benefits perceived by enrolees and solidarity among community members. Collaboration of government, NGO's and donor agencies is very crucial in extending coverage; similarly overcoming the mistrust that people have from such schemes and subsidizing the insurance for the many who cannot pay the premiums are important factors for success of CBHI in India. One of the biggest challenges for the health system is to address the piecemeal approach of CBHI schemes in extending health insurance and inability of such schemes to cover a large number of poor and the unorganized sector workers. Also, there is a need for a stronger policy research to demonstrate: 1) how such schemes can create a larger risk pool, 2) how such schemes can enrol many people in the unorganized sector, 3) the interaction of CBHI schemes with other financing schemes and its link to the health system. [12]

Acharya & Ranson (Acharya A, 2005) Health indicators in India may have seen substantial improvements in recent decades but quality and affordable health care services continue to elude the poor. Government provided health services only partially meet the needs of the rural and urban poor in the informal sector and making equitable and affordable medical care accessible to this segment remains a challenge. It is here that community-based health insurance (CBHI) schemes could provide viable alternatives. Four such CBHI schemes, that form the focus of this paper, are sustained by a pooling of resources as well as the regular "prepayment" of a small amount as premium, to enable poorer communities to meet high out-of-pocket medical expenses. While such schemes are still in their infancy, to ensure a wider coverage and acceptance, CBHI schemes could be attached to other decentralised agencies of governance such as panchayati raj institutions. [13]

Prasad & Raghvendra (Prasad N, 2012) The experiment in restructuring the healthcare sector through the Aarogyasri community health insurance scheme in Andhra Pradesh has received wide attention across the country, prompting several states governments to replicate this "innovative" model, especially because it supposedly generates rich electoral dividends. However, after a critical scrutiny of this neo-liberal model of healthcare delivery, this paper concludes that the scheme is only the construction of a new system that supplants the severely underfunded state healthcare system. It is also a classic example of promoting the interests of the corporate health industry through tertiary hospitals in the public and private sectors. [14]

Aggarwal (A., 2010) Using propensity score matching techniques, the study evaluates the impact of India's Yeshasvini community-based health insurance programme on health-care utilisation, financial protection, treatment outcomes and economic wellbeing. The programme offers free out-patient diagnosis and lab tests at discounted rates when ill, but, more

importantly, it covers highly catastrophic and less discretionary in-patient surgical procedures. For its impact evaluation, 4109 randomly selected households in villages in rural Karnataka, an Indian state, were interviewed using a structured questionnaire. A comprehensive set of indicators was developed and the quality of matching was tested. Generally, the programme is found to have increased utilisation of health-care services, reduced out-of-pocket spending, and ensured better health and economic outcomes. More specifically, however, these effects vary across socio-economic groups and medical episodes. The programme operates by bringing the direct price of health-care down but the extent to which this effectively occurs across medical episodes is an empirical issue. Further, the effects are more pronounced for the better-off households. The article demonstrates that community insurance presents a workable model for providing high-end services in resource-poor settings through an emphasis on accountability and local management. [15]

Objectives of the study

To obtain the overall comprehensive understanding of BSBY in terms of existing structure and functioning of the scheme.

- To know the awareness about BHAMASHA scheme among eligible families in the district.
- To explore the utilization of benefits in empanelled hospitals among the BHAMASHA beneficiaries.

4.Methodology

1) Study Design: Descriptive
2) Setting: Axa france branch office, Jaipur
3) Duration: February to May 2018 (3 months)
4) Data collection procedure: Secondary data was collected and analysed of the running policy in the state from Internet, RFP available in the office.
5) Data Collection sources: Internet & RFP
6) Data analysis: Data will be analysed with the help of advance Microsoft excel function

5.Observation & Findings

5.1 Overview of the Scheme [17]

The Scheme aims to insure about 1 crore (one crore) families over a period of one year and covers 1,045 procedures that can be availed medical services for these ailments in empanelled Govt. and Private Hospitals. for General Illnesses up to Rs. 30,000/-, and with a provision to pay up to Rs 3,00,000 per year per family for certain specified procedures with respect to Critical Illnesses on cashless basis through Bhamashah Card. Also, there are few listed procedures reserved for Government hospital only and cannot be availed in private hospitals. Identified Diagnostic Procedures as up to Rs. 5000 per year per Family can be availed in any Empanelled hospital after referral from Public hospitals.

5.2 Objective of the Scheme [17]

The main objective of the Scheme is to provide free medical, surgical treatment and diagnostic procedures in certain specified Government and empanelled Private hospitals to the members of any eligible family as laid down in the document. Aim of the scheme is to provide hassle-free IPD service to the beneficiaries therefore it will be the responsibility of the successful bidder to put in place a flawless mechanism which will ensure the achievement of the above said objective.

5.3 Scope of the scheme [17]

The Scope of the Scheme will be to provide coverage as per entitlement for the eligible expenses incurred by the eligible person on behalf of himself or any member of his or her family for the treatment of procedures listed in the Scheme. The coverage will include bed charges in General ward, Nursing and boarding charges, Surgeons, Anaesthetists, Medical Practitioner, Consultants fees, Anaesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray and Diagnostic Tests, Expenses incurred for diagnostic test and medicines up to 7 day before the admission of the patient and cost of diagnostic tests and medicine up to 15 days of the discharge from the hospital for the same ailment/ surgery including transport expenses which will also be the part of the package.

5.4 Beneficiaries under the scheme [17]

The scheme includes beneficiaries in two categories, i.e.:
a) Swasthya Bima Yojana for National Food Security Scheme and Rashtriya Swasthya Bima Yojana families.
b) Swasthya Bima Yojana for voluntary families i.e. Non- National Food Security Scheme and Non Rashtriya Swasthya Bima Yojana families.

5.5 Beneficiary eligibility [17]

a) All the families under RSBY and those NFSS beneficiaries who have got themselves enrolled under the Bhamashah Scheme shall be covered under this health insurance scheme.
b) The Scheme shall be implemented on the Bhamashah Cards/ RSBY cards to the beneficiaries.
c) The benefit will be on floater basis and can be availed of individually or collectively by members of the family during the policy year with no restriction on the number of times the benefit is availed. The unutilized entitlement will lapse at the end of every policy year.

5.6 Pre-existing diseases [17]

Pre-existing conditions/diseases are to be covered for families under RSBY & NFSS from the first day of the commencement of policy, subject to the exclusions as per the scheme. For Voluntary families, pre-existing conditions /diseases would be covered post completion of 1 year of the policy subject to the exclusions under the Scheme.

5.7 Sum insured and period of insurance [17]

The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary up to Rs. 30,000/- per family per year for the general medical and surgical procedures, and to pay up to Rs 3,00,000 per year per family for certain specified procedures for Critical Illnesses in any of the empanelled hospitals subject to package rates on cashless basis through Bhamashah Card.

5.8 Claim process [17]

Bhamashah Card forms the basis for the provision of treatment to a beneficiary. The beneficiary will present the Bhamashah card (or other identity related to RSBY) to the Swasthya Mitra at the hospital desk prior to availing any treatment. Swasthya Mitra will register the patient in the system using the card no. and the Aadhar card number of the beneficiary. In case of any IPD treatment is required, the beneficiary will present the doctor's prescription and advisory to Swasthya Mitra at the hospital desk. Swasthya Mitra will block the required treatment package in the system and will authorize the transaction using the Aadhar card details.

5.9 Cashless transaction [17]

It is envisaged that for each hospitalization the transaction shall be cashless for covered procedures. Enrolled beneficiary will go to hospital and come out without making payment to the hospital subject to procedure covered under the scheme. When the beneficiary visits the selected network hospital and services of selected network hospital should be made available (Subject to availability of beds).

5.10 Claim settlement [17]

The Hospital will raise the bill to the insurer. The insurer shall process the claim and settle the claims expeditiously to ensure that the Hospitals provide the services to the beneficiaries without fail. In case of any failure in provision of the services from the Hospitals due to pending bills, the insurer will be held responsible.

5.11 Health camps & 24x7 call centre [17]

Free Health Camps/ Screening camps will be conducted by the Insurer and by the empanelled hospital with the prior permission of the insurer. The insurer shall ensure that minimum of one camp per month in each block will be held in each policy year, under the supervision of insurer. Network hospital shall carry necessary screening equipment along with specialists (as suggested by the State Health Assurance Agency) and other Para-medical staff. A 24x7 Call Centre working 365 days a year, toll free helpline with online workflow will also be established by the insurer.

Table 5 Scheme Structure [19]

Agency	Work	Under control of
Government of Rajasthan	1)Custodian of the scheme Bhamashah Swasthya Bima Yojana. 2)Provide funds for implementation of Swasthya Bima Yojana.	Principal Secretary, Health
Medical and Health Department	1)Implementing Agency for the scheme through SHAA. 2)Monitoring and control over entire scheme through District Collectors,Directors & CMHOs	CEO, SHAA.
Rajasthan State Health Assurance Agency	1)Undertake all activities related to implementation of Bhamashah Swasthya Bima Yojana. 2)Fixing accreditation criteria and accreditation of private hospitals in association with Insurance Company. 3)Price setting of packages and finalization of packages through committee of technical experts. 4)Preparation of Medical Protocols for identified packages. 5)Medical Audit of Claims. 6)Grievance Redressal 7)IEC plan for the scheme to be followed by Insurance Company. 8)Monitoring and check that clauses of all RFPs/agreements are being complied.	CEO, SHAA
IT Platform	Procure, provide, implement and manage IT platform for the scheme.	SHAA
Swasthya Margdarshak	At the facility level to provide assistance to patients at facility and undertake other activities related to	Respective Health Institution

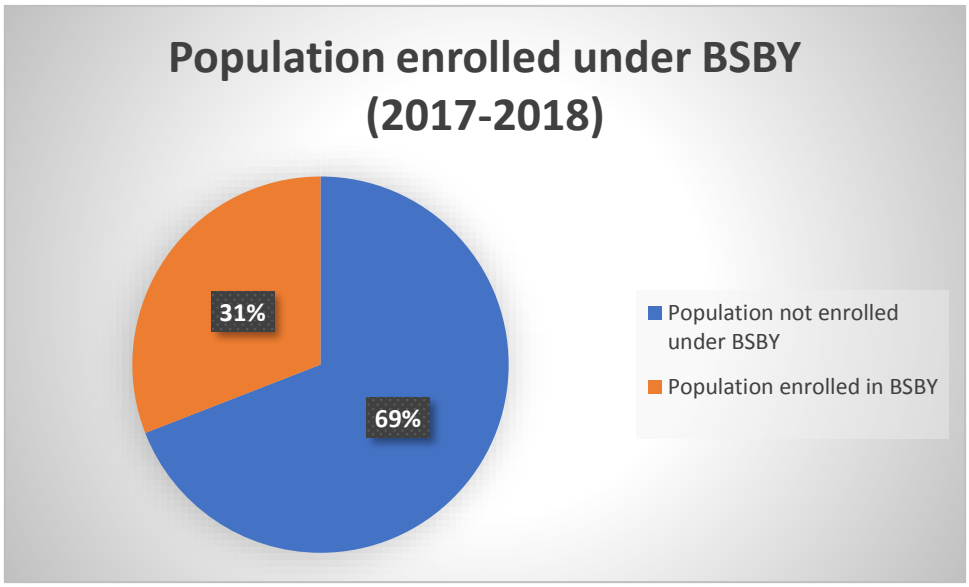
	implementation of the scheme.	
Health Institution	Providing Health Services to beneficiary patients.	SHAA/ Insurance Company
Insurance Company	Provide Health Insurance Cover as per agreement	SHAA

Table 6 Scheme Structure at Institutional level [19]

S. No.	Authority	Responsibility
1	Superintendent/PMO/MoIC	Overall implementation of the scheme
2	Specialist/treating doctor	Guiding the patient for getting benefit under the scheme. Identifying the IPD package under the scheme for the patient. Treating the patient.
3	Routine IPD counter of the Institution	Re-checking the patient that whether he/she is a beneficiary under the scheme. If Yes; guiding the patient towards the Swasthya Margdarshak.
4	Swasthya Margdarshak	• Identify the patient as beneficiary under BSBY. • If the patient is not carrying identity then guide the patient to bring the identity related to NFSA or RSBY. • Provide information regarding available amount in the wallet of beneficiary. • Blocking of the IPD package for the beneficiary. • Assisting the patient in case of any problem/discharge/follow-up/referral.

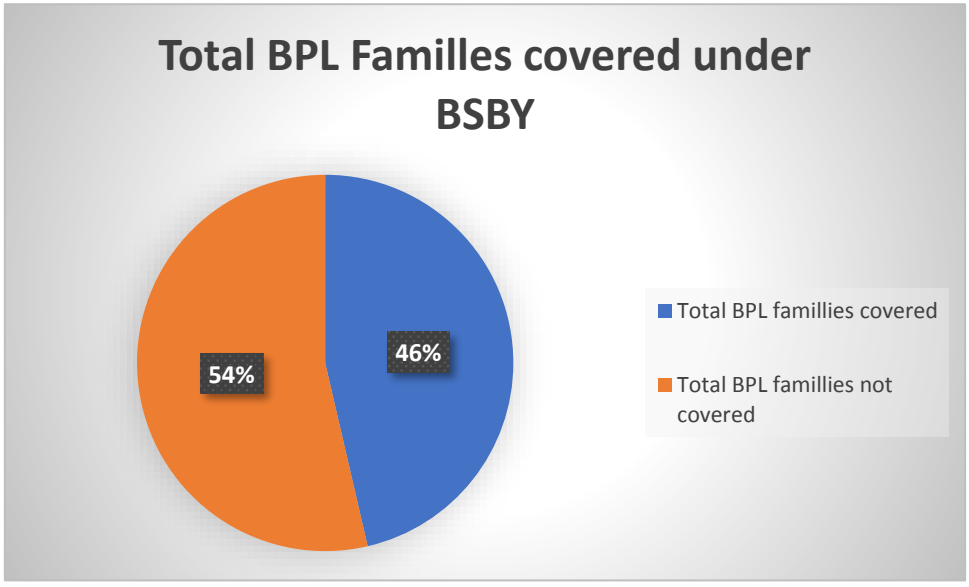
B Data Analysis

Figure 1 – Population enrolled in BSBY



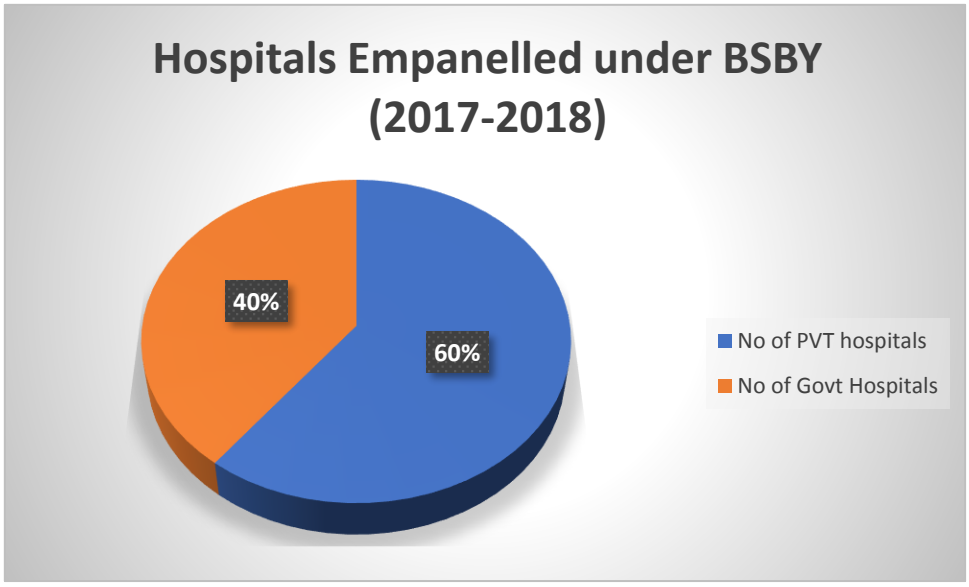
The above pie-chart depicts that 31% of total Rajasthan's population is enrolled under BSBY were as remaining population is not enrolled.

Figure – 2 BPL Families enrolled under BSBY



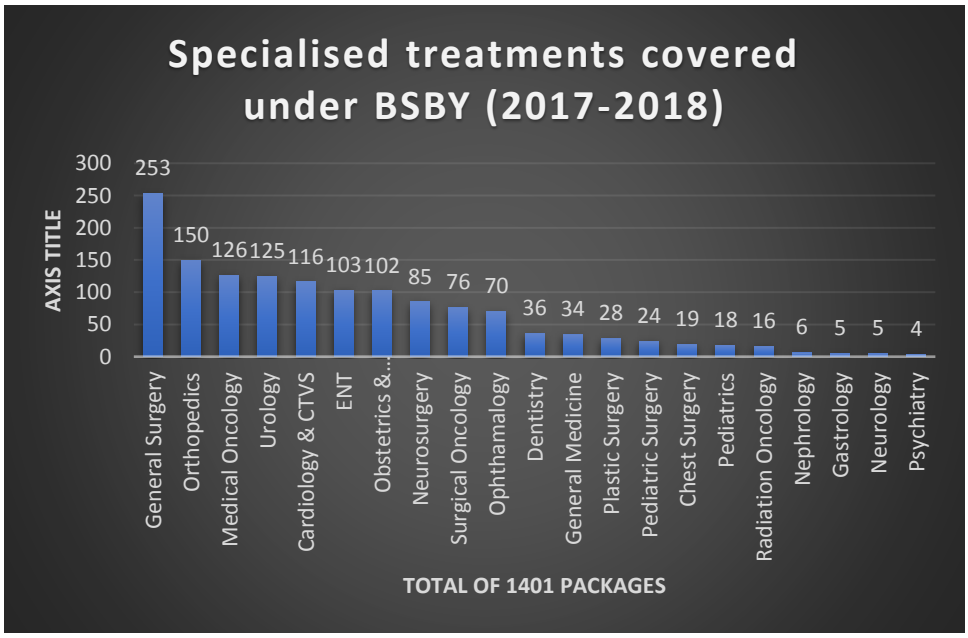
Out of all BPL families only 46% of then are covered under BSBY were the remaining 54% are not covered under BSBY indicating lack of awareness of BSBY and its benefits. Government need to take initiatives in promotion and advertising so that more population can be benefited from the scheme.

Figure 3 – Hospitals empanelled under BSBY



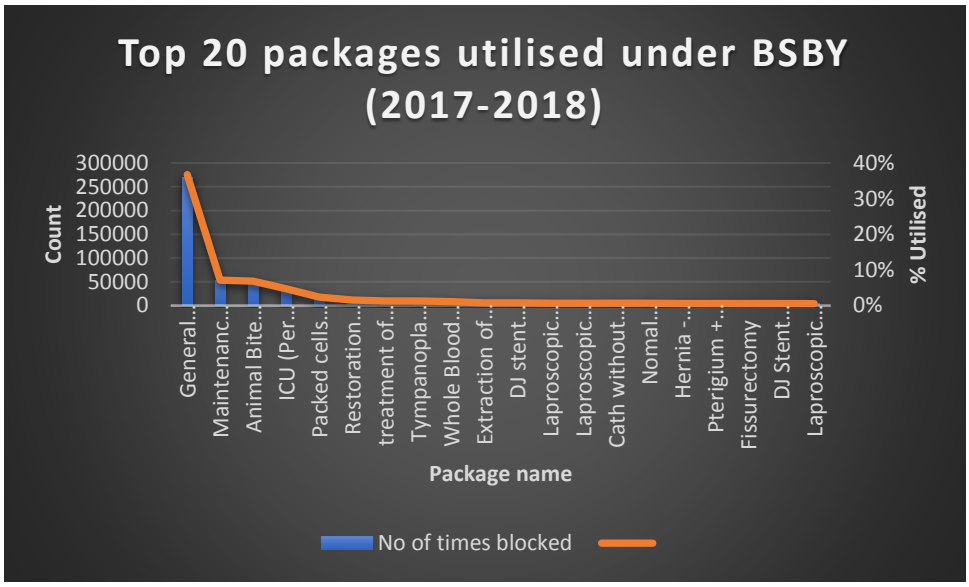
The above pie chart depicts that 60% of the hospitals are empanelled under private sector and remaining 40% are empanelled under government sector.

Figure 4 - Specialised treatments covered under BSBY



The above graph depicts that a total of 21 specialities are present under which different treatments are covered under BSBY.

Figure 5 – Top 20 utilised packages under BSBY

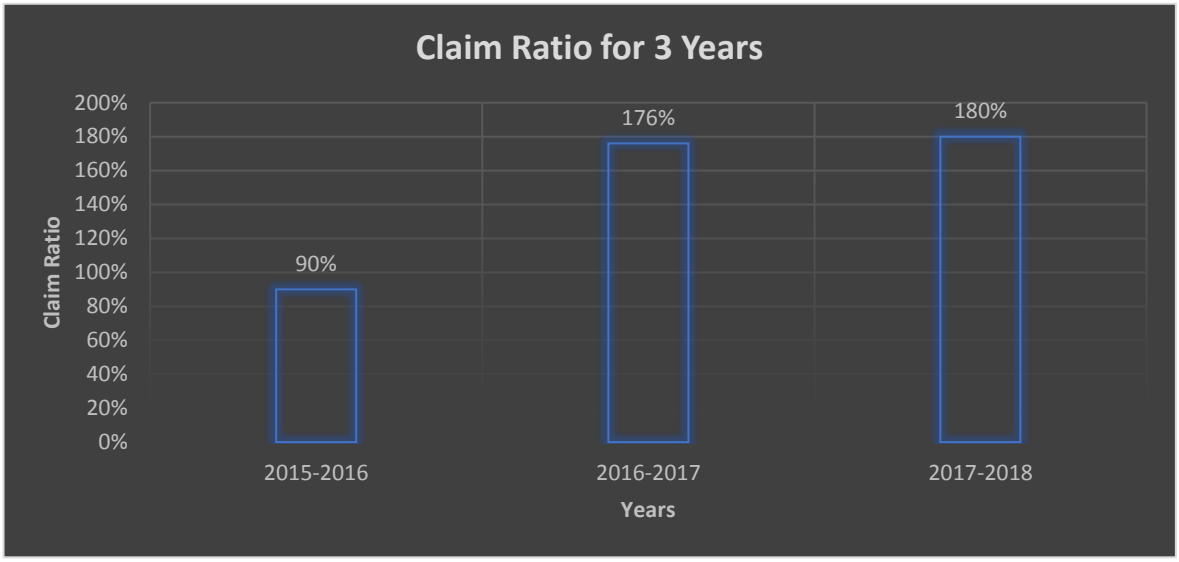


The above graph depicts the top 20 packages which are most utilised under the scheme

Table – 7 Extrapolation of claim ration for the FY 2017-2018

Date	Amount	Difference	% Increase
13-12-2017 - 27-12-2017	233079250	-	-
28-12-2017 - 11-01-2018	294553475	61474225	26%
12-01-2018 - 26-01-2018	306897825	12344350	4%
27-01-2018 - 10-02-2018	347823850	40926025	13%
11-02-2018 - 25-02-2018	365957250	18133400	5%
26-02-2018 - 12-03-2018	361713525	-4243725	-1%
13-03-2018 - 27-03-2018	431091775	69378250	19%
28-03-2018 - 11-04-2018	445555800	14464025	3%
12-04-2018 - 26-04-2018	434263950	-11291850	-3%
27-04-2018 - 11-05-2018	520098000	85834050	20%
12-05-2018 - 17-05-2018	156476175	-	0%

Figure 6 – Claim ratio of BSBY for 3 consecutive years



The above graph depicts the claims ratio for 3 years i.e 2015-2016 the claim ratio was 90%, for the next year claim ratio went as high as 176% & for the current period (December 13, 2017 to May 2018) the claim ration is as high as 180% (forecast).

Top 20 Private Hospitals utilising higher number of packages

Figure – List of top 20 private hospitals

	Top 20 Private Hospitals utilizing higher number of packages		
Sr.no	**District**	**Hospital Name**	**Package count**
1	Udaipur	GEETANJALI MEDICAL COLLEGE HOSPITAL	17344
2	Jaipur	MAHATMA GANDHI HOSPITAL	15479
3	Udaipur	PACIFIC INSTITUTE OF MEDICAL SCIENCES	14168
4	Jaipur	NIMS MEDICAL COLLEGE HOSPITAL	13385
5	Jaipur	Jaipur National University Institute for Medical Sciences and Research Center	11976
6	Jaipur	BARALA HOSPITAL	9717
7	Udaipur	PACIFIC MEDICAL COLLEGE HOSPITAL	7838
8	Udaipur	GBH General Hospital	6180
9	Bharatpur	Meda Daulati Dental Hospital	5260
10	Bhilwara	Ramsnehi Chikit AND ANU Kendra	4970
11	Rajasamand	Ananta Institute of Medical Science Research Center	4601
12	Jaipur	Apex Hospital pvt ltd	4326
13	Jhalawar	Nirogdham Hospital n Research Center	4010
14	Pali	Bhagwan Mahavir hospital	3908
15	Dausa	Navjeevan Hospital	3831
16	Jodhpur	Shriram Super speciality surgical Hospit	3659
17	Siker	Get Well Hospital and Research Centre	3632
18	Ganganagar	BALAJI SURGICAL AND DENTAL HOSPITAL	3604
19	Jaipur	AADINATH ENT and GENERAL HOSPITAL	3604
20	Jaipur	Metro Mas Hospital Heart Care n Multi	3568

Top 20 Government Hospitals utilising higher number of packages

Figure – List of top 20 government hospitals

	Top 20 Government Hospitals utilising higher number of packages		
Sr.no	**District**	**Hospital Name**	**Package count**
1	Ajmer	Jawahar Lal Nehru Hospital	15892
2	Jaipur	SMS Hospital Jaipur	15086
3	Kota	New Hospital Medical College Kota	10306
4	Alwar	Rajeev Gandhi General Hospital Alwar	9923
5	Kota	Maharao Bhim Singh Hospital	8305
6	Jodhpur	Mathura das Mathur Hospital Jodhpur	7690
7	Udaipur	Maharana Bhupal Govt Hospital	6969
8	Ganganagar	DISTRICT HOSPITAL SGNR	5727
9	Jhalawar	Shri Rajendra Sarvajnik Hospital Medical College Jhalawar	4115
10	Bikaner	Eye Dental and ENT Hospital Bikaner	3998
11	Rajasamand	R K District Hospital Rajsamand	3872
12	Chittaurgarh	Shri Sanwaliya Govt Hospital Chittorgarh	3692
13	Jodhpur	MATHMA GANDHI HOSPITAL JODHPUR	3614
14	Bhilwara	Mahatma Gandhi Hospial Bhilwara	3591
15	Bikaner	Mental Hospital Bikaner	3463
16	Dhaulpur	Sadar Hospital Dholpur	3291
17	Pali	Govt Bangur Dist Hospital	2906
18	Baran	Govt District Hospital Baran	2597
19	Jaipur	Govt RDBP Jaipuria Hospital Jaipur	2443
20	Jodhpur	Umaid hospital Jodhpur	2396

Total Utilization of packages in BSBY in FY 2017-2018

	Package Rate	Package Count
Government Hospitals	**742104675**	**298535**
Private Hospitals	**3196582875**	**457457**
Total	**3938687550**	**755992**

Awareness on Bhamashah Swasthya Bhima Yojana

Beneficiaries are aware about the services which are available under BSBY. But, they are not aware of the range of services available/provided within this scheme by institutions. According to BSBY, beneficiary is not supposed to pay any fee against hospitalization/investigations/medication. But, some hospitals do charge money from the patients against the services they are providing although they claim the blocked amount for the said package. Beneficiaries were not aware of the free services. These issues clearly indicate the lack of awareness among the beneficiaries regarding the range of services.

C. Testimonials [22]

Screen shots of some beneficiaries got benefited from the scheme.

Aditya
Hanumangarh

I had a pain in my stomach for a long time, under the Bhamashah Health Insurance Scheme, my free penance operation was done during the treatment, which I am now healthy.

Kaushalya Devi
Barva, Baran

I had fracture on my foot. We got a lot of financial support from free treatment under the Bhamashah Health Insurance Scheme, now I can walk.

Nisha
Village-bai chauhan, alwar

Bamashah Health Insurance Scheme is a very good scheme of the government. Son's operation was free from health card, not a single penny.

Durga Lal
quota

My father's stomach operation was done free of cost from Bhamashah Swasthya Bima Yojana and there was no money in medicine and checks.

Ashok Kumar Jat
Sikar

Government's Bhamashah Health Insurance Scheme is a beneficial scheme for the common man. Under this plan my sister is treated free

Amira
Tonk

I had cataracts, which was free operation under Bhamashah Health Insurance Scheme. This scheme of government is very beneficial for the common man.

D. Frauds

Article published in Dainik Bhaskar [18]

Bamasahad's allegation of forgery in the plan

Quota | A case was registered in the Bamashah Health Insurance Scheme on the ENT Surgeon of the city, for making false claims.

Bhaskar News Network | Last Modified - Apr 03, 2018, 05:35 AM

Quota | A case has been registered in the Bamashah Health Insurance scheme for the city's ENT Surgeon, to furnish the wrong claim by fraudulent. Two youths of the area have complained to the Jawahar Nagar police station.

The youth said that their teeth were told poor in the medical camp in the village, after which they were brought to Kota, Bhamashah card was ordered and a whole hospitalized in Indra Vihar was completed. Both of them have alleged that only tooth was to be cleaned, but the doctor snatched one of his noses to take a wrong claim and took photographs. At the same time, taking a second to the Operation Theater and seated and brought it out. When both felt that something went wrong, he talked to the doctor on the phone and with the recording of the whole conversation, complained to the Jawahar Nagar police.

Article published in Financial Express [22]

Rajasthan Health Insurance: Frauds get easy as mandatory Aadhaar checks eased, insurers complain

By: Sunil Jain | New Delhi | Published: April 20, 2018 5:07 AM

Health insurance claims in Rajasthan under the government's Bhamashah Swashthya Bima Yojana have shot up dramatically, from Rs 7.5 crore in the first week — the current scheme began on December 13, 2017 — to Rs 20.3 crore in the 17th week, taking the current claims ratio to around 70% already (see graphic).

Health insurance claims in Rajasthan under the government's Bhamashah Swashthya Bima Yojana have shot up dramatically, from Rs 7.5 crore in the first week — the current scheme began on December 13, 2017 — to Rs 20.3 crore in the 17th week, taking the current claims ratio to around 70% already (see graphic). Based on current trends, the ratio for the full year could be as high as 120% despite the fact that the premium charged rose 3.4 times since last year. In 2015-16, the first year of the scheme, the claims ratio was 90% — claims of Rs 320.7 crore were made against the premium of Rs 357.4 crore — and this went up to 176% in 2016-17.

The high claims ensured the premium charged per family rose almost 3.5 times, from Rs 370 in the first two years to Rs 1,263 now. The central government's National Health Protection Scheme (NHPS), likely to be rolled out soon, is based on the Bhamashah model. Neither officials of the Rajasthan government or of the insurance company — New India Assurance — responded to email queries on the scheme and its problems.

6 Conclusion:

This study presents a brief overview of Swasthya Bima Yojana sponsored by State Govt. of Rajasthan. Swasthya Bima Yojna will be a boon for Below Poverty Line(BPL) families as Rajasthan is only implementing the RSBY for Categories other than BPL, such as NREGA enrolments, as Out-of-Pocket Expenses (OOPE) due to expenditure on healthcare services causes' significant economic burden on the households. Thus, implementing health financing mechanisms such as state sponsored health insurance schemes that will protect the citizens from financially catastrophic effect of illness.

Although there are benefits from this Scheme(testimonials), still there are many frauds going on in this scheme (newspaper articles).

Total population enrolled in BSBY Scheme are 31%. There are still 69% of population yet to enrol in scheme. 60% of empanelled hospitals are in private sector. But, only 40% of government hospitals are empanelled under BSBY indicating the need of strengthening the infrastructure. Treatment were provided for 21 different specialized departments in which General Surgery (253) has the highest number of packages, followed by Orthopaedics (150) and Medical Oncology (126). But, in case of utility trends, General Ward (36%), Haemodialysis (10%) and Animal bites (7%) followed by ICU (5%) are the most utilised packages.

In FY 2015-16 premium paid per family under BSBY scheme is Rs. 370. It is the same for 2016-17. Although premium raised to 1263 Rs in FY 2017-18, the claims are as high has 70% by the month of May and forecasted claims by the end of FY could be 782%

Out of all BPL families only 46% of then are covered under BSBY were the remaining 54% are not covered under BSBY indicating lack of awareness of BSBY and its benefits. Government need to take initiatives in promotion and advertising so that more population can be benefited from the scheme.

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