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Health insurance for India's poor

Meeting the challenge with information technology

A publication in the German Health Practice Collection

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German Health Practice Collection

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The Collection covers projects supported by German Development Cooperation (GDC) and its international and country-level partners around the world. GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organisations: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH and KfW Development Bank (KfW). The projects are drawn from a wide range of technical fields and geographical areas, at scales running from the local to the global. The common factor is that they make useful contributions to the current state of knowledge about health and social protection in development settings.

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■ **Front cover photo:** A man displays the biometric Smart Card which provides him, his son and three other family members with access to free inpatient care up to Rs 30,000 (400 EUR) per year under Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance scheme for Indians living below the poverty line. Launched in 2008, RSBY now covers more than 41 million households – an estimated 124 million people.

Contents

Executive Summary	4
Why RSBY?	6
Towards universal access to health services	8
An overview of RSBY	15
RSBY takes flight: Recent innovations to the scheme	20
Achievements and challenges	26
The way forward for RSBY	32
Lessons for the successful implementation of health insurance schemes	33
Peer review	35
Acknowledgements	37
References	38

Acronyms

AABY	Aam Aadmi Bima Yojana
BPL	Below the poverty line
BMZ	Federal Ministry for Economic Cooperation and Development
GDP	Gross Domestic Product
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH
IGSSP	Indo-German Social Security Programme
IT	Information technology
MIS	Management Information System
MoLE	Ministry of Labour and Employment
PDS	Public Distribution System
PPP	Public Private Partnership
RSBY	Rashtriya Swasthya Bima Yojana
SNA	State Nodal Agency
UWSSA	Unorganised Workers' Social Security Act
WHO	World Health Organization

Executive summary

This publication describes how the Government of India has extended protection against catastrophic health expenditures to poor and informal workers through Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance scheme whose design and implementation is supported by Germany's Federal Ministry for Economic Cooperation and Development (BMZ).

Situation

Government spending on health in India is one of the lowest in the world. The public health system is unable to adequately meet the population's health needs, and private providers account for a huge proportion of health services. Both public and private providers are poorly regulated and of uneven quality. Private expenditure represents 70 per cent of total expenditure on health; of this, 86 per cent are out-of-pocket payments made directly by patients.

Informal workers constitute 94 per cent of the Indian workforce; the vast majority are not protected in the event of illness. Ill health is a leading cause of indebtedness among the poor.

Approach

Since 2008, the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), on behalf of BMZ, has been supporting India's Ministry of Labour and Employment (MoLE) on the design and roll-out of RSBY.

RSBY is structured as a public-private partnership. It is led by the central government, but implemented by authorities in India's states and union territories in cooperation with public and private insurance companies, hospitals and civil society organisations.

RSBY provides hospitalisation coverage up to 30,000 Rupees (EUR 400) per year for up to five members of households living below the poverty line. There are no age limits and pre-existing conditions are covered. Premiums are subsidised by the central and state governments. Insurance companies are selected by state authorities to implement RSBY. They enrol households directly in villages and issue beneficiaries with a biometric Smart Card which can be used to access cashless treatment at any public or private hospital across India which is empanelled with the scheme.

RSBY makes extensive use of information technology. The Smart Cards issued to beneficiaries contain their photographs and fingerprints; this allows their identity and eligibility to be verified at hospitals when they seek treatment, thereby reducing the likelihood of fraud. Empanelled hospitals send RSBY transaction data to central servers on a daily basis; insurance companies receive and settle claims online, directly with hospitals.

Starting in 2011, RSBY eligibility has been extended to new categories of informal workers, including street vendors, domestic workers, rag-pickers, taxi and autorickshaw drivers, and mine workers. Certain states have topped up RSBY's standard benefits package with additional coverage for tertiary care; pilot programmes have extended the RSBY model to include outpatient care and have tested the suitability of RSBY's Smart Card platform for administering other social benefits, such as life and disability insurance and food subsidies.

Since 2011, under the Indo-German Social Security Programme, GIZ has worked closely with the MoLE to refine RSBY's design and expand its coverage, upgrade its IT systems, build institutional capacity in state-level implementation agencies, extend its Smart Card technology as a platform for other social security schemes, and develop monitoring tools to evaluate the scheme's outcomes.

Achievements

The following are some of RSBY's main achievements:

- **Rapid scale-up to become one of the largest health insurance schemes in the world.** In seven years RSBY, which is a voluntary scheme, has grown to cover 41.2 million families – approximately 124 million beneficiaries – in 28 states and union territories. More than 10,500 hospitals (nearly 60 per cent of them private) are empanelled with the scheme.
- **Improved access to health care.** Since 2008 RSBY has covered some 10.6 million hospitalisations. Despite a shortage of hospitals, particularly in rural areas, the hospitalisation rate in RSBY districts has risen continuously, from 1.86 per cent to 3.04 per cent between the first and fourth rounds of implementation.
- **More women are enrolling in RSBY and using services.** The proportion of women enrolling in RSBY has risen from 41 to 49 per cent of all beneficiaries between the first and fourth rounds of the scheme. Once enrolled, women tend to utilise services more than men.

- **Lower out-of-pocket expenditure for enrolled families.** Several evaluations show that families enrolled in RSBY have significantly lower direct expenditure on inpatient care than those who are not enrolled.
- **High levels of beneficiary satisfaction.** Majorities of households surveyed in evaluations are satisfied with the scheme and intend to renew their enrolment.
- **RSBY IT platform successfully used to administer other social security schemes.** Food subsidies are being provided in one state via RSBY's Smart Card platform; a life and accident insurance scheme is being delivered via the RSBY platform in another. The MoLE plans to issue a social security card for unorganised workers based on the smart card technology which shall provide access to several social security schemes.

Lessons learned

RSBY demonstrates that a government-led social security scheme, designed in close partnership with public and private sector actors, can be successful in extending protection against catastrophic health expenditure in a country as large as India. Its success lies in part in the decision to tailor the scheme to the needs of its target audience (i.e. making it cashless, paperless and portable). RSBY provides access to public and private hospitals, thus significantly enlarging the

network of healthcare providers for the poor and empowering them with greater choice. A focus on strong IT systems has helped to combat fraud, enabled the swift settlement of claims, and allowed close monitoring of the scheme's performance.

Future outlook for RSBY

In April 2015, the responsibility for RSBY was transferred to the Ministry of Health & Family Welfare (MoHFW). The essential features of the scheme as of now remain unchanged. GIZ will continue to support its implementation. Learnings from RSBY will help India's government to develop an effective model to achieve its goal of universal health coverage. Areas which may require further attention include:

- extending coverage to all informal workers;
- revising the benefits package to reflect increasing costs of treatment, as well as outpatient and tertiary care services;
- strengthening existing systems for identifying fraud and addressing grievances;
- establishing an independent, national body to administer the scheme; and
- improving the quality of health services provided under RSBY.

Box 1. Key Messages

Situation. Informal workers constitute 94 per cent of India's workforce; the vast majority are not adequately protected in the event of illness. Some 2 per cent of Indian households are impoverished each year as a result of catastrophic health expenditure.

Approach. The national health insurance scheme RSBY provides hospitalisation coverage for up to five members of households living below the poverty line, up to an annual ceiling of Rs 30,000 (EUR 400). Through the use of biometric Smart Card technology, coverage under the scheme is paperless, cashless, and available to beneficiaries at empanelled public and private hospitals across India.

Results. More than 41 million households are enrolled in RSBY and 10.6 million hospitalisations have been covered since the scheme's launch. After four years of implementation, the average hospitalisation rate in RSBY districts has risen from 1.86 per cent to 3.04 per cent.

Lessons learned. A government-led insurance scheme designed and implemented in close partnership with private sector and civil society actors and utilising cutting-edge information technology can be successful in extending social protection to millions of poor citizens, even in a country as large and diverse as India.

Why RSBY?

In Chekuasol village of Paschim Medinipur district, in the Indian state of West Bengal, the life of a woman named Sefali Lohar was saved by a small plastic card.¹ For more than two years Sefali had been suffering from severe pain in her abdomen. Although she was in obvious need of medical care, there was no question of seeking help: Sefali and her husband, Bijay, struggled to support their family of five on their meagre earnings and there was simply no money available to pay a doctor. Sefali continued to work in great discomfort until one day the pain became unbearable. Her family rushed her to the hospital where the attending physician diagnosed her with a large abdominal tumor that required immediate surgery.

The costs of the procedure and hospital stay – Rs. 26,500 (EUR 353)² – were beyond anything Sefali and her husband could imagine, and they were about to leave the hospital with her condition untreated. But the physician knew that the Lohars, as a family living below the poverty line (BPL), were likely to be eligible for hospitalisation costs of up to Rs. 30,000 (EUR 400) per year under Rashtriya Swasthya Bima Yojana (RSBY), a national health insurance scheme launched by the Government of India in 2008. When he asked the couple if they were enrolled in RSBY, Bijay remembered the plastic Smart Card they had received earlier that year.

He found the card at home and brought it to the hospital, where administrators checked the biometric data in the card and verified that Sefali was entitled to free treatment. Shortly thereafter, she underwent a successful operation to remove the tumor. Sefali recovered fully from the surgery and was able to go back to work, free of debilitating pain.

Many poor Indians suffer from painful, untreated conditions because they lack the money to pay for health care. This is particularly true for women who, on the whole, enjoy a lower social status than men in Indian society and whose health needs tend not to be prioritised when decisions are made about household expenditures. In terms of gender equity in health and survival, India ranks 132 out of 134 countries, according to the World Economic Forum (Raj, 2011). One reason for women's poor health outcomes is that, as in the case of Sefali Lohar, they often do not get the care they need at the time they need it.

RSBY, which is designed to protect India's poor from the consequences of catastrophic health expenses, is slowly changing this situation. With each passing year women represent an ever-greater proportion of the beneficiaries enrolled in the scheme, which is currently estimated at 130 million people countrywide; once enrolled, women also utilise



■ *RSBY is expanding access to health care for millions of Indian women. Women whose husbands work as migrant labourers can now use the Smart Card to get treatment for themselves and their children when they need it, instead of waiting for their husbands to return home.*

¹ The story of Sefali Lohar comes from MoLE *Rashtriya Swasthya Bima Yojana: Health and Hope for All*, a collection of beneficiary testimonials.

² This publication uses an exchange rate of 75 Indian Rupees to 1 Euro.

benefits under RSBY in greater numbers than men. And in West Bengal, where Sefali Lohar lives, it is now possible for women to enrol directly in the scheme as 'heads of household' in their own right, rather than being covered in their capacity as spouses or other dependents. This shift, which the Government of India has mandated to take nationwide in the next phase of the scheme, gives women more control over decision-making when it comes to seeking health care.

This is but one of the many ways that RSBY – now one of the largest health insurance programmes in the world – is fundamentally changing the lives of India's most vulnerable, ensuring that members of families living below the poverty line and certain categories of informal workers are able to obtain the health services they need, without the risk of financial ruin.

A national health insurance scheme for India's poor

India is firmly committed to the goal of universal health coverage, which envisages that everyone be able to access quality health services without fear of impoverishment. RSBY is one of a portfolio of measures introduced by the Government of India under the auspices of the Unorganised Workers' Social Security Act (UWSSA) of 2008 to extend social protection to the poorest members of society.

RSBY is an audacious undertaking: the extension of cashless, paperless and portable hospitalisation benefits to hundreds of millions of poor people nationwide. Yet despite daunting odds, the RSBY model has proven robust. From its modest start in two states in April 2008, RSBY is now implemented in 28 states and union territories of India and, as of January 2016, had enrolled 41.2 million families and covered the costs of 10.6 million hospitalisations.

Do you have questions, feedback or other comments? Get in touch with the Indo-German Social Security Programme via igssp@giz.de. For more contact information see Box 6 on page 37.



■ RSBY is a cashless, paperless and portable scheme which allows beneficiaries to access hospital care in public and private facilities countrywide. Biometric Smart Cards, such as the one shown here, contain beneficiaries' photographs and fingerprints and are used by hospitals to verify their eligibility to receive free treatment.

The Federal Republic of Germany, with its well-established social insurance system, has been an important partner for the Government of India in the design and implementation of RSBY. On behalf of the Federal Ministry for Economic Cooperation and Development (BMZ), the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) has been working closely with India's Ministry for Labour and Employment (MoLE) practically since RSBY's inception, providing policy advice on the scheme's design, supporting the IT system on which the Smart Cards run, building the capacity of institutions and personnel to implement RSBY at the state level, and evaluating the implementation and results of the scheme on a continuous basis.

This publication, which builds upon an earlier version published in 2011, describes the evolution of RSBY, with a particular focus on its achievements over the period 2011 to 2014 in expanding coverage, upgrading its IT systems, building institutional capacity in state-level implementation agencies, and extending its Smart Card technology as a platform for other social security schemes. In doing so, it makes clear why RSBY has attracted attention from health financing and social protection experts the world over, who see the potential for some of its innovative features to be applied in contexts far beyond India's borders.

Towards universal access to health services

An international push for universal health coverage

According to the World Bank (2014), some 1.2 billion people worldwide were living in extreme poverty (defined as less than USD 1.25 per day) in 2010 and approximately twice as many were living on less than USD 2 per day, the average poverty line for developing countries. While illness and accidents are risks faced by all people over the course of their lives, the immediate and long-term consequences of such misfortunes are particularly severe for the world's poor, who often lack a safety net to help them withstand the costs of medical care and the loss of employment and income due to illness or disability.

The World Health Organization (WHO) estimates that about 150 million people suffer financial catastrophe every year as a result of using and paying for health services, while another 100 million are pushed below the poverty line. In some countries, up to 11 per cent of the population can experience severe financial hardship every year and up to 5 per cent can be forced into poverty as a result of catastrophic health expenditure (WHO, 2010). While the poor are particularly vulnerable, even families with relatively stable finances can find themselves impoverished as a result of unexpected health-related events.

Globally, the need for universal health coverage – ensuring that all people have access to health services, without the risk of financial hardship – is becoming ever more urgent as a result of rising health costs linked to ageing populations,

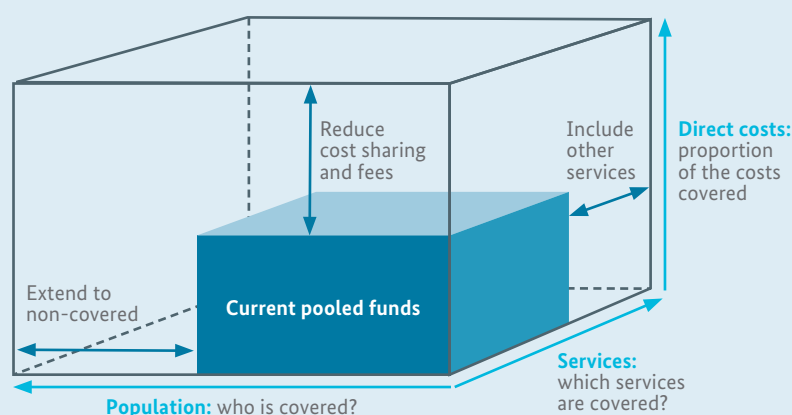
growing levels of chronic disease and the advent of new and expensive medical treatments (WHO, 2010). An important milestone was reached in 2005 when WHO member states, recognising that timely access to health services is critical for promoting and sustaining health, committed to developing their health financing systems to support its achievement.

The promise of social insurance schemes

Governments have different policy options at their disposal for moving closer to universal coverage, but in choosing among them they must attempt to tackle three fundamental challenges: increasing the availability of resources for health, reducing reliance on direct payments for care, and promoting the efficient and equitable use of resources (WHO, 2010).

The WHO recommends social health insurance schemes as the most efficient and equitable way to increase population coverage. Such schemes use solidarity-based mechanisms, in which the rich subsidise the poor and the healthy subsidise the sick, to finance the costs of medical treatment while protecting people from unaffordable costs. By pooling prepayments from a large population of people, in advance of illness, such schemes make it possible for the costs of treatment and rehabilitation to be funded, when eventually needed, for those who are covered. While the ultimate goal of 'filling the box' (see Figure 1) – 100 per cent of the population covered for 100 per cent of available services and 100 per cent of the cost – will always remain a challenge, countries with prepayment and pooling mechanisms are better positioned to achieve this than those that do not (WHO, 2010).

Figure 1: Three dimensions to consider when moving towards universal coverage



Source: WHO, 2010

Box 2. The role of information technology in social health insurance systems

Over the past five years, more and more countries have begun implementing national health insurance schemes in order to expand citizens' access to health services and to protect them from financial risk. Despite a diversity of approaches, the schemes share one common feature: their extraordinary dependence upon the use of information technology.

The administration of any health insurance scheme requires a continuous flow of data for decision-making: schemes must be able to identify eligible beneficiaries, enrol them in the scheme, pay health providers for treatments, and track transactions and expenditures. While these various elements can be managed by exchanging information in paper form, the sheer volume of information which is exchanged in administering a national insurance scheme makes this highly impractical and increases the risk of manual errors. Information technology has become indispensable for the exchange of accurate and timely data, as well as for the proper identification of beneficiaries (i.e. use of biometric data).

Source: PATH (2012). Determining Common Requirements for National Health Insurance Information Systems.

There are many ways to design, finance and implement social health insurance schemes, and no one approach is suitable for all settings. However WHO highlights several lessons which have been learned from countries that have already invested in such approaches. First, in every country there will always be a population of people who will be unable to pay into the scheme (e.g. through premiums or deductions) and whose participation in the scheme will need to be subsidised through pooled funds. Second, participation in social insurance schemes should be compulsory, to avoid situations where the healthy and the better-off choose not to contribute. And third, bigger beneficiary pools are preferable to smaller ones; not only are they more economically viable in the long term, but they are also more efficient to administer (WHO, 2010).

The road to universal health coverage in India

■ Rapid growth, but broad and deep developmental challenges

India's transformation over the past half century has been nothing short of astonishing. Since its earliest days as a newly independent nation – wracked by poverty, hobbled by a weak economy and scarred by the experience of partition – the country has emerged as a leading geopolitical force on the world stage. Robust economic growth, enabled by policies of economic liberalisation introduced in the early

1990s, has fuelled booms in a number of high-skilled fields, including information technology (IT), pharmaceuticals and biotechnology. Life expectancy has nearly doubled since independence, literacy rates have risen and more girls are going to school. There are plenty of indicators to suggest that the world's biggest democracy is on the path to a brighter future.

India's development in recent years has been paradoxical, however, because gains in the economic sphere are taking place against a backdrop of broad and deep developmental challenges (Horton and Das, 2011). Depending on how it is measured (see Box 3), anywhere from 30 to 55 per cent of India's population lives in poverty. This 'daunting toll of deprivation' places India behind neighbours such as Pakistan, and behind major emerging economies like Brazil and China, in terms of the proportion of the population that is impoverished (Horton and Das, 2011).

In the 2014 *Human Development Report*, India was ranked 135 out of 187 countries for which data was available. While India's Human Development Index (HDI) has steadily improved, increasing from 0.369 in 1980 to 0.586 in 2013, it remains under the average for countries in the South Asia region (0.588) and for other countries in the 'medium human development group' (0.614) to which India belongs (UNDP, 2014).

Box 3. Measuring poverty in India

Using a method that takes into account the income required for a minimal basket of goods and services (including food, clothing, household durables and health care), the **Government of India Planning Commission** found that **29.8 per cent** of the country's population was poor in 2009-10 (down from 37.2 per cent in 2004-5). In rural areas one-third of the population (33.8 per cent) was poor, compared to one-fifth of the population (20.9 per cent) in urban areas (Government of India, 2012).

The **World Bank** (2014) estimates that 394 million people, or **32.7 per cent** of the population, were living under the international poverty line of US\$1.25 per day (in terms of purchasing power parity) in 2010.

The United Nations Development Programme calculates a **Multidimensional Poverty Index (MPI)**, a composite measure of deprivation which identifies multiple deprivations in the same households in education, health and living standards. Based on 2005-6 data, **55.3 per cent** of Indians were multidimensionally poor and another 18.2 per cent were close to multidimensional poverty. The fact that the MPI is significantly higher than income-based poverty alone points to the fact that families living above the poverty line may still suffer deprivations in health and other living conditions (UNDP, 2014).

Table 1. Key health indicators for India, compared to South East Asia, lower middle and high income countries, and global averages

	India	South East Asia	Lower middle income countries [*]	High income countries	Global
Life expectancy at birth (2012)	66	67	66	79	70
Women	68	69	68	82	73
Men	64	66	64	76	68
Total Fertility Rate (per woman)	2.5	2.4	2.9	1.7	2.5
Maternal Mortality Ratio (per 100,000 live births) (2013)	190	190	240	17	210
Infant Mortality Rate (deaths per 1,000 live births)	44	39	46	5	35
Under-5 Mortality Rate (per 1,000 live births)	56	50	61	6	48
Proportion of children under-5 who are underweight (2006-2012)	43.5%	26.6%	24.1%	1.4%	15.1%
Mortality from malaria (per 100,000 population) (2012)	2.3	2.3	13	–	11
Tuberculosis prevalence (per 100,000 population) (2012)	230	264	169	31	237
Age-standardised mortality rates by cause (per 100,000 population) (2012)					
Communicable diseases	253	232	272	34	178
Non-communicable diseases	682	656	673	397	539
Injuries	116	99	99	44	73

Source: WHO (2014), World Health Statistics, 2014

^{*} India is classified as a lower middle income country.

In India, as in most countries, a disproportionate burden of death and disability is borne by the most vulnerable members of society. Women, the poor and members of scheduled castes and tribes are more likely to experience ill health than other groups. Geography also plays a role. There are great variations in health outcomes between the country's 29 states and seven union territories, as well as between rural and urban areas.

The structure of the healthcare system both contributes to and perpetuates these inequalities in health. Those individuals who have the greatest need for health care are the ones who are least likely to access appropriate services (Balarajan et al., 2011). The two-tiered nature of the Indian health system means that a tiny, privileged slice of the population which is able to pay for health services benefits from world-class care, while those unable to do so often cannot access even basic services. Moreover, the country's focus on providing specialist-delivered services in hospitals, rather than primary healthcare services closer to communities, has both compounded inequalities and led to skyrocketing healthcare costs (Reddy et al., 2011). 'Health care, far from helping people rise out of poverty,' concludes another group of public health experts in *The Lancet* (Patel et al., 2011), 'has become an important cause of household impoverishment and debt.'

■ Health financing in India

The healthcare system established in India in the post-independence period mirrors the British model, with a network of government-run facilities providing the population with health services. Its guiding vision was set forth in the Bhole Committee report of 1946, which recommended that comprehensive preventive and curative services be integrated at all levels and made available to all citizens, irrespective of their ability to pay (Reddy et al., 2011). The public health system as it has evolved over the past six decades falls short of this ideal, however. Chronically low levels of government spending on health – approximately one percent of the country's Gross Domestic Product (GDP), one of the lowest levels in the world – have left public sector facilities unable to meet the population's health needs adequately. India has seven doctors and seven hospital beds for every 10,000 people; in high income countries, the average is 30 doctors and 54 hospital beds for every 10,000 people (WHO, 2014). Although services at public facilities are ostensibly free of charge, patients seeking treatment regularly incur costs for care (Jain, 2014).

In part due to the weakness of the public health system, private sector facilities and providers account for a huge proportion of health services in India. They have become the 'default option' for many Indians who do not see public facilities as a credible alternative (Reddy et al., 2011). They are poorly regulated and of uneven quality, however, and tend to favour expensive curative services over more economical



■ *India's public health system is under-resourced and unable to adequately meet the population's health needs. While many treatments are ostensibly free of charge, patients regularly pay user fees as well as costs for medicines and other supplies.*

preventive care. According to the World Health Organization (2014), private expenditure accounted for 70 per cent of total expenditure on health in India in 2011, and of this, 86 per cent was out-of-pocket expenditure paid directly by patients (see Table 2).

This has clear implications for both the health and economic circumstances of India's poor. First, the fact that most treatments, even for routine outpatient care, must be paid for privately means that many individuals postpone treatment for minor ailments – potentially allowing them to progress into major health concerns – and skip important health checks, including antenatal visits. According to data from the National Family Health Survey (2005–6), some 28 per cent of ailments in rural areas and 20 per cent in urban areas were not treated for financial reasons – up from 15 per cent and

10 per cent, respectively, only a decade earlier (Kumar et al., 2011).

Second, it means that ill health is a leading cause of indebtedness among the poor. The cost of healthcare payments pushes over 2 per cent of the population into poverty every year. People go to great lengths to cover the costs of inpatient care: in 2004, nearly half of hospital admissions in rural areas and a third in urban areas were paid for through loans or the sale of assets (Kumar et al., 2011). Medicines are the largest single element of these costs; along with payments for diagnostic tests and medical appliances, they comprise more than half of out-of-pocket expenditures. Ancillary costs, such as transportation and lost wages, add to the burden (Balarajan et al., 2011).

Table 2. Health expenditure in India, compared to South East Asia, lower middle and high income countries and global averages (2011)

	India	South East Asia	Lower middle income countries	High income countries	Global
Total health expenditure, as % of Gross Domestic Product	3.9	3.7	4.4	11.9	9.1
Private expenditure on health, as % of total expenditure on health	69.5	63.3	63.4	38.6	41.1
Out-of-pocket expenditure, as % of private expenditure on health	86.3	84.3	87.1	37.6	49.7
Per capita total expenditure on health (PPP int. \$) (2011)	146	142	163	4319	1053
<i>Source: WHO (2014), World Health Statistics, 2014</i>					

■ Testing ways to reduce out-of-pocket expenditure

Just as has been the case in a growing number of countries worldwide, steady increases in healthcare costs and the growing problem of health-related impoverishment have pushed the question of health financing ever higher on the agenda in India. Over the past decade, consistently high economic growth rates have made it possible for the government to increase its expenditure on health. The country's Twelfth Five Year Plan (2012–2017) foresees an increase in government health spending from 1.1 per cent to 3 per cent of GDP (Jain, 2014).

While increased budget allocations are needed and welcome, they are – on their own – insufficient to address the scale of the country's health financing challenges. Thus, like their counterparts in other countries, officials and policymakers in India have increasingly looked to demand-side measures, such as health insurance schemes, as a way to expand access to health care, especially for those who cannot afford to pay for care themselves.

Health insurance coverage in India has historically been underdeveloped and fragmented. Results from the National Family Health Survey (2005–6) show that only 10 per cent of Indian households have at least one member covered by a medical insurance scheme (Kumar et al., 2011). According to WHO (2014), prepaid insurance accounts for only 4.6 per cent of all private expenditure on health in India. Given that unorganised workers compose the vast majority of the workforce, employer-linked insurance schemes could realistically only represent a small part of a larger solution. The way forward for India lay in some form of social insurance.

In the early to mid-2000s, the central government and a handful of state governments began experimenting with narrowly-targeted social insurance schemes based on a Public-Private Partnership (PPP) model. The schemes were funded by the government, which paid premiums on behalf of categories of beneficiaries, and were implemented by insurance companies. Although most of these schemes proved to be ineffective and shut down after a year or two, some important lessons were learned which informed a much larger-scale effort which was announced soon thereafter.

A commitment to protect India's unorganised workers

In a speech delivered on August 15, 2007, the 60th anniversary of India's independence, Prime Minister Manmohan Singh hailed India's many achievements before cautioning, 'India cannot become a nation with islands of high growth and vast areas untouched by development' (WIAS, 2007). He outlined his government's vision of 'inclusive growth,' which would be achieved through massive increases in public spending on education, health, agriculture and rural development. He also announced three new initiatives which would strengthen social protection and extend social insurance coverage to hundreds of millions of people living below the poverty line. One of these was Rashtriya Swasthya Bima Yojana, a new health insurance scheme aimed at unorganised workers and their families.

According to the MoLE, a total of 465 million people were employed in India in 2009–2010 and 437 million (94 per cent) of these worked in the unorganised sector. Under the Unorganised Workers' Social Security Act, an unorganised worker is defined as someone who works from home, is self-employed, or who works for wages in the organised sector but is not covered by certain labour-related statutes³ (MoLE, 2014).

India's informal workforce is highly heterogeneous. It includes, among many others, small farmers, artisans, salt workers, rag pickers, fishermen, landless labourers, brick kiln workers, construction workers, beedi rollers, tailors, weavers, domestic workers, scavengers and recyclers, sanitation workers, cab drivers, shoe shiners, fruit vendors, newspaper vendors, barbers, taxi drivers, lunch deliverers (*dabbawala*) and domestic workers. What holds this huge and disparate group together is the fact that its members all lack a formal employer-employee relationship and social security protection – and are among the country's poorest citizens.

³ Specifically, the Employees Compensation Act (1923), the Industrial Disputes Act (1947), the Employees State Insurance Act (1948), the Employees' Provident Fund and Miscellaneous Provision Act (1952), the Maternity Benefit Act (1961) and the Payment of Gratuity Act (1972).

■ RSBY's core criteria

Informal workers living below the poverty line were the main target group for RSBY. The objectives of the scheme were twofold: first, to increase access for unorganised workers to quality health care by providing them with the option to be treated in public and private facilities, and second, to reduce the out-of-pocket expenditures which they incur for hospitalisation costs.

In October 2007, the MoLE was assigned responsibility for designing and overseeing the implementation of RSBY. Right from the start, the core criteria for the scheme were clear:

- The scheme needed to be **cashless**. RSBY's future beneficiaries were poor and could not be expected to pay for services upfront and be reimbursed later.
- The scheme needed to be **paperless**. Many in the target audience were not literate and would not be in a position to undertake documentation to enrol in the scheme, or to avail themselves of its benefits.
- The scheme needed to be **portable**. Many informal workers migrate from state to state to take advantage of seasonal employment opportunities and needed to be covered anywhere across the country.

Some other principles were also deemed important. RSBY needed to be sustainable: incentives (financial and otherwise) had to be aligned in such a way that states, insurance companies, hospitals and beneficiaries all came on board – and stayed on board. Continuous support for the scheme would be essential if it were to move towards its ultimate goal of universal coverage for unorganised workers.

At the same time, the scheme needed to be flexible, adaptable and driven by evidence. This meant that information management systems needed to facilitate a continuous flow of commonly agreed and comparable sets of data between hospitals, insurers and government authorities – and that this data must be quickly analysed and reported on a website available to all stakeholders.

All of this needed to be built, more or less from scratch. Anil Swarup, the Director General for Labour Welfare at the MoLE who led RSBY for the first five years, is quoted as saying that 'this was an assignment that no one wanted to take on initially' (Schaap, 2013).

■ Germany's contribution

Under its first chancellor, Otto von Bismarck, Germany established the world's first social protection system with adoption of the Health Insurance Bill (1883), the Accident Insurance Bill (1884) and the Old Age and Disability Insurance Bill (1889). As it has strengthened this system, Germany has also maintained an abiding interest in using its accumulated experience to support the development of social protection measures in countries around the world. By early 2008, technical advisors from the former Deutsche Gesellschaft für Technische Zusammenarbeit⁴ working on behalf of the Federal Ministry for Economic Cooperation and Development, and the World Bank had emerged as the principal partners to the MoLE in the design and implementation of RSBY. This work was one part of a larger development co-operation agreement between the governments of Germany and India which, at the time, included health and sustainable economic development as priority areas.

In 2011, GIZ's advisory role was expanded with the establishment of the Indo-German Social Security Programme (IGSSP), implemented on behalf of the Federal Ministry for Economic Cooperation and Development. The programme supports the MoLE and other ministries to implement provisions of the 2008 Unorganised Workers' Social Security Act aimed at extending health insurance, pensions and life and accident insurance to informal sector workers. Its main focus has been on improving the design and implementation of RSBY. Since 2011, GIZ has been the main advisor to the Government of India with respect to the scheme.

⁴ In 2011 the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) merged with Deutsche Entwicklungsdienst (DED) and Internationale Weiterbildung und Entwicklung (InWEnt) to form the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). Throughout the remainder of this publication, we refer to GIZ as the organisation responsible for support to RSBY.

An overview of RSBY

This chapter provides a basic overview of the ‘what’ and ‘how’ of Rashtriya Swasthya Bima Yojana. It begins by describing RSBY from the beneficiary perspective, focusing on the enrolment process and benefits, and then moves behind the scenes to look at the roles of key stakeholder institutions and the processes which link them together.

How beneficiaries experience RSBY: Eligibility, benefits and use of services

When RSBY was first launched, eligibility criteria for the scheme could not have been simpler: all families living below the poverty line in participating districts were free to enrol. In India, such families are identified through a household survey and their details are included in an official ‘BPL list’ prepared by the government.⁵ The decision to base eligibility on the BPL list was the logical outcome of one of RSBY’s core principles – that the scheme should be paperless. The hundreds of millions of Indians who work informally have little or no way to prove their income or work status, and requiring them to do so would have been both unreasonable and impractical.



■ An auto rickshaw in Gujarat advertises an upcoming enrolment camp for RSBY. Insurance companies are responsible for publicising enrolment opportunities and for making eligible beneficiaries aware of registration procedures.



■ Enrolling in RSBY usually takes only 10 to 15 minutes. All the members of the household who wish to be covered as beneficiaries (up to five in total) must appear in person to be fingerprinted and photographed.

In April 2008, in the village of Chappar in the Yamunanagar district of Haryana state, RSBY’s first BPL family enrolled in the scheme. Its members did so in much the same way that beneficiaries continue to register with RSBY some six years later: through a face-to-face interaction at a mobile enrolment station. RSBY registration teams, comprising insurance company representatives and field officers employed by district authorities, travel the length and breadth of the country enrolling eligible beneficiaries. They set up temporary registration points at town halls, local government offices, schools or even on tables outside on the street. As they visit a given town or village only once a year, their arrival is publicised well in advance.

Enrolling in the scheme takes approximately 10 to 15 minutes. Each family pays a Rs. 30 fee (EUR 0.40) to join the scheme and provides the first and last names of the head of the household, the spouse and up to three other designated beneficiaries that are already part of the BPL list. All family members to be enrolled in the scheme must be present on the day of enrolment, in order that they be photographed and fingerprinted. Using a laptop, scanner and card printer, the registration team generates a RSBY membership card – a biometric Smart Card capable of storing photographs,

⁵ While the BPL lists are the most practical way to identify beneficiaries, the limitations should also be noted: the current lists are more than 10 years old and the data they contain are often incomplete and riddled with mistakes and inconsistencies. Identifying RSBY’s beneficiaries is a complex and time-consuming task. Challenges related to the use of BPL lists are discussed at length in La Forgia & Nagpal (2012).



■ **left:** A young girl is fingerprinted as part of the RSBY enrolment process.

■ **right:** Once enrolled, new beneficiaries receive a biometric Smart Card, information about the scheme's benefits, and a list of public and private hospitals in their area which are empanelled with RSBY.

fingerprints and other personal information – on the spot. The insurance company representatives provide the families with information about their benefits and a list of empanelled hospitals where they can receive services.

Once insured, RSBY provides hospitalisation coverage up to a maximum of Rs. 30,000 per year (EUR 400) for the five members of the family on a floater basis. All hospitalisation-related expenses are covered for most types of hospitalisations, and package rates have been fixed for almost 1,100 medical and surgical procedures. Unlike some other government-sponsored schemes in India, RSBY covers frequently-occurring conditions such as diarrhoea, dysentery, gastritis, respiratory infections and malaria, as well as more serious illnesses such as heart disease, diseases of the kidney and urinary systems, gynaecological disorders and accidents and injuries (La Forgia & Nagpal, 2012).

RSBY also provides a transportation allowance of Rs. 100 (EUR 1.30) for each hospitalisation event, up to a maximum of Rs. 1,000 per year (EUR 13). All pre-existing medical conditions are covered from the day of enrolment and there are no age restrictions for beneficiaries. Maternity and infant benefits are part of RSBY: not only are deliveries covered under the scheme, but an infant is automatically covered for the first year of its life if the mother is enrolled.

Regular outpatient services, such as diagnosis and treatment of common diseases and minor injuries, are not covered under RSBY (although some states have begun to extend RSBY benefits for outpatient care, see 'Extending RSBY' in the next chapter). Although outpatient services account for a larger overall proportion of health expenditure than inpatient care, per episode costs related to hospitalisation were deemed more likely to be 'catastrophic,' pushing patients and their families into debt or deepening their impoverishment (Jain, 2014).

Beneficiaries under RSBY are empowered to seek treatment at any hospital – public or private, within their home state or outside it – which participates in RSBY. After the patient presents his or her Smart Card, the hospital verifies the patient's identity by checking whether the patient's fingerprint matches that stored in the card. If it does, and there is enough of the Rs. 30,000 annual allowance left on the family's card, the patient receives cashless treatment. As of August 2015, more than 10,500 hospitals across India were empanelled in the scheme.⁶

Once enrolled in RSBY, families who have questions about their coverage can seek support from the RSBY District Kiosk, the focal point for RSBY activity in each district. Staff at the kiosk can help them to replace lost or damaged cards, change details on their cards, update the names of beneficiaries, split their annual allowances between two cards, and get more information on benefits and empanelled hospitals. Until now, enrolment in RSBY has been on an annual basis, meaning that to continue coverage a family has had to re-enrol each year. The MoLE has proposed to switch to a three-year enrolment period from 2015.

⁶ See RSBY website www.rsby.gov.in

How RSBY works: The architecture of the scheme⁷

Although RSBY is financed largely by the government, it is essentially a public-private partnership in its implementation arrangements. In addition to national and state authorities, insurance companies, hospitals and intermediary organisations (referred to as ‘third party administrators’) play critical roles. Civil society organisations are also engaged to undertake specific activities. The design of RSBY therefore reflects a dense web of shared responsibilities and incentives, and a complex management structure and well-tested processes are required to operate the scheme smoothly. RSBY’s process flow is described below.

■ Concluding an agreement between central and state government

RSBY is a central government scheme which is implemented by states and union territories through their respective authorities. When a state wishes to participate in RSBY, it concludes a Memorandum of Understanding with the central MoLE. Under the scheme, the costs of beneficiary premiums are split between the central government, which pays 75 per cent, and the states, which pay 25 per cent (except in Jammu and Kashmir and the North Eastern states, where the split is 90/10). The central government provides technical guidance and assistance to the states in the implementation of the scheme, guides and supports efforts to monitor and evaluate RSBY at state level, and also undertakes national-level monitoring and evaluation.

■ Setting up a State Nodal Agency and preparing beneficiary data

In each participating state, a State Nodal Agency (SNA) is established to support and supervise the implementation of RSBY. The SNA is a dedicated agency set up and owned in each state by the department of labour or health, and staffed by government employees and professionals. The operations of the SNAs are partially funded through the Rs. 30 registration fee paid annually by enrolled families.

In each state, the SNA prepares data about eligible beneficiaries. The MoLE validates the dataset, and then assigns a unique number to each beneficiary family. The data is encrypted, so that only an appointed agency can read it, and uploaded by the MoLE to the central RSBY website.

■ Selecting insurance companies

Each state determines which districts will participate in the scheme; many states began by rolling out RSBY in a handful of districts, gradually scaling up coverage year by year. The State Nodal Agency selects the insurance companies which will implement RSBY through an open tender process, which includes competitive bidding on beneficiary premiums. In some states, the same insurance company covers all participating districts; in others, more than one insurance company is involved. However only one company can be selected in any given district.

■ Empanelling healthcare providers

Once contracted by the SNAs, insurance companies are responsible for empanelling hospitals and other healthcare institutions based on prescribed criteria and keeping up-to-date lists with the details of these facilities to provide to beneficiaries upon enrolment.

Hospitals participating in the scheme commit to providing anyone holding a Smart Card with care, including hospital stays; a specified set of day surgeries, therapies and treatments; and the reimbursement of travel expenses within predefined limits. They agree to charge insurance companies according to a standard set of rates.



■ Many hospitals have set up help desks, such as this one, specifically for RSBY beneficiaries. Empanelled hospitals use special hardware and software to process transactions involving RSBY cardholders.

⁷ This section draws heavily upon Jain (2014).

The insurance companies provide newly-empanelled hospitals with the hardware (such as card readers and fingerprint readers) and software they will need to facilitate paperless transactions on behalf of RSBY beneficiaries. They also train hospital representatives how to use the software to transmit RSBY transaction data to the company and to the government on a daily basis.

As soon as a healthcare provider is empanelled by an insurance company, it is automatically empanelled by all the others. This is what allows the portability of RSBY benefits countrywide.

■ Enrolling beneficiaries

Insurance companies are also responsible for enrolling beneficiaries. Working off the validated beneficiary list prepared by the respective SNA and provided via the RSBY website, the insurance companies set up an enrolment schedule for each district and are obliged to undertake intensive efforts to generate awareness about the scheme. To this end, they often outsource tasks to third party administrators and hire non-governmental organisations or microfinance institutions to disseminate information about enrolment opportunities via posters, brochures, media campaigns and events.

During enrolment itself, representatives of the insurance company are accompanied by local government officials, called Field Key Officers, whose role is to verify the legitimacy of each newly enrolled family. A family can only be enrolled when the officer inserts his or her Smart Card and provides his or her fingerprint to authenticate that the correct beneficiary is receiving the Smart Card. Information about all new beneficiaries is stored on the Field Key Officer's Smart Card, an anti-fraud measure which allows all new beneficiaries to be traced back to a specific official.

■ Paying premiums

Insurance companies receive a premium for each family they enrol in RSBY. The exact amount of the payment to the insurer is calculated according to the data downloaded from the Field Key Officers cards and the encrypted data generated by the enrolment software.

■ Utilising services and settling claims

Under RSBY, the insurers act as both contractor and payer for services, and are responsible for settling hospital claims. After discharging a Smart Card holder following treatment, the hospital uses the RSBY-specific transaction software, which records all information on Smart Card bearers, the care they receive and the costs involved, to send a paperless claim to the insurance company and a record to the state and central government. After reviewing the claims, the insurance company settles them directly, online, with the hospital.



■ A mobile van is used to promote RSBY enrolment in the state of Meghalaya. Potential beneficiaries need to know when and where to enrol and how to check whether they appear on the official list of households below the poverty line.

RSBY's backbone: Information systems

The key to RSBY's success as a cashless, paperless and portable insurance scheme lies in its effective use of information technology. Few if any insurances schemes in developing countries use technology at the scale which RSBY does (Jain, 2014). Five main technological elements underpin RSBY's operations:

- **Smart Card technology.** The Smart Cards, issued to each family upon enrolment, are the portable elements of the RSBY system, used for recording and processing data and financial transactions.
- **Biometric technology.** Each Smart Card contains the fingerprints of the family members covered by the scheme. Biometric technology is used to verify the identities of RSBY beneficiaries when they enrol, as well when they seek treatment at empanelled facilities.
- **Key Management System.** The Key Management System is a set of processes which ensures security, reduces fraud and improves accountability by making sure that Smart Cards are issued to and used by the right people. Only persons with 'security' Smart Cards are able to authorise changes or transactions on the chip of a beneficiary's Smart Card. 'Security' Smart Cards are used by Field Key Officers during enrolment, at empanelled health facilities to record transactions, and at District Kiosks where certain types of changes to Smart Cards can be made.

- **Web-based data transfer.** A web-based data transfer system enables RSBY to be a paperless scheme: claims are submitted online by hospitals, and insurers settle the claims with online payments. In addition, an elaborate back-end data management system has been developed for RSBY which allows the flow of real-time data from across India to state and central governments.
- **Web portal services.** RSBY's website (www.rsby.gov.in) provides information about RSBY to interested audiences, and also plays a crucial role for internal stakeholders as a portal for data transfer, data sharing, and monitoring.



- *A new beneficiary can only be enrolled in the scheme when a Field Key Officer inserts his or her card into a Smart Card reader. This signifies that the beneficiary's identity and eligibility have been verified.*

RSBY takes flight: Recent innovations to the scheme

Rashtriya Swasthya Bima Yojana started off slowly, in just a handful of states, but gradually gained momentum as more and more states saw that the new scheme was working. By RSBY's third anniversary, more than 23 million families from 341 districts and 23 states had enrolled in the scheme. Despite the inevitable technical challenges, RSBY's innovative technology platform was functioning largely as intended. The scheme's potential to protect ever more citizens against financial ruin was also increasingly apparent and the government began expanding RSBY eligibility to new categories of informal workers. Reviewing the scheme's early years, a group of experts observed that, in the areas of enrolment, transactions, incentives for service provision, the role of the private sector and accountability mechanisms, 'the design of RSBY steered clear of the problems faced by India's traditional central programs, while building on the country's emerging strengths' (Palacios et al., 2011, p.viii).

At the same time, as it grew in size and prominence RSBY began to face new challenges in terms of information dissemination, capacity building, quality assurance and data management. RSBY had already demonstrated its viability, but there was much that needed to be done to improve the scheme's implementation, to extend its benefits to more families and, in doing so, to bring India closer to universal health coverage.

While technical advisors from GIZ had been involved since 2008 in advising the MoLE on the design of RSBY, and working informally with State Nodal Agencies on its implementation, the launch of the Indo-German Social Security Programme in 2011 marked a turning point in terms of German engagement with Rashtriya Swasthya Bima Yojana. Advisors with the programme have acted in a dual role, both providing policy advice to the MoLE on ways to extend health coverage to as many poor families as possible, and supporting the actual implementation of measures to strengthen RSBY's operations.

This chapter describes some of the key initiatives undertaken over the period 2011 to 2014 with support from the Indo-German Social Security Programme to optimise the design and implementation of RSBY.

Extending RSBY: More beneficiaries and broader benefit packages

■ Adding new categories of informal workers

Starting in 2011, the Government of India began extending RSBY eligibility to new categories of informal workers in an effort to reach families who may have been missing from flawed or incomplete BPL lists or who were needy, even if they were not classified as living below the poverty line. The first expansion included street vendors, domestic workers, *beedi* (local cigarette) workers, building and other construction workers, and certain workers under the Mahatma Gandhi National Rural Employment Guarantee Act, a public works scheme launched in 2005. Later, in June 2013, these groups were joined by rag-pickers, taxi and auto-rickshaw drivers, sanitation workers and mine workers.

In implementing these changes in practice, a major area of focus has been the preparation of beneficiary lists. Preparing consolidated lists is fraught with difficulties, including duplications of names and missing data points. As no lists exist for newly eligible categories of unorganised workers in most states, it takes considerable effort to identify beneficiaries and to enrol them in the scheme.

Another recent change has been the decision to integrate a national health insurance scheme for weavers and artisans, administered by the Ministry of Textiles, with RSBY. The Indo-German Social Security Programme has advised both the MoLE and the Ministry of Textiles on how beneficiaries from the latter's scheme could be covered under the standard RSBY hospitalisation benefit while retaining an outpatient benefit which they had received under the old scheme.

Box 4. RSBY as the basis for universal health insurance

In the states of Chhattisgarh and Meghalaya, state authorities have decided to make coverage under RSBY universally available to their entire populations. In both cases, the state government has agreed to pay the full premium for all enrolled families who are not otherwise covered under RSBY's designated beneficiary categories and subsidised by the central government.

Chhattisgarh began implementing RSBY in 2009; three years later, it took the decision to universalise RSBY across all 27 districts. In addition to the 3.2 million families in Chhattisgarh eligible for RSBY under its standard categories, another 3.3 million families living above the poverty line were also given the opportunity to enrol. By 2014, approximately 1.7 million of them had done so.

The experience in Meghalaya has been similar. Since May 2013, approximately 40 per cent of the non-BPL population has enrolled in the Megha Health Insurance Scheme, as RSBY is known in the state.

Source: GIZ; RSBY Connect, July 2013.

■ Exploring the feasibility of covering outpatient treatment under RSBY

One of RSBY's limitations is that it does not cover outpatient treatment. Costs related to outpatient care, while generally less than those for inpatient care, are incurred frequently, affect most families, and can pose a serious financial burden. In this respect, RSBY will better meet its goal of protecting against health-related impoverishment if its coverage is expanded to include outpatient treatment.

With this in mind, the Government of India in 2012 initiated two pilot projects in the states of Odisha and Gujarat to test the feasibility of covering outpatient treatment under RSBY. These experiments, which were also supported by the Micro Insurance Innovation Facility of the International Labour Organization, sought to test the impact of a comprehensive health benefits package upon patients' health-seeking behaviour and the effects of outpatient coverage upon the utilisation of inpatient services.

In the pilot sites, private doctors and primary healthcare facilities providing outpatient services were empanelled into the scheme, and all enrolled RSBY families were entitled to visit any provider in the network, using their Smart Cards to verify their identities and eligibility for coverage. Results from these districts showed that coverage of outpatient services does have an effect on health-seeking behaviour (i.e. seeking primary care early, rather than going to the hospital in an acute state) and that the use of inpatient services declined. The pilot projects also showed that the technology and paperless procedures employed in RSBY's original approach can be extended to outpatient care settings, but with a different provider payment mechanism (Jain, 2014).

■ Topping-up RSBY's standard benefits package

While the standard RSBY benefits package includes up to Rs. 30,000 (EUR 400) for inpatient treatment costs, four states have taken steps to expand RSBY's package beyond this amount. The Indo-German Social Security Programme has worked with the authorities in these states to introduce these changes by, for example, providing new versions of software and advising on the preparation of tender documents which stipulate the requirements for insurance companies bidding to implement RSBY in participating districts.

Himachal Pradesh was one of the first states to extend a top-up Critical Care Package to RSBY beneficiaries. Under this package, each enrolled family can claim an additional benefit of up to Rs. 175,000 (EUR 2,333) through its RSBY Card for tertiary-level care including procedures such as heart surgeries, neurosurgeries, transplants, spinal surgeries, and cancer treatments.

In Mizoram families are covered up to Rs. 30,000 for ongoing illnesses and up to Rs. 270,000 (EUR 3,600) for critical illnesses. Under the Megha Health Insurance Scheme, in Meghalaya, each beneficiary household is entitled to a total of Rs. 160,000 (EUR 2,133) in cashless care, including Rs. 30,000 for cancer treatment and Rs. 70,000 (EUR 933) for critical care.

In Kerala the standard RSBY package has been topped up in a number of ways. Beneficiaries receive a cashless treatment benefit of up to Rs. 70,000 for diseases related to the heart, brain and liver; for cancer treatments; and for traumas related to accidents. Insured families are also entitled to a personal accident claim of Rs. 200,000 (EUR 2,666) in the case of the accidental death of the head of the household or spouse.

Strengthening RSBY's information technology platform

As RSBY has grown in size and evolved in new directions, RSBY implementation teams have provided a steady stream of feedback to the MoLE on the software and systems which underpin the scheme's Smart Card technology. At the request of the ministry, the Indo-German Social Security Programme has identified areas where enhancements to RSBY IT systems are needed, developed the detailed technical requirements for proposed changes, and managed all aspects of the upgrades, including testing new software and systems prior to their release. It has also trained and supported teams in the field to work with new versions of software and has overseen technical and operational troubleshooting as the updates have been rolled out.

■ Upgrading to 64 kB Smart Cards

The first RSBY Smart Card, launched in 2008, had a 16 kB chip; this was subsequently upgraded to 32 kB. In 2011, the MoLE decided to upgrade the cards again – to 64 kB – to allow for more data to be stored on beneficiaries' cards (including that related to other social security schemes, see 'Facilitating the convergence of social security schemes' below) and to improve the cards' security.

The Smart Card upgrade had to be managed very carefully so that the more than 30 million families already in possession of a 32 kB Smart Card when the upgrade began could continue using them, uninterrupted, until receiving a 64 kB card when re-enrolling the following year. The first 64 kB Smart Card was issued in Kapurthala in Punjab in July 2012.

■ Strengthening management information systems and streamlining claims settlements

For the MoLE to be able to monitor the progress of RSBY in real time, it requires a powerful management information system (MIS). The Indo-German Social Security Programme has worked with the ministry to develop an MIS for RSBY which brings together data from the State Nodal Agencies, hospitals and insurance companies into an integrated system. Among the many important benefits of the improved MIS is the ability to quickly flag data abnormalities which could indicate instances of fraud or other malpractice.

As part of this same effort, new software was developed to make the status of claims under the scheme transparent for all stakeholders. This allows government authorities at the state and central level to track claims settlement more closely and to ensure that service delivery to RSBY beneficiaries is not affected as a result of delays or non-payment of hospital claims.

Building capacity for improved implementation

■ Institutionalising a system for capacity building

In order to keep pace with the rapid scaling-up and evolution of RSBY – including changes to the technology platform – the MoLE and the Indo-German Social Security Programme worked together closely to design and implement a systematic approach to capacity building which provides regular training to implementing teams working at various levels. This includes, but is not limited to, training on the use of new software systems, quality control in hospitals, and awareness building at beneficiary level.

While this capacity building effort is organised centrally, it is executed in a decentralised manner. A capacity building team at the national level facilitates the development of standardised training manuals, presentations and learning materials for key stakeholder groups such as district managers, field officers, hospital staff and members of enrolment teams. They also oversee the preparation of master trainers who then undertake a regular schedule of trainings and workshops with hospitals, insurance companies and third party administrators at the state level.

■ Establishing the RSBY Professionals Programme

The success of RSBY in any given state depends in large part upon the capacity of the State Nodal Agency to implement and monitor the scheme effectively. However in some states, these agencies either do not have sufficient manpower or lack the requisite mix of skills to work with RSBY's management and financial processes.

As a contribution to building sustainable capacity for RSBY, the Indo-German Social Security Programme and the MoLE created the RSBY Professionals Programme in 2012. The programme identifies qualified graduates in the fields of health management, economics, medicine, social work and rural development and trains them to take up positions within State Nodal Agencies in support of RSBY implementation. This approach has a dual benefit: it supports the implementing states' need for well-trained personnel and simultaneously builds interest among Indian graduates to become involved with the country's social security schemes.

After a few weeks of initial training the participants undertake work placements, supported by the Indo-German Social Security Programme, at different State Nodal Agencies for up to 12 months. Thereafter the trained professionals can be employed directly by State Nodal Agencies, insurance



■ A group of 'RSBY Professionals' proudly display their certificates at the end of their initial training programme.

companies or third party administrators. The MoLE and advisors with the Indo-German Social Security Programme continue to mentor the professionals, as needed, during this period and to bring them together regularly to exchange experiences. Since its start in April 2012 the RSBY Professionals Programme has trained 24 professionals.

Facilitating the convergence of social security schemes

Under India's federal governance structure, both the central government and state authorities are responsible for the implementation of social security programmes. Despite being aimed at the same target audiences, these initiatives often have not been well coordinated. Efforts are sometimes duplicated, gaps in coverage remain, eligibility criteria do not always correspond and application processes are too complicated. As a result the poor often struggle to access social security support to which they are entitled.

There is a growing recognition at policy level that greater coherence between schemes and the convergence of different programmes onto a single platform would be more efficient and transparent, and move the country in the direction of more comprehensive social security. As the technological platform which was developed for RSBY holds great potential to deliver other types of social security benefits to the same pool of beneficiaries, the Indo-German Social Security Programme has been providing strategic and technical support to a variety of stakeholders at central and state government levels on ways that different schemes could be administered via the RSBY Smart Card.

In addition to supporting the technical upgrade of the RSBY Smart Card from 32 to 64 kB, which has made it possible for other schemes beyond RSBY to be run through the card, the Indo-German Social Security Programme has also worked with the government to develop appropriate 'process flows' – mapping out the steps which would be needed to integrate other schemes into the existing Smart Cards – and to coordinate pilot initiatives to test the feasibility of 'convergence.' Efforts have included the following:

- The RSBY Smart Card platform has been used to deliver benefits for the **Aam Aadmi Bima Yojana (AABY) life, accident and disability insurance scheme**, a central government initiative which targets the same beneficiaries as RSBY. With the agreement of the MoLE and the Ministry of Finance, a pilot programme in Punjab in 2013 tested the feasibility of automatically enrolling all new RSBY beneficiaries in AABY. Merging the two schemes resulted in a reduction in administrative costs, better quality data about beneficiaries and improved beneficiary awareness.
- The **Indira Gandhi National Old Age Pension Scheme** provides a monthly pension to people over the age of 60 who are living below the poverty line – a target population which is also eligible for RSBY. With the goal of improving enrolment data and ensuring that the benefits of both schemes are available to those eligible for them, the MoLE and the Ministry of Rural Development agreed to conduct a pilot study in four districts of Jharkhand to compare and merge the beneficiary datasets. The result was a comprehensive and corrected beneficiary list which was used to increase enrolment for both schemes.
- Since October 2012, the RSBY Smart Card is being used in Chhattisgarh State to improve the distribution of subsidised food grains and kerosene through the **Public Distribution System (PDS)**. In Chhattisgarh, where RSBY has been universalised to all families, the RSBY Smart Card is now loaded with the beneficiary's PDS benefit and can be used as a ration card at designated Fair Price Shops in the state. Beneficiaries' identities are biometrically verified at each usage, which helps to reduce leakages, instances of fraud and the use of 'ghost' cards. In addition, real-time information about food purchases is available on government servers. The government of Chhattisgarh has already seen huge cost savings, and there is substantial interest on the part of other states to use the RSBY Smart Card to deliver PDS benefits.

Supporting the evaluation of outcomes

In addition to regularly monitoring data generated by RSBY's management information system, on behalf of MoLE, the Indo-German Social Security Programme also supports independent process and outcome evaluations to assess whether RSBY is achieving its goals.

In 2012 the Indo-German Social Security Programme supported an evaluation examining the process of RSBY implementation, as well as access to health services and out-of-pocket expenditures on hospitalisation, in selected districts of the states of Bihar, Karnataka and Uttarakhand. This evaluation explored the experiences of families enrolled in RSBY as compared to those not enrolled. Hospital staff, representatives of insurance companies, and state-, district- and field-level implementers were also covered as part of this evaluation. In 2013, similar evaluations were supported in the North-Eastern States of Manipur, Meghalaya, Mizoram and Nagaland. Results from these studies are discussed in the next chapter, 'Achievements and Challenges.'

The Indo-German Social Security Programme commissioned out a three-year longitudinal panel evaluation to measure RSBY's impact on access to health facilities, out-of-pocket expenditure on hospitalisation, and beneficiaries' health status. This evaluation, carried out by two consortia of reputed Indian and German research agencies, includes two rounds of data collection in eight states and another four rounds of data collection in four states, making it the most extensive and only long-term of evaluation of RSBY's outcomes to date.

In addition to its support for these specific evaluations, the Indo-German Social Security Programme also provides support to states to build their capacity to commission and oversee their own evaluations. The programme has developed a 'modular approach' which allows stakeholders to pick and choose components from the evaluation process and has assisted with the empanelment of research agencies.



■ Researchers undertaking a survey of RSBY enrolled and non-enrolled households in Mizoram meet with members of a village council to discuss the evaluation process.

Achievements and challenges

Rashtriya Swasthya Bima Yojana is a national scheme, but the fact that it is administered at the state level means that, in practice, there are more than two dozen individual 'RSBYs' which share a set of core characteristics, but are also distinctive in terms of their implementation and results. This section highlights the scheme's achievements and draws attention to some of the diverse issues which have arisen as RSBY has been rolled out countrywide.

Reach and enrolment

In the seven years since its launch, RSBY has scaled up with impressive speed to become one of the largest health insurance schemes in the world in terms of number of beneficiaries. As of January 2016, it was providing coverage to 41.2 million families, or 55.3 per cent of families living below the poverty line in districts where enrolment in RSBY has begun. RSBY is now being implemented countrywide, in 399 districts in 28 states and union territories. A total of 10,666 hospitals – 6,276 private and 4,390 public – have been empaneled with the scheme.⁸ Key data related to RSBY's performance can be found in Table 3.

The steady increase in the number of RSBY beneficiaries (see Figure 2) can be attributed to the gradual expansion of RSBY to more and more states, but also to the popularity of the scheme itself. In states where RSBY is already operational, high proportions of families are re-enrolling and others are enrolling for the first time.

Another factor which has aided the scheme's growth is the fact that enrolment campaigns have generally covered districts as prescribed. Evaluations of RSBY's implementation at both state and national level have found that most beneficiaries travel less than five kilometres to reach an enrolment station, and most get their Smart Cards on the same day (Jain, 2014). Preliminary results from the longitudinal panel evaluation being supported by the Indo-German Social Security Programme in Kerala, Gujarat, Tripura and Mizoram show that 77 per cent of surveyed households reported having an enrolment station within two kilometres of their homes.⁹

Table 3: RSBY at a glance

Number of families enrolled	41,243,184
Number of persons enrolled	Approx. 124 million
Number of states and union territories where RSBY is being implemented	28
Number of active districts	399
Number of hospitals empanelled	10,666
Number of hospitalisation cases	10,630,269
Average hospitalisation rate after	
one year of implementation	1.86%
two years of implementation	2.02%
three years of implementation	2.58%
four years of implementation	3.04%
Average premium for active districts (August 31, 2015)	Rs. 330 (EUR 4.5)
Average burnout ratio* of insurance companies for all active districts (August 31, 2015)	80.68%

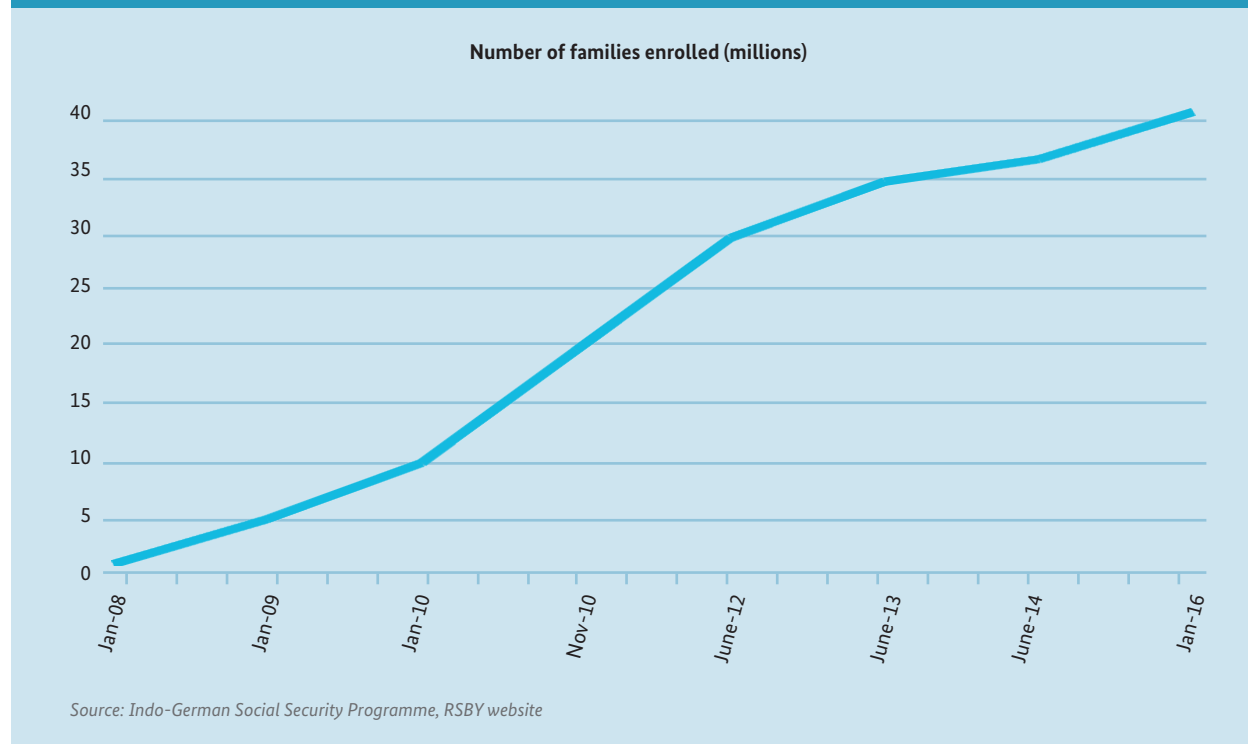
*The burnout ratio is the percentage of money which has been spent by an insurance company on RSBY as a percentage of the premium it receives from the government.
Data as of September 2015 unless otherwise noted.

Source: Indo-German Social Security Programme, RSBY website

⁸ RSBY website (www.rsby.gov.in)

⁹ IGSSP, unpublished data. *Longitudinal Panel Evaluation in States of Uttar Pradesh, Uttarakhand, Bihar, West Bengal, Kerala, Gujarat, Mizoram and Tripura. 2013-2017*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.

Figure 2: RSBY enrolment over time



■ Challenges to address

Despite these important successes, the RSBY conversion rate (the proportion of eligible families who are enrolled in the scheme) varies greatly from state to state, and there are several areas where enrolment processes still need to be improved. One of the biggest obstacles to improving the conversion rate lies in the quality of the list of eligible beneficiaries. As the categories of eligible workers are expanded, the process of developing up-to-date consolidated lists of beneficiaries has become increasingly challenging. Lists of different categories of beneficiaries are prepared by different agencies and departments, and these need to be reconciled with one another to remove duplications and assure correct information.

Another issue which needs attention is increasing the number of family members who are designated as beneficiaries on each RSBY Smart Card. There may be a need to revise incentives to encourage insurance companies to strive to enrol the maximum number of beneficiaries (five) per family (La Forgia & Nagpal, 2012).

While most families enrolling in RSBY receive their Smart Cards on the spot, evaluations (IGSSP, 2013a-d) have revealed that this is not always the case in certain of the North-Eastern States. Printing and issuing Smart Cards under difficult conditions (i.e. inaccessible terrain, lack of electricity) is one of the main challenges facing RSBY, but efforts must continue to be made to ensure that cards are issued in a timely manner.

Finally, emphasis must be placed on enticing as many public and private hospitals as possible to empanel under RSBY to ensure that beneficiaries have easy access to care. In this respect, it is important that the reimbursement rates paid to hospitals for services under RSBY be regularly reviewed and updated, and that attention continue to be paid to the timely settlement of hospital claims.

Increase in access to health care

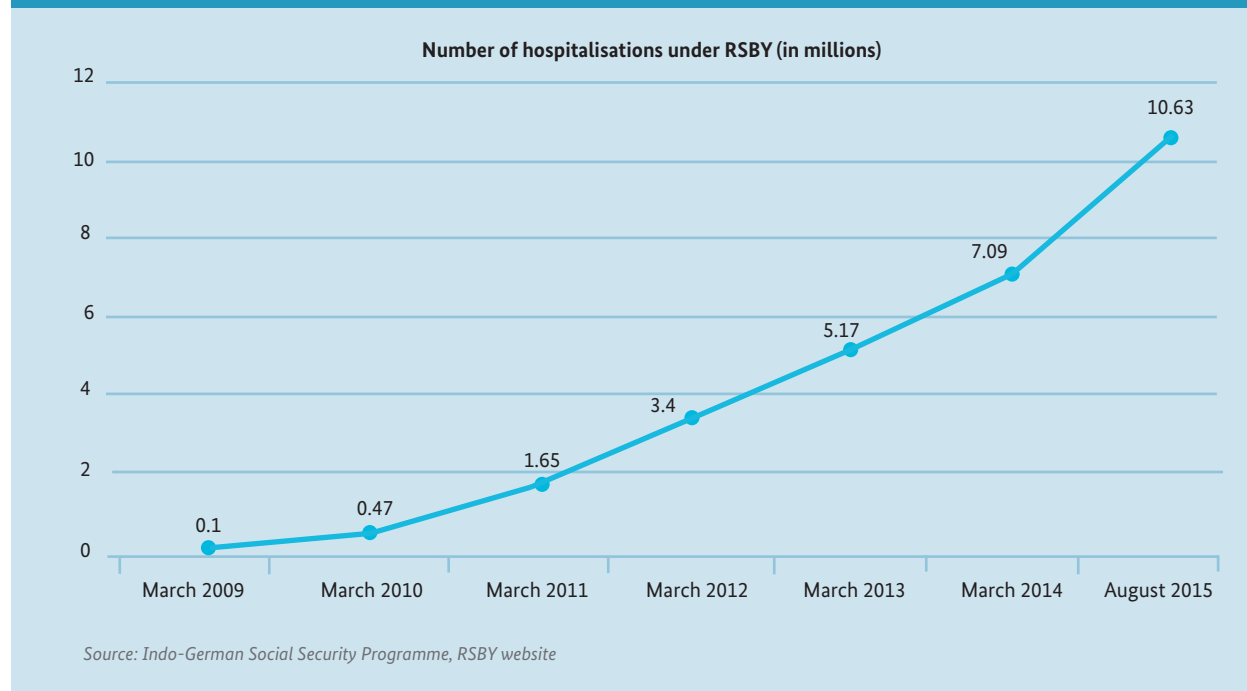
As of August 31, 2015, RSBY had covered some 10.6 million hospitalisations.¹⁰ Figure 3 shows the trend in hospitalisation cases over time.

Data from the MoLE show a continuous increase in the rate of hospitalisation in RSBY districts. In those districts which have implemented RSBY for only one round, the hospitalisation rate stands at 1.86 per cent; in those districts where RSBY has been implemented for four or more rounds, the hospitalisation rate has risen to 3.04 per cent. By comparison, the National Sample Survey of 2006 found a hospitalisation rate of 1.75 per cent for Indians in the bottom two wealth quintiles and 2.4 per cent for the population as a whole (Jain, 2014). While there is a need to interpret these figures with caution, given the great variation in hospitalisation rates across states, it is clear RSBY is improving access to health care for the country's poor.

In the year 2013-2014, approximately 60 per cent of the hospitalisations which have been covered by RSBY have been in private hospitals. Preliminary results from the longitudinal panel evaluation being supported by the Indo-German Social Security Programme¹¹ have shown that beneficiaries are accessing private health facilities more than public ones. For example, most enrollees and non-enrollees in Bihar (80 and 75 per cent respectively), Uttarakhand (75 and 64 per cent) and Uttar Pradesh (66 and 63 per cent) are hospitalised in private health facilities. This suggests that RSBY is succeeding in its goal of providing poor beneficiaries with access to private healthcare facilities by offering them a choice of healthcare providers which extends beyond the public health service.

The fact that beneficiaries can choose where to seek treatment provides incentives for both public and private facilities to attract patients by offering better care. Public hospitals are permitted to use part of the income they receive from RSBY claims to invest in quality improvements and to incentivise their staff.

Figure 3: Chart showing cumulative number of hospitalisations, 2009-2015



¹⁰ RSBY website www.rsby.gov.in

¹¹ IGSSP, unpublished data. *Longitudinal Panel Evaluation in States of Uttar Pradesh, Uttarakhand, Bihar, West Bengal, Kerala, Gujarat, Mizoram and Tripura. 2013-2017*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.

■ Changes in women's access to services

Since 2008 there has been a progressive increase in the proportion of women who enrol in RSBY and utilise services under the scheme. While only 41 per cent of beneficiaries were female during the first round of the scheme, this increased to 49 per cent by the fourth round. Once enrolled, women tend to utilise services under RSBY more than men do: by round four, women accounted for 52 per cent of hospitalisations, up from 43 per cent in the first round.¹²

A small, but important qualitative study undertaken in two districts in Haryana in 2012, under the auspices of the Indo-German Social Security Programme, sheds light upon the gender dimensions of these enrolment and service utilisation figures. In focus group discussions with both RSBY beneficiaries and non-beneficiaries, researchers found that the decision to enrol the family in RSBY generally lay with the man as head of household and that women, for the most part, did not wield great influence over this step. However once the Smart Cards were issued, women were in a much stronger position than before to take independent decisions about their health and to avail themselves of services when needed. For women who are otherwise dependent upon their husbands for financial resources, RSBY's cashless approach supports more equitable access to quality health care (Cerceanu, 2012).

■ Barriers to utilisation

While utilisation rates are rising with each successive round of RSBY implementation, evaluations supported by the Indo-German Social Security Programme have also pointed to some of the factors which limit the use of services. While RSBY is now quite well known as a health insurance scheme for the poor, many people – even those covered by it – do not have a detailed understanding of its benefits. The evaluation in Karnataka, Uttarakhand and Bihar, for example, found that 70 per cent of beneficiaries didn't know that RSBY covers the cost of medicines and diagnostic tests (IGSSP, 2012). Studies in the North-Eastern States found that beneficiaries had better knowledge of RSBY's benefits than non-beneficiaries, but even among those covered by the scheme there were widely varying levels of knowledge about RSBY's benefits package. In Nagaland, for example, 67 per cent of those surveyed who were enrolled in RSBY and had been hospitalised knew that the scheme covers the costs of medicines during hospitalisation (IGSSP, 2013d). By contrast, only 21 per cent of respondents in Meghalaya and 17 per cent in Mizoram knew this (IGSSP, 2013b-c).

Another common problem is that beneficiaries do not receive adequate information about empanelled hospitals in their area at the point of enrolment, and therefore do not always know where they can use their Smart Cards when they fall ill. This finding has been further endorsed in the longitudinal panel evaluation currently underway.



■ *These women, who have just enrolled in RSBY, leave an enrolment station with their new Smart Cards and information on empanelled hospitals in the area. However, evaluations have found that not all beneficiaries receive such information at the point of enrolment – a fact which affects the utilisation of services.*

¹² Data provided by Indo-German Social Security Programme, 2014.

Many of these problems can be traced back to the point of enrolment; insurance companies need to be more active in building awareness of RSBY benefits and processes when signing up new members, including providing information in formats that are suitable for individuals who may not be literate. However the task of improving beneficiary awareness may require additional measures, such as working through local civil society organisations and social workers affiliated to the National Health Mission.

Reduction in out-of-pocket payments

Evaluations of RSBY undertaken at the national and state levels have shown that out-of-pocket expenses for hospitalisation are lower for families enrolled in RSBY than for those who are not enrolled.

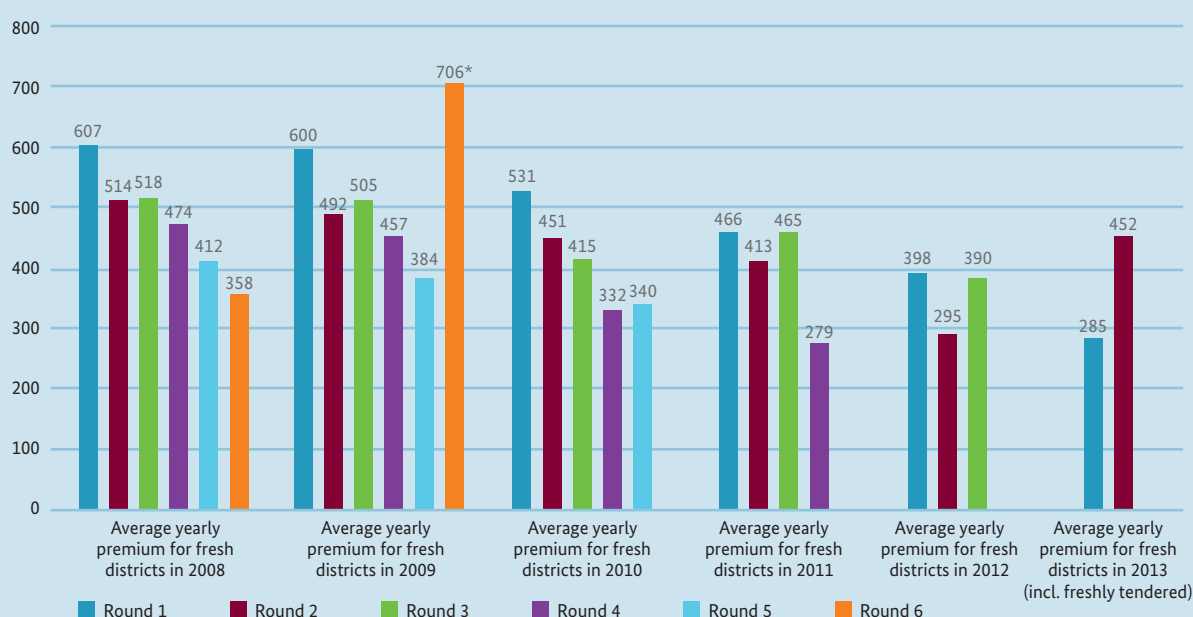
A 2012 survey supported by the Indo-German Social Security Programme in Uttarakhand, Karnataka and Bihar (IGSSP, 2012) found that 90 per cent of RSBY enrolled patients did not incur any hospital costs, compared to RSBY eligible non-

enrolled patients who spent Rs. 17,000 (EUR 227) on average per year on hospitalisations. Similar evaluations conducted in the North-Eastern States of Manipur, Meghalaya and Nagaland (IGSSP, 2013a-d) generated more mixed results: while 80 per cent of RSBY card holders in Nagaland incurred no costs for hospitalisations, only half of those in Manipur and 37 per cent in Meghalaya received completely cashless treatment. The out-of-pocket expenses which were incurred were often related to the costs of medicines and transportation; studies in a number of states have revealed that transportation allowances are not always paid to beneficiaries.

Decreases in premium levels

When RSBY was first launched in 2008, the average premium for beneficiaries in participating districts was approximately Rs. 600 (EUR 8) per family per year. By 2011, this had dropped to Rs. 466 (EUR 6) per family per year. For those districts which began implementing RSBY in 2013, starting premiums are now less than Rs. 300 (EUR 4) per family per year (Jain, 2014; IGSSP, 2014). Trends in average premiums are shown in Figure 4.

Figure 4: Average yearly premiums for fresh RSBY districts, by year and round



* The premium figure for Round 6 is a reflection of the high premiums charged in districts in Kerala (Rs. 738 per annum). As few states are in the sixth round of implementation, the premiums from Kerala carry disproportionate weight in the average figures.

Source: Indo-German Social Security Programme.

This steady decrease in premiums runs counter to the experiences of many health insurance schemes where premium levels tend to rise over time. In the case of RSBY, there are likely to be multiple reasons behind the premium drops: competition among insurance companies, large economies of scale and reductions in technology costs may all play a role. Moreover, the decreases could represent a type of price correction, as the initial premiums in 2008 were established in the absence of any real data (Jain, 2014).

As the scheme goes forward, it will be important to monitor data on premiums carefully to ensure that they are maintained at a level that is sustainable for insurance companies in the long term. When premium levels are too low, insurance companies can become reluctant to settle claims; hospitals, in turn, lose motivation to participate in insurance schemes as the number of rejected claims rises.

Beneficiary satisfaction

Because RSBY is a voluntary scheme, the proportion of beneficiaries who choose to re-enrol is an important indicator of the scheme's success. Studies conducted in multiple states have shown that the vast majority of beneficiaries treated under RSBY are satisfied with the scheme and intend to renew their enrolment (see also La Forgia & Nagpal, 2012). The most recent wave of the longitudinal panel evaluation, for example, shows that 98 per cent of those surveyed in Kerala and 90 per cent of those surveyed in West Bengal were satisfied with the scheme. Ninety-eight per cent of enrolled households surveyed in West Bengal, Bihar and Uttar Pradesh expressed their willingness to re-enrol in RSBY.¹³

RSBY's cashless design, shorter waiting times at empanelled hospitals and politer treatment by staff were named as positive features of the scheme. As many of RSBY's beneficiaries have never before had any form of health insurance, it is difficult to assess whether these high levels of support will be sustained in the future. However they provide an indication of the degree to which the RSBY coverage is valued by its target populations.

Echoes beyond India

As RSBY has undergone its remarkable growth over the past six years, it has attracted increasing attention from outside India's borders: delegations from Bangladesh, Cambodia, Ghana, Indonesia, Namibia, Nepal, Nigeria and Tanzania have visited India to learn from RSBY and to explore features which could improve their own health insurance schemes. In some cases these visits have led to concrete changes. In Ghana, for example, a Smart Card similar to the one used in RSBY has been introduced into the country's National Health Insurance Scheme.

In addition to hosting visiting delegations, representatives of the Indian government and advisors from the Indo-German Social Security Programme have also worked closely with counterparts from Bangladesh, Nepal and Pakistan, advising them on aspects of their health insurance programmes.

¹³ IGSSP, unpublished data. *Longitudinal Panel Evaluation in States of Uttar Pradesh, Uttarakhand, Bihar, West Bengal, Kerala, Gujarat, Mizoram and Tripura. 2013-2017*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.

The way forward for RSBY

RSBY has exceeded the expectations of many observers who questioned whether a government-run scheme could be successful in a country as large, diverse and complex as India with its often perceived shortcomings in policy implementation and accountability. At the same time, international experience suggests that government-sponsored health insurance schemes such as RSBY require many years of adjustment and fine-tuning before they are implemented truly efficiently and effectively (La Forgia & Nagpal, 2012).

In April 2015, the responsibility for RSBY was transferred from the Ministry of Labour & Employment (MoLE) to the Ministry of Health & Family Welfare (MoHFW), which is developing a new health protection programme based on past experience with RSBY. The new scheme, to replace RSBY, will provide higher coverage and expand the number of beneficiaries. The fast implementation and growth of RSBY is a huge success. However there are a number of areas in which further improvements are suggested.

- **Expansion to all unorganised workers.** RSBY could be opened up to all unorganised workers, not only those below the poverty line, thereby emerging as a platform for universal health coverage in India. While the government could continue to subsidise premiums for families below the poverty line, the premiums for others could be paid by employers or by beneficiaries themselves.
- **Revision of benefit package.** The current benefit package should be revisited, with the objective of increasing standard coverage from Rs. 30,000, which was set in 2008, to a level commensurate with the increasing cost of treatment.



- *Extending RSBY to cover tertiary care would help to address India's growing burden of non-communicable diseases.*

The government could also consider modifications that would allow beneficiaries to access tertiary care services to treat the country's growing burden of non-communicable diseases. Outpatient coverage could also be integrated into RSBY's core design, thereby extending the scope of financial protection to routine health expenditures and shifting the focus of health insurance from emergency treatments towards preventative care.

- **Convergence of social security schemes.** The pilot efforts which have been undertaken to administer the Aam Aadmi Bima Yojana life, accident and disability scheme and the Public Distribution System for food subsidies suggest that scaling up these convergence efforts could lead to greater efficiency and transparency of social security and welfare schemes.
- **A strong monitoring mechanism.** Fraud and abuse are inherent challenges for any health insurance scheme. By investing in a strong management information system for RSBY, the conditions have been set to ensure that instances of fraud are identified and acted upon quickly. However in the future a more institutionalised approach to data analysis aimed at uncovering malpractice is needed. The process of grievance redressal needs to be accelerated and the quality of investigations enhanced.
- **Quality of health care.** Greater attention needs to be paid to the quality of care under RSBY. At present only a very basic system of hospital grading is in place to measure the quality of services being provided to RSBY beneficiaries. Low quality of care is a problem which pertains to both public and private hospitals in India. Experience from other countries, however, suggests that demand-side approaches to health financing, such as RSBY, can be effective in enhancing the quality of care provided when the purchaser of services (government) alters the incentive structure to encourage hospitals to improve their care (Jain, 2014).
- **Autonomous management structure.** There is currently no independent management structure in place for the implementation of RSBY at the national level. Government should consider setting up a dedicated body staffed with experienced professionals to manage the scheme. This would ensure a higher degree of professionalism, as well as avoiding conflicts of interest.

Lessons for the successful implementation of health insurance schemes

Rashtriya Swasthya Bima Yojana has travelled a long distance since 2008; many of the lessons learned along the way are relevant not only for RSBY as it improves its performance further, but also for policymakers in other countries.

Adopt a partnership approach

The success of RSBY lies in its design as a robust partnership between dozens, if not hundreds, of public and private sector institutions. Critically, the Government of India engaged in a partnership approach with the private sector right from the design stage, rather than simply outsourcing tasks to it later on. This approach resulted in clear agreements about the roles and responsibilities of each stakeholder, and also led to a willingness to continuously revisit elements of the scheme's design and processes as it was rolled out.

Design the scheme with beneficiaries' needs in mind

National health insurance schemes should be designed with beneficiaries at their centre and with ease of use in mind. RSBY is tailor-made for its beneficiaries: the scheme is paperless, cashless and portable. These three criteria are essential for a target group whose members are primarily poor and unable to pay advances on medical costs; who are often not literate and have difficulty filling in forms; and among whom are many migrant workers who need to be able to receive treatment countrywide.

Develop a 'business model' and be guided by processes, not targets

RSBY is the first example of a government-supported social security scheme in India which is guided by a business model. The scheme has deftly woven together the needs of informal workers for health services and financial protection, on one hand, with the interests of insurance companies and hospitals to tap into an enormous market for services, on the other. Because the underlying business model relies on market mechanisms and incentives for stakeholders to scale up the scheme, there was no need for the government to set and pursue numeric targets when rolling out RSBY. Rather, the focus was on implementing processes and building the capacity of stakeholders to play their designated roles.

Build effective governance structures

RSBY has highlighted the need for functional, well-equipped and autonomous management bodies, at all levels, which are responsible for implementation. These should be designed along with the rest of the scheme and must be provided with appropriate resources to fulfil their envisioned roles. Attention needs to be paid to the size and required capacities of management teams. Both national and state-level bodies, while independent, should report to the relevant line ministry to ensure coordination.

Develop strong control mechanisms

RSBY has demonstrated that the effective implementation of a national health insurance scheme depends on a strong monitoring system which generates real-time data for the government and other stakeholders. Such data can be triangulated with concurrent evaluations to measure outcomes. In addition, the existence of an accessible and functional grievance redressal mechanism is important for improving stakeholder satisfaction.



■ RSBY was designed with the needs of its beneficiaries, such as this young family, in mind. Over the past six years it has worked tirelessly to publicise its benefits among eligible population groups who may not be familiar with the concept of health insurance.

Communicate strategically

In a scheme as complex as RSBY, regular targeted communications are essential for keeping diverse stakeholders linked together as part of a common effort. A comprehensive communication strategy which customises messages for different target groups should be prepared right from the inception of any national health insurance scheme. Bearing in mind that poor families often have little or no knowledge about insurance, special emphasis should be placed on making the target beneficiaries aware of the scheme, its benefits, and their rights in using it.

Invest in standardisation, but leave room for flexibility

A national insurance scheme can only function smoothly if there is a high degree of standardisation in terms of the tools and technology being used across the country. At the same time, with a scheme as complex as RSBY, it is necessary to be responsive to conditions on the ground. Provisions and processes need to be constantly reviewed and, if necessary, revised to accommodate feedback from implementation teams.

Encourage sustained political ownership

In some countries, setting up a public health insurance scheme may represent a paradigm shift from a supply side to a demand side approach to healthcare provision – a significant change which can trigger opposition in some sections of the healthcare system. Strong political ownership is therefore a prerequisite for the sustainability of a social health insurance programme with multiple layers of governance, diverse stakeholder needs, financing challenges and varying levels of health system preparedness.

Take a chance and get started

RSBY demonstrates that it is possible to achieve very impressive results even in the face of unforeseen problems to which there are, as yet, no good solutions. One of the important factors behind RSBY's success, according to Helmut Hauschild, the head of the Indo-German Social Security Programme, was the decision by the MoLE to make RSBY voluntary for the states: those who wished to participate were welcome, but states were not required to join. This obviated the need for a drawn-out process of political bargaining between the central government and the states which might well have ended in stalemate. 'They started with some early believers and showed that it could work,' explained Hauschild. With time, more and more states joined the scheme.

Peer review

To be included in the German Health Practice Collection, a project or programme must demonstrate that it comes close to meeting a majority of the Collection's criteria (see Box 5).

In reviewing this publication, a senior economist at the World Bank has agreed that lessons from Rashtriya Swasthya Bima Yojana – and the Indo-German Social Security Programme's support to the scheme – are worth documenting and sharing widely. The reviewer offered the following reflections on the Collection's specific criteria:

Effectiveness

With more than 41 million poor and vulnerable households covered by the scheme, RSBY has been effective in closing the coverage gap and in increasing access to hospitalisation care for members of households living below the poverty line. Incentivising insurance companies to enrol as many eligible beneficiaries as possible has been important to this success. Evidence on the reduction of out-of-pocket expenditure is less conclusive, however, and it is premature to assess RSBY's impact on the quality of hospitalisation care being received by beneficiaries.

Innovation

RSBY represents an innovative approach to service provision to the poor: it combines the use of smart technology to verify beneficiary identities and track transactions, on the one hand, with a public-private partnership model for service delivery and administration, on the other. The scheme's technology platform – including the Smart Cards, transaction software and MIS system – has greatly strengthened the capacity of the State Nodal Agencies by enabling an output-based payment approach for both beneficiary enrolment and provision of hospital services. Recently, with support from the Indo-German Social Security Programme, the programme has begun to explore important areas such as outpatient care and the convergence of social protection programmes on a common technology platform.

Transferability

Low- and middle-income countries who wish to launch a national health insurance scheme for the poor can learn from aspects of the RSBY experience, particularly its design and use of technology. Certain adaptations to the model would be required, however, to make it suitable for various national contexts. For example, few developing countries have mature health insurance markets; in India the robust regulatory framework in place prior to the creation of RSBY bolstered competition and helped to keep premiums in check.

Participatory and empowering

RSBY beneficiaries are empowered to choose among public and private healthcare providers, who now have incentives to compete for their 'business.' Moreover, through the Smart Card technology, RSBY coverage is portable – an extremely important feature for beneficiaries who migrate for work and are now able to access services both at home and at their places of destination.

Gender awareness

RSBY is gender neutral by design. Although the enrolment rate among women has been lower than that of men since RSBY's inception, the gap has been decreasing over time. A change in operational policy which allows wives to enrol the household when the husband is not available has contributed to this trend.

Quality of monitoring and evaluation

RSBY's strong management information system allows enrolment and hospital transactions to be tracked down to the level of individual cases. The real-time flow of data has made it possible for state and central government authorities to monitor the operational status of the programme on a continuous basis. However State Nodal Agencies are not yet taking full advantage of the rich data which is available and the evaluations which have been undertaken to date have focused more on RSBY's implementation, as opposed to programme outcomes and impacts.

Comparative cost-effectiveness

No comprehensive cost-effectiveness analysis of RSBY has been undertaken to date. This limits the depth of current policy discussions about whether the future of universal health care in India should lie in greater investment in the traditional public funding and public provision model, or in the demand-driven financing model embodied by RSBY.

Box 5. Publication process of the German Health Practice Collection

In response to annual calls for proposals, experts working in GDC-supported initiatives propose projects that they regard as good or promising practice to the Managing Editor of the GHPC at ghpc@giz.de. All proposals are then posted on the [Collection's website](#) to allow GDC experts and the interested public to compare, assess and rate them. The proposals are also discussed in various technical fora in which German experts participate.

Informed by this initial peer assessment, an editorial board of GDC experts and BMZ officers select those they deem most worthy of publication. Professional writers then make on-site visits to collect information, working closely with the local partners and GDC personnel who jointly implement the selected projects.

Each report is submitted in draft form to independent peer reviewers who are acknowledged internationally as scholars or practitioners. The reviewers assess whether the documented project represents 'good or promising practice,' based on eight criteria:

- Effectiveness
- Transferability
- Participatory and empowering approach
- Gender awareness
- Quality of monitoring and evaluation
- Innovation
- Comparative cost-effectiveness
- Sustainability

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Changqing Sun, a senior economist at the World Bank, reviewed the publication and provided valuable comments.

This document builds upon a publication in the German Health Practice Collection which was written by Stuart Adams in 2011. Karen Birdsall was responsible for revising the publication to reflect recent developments. Anna von Roenne, the Managing Editor of the German Health Practice Collection, provided extensive editorial assistance and coordinated production of the publication.

Box 6. Contact

You can contact the Indo-German Social Security Programme with questions or feedback concerning RSBY via:

Helmut Hauschild, Programme Director
Indo-German Social Security Programme
Deutsche Gesellschaft für
Internationale Zusammenarbeit (GIZ)
B-5/1, 2nd Floor, Safdarjung Enclave
New Delhi 110029, India
igssp@giz.de

RSBY's website provides further information in English and Hindi:

www.rsby.gov.in

References

- Balarajan Y et al. (2011). Health care and equity in India. *The Lancet*, 377: 505-15.
- Cerceau S (2012). *Gender equality in access to health care: The role of social health protection. A case study on India's national health insurance scheme RSBY*. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit.
- Government of India (2012). *Press Note on Poverty Estimates, 2009-2010*. New Delhi: Government of India Planning Commission.
- Horton R, Das P (2011). Indian health: the path from crisis to progress. *The Lancet*, 377: 181-3.
- IGSSP (2012). *Assessment of Implementation Process of Rashtriya Swasthya Bima Yojana in Select Districts of Bihar, Uttarakhand and Karnataka*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.
- IGSSP (2013a). *Assessment of Implementation Process of Rashtriya Swasthya Bima Yojana (RSBY) in Manipur*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.
- IGSSP (2013b). *Assessment of Implementation Process of Rashtriya Swasthya Bima Yojana (RSBY) in Meghalaya*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.
- IGSSP (2013c). *Assessment of Implementation Process of Rashtriya Swasthya Bima Yojana (RSBY) in Mizoram*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.
- IGSSP (2013d). *Assessment of Implementation Process of Rashtriya Swasthya Bima Yojana (RSBY) in Nagaland*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.
- IGSSP (2014). *Health Insurance. Indo-German Social Security Programme (IGSSP)*. New Delhi: Deutsche Gesellschaft für Internationale Zusammenarbeit, Indo-German Social Security Programme.
- Palacios R, Das J, Sun C (2011). *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Swasthya Bima Yojana*. New Delhi: Centre for Policy Research.
- Jain N (2014). Rashtriya Swasthya Bima Yojana: A step towards universal health coverage in India. In: *India Infrastructure Report 2013-14: The Road to Universal Health Coverage*. Hyderabad: IDFC Foundation/Orient Blackswan Private Limited.
- Kumar AKS et al. (2011). Financing health care for all: challenges and opportunities. *The Lancet*, 377: 668-79.
- La Forgia G, Nagpal S (2012). *Government-Sponsored Health Insurance in India: Are You Covered? Directions in Development*. Washington, DC: World Bank.
- MoLE (2014). *Annual Report 2013-2014*. New Delhi: Ministry of Labour and Employment, Government of India.
- MoLE (s.d.). *Rashtriya Swasthya Bima Yojana: Health and Hope for All*. New Delhi: Office of Director General of Labour Welfare, Ministry of Labour and Employment.

- Patel V et al. (2011). Universal health care in India: the time is right. *The Lancet*, 377: 448-9.
- PATH (2012). *Determining Common Requirements for National Health Insurance Information Systems*. Seattle: PATH.
- Raj A (2011). Gender equity and universal health coverage in India. *The Lancet*, 377: 618-9.
- Reddy KS et al. (2011). Towards achievement of universal health care in India by 2020: a call to action. *The Lancet*, 377: 760-8.
- Schaap F (2013). Health care for all. *Akzente*, January 2013: 30-33.
- UNDP (2014). *Human Development Report. Sustaining Human Progress: Reducing Vulnerabilities and Building Resilience*. New York: United Nations Development Programme.
- WHO (2010). *The World Health Report 2010, Health Systems Financing: The path to universal coverage*. Geneva: World Health Organization.
- WHO (2014). *World Health Statistics 2014*. Geneva: World Health Organization.
- WIAS (2007). Manmohan Singh offers a new deal to Indian farmer and common man. *Asian Tribune*, World Institute for Asian Studies (WIAS), 16 August 2007.
- World Bank (2014). *Poverty Overview*. Available at <http://www.worldbank.org/en/topic/poverty/overview> [Accessed 6 October 2014].

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Programme to Foster Innovation, Learning and Evidence
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Friedrich-Ebert-Allee 36 + 40
53113 Bonn, Germany
Tel. +49 228 44 60 - 0
Fax +49 228 44 60 - 1766

Dag-Hammarskjöld-Weg 1-5
65726 Eschborn, Germany
Tel. +49 6196 79 - 0
Fax +49 6196 79 - 1115

ghpc@giz.de
www.health.bmz.de/good-practices

Writer
Karen Birdsall

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Stuart Adams

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Karsten van der Oord

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Addresses of the BMZ offices

BMZ Bonn
Dahlmannstraße 4
53113 Bonn, Germany
Tel. +49 228 99 535 - 0
Fax +49 228 99 535 - 3500

BMZ Berlin
Stresemannstraße 94
10963 Berlin, Germany
Tel. +49 30 18 535 - 0
Fax +49 30 18 535 - 2501

poststelle@bmz.bund.de
www.bmz.de