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Health insurance for India's poor

A publication in the German Health Practice Collection



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Acronyms and Abbreviations

AABY	Aam Admi Bima Yojana	InWEnt	Capacity Building International, Germany
BPL	Below the poverty line	KfW	KfW Entwicklungsbank
BMZ	Federal Ministry for Economic Cooperation and Development, Germany	KMS	Key Management System
DALYs	Disability Adjusted Life Years	LMIC	Lower middle income country
DED	German Development Service	MDG	Millennium Development Goal
DKM	District Key Manager	MFI	Microfinance institution
ESI	Employers State Insurance Corporation	MoHA	Ministry of Home Affairs, Government of India
FKO	Field Key Officer	MoHFW	Ministry of Health and Family Welfare, Government of India
GDC	German Development Cooperation	MoLE	Ministry of Labour and Employment, Government of India
GII	Gender Inequality Index	MoSPI	Ministry of Statistics and Programme Implementation, Government of India
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit*	MPI	Multidimensional Poverty Index
GOI	Government of India	NFHS	National Family Health Survey
GoIPC	Government of India Planning Commission	NOAPS	National Old Age Pension Scheme
GPHC	German Health Practice Collection	NSSO	National Sample Survey Office, MoSPI
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)	RSBY	Rashtriya Swasthya Bima Yojana
HIC	High income country	SSPK	Social Security Programme Karnataka
HDI	Human Development Index	TPA	Third party administrator
IEC	Information, education and communications	UT	Union Territory
IGSSP	Indo-German Programme for Social Security	WHA	World Health Assembly

* The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH was formed on 1 January 2011. It brings together the long-standing expertise of the Deutscher Entwicklungsdienst (DED) gGmbH (German development service), the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH (German technical cooperation) and InWEnt – Capacity Building International, Germany. For further information, go to www.giz.de.

Health insurance for India's poor

Meeting the challenge with information technology

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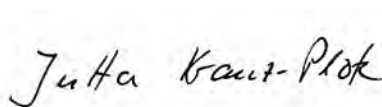
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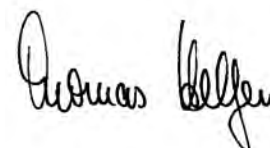
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German Health Practice Collection

Objective

In 2004, experts working for German Development Cooperation (GDC)¹ and its international and country-level partners around the world launched the German HIV Practice Collection and, in 2010, expanded it into the German Health Practice Collection (GHPC). From the start, the objective has been to share good practices and lessons learnt from BMZ-supported initiatives in health and social protection. The process of defining good practice, documenting it and learning from its peer review is as important as the resulting publications.

Process

Managers of GDC-supported initiatives propose promising ones to the Managing Editor of the GHPC at ghpc@giz.de. An editorial board of health experts representing GDC organizations at their head offices and in partner countries select those they deem most worthy of write-up for publication. Professional writers then visit selected programme or project sites and work closely with the national, local and GDC partners primarily responsible for developing and implementing the programmes or projects.

Independent, international peer-reviewers with relevant expertise then assess whether the documented approach 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

Only approaches meeting most of the criteria are approved for publication.

Publications

All publications in the GHPC describe approaches in enough detail to allow for their replication or adaptation in different contexts. Written in plain language, they aim to appeal to a wide range of readers and not only specialists. They direct readers to more detailed and technical resources, including tools for practitioners. Available in full long versions and summarized short versions, they can be read online, downloaded or ordered in hard copy.

Get involved

Do you know of promising practices? If so, we are always keen to hear from colleagues who are responding to challenges in the fields of health and social protection. You can go to our website to find, rate and comment on all of our existing publications, and also to learn about future publications now being proposed or in process of write-up and peer review. Our website can be found at www.german-practice-collection.org. For more information, please contact the Managing Editor at ghpc@giz.de.

¹GDC includes the Federal Ministry for Economic Cooperation and Development (BMZ) and its implementing organizations: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and KfW Entwicklungsbank. GIZ was formed on 1 January 2011. It brings together the long-standing expertise of DED, GTZ and InWEnt. For further information, go to www.giz.de.

Executive Summary

India is home to more than 1.2 billion people and almost one-third live below the poverty line (BPL), as defined by the Government of India. On 2 October 2007, the Government launched a national insurance scheme or, in Hindi, Rashtriya Swasthya Bima Yojana (RSBY). The scheme's first five-year target is, by the end of 2012, to provide all India's BPL families with enough health insurance to avoid catastrophic health expenses due to serious illness or injury.

Each family's RSBY policy comes due for renewal once per year and identifies up to five family members as beneficiaries, while assuming that any infant (<1) is covered by its mother's coverage. The family pays a nominal fee for enrolment or renewal but, otherwise, the policy provides cash-and-paperwork-free hospitalization, including overnight stays and day surgeries and treatments not normally provided as part of out-patient care in smaller clinics. It also provides reimbursements for travel expenses.

India's 28 States and 7 Union Territories (UTs) choose to opt into RSBY under agreements whereby the Government of India usually pays 75 percent (but sometimes 90 percent) of the per-family premiums charged by insurance companies. States/UTs issue public calls for bids and then give selected insurance companies guidance and support as they enrol BPL families and "empanel" hospitals that agree to provide specified services and medicines at specified rates. Upon enrolment, families are given electronic Smart Cards that enable cash-and-paperwork-free transactions at hospitals and automatic billing of insurance companies.

RSBY provides flexibility for States/UTs to combine it with other insurance schemes and extend coverage beyond BPL families and beyond the hospital care covered by RSBY. It is a major addition to the Government's efforts to achieve universal access to good, affordable health care. Since promoting and

supporting universal coverage is a top priority of Germany's cooperative development policy, Germany has been pleased and privileged to join the World Bank as one of the two main international partners providing technical guidance and support during design and roll-out of RSBY.

After a six month design process, roll out began in April 2008. RSBY is a massive public-private-partnership (PPP) scheme presenting many challenges, so roll-out continues to be a gradual, learn-by-trial-and-error, District-by-District process. Yet, just over three years after roll-out-began, all but one of the 28 States have opted into RSBY and participating States/UTs have already planned, begun or completed first rounds of enrolment in 378 of India's 640 Districts. As of 20 May 2011, there were 23.5 million BPL families in possession of Smart Cards and 8,300 empanelled hospitals where they could use their cards.

Data from 167 Districts where RSBY has been operating for at least one year show upward trends in the average number of beneficiaries (now 2.7) identified on each Smart Card, the percentage who are women and the percentage who receive in-patient care each year. (Last year, 2.8 percent received in-patient care whereas, in 2004, only 1.7 percent of the poorest 40 percent of Indians received in-patient care.) It is early days for the RSBY and, as this publication shows, it still faces many challenges but its early achievements make it well worthy of write-up as an example of promising practice from which readers in other countries have much to learn.

Overview of RSBY

India and Germany are united in their commitment to Article 25 of the Universal Declaration of Human Rights (1948) which states that everyone has a right to the health care and social protection they need to maintain their own and their family's health and well-being in the event of illness, disability or old age. In recent years, they have supported a number of World Health Assembly (WHA) resolutions addressing the need to provide universal coverage with good, affordable health care. The latest of these – proposed by Germany and adopted by the 64th WHA in Geneva on 24 May 2011 – urges countries to develop health-financing systems that make it unnecessary for people to pay for health care at point of delivery, that pool risks among their populations and that avoid catastrophic health care expenditure and impoverishment of families (WHA, 2011).

The Government of India had just such a health-financing system in mind on 2 October 2007 when it officially announced the Rashtriya Swasthya Bima Yojana (RSBY). Translated from Hindi, the name means National Health Insurance Scheme and implies that it could eventually cover all residents of India. Initially, RSBY's stated goal is to cover below-the-poverty-line (BPL) workers in the informal sector of the economy and their families. More than 94 percent of all India's workers are in the informal sector. They and their families include virtually all BPL people in India. They constitute almost one-third of the country's entire population and number around 385 million people.

India's Ministry of Labour and Employment (MoLE) is the Nodal Ministry responsible for design and implementation of RSBY, while the Ministry of Health and Family Welfare (MoHFW) is a lead participant. Since early 2008, the World Bank and Germany have been providing technical support during design, roll-out and early problem identification and

resolution. Beyond those four organizations, RSBY is a massive public-private-partnership (PPP) scheme.

After official announcement of RSBY on 2 October 2007, there were six months of preparation before roll-out began on 1 April 2008. Just over three years later, at the end of May 2011, its active partners include most of India's 35 States and Union Territories, more than half of their 640 Districts, eleven private insurance companies, many third party administrators, and almost 8,300 public and private hospitals. More than 23 million BPL families are enrolled in RSBY and in possession of the scheme's electronic Smart Cards, allowing them to go to any one of those 8,300 hospitals and receive treatment with no cash or paperwork required.

It is early days for RSBY, too early to give it a comprehensive and rigorous evaluation. However, there is more than enough evidence to show that its achievements have been impressive. Readers in other countries have much to learn from India's RSBY experience as they, too, work on developing health-financing systems (including health insurance schemes) that move their countries further towards the goal of universal coverage with good, affordable health care. With those readers in mind, this publication tells RSBY's story to date and begins by setting RSBY its uniquely challenging Indian context.

India and its development challenges

An exceptionally large, diverse and complex country

From 2001 to 2011, India's population grew by 181 million people to 1.21 billion. Now down to around 1.4 percent per year, its rate of growth is on the decline but India is still on course to overtake China as the world's most populous country by 2025 (MoHA, 2011).

In land area, India is less than one-third the size of China, the United States or Canada. Its population is densely packed into its more habitable areas, including three of the world's twelve most populous cities: Mumbai, Delhi and Kolkata. Its climate varies from tropical monsoon to northern temperate; its terrain from Himalayas to high plateau to flat and rolling plain to desert; but nothing varies more than the cultural traditions of its regions and their people. Indians have 15 official languages (e.g., Hindi, Bengali, Telugu, Marathi, Tamil, and Urdu) and recognize English as a subsidiary official language, important for countrywide communications, public affairs and commerce. More than 80 percent of Indians are Hindu and more than 13 percent are Muslim but many millions are Christian, Sikh or adherents to other faiths. Roughly one-quarter belong to the country's many hundreds of Scheduled Casts and Tribes.

The world's largest parliamentary democracy, India has a federal system of government with 28 States, 7 Union Territories, 640 Districts, almost 6,000 Sub-districts, and more than 5,000 Towns and 600,000 Villages. The legislative branch of the Government of India (GOI) is bicameral, with a Council of States or Rajya Sabha (upper house) and People's Assembly or Lok Sabha (lower house.) Currently, 17 political parties or coalitions hold 4 or more seats in the Lok Sabha. There are dozens of other national and regional political parties and coalitions and many political pressure groups. All contribute to India's



An insurance company representative and an entertainer from a local NGO tell villagers about RSBY and where they can enrol.

reputation as a country where political debate is lively, consensus is hard to reach and bureaucratic inertia and corruption are constant threats to good governance.

A booming economy

India's Gross Domestic Product grew by an average of 7.5 percent per year during the first eleven years of the second millennium, from the start of 2000 to the end of 2010. This gave India the world's second fastest growing economy, after China's (IMF, 2001-2011). The World Bank estimates that, by 2009, India's Gross National Income (GNI) per capita had risen to US\$ 1,220 and was equivalent to US\$ 3,280 in terms of purchasing power parity.

Year after year, India has been moving up through the ranks of what the World Bank classifies as lower middle income countries (LMICs) but, to put this in perspective, it still has far to go before it enters the ranks of high income countries (HICs). In 2009, HICs had average GNIs per capita of US\$ 37,000 (30 times India's) or US\$ 36,213 (15 times India's) in terms of purchasing power parity (World Bank, 2011).

Significant achievements in development

Average life expectancy at birth is one of the best indicators of a country's level of human development. During 1950-1955, India's average life expectancy was 38 years, ten years below the World's 48 years and 31 years below Northern Europe's 69 years. By 2005-2010, its average life expectancy had increased to 64 years, just four years below the World's 68 years and 15 years below Northern Europe's 79 years (UN, 2011). India's Ministry of Health and Family Welfare (MoHFW) projects that the country's average life expectancy at birth will be more than 68 years during 2011-2015 and more than 71 years during 2021-2025 (MoHFW, 2009).

Increases in educational attainment are essential to a country's progress towards higher levels of human development. They improve labour productivity and capacity to absorb new technology and they increase incomes, improve nutrition, and lower rates of birth, disease and mortality. In 1950, only 25 percent of Indian adults (15+ years old) had ever been to primary school and only 2.1 percent had ever been to secondary school. By 2010, more than 67 percent had been to primary school; more than 40 percent to secondary school and 5.8 percent had at least some post-secondary education (Barro and Lee, 2010).

Enrolment of 6-to-11-year-olds in primary school increased from 83 percent in 2000 to 95 percent in 2008 and India is on track to achieve the Millennium Development Goal (MDG) of universal primary education well before the 2015 target date. It missed the 2005 target for achieving gender parity in primary education but, from 1990 to 2006, girls' enrolment went up from 60 percent to 82 percent, while boys' enrolment went up from 76 percent to 94 percent (MoSPI, 2009). India's 2011 census found that, since the 2001 census, effective literacy among Indians

seven-plus years old had gone up from 64.8 percent to 74.0 percent and the gender gap in literacy was closing. Literacy among males went up from 75.3 percent to 82.1 percent (a difference of 6.9 percent) while literacy among females went up from 53.8 percent to 65.5 percent (a difference of 11.8 percent) (UN, 2011).



As word spreads, more villagers line up to enrol.

Major challenges: multidimensional poverty and inequality

While India speeds towards achieving the MDG of universal primary education, it lags behind on achieving most of the other MDGs. Reasons include its complex system of government, with action required by governing bodies at National, State, Union Territory, District, Sub-district, Town, and Village levels. Coordination and accountability are weak, policies are often inconsistent or absent and delivery of public services is often ineffective.

One underlying problem is deep and persistent poverty, spread widely but unevenly across the country. The GOI's September 2009 report on the country's progress towards the MDGs said that the proportion of India's population falling below the national poverty line decreased from 37.2 percent in 1990 to

27.5 percent in 2004 and was projected to decrease to 22.1 percent by 2015, not reaching the 18.6 percent required to meet the MDG of halving poverty from the 1990 baseline by 2015 (MoSPI, 2009).

In November 2009, a GOI-appointed Expert Group issued a report saying the long-standing method of measuring poverty on the basis of income required for a minimally nutritious diet was no longer adequate. The GOI adopted the Group's recommendation of a new method that takes into account: income required for a minimal basket of goods and services including food, clothing, household durables, education, and health care; adjustments for each State and for its urban and rural populations, since the cost of living varies widely across India.

By applying this new method, the Group found that, in 2004-2005, 37.2 percent of Indians fell below the poverty line (BPL) but this varied from a low of 9.0 percent in one small State (Nagaland) to a high of 57.2 percent in one large State (Orissa). It also found that poverty was more prevalent in rural areas, where 41.9 percent of people were BPL, than in urban areas, where 25.7 percent were BPL (GoIPC, 2009). Box 1 shows how the World Bank, too, has changed its estimates of poverty in India.

The latest National Sample Survey on household consumer expenditure found that, in the five years from 2004-2005 to 2009-2010, the proportion of all Indians who were BPL declined from 37.2 percent to 32.0 percent (The Hindu, 2011). Though poverty is on the decline, there are still more than 385 million people living BPL in India – many more than the 311 million people in the total population of the world's third most populous country, the United States.

Another underlying problem is inequality not only between States, urban and rural people and high and low income people but also between the majority and minorities that include members of Scheduled Casts and Tribes. Cutting across all other inequalities is the pervasive inequality of girls and women. Compared to Indian males, Indian females have far less access to education, gender-suitable health services, and jobs. Such is the prejudice against females that prenatal sex determination and sex-selective abortion have become increasingly common. India's 2011 census found that the Sex Ratio (number of girls per 1000 boys) of 0-6-year-olds had fallen to 914, the lowest it had been since India gained independence in 1947. (See Box 2 for an assessment the impacts of inequality.)

Box 1. World Bank's old and new estimates of poverty in India

In 2008, the World Bank revised the international poverty line upwards from US\$1 to US\$1.25 per person per day in terms of purchasing power parity, based on 2005 prices. It explained that the reason for the change was more complete and accurate data from developing countries and, also, emphasized that the international poverty line is meant to enable international comparisons and usually differs from national poverty lines as defined by national governments. It estimated that the percentage of Indians living below the old US\$1 international poverty line had declined from 42 percent in 1981 to 24 percent in 2005, while the percentage living below the new US\$1.25 international poverty line had declined from 60 percent in 1981 to 42 percent in 2005 (Ravallion et al., 2008).

Towards universal access to essential health services

A global challenge: overcoming financial barriers to health

Around the world for more than a thousand years, commercial, faith-based and other non-governmental health care providers have been establishing clinics and hospitals, charging most patients enough to cover the costs, subsidizing some, but providing many with substandard care or none at all.² In recent

centuries, employers, trade unions and guilds have been prominent in this whole endeavour, often by taking a portion of wages to cover costs of health and social insurance for workers and their families. In the absence of adequate insurance, an individual's ill health or disability has often been ruinous to their whole family as it struggles to pay for the individual's care and replace their contributions to the family's economy.

Box 2. The impacts of inequality on human development in India

In 2010, the UN's Human Development Report (HDR) added two new indices to its existing Human Development and Gender Inequality Indices and reported the following results:

The Human Development Index (HDI) takes into account average income, life expectancy and years of schooling. India's HDI was 0.519 (where 1.0 was ideal) and it ranked 119 out of 169 countries putting it well within the Medium Human Development category.

The Inequality-adjusted HDI takes into account disparities in income, life expectancy and schooling. Doing this resulted in downward adjustments to India's HDI by 29.6 percent to 0.365, to the HDI's income component by 14.7 percent, to its life expectancy component by 31.3 percent and to its schooling component by 40.6 percent.

The Multidimensional Poverty Index (MPI) is a measure of deprivation in at least two to six of ten variously-weighted components of health (nutrition, child mortality), education (years of schooling, children enrolled) and standard of living (cooking fuel, toilet, water, electricity, floor, assets). Based on 2000-2008 data, 55.4 percent of Indians were poor and accounted for more than one-third of the world's 1.75 billion poor.

The Gender Inequality Index (GII) is a measure women's unequal access to gender-appropriate reproductive health services (indicated by maternal mortality and fertility), empowerment (indicated by parliamentary representation and schooling to at least secondary level) and paid employment (indicated by labour force participation). India's GII was 0.748 (where 0.0 was ideal) and it ranked near the bottom at 122 out of 137 countries.

²Written in Sanskrit around two thousand years ago, the Charaka Samhita Sutra is Indian's oldest surviving medical encyclopaedia and it describes the requirements of a good hospital and its staff.

Under its first Chancellor, Otto von Bismarck, Germany established the world's first social protection system with the Health Insurance Bill (1883), Accident Insurance Bill (1884) and Old Age and Disability Insurance Bill (1889). As Germany strengthened this system, other European countries followed its example. In the United Kingdom, for example, Sir William Beveridge's 1942 report to Parliament on Social Insurance and Allied Services led to establishment of the National Health Service in 1946 and the UK Government's commitment to provide good high care to everyone, without means-testing. Each European country has developed its own unique social protection system but they have mostly been based on the principle that all residents of a country are entitled to good, affordable health care through some combination of public and private clinics, hospitals and financing and with public financing coming through some combination of taxation and social insurance premiums.



A laptop computer, RSBY software and peripherals provide everything needed for one-stop enrolment and distribution of Smart Cards.

When they voted to adopt the Universal Declaration of Human Rights in 1948, most UN Member States endorsed Article 25. It specifies everyone's right to the health and social care they need to maintain their own and their family's health and well-being in the event of illness, disability and old age.

Since 1948, there have been numerous reports by the World Health Organization (WHO) showing how far most developing countries are from achieving Article 25's implied goal of universal access to good, affordable health care. These ones stand out as being especially relevant today:

- **The world health report 2000** identified the most common weaknesses of health systems and suggested ways they could be strengthened, including by reforming their health-financing systems and targeting the poor with health insurance (WHO, 2000). These were all ways countries could reach towards Millennium Development Goals (MDGs) 1, 4, 5 and 6: eradicate extreme poverty and hunger; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria and other diseases.
- **In 2005, a WHO report on social health insurance** to the 58th World Health Assembly (WHA) recommended that countries reform their health-financing systems and develop health insurance schemes whereby their populations share risks, pool resources and avoid catastrophic health-care expenditures that impoverish individuals and their families. It also recommended that countries take advantage of opportunities for collaboration between public and private providers of both health care and health insurance (WHO, 2005). The WHA resolved to adopt the recommendations (WHA, 2005).
- **The world health report 2008** emphasized universal coverage as one of the four pillars of primary health care and said such coverage required patient-centred care with no financial or other barriers preventing access to care (WHO, 2008). A good complement to that report is a 2008 WHO bulletin discussing such barriers and ways of overcoming them (Carrin et al., 2008).

- **The world health report 2010** provided guidance on how countries can achieve universal access by finding their own answers to three questions (WHO, 2010): How can they finance a health system with the capacity to deliver good health care to everyone? How can they protect people from the financial consequences of ill-health? How can they encourage the optimum use of available resources?

In Berlin on 22 November 2010, WHO launched the above report at the Ministerial Conference on Health Systems Financing – Key to Universal Coverage. As follow-up, Germany proposed a resolution adopted by the 64th WHA in Geneva on 24 May 2011. It urges countries to develop health-financing systems that make it unnecessary for people to pay for health care at point of delivery, that pool risks among their populations and that avoid catastrophic health care expenditure and impoverishment of families (WHA, 2011).

India’s challenge

Figures 1 and 2 provide a few indicators of the magnitude of Indian’s challenge as it moves towards universal coverage with essential health care. As shown in Figure 1, Germany and the United Kingdom are typical of Western European countries in that their per capita spending on health care alone exceeds India’s entire per capita income. They have their own unique ways of financing health care but do it mostly through government, with some combination of revenues from taxation and social insurance contributions. In India, by contrast, more than two-thirds of financing for health care comes from the private sector; almost three-quarters of private sector financing consists of out-of-pocket spending by patients and their families; out-of-pocket spending accounts for half of all financing for health care.

Figure 1. 2009 national health expenditures in three countries

	India	Germany*	UK
Health expenditure:			
As percentage of GDP	4.2%	11.3%	9.3%
Per capita:			
In \$US	\$45	\$4,620	\$3,285
Purchasing power parity	\$132	\$4,129	\$3,399
Sources:			
Government:	32.8%	75.7%	83.6%
Social security funds	5.2%	68.7%	0.0%
Ministries	27.6%	7.0%	83.6%
Private:	67.2%	21.2%	16.4%
Private insurance	1.5%	9.1%	1.1%
Out-of-pocket	50.0%	11.4%	10.4%
NGOs and other	15.7%	0.7%	4.9%

Source: National Health Accounts. World Health Organization, April 2011. Available at www.who.int/nha/en/

*The percentages in these accounts do not always add up to 100.

Weaknesses and inequalities in a health care system are nowhere more evident than in health outcomes for women and children. India's Ministry of Health and Family Welfare (MoHFW) estimates that, in 2004-2005, maternal mortality in India averaged 254 per 100,000 live births and ranged from 95 in one State to 480 in another (MoHFW, 2009). These rates compare to maternal mortality of less than 10 per 100,000 live births in Western European countries.

Figure 2, shows selected findings of India's third National Family Health Survey (NFHS-3), done in 2005-2006. The high fertility rates indicate that many women have little or no access to family planning advice and supplies. Many receive little or no antenatal or postnatal care, where they might benefit from interventions (e.g., advice on good nutrition) protecting their own health and that of their babies. Many children do not receive all of the recommend-

ed vaccinations (for tuberculosis, diphtheria, polio, and measles) and extremely high percentages are stunted, underweight or wasted. Those factors all help explain the findings that, at the time of the survey, 74 out of a thousand Indian children (compared to 4 out of 1000 German children and 6 out of 1000 UK children) were dying before they reached their fifth birthday; children from the poorest 20 percent of Indian households were three times more likely to die than children from the richest 20 percent (IIPS et al., 2007).

By increasing overall health financing and the share of it done through government – and by spending the money efficiently and effectively – India can develop a health system with the capacity to deliver satisfactory health care to women, children and everyone else and it can also ensure that poverty is not a barrier stopping access to that system.

Figure 2. Indicators of health inequality in India, 2005-06

	Household by Income		
	Richest 20%	Poorest 20%	All
Women's fertility rate	1.78	3.89	2.68
No antenatal care during last pregnancy	2.6%	41.3%	22.8%
No postnatal check-up after last birth	20.7%	80.7%	57.6%
Children (12-23 months) receiving			
all recommended vaccinations	70.0%	24.4%	43.55
Malnutrition among children under 3:			
Stunted (under height)	25.3%	59.9%	44.9%
Under weight	19.7%	56.6%	40.4%
Wasted (under weight for height)	12.7%	25.0%	22.9%
Deaths/1000 of children under 5	33.8	100.5	74.3

Source: IIPS et al (2007). National Family Health Survey (NFHS-3), 2005-06: India. Mumbai, International Institute for Population Sciences (IIPS) and Macro International.

How India is meeting the challenge

On 15 August 2007, the 60th anniversary of India's independence, Prime Minister Manmohan Singh stood on the ramparts of Delhi's historic Red Fort and hailed India's achievements. He then cautioned, "India cannot become a nation with islands of high growth and vast areas untouched by development, where the benefits of growth accrue only to the few" (WIAS, 2007). He outlined his Government's vision of "inclusive growth" achieved through massive increases in public spending on education, health, agriculture, and rural development and a number of major new initiatives. Three of these would strengthen social protection and extend social insurance coverage to hundreds of millions of people living below the poverty line (BPL):

- **Extension of the existing National Old Age Pension Scheme (NOAPS)**, raising the benefit level for BPL people over the age of 65 in those States willing to match increased contributions from the GOI;
- **Aam Admi Bima Yojana (AABY), a new life insurance scheme for all rural landless households**, covering death and disability and providing educational assistance for children, with the premiums split 50:50 between the GOI and States;
- **Rashtriya Swasthya Bima Yojana (RSBY), a new health insurance scheme for all BPL informal sector workers and their families** with the premiums split 75:25 between the GOI and States and small registration/annual renewal fees paid by the workers. In India, the informal sector accounts for more than 94 percent of all active workers and virtually all BPL workers (MoLE, 2010).

The vision, strategies and major new initiatives outlined in the Prime Minister's speech were subsequently embodied in India's Eleventh Five Year Plan (2007-2012). As indicators for the purposes of monitoring and evaluation, the plan sets a number of ambitious goals for 2012. Among the health-related goals are to more than double public spending on health (raising it from 0.9 percent of GDP to 2-3 percent of GDP); to reduce women's fertility to 2.1, to reduce maternal mortality to 100/100,000, to reduce child (<3) malnutrition by 50 percent, and to reduce infant (<1) mortality to 28/1,000 (Planning Commission, Government of India, 2008).

In 2009, the Government announced that, starting in 2010, its Ministries would begin issuing five Annual Reports to the People on Health, Education, Environment, Infrastructure and Employment and these would cover progress towards the goals set by the Plan. The 2010 Annual Report to the People on Health, for example, says that infant (<1) mortality declined from 129/1,000 in 1971 to 53/1,000 in 2008 but it was still much higher in rural areas (58) than urban areas (36) (MoHFW, 2010).



A camera takes photos of people who will be the main cardholders.

How Germany is cooperating with India

In 2008, Germany and India celebrated the 50th anniversary of Indo-German development cooperation and signed a new development cooperation agreement. Aligned with India's Eleventh Five Year Plan, the agreement specifies priority areas for German contributions to implementation:

- **Environment**, including environmental protection and management of natural resources;
- **Energy**, including measures to ensure a stable and environmentally sound energy for sustainable economic growth;
- **Sustainable economic development**, including support for micro-credit, reform of rural cooperative banks, development of financial and other instruments for small and medium sized enterprises, and social protection for the poor.

In each priority area, Germany cooperates with the GOI and States and often focuses on particular programmes or projects in particular States. At State level, the former GTZ and InWEnt and the new GIZ have been partnering with Karnataka's Ministry of Labour on the Social Security Programme Karnataka (SSPK) which aims to expand and strengthen social protection for informal sector workers and their families. GOI level, the former GTZ, the new GIZ and the World Bank have been the main international partners of India's Ministry of Labour and Employment (MoLE) as it gets RSBY established.

Germany's collaborations on the SSPK and RSBY align with its policies of making universal coverage with health care and social protection priorities in its contributions to international development (BMZ, 2009). In April 2011, Germany strengthened its commitment to social protection in India by establishing

the Indo-German Social Security Programme (IGSSP). Henceforth, the IGSSP will work closely with the Ministry of Labour and Employment (MoLE), other Ministries and their partners in the public, private and civil society sectors to oversee GIZ's contributions to the RSBY and other social protection initiatives, with particular focus on BPL workers in the informal sector of the economy.



Recording a thumbprint to identify a beneficiary.

Rastriya Swasthya Bima Yojna (RSBY)

Getting established, with support from partners

India's Prime Minister informally announced RSBY on 15 August 2007 but officially announced it on 2 October 2007 as a new programme of the Ministry of Labour and Employment (MoLE). The Ministry then needed some months to secure agreements with partners and work with them on designing the scheme and preparing for its roll-out through States, Districts and insurance companies to BPL families. By early 2008, Germany – represented by the former GTZ and the new GIZ – and the World Bank had become the two principle partners and were providing technical support to the design and implementation process.

Germany has been supporting initial preparation and on-going refinement of the documents that constitute the regulatory framework and that serve as the main tools for implementation. These include: guidelines laying out the responsibilities of different stakeholders; templates for memoranda of understanding (MOUs) with States and for contracts with insurance companies; draft agendas and participation lists for information and training workshops. As roll-out proceeds and challenges and opportunities emerge, Germany has helped strengthen RSBY by, for example, facilitating the introduction of maternity benefits. At State level, Germany has been responding to requests for support from other States as they opt to participate in RSBY (Jain, 2010).

The World Bank has been supporting the development, maintenance and on-going improvement of RSBY's technology platform and information management system, including RSBY's insurance Smart Cards and website.

Defining the problem

Rashtriya Swasthya Bima Yojana (RSBY) is Hindi for "National Health Insurance Scheme." Eventually, it could cover everyone in India. Initially, it is practical and affordable to cover only BPL workers in the informal sector and their families. This is far from a modest objective, since it means covering virtually all BPL people in India and they currently constitute almost one-third of India's 1.21 billion people.



On-the-spot printing of Smart Cards.

As it was getting established in 2007-2008, the RSBY team had enough information to define the approximate dimensions of the problem it was challenged to address. Since then, the Report of the Expert Group to Review the Methodology for Estimation of Poverty (2009) has redefined "below the poverty line (BPL)", established a new method for measuring poverty and provided new baseline data against which progress on poverty reduction can be measured (GoIPC, 2009). In addition, the MoLE has provided more accurate and up-to-date information on BPL workers in the informal sector in its first Annual Report to the People on Employment, published in July 2010. Henceforth, preparing and publishing these annual reports will be significant parts of the Ministry's efforts to monitor and report on progress toward those Five Year Plan goals for which it is responsible, including goals pertaining to RSBY (MoLE, 2010).

The Annual Report's estimates and projections show that the portion of the population in the working age group (15-59 years) grew from 57.7 percent in 2001 to 62.7 percent in 2011 and is continuing to grow. There is now a potential labour force of almost 760 million workers but only 70 percent actually participate in the labour force, for a total of around 540 million active workers. Reasons for non-participation include continuing (though declining) bias against participation by women, high levels of unemployment among young adults, and varying levels of unemployment across the country.

Less than 6 percent of active workers participate in the organized sector, characterized by higher earnings and job security. More than 94 percent are in the informal sector. Of these, the majority are self-employed and do not earn wages but profit from their own small and marginal agricultural and business enterprises. The rest are wage-earners but most do not have regular jobs and, instead, work on a casual basis. This is especially so in rural areas where 33 percent of all workers depend on casual jobs for income. Many have several jobs each year and migrate to take advantage of seasonal employment opportunities. Casual wage-earners and their families are among the poorest of the poor in India.

The GOI and the States share responsibility for health care and social protection in India. States provide the greater share of government financing for health care but the GOI finances research and policy development, establishes countrywide programmes, and encourages State buy-in by offering to share costs. Prior to 2007, total government financing fell far short of being enough to build sufficient capacity into the health system to serve everyone adequately. Attempts to provide access to those who could not afford to pay out of their own pockets were few, narrowly-targeted, underfunded and largely ineffective.

Most poor people were not covered by health insurance schemes, those who were covered were often unaware of the fact, and those who were aware were often discouraged by complicated regulations, restrictions and procedures with rewards too small to make the effort worthwhile. Not the least of problems was that many of the poorest people were illiterate and difficult to reach with information. Many were mobile and even those who were not mobile were unlike workers in the organized sector in that they did not report to places of work where human resources personnel and procedures were in place to provide them with information and help them take full advantage of any health insurance schemes that might be on offer.



A Smart Card identifies the main card holder on the front while its chip has all required data about her other family members enrolled as beneficiaries.

Agreeing on principles

During the design process, the RSBY team gradually reached implicit agreement on what can now be seen as three guiding principles (Palacios, 2010):

1. **The scheme must work from the beneficiaries' perspectives.** It must be user-friendly even for BPL families who are illiterate and move from place to place across India. This means:
 - a. Enrolment must be easy, offered in convenient locations and require only one visit.

- b. The enrolment fee must be nominal and there must be no premiums other than those paid for and split by the GOI and the States. often been confined either to urban residents or rural residents within particular States.
- c. Eligibility conditions must be clear and simple, confined to the requirement that a family's details can be found on District BPL lists prepared by the State.
 - i. The insurance cards must be valid at all qualified public and private hospitals.
- d. Pre-existing conditions must be covered and there must be no other complicated exclusions.
- e. There must be direct interface between BPL family members and insurers at time of enrolment. This ensures that insurers get all relevant information on family members, family members get all relevant information on coverage from insurers, applications can be approved on the spot, and successful applicants pay their fees and receive their insurance cards on the spot.
- f. Successful applicants must pay their own enrolment fees, to demonstrate their serious wish to become RSBY policy holders and to give them a sense of ownership over their new policies and insurance cards.
- g. The insurance cards must allow for paperless and cashless transactions when family members go to hospitals for diagnosis and treatment. People with little or no cash should not be discouraged by having to make front-end cash payments and then having to apply for reimbursements.
- h. The insurance must have no boundaries, meaning that it must be transportable and the cards valid anywhere in India. Previous insurance schemes for BPL families have
 - 2. **The scheme must be sustainable.** This means that financial and other incentives for States, insurers and policy holders must be sufficient to keep RSBY aligned with its objectives and moving towards its goals.
 - 3. **The scheme must be flexible, adaptable and based on timely evidence.** This means the information management system must facilitate a continuous flow of commonly agreed and comparable sets of data from insurers and hospitals to RSBY at State and GOI levels and that data must be quickly analyzed and reported on an RSBY website.

Setting objectives

RSBY's intended beneficiaries are BPL workers in the informal sector and their families but, as the above principles emerged through the design process, it was agreed that it would not only be unreasonable but also impractical to require self-employed or casual workers to present proof of their employment status. Instead, the only requirement should be that a family's details can be found on District BPL lists prepared by States. With that decided, RSBY's objectives could be stated as follows:

1. To protect all BPL families from catastrophic health expenditures when family members require hospitalization for any reason, including pre-existing conditions.
2. To ensure that the treatment BPL families receive is of high quality and fairly priced, by empaneling (certifying and listing) qualified public and private hospitals.

3. To give all BPL families freedom to choose from among all empanelled public or private hospitals across India.
4. To make RSBY as user-friendly as possible even for illiterate people, with transactions that require no cash and no paperwork.

Laying out the parameters

During the design process it was agreed that each RSBY policy should cover up to five members of a family and require renewal once per year. That and other agreed parameters of RSBY are outlined in Figure 3.

Figure 3. Main parameters of RSBY

Parameter	Description
Eligibility	To qualify, families must be on District BPL lists prepared by States. Each policy covers up to five members of a BPL family including the household head, spouse and three dependents but infants are covered through mothers. All family members to be enrolled must be present at time of enrolment.
Benefits	Coverage is for hospitalization, including hospital stays of 24 hours or more and a specified set of day surgeries, therapies and treatments (for example, haemodialysis, radiotherapy and treatment of fractures and dislocations). Not covered are normal outpatient services such as diagnosis and treatment of common diseases and minor injuries. Coverage includes hospitalization expenses up to Rs. 30,000 (30,000 Indian Rupees or the equivalent of EURO 500) per year for a five-member family and travel expenses up to a total of Rs. 1,000 (Euro 16) per year or a maximum of Rs. 100 (EURO 1.60) per visit.
Policy period and fees	The policy period is for one year, usually starting on the first day of the month after enrolment. The fee is Rs. 30 (EURO 0.50) paid once per year at time of enrolment and renewal.
Premiums (paid by government)	Per BPL family premiums are determined through competitive bidding by insurance companies. [So far, premiums have averaged around Rs. 560 (EURO 8.70 per year.)]
Financing	The cost of premiums is split 75%:25% between the GOI and State Governments except in the Jammu and Kashmir and north-eastern States, where the cost of premiums is split 90%:10%.

Designing tools and procedures

To prepare for roll-out and day-to-day operations, the RSBY team designed a set of tools and procedures to guide and support the steps outlined in the next sub-section (Rolling out RSBY, step by step) and then to maintain, monitor, evaluate, and improve the processes so established.

For the most part, the methods for designing this material were fairly standard: for example, drafting and revising documents through workshops and other consultations until all relevant stakeholders agreed they were ready for use but would be continually improved as problems and opportunities emerged. The same was true of most of the products: policies, guidelines, templates and software for managing information and processing transactions,

IEC material for District kiosks and mobile units and hospitals, and so on.

Emerging from the design process, however, were two innovations so important that they are now seen to be essential elements of RSBY: the very things that make it work even for illiterate and mobile workers and their families and that make it user-friendly not only for BPL families but for States/Union Territories, Nodal Agencies, insurance companies, public and private hospitals and all other stakeholders right across India.

One of these innovations is the Smart Card, an electronic health insurance card that eliminates the need for cash and paperwork (see Box 3). The other innovation is a website that stands at the centre of RSBY's system for managing all IEC (see Box 5).

Box 3. Smart Cards: making health insurance easy

At time of enrolment, every BPL family is issued a Smart Card. This is an electronic card with photographs, fingerprints and all other information needed to identify BPL family members when they go to hospitals for treatment. All empanelled hospitals have card readers and computers with software that links them to District servers. These servers facilitate two-way flows of data that confirm the identity and eligibility of cardholders; confirm that cardholders have enough remaining in their annual allowances to cover the costs of hospitalization and travel; record all relevant information needed to ensure transfers of money from insurance providers to hospitals. [Since hospital computers are not always connected online – e.g., due to power failures – Smart Cards are designed to work in offline environments and record such data as the amounts taken from annual allowance during transactions.] This whole system of recording and processing data is known as the Key Management System (KMS).

Among the many benefits of Smart Cards are: portability, so a mobile family can go to any RSBY-empanelled hospital in India; fraud prevention, since information on the cards verifies cardholders' identities; removal of poverty and illiteracy as barriers to hospitalization, since the cards eliminate any need for cash or paperwork.

Smart Cards also provide incentives:

- **To insurance providers**, making them eager to recruit BPL families for enrolment since issuing cards ensures they will collect the agreed per-family premiums paid by government.
- **To empanelled hospitals**, making them ready to accept BPL people as patients, since the cards ensure full and timely payment for medical services and medicines at an agreed set of rates.



A Field Key Officer verifies that he has witnessed and approved enrolment by putting his FKO card into one reader while another reader records his verification on the Smart Card.

Rolling out RSBY, step by step

Figure 4 summarizes progress on rolling out RSBY up to 20 May 2011. Its RSBY-specific information is taken directly from RSBY's website, where readers may go for more recent information (see Box 5). Some enrolment of BPL families was taking place as early as February 2008, during the process of designing and testing RSBY's initial set of operational tools and procedures. Formal roll-out began on 1 April 2008 and can be described as a series of steps, all supported by documents and software available on RSBY's website:

1. Establishing partnerships between the GOI and States/UTs

Memoranda of understanding (MOUs) usually specify that the GOI, represented by the MoLE, covers 75 percent of the per-beneficiary premium charged by insurance companies but in Jammu and Kashmir and the north-eastern States, the GOI covers 90 percent of the premium. In addition, the GOI provides technical guidance and assistance to State/UT governments and their Nodal Agencies; guides and supports monitoring and evaluation (M&E) in States/UTs and does M&E countrywide.

State and UT Governments or their Nodal Agencies:

- Cover 25 percent of the per-beneficiary premium (or 10 percent in the case of the few states mentioned above) plus any administrative expenses that are not covered by any of their implementing partners (e.g., insurance companies). The fees paid by BPL families – usually Rs. 30 (EURO 0.50) – at times of enrolment and annual renewal provide enough revenue to cover these costs.
- Select Districts to be covered by RSBY, delegating this responsibility to an Inter-departmental Task Force with representatives from, at minimum, State/UT departments of labour, health and rural development. As shown in Figure 4, many States have selected all or most of their Districts but some have selected only a few and plan to cover more after RSBY has been successfully piloted in those few.
- Provide a complete and up-to-date list (in RSBY-prescribed format) of all BPL households in each selected District. As discussed later, this has proved problematic. These lists derive their data from censuses which miss capturing mobile families and others and which may have been done some time ago.
- Contract with private insurance companies giving them primary responsibility for enrolling and insuring listed BPL families and, also, for empanelling hospitals while also giving them guidance and assistance.
- Make public hospitals and clinics easily available for empanelling by linking them in

networks and setting up mechanisms (e.g., societies or trusts) enabling joint administration of funds.

- Do State/UT-level M&E and provide data in prescribed formats and using prescribed software to enable countrywide M&E.

2. Establishing State/UT Nodal Agencies

Each State/UT gives a Nodal Department responsibility for implementing RSBY. Often they choose State/UT departments or agencies responsible for labour, health or rural development. The Nodal Department then establishes or identifies a Nodal Agency to which it delegates responsibility for administering RSBY. Nodal Agencies work in concert with or on behalf of States/UT Governments on the tasks outlined in step 1 (above) and also as they:

- Call for bids from insurance companies and establish expert committees to evaluate the technical and financial merits of all bids and then choose no more than one insurance company to enrol and ensure BPL families in each selected District. Send selected bids to the GOI's Approval and Monitoring Committee and, when approved, contract with the selected insurance companies.
- Appoint a Nodal Officer for RSBY in each District, with responsibility for also acting as the District Key Manager (DKM) in charge of the Key Management System (KMS) from District level and responsible for ensuring the proper and secure issue and use of insurance Smart Cards and accurate and complete recording and reporting of all prescribed data.
- Organize State/UT-level workshops, with financing and technical support from the GOI, to familiarize responsible personnel

from key stakeholder organizations with RSBY and how it will be launched and managed in each District. Workshops begin with an RSBY film and general presentation, followed by separate presentations by stakeholders including one on how Smart Cards and the associated Key Management System work. Participants typically include representatives from Nodal Agencies, insurance companies, State/UT departments of labour, health and rural development, and hospitals from selected Districts as well as the Chief Medical Officers of those Districts.

- Establish Nodal Agencies' District Headquarters, equipped with servers and RSBY-prescribed software needed for all DKM functions.
 - Appoint the required number of Field Key Officers (FKOs), as specified in contracts with insurance companies. FKOs accompany insurance company representatives during enrolment, providing assistance and guidance, ensuring compliance with prescribed procedures and recording data in prescribed formats.
 - Work with insurance companies on the tasks described in step 3 (below).
 - Provide mechanisms for addressing grievances including call centres with toll-free cell numbers.
- ## 3. Establishing partnerships with insurance companies
- Some States/UTs and their Nodal Agencies have chosen the same insurance company to cover all of their selected Districts and some have chosen different companies for different districts. As of May 2011, there are eleven insurance companies

delivering RSBY insurance across India and they are charging premiums ranging from Rs 330 to Rs 825 (EURO 5.15 to EURO 12.85) and averaging Rs. 560 (EURO 8.70) per BPL family per year. As mentioned, the GOI and States/UTs pay these premiums and split the costs 75:25 or, in a few cases, 90:10. Contracts with insurance companies specify that they:

- With Nodal Agencies, organize District workshops to familiarize responsible District-level personnel with RSBY and how it will be launched and managed. These are similar to the State/UT-level workshops described in step 2 and have similar types of participants.
- With Nodal Agencies and District-level officials, ensure that a sufficient number of conveniently located hospitals have been empanelled and listed prior to the start of enrolments, so BPL families can be given lists at time of enrolment and know which hospitals will accept their Smart Cards.
- Make arrangements with hospitals as described in step 4, below.
- With Nodal Agencies and State/UT/District-level officials, establish a District Kiosk prior to commencement of enrolment in each District. See Box 4.
- With Nodal Agencies, develop schedules for village-to-village enrolments, organize venues (e.g., village schools) and provide advance publicity so local BPL families know about RSBY and when and where to enrol.
- With Nodal Agencies and NGOs, take steps to increase general awareness and specific knowledge across Districts and in towns, villages and hospitals. Posters, brochures, media campaigns, and events organized by local organizations are among the methods being used presently. NGOs and Nodal Agency FKO also help facilitate actual enrolment processes.

Box 4. District Kiosks

A District Kiosk is the focal point of activity in each District, especially for BPL families who have already been issued with Smart Cards. In most cases, they will have enrolled at mobile stations in their own towns and villages but they can go to the kiosk in the same District where they enrolled to replace lost or damaged cards, change details on their cards, split their annual allowances between two cards, and to get more information on benefits, empanelled hospitals and so on. Guidelines for kiosks say they must operate in the same manner as enrolment stations in that everything must be done in one visit so BPL families are not discouraged by having to come back two or three times.

4. Establishing third party administrators (TPAs)

Contracts with insurance companies often specify that they can subcontract with Third Party Administrators (TPAs) to carry out some of their responsibilities and TPAs may subcontract to others. Microfinance institutions (MFIs) or NGOs are the usual front-line subcontractors and their subcontracts vary widely in content but typically focus on spreading the RSBY message and enrolling BPL families in towns and villages. India has more than 5,000 towns and more than 600,000 villages, so this is an enormous countrywide task requiring many thousands of contributions.



A new enrollee has to pay the small annual fee before she receives her Smart Card.

5. Empanelling hospitals

Insurance companies have primary responsibility for empanelling and de-empanelling hospitals and keeping up-to-date lists they can provide to BPL families when they enrol and receive their insurance Smart Cards. As of 20 May 2011, insurance companies have empanelled a total 8,280 hospitals across India and, of those, 5,789 (70 percent) are private and 2491 (30 percent) public. Empanelled hospitals agree to:

- Provide anyone presenting a Smart Card with care that may include hospital stays of 24

hours or more or any of a specified set of day surgeries, therapies and treatments and, also, to reimburse them for travel expenses within predefined limits. They agree to a standard set of rates and to charge these rates to the insurance companies. They are not permitted to ask for any other contributions from card holders, provided their cards show they have enough remaining of their annual RSBY policy allowances to cover the expenses.

- Install RSBY-specified hardware and RSBY-provided software. (For public hospitals, the costs are born by insurance companies are covered by the premiums. Private hospitals pay for their own installations.) These hospital-based information systems are used to record all required information on card bearers, the care they receive and the costs involved and also to submit invoices to insurance companies. RSBY's software makes the processing of records and transactions more or less automatic once the correct information has been entered into the system.
- Identify staff to undertake training and assume responsibility and to provide any basic training and assistance to other hospital staff that may be necessary.
- Comply with the spirit and letter of RSBY or risk de-empanelment and the loss of BPL patients and reimbursements from insurance companies. So far, three insurance companies in four States have de-empanelled at total of 158 hospitals.

6. Enrolling BPL families

As shown in Figure 4, more than 23.4 million BPL families are in possession of Smart Cards as of 20 May 2011. To become enrolled or renew enrol-

ment, BPL families must be made aware of RSBY, the benefits it has to offer, which families are eligible to apply, and the number and characteristics of family members who can be named as beneficiaries. Insurance companies have primary responsibility for providing this awareness but may subcontract to TPAs. In either case, Nodal Authorities and FKO provide guidance and support.

BPL families must also know whether or not they can be found on the official BPL list for their District – which should be posted at convenient locations in towns and villages – and what to do if they cannot be found on the list. In addition, they must know where and when they can enrol and that they must bring to enrolment all family members they wish to have named as beneficiaries but that they need not bring infants, who are covered by their mothers' coverage.

At time of first enrolment and annual renewal, BPL families must pay the annual Rs. 30 fee and be provided with detailed information on their benefits, lists of empanelled hospitals and toll-free telephone numbers they can call with questions,

problems and complaints. FKO must be present and authenticate each family's Smart Card before it is given to the family.

7. Establishing information and M&E systems

Smart Cards are portable elements of the RSBY's system for recording and processing data and financial transactions. The Key Management System (KMS) is at the core this system and provides security by ensuring that each Smart Card is issued to the right person and used by the right person in right place. Another important element of the system is the RSBY's website, which makes reports on date produced by the system readily available to all stakeholders (see Box 5). Steps 1 to 6 above indicate how this system is put in place and how it gets used. It provides essential data for ongoing monitoring and evaluation that takes place at all levels as staff of thousands of partner organizations identify problems and find solutions in the normal course of doing their work, in meetings and workshops, and through evaluation studies. One result is the continual upgrading of documents, software and other tools

Box 5. RSBY's one-stop IEC centre: a user-friendly and comprehensive website

At centre of RSBY's entire system for managing information, education and communications (IEC) is a website designed primarily for the use of stakeholders but readily accessible by anyone else. It provides easy-to-understand information about the scheme and how it works; up-to-date information about the scheme's status countrywide and in each state; the latest versions of the policies, guidelines, templates, and other documents and software various stakeholders need; monitoring and evaluation reports; and a comprehensive set of FAQs.

RSBY aims to make this website everything a good public health insurance scheme's website should be, putting all relevant information and operational tools within easy reach of anyone who needs them and of anyone who is merely interested. Readers can find the website at <http://www.rsby.gov.in/>. Insurance companies and other stakeholders can log in and upload or download detailed or confidential information of special interest to them.

Monitoring and evaluation of RSBY

The raw numbers, so far

India's Eleventh Five Year Plan (2007-2012) sets a target of covering 60 million BPL families with RSBY by the end of the five-year planning period or, roughly, the end of 2012. RSBY sometimes restates this to say the target is to cover 300 million BPL people. This matches the estimate, at the time the plan was written, that there were 300 million BPL people in India. It also fits with RSBY policy of allowing up to five family members (family head, spouse and three dependents) as beneficiaries on each Smart Card. (As discussed earlier, the GOI has been using a new methodology for measuring poverty since 2009 and applying it yields an estimate of roughly 385 million BPL people.)

As shown in Figure 4, more than 23.4 million BPL families have Smart Cards as of 20 May 2011. Enrolment did not get underway until April 2008 and has been scaling up at a good pace ever since. While total enrolment may fall short of 60 million by the end of 2012, there is good reason to expect it to be well over half way towards that target. Given the enormity of the task and the thousands of partners required to carry it out, that will be an impressive achievement.

With up to five family members covered by each Smart Card, the 23.4 million cards could, in theory, be covering up to 117 million BPL people. In fact, during roll-out most cards are naming fewer beneficiaries. As card holders become more familiar with the benefits provided by RSBY insurance, they may add more family members. Meanwhile, whether or not they are named as beneficiaries, all family members benefit when even one member avoids catastrophic health expenditures. Finally, participation in RSBY is voluntary and the best that can be expected is that all BPL families will be made aware of it and most will enrol.

RSBY evaluation policy and practice

Agreements between the GOI and States/UTs require that the latter commission third party evaluations after RSBY has been fully operational in a State/UT for a year, and then every year thereafter. As of May 2011, six States have had their first evaluations done and many others are in process of getting them done. The GOI has recently developed a standard questionnaire to be used in these evaluations so that results will be comparable, and this questionnaire will be refined through use.

So far, there has been no comprehensive country-wide evaluation of RSBY but following are the summarized results of State-level evaluations and other studies done so far.



New enrollees leave an enrolment station with their new Smart Cards and information on their insurance coverage and hospitals that will accept their cards.

Figure 4. Status of RSBY roll-out, 20 May 2011

States and Union Territories	Population 2011 Census	Number of Districts	Number Selected ^b	BPL Families Listed	BPL Families Enrolled	%	Empan-elled Hospitals
Andhra Pradesh	84,665,533	23					
Arunachal Pradesh	1,382,611	16	7	61,982	23,970	39%	
Assam	31,169,272	27	5	494,929	204,584	41%	48
Bihar	103,804,637	38	38	10,120,076	5,527,940	55%	738
Chhattisgarh	25,540,196	18	18	1,493,051	1,423,157	95%	640
Goa	1,457,723	2	2	6,953		0% ^c	2
Gujarat	60,383,628	26	27	2,953,347	191,086	6%	1,142
Haryana	25,353,081	21	21	1,241,785	635,639	51%	633
Himachal Pradesh	6,856,509	12	12	292,378	237,946	81%	177
Jammu & Kashmir ^a	12,548,926	22					
Jharkhand	32,966,238	24	21	2,766,539	1,329,254	48%	328
Karnataka	61,130,704	30	6	338,931	157,405	46%	179
Kerala	33,387,677	14	14	2,532,722	1,584,245	63%	290
Madhya Pradesh ^a	72,597,565	50					
Maharashtra	112,372,972	35	31	3,957,688	1,502,152	38%	948
Manipur	2,721,756	9	1	27,575	18,259	66%	4
Meghala	2,964,007	7	5	117,417	59,055	50%	72
Mizoram	1,091,014	8	8	54,273	15,240	28%	72
Nagaland	1,980,602	11	4	50,060	39,290	78%	6
Orissa	41,947,358	30	12	704,717	433,079	61%	114
Punjab	27,704,236	20	20	449,123	195,802	44%	486
Rajasthan ^a	68,621,012	33	4				
Sikkima ^a	607,688	4					
Tamilnadu	72,138,958	32	2	454,736		0% ^c	32
Tripura	3,671,032	4	4	303,335	258,402	85%	29
Uttar Pradesh	199,581,477	71	71	10,120,673	3,905,127	39%	1,696
Uttarakhand	10,116,752	13	15	613,524	342,022	56%	150
West Bengal	91,347,736	19	19	5,146,075	3,528,584	69%	361
Delhi Cap. Terr.	16,753,235	9	10	894,650	144,518	16%	122
Chandigarh UT	1,054,686	1	1	9,668	4,913	51%	11
Five remaining UTs	2,274,601	11			(1,727,964) ^d		
Totals	1,210,193,422	640	378	45,206,207	23,489,633^c	52%	8,280

^a These States are in the early stages of implementing RSBY.

^b Mismatches between the number of Districts and the number selected arise not only because some Districts have not yet been selected but because there is sometimes pooling whereby two Districts are administered as one or arrangements whereby a State/UT covers Districts in a neighbouring State/UT.

^c The numbers and percentages of BPL families enrolled in Goa and Tamilnadu are not yet reported as of 20 May 2011..

^d 23,489,633 Smart Cards are in use as of 20 May 2011 but lags in reporting mean that 1,727,964 have yet to be accounted for in State/UT reports.

A look at beneficiary and staff experience in Kerala hospitals

The first State-level evaluation took place in Kerala, where the State has combined the RSBY with its Comprehensive Health Insurance Scheme and offers coverage to everyone. It makes a distinction between “BPL families (Poor)” found on its own list and “BPL families (Absolute Poor)” found on a shorter list derived from the GOI Planning Commission. All are given Smart Cards but those not on the Absolute Poor list do not qualify for GOI subsidy and have to pay an enrolment fee of RS 100 while the State covers their entire premium.

Enrolment in Kerala began in October 2008. Almost a year later, independent evaluators did a survey covering 108 RSBY beneficiaries and 26 hospital personnel in 26 empanelled hospitals spread through four Districts (Sunny et al., 2009). Among the many findings were:

- Hospital personnel said their hospital had agreed to be empanelled to increase goodwill (61.5 percent), to increase visibility (46.2 percent), to increase revenue (38.5 percent), and to increase capacity utilization (30.8 percent). Most were happy with the speed of claims processing (usually 15 days or less) and none reported rejection of claims.

- Beneficiaries reported the number of family members covered by their Smart Cards as follows: two members, 13 percent; three members, 42.6 percent; four members, 31.5 percent; five members, 13.6 percent.
- Asked to rate the treatment they had received, 64.8 percent of beneficiaries rated it excellent, 25.9 percent very good, 5.6 percent good, 3.7 percent average. Only 0.9 percent reported no improvement in their health condition while 89.8 percent said their condition had improved completely. All said there was sufficient money on their Smarts Cards to cover the costs, but 64.8 percent said they were given no information on costs either before or after treatment so they did not know how much of their annual allowances they had left on their cards.

The evaluators concluded the scheme “has contributed immensely” to ensuring health care for the poor but noted many opportunities for improvement. They recommended more IEC for all stakeholders so they fully understood the scheme and their duties (e.g., hospital personnel’s duty to inform beneficiaries about costs of treatment) and more empanelling of hospitals with better facilities.

Box 6. What happened to Undendra encouraged other villagers to enrol in RSBY

Undendra manages to support a family of six on meagre earnings from his grocery shop in a small village in Begusari District of Bihar. One day he ruptured his intestine in a serious accident and he almost died of excessive bleeding as he was rushed from one hospital that was not properly equipped to another where he could not afford the treatment. At the second hospital, they learned that he had a Smart Card and transferred him to empanelled hospital in time to save his life. Without the Smart Card, the treatment would have cost Rs 20,000 (EURO 310) and the only way he could have afforded that would have been to sell the small hut that was his family’s home. The card also covered his post-operation medicines and his travel expenses and he and his whole family were immensely relieved of worry as Undendra continued to run his grocery store. As the news spread through Undendra’s village and beyond, many other families enrolled in RSBY to make sure that they, too, would get the hospital care they needed when they needed it and without being driven out of their homes and deeper into poverty.

A look at stakeholders' experience in Uttar Pradesh

Jaunpur is one of 71 Districts in Uttar Pradesh, India's most populous State and one of its poorest. By the fall of 2009, 51 percent of the Jaunpur's 222,000 listed BPL families were enrolled in RSBY. A survey at that time interviewed 4 hospital staff, 3 insurance company staff, 3 government officials and representatives of 236 poor families: 98 not enrolled in RSBY, 104 enrolled but yet to use their Smart Cards and 34 enrolled and already using their Smart Cards (Amicus Advisory, 2009). Among the findings were:

- Of the 98 non-enrolees, 50 percent did not know how to enrol (though one third of them were carrying cards showing they were on the BPL list) and 40 percent could not find their names on the BPL list.
- Of the 34 user-enrolees, 71 percent said they were satisfied with the care they had received at hospitals and 68 percent said there had been a decline in their health care expenditure as a result.
- The average number of beneficiaries named on Smart Cards was only 1.46 percent and this seemed to be largely because BPL families were not fully aware of opportunities to enrol more

family members and did not bring them to enrolment.

- Not enough of the District's hospitals were empanelled and those that were empanelled often lacked the staff and facilities needed to provide appropriate care of good quality for all health conditions covered by RSBY.
- While there were no problems with the RSBY technology, there were problems with the manufacture of the Smart Cards (contracted out to different suppliers) and an apparent absence of quality control.

The study had a number of recommendations, several emphasizing the need for more IEC among all stakeholders and for more stringent ongoing monitoring and evaluation so problems could be addressed in timely manner. It recommended that there be an effective, on-the-spot grievance mechanism for dealing with such problems as BPL families finding their names were not on BPL lists. In addition, it recommended that the State extend RSBY to cover out-patient care for some of the reproductive health, childhood health and other concerns that are particularly prevalent among BPL families.

Box 7. Sudhir's Smart Card saved his mentally handicapped son from suffering

Sudhir and Santosh, his mentally handicapped son, live in a small village in the Bijnor District of Uttar Pradesh. Santosh suffered a severe burn to his left leg in an accident but Sudhir could barely afford to house and feed his family, let alone get proper treatment for Santosh's burn, so he settled on the futile efforts of a village doctor to ease Santosh's suffering. Then someone told him about RSBY and the fact that it covered pre-existing conditions. He enrolled and took Santosh to Beena Prakesh Hospital. The treatment worked and not only did it cost Sudhir nothing but, thanks the Smart Card's allowance for travel, the hospital gave him Rs 100 (EURO 1.55) to cover travel expenses.

A household survey in Gujarat

Gujarat has a population of more than 60 million people spread over 26 Districts. It began rolling out RSBY in ten Districts in the spring of 2009 and a year later commissioned a survey covering a random and stratified sample of more than 13,000 households in those Districts (Datamation Consultants, 2010). Roughly one-third were not enrolled in RSBY, one-third were enrolled but had not yet used their Smart Cards and one-third were enrolled and had used their Smart Cards. Among the findings were:

- Most households (94 percent) were aware of RSBY. By far the most common way they became aware was through family and friends (46.5 percent). Though 20.7 percent had learned about RSBY from leaflets, only 6.4 percent had learned about it from radio, television or newspapers.
- Though general awareness was high, specific knowledge was often lacking. Of BPL households not yet enrolled, only 73.2 percent knew they were eligible. Among those who knew they were eligible, reasons given for not enrolling were not understanding the scheme (25 percent), belief that it was of no use to them (34.3 percent) and thinking the enrolment station was too far away (23 percent).
- Of BPL families enrolled, only 41.6 percent said they had seen a list of BPL families posted anywhere before they enrolled. At time of enrolment, only 69.3 percent had been given lists of empanelled hospitals, only 18 percent had been given instructions on how to use their cards, only 5.5 percent had been told who to contact if they had a query, only 5.2 percent had been told about the District Kiosk, and only 2 percent had been given a toll free number to call.

- Despite the above, 72.1 percent of those who enrolled were satisfied with the enrolment process and 90 percent said they intended to renew their Smart Cards.
- Of those who had used their Smart Cards, 82.9 percent were satisfied with the treatment they received and would recommend the same hospital to others. However, 62 percent said they had not been informed of the cost beforehand, 35 percent said they had not been informed of the balance left on their cards afterwards and 16.6 percent said they had been required to give money to hospital staff.



The head of her household, this young mother has brought her daughters, mother and grandmother to be enrolled as RSBY beneficiaries.

Box 8. Paid for with a Smart Card, four operations saved Rekha from certain death

Rhekha's husband supports their family of five with his vegetable stall in a poor neighbourhood of Delhi. Approaching her 40th birthday, she ignored a painless discharge from her uterus until she could barely walk and her daughter-in-law urged her to go to a nearby private hospital her family had learned to trust. A doctor told her she needed to undergo surgery immediately and she ended up having four operations and staying in the hospital for five days, under heavy medication and close observation. The total bill for the operations and hospital stay came to more than the amount available on the family's Smart Card but the hospital gave her free medicines for five days after she left the hospital and also free follow-up consultations. The doctor told her that if she hadn't had the operations immediately she probably would have died and it is by no means certain that, if they had not had the Smart Card, her family would have been able to arrange a loan soon enough to save Rhekha's life.

A pilot survey of beneficiary experience at hospitals in Haryana

In September and October 2010, a study tested the feasibility of doing a survey using an adapted Hindi-language form of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospital Survey developed for the US Department of Health and Human Services (Westat, 2010). Conducted in 20 empanelled hospitals in Haryana, the test survey covered 38 RSBY patients and 40 non-RSBY patients and the study concluded such a survey could produce very rich results. The test survey's findings for the 38 RSBY patients included:

- 69 percent first learned of RSBY through friends or family members and 61 percent first learned of their chosen empanelled hospital in the same way. Few had learned through official sources.

- 97 percent (all but one of the 38) said that the RSBY Smart Card was the reason for their decision to get treatment for their condition.

- 89 percent were very satisfied with their treatment, 95 percent were very satisfied with the hospital staff and 95 percent were very satisfied with the hospital.



This couple and three of their children have just been enrolled as RSBY beneficiaries.

Achievements and challenges

Attended by representatives of Government, health insurance companies and other business enterprises, the Health Insurance Summit 2008 took place in Mumbai on 8 December 2008. It hailed the rapid growth of India's private insurance industry and also hailed the on-going roll-out of RSBY. While saying it was too early to tell if RSBY would work, Summit participants agreed that it held out the promise of a public-private partnership that could see health insurance extended even to the poorest of all Indians (CII and KPGM, 2008).

Robert Palacios, Lead Specialist, Social Protection, South Asia, World Bank, heads up the World Bank team that, alongside Germany's GIZ team, has been providing technical support to India's Ministry of Labour and Employment (MoLE) through design and roll-out of RSBY. In a recent paper, he described RSBY at this early stage as follows:

RSBY is a proof of concept in progress. Its success in the next five years depends on whether central and state governments can get insurers and hospitals to play by the rules and remove obstacles from the path of poor households that need hospitalization. It will be especially important in the next few years to monitor progress in this regard through MIS data, surveys and field reports. There is strong political will to use evidence to improve the scheme and few programs in India can claim the level of transparency that characterizes RSBY today. However, the oversight of a complex program like RSBY with tens of millions of members, two dozen state governments, a dozen insurers and thousands of hospitals will require a strong institutional presence at the centre, perhaps in the form of a stand-alone agency. The faster this institutional capacity is developed, the more likely it is that RSBY will take its short term success in the narrow area

Box 9. Increased access, especially by women

An internal analysis (RSBY, 2011) found evidence that RSBY is increasing access to inpatient hospital care in the 167 Districts where it has been operating for at least one year.

In those Districts, 9.9 million BPL families had been issued with Smart Cards and there were an average of 2.7 beneficiaries on each card, for a total of 26.7 million beneficiaries. Of those, only 9.6 million (36 percent) were female and the analysis suggested that this may have been due to inadequate publicity for the scheme. However, of those beneficiaries who had actually made use of the cards, 40.1 percent were female.

In 9 of the 167 Districts, RSBY had been operating for two or more years. Of all beneficiaries who made use of the cards in those 9 Districts, 48 percent were female during the first year and 53 percent were women during the second year. During the first year, 2.86 percent of female beneficiaries used Smart Cards for hospital care compared to 2.42 percent of male beneficiaries. During the second year, 4.33 percent of female beneficiaries used Smart Cards for hospital care compared to 2.89 percent of male beneficiaries.

The analysis concluded that these trends should be monitored carefully, partly with a view to ensuring that beneficiaries don't begin to over-utilize hospital care.

of enrolment and hospitalization for the poor and leverage it to achieve a much broader agenda that may even extend beyond the health sector. (Palacios, 2010)



A banner by the entrance tells people this hospital accepts Smart Cards.

Robert Palacios' paper and the evaluation's described in the previous section of this publication highlight the following challenges:

1. **Absence of comprehensive strategies, structures and content for information, education and communications (IEC)** leaves many BPL families and staff of stakeholder organizations (NGOs, hospitals and others) ill-informed about RSBY and the opportunities and responsibilities it bestows on them. It is especially important that RSBY policy holders be well informed so they can take full advantage of RSBY and ensure, for example, that women, children and the other most vulnerable members of their families are identified as beneficiaries on their Smart Cards.
2. **Out-of-date and incomplete lists of BPL families** and failure to prominently post and publicize those lists all lead to much confusion and frustration. Many BPL families do not know they are eligible for RSBY and many believe they should be

eligible but cannot find their names on the lists. The GOI's RSBY team has been identifying such problems as they emerge and supporting States/UTs as they revise their BPL lists and improve their procedures so that there are fewer problems in the second and third years of operation.

3. **Insufficient attention to quality control of all RSBY-associated products and services** undermines RSBY in some Districts. For example, word soon gets around when Smart Cards don't work because they are flawed in their manufacture or in their processing at enrolment stations, so card holders may come to believe the cards are worthless and others may believe they are not worth getting. Similar problems occur if hospitals do not deliver the quality of care beneficiaries are entitled to expect or if hospital staff demand under-the-table payment for services that should be free to holders of Smart Cards.
4. **RSBY presents opportunities to address maternal, childhood and other health conditions** that are especially prevalent among the poor and these opportunities should be more fully explored in the months and years ahead. Meanwhile, RSBY has added maternity and new-born care to the lists of medical procedures it covers.
5. **Excellent monitoring and evaluation, including special studies focusing on problems such as the failure of eligible BPL families to enrol and the failure of enrolled families to utilize their cards,** will be essential to the success of RSBY. As the evaluations described in the foregoing section suggest, this will require solving such difficult problems as how to design and implement surveys that work for poor, illiterate and mobile people who speak many different languages.

6. **Vigilance against fraud is essential** in any insurance scheme, no matter how sophisticated the technology used to prevent fraud. Given that RSBY is a massive public-private partnership scheme, the GOI's RSBY scheme is keenly aware that such vigilance must always be one of their highest priorities.



At a hospital's front desk, this woman's thumbprint matches the one on her husband's Smart Card and confirms that she is a beneficiary.

India's States and Union Territories have most of the responsibility for ensuring that all of their residents have access to good, affordable health care. This means they are largely responsible for meeting the above challenges and making a success of RSBY. However, they will need strong leadership, guidance and support from the Government of India and this will require a strengthening of institutional capacity at that level.

Lessons Learned

Advanced technology makes it possible for national governments to deliver health insurance and other social protection programmes to entire populations or to sub-populations even in a country as populous, diverse and complex as India. This is so even in federal systems where states, provinces or territories are largely responsible for health and social protection.

Public-private partnerships (PPPs) involving thousands of organizations from the public, private and civil society sectors can deliver such programmes, thanks to that advanced technology.

Information, education and communications (IEC) is critical to the success of even the most advanced programme and is especially critical when there are thousands of partners involving in delivering a programme and many millions of existing and potential beneficiaries. There must be appropriate IEC targeting each category of partner or beneficiary, so that all understand the programme and what it requires of them.

Comprehensive quality control is equally critical. “The devil is in the details” is an apt reminder that a programme can be seriously undermined by the failure of just one of its elements. It is one thing to get people to go to a hospital once, for example, but they may not return or recommend the hospital to relatives and friends if the care they get is less than satisfactory.

Comprehensive monitoring and evaluation goes hand-in-hand with quality control and should include special studies into emerging problems and possible new solutions and opportunities for action.

It all starts with the courage to get started and RSBY demonstrates that it is possible to achieve very impressive results even in the face of known or unforeseen problems to which there are, as yet, no good solutions.

Women, infants and children can benefit even when they are not specifically targeted at the outset of a programme but they can benefit even more, with special attention as the programme develops, expands and strengthens.

Peer Review

Two independent peer reviewers have read this publication and one has said she has “no hesitation” in concluding that the RSBY qualifies as “good or promising practice.” The other has said it qualifies “primarily because of the staggering scale RSBY has achieved in a short period of time and the innovative model India has chosen for its health insurance.” She adds that the RSBY model is different from those used by many other lower middle income countries and is “not necessarily better, but certainly a model to watch.”

The two peer reviewers agree that it is too early to fully assess the RSBY against the eight criteria for the German Health Practice Collection (GHPC). Based on the information provided in this publication, their early assessment of this young programme can be summarized as follows:

Effectiveness

The RSBY has been extraordinarily effective at scaling up rapidly in a very populous and complex country. The fact that it targets the poor and aims to reduce out-of-pocket expenditures is laudable and early results are encouraging. However, it remains to be seen how well it will achieve those aims and increase social protection, improve health outcomes, and advance equity.

Transferability

Aspects of the RSBY model may be transferable to some countries but not to all. It is probably best-suited to countries with well-established private insurers, numerous providers of health care of relatively good quality and existing or new financial resources to subsidize insurance premiums. The Smart Card technology is widely transferrable and a good way of ensuring that illiteracy and lack of cash do not prevent access to essential health care.

Participation and Empowerment

A massive public-private partnership scheme with built-in flexibility, so each state can adapt it as it sees fit, the RSBY presents many opportunities for participation and empowerment. How well stakeholders take advantage of these opportunities remains to be seen but there is already evidence that RSBY is being improved to better meet the needs of women and children and this suggests that stakeholder groups are likely to argue for and achieve other improvements.

Gender awareness

RSBY was not conceived as a scheme that pays special attention to the health care needs of women and girls, but it is proving to be ever more successful at addressing those needs. This is occurring as RSBY policies are adjusted and as male family heads come to recognize the advantages of naming their wives, daughters and other female relatives as beneficiaries on their Smart Cards.

Monitoring and Evaluation

The requirement that states commission annual evaluation surveys and the effort to standardize those surveys are commendable. However, there will be on-going need for improving survey questionnaires, methodologies and reports. In addition, such surveys may be good for measuring user awareness, enrolment, utilization and satisfaction but there will be need for additional evaluations that focus on the financial and health impacts of RSBY including its cost-effectiveness and its contributions to social protection, health outcomes and equity.

Innovation.

There is no other health insurance scheme quite like RSBY in low and middle income countries. Particularly

notable is the reliance on private insurers, the combination of federal and state subsidies of insurance premiums and the successful adaptation of up-to-date information technology to make the scheme user-friendly for India's poor, mobile and illiterate populations.

Cost-effectiveness

There is insufficient evidence to show that it is cost effective. There is apparent need for research into how much social protection RSBY is providing and at what cost, how many Disability Adjusted Life Years (DALYs) RSBY is saving and the extent to which independent experts and RSBY stakeholders are satisfied that RSBY is addressing the most urgent needs for social protection and health care. There is some concern that private insurer profits could potentially be excessive. Policymakers will have to consider whether the current mechanism for engaging insurers as "full risk" partners, who receive and manage large budgets, can create perverse incentives to under-provide care to the poor. All of this should be closely monitored and evaluated.

Sustainability

RSBY is already covering many millions of households across India. This means it would be difficult, politically, to take it away and there is likely to be demand for coverage of ever more people and ever more medical procedures, including out-patient procedures, in the years ahead. The extent to which national and state economies continue to grow (or stagnate, in the case of some of poor states) will impact on the extent to which federal and state governments will be willing and able to accommodate these demands.

The two peer reviewers foresaw a number of challenges in the years ahead. Three major challenges will be:

To extend RSBY coverage to out-patient services that address some of the diseases and injuries that contribute most to lost DALYs among India's poor and, also, contribute most to financial burden on the poor due to out-of-pocket spending on health care and loss of income when productive family members are disabled.

To harmonize or integrate the many health insurance schemes that target India's poor, some of them specific to certain states or districts or particular sub-populations (e.g., agricultural workers and member of particular castes or tribes).

To strengthen quality control and improvement both among health care providers and insurance providers, with a view to ensuring that beneficiaries are getting services of good quality and the federal and state governments are getting good value for their contributions to RSBY. Fraud prevention can be seen as one element of quality control.

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