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Health insurance for India's poor

Meeting the challenge with information technology

Context

With 1.2 billion people, 28 States and 7 Union Territories containing a total of 640 Districts and more than 600,000 towns and villages, India is one of the world's most populous, politically complex and culturally diverse countries. It also has one of the world's fastest growing economies but some of its regions prosper while others lag behind and, even in prosperous regions, the benefits of economic growth do not reach far down into the informal sector of the economy. This sector is where 94 percent of the country's workers support their families by serving as self-employed farmers, micro business owners, low-paid wage earners, and casual labourers (many of whom are highly mobile). Almost one-third of the country's people still live below the poverty line (BPL), as defined by the Government of India, and they consist almost entirely of informal sector workers and their families.

Poverty and illiteracy make BPL families highly vulnerable to disease and injury and also to financial catastrophe when disease and injury strike. Disease and injury require expenditures on health care which these families can ill afford and, at the same time, often reduce their incomes by disabling productive family members. In India's federal system, public spending on health care is split between the national, state and territorial governments and accounts for only one-third of all spending on health care. Half of all spending on health care is out-of-pocket spending by patients and their families.

There have been many attempts to provide health insurance to India's poor but they have usually been under-funded and narrowly targeted, covering the poor in certain states or districts or particular sub-populations (e.g., agricultural workers or members of particular castes or tribes). They have also often had cumbersome bureaucratic rules and procedures that have made them largely inaccessible to illiterate, casual, mobile and many other informal sector workers and their families. In recent years, the private insurance industry has expanded to serve India's rapidly growing middle class and this has created new opportunities for public-private partnership schemes that provide insurance for the poor.

A father and son display the family's new Smart Card.

Rashtriya Swasthya Bima Yojna (RSBY)

On 2 October 2007, the Government of India announced a massive new public-private partnership scheme called Rashtriya Swasthya Bima Yojna (RSBY). Translated from Hindi, the name means "National Health Insurance Scheme" and suggests its potential for gradual expansion until, ultimately, it ensures that everyone in India has access to essential health care and protection from financial catastrophe due to illness or injury. The scheme's initial 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.

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

RSBY is a programme of India's Ministry of Labour and Employment (MoLE). It is overseen by a steering committee with representatives from the Ministry of Health and Family Welfare (MoHFW) and other key ministries. World Bank and German Development Cooperation (GDC), via its implementing agency Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), provide technical support. Germany's Federal Ministry for Economic Cooperation and Development (BMZ) recently confirmed its commitment to RSBY by putting its support under the umbrella of GIZ's new Indo-German Social Security Programme.

States and Union Territories have ultimate responsibility for providing essential health care to their populations and they decide whether or not they want to opt into RSBY. When they opt in, they sign agreements whereby the Government of India usually covers 75 percent (but sometimes 90 percent) of the cost of per-family premiums charged by insurance companies.

Under their RSBY agreements, States and Union Territories designate Nodal Departments (usually ministries responsible for health, labour or rural development) to act as their counterparts to India's MoLE. The Nodal Departments then identify or establish Nodal Agencies to administer RSBY and these, in turn, appoint Nodal Officers for each District they cover with RSBY.

▶ To download the full version of this report and other publications in this collection, go to www.german-practice-collection.org.

Nodal Departments and Agencies issue public calls for bids from insurance companies. They 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. Contracts with insurance companies often permit them to sub-contract with third party administrators (TPAs) to carry out some of their responsibilities and TPAs may, in turn, sub-contract with community-based organizations to handle such tasks as spreading the RSBY message and guiding villagers towards enrolment stations.

The main parameters of RSBY

During its initial five-year phase, the main parameters of RSBY are as follows:

Eligibility. To qualify, families must be on District BPL lists prepared by the 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 (e.g., treatment of fractures, haemodialysis and radiotherapy). Not covered are normal outpatient services such as diagnosis and treatment of common diseases and minor injuries. The annual allowances are: medical expenses up to Rs. 30,000 (€ 500) per year for a five-member family; travel expenses up to Rs. 1,000 (€ 16) per year or a maximum of Rs. 100 (€ 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.

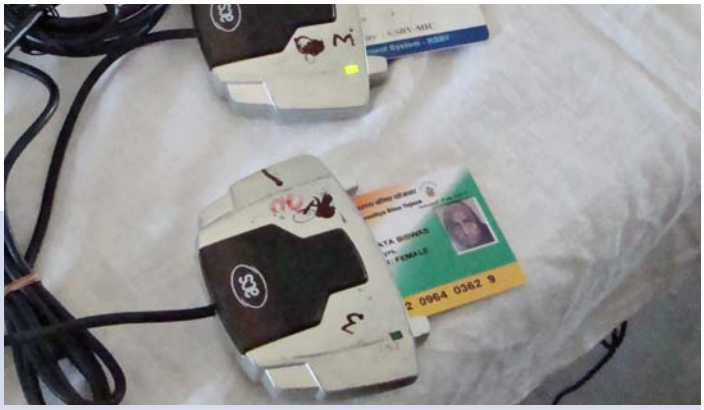
The fee is Rs. 30 (€ 0.50) paid once per year at time of enrolment and renewal.

Premiums (paid by government). Per BPL family premiums are determined through competitive bidding by insurance companies. So far, premiums have averaged around Rs. 560 (€ 8.70) per year.

RSBY provides flexibility for States and Union Territories to expand coverage to more people and more medical services provided they do so at their own expense. The State of Kerala, for example, has combined RSBY with its Comprehensive Health Insurance Scheme and offers coverage to everyone.

Smart Cards and the Key Management System (KMS)

A massive public-private partnership scheme that aims, within five years, to extend health insurance to more than 60 million BPL families in more than 600,000 towns and villages would seem to present an overwhelming challenge. This is especially so given that members of those families speak many different languages and dialects and are often illiterate and mobile. It could not be done without modern information technology (IT).



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

Mobile RSBY enrolment teams with representatives from insurance companies or TPAs, together with Field Key Officers (FKOs) from Nodal Agencies, reach BPL families where they live, whether in rural villages or urban neighbourhoods. Upon enrolment, no one in a family is required to read or write. Instead, the person who will be the family's main policy holder is photographed and that person and all other family members who will be beneficiaries are thumb-printed. The family answers questions verifying they are on the District BPL list and providing their names, genders and ages. All relevant information is entered into the family's electronic RSBY file and either printed on the face or entered into a chip on an electronic insurance Smart Card. After the FKO verifies it with his FKO card, the family pays the nominal fee and receives its Smart Card and, also, fact sheets or pamphlets explaining their RSBY benefits and listing hospitals that will accept their Smart Card for treatment.

At hospitals, RSBY beneficiaries need only present their Smart Cards and press their thumbs on readers to be identified and admitted for treatment. RSBY's Key Management System (KMS) enables the rapid processing of all transactions and the rapid transfer of information between enrolment stations, Nodal Agencies, Nodal Departments, the MoLE's RSBY team, insurance companies and hospitals.

▶ RSBY's website can be found at www.rsby.gov.in. Designed both for RSBY stakeholders and anyone else who may be interested, it provides

- information about the scheme, how it works and its status;
- policies, guidelines, templates, and other documents and software for various RSBY stakeholders;
- monitoring and evaluation reports;
- and a comprehensive set of FAQs.

RSBY's early achievements

After a six month design process, roll-out of RSBY began in April 2008. As anticipated, roll- out has been presenting many challenges and 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 India's 28 States have opted into RSBY and participating States/ Union Territories 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 identified on each Smart Card (now 2.7), the percentage who are women and the percentage who receive in-patient care each year. Last year, 2.8 percent of RSBY beneficiaries in these Districts received in-patient care, whereas in 2004 only 1.7 percent of the poorest 40 percent of Indians received in-patient care.

At a hospital's front desk, this woman's thumbprint matches the one on her family's Smart Card.

Monitoring and evaluation

Under their agreements, States and Union Territories are required to commission third party evaluation surveys after RSBY has been fully operational for a year and then every year thereafter. As of May 2011, six of these had been done and had found high levels of satisfaction among beneficiaries who had used their Smart Cards to get treatment. In the State of Kerala, for example, 64.8 percent rated their treatment excellent, 25.9 very good, 5.6 percent good, and 3.7 percent average. Only 0.9 percent reported no improvement in their health, while 89.8 percent said it had improved completely.

While early results have been promising, those surveys and other looks at RSBY have identified need for improvement in BPL lists, which are often out-of-date and incomplete; information, education and communications; quality control of all RSBY-associated products and services; fraud prevention; and monitoring and evaluation with particular focus on RSBY's contributions to improved health, social protection and equity.

Peer review

Two independent peer reviewers agree that it is too early to fully assess RSBY against the eight criteria for the German Health Practice Collection: effectiveness, transferability, participatory and empowering approach, gender awareness, quality of monitoring and evaluation, innovation, comparative cost-effectiveness, and sustainability. However, they also agree it has gone far enough towards meeting most of the criteria to qualify as "good or promising practice." This is "primarily because of the staggering scale [it has] achieved in a short period of time" and because it is an innovative model for health insurance, which is "not necessarily better" than other models "but certainly a model to watch."

As for the future of RSBY, the peer reviewers comment that one of the challenges will be to extend coverage to out-patient services that address some of the diseases and injuries that contribute most to disability in India. Another challenge will be to harmonize or integrate the many health insurance schemes that target India's poor.

Would you like to know more?

This is a summary of a longer publication. If you would like to see the full version or if you are interested in other publications in the German Health Practice collection, please go to www.german-practice-collection.org.

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