

**The Early Success of India's Health Insurance for the Poor, RSBY**

---

Victoria Fan

---

June 2013

---

[www.cgdev.org/publication/early-success-indias-health-insurance-poor-rsby](http://www.cgdev.org/publication/early-success-indias-health-insurance-poor-rsby)

---



---

**ABSTRACT**

---

In just five years, India's Rashtriya Swasthya Bima Yojana (RSBY, translated as "National Health Insurance Programme") has expanded health-care access. Where dozens of "microinsurance" and NGO pilots failed to scale up, RSBY has already provided more than 110 million people (almost 10 percent of India's population) with heavily subsidized health insurance, providing up to US\$550 annually to finance secondary hospital care. Although the research evidence on RSBY is still developing, early results are encouraging: increased utilization and hospitalization; some indication of reduced out-of-pocket payments for healthcare; and a means of identification with a clearly linked entitlement. While RSBY still faces challenges, particularly on the quality of care of increased hospitalization rates, RSBY has aligned incentives for both public and private hospitals to deliver better care.

In this essay, Victoria Fan tells the story of how RSBY came into being under the leadership of Anil Swarup—whom she describes as an "unassuming officer of the Indian Administrative Service"—and outlines the program's early successes and opportunities for future progress.

---

The Center for Global Development is an independent, nonprofit policy research organization that is dedicated to reducing global poverty and inequality and to making globalization work for the poor. CGD is grateful to its funders and board of directors for support of this work.

Use and dissemination of this essay is encouraged; however, reproduced copies may not be used for commercial purposes. Further usage is permitted under the terms of the Creative Commons License. The views expressed in this paper are those of the author and should not be attributed to the board of directors or funders of the Center for Global Development.

## **Contents**

Introduction .....	1
How RSBY Came Into Being.....	2
Key Features of RSBY’s Success .....	3
Leadership—Right Mandate, Right Time, Right Person.....	3
Information Technology and Smart Cards.....	3
Hospitals Compete for Patients .....	4
Insurance Companies Compete on Premiums .....	4
Incentives Through Additional Payments and Not Targets.....	4
A Constructive State-to-Center Relationship.....	5
What’s in RSBY’s Future?.....	5

## Introduction

Here in Washington DC, I recently met one of India's most important but least known health-sector leaders: Anil Swarup, an unassuming officer of the Indian Administrative Service. Unbeknownst to most Indians, let alone the wider world, Swarup was the driving force behind India's massive health insurance program for the poor, Rashtriya Swasthya Bima Yojana, which means "National Health Insurance Program" and is best known by its acronym, RSBY. In just 5 years, RSBY has enrolled more than 34 million families (or about 110 million poor people) and provided coverage of secondary hospital care, with an annual benefits cap of about US\$550 for a family of five. (As a comparison, Obamacare in the United States is aimed at increasing coverage for the country's 49 million uninsured people.<sup>1</sup>)

In India, this is a remarkable achievement. In recent decades, dozens of "microinsurance" and small-scale NGO pilots across the country have offered much smaller benefits and have failed to expand risk pools and scale up.<sup>2</sup> The national government similarly failed in a previous attempt to expand what was labeled the Universal Health Insurance Scheme.<sup>3</sup> Meanwhile, dilapidated public health facilities, which are supposedly responsible for offering universal access to health care, have been riddled with poor management and high health worker absenteeism (over 40 percent in most states and as high as 70 percent in states such as Bihar).<sup>4</sup> Private providers have filled the vacuum, offering care with huge variations in quality, for which most families must pay out of pocket.

In this context, RSBY is nothing short of a dream come true for millions of Indians. Before RSBY, only about 5 percent of Indians had any health insurance. RSBY has provided coverage to an additional 10 percent of the population, covering 110 million people and 34 million households in just five years.<sup>5</sup>

While the rigorous research evidence on RSBY and related government-based health insurance in India is still developing,<sup>6</sup> RSBY's early results are encouraging: utilization of care

---

<sup>1</sup> David Morgan, "Obamacare Enrollment: Will Enough People Sign Up?" *Huffington Post* (Reuters), May 5, 2013, [www.huffingtonpost.com/2013/05/05/obamacare-enrollment\\_n\\_3218071.html](http://www.huffingtonpost.com/2013/05/05/obamacare-enrollment_n_3218071.html).

<sup>2</sup> Alexander S. Preker and Guy Carrin, eds., *Health Financing for Poor People: Resource Mobilization and Risk Sharing* (Washington, DC: The International Bank for Reconstruction and Development, 2004).

<sup>3</sup> Department of Financial Services (Ministry of Finance, India), "Universal Health Insurance Schemes (UHS)," <http://financialservices.gov.in/insurance/gsois/uhs.asp>.

<sup>4</sup> Nazmul Chaudhury et al., "Health Personnel Absenteeism in India: Descriptive Statistics and Correlations," Princeton University, Center for Health and Wellbeing working paper series (2008).

<sup>5</sup> RSBY (Government of India), "Rashtriya Swasthya Bima Yojana," [www.rsby.gov.in](http://www.rsby.gov.in).

<sup>6</sup> On RSBY: Roberto Palacios, Jishnu Das, and Changqing Sun, *India's Health Insurance Scheme for the Poor: Evidence from the Early Experience of the Rashtriya Bima Yojana* (New Delhi: Centre for Policy Research, 2011); RSBY (Government of India), "Research & Evaluation," [www.rsby.gov.in/Documents.aspx?ID=14](http://www.rsby.gov.in/Documents.aspx?ID=14). For a comprehensive review of government-sponsored health insurance in India: Gerard La Forgia and Somil Nagpal, *Government-Sponsored Health Insurance in India: Are You Covered?* (Washington: World Bank, 2012); Victoria Fan,

including hospitalization is up and out-of-pocket payments are down. Importantly, participants are provided with a means of identification that is clearly linked to the benefits to which they are entitled. While RSBY still faces several challenges, particularly related to substitution between inpatient and outpatient care and the quality of care of increased hospitalization, RSBY has empowered citizens to demand services to which they are entitled and aligned incentives for both public and private hospitals to deliver better care. In my view, RSBY is the most encouraging news in India's health sector today.

## **How RSBY Came Into Being**

In recent talks at the World Bank and Brookings, Swarup described how RSBY came into being. In 2007, Prime Minister Manmohan Singh committed to a national expansion of health insurance. Soon thereafter, several different ministries convened to make Prime Minister Singh's vision a reality—and Swarup's superior sent him to attend the meeting in his place. Yet the other ministry representatives in attendance—very well aware of the challenges of health insurance—all refused to take up the gauntlet. Among those saying no thank you were the Ministry of Health & Family Welfare (which was already supposed to provide national health care through the public sector) and the Department of Banking and Insurance in the Ministry of Finance (which had insurance expertise but had been slow to expand the existing Universal Health Insurance Scheme).

The officials looked to Anil Swarup, the junior Ministry of Labour and Employment officer sitting in the far corner of the room, and pointed out that his ministry had responsibility for people working in the informal sector. Expanding health insurance coverage should be the job of the Ministry of Labor and Employment, they said. Swarup put his palms together and listed a number of reasonable objections. Chief among them: his ministry was poorly suited for the task at hand, and such a difficult job surely required more experienced leadership.

The group would have none of it. And, as Swarup points out, "I was anyway the most junior member sitting in that room, so it was given to me," perhaps referring to how many things in India get done. And that was that.

What followed, he said, were six sleepless nights, 300+ questions on paper, a wide series of consultations, and, eventually, the birth of RSBY.

But Swarup's modesty and humility, I think, have been a key component to the success of RSBY. There is something to be said about a mind open to new ideas and not yet cynical or hardened from reality, a constant theme that emerges in his talks. RSBY's new ideas and new approach represent a disruptive innovation in Indian health-care.

---

Anup Karan, and Ajay Mahal, "State Health Insurance and Out-of-Pocket Health Expenditures in India," CGD Working Paper 298 (Washington: Center for Global Development, 2012).

## **Key Features of RSBY's Early Success**

There are many lessons from RSBY, but here are a few.

### **Leadership—Right Mandate, Right Time, Right Person**

First, India's economic growth and rising incomes created a real opportunity to undertake health insurance in a serious way—but it only happened after Prime Minister Singh took the personal initiative to commit to social health insurance. Second, supported by his superiors in the Ministry, Swarup proved equal to the task at hand, and built the right strategy and team to make the program a reality. We will never know what might have happened if not for Prime Minister Singh's personal investment, or if implementation responsibility had been given to a different person. But the failure to bring the previous Universal Health Insurance Scheme to scale suggests that the likely counterfactual would have been business as usual, not an unprecedented success. In addition, there were several other enabling factors, such as the economic climate, national political leadership, and leadership within the Ministry of Labour and Employment.

### **Information Technology and Smart Cards**

Smart cards are a critical component of RSBY and have several key benefits. First, RSBY is targeted to the poor, a population that is largely illiterate and highly mobile, and RSBY smart cards use biometrics to identify patients who would otherwise be unable to read or sign their names. Second, the smart card systems ensure seamless and paperless payments from the insurance company to the hospital, without requiring up-front payment by patients. Third, the electronic enrollment and claims data are constantly monitored for patterns and fraud to, for example prevent duplicate enrollment or treatment of fake patients. While the RSBY card can contain the Indian universal identification (UID) in addition to the identification provided by RSBY, the RSBY identification system has the advantage of being operational offline, without internet access.<sup>7</sup> (See related work on biometrics by my colleague Alan Gelb.)<sup>8</sup>

Attention to operational detail was critical. Smart cards are issued on the spot when people enroll. People pay a fee of INR 30 (60 US cents) to enroll, ensuring genuine buy-in and

---

<sup>7</sup> Latha Jishnu and Jyotika Sood, "Unique Identity Crisis," DownToEarth.org, May 15, 2012, [www.downtoearth.org.in/content/unique-identity-crisis](http://www.downtoearth.org.in/content/unique-identity-crisis).

<sup>8</sup> Alan Gelb and Julia Clark, "Covering the 7th Billion Child: Can We Learn from Indian Health Insurance," Global Health Policy [blog], Center for Global Development, November 7, 2011, [www.cgdev.org/blog/covering-7-billionth-child-can-we-learn-indian-health-insurance](http://www.cgdev.org/blog/covering-7-billionth-child-can-we-learn-indian-health-insurance); Alan Gelb and Julia Clark, "Identification for Development: The Biometrics Revolution," CGD Working Paper 315 (Washington: Center for Global Development, 2013), [www.cgdev.org/publication/identification-development-biometrics-revolution-working-paper-315](http://www.cgdev.org/publication/identification-development-biometrics-revolution-working-paper-315).

alerting them of their right to access hospital care. This is a fraction of the total premium (around INR 500–600), with the remainder paid by government. Extensive real-time information and up-to-date documentation is publicly available through the dedicated RSBY website (see [www.rsby.gov.in](http://www.rsby.gov.in)).

### **Hospitals Compete for Patients**

RSBY enables patients to seek care at any hospital participating in RSBY, even in hospitals outside their district of residence—a critical benefit given that there are an estimated 100 million people in India living and working in a place that is not their official residence (called “migrant workers” within India). Prospective patients can choose which hospital to access, so both public and private hospitals are incentivized to bring in more patients by offering better care. To date nearly 5 million people have sought care from hospitals under RSBY, a boon for hospitals and likely for patients as well.

### **Insurance Companies Compete on Premiums**

Under RSBY, each district in India is managed by one insurance company, each of which holds a monopoly in that district. Each year, however, insurance companies must earn their assignment by winning a competitive bidding process at the district level. Today, 15 companies compete with each other for the right to administer RSBY. Insurance companies are incentivized to enroll as many people as possible through a premium payment per enrollee.

Even better, this form of competition creates only modest additional transaction costs because each hospital bills only a single insurance company. In contrast, the large number of insurance companies in the United States has spawned a billing industry and excess administrative costs of approximately \$190 billion.<sup>9</sup>

### **Incentives Through Additional Payments and Not Targets**

Swarup noted that when he first presented his program design, his bureaucratic colleagues were befuddled to learn that RSBY would not have “targets” such as “How many people will be enrolled by such and such date?” But Swarup wisely noted that insurance companies were incentivized to enroll as many people as they possible could; they would get paid a premium for each additional person they enrolled. This use of additional payments rather than targets was critical; it’s also a key feature of Cash on Delivery Aid,<sup>10</sup> a form of performance-based financing developed by Nancy Birdsall and Bill Savedoff here at the Center for Global Development.

---

<sup>9</sup> Institute of Medicine, “The Cost of Health Care,” <http://resources.iom.edu/widgets/vsrt/health-care-waste.html>.

<sup>10</sup> Center for Global Development, “Cash on Delivery Aid,” [www.cgdev.org/initiative/cash-delivery-aid](http://www.cgdev.org/initiative/cash-delivery-aid).

## **A Constructive State-to-Center Relationship**

To participate in RSBY, states put up 25 percent of the premium, while the central government pays the remainder. This 25 percent helps to ensure buy-in from state governments, which are responsible for administrative costs. Meanwhile, Swarup and his team frequently visit districts to provide technical assistance and guidance, often supported by the German government (through GIZ). States, moreover, are enabled to tailor RSBY to fit local needs. Consequently, a few states have already chosen to expand coverage to their entire populations (namely, Chhattisgarh, Meghalaya, and Kerala). Today all but one state of India (Tamil Nadu) is participating in RSBY.<sup>11</sup>

## **What's in RSBY's Future?**

Despite Anil Swarup's recent departure from RSBY (an inevitable transition given his temporary post through the IAS),<sup>12</sup> RSBY has a hopeful future with several new developments:

- (1) Responding to previous criticism of its benefit package focused on inpatient services (largely secondary care), the RSBY platform is expanding into outpatient care, with pilots in Gujarat, Odisha, Andhra Pradesh, and Punjab. A critical design issue will be to craft an appropriate benefit package and ensure the right fee schedule, such that primary and preventive health services rather than unnecessary inpatient or surgical care are incentivized. (Nevertheless, RSBY's choice of inpatient secondary services represents a more affordable middle way than a focus on expensive tertiary services as seen in several state-led health insurance programs.)
- (2) The RSBY platform is undergoing national expansion to reach other subgroups, such as unorganized workers in India's large informal economy.<sup>13</sup> In the long run, I hope this signals movement toward the gradual expansion of full population coverage. Moreover, given the wide variation within the informal economy, the gradual population expansion needs to account for considerations of equity, gender, cost-effectiveness, and other principles.
- (3) The RSBY smart card platform is helping to update and correct state below-poverty-line (BPL) registries. More importantly, at the request of other ministries,

---

<sup>11</sup> Tamil Nadu is the last hold-out because of the politics of its competing state health insurance program.

<sup>12</sup> Press Trust of India, "Swarup Panel Will Help Restart Stalled Projects," *Business Standard*, June 7, 2013.

<sup>13</sup> A recent expansion of occupational categories include rickshaw pullers, rag pickers, mine workers, sanitation workers and auto rickshaw drivers and taxi drivers, which builds upon prior expansion to street vendors, beedi workers, domestic workers, building and other construction workers, and eligible MGNREG workers. See: "Union Cabinet approves extension of RSBY to other occupational groups," *Business Standard*, June 4, 2013.

the platform is being leveraged to support other entitlements including Life and Disability Insurance and the Public Distribution Services.<sup>14</sup>

- (4) The rich enrollment and claims databases could be tapped for disease surveillance and monitoring of births and deaths—potentially serving as a basis to improve birth and death registration and generate vital statistics – if the data are shared or compared with data from the Ministry of Home Affairs Office of the Registrar General of India.

Admittedly, RSBY still faces several challenges that threaten its longer-term sustainability and impact. Two regular criticisms of RSBY are that there is poor targeting and poor quality of care. The challenges of improving include the following:

- (1) *Improving targeting*: RSBY largely targets poor beneficiaries as identified by BPL lists. These lists, however, are known to have several problems that also affect other entitlement schemes. The most recent list (compiled in 2002) is outdated; even an up-to-date list would be likely to miss a significant portion of India's poorest households.<sup>15</sup> While RSBY has seen early success in updating the BPL lists, it must be especially attentive to including eligible households that have been overlooked in the BPL census (false negatives). To its credit, RSBY has vigorously sought to remove those who are no longer poor from the rolls (false positives).
- (2) *Improving the quality of care*: In any insurance program, there are often countervailing forces that affect the quantity and quality of care. In RSBY, on the one hand insurers have de facto incentives to reduce the quantity of health services used to maximize profits from premiums collected, which may manifest as increases in enrolment with minimal enrollee knowledge of RSBY's benefits. On the other hand, doctors are incentivized by fee-for-service to induce demand of unnecessary services, which are likely exacerbated by power differentials between doctors and their poor, illiterate patients. (The power differential issue is a challenge not only for RSBY but for any health-care program in India.) To improve quality of care, RSBY must both better inform and educate beneficiaries and redesign provider incentives. Throughout, RSBY should learn from its experimentation and adapt its strategies to reflect those experiences.
  - *Educating beneficiaries*: Many enrollees lack knowledge of their rights and benefits—on both extremes of not knowing their benefits (from insurers

---

<sup>14</sup> "Chattisgarh and Kerala Using RSBY Cards for Public Distribution System," *The Economic Times*, January 22, 2013, [http://articles.economicstimes.indiatimes.com/2013-01-22/news/36484590\\_1\\_rsbypds-beneficiaries-public-distribution-system](http://articles.economicstimes.indiatimes.com/2013-01-22/news/36484590_1_rsbypds-beneficiaries-public-distribution-system).

<sup>15</sup> Jyotsna Jalan and Rinku Murgai "An Effective 'Targeting Shortcut'? An Assessment of the 2002 Below-Poverty Line Census Method," Working Paper No. 8, Center for Studies in Social Sciences, Calcutta, 2011, [www.ctrpfp.ac.in/WP-2011-08.pdf](http://www.ctrpfp.ac.in/WP-2011-08.pdf); Sabina Alkare and Suman Seth, "Identifying BPL households," *Economic and Political Weekly* 48(2)[January 12, 2013].



not informing enrollees of their benefits) or alternatively using unnecessary services (largely from the power differential between doctors and patients). A few pilot campaigns to improve patient information and education are currently underway.<sup>16</sup> These pilots will need to focus at both the time of enrollment and after, and beneficiary knowledge of RSBY benefits represent an important performance indicator of RSBY, particularly of insurers. Complementing efforts to educate beneficiaries, insurer performance at district level should be monitored through accountability/transparency mechanisms to ensure that enrollees are aware of their benefits.

- *Redesigning provider incentives:* Current payments to health-care providers are made on a fee-for-service basis, effectively incentivizing greater quantity but not quality of services (and representing a long-run risk to RSBY's sustainability). Hence RSBY should structure its fee schedule to incentivize prevention and primary care; move away from a fee-for-service model by incorporating pay-for-performance measures (as done in Rwanda, for example);<sup>17</sup> design and implement quality incentives at the hospital, district, and state levels (e.g., top-ups to states or insurers with better quality); and improve hospital regulation and accreditation.

(3) *Create robust and adaptable institutions to ensure improvement:* RSBY's management information systems (MIS) represent a major shift in public health-care management in India, as described above. Nevertheless, the quality of RSBY's claim and enrollment data still needs improvement for better management. To do so, RSBY management must pay greater attention to the institutional arrangements and architecture, human resources, and incentives to ensure continuous improvement even with major leadership changes in RSBY. Many government-sponsored health insurance programs in India face severe human resources constraints.<sup>18</sup> In encouraging sustained improvements in performance, my colleague Lant Pritchett and his co-authors have proposed an approach that encourages 'authorizing environments' for decision-making that encourage experimentation and 'positive

---

<sup>16</sup> Erland Berg et al., "Motivating Agents to Spread Information: The Role of Explicit Incentives and Social Identity-Matching," Presentation at India Central Session, Growth Week 2011, London School of Economic, September 21, 2011, slides available at [www.theigc.org/sites/default/files/indiacentral\\_gw2011.pdf#page=43](http://www.theigc.org/sites/default/files/indiacentral_gw2011.pdf#page=43); Jessica Leino and Jishnu Das, "Evaluating the RSBY: Lessons from an Experimental Information Campaign," *Economic and Political Weekly* 46(32)[August 6, 2011].

<sup>17</sup> Paulin Basinga et al., "Effect on Maternal and Child Health Services in Rwanda of Payment to Primary Health-Care Providers for Performance: An Impact Evaluation," *Lancet* 377(9775): 1421–1428.

<sup>18</sup> Gerard La Forgia and Somil Nagpal, *Government-Sponsored Health Insurance in India: Are You Covered?* (Washington: World Bank, 2012); see also Milan Vaishnav, "Resizing the State: What if the Indian State is Actually Not Big Enough?" *The Caravan*, October 1, 2012. <http://caravanmagazine.in/perspectives/resizing-state>

deviance'.<sup>19</sup> As Indian programs are notorious for stagnation after losing their founding leadership, robust institutions are essential for ensuring RSBY's long-term survival.

- (4) *Ensure smarter, sustainable spending*: Universal health programs in all countries must control costs and get better value for money as citizens grow wealthier and increase their demand for health care. In India too, amidst inevitable growth in health-care expenditures, RSBY will need to expand its benefit package to its population to meet evolving demand, all while ensuring smart, efficient, and sustainable public spending. Moving forward, India will need to design and implement fair priority-setting institutions to ensure that public dollars for health are spent in the most cost-effective and equitable manner. My colleagues Amanda Glassman and Kalipso Chalkidou have proposed an agenda to improve priority setting,<sup>20</sup> which offers instructive advice for RSBY and the Ministry of Labour and Employment.

RSBY has an exciting future with many challenges ahead and much work ahead of it. The dream of access to affordable, quality health-care is not yet realized for many more millions of Indians. Moving forward, RSBY will need to work on the design of long-run institutions (challenges 3 and 4 above) to ensure ever-improving performance.

*I thank Anil Swarup, Robert Palacios, Changqing Sun, Nishant Jain, Anup Karan, Bill Savedoff, Milan Vaishnav, Arvind Subramanian, Alan Gelb, Amanda Glassman, Lawrence MacDonald, and Nancy Birdsall for excellent comments and Rachel Silverman for excellent research assistance.*

---

<sup>19</sup> Matt Andrews and Lant Pritchett, "Escaping Capability Traps through Problem-Driven Iterative Adaptation (PDIA)," CGD Working Paper 299 (Washington: Center for Global Development, 2012), [www.cgdev.org/publication/escaping-capability-traps-through-problem-driven-iterative-adaptation-pdia-working-paper](http://www.cgdev.org/publication/escaping-capability-traps-through-problem-driven-iterative-adaptation-pdia-working-paper).

<sup>20</sup> Priority-Setting Institutions for Global Health Working Group, *Priority Setting in Health: Building Institutions for Smarter Public Spending* (Washington: Center for Global Development, 2012), [www.cgdev.org/publication/priority-setting-health-building-institutions-smarter-public-spending](http://www.cgdev.org/publication/priority-setting-health-building-institutions-smarter-public-spending).