Rollout of RSBY in Karnataka
Status and Issues

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POLICY CONTEXT

- The incidence of health-related risks among unorganised workers in Karnataka is very high
- Given the poor state of public health delivery and absence of formal social protection, unorganised worker households have been forced to depend largely on informal sources to finance health expenditure.
- This led to spiralling high-interest debts and poverty among them.
- The health policy of Karnataka government emphasises ‘equity, integrity and quality in health care’.
- Considering the implications of health for poverty and vulnerability of the poor to health shocks, the state government has been promoting health insurance schemes among poor to mitigate the adverse effects of ill health.
- Rashtriya Swasth Bima Yojana (RSBY) is one such example of policy for inclusion through health insurance.

RSBY

- Karnataka government has introduced RSBY, a Central Government scheme, in 2009-10.
- The scheme, which is operated by the Department of Labour, aims to improve “access of BPL families to quality medical care for treatment of diseases involving hospitalization and surgery through an identified network of health care providers”.
- Rs. 30,000 of cover for a household of five members on floater basis
- Only Rs. 30 is the contribution from the beneficiary household in a year
- Cashless cover – access to a network of private and public hospitals
- RSBY has been implemented in 5 Karnataka districts (Bangalore Rural, Belgaum, Dakshin Kannada, Mysore and Shimoga) since February 2010
- Insurance company and TPAs for all the districts have been appointed
- State and district level workshops were held in December 2009 and January 2010 to plan for the implementation
- RSBY has novel features to achieve high rates of enrolment and utilisation

Design features that aim to improve enrolment

- Data on eligible BPL households is prepared by the State Government and provided to the Insurance company
- A schedule of enrolment programme is to be worked out by the government in consultation with the Insurer for each enrolment station/village in the district.
- Advance publicity of the visit of the enrolment team (representatives of the government, insurance company and TPA) by the State Government/Nodal Agency in respective villages.
- List of BPL households should be posted prominently in the enrolment station/village by the Insurer.
- Enrolment team to visit each enrolment station/village on the pre-schedule dates for purpose of:
  - Taking photograph of the head of the household and other eligible members
  - Taking thumb impression of the head of the family and the other eligible members
  - Enrolment and issuance of smart card on the day of enrolment
- At the time of enrolment, the government official will identify each beneficiary in the presence of the insurance representative
- Payment of only Rs. 30 per household per annum

Design features that aim to improve utilisation

- Issue of card on the day of enrolment
- Insurance cover of Rs.30,000 per household (of five members) per annum on a family floater basis.
- Coverage of pre-existing conditions (subject to minimal exclusions)
- Coverage of expenses on hospitalization and surgical services (including daylong ones).
- Cashless coverage of all health services in private and public hospitals
- Provision for a smart-card based system of beneficiary identification/verification and processing of client transactions at the empanelled hospitals.
- Provision for reasonable pre and post-hospitalization expenses for one day prior and 5 days after hospitalization, but subject to a maximum share of the total costs of the hospitalization
- Transport allowance of Rs.100 per event of hospitalisation (subject to ceiling of Rs.1000 per annum)
- Split card facility to overcome exclusion problems on account of migration
- The Insurance company will provide a pamphlet along with Smart Card to the beneficiary indicating:
  - The list of the networked hospitals
  - Availabile benefits
  - The names and details of the contact person in the district.

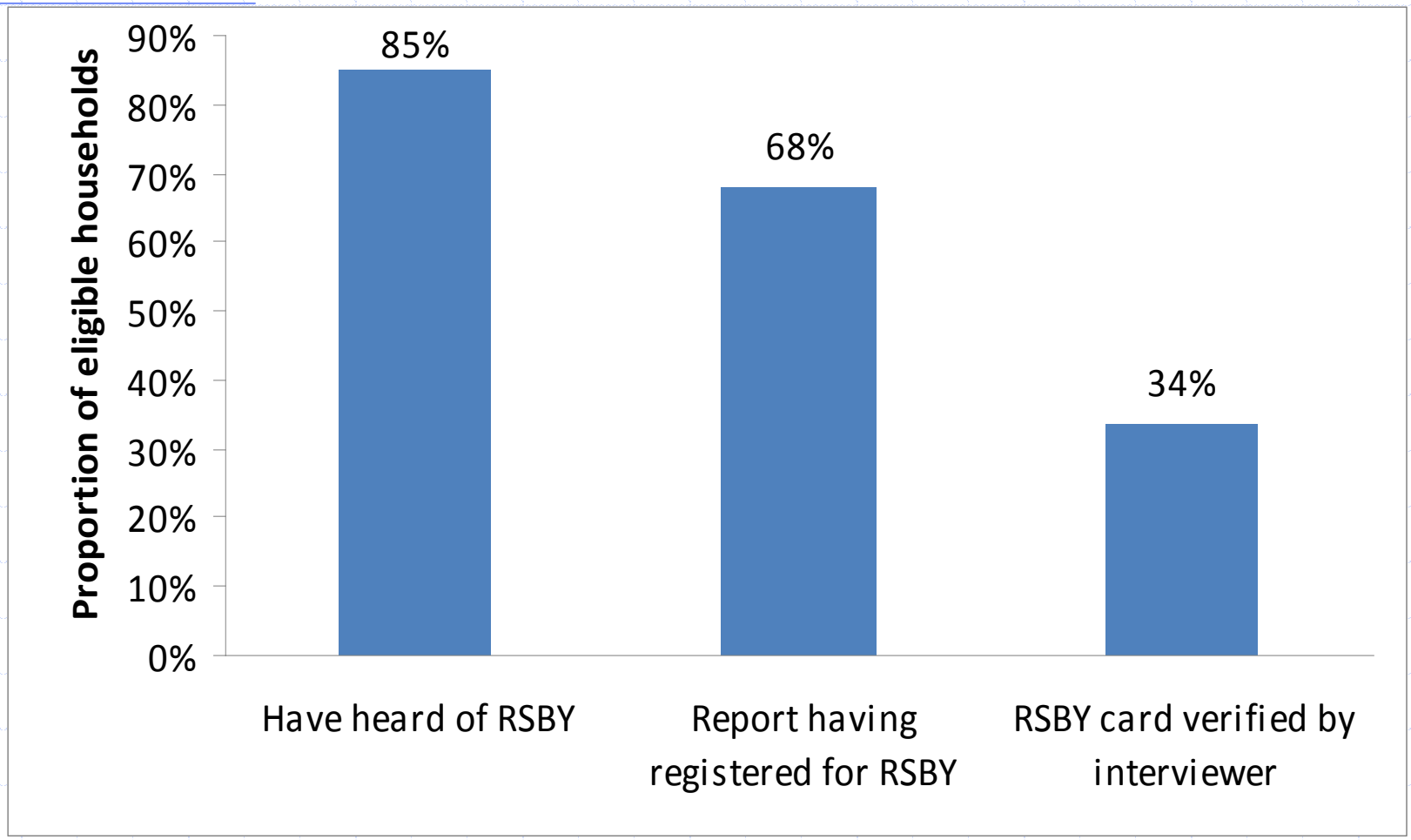
Questions

- How many eligible households have been enrolled in the scheme?
- How many eligible households have availed RSBY benefits?
- What factors influenced enrolment and utilisation by eligible households?

Data and methodology

- We use part of the data collected for an ongoing study on *Health Insurance and Role of Information* undertaken in collaboration with Oxford University, LSE and ISEC as a part of iiG programme
- We have canvassed structured questionnaire among 3,647 sample households in 222 sample villages in Karnataka
- Sample households have been drawn from the list of eligible households (i.e., the same list that is used by the government to provide RSBY benefits)

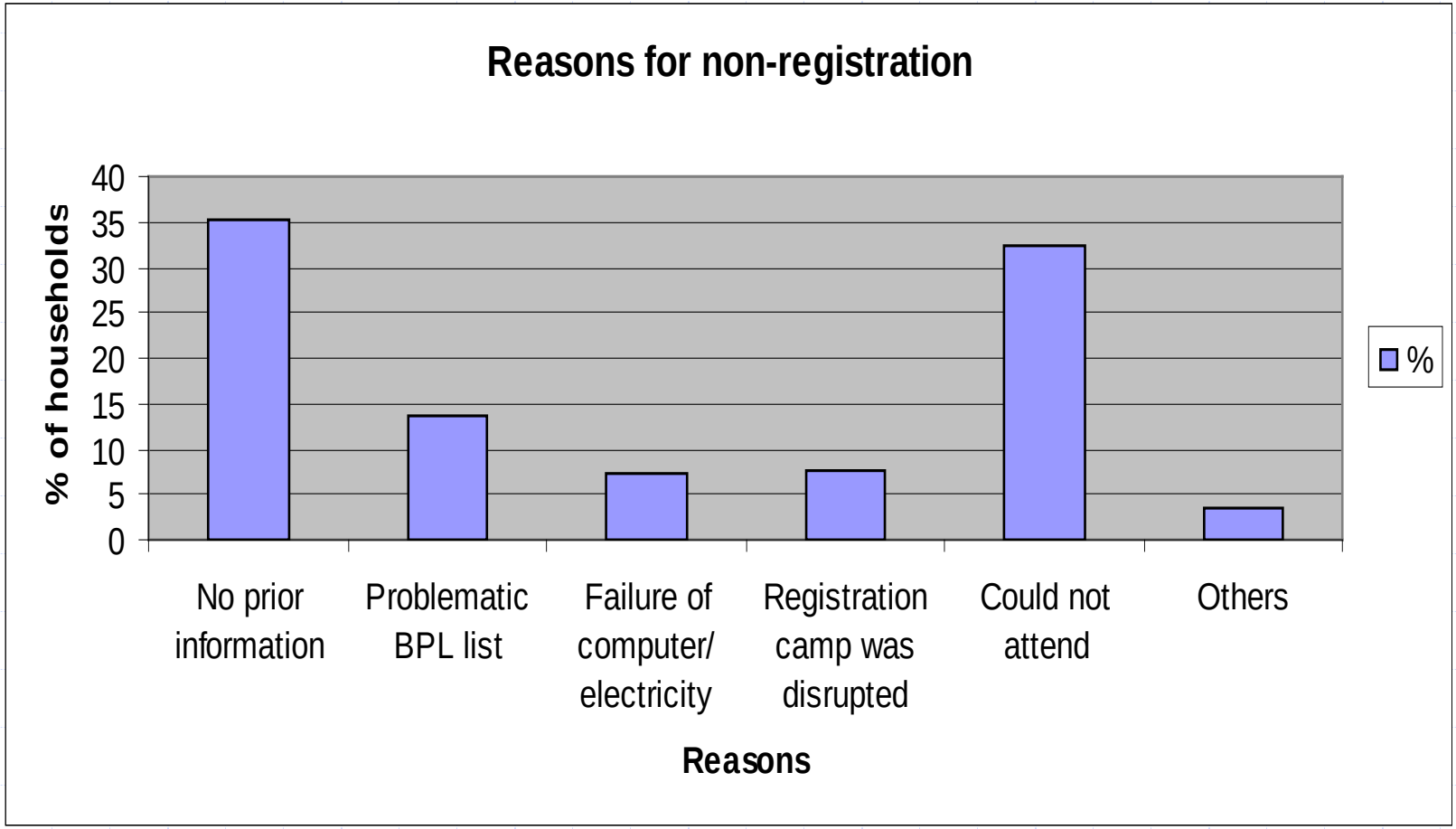
Results on enrolment



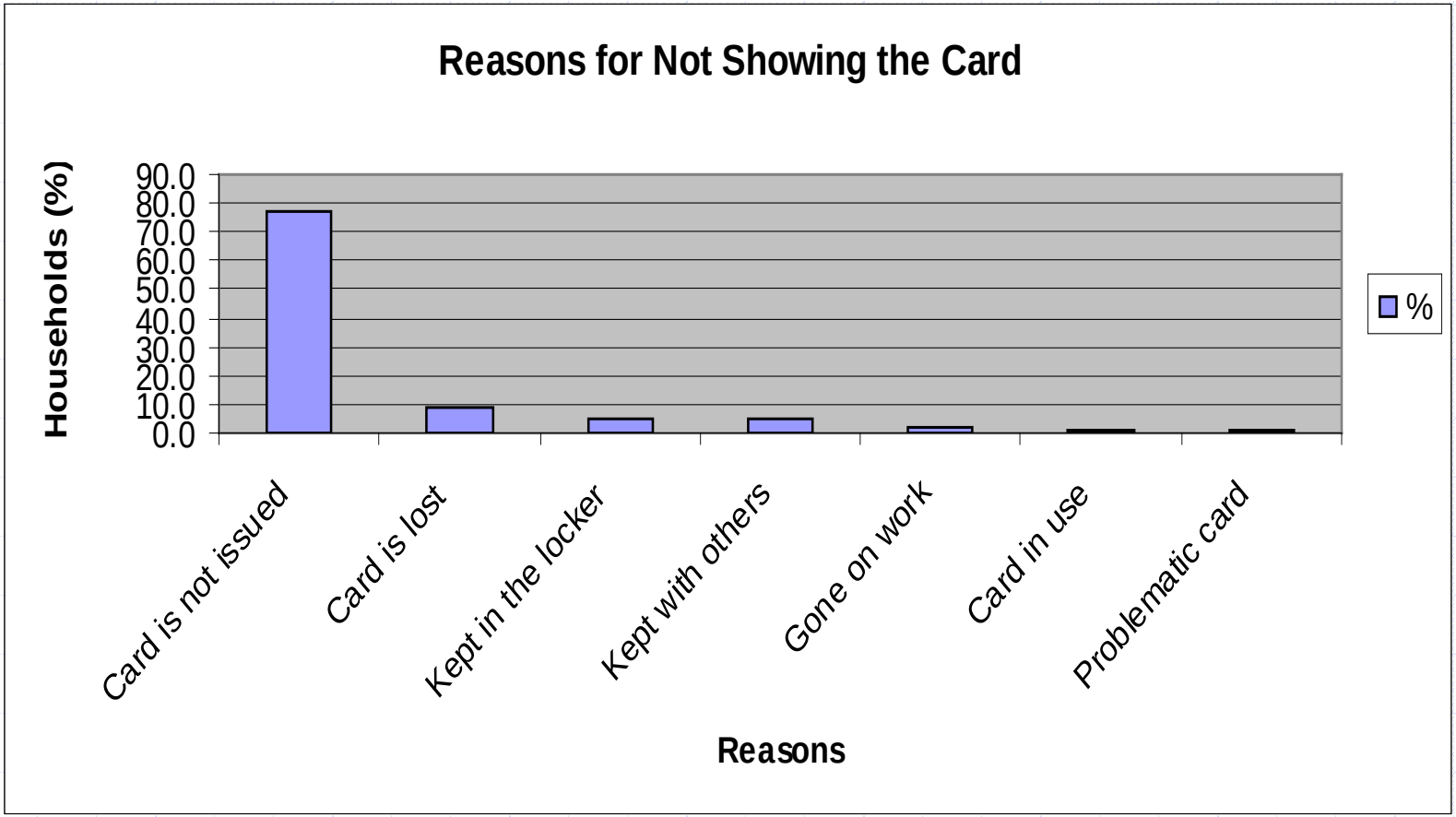
`Many a slip between cup and lip'

- First slip
  - 15% of sample households did not hear about `health insurance scheme meant to include the poor'
  - This is the failure of information provision
- Second slip
  - 17% of the sample heard about RSBY; but did not register
  - Registration failure
- Third slip
  - In the case of 34% of the households, field investigators could not verify the card
  - Failure to deliver the cards

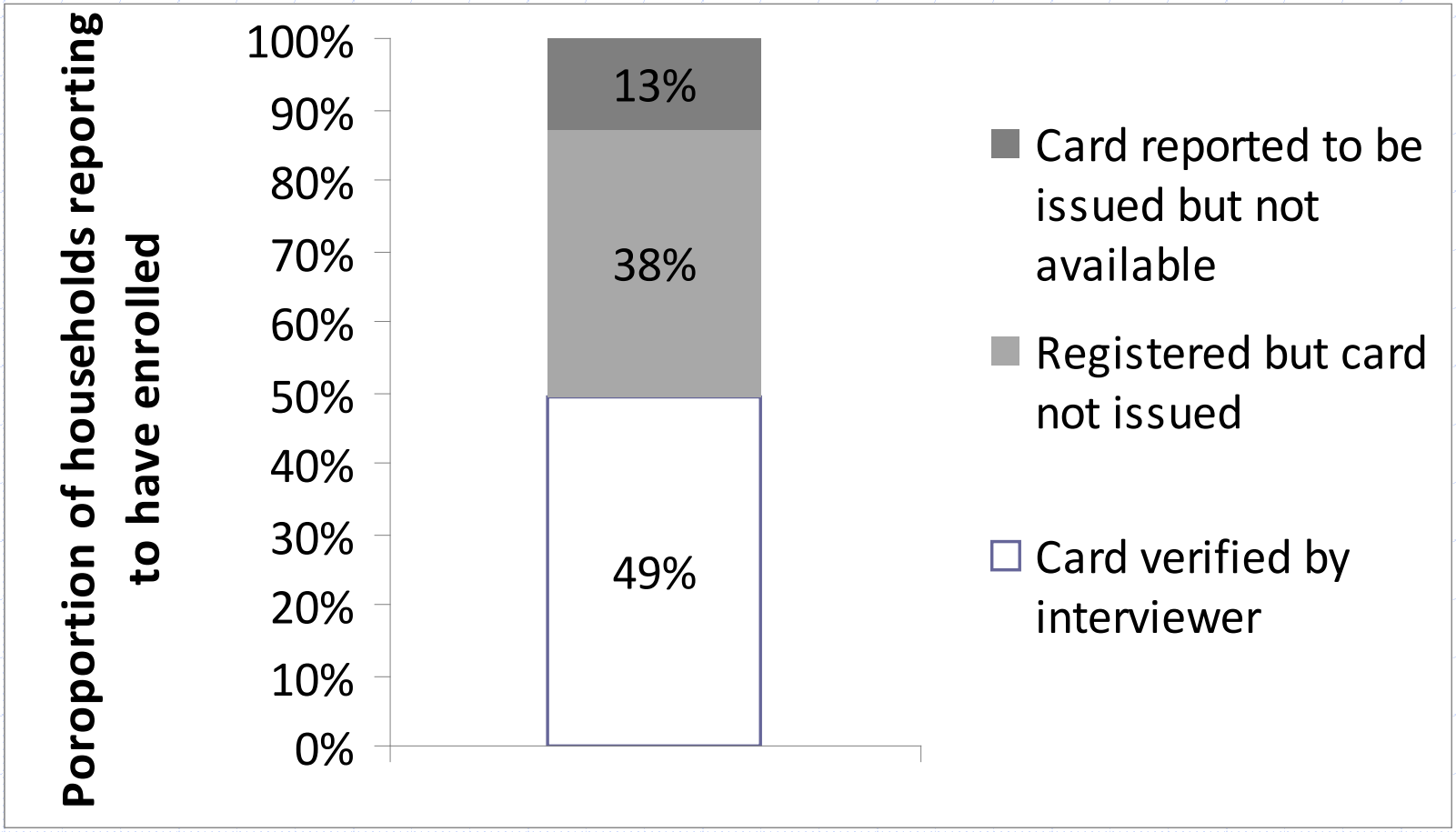
Second slip: Why households could not register



Third slip: Why card was not with the household at the time of survey



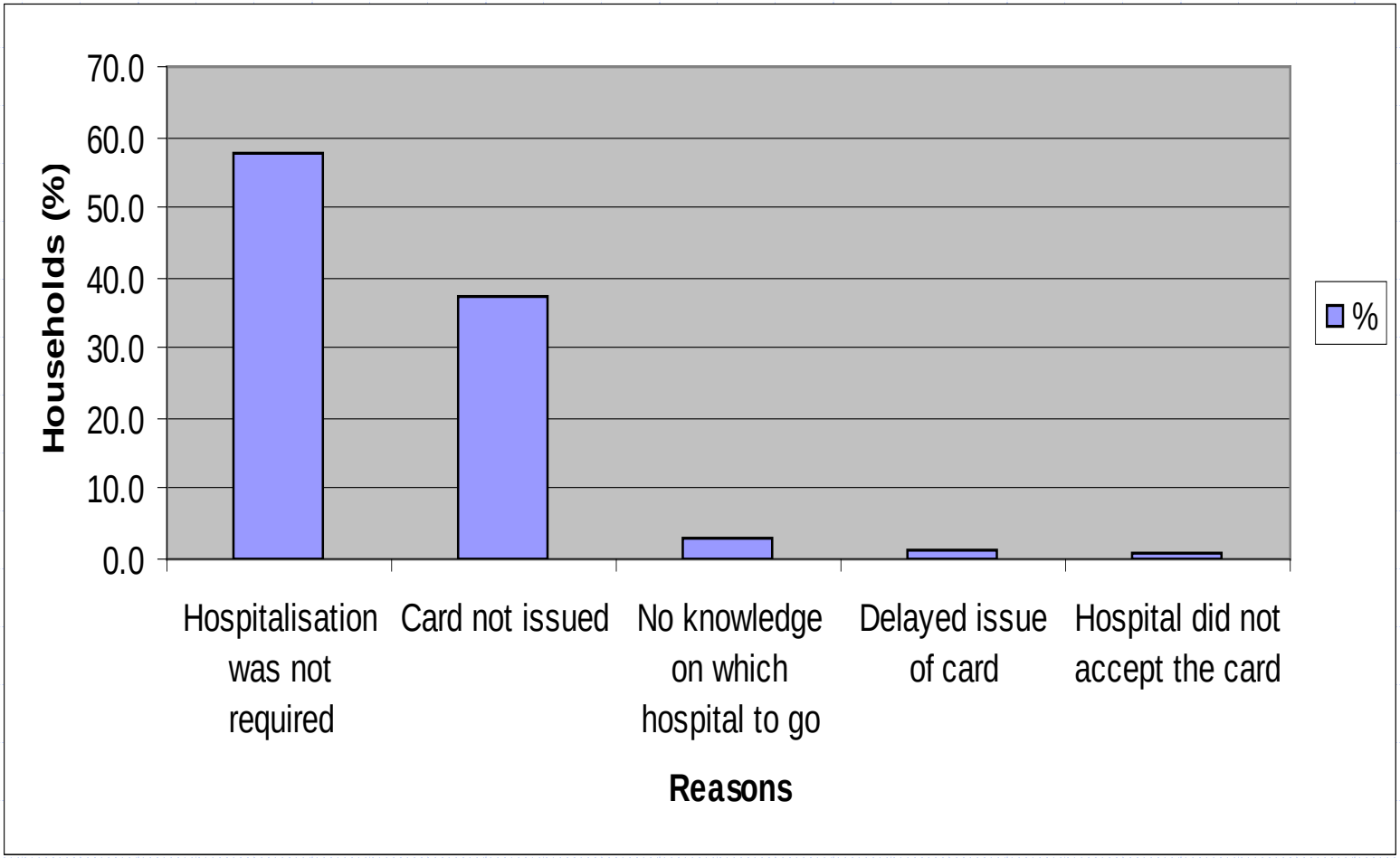
Results on issue of card



Utilisation

- Only 10 out 3647 sample households could utilise the card and obtain benefits
- 27 households tried to use; but, did not succeed
- This is 3 months after the enrolment
- What are the reasons for low utilisation?

Reasons for low utilisation



Conclusions

- The RSBY scheme has some attractive design features
- Potential to make a big difference
- But some major implementation problems:
  - Poor information on when and where cards will be issued
  - Not issuing cards on the day of day of registration
  - Delays in distributing cards
  - Lack of knowledge about:
    - Where to get cards if not already having one
    - How/where to use cards
  - Hospitals not ready

Conclusions (contd.)

- Success will depend on **coordination** between a large number of actors
  - Anganwadi teachers
  - Rural Development and Panchayat Raj Department
  - GOK department of labour
  - Hospitals
  - GOK department of health
  - Central government
  - Third-party agents
  - Insurance company
  - District officials
- Our experience would suggest that the buy-in of senior district officials is crucial to achieving this coordination

Conclusions (contd.)

- Incentive misalignment?
  - Insurance company incentivised to sign people up for the scheme, to collect premium subsidy from the government – drives revenue from its point of view
  - Insurance company **not** incentivised to facilitate and encourage utilisation – drives costs from its point of view
- **Hospitals** benefit from utilisation (if the agreed rates are high enough)
  - Hospitals could be motivated to encourage utilisation
  - Health camps? Telephone helpline?

Thank you