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Health Financing and Delivery in India: An Overview of Selected Schemes

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List of Acronyms

AP	Andhra Pradesh
BPL	Below poverty line
CGHS	Central Government Health Scheme
CHC	Community Health Centre
ESIS	Employees State Insurance Scheme
GDP	Gross domestic product
HRW	Human Rights Watch
ICDS	Integrated Child Development Scheme
IMR	Infant mortality rate
IT	Information technology
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NCEUS	National Commission for Enterprises in the Unorganized Sector
NFHS	National Family Health Survey
NHRC	National Human Rights Commission
NHSRC	National Health Systems Resource Centre
NIOH	National Institute of Occupational Health
NCMH	National Commission on Macroeconomics and Health
NSSO	National Sample Survey Organization
PHC	Primary Health Centre
PHFI	Public Health Foundation of India
RDPR	Department of Rural Development and Panchayati Raj
RSBY	Rashtriya Swasthya Bima Yojana
SEWA	Self-Employed Women's Association
TB	Tuberculosis
UPA	United Progressive Alliance
WHO	World Health Organization

Contents

Abstract

India is notorious for its health inequities, a situation brought about by years of meagre state spending and the establishment of a large and largely unregulated private sector. However, in recent years, the government has made attempts to provide health protection to poor and vulnerable citizens. Chief amongst these is the Central Government's *Rashtriya Swasthya Bima Yojana* (RSBY), which is estimated to have provided, along with several other large state specific schemes, coverage for about 247 million people or over one-fifth of India's population (Reddy *et al*. 2011). This paper analyzes some of India's most prominent schemes from the perspective of poor informal women workers, a specific focus rising from the fact that women informal workers tend to have special needs and poorer health than their male counterparts.

The paper analyzes a variety of schemes, which differ in their structure and financing: the RSBY scheme, which is run by the Central Government; the Vimo SEWA scheme, which is the community-based health insurance scheme of the Self Employed Women's Association (SEWA) that is now active in nine states in India; the *Yeshasvini* scheme in Karnataka, which works in collaboration with farmer cooperatives; and the *Rajiv Aarogyasri* scheme in the state of Andhra Pradesh. The analysis focuses on five key aspects of the schemes: inclusiveness and access for informal workers; the quality of services being provided; awareness of the scheme among its intended beneficiaries; the scheme's impact on reducing out-of-pocket expenditure on health care; and the scheme's ability to provide access to women.

The paper shows that a range of institutional innovations are possible in terms of bridging the health equity divide. What is also clear, however, is that without a comprehensive approach to raising the living standards of poor workers, including the provision of primary healthcare and preventive health services, health inequities are unlikely to decline significantly.

Introduction[1]

On August 29, 2010, one of India's leading English dailies carried a shocking headline: *She gave birth, died. Delhi walked by* (*Khandekar* 2010), which told the story of a poor woman who died while giving birth on the pavement in a busy shopping area in Delhi. This was not an isolated case. More recently, in July 2011, India's National Human Rights Commission (NHRC) issued notices to senior government officials in New Delhi after a woman was forced to deliver outside a hospital (NDTV 2011). These cases are a reflection of the plight of the poor in India, a majority of whom is unable to access health services. Until recently, only 10 per cent of Indians had any form of medical insurance, and often it was highly inadequate (National Rural Health Mission Document 2005-2012).

Recognizing this, several state-based and central health insurance initiatives have been launched in recent years. The largest of these initiatives is the central government's national health insurance scheme, the Rashtriya Swasthya Bima Yojana (RSBY), which started in April 2008 and is being implemented in 25 of India's 28 states and seven union territories.[2] The RSBY is significant as it is the first serious national effort at a health insurance scheme for informal sector workers and those living below the poverty line (BPL). It aims to provide coverage to groups of informal workers such as construction workers, street vendors, *bidi* (a local cigarette) workers, beneficiaries under the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) who have worked for more than 15 days in the preceding financial year, and approximately 4.75 million registered domestic workers.

Before the launch of this scheme, the central government provided health insurance only to formal sector workers through two large government health insurance schemes even though the informal sector in India constitutes almost its entire workforce. Ninety three per cent of the total workforce in India (NCEUS 2007) is in the informal sector and accounts for 60 per cent of its gross domestic product (GDP) (Chen 2003). A vast majority of this workforce is comprised of the absolute poor.

The National Committee on the Unorganized Sector (NCEUS) submitted its first Report on Social Security for Unorganized Workers in May 2007. The report recommended the creation of a national minimum social security for all eligible informal workers. Consequently, the Indian Parliament passed the Unorganized Sector Workers' Social Security Bill in December 2008 to provide life, disability, health, and old age insurance to informal workers (NCEUS 2007). The National Health Insurance Program or the Rashtriya Swasthya Bima Yojana (RSBY) (http://www.rsby.gov.in) was announced under this new legislation. It is the first national health insurance scheme in India and provides Rs 30,000 (approximately US $583)[3] to families to cover medical expenses at participating hospitals on a floater basis. The total insurance amount can be used for meeting health expenses of one person or used jointly for two or more members of the family.

It is estimated that the RSBY, along with several other large state specific schemes, has helped provide coverage to about 247 million people or over one-fifth of India's population (Reddy *et al.* 2011). Studies show an expansion in the breadth of coverage; until 2004, only 1.7 per cent of the poorest 40 per cent in India were accessing facilities for hospitalization (NSSO 2004, cited in RSBY operational manual). However, in 2011, based on the data for 167 districts that have completed one full year of operation, 2.6 per cent of the poor were able to access these facilities (Rajasekhar *et al.* 2011).

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1. This paper was originally written in January 2012. Since then, there have been important changes in the health sector in India, not least of which was the publication of the High Level Expert Group's report on extending universal access to health care in India in 2012. The report has recommended a staggered increase in government health expenditure as well as the promotion of free primary healthcare. However, the RSBY will remain in place to provide cover for secondary and tertiary care. The conditions of the inclusion into the RSBY have also been extended to include specific sectors of informal workers such as waste pickers.

2. The RSBY's website contains complete information, some of which is summarized here: http://www.rsby.gov.in/Documents.aspx?ID=14.

3. Currency conversion in this case study is based on the mid-market rate on January 16, 2012 of Rs 1 = US $.019457, per www.xe.com

This paper will analyze the RSBY, Vimo SEWA, now active in nine states in India, Yeshasvini in Karnataka, and Rajiv Aarogyasri in the state of Andhra Pradesh, to determine the impact of these programmes on providing protection from health costs to the poor and to informal workers. Rajiv Aarogyasri, launched as a scheme for the absolute poor, has expanded to provide health coverage to about 85 per cent of that state's population. Yeshasvini has been providing secondary and tertiary health care to agricultural workers in Karnataka with the help of cooperative societies, which have a strong culture in the state. SEWA has been involved for over two decades, initially in the state of Gujarat and now in eight other states as well, in providing health insurance to poor, informal women workers and their families. Vimo SEWA has the longest learning experience among all these schemes and the most experience working closely with women in the informal workforce.

The paper is based on the theory that institutions (such as these health schemes) reflect the underlying social and political dynamics of the society in which they are produced and, in their impact on society, reproduce those dynamics (Althusser 1970). The paper shows that the health schemes that have made genuine efforts to promote equality more generally amongst the target population have been more successful in extending health coverage than those that have not.

The paper will focus on five key aspects of the schemes: inclusiveness and access for informal workers; the quality of services being provided; awareness of the scheme among its intended beneficiaries; the scheme's impact on reducing out-of-pocket expenditure on health care; and the scheme's ability to provide access to women. The paper has a specific focus on women informal workers, who tend to have special needs and poor health. Their work hours are long and income small. Moreover, their working conditions are such that their health deteriorates over time. Poverty exposes them to unsanitary living conditions and lack of access to basic living requirements such as clean water. As a result, their risk profile for contracting preventable illnesses is high. In addition, these women are also responsible for household work, such as collecting water every day, which puts even greater strain on their bodies.

Section 1 of the paper provides background information of the challenges of India's health care system, its public health infrastructure and its demographic and health challenges. Section 2 discusses the structure, financing, and benefits extended under the four schemes listed above and analyzes the schemes' performances. Section 3 presents further discussion, drawing out the main themes of the paper and conclusions.

I. Overview of India's Health Care and Demographic Indicators

One of the big challenges of India's health care system is the financial burden it puts on households in terms of out-of-pocket spending, which, as more than three quarters of the health care expenditure is met by households, remains one of the main causes of impoverishment (Balarajan *et al*. 2011). About 39 million additional people fall into poverty each year as a result of this expenditure (Balarajan *et al*. 2011). While most health insurance schemes focus on providing coverage for hospitalization, studies have shown that it is the outpatient care that leads to more impoverishment than inpatient care (Berman *et al*. 2010).

Institutional Structure of Public Health Care in India

India's health care system was carefully structured at the time of Independence to provide primary, preventative, and curative health care within a reasonable distance of the population even in remote, rural areas. It was envisaged as a three-tiered system – a vast network of primary health centres with referral linkages to secondary and tertiary care. Primary Health Centres (PHCs) were set up; one for every 30,000 people in the plains and every 20,000 people in hilly and tribal areas. Community Health Centres were set up to provide more specialized health services (Duggal and Gangolli 2005). A district-based system of secondary care was the next level of care; the last level was tertiary care.

However, the system did not function as envisaged. Posts remained vacant as doctors were reluctant to go into far-flung rural areas, essential medicines were in short supply, and staff was unsympathetic. As a result, a large number of people, both in urban and rural areas, used the services of private providers.

Quality of Private Sector

The private sector filled in the gaps, but the quality of this care was and is highly varied. In rural and poorer urban areas, even people without medical degrees set up practices to fill in the huge vacuum for services. The private sector now provides most health care services, and it is where the bulk of manpower and infrastructure rests: approximately 80 per cent of all doctors, 75 per cent of all dispensaries, and 60 per cent of all hospitals in India are now in the private sector (Narayan *et al*. 2003, cited in Baipai and Goyal, 2004). The National Commission on Macroeconomics and Health (NCMH) found that the distribution of the health services was highly skewed towards urban areas, with an absence of uniform standards, treatment protocols, or even regulations (NCMH 2005).

Private sector health care is provided on the basis of fee-for-service and is for profit. Private corporate hospitals, registered under the Indian Companies Act, are owned by shareholders and are run like any other private limited company. Some also offer their services for a premium paid to them directly or through medical insurance companies (Garg 1998). Government hospitals, unable to compete with the resources of this high-end private care, have suffered a further setback as the best teaching faculty, specialists, and other medical staff have left for better infrastructure, work environments, and remuneration in the private sector.

Quality of Public Sector

The quality of public sector services and infrastructure has been steadily declining in many states. Government health care is seen as being poor quality, so only when people cannot find or afford private health care do they go to a government hospital. Staff members are frequently rude and uncooperative, especially with poorer patients. There is a complete lack of accountability, with people having little redress in cases of neglect or negligence. This has all impacted on the ability of other attempts to introduce innovative health schemes in the public sector. For example, the National Rural Health Mission in Uttar Pradesh was severely affected by the poor quality of the public health services in that state (Varia 2009) such that there were no specialists, funds for ambulances, or blood storage facilities.

Mismanagement in Health Care

The success of the vast new national health insurance programme (RSBY) will depend in part on how well resources are managed. How judiciously does India utilize its health care budget? Why does India have such poor outcomes in public health? Is it because of budgetary constraints, mismanagement of resources, or other reasons?

Overall, India spends very little on health care. Public spending by 2004-05 was only about 0.9 per cent of the GDP, ranking India 171 among 175 nations on health care spending. The UPA government has managed to increase this spending to only 1.4 per cent of the GDP (WHO 2008). Bangladesh and Indonesia respectively spend about US $14 and US $19 per capita on health, which is relatively less than the per capita spending by India (US $23), but the health outcomes in terms of child mortality are considerably better in these countries: 74 for Bangladesh and 45 for Indonesia compared to 93 for India (World Bank 2003; Nundy 2005).

An additional problem is the way these resources are managed and distributed. Researchers have pointed out how the distribution of resources is skewed toward salaries and other consumption expenditure with very little directed towards capital expenditure on buildings, machinery, and equipment. This eventually leads to poor services and lack of availability of drugs and equipment at health care facilities (Garg 1998).

A further problem is corruption. Transparency International India pointed out that health, which has the maximum public interaction, is also the second most corrupt sector after the police. The *Karnataka Lok Ayukta* (ombudsman) estimated that at least 25 per cent of the budget in health care was siphoned through corrupt practices involving all categories of government health functionaries (Nundy 2005). The Lok Ayukta's report also found that unlicensed manufacturers of drugs and blood bank operators had been given large orders. In the private sector, patients were exploited through unnecessary tests. This may be a major area to work on for the health insurance schemes, where there have been reports of unnecessary surgeries and other malpractices (Nundy 2005). Better standards of monitoring and accountability need to be set up.

Financing Health Care

In India, health is primarily the responsibility of the states even though the central government is a major source of financing. The central government finances curative services in central government hospitals and clinics and also provides support for disease control programmes. However, the responsibility of implementation of the programmes rests with the states. The states are required to fund their own hospitals and primary health care centres. Programmes are funded with the help of general tax and non-tax revenues. These include grants and loans received from both internal and external agencies (Garg 1998).

Before the launch of the RSBY, the central government's financing of health insurance schemes was focused only on the formal sector through two large insurance schemes – one for central government employees (Central Government Health Scheme, or CGHS) and another for low-salaried workers from the organized sector (Employees State Insurance Scheme, or ESIS). The government also finances health services for employees of certain state-owned enterprises like defense and for most public sector employees (Garg 1998).

India's Demographic and Health Indicators

India's demographic indicators have improved dramatically in the past few years, but there is a long way to go. The National Family Health Survey (NFHS), a large-scale survey conducted every few years in a representative sample of households throughout India, has been repeatedly showing serious levels of malnutrition. NFHS data over three surveys, from 1992 to 2006, showed there was very little improvement in nutritional levels even though India achieved high economic growth during this period.

The third round of NFHS (NFHS-3, done in 2005-06) pointed to the increasing disparities in the health condition of different groups of the population in the same city, an indicator of the vastly different access of these groups to health care. Currently, the urban infant mortality rate (IMR) is 36 per 1,000 live births as compared to the rural IMR of 58.

In NFHS-3, the under-five mortality rate was 73 for every 1,000 live births among the urban poor compared with the average of 48 among all city dwellers in India. This finding may be of particular interest to this study as the majority of the informal workers are part of the urban or rural poor.

India continues to have extensive poverty. A 2007 estimate of poverty by Abhijeet Sengupta, economist and member of the government's Planning Commission and others, showed that 77 per cent of Indians lived on less than US $0.40 (Rs 20) a day.

Gender Disparity

Gender disadvantages between men and women remain a serious concern in India. The preference for sons leads to sex-selective abortions; biases against girls have a serious impact on their quality of life, access to health, and survival. This disparity, which begins at birth, translates into how women use and access resources. Forty one per cent of women and 18 per cent of men age 15 to 49 have never been to school. Fewer women than men have any exposure to any form of media: NFHS-3 data showed that 35 per cent of women had no regular exposure to newspapers or television compared with 18 per cent of men. This may well point to the need for better-targeted schemes for women.

2. Design, Performance and Analysis of Four Health Insurance Schemes in India

The four schemes outlined below were chosen to illuminate differences of scale and scope and in terms of whether they were initiated by the government – central or state level – or non-governmental organizations. The target populations all included informal workers. **Table 1** gives some basic details.

Table 1 Overview of the Four Selected Schemes

Schemes Reviewed	**Rashtriya Swasthya Bima Yojana (RSBY)**	**Vimo SEWA**	**Rajiv Aarogyasri**	**Yeshasvini - Community Based Health Insurance – Private Sector Initiative**
Initiator	Central government	Community-based health insurance scheme	State government	Private sector, through community-based cooperatives
Scope	National Health Insurance Scheme, to be India-wide	Nine states of India	Southern state of Andhra Pradesh	Southern state of Karnataka
Targeted population	Below poverty line and certain categories of informal workers	Poor women workers in the informal sector and their families	Below poverty line population	Mostly agricultural workers who are members of cooperative societies

The Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme)

On April 1, 2008, the Indian government launched the Rashtriya Swasthya Bima Yojana (RSBY) to provide health coverage to informal workers and those living below the poverty line (BPL). RSBY has become one of the largest health insurance schemes in the world (Reddy *et al*. 2011). It is aiming to address the needs of different groups of informal sector workers such as building and other construction workers, street vendors, *bidi* workers, domestic workers, and rickshaw pullers. It also includes workers who may not have found employment for some time but have worked under the MGNREGA[4] (thus those who worked for more than 15 days in a previous financial year would also be entitled to coverage).[5]

Structure, Financing, and Benefits Package

The scheme is largely funded by the central government, which finances 75 per cent while state governments put in the remaining 25 per cent; the exception is in the North Eastern states, where the contribution of central government and state government is in the order of 9:1. States have the flexibility to modify the scheme, its coverage, the package provided, and even the cost of various procedures, and, while the cen-

4 The Act, promulgated in 2005, aims at enhancing the livelihood security of people in rural areas by guaranteeing them hundred days of wage-employment in a financial year. See http://nrega.nic.in/netnrega/home.aspx.

5 See http://www.rsby.gov.in/.

tral government worked out an initial package, coverage is not limited to it. For instance, Kerala state has decided to extend the scheme to above poverty line families as well (Research Institute, Rajagiri College of Social Sciences 2009). Based on feedback from insurance agencies, the initial central government package is also being revised to include more procedures, from 726 to 1,100 (Reddy *et al*. 2011).

The scheme covers hospitalization charges up to Rs 30,000 (US $583) for up to five members of a family, which includes the head of the household, spouse, and up to three dependants. Pre-existing conditions are covered, and there is no age limit. Beneficiaries of this scheme are required to pay only about Rs 30 (US $0.58) as a registration fee while the government pays up to Rs 750 (US $14.60) per family per year. The scheme also provides a transport allowance of up to Rs 1,000 (US $19.47) per year. However, according to the RSBY website, the scheme does not cover outpatient care or the cost of medicines.

The scheme works through a good information technology (IT) system. Beneficiaries are issued a smart card that stores their name, age, photograph, and thumb impression. Beneficiaries need to present this smart card to participating hospitals to receive treatment. Hospitals have the technology to submit these transactions online to insurance companies for reimbursement.

Insurance companies are selected on the basis of bidding. Every state government tenders coverage to public and private insurance companies. The scheme does not encourage competition at the district level as only one insurance company is allowed in a district. However, an increasing number of insurance companies are entering the bidding process, from six at the scheme's beginning to a current 11 (RSBY 2011). There is criticism of handing over to insurance companies and smart card subcontractors the responsibility for the enrollment of families. There is also criticism of tying the services of public and private hospitals to insurance companies, a practice that could have potential consequences in determining risk selection (Reddy *et al*. 2011).

Box 1 Salient Features of RSBY

- Hospitalization is covered for up to Rs. 30,000 for a family of five on a floater basis.
- Transportation charges are covered up to a maximum of Rs 1,000 with a limit of Rs 100 per hospitalization.
- Pre- and post-hospitalization is covered up to one day prior to hospitalization and up to five days from the date of discharge from the hospital.
- All pre-existing diseases are covered.
- There is no age limit.
- The system is IT-enabled – once a hospital is empanelled, a nationally-unique hospital ID number is generated so that transactions can be tracked at each hospital.
- There is no coverage for outpatient expenses or cost of drugs.

Source: Swarup and Jain 2010

Performance of RSBY

With about 100 million people provided health insurance under the scheme, the RSBY could be viewed as being highly successful in expanding the breadth of coverage. However, these results are not consistent across states. Data from the 10 states where one or more districts have completed two years under the scheme point to large variations in results between high performing states, such as Kerala, and low performing ones such as Uttar Pradesh. While Kerala and Delhi show a sharp increase in enrollments in the second year, the states of Haryana and Uttar Pradesh actually show a reduction in enrollment (RSBY website 2011b),

pointing to the difference in the level of interest taken by the state administration, to the effectiveness of the implementation of the scheme, and to an indication, perhaps, of the quality of health care.

In terms of its coverage, the scheme provides only secondary level health care. Health coverage of Rs 30,000 is sufficient protection for most households in a given year (Rajasekhar *et al*. 2011), with a poor household in Karnataka spending on average Rs 20,000 on hospitalization each year (Rajasekhar *et al*. 2011). However, the big gap is in the lack of provision of medicines or outpatient care, which has been shown to be a bigger reason for impoverishment when compared with inpatient hospital expenses (Peter *et al*. 2010). The main reason for excluding drugs and outpatient coverage from the RSBY has to do with regulatory issues. In the present health system, physicians can increase the number of patient visits and prescribe unnecessary and expensive medicines. In addition, prescription drugs can be easily obtained over the counter in India, which makes it more difficult to enforce any regulations (Reddy *et al*. 2011). But in the absence of comprehensive coverage, the risk of continuing high out-of-pocket expenses seems likely in the population groups that the programme seeks to protect against further impoverishment.

Inclusion and Access for Informal Workers

The scheme, undoubtedly, has come as a relief for families who did not previously have any access to health coverage. A story in the newspaper *Mint* described how for Rajkumar, an informal daily-wage worker, the scheme fulfilled its objectives. It saved him from going into deep debt after his wife Rekha was diagnosed with tuberculosis (Halarnakar, 2010). Rekha was able to get healthcare without the family borrowing money and going into deep debt. The process, too, was smooth and quick. The family's smart card was issued within two hours of taking their fingerprints, and from then on access to any of the 5,000 hospitals under the network was easy. The family was satisfied with the results of the scheme as was the hospital, which was reimbursed by the insurance company. "I don't know what exactly the system is, but it is a system that works for people like us," Rajkumar told *Mint*.

Success stories such as this, however, need to be viewed in context of the larger structural problems with the process of inclusion, which leaves legitimate beneficiaries out of the scheme. The criterion for inclusion is based on a Below Poverty Line (BPL) list of people drawn up through the Planning Commission of India. The BPL list is known to be very problematic. It is an economic benchmark used to identify families in dire poverty so that they can get aid. However, the data is based on a survey conducted in 2002, and the list itself is known to be faulty. Moreover, the status of BPL data in different states has been varied: Kerala identified its own indicators, but several states do not have and therefore did not contribute a BPL list to the Planning Commission, which makes it difficult for the scheme to reach genuine intended beneficiaries. In many states, genuine informal workers are not on the list, leading to local tensions. In Karnataka, the scheme was implemented only in some select districts in rural areas, using data from a separate survey. Names of members in the list of eligible households were incorrect. In some cases, the name of the head of the household, required for issuing the smart card, was missing from the list. Such households were not allowed to register using another member as head of family. Thus, in families where the head of the household was ill or deceased, family members were unable to register.

In Uttar Pradesh, despite the presence of a BPL list, the enrollment teams could track only 50 per cent of the names on the list. In the absence of these names, the private insurance company given the RSBY contract, ICICI Lombard, was able to issue only 834,000 smart cards against a target of 1.924 million families (Singh 2010).

The registration process itself is also problematic. The scheme requires families to register in their home states on the basis of the BPL list (Sharma *et al*. 2008). This means that migrant workers, who have been unable to return home for long periods of time and therefore are not registered, cannot use the scheme even during times of illness. Moreover, the Karnataka study (Rajasekhar *et al*. 2011) showed that while in

most villages, enrollment took place either at the government school building or *gram panchayat* office, in many cases, families had to go to another village to enroll. Travel was not most suited to the needs of the informal work force, who would suffer loss of wages with work hours lost. In addition, often there was no advance information given on when these registration camps would be held. Even the time and venue was not specified in advance (Rajasekhar *et al*. 2011), so when the enrollment camps were organized, many people were away on daily wage work or in the fields. In the absence of more information, many of these people believed they would be able to enroll in the late afternoon or the following day, which they could not. The procedures required the presence of the head of the household for the smart card to be issued. In no case was this condition relaxed.

Information and Awareness

Information and awareness are critical if a scheme is to reach the genuine beneficiaries, and RSBY managers acknowledge this. Under the scheme, state governments are responsible for creating effective programmes for spreading awareness. However, most states have handed over this function to insurance companies, who have a clear disincentive for doing this: more awareness would only lead to more claims and increase the chances of loss for insurance companies. Insurance companies in some districts "forgot" to provide a basic requirement to the customers: a list of network hospitals (Rajasekhar *et al*. 2011). Much of the information that people received was through word of mouth; the most common way in which people learned of the scheme was through family and friends.

Quality

The effectiveness of any health insurance scheme will depend on the quality of health infrastructure, whether in the public or private sector. As noted in an earlier section, there are large variations in the quality of healthcare at the national level, and both public and private sector function without any accountability. The poor are more likely to suffer from this lack of regulation. It may be worthwhile for the RSBY to not only focus exclusively on the number of smart cards that have been issued to judge the overall success of the scheme but also on the overall quality of health provisioning. The Ministry of Labour is implementing the scheme with little involvement of the Ministry of Health, which indicates the focus of the scheme has been implementation with no systems set up to monitor its health component.

As discussed earlier, India's health care is highly privatized and functions with very little regulation. It is not a surprise, then, that the majority of the hospitals empanelled by the RSBY are in the private sector. According to its own website, the RSBY has empanelled 4,923 private hospitals compared to 2,267 government hospitals. Furthermore, an evaluation from Kerala shows the number of private hospitals that had either better infrastructure or better facilities was low. The quality of services was also affected by the fact that many of the empanelled hospitals did not have many of the required specialist services (Research Institute, Rajagiri College of Social Sciences 2009).

The long-term impact of the RSBY on the public sector and future health costs need to be considered if substantial resources continue to be channeled into the private sector. So too does the further increased hospitalization of health care need to be examined; hospital-based health coverage is only effective in reducing household expenditures when there is a robust, supportive primary health system that extends to under-served areas so hospitalization can be avoided.

Out-of-Pocket-Payments

A big part of health care expenses in India are out-of-pocket payments (Peters *et al*. 2010). RSBY can have only a limited effect in reducing out-of-pocket payments as it does not include outpatient visits or the cost

of drugs. Research by Peters and colleagues estimated that in 2004, around 63.22 million individuals or 11.88 million households fell below the poverty line due to health care expenditures, the majority of which were outpatient care costs paid out-of-pocket; the amount for each visit was small, but visits were frequent. Based on these results, the researchers point out that "schemes like RSBY have typically been designed based on strong assumptions and little evidence about the risks faced by poor households and the best approaches to addressing them" (Peters *et al*. 2010:70).

If, on the other hand, the primary health care system is functional and strong, the scheme can provide additional benefits through secondary care. In Tamil Nadu, for example, primary care and secondary care are already well provided through the public sector (Reddy *et al*. 2011). In states where the primary care is not so sound, Reddy *et al*. state that insurance schemes must aim for better integration with the public sector through a referral system.

In the absence of coverage for outpatient visits or drugs, the RSBY risks being a band-aid solution to a much larger problem. Studies have shown people delay going to a doctor for as long as they can. Such delays could lead not just to longer hospitalization but also to income loss for informal workers. Often, the impact on women's health of waiting to seek care is more severe because women are very unlikely visit a doctor if they have to pay for the services.

Gender and Access

Given the pattern of gender relations in India, the RSBY will need to do a lot more to make the scheme more accessible to women. The RSBY's national gender analyses of enrollments shows the number of men among the families issued smart cards was far greater than the number of women, in the order of two thirds to men and one third to women. There are also large gender disparities between different states. Encouragingly, though these were few, there were some districts where enrolled women outnumbered men. Trends from nine districts that have completed the second year with RSBY indicate more women may be accessing health services, which may be the result of more information being readily available (RSBY website 2011a).

Vimo SEWA Health Insurance Scheme

Launched in 1992, Vimo SEWA is a health insurance scheme that aims to help provide hospital-based coverage to poor women workers in the informal sector. Set up by the Self-Employed Women's Association (SEWA), a labour union of over 1.3 million women workers in the informal economy, Vimo SEWA has members spread across nine states of India (Shah 2008). Vimo SEWA started in 1992 with a membership of 5,000, which increased to 30,000 by 2001 and tripled in a year's time to 90,000 (Acharya and Ranson 2005). Out of SEWA's total membership of some 1.3 million women, Vimo SEWA's current membership stands at 200,000.

SEWA's members come from different sectors of the informal work force: agricultural labourers, construction workers, street vendors, and home-based workers, among others. Ela Bhatt, who founded SEWA in 1972, made special efforts to study the issues around the health of women workers in collaboration with the National Institute of Occupational Health (NIOH) in Ahmedabad. As a result, SEWA's approach to women's health is tailored to women workers' needs and focuses on reducing their barriers to access. As mentioned earlier, women workers have special needs as their health deteriorates over time due to the long hours and/or hazardous nature of their work. For instance, they have a higher rate of fractures and accidents (Desai 2009). Unsanitary living conditions and a heavy load of household work add to the strain on their bodies. Their families' needs take priority, and women often do not seek treatment for their own medical needs.

Vimo SEWA is integrated into a broad, comprehensive health care approach tailored to the needs of women workers that helps them work towards better health and makes interventions to lessen the strains on their bodies (Lund 2009; Shah 2008). In this model, SEWA Union works with women workers in general terms while SEWA Health aims to provide specific health services to the poorest among them, particularly those who are living below the poverty line (less than US $1 per day) (Ranson *et al*. 2004). SEWA's health centres provide preventive and curative services in and around Ahmedabad and in nine other rural districts.

Structure, Financing and Benefits Package

Initially, Vimo SEWA partnered with the United India Insurance Company (a subsidiary of the Government Insurance Company). However, it soon realized that insurance companies do not have any experience in insuring the poor, which requires a different approach. Eventually, in 1994, SEWA decided to run Vimo SEWA by itself. It was a new challenge, but SEWA did learn how to administer the scheme in a sustainable way. It also learned that it could increase its membership by improving the quality of its services (Shah 2008).

Vimo SEWA now provides life, hospitalization, and asset insurance as an integrated package. Membership is voluntary. Women between 18 and 55 can join the scheme as principal members and can include their husbands and children. Members remain eligible for hospitalization benefits until 70 years of age provided they remain insured every year after the age of 55 (Ranson *et al*. 2004).

SEWA's team of trained community-based health workers, called *aagewans*, interact on a regular basis with the community while providing information on how to prevent diseases and how to access services and file claims. The *aagewans* are grassroots-level workers who come from the community itself (Sinha *et al*. 2006).

Since 2001, SEWA has implemented three different insurance policies. The most popular of these policies provides coverage of hospitalization expenses up to Rs. 2,000 (US $38.91) per year. The two other, more expensive policies provide coverage between Rs 5,500 (US $107) and Rs 10,000 (US $214) per year. In all policies, hospitalization claims require 24-hour admission.[6] Vimo SEWA does not cover outpatient visits because it believes this would not be an efficient use of its limited resources. It should be noted, however, that Vimo SEWA operates in tandem with SEWA's health cooperative, *Lok Swasthya Mandali*, which provides basic outpatient primary care services to SEWA members. Vimo SEWA has, in recent years, moved to a cashless system. It has agreements with 37 hospitals – six of which are public, six private, and 25 charitable – for providing quality care to its members (Chatterjee 2007). Previously, SEWA members had to mortgage assets, sell jewelry, or go to a money lender to borrow money for health care.

Vimo SEWA members have an option of making a one-time fixed deposit in SEWA Bank, and the interest from this deposit pays the annual Vimo premium. Those members who do not take this option pay an annually revised advance premium. SEWA exempts some diseases from coverage. Premiums could range from Rs 175 (US $3.40) annually to Rs 375 (US $7.30). The premium is usually collected between October and December by SEWA's community-based workers. Vimo SEWA makes efforts to ensure sufficient communication around this process; before the date of the premium collection, meetings are held at the village level, door-to-door campaigns are organized, and materials are distributed (Devadasan 2006).

6 Information in this section on Vimo SEWA is available on their website: http://www.sewainsurance.org/aboutus.aspx

Box 2 Salient Features of Vimo SEWA

- Insurance coverage is available to SEWA members. Husbands cannot enroll unless their spouse is an enrolled SEWA member.
- Insurance covers hospitalization expenses from Rs 2,000 per year to Rs 10,000 per year.
- Hospitalization claims require at least 24-hour admission.
- Premiums could range from Rs 175 annually to Rs 375.
- Women must be between 18 to 55 years of age to enroll for annual membership.
- Life insurance coverage terminates at age 64. However, the other coverage continues so long as the member pays the premium until the age of 70. (In India, health insurance schemes do not cover those aged 70 and above although the Vimo SEWA scheme has recently changed to offer a lifetime renewal after age 70).
- Conditions exempted from coverage include chronic tuberculosis, certain cancers, diabetes, hypertension, piles, and health problems related to alcohol and drug abuse.

Source: http://www.sewainsurance.org/default.asp?iID=275 and http://www.sewainsurance.org/default.asp?iId=2

Performance of Vimo SEWA

SEWA has had significant success in improving access to health care for poor women working in the informal sector and for their families. As mentioned above, as part of a comprehensive health approach, SEWA not only provides health insurance but also works at providing primary health care through 60 stationary health centres and mobile health camps. In addition, it conducts programmes on health education and training, capacity building among local SEWA leaders, and helps provide low-cost drugs through drug shops (Ranson *et al*. 2004).

A large factor in SEWA's success is its understanding of the living and working conditions of its members, which has enabled it to reach the poorer workers and their families. Evaluations of SEWA suggest the following reasons for this achievement: SEWA takes the services to the workers rather than trying to bring the workers to the services; services are delivered by (or at least in part by) the poorer workers themselves; and services are generally combined with efforts to educate and mobilize the community. For example, prior to holding health camps, SEWA Health workers go door-to-door, educating people about the service (Ranson *et al*. 2004).

Inclusion and Access for Informal Workers

SEWA believes strongly in equity and tries to make the Vimo scheme more inclusive for all of its members, working to solve problems as they are identified. SEWA's team of trained aagewans (informal worker members themselves) work actively with members to identify problems and intervene wherever necessary. For instance, a 2003 SEWA study showed that while the poor were able to enroll in the insurance scheme, not everyone was submitting claims. A study conducted by the World Bank also found that despite Vimo SEWA including the very poor (Ranson 2001), relatively few of those members who were hospitalized were reimbursed through the scheme. It was noted that the women were not eligible for reimbursement, the claims were not eligible, or the women were not submitting claims.

The problem was compounded in the poorest areas and in rural areas. For the poorest, better access to services needed to include transport costs to the hospitals as well as admission charges especially since two-thirds of SEWA members are in rural areas. It was also difficult for this group of workers to get health staff to cooperate in filling out the forms necessary to submit a claim. On the basis of this feedback from the World Bank report, SEWA started cashless agreements with local hospitals in specific areas of Gujarat.

Knowing that its members are unable to process claim submissions, the health workers also now help them with the cashless claim submission and provide members with more education on prevention and early treatment of illnesses.

SEWA has worked pro-actively towards inclusion. There is more to be achieved, but SEWA provides a good model for interventions to reduce barriers to access to health care for informal women workers.

Information and Awareness

SEWA realizes that the deep-rooted inequalities of the health system also work as barriers that prevent hospitalization among the poorest and that women need to be empowered with information (Shah 2008). To this end, between 1985 and 2000, about 200 SEWA members were trained as local health workers for their own villages and urban neighborhoods (Dayal 2001, cited in Lund 2009). They help make referrals to hospitals and form a critical link between the members and the administrative staff. In addition, as mentioned earlier, SEWA works actively with the community so it can see the benefits of health insurance. The rapid growth in Vimo SEWA's membership numbers is a demonstration of this awareness-raising work with extremely poor women.

Quality

SEWA provides limited preventive and curative services to its members with the help of its own health centres. If necessary, health workers may refer women to a hospital and may even accompany women to the hospitals. At the same time, members are encouraged to use public health care facilities wherever possible and are provided with education on medical malpractices, a result of some studies that indicated how the poor and vulnerable segments of informal women workers may be more exposed to medical malpractice.

For instance, Vimo SEWA found 43 per cent of the claims submitted to it were for hysterectomies. Because the age of hysterectomy claimants was sometimes as low as 22 years and the average age only 37 years, it led to concerns that these were unnecessary surgeries (Desai 2009). These concerns have since been confirmed by Indian health activists who argue that many doctors are pushing Indian women into unnecessary tertiary procedures such as hysterectomies in order to claim the benefits from the RSBY (McGivering 2013). SEWA has since started educating its members, making them aware that such malpractices take place.

Despite SEWA's efforts, delay in seeking health care is fairly common among informal workers, which eventually leads to high hospitalization costs. The lack of inexpensive, good quality outpatient services in workers' neighbourhoods leads to a preference for hospitalization (Desai 2009). An analysis of Vimo SEWA's claims from 2007 to 2009 found that over 40 per cent of claims were for preventable conditions or conditions that could be treated in earlier stages without hospitalization (Desai 2009). The highest claim rates were for malaria and fevers and for the water-borne diseases of diarrhea, gastroenteritis, or typhoid (Desai 2009).

Out-of-Pocket Payments

Out-of-pocket expenditure on drugs forms a significant part of health care expenses, and even at public hospitals, patients have to pay for drugs. In fact, Vimo SEWA has found that expenditure on medicines is the primary cost component of hospitalization claims (Desai 2009).

As mentioned earlier, outpatient care and medicine are not covered under Vimo SEWA, but the Lok Swasthya Mandali (the health cooperative) does provide medicines at very low cost through its pharmacies and health workers.

Gender and Access

Even though Vimo SEWA focuses on informal women workers, its members' treatment seeking behaviour still reflects gender disparity. While women are the primary members of Vimo SEWA, claim rates for men are slightly higher, followed by children's, and, lastly, women's (Desai 2009).

SEWA has identified several barriers that affect access to health care for poor women workers. When going to a health facility, women workers must consider the inconvenience that their absence may cause to their families as they may not be able to prepare meals or fulfil other household responsibilities. Women are also least likely to seek health care if they have to incur out-of-pocket expenses. Therefore, in women, primary illnesses are often a cause of hospitalization. Eventually, this not only leads to higher costs of health care for these workers but also leads to income loss (Shah 2008). Finally, women's access to health care is also limited by the deep-rooted biases that make women themselves allocate more resources to men. This again underscores the need for providing health care in women's neighbourhoods, for health insurance schemes that cover visits to doctors, and for broader societal changes that empower women.

Yeshasvini Health Insurance Scheme

Agricultural workers account for a majority of India's informal workforce, or 253 million of the 395 million informal sector workers (NCEUS 2007). The Yeshasvini Health Insurance scheme, introduced in the southern state of Karnataka in 2003, demonstrated that it was possible to provide affordable health insurance for secondary and tertiary care to large numbers of informal agricultural workers. It currently has three million members, or approximately nine per cent of the total rural population of Karnataka state (Aggarwal 2010), making it one of the world's largest rural health insurance schemes according to Kuruvilla and Liu (2007).

The scheme was conceived by Dr. Devi Shetty, who wanted to extend health services to poorer people in rural areas. He realized that the only institutions in Karnataka that could connect rural farmers and rural peasants were cooperative societies. Karnataka has had a long history of cooperative movement; currently there are over 31,000 cooperative societies (Kuruvilla and Liu 2007).

All farmers who have been members of a cooperative for at least a year are eligible to participate in the new Yeshasvini scheme. Yeshasvini provides free outpatient consultation as well as insurance coverage for inpatient surgical procedures so as to prevent indebtedness as a result of catastrophic illnesses. Yeshasvini does not provide coverage for inpatient care if there is no surgical procedure.

Structure, Financing and Benefits

Yeshasvini charges a small premium to insure its members for high cost surgeries. Currently, the annual premium is fixed at a flat rate of Rs 120 (US $2.33) per person. In addition, a 15 per cent discount is offered on family packages for five members (Aggarwal 2010). Members can get surgical services at a network of 349 hospitals across 27 districts (Aggarwal 2010) in the state. More than 1,600 surgical procedures are covered under the scheme. The maximum coverage provided for a participant is Rs 200,000 (US $3891.40). The rate for each surgery is fixed with the network hospitals.

Yeshasvini is a cashless scheme, and members are covered for all charges associated with any surgical procedure. All diagnostic tests required before a surgery are covered as well. Patients do need to pay for their transport costs (Kuruvilla and Liu 2007).

Premiums are collected through a network of state-run postal offices, which also track monthly payments and issue the Yeshasvini member cards. By early 2005, the scheme covered a quarter of the cooperatives' 10

million members (Khanna *et al* 2005). The scheme is a self-funding one, governed by the Yeshavini Trust. By collecting the insurance fees upfront for a year, the Trust was able to minimize its initial need for funds.

In addition to its self-funding, the scheme receives considerable subsidies from the government, amounting to Rs 40 million (US $778,280) in the third year of operation (Radermacher *et al*. 2005). It is now considered a "state government programme," with the state now contributing half of the farmer's premiums. The fact that the programme utilizes state government health facilities also cuts down on the scheme's financial costs.

Box 3 Salient Features of Yeshasvini Health Insurance Scheme

- The annual premium is a flat rate of Rs 120 per person.
- The scheme is cashless, and members are issued a Yeshasvini member card.
- The maximum coverage provided for a participant is Rs 200,000.
- Only surgical procedures for inpatients are covered. More than 1,600 surgical procedures are covered under the scheme.
- Free outpatient consultation at all participating hospitals is included.
- Diagnostic tests are required before surgeries are covered.
- Patients do need to incur transportation costs.
- Premiums are collected through a network of state-run postal offices.
- From 2006, the following medical benefits were included: dog bite; snake bite; bull gore injuries; drowning; electric shock; and other accidents occurring while operating agricultural implements. In addition, vaginal birth, neo-natal care and angioplasty procedures were also included.

Source: http://www.yeshasvini.kar.nic.in/

Performance of Yeshasvini

Yeshasvini has made an impact in covering some high-cost procedures. Numerous studies have analyzed and commented on the financial protection against health risks that it has managed to provide for poor farm workers (Grossman 1972, cited in Aggarwal 2010). For example, Aggarwal states that as the scheme prevents delays in seeking care and treatment outcomes are likely to be better and recovery faster. This also reduces the risk of serious income loss for informal workers, who need to be back at work early considering they rely mainly on their own labour and on assets such as livestock for income generation (Aggarwal 2010). Yeshasvini has also managed to overcome several obstacles in trying to reach informal workers, especially agricultural labourers. These groups are often not a homogenous category; they are geographically dispersed and difficult to reach. They are often poor, without any income, and are in need of social security. Because of these barriers, any prior work with this group had only been taken up by non-governmental organizations; the private sector had not yet ventured into creating such a scheme (Kuruvilla and Liu 2007).

The scheme has also been successful because it has managed to develop a highly successful partnership with the cooperative sector. The state government of Karnataka stepped in, with the Department of Cooperation urging cooperative societies to get their members to join. When the scheme was launched, members had access to free treatment at 150 hospitals for up to Rs 100,000 (US $1,945.70) for Rs 5 (US $.10) a month. The government support and subsidies mentioned earlier have also helped significantly.

However, there is disagreement on the long-term financial sustainability of the scheme, which now depends heavily on the state government subsidies mentioned earlier. Aggarwal (2010) argues that Yeshasvini is not financially sustainable because even though it has large numbers of members, it provides high-cost surgeries at very low cost. However, a Harvard Business School case study views Yeshasvini as a successful

model that has demonstrated it is possible to enroll large groups of poorer people in a low-cost insurance scheme, which, because of these large numbers, can function without incurring any losses. The case study estimates only eight per cent of policyholders would require medical procedures, and thus the total funds collected would cover the costs of treatment (Khanna *et al*. 2005: 10).

The case study specifically shows that the scheme used existing infrastructure to reduce costs: it did not have to create additional health centres; the state had enough open hospital beds (the average occupancy of hospitals in Karnataka was only 35 per cent before Yeshasvini was launched, mainly due to lack of affordability); and there were 30 private medical colleges, each with over 500 beds (Ibid).

Access and Inclusion for Informal Workers

The enrollment schedule has been kept long and flexible, namely spread across five months from January to May. These are the months when cash crops such as cotton and sugarcane are harvested, making it easier for farmers to pay the subscription. The mode of payment is also flexible: it is decided by the local cooperative societies depending on local conditions. The scheme demonstrates a strong component of community ownership, along with strong management, which has contributed to its success (Aggarwal 2010). However, there is still poor enrollment with only 35 per cent of the target population covered (Reddy *et al*. 2005), which points towards the necessity of actively doing awareness programmes.

Information and Awareness

Health camps are regularly organized to spread awareness among the people about health and health insurance. The scheme depends heavily on cooperative societies to reach out to its members.

Quality

The Yeshasvini scheme developed out of an efficient partnership between the government, private, and cooperative sectors and made use of their respective strengths to provide quality health care to vulnerable groups and the hard-to-reach population of agricultural workers (Aggarwal 2010). Further, it seems the constraints of quality in the health system have not affected the services delivered through Yeshasvini – none of the research so far has pointed to problems of quality with the Yeshasvini scheme (Aggarwal 2010). In fact, Yeshasvini has been pointed out as one of the most innovative programmes in community health financing in India.

Yeshasvini has developed detailed procedures for enrollment, empanelment of hospitals, treatment and claim settlement, and monitoring. It has its own system of evaluating hospitals (some of them super-specialty) before they can join the network. The hospitals enrolled in the scheme have at least 25 beds and are equipped with modern health facilities. To avoid the risk of unnecessary surgeries, Yeshasvini has a fixed rate, which is 40 to 50 per cent below the market rate, meaning that doctors have less financial incentives to perform surgery. These rates have not been modified since the scheme was launched despite inflation.

Out-of-Pocket Payments

The scheme does not provide comprehensive health care and provides mainly tertiary care. Therefore, it has no impact on out-of-pocket expenses that may be incurred by people who require drugs and outpatient care. The aim of the scheme is to reduce indebtedness due to catastrophic health causes.

Gender and Access

About 60 per cent of Yeshasvini's members are men and 40 per cent are women. Women often are not members of farmer's cooperatives that the scheme reaches out to. Research has shown that the cooperative member, usually a man, is the first to enroll and family members may come later. Thus, as in the other schemes, fewer women are able to get access, and a more targeted approach needs to be devised so the benefits of these schemes can start to reach women in larger numbers. Yeshasvini has started offering a reduced fee for the household to help with women's enrollment (Radermacher *et al*. 2005).

Rajiv Aarogyasri Health Insurance Scheme in Andhra Pradesh

Rajiv Aarogyasri was launched by the government of Andhra Pradesh in 2007 to provide health coverage to the below poverty line population in the state. The scheme has now extended its mandate to include above poverty line families and is providing coverage to 20.4 million families, comprising about 85 per cent of the total population of the state (Reddy *et al*. 2011).

Structure, Financing and Benefits

The scheme is run by the Aarogyasri Health Care Trust, set up under the chairmanship of the Chief Minister and administered by a Chief Executive Officer from the Indian Administrative Service. A single insurance company, selected through competitive bidding, administers the scheme under the overall supervision of the state government.[7]

The scheme provides health insurance for hospitalization up to Rs 200,000 (approx. US $ 4500) in a year at a network of 200 approved public and private hospitals. It covers major tertiary care expenses, including expensive procedures and immediate pre-and post-operative expenditure. Patients can select the hospital where they want to be treated.

The scheme is cashless, and the government covers the cost of the premium as well. On enrollment, beneficiary households receive a Rajiv Aarogyasri Health Insurance Card. Those holding a "white card" – given by the state to BPL families – are readily provided with the Aarogyasri health card. There is no limit on the number of family members that can be enrolled.

The benefits package includes 942 surgical procedures and 144 medical diseases. There is no deductible or co-payment for those seeking care. Providers are paid on the basis of rates specified by the Aarogyasri Trust in consultation with medical experts. The payment covers the entire cost of treatment from the date of admission to discharge as well as a maximum of 10 days after the discharge. Any complications occurring while the patient is still in hospital are covered as well. The package rate includes consultation, medicine, diagnostics, implants, food, cost of transportation, hospital charges, and post-operative hospital stay (Joint Learning Network N.d).

The scheme uses health workers to help beneficiaries navigate the system. Aarogyasri has a team of 4,000 *Aarogya Mithras* (health workers), who work in primary health centres across the state. These health centres are often the first points of contact for most families seeking care. District hospitals and network

7 This information and details about the scheme are available at: https://www.aarogyasri.gov.in/en.

hospitals also have help desks manned by Aarogya Mithras to facilitate smooth service delivery for Aarogyasri beneficiaries (Joint Learning Network N.d).

Under the scheme, all network hospitals are required to hold a specified number of village health camps in order to maintain their network status. The health camps help in screening for diseases as well as in providing preventive care. Minor ailments are treated at the camp itself, and those people that require further consultation are referred to network hospitals free of cost under Aarogyasri benefits (Joint Learning Network N.d).

Box 4 Salient Features of Rajiv Aarogyasri

- The scheme is cashless. State government covers the cost of the premium.
- Major tertiary care expenses, including expensive procedures, are covered.
- Health insurance is provided for hospitalization up to approximately US $4,500 a year at a network of 200 approved public and private hospitals.
- Transport costs are covered for the patient identified for surgery or treatment.
- There are Aarogyasri assistance counters at every network hospital.

Performance of Aarogyasri

Andhra Pradesh has managed to extend the scheme to the entire state and, as Reddy *et al*. conclude, the scheme is achieving "equity and universalism in a limited sense" (Reddy *et al*. 2011:27). It falls short of providing universal health coverage to the state's entire population and, as with the other schemes reviewed in this paper, fails to achieve more comprehensive health coverage as its focus is mainly tertiary care.

With vast amounts of money being spent on running the scheme, long-term sustainability is an issue. The state is spending a total of Rs 17.25 billion (US $300 million) a year on the scheme in addition to Rs 9.75 billion (US $190 million) as premiums for health insurance to below poverty line families (*Times of India* 2011). Finding it difficult to sustain the cost, the state government asked the central government to share the costs, but this was refused (*Times of India* 2011).

Inclusion and Access for Informal Workers

The scheme has reached a large number of beneficiaries: about 11 per cent of the BPL population in the state was utilizing the scheme in 2008, about 87 per cent of whom were from rural areas. As the following discussion will show, however, this fact does not mean that the scheme has been able to provide good quality services to its beneficiaries. It is also difficult to know how many informal workers specifically have been reached by the scheme as it does not categorize its members by status in employment. However, as informal workers make up such a large share of total employment in India (NCEUS 2007), it can be assumed that a large proportion of its members are informal workers.

Information and Awareness

The scheme depends mainly on the 500 health camps set up in 13 districts by about 180 network hospitals (Joint Learning Network N.d). These health camps treat around 4,000 people daily and work as mobilizing centres to enroll people in the scheme. Other points of outreach are the primary health centres and government hospitals in the district, where the representative of the insurance company has an Aarogyasri help desk. On the recommendation of the doctors, the help desk refers patients to the hospitals in the network.

Quality

The state government is already finding ways of pruning costs associated with the scheme. For example, since November 2011, it has decided to remove 133 procedures from the list of benefits obtainable through the private sector. At the same time, some media reports state some government hospitals are not taking up Aarogyasri cases. Moreover, medical associations point out that government hospitals in small towns and districts do not have the infrastructure to handle the surgeries they are taking over from corporate hospitals. Again, there have been problems with malpractice, where unnecessary surgical procedures such as hysterectomies, tonsillectomies, and appendectomies have been recommended by private hospitals so that they can make claims on state resources. Many of these unnecessary surgeries (68 per cent) were performed on women aged 21 to 40 (Reddy *et al*. 2011).

Out-of-Pocket Payments

As with other schemes, evaluations have found that people were paying for various conditions that were not covered by the scheme, such as diarrheal diseases (IIPH-Hyderabad 2009, cited in Reddy *et al*. 2011). In a survey conducted in Andhra Pradesh, 58 per cent of the Rajiv Aarogyasri Scheme patients reported having incurred out-of-pocket expenses with an average Rs 3,600 (US $70) per patient (IIPH 2009, cited in Reddy *et al*. 2011).

A survey conducted by Mitchell *et al*. (2011) found that households incurred out-of-pocket expenses not only for care at hospitals, but at all levels of health facilities and providers. This suggests that there has been little reduction in households' medical expenditure, even after Aarogyasri. The survey also found that households holding the Aarogyasri card reported as high or higher treatment costs compared to those without the card. The researchers concluded that care at these facilities is far from costless:

> Reported costs of treatment ranged from around Rs 500 for those who sought care with RMPs (registered medical practitioners) to over Rs 1,900 for those seeking care at private hospitals. Further, those experiencing protracted illnesses (that is, a duration of more than two weeks) faced costs upwards of Rs 4,300 at private hospitals.
>
> (Mitchell *et al*. 2011:18)

Gender and Access

It is not clear how many women are actually accessing health services through the scheme. As the scheme does not impose any limitations, there is much more scope of women enrolling for the scheme, but data on usage of services by gender is not available.

Discussion and Conclusions

This section draws together threads of comparison and difference between the schemes and presents some questions and implications for further policy reform. In summary, this paper has looked at four different health schemes operating in India. The schemes are all financed differently. They range from the central government funded RSBY and the state government funded Rajiv Aarogyasri Scheme to private sector and community-based financing models (Vimo SEWA and Yeshasvini schemes). They also vary in scope between those that operate in a single state to those that operate over all or most of India. Finally, all of the schemes target the poor, but only one specifically targets poor women (Vimo SEWA), two explicitly target poor workers (Vimo SEWA and Yeshasvini), and one includes specific occupational groups (RSBY). Across all of the above differences, what this paper has shown is that health schemes that are rooted in highly unequal societies are likely to reproduce that inequality. However, it is also clear from some of the ex-

amples that the institutional reproduction of inequality can, to some extent, be mitigated if health schemes are integrated into programmes that seek to improve living and working conditions more generally. Vimo SEWA is an obvious example of this, integrating its health insurance scheme with occupational health and primary health services as well as with livelihood programmes. The Yeshasvini scheme, by rooting itself in the cooperative movement, has achieved this in a more limited way. The RSBY, on the other hand, has not been based on such a solid ground – it is a product of a highly unequal society where, relatively speaking, much less work has gone into uplifting the lives of the poor. Scant attention has been paid to the state provision of basic primary healthcare, so much so that Vimo SEWA itself worries about the quality of care its members will receive in government institutions. In this context, it is unlikely that such a health insurance scheme would serve to lessen health inequalities.

There is much that the RSBY could learn from Vimo SEWA in terms of a more comprehensive approach to healthcare. Vimo SEWA provides access to primary care through a network of SEWA health centres. SEWA's comprehensive approach has a strong component of disease prevention and education. It also facilitates availability of high quality, low-cost drugs. However, Vimo SEWA is a member-based, worker-oriented scheme that works through highly motivated community-based workers; it may not be scalable to a national level. There are important lessons, however, in the Vimo SEWA model on working with members and on how best to make health insurance schemes more inclusive for the poorest of the poor. A considerable measure of Vimo SEWA's success has been its ability to reach some of the poorest workers, a challenging task given their marginalization and inability to access information.

Focus on Inpatient Care

The major focus of health insurance schemes in India is on hospital-based care. Most of the schemes do not provide coverage for outpatient care or the cost of drugs. This leaves a big gap in their objective of preventing impoverishment due to health care. Berman *et al.* (2010) have shown that outpatient care leads to more impoverishment than inpatient care. The schemes may thus be having only limited impact in reducing household expenditure on health care.

The focus on hospital-based coverage may also be leading to delays in treatment and incentivizing people towards electing for inpatient care. Experience from Vimo SEWA shows how the design and structure of health insurance schemes that focus more on hospitalization could act as a disincentive in seeking early care, more so for informal workers. In the absence of affordable outpatient care, the poor often do not seek treatment until they are not able to work at all. By the time they seek treatment, it may be more expensive and may translate into more wage loss due to their inability to earn incomes during and after hospitalization (Desai 2009).

In a little over three years, the RSBY has provided hospital-based insurance coverage to about 100 million people in a challenging and complex political and administrative environment. This alone is no small achievement. For a large number of India's poorest, it has helped provide access to hospital-based care that they could not have accessed earlier. An IT-enabled network of hospitals and insurance companies has ensured efficient and cashless delivery of health care to people below the poverty line through the use of a simple card across the country. However, for the RSBY to be able to provide a more comprehensive health care that truly reduces the burden of health costs on poor households, some areas need to be strengthened and gaps addressed. Hospital-based coverage may work well in areas that have a robust public health system with a strong primary health care component, but India's public health system is weak, and primary care is among its weakest components. Hence, this means poorer people still have to pay substantial health costs.

Cost of Drugs

The cost of drugs also imposes a high economic burden on impoverished households. The unregulated health sector environment has dissuaded health insurance schemes from including drugs in their package

as it is easy to purchase prescription drugs over- the-counter. A physician-pharmacist nexus may also drive up costs of unnecessary prescriptions. The government needs to regulate the system and bring in an essential medicines list as well (Reddy *et al*. 2011).

Focus on Tertiary Care

While large amounts of public money are being spent on health care by both the central and state governments, much of the spending is only on tertiary care. Reddy *et al*. (2011) suggest that a disproportionate share of government spending – over one-fifth of all government spending during 2009-10 – is going towards tertiary health. In the states of Delhi, Andhra Pradesh and Tamil Nadu, over half of all government expenditure on health care is on tertiary care. Delhi spends about 52 per cent of its budget on hospital care (Reddy *et al*. 2011). Yet, for poorer informal workers, primary health care services are crucial in allowing them to prevent or treat illness early on so that they may continue working.

Information

People, especially poorer people, need to know about schemes, what they offer, and the conditions for access if they are to take advantage of them. The RSBY appears to contain a structural problem where the information function is not being adequately taken up either by the central state or the private insurance companies. SEWA uses education about insurance given by its own health educators as a critical link in both providing information and in making referrals to hospitals. Both Yeshasvini and Aarogyasri use health camps (as does SEWA in a more limited way) and Yeshasvini makes extensive use of the cooperatives through which it works to reach out to members and inform them of the health services available.

Gender and Access

A high level of gender bias that disadvantages women is reflected in the usage of both the RSBY and Yeshasvini. Vimo SEWA has studied in detail the barriers faced by women in accessing health care. It actively works towards improving services to be able to get past some of the barriers. Given the poor state of women's health in India, the schemes, overall, do need to place special emphasis on how to improve women's access to health services.

Issues of Access by the Poor

At the same time, another issue that the implementation of RSBY raises is that of access to health services itself. Inclusion under RSBY is being determined on the basis of BPL, and there are question marks over the way people have been included in the BPL list. There is also a bigger issue of the distinction between people above and below poverty line. Some of these issues will need to be worked through as the RSBY achieves more breadth of implementation. The RSBY eventually intends to cover approximately 350 million BPL informal sector workers. This will still leave out a significant number of informal workers above the poverty line, (Reddy *et al*. 2011) an issue that will need to be addressed urgently.

Barriers for Migrant Workers

While the RSBY is making efforts to remove barriers faced by migrant workers by allowing portability of health smart cards across states, it may still be missing out on migrant workers in many places because

of its design. It is possible that many families on the BPL list who could not be traced are migrant workers. These families, who may have migrated for long periods of time to another state, will not be able to use benefits under the scheme until the time they return and register on the basis of the BPL list in their home state (Sharma *et al*. 2008). With the rapid increase in the number of in-country and cross-border migrants worldwide, this is an important and urgent issue.

Private Sector Involvement

Another area of concern is the nature and extent of private sector involvement. Except in Vimo SEWA, which makes a concerted effort to get its members to use services from the public sector, the other schemes, operated through commercial health insurance companies, have moved towards having 70 to 90 per cent private healthcare providers (Reddy *et al*. 2011). This may well be necessary due to the weak public sector in some areas, but as this selection has been left to commercial insurance companies, it is possible that private sector service providers are being preferred. This also raises several issues about the private sector's long term impact on the public health system, on the sustainability of the scheme, and on escalation in healthcare costs.

It is not very clear at this stage how many of the high cost schemes such as Rajiv Aarogyasri are actually sustainable over the long term. Some signs of distress are evident in Aarogyasri's attempts to cut costs by limiting the numbers of procedures that can be done by private practitioners. However, this cutting needs to be done in a more ordered manner depending on which services are available where.

Quality

Quality of care in the private sector is highly varied. It ranges from unqualified people practicing as doctors to world-class hospitals. In many places, private hospitals are not well equipped to provide all services. There is an urgent need to regulate the private sector, which so far has functioned without any protocols or standards.

It is not clear at this stage what kind of health monitoring is taking place in a large scheme such as the RSBY. Has it started to make any difference to health demographics? Is the IMR, especially in rural areas and poorer urban areas, starting to decline? A health scheme needs to be transparent about its impact on health. The scheme is being administered by the Ministry of Labour, but the Ministry of Health needs to be involved as well to monitor and set quality standards. The issue of needless surgeries deserves attention. An unregulated environment, a highly vulnerable population and for-profit hospitals, aided and abetted by commercial insurance agencies, could become a toxic and lethal mix.

The RSBY has created a vast IT-enabled network of hospitals across India, a challenging task, and the achievement should be applauded. There is an opportunity to build on it and integrate the large number of insurance schemes that have been launched in recent years. States need to use the resources being provided by RSBY and then consider top ups, instead of duplicating efforts, which too are not leading to the desired impact of reducing out-of-pocket costs.

Finally, it is time to get rid of a two-tier system of health care: world-class hospitals for the rich and poor quality hospitals for the poor, where deaths due to apathy and neglect can go unchecked and unnoticed. This paper has shown that India has schemes in place which demonstrate that a range of institutional innovations are possible in terms of bridging this divide. What is also clear, though, is that without a comprehensive approach to raising the living standards of poor workers, including the provision of primary healthcare and preventive health services, health inequities are unlikely to decline significantly.

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