

The RSBY scheme as a pathway towards universal health coverage in India: assessment of its performance and implementation

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52nd Master of Public Health/International Course in Health Development

September 21, 2015 – September 9, 2016

KIT (ROYAL TROPICAL INSTITUTE)

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The RSBY scheme as a pathway towards universal health coverage in India: assessment of its performance and implementation

A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

by

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Declaration:

Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis "Facilitators and barriers to universal coverage in India" is my own work.

Signature.....

52nd Master of Public Health/International Course in Health Development (MPH/ICHD)

September 21, 2015 – September 9, 2016

KIT (Royal Tropical Institute)/ Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

September 2016

Organised by:

KIT (Royal Tropical Institute) Health Unit

Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/ Free University of Amsterdam (VU)

Amsterdam, The Netherlands

Contents

Chapter 1: Background Information on India	1
1.1 Political profile	1
1.2 Demographic and socio-economic profile	1
1.3 Health and epidemiological profile.....	3
1.4 Overview of the Indian health system	3
1.5 Health financing in India.....	4
1.6 Health insurance in India	6
Chapter 2: Problem statement, Justification, Objectives and Methodology	8
2.1 Problem statement.....	8
2.2 Justification	9
2.3 Objectives	10
2.4 Methodology	10
2.4.1 Analysing public policies.....	10
2.4.1.1 Public policy: A brief mapping of the concept	10
2.4.1.2 Public policy analysis: A brief overview	11
2.4.1.3 Methodology of Public Policy Analysis.....	12
2.4.1.4 Conceptual framework of the study	13
2.4.1.5 Study Approach	15
Chapter 3: Study Results and Findings.....	16
3.1 Analysis of the Rashtriya Swasthya Bima Yojna (RSBY) scheme's performance	16_Toc469573877
3.2 Effectiveness	17
3.2.1 Low awareness	18
3.2.2 Gap between actual and target for enrolment.....	19
3.2.3 Gap between actual and target utilization.....	21
3.2.4. Extent of OOP mitigation.....	22
3.3 Unintended effects	23
3.4 Equity	24
3.5 Costs	24
3.6 Feasibility	25
3.6.1 Misaligned incentives and low premium	25
3.6.2 Problematic BPL list.....	26
3.6.3 Public-Private choices	26
3.6.4 Pricing of packages	27
3.6.5 Technology	27
3.6.6 Settlement of claims	27
3.6.7 Grievance redressal and monitoring.....	28

3.6.8 Narrow coverage.....	28
3.6.9 Lack of hospitals	29
3.7 Acceptability	29
3.7.1 Providers	29
3.7.2 Card holders.....	30
3.7.3 Insurance and TPAs	30
Chapter 4: Discussion of Findings.....	31
4.1 Evidence informed approaches to improve RSBY	31
4.1.1 Primary care, outpatient treatment and medicines:	31
4.1.2 Awareness generation.....	32
4.1.3 Claims processing:	32
4.1.4 RSBY PLUS:.....	33
4.1.5 Fiscal sustainability:	33
Chapter 5: Conclusion and recommendations.....	34
5.1 Conclusion.....	34
5.2 Recommendations	35
5.3 Study limitations	35
References.....	36

List of abbreviations

TPA	Third party administrator
THE	Total Government Health Expenditure
OOP	Out of pocket expenditure
CGHS	Central government health scheme
JBY	Janashree Bima Yojana'
NCCHPP	National collaborating centre for health public policy
CHIAK	Comprehensive health insurance agency of Kerala
CHE	Catastrophic health expenditure
AABY	Aam admi bima yojana
MGNREGA	Mahatma Gandhi National rural employment guarantee act
GOI	Government of India
UN	United Nations
WHO	World Health Organisation
ESIS	Employment state insurance scheme
GDP	Gross Domestic Product
PHRN	Public health resource network
NHRC	National Human Rights Commission
WHR	World Health Report
GNI	Gross National Income

UNDP	United Nations Development Program
NHS	National Health Service
GGE	General Government Expenditure
GSHIS	Government sponsored health insurance scheme
HELP	High level expert committee
NCD	Non communicable disease
IMR	Infant mortality rate
MOHFW	Ministry of health & family welfare
MMR	Maternal mortality rate
NFHS	National family health survey
NCD	Non communicable diseases
NHP	National health policy
RSBY	Rastriya Swasthya Bima Yojana
RGJAY	Rajiv Gandhi Jeevandayee Arogya Yojana
SHI	Social health insurance
APL	Above Poverty Line
BPL	Below Poverty Line
THE	Total health expenditure

List of figures and tables

List of figures

Figure 1: Political map of India.....	1
Figure 2: Logic model for effect of RSBY.....	7
Figure 3: Trends in OOP (1993-2012).....	21

List of Charts

Chart 1: Distribution of current health expenditure by source of financing.....	5
Chart 2: Health Financing (2013-13).....	5
Chart 3: Health Financing Schemes.....	5

List of Tables

Table 1: Dimensions for analysing the RSBY scheme.....	11
Table 2: Search Table.....	16
Table 3: Implementation status of RSBY.....	18

Acknowledgement

I would like to thank everyone involved in making this thesis possible even though I am unable to name them all here.

First of all, my sincere gratitude goes to my thesis advisor and back-stopper for their patience, gentle prodding and guidance. This thesis would not have been possible without them.

I wish also to thank the entire faculty at KIT especially the course co-ordinators - Zwanikken P, Gerretsen B, Kane S, Annemarie TV, Molenaar M and Sahebodin R, for the warm welcome, understanding and support throughout the rigorous academic year.

I would like to thank the Royal Tropical Institute and the Netherlands government (NUFFIC) for the wonderful opportunity to gain a master's degree in public health and the chance to experience Europe.

Finally, I would like to thank my wife and my family for supporting me always.

Abstract

Introduction

The RSBY health insurance scheme was launched in 2008 to combat medical impoverishment and increase health access for the BPL population of India. However, its effectiveness remains in question.

Objective of the study

The objectives of the study are to appraise the existing literature on the performance of the RSBY scheme and to suggest improvements using evidence informed approaches from India and abroad.

Methods

The study is based on a literature review of published articles, policy documents and official data available from the RSBY online database. The study used the framework for analysing public policies developed by the National Collaborating Centre for Healthy Public Policy (NCCFHPP).

Findings

There is inadequate level of awareness, low to moderate enrolment and poor utilization. OOP spending has not declined since the launch of RSBY. Performance is affected by weakness in design and poor implementation by TPAs, Insurers and hospitals.

Conclusions

Despite the grand scale of the scheme, the RSBY has some limitations in both the design and operations. Due to the numerous actors involved in implementation, the management has become complicated and the question of feasibility on whether there exists a reliable system of incentives and sanctions, and administrative mechanisms to guide the activities of all actors remains valid.

Recommendations

The RSBY should not only be hospital centric but include primary care with medicine reimbursements for OPD services, input better grievance redressal and monitoring mechanism, expand enrollee base to include premium paying population and/or integrate with existing schemes - ESIS and CGHS.

Key words: RSBY, India

Word count: 12,451

Chapter 1: Background Information on India

1.1 Political profile

India is the seventh largest country in the world and the second most populous nation with over 1.3 billion people after China. Politically, India is divided into 29 states and 7 Union territories and follows a federal system of parliamentary democracy. Traditionally, the Indian governmental system has been known as a ‘quasi-federal’ system with a strong centre and subservient states. For administrative purposes, each state is sub-divided into districts, sub-districts and villages. Sub-districts are known by a variety of local names such as tehsils, talukas, blocks, mandals and sub-divisions. Villages and urban local bodies are the lowest sub-division in rural India and urban India respectively. The Gram Panchayat is the smallest administrative unit. Each Gram Panchayat covers a large village or a cluster of smaller villages with a combined population exceeding 500.

Figure 1: Map of India



Source: Prokerala.com

1.2 Demographic and socio-economic profile

With over one sixth of the world's population and a population growth rate of 1.2 %, the current projections show that India is expected to take over from China as the world's most populous country by 2020 India has one of the youngest populations in the world with more than 50 % below the age of 25 years and more than 65 % below the age of 35 (UN, 2015). The sex ratio for India at the last census in 2011 was 940 females per 1000 males. In India, the northern state of Uttar Pradesh is the most populated with 190 million while Dadra and Nagar Haveli and the southern island of Lakshadweep are the least populated with 34 0000 and 64,000 people, respectively. The population of India is diverse and consists of more than two thousand ethnic groups and is represented by four families of languages namely Indo-European, Dravidian, Austroasiatic and Sino-Tibetan as well as other smaller language isolates. India is also home to all the major religions of the world.

According to the World Bank, India today is one of the world's fastest growing economies with a GDP growth rate of 7.6 % per annum and a per capita Gross National Income (GNI) of US\$ 1590 in 2015. Currently the 7th largest economy in the world in terms of its nominal GDP, and though it remains predominantly an agricultural economy, the recent growth is driven by the services sector. However, socio-economic inequalities continue to exist with 21.3 % of the population still below the poverty line at US \$ 1.90 per day (World Bank, 2016). Although adult literacy rate has improved with a national average of 74 %, there continues to be a big gender disparity with a rate of 82.14 % for men and 65.46 % for women. In terms of human development index, India continues to rank low at 130th among 188 countries, and there are wide disparities between urban and rural India (UNDP, 2015) About 70 % of India's population live in rural areas, with 51% engaged in casual manual labour and just 30 % depending on cultivation as their 'main' source of income (Ministry of rural development GOI, 2011). In rural India, the deprivation levels in rural India are still very high. The socio-economic and caste census data of 2011 points to the main earner in 74 % of all rural households drawing a monthly income below Rs.5,000 (\$100 USD) (Ministry of rural development GOI, 2011)

1.3 Health and epidemiological profile

In India, about 1/4th of all mortality is caused by diarrhoeal diseases, tuberculosis, malaria and respiratory infections. India is experiencing an epidemiological transition with the rise of non-communicable diseases such as cancer, diabetes, cardiovascular diseases etc. owing to changing lifestyles from rapid urbanization and economic growth, communicable diseases such as TB, viral encephalitis, malaria, kala azar, dengue, chikungunya and other vector and water borne diseases such as cholera, diarrhoeal diseases, leptospirosis continue to be prevalent. As with other developing countries, India faces a triple burden of diseases which is a) a backlog of common infections, undernutrition, and maternal mortality b) emerging challenges of Non Communicable Diseases (NCDs) such as cancer, diabetes, heart disease and mental illness, and c) problems directly related to globalization such as pandemics and health consequences of climate change. Overall, communicable diseases account for 24.4% while maternal and neonatal ailments contribute to 13.8% of the entire disease burden. At present, NCDs and injuries at 39.1% and 11.8% respectively constitute the bulk of the India's disease burden (Central Bureau of Health Intelligence GOI, 2015). In India, Infant mortality rate has seen a 50% decrease during 1990-2012 with current rate at 39 per 1000 live births in 2015. Maternal mortality ratio has also seen a decrease from 437 in 1990 to 181 per 100,000 live births. Under-5 Mortality currently stands at 47.7 per 1000 live births with life expectancy at 68.3 years and fertility rate at 2.4% for the country. Sanitation in India, however, continues to be a major problem. Even though the percentage of population having access to improved water source has risen to 94.1%, the percentage of population having improved sanitation facilities remains low at 39.6% with even lower rates when segregated for the rural areas (Central Bureau of Health Intelligence GOI, 2015)

1.4 Overview of the Indian health system

Since independence, the Indian health system has been governed by a federal structure between the centre and the states. Health is designated as a state subject and the states are given the primary responsibility for health service delivery while the task of devising comprehensive health policies, national health programmes for infectious diseases etc. are the mandate of the central government. At the national level, the organizational structure is headed by the Union ministry of health and family welfare. At the state level, the organizational structure flows from a state department of health and family welfare to a regional set-up covering 3-5 districts. Each district level unit is served by several primary health centres (PHC) covering 30,000 population (20,000 in hilly, desert or difficult terrain)

supported by a sub-centre. The sub-centres are the most basic unit of health at the village level, catering to a population of 5000 (3000 in hilly areas) and serve as the first point of contact to the public health care system in India. The Indian health system provides allopathic, homeopathic, ayurvedic and other forms of traditional health services. Since the last few decades, the private sector has seen a predominant presence in India, with the private health sector now providing about 80 % of the total outpatient and 60 % of the total inpatient care across the country. With this high dependence on private providers, who are primarily profit-driven, health services are concentrated in the urban areas (Loh et al, 2013). However, the majority of India lives in the rural areas primarily served by underfunded government medical facilities. Further, a big part of healthcare expenses in India are out-of-pocket payments. Out of pocket spending accounts for almost 70 % of the total health expenditure of the country (MOHFW, 2014)

1.5 Health financing in India

Countries around the world follow different mechanisms of financing for their health systems. Health financing involves the functions of revenue collection, pooling of resources and purchasing of health services. These financing functions can be broadly categorised under 3 main health financing models, namely (a) the National Health Service or Beveridge Model, characterised by compulsory universal coverage, national general revenue financing, and national ownership of health sector inputs. An example of this system is the NHS in UK. (b) The social health insurance or Bismarck model with compulsory universal coverage under a publicly mandated social security system financed by employee and employer contributions to non- profit insurance funds with public and private ownership of sector inputs. A good example being the Social Health Insurance in Germany; (c) The Private Health Insurance or Consumer Sovereignty Model which is employer based or individual purchase of private health insurance and private ownership of health sector inputs. Example of the private insurance model is the USA. (Schieber G et al, 2006)

In India, the three forms of health financing exist in some form or the other, simultaneously. There is a tax- financed public delivery system providing for primary to tertiary care, several government financed health insurance schemes for government employees and Below Poverty Line (BPL) and the unorganised worker populations, as well as a growing private health insurance sector. Although health is primarily the responsibility of the individual 29 states, the central/union government takes the bigger responsibility of this source of financing.

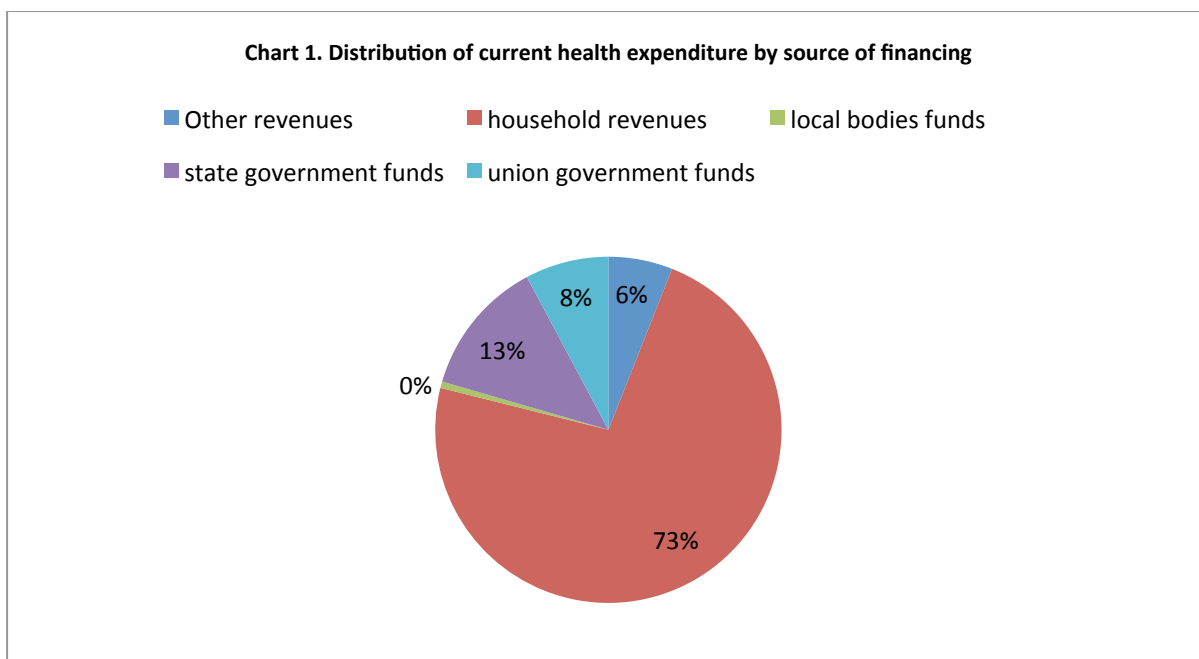


Chart 1: Distribution of current health expenditure by source of financing

Indicator	percentage
THE as % of GDP	4 %
TGHE as % of THE	28.6 %
Govt exp on health as % of GD	1.2 %

Chart 2. Health financing (2013-14)

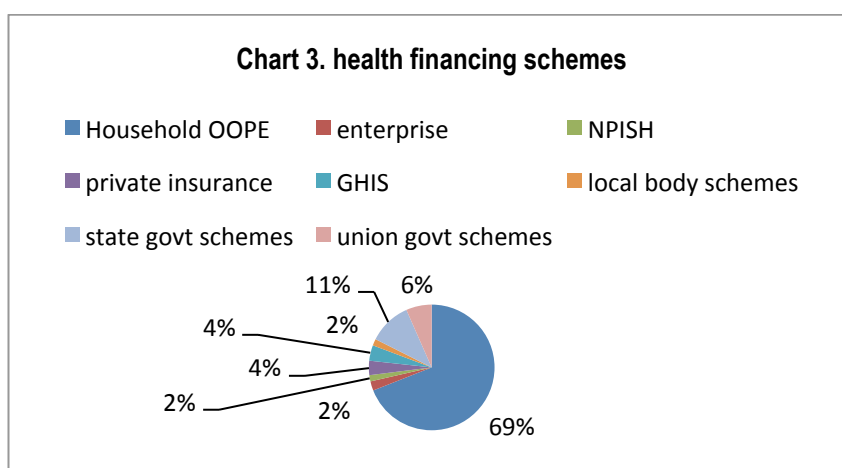


Chart 3: Health Financing Schemes

Source: National Health Accounts estimates for India 2013-14

As can be observed from chart 2, about 73 % of health care expenditure is financed from household revenues which include prepayment costs for public and private insurances. With 69 % of the Total Health Expenditure (THE) in 2015, out of pocket (OOP) spending in India forms the main source of health financing. The total government spending on health is just about 1.2 % of GDP in 2014 and has not seen any increase in 2015-16. This is low compared to the government expenditure on health in China at 3 %, USA at 8.3 and a global average of 5.4 % GDP (Loh et al, 2013). In India, medical impoverishment can be broken down as 79 % due to outpatient costs made up of small but frequent payments and only 21% due to inpatient care costs. Of these, “70% of the total OOP expenditure is on purchase of drugs” (Berman P, 2010; Garg and Karan, 2009).

1.6 Health insurance in India

India began introducing health insurance with the Employees State Insurance scheme (ESIS), for low salaried formal sector workers and the Central government health scheme (CGHS) for civil servants in 1952 and 1954 respectively. Although subsidised by the government, these schemes are on contributory basis and confined to a small segment of the population. The two schemes currently cover about 5 % of the population or about 60 million people in India. According to the Insurance Regulatory and development Authority (IRDA) approximately 17 % of the population have some form of health insurance in India; with about 15.5 % of the population covered by some form of public insurance (Mehra, 2014). With liberalization of the economy in the nineties, and the setting up of the IRDA in 2000, various private insurance schemes have been established. However, the reach of private insurance has been limited at just over 5 % of the population. (Reddy et al, 2011) In the case of public health insurance, India has a fragmented selection both at the national as well as state levels operating under different ministries and departments with often overlapping benefits and beneficiaries. Accordingly, several mergers and replacements have taken place with older versions revised under new models (Ahuja, 2004). The more recent offerings are the Janashree Bima Yojana’ (JBY) launched in 2000 covering 45 occupational groups from the unorganized sector, the ‘Aam Admi Bima Yojana’ (AABY) launched in 2007 as a social security scheme for rural landless households providing coverage for death and disability by accident to the head of the household or one member per household. These two schemes (JBY and AABY) were merged in 2013. Another such scheme the ‘Universal health insurance scheme’ was set up in 2003 by the four public sector general insurance companies in India to target access to health care for below poverty line families. In 2008, this scheme

was superseded by and subsumed under the newer Rastriya Swasthya Bima Yojana (RSBY) scheme. Overall, these public sector schemes, predominantly targeted at the BPL and unorganized workers, are unable to provide substantial risk pooling, unable to get cross-subsidisation from the rich and tend to focus only on high cost secondary and tertiary procedures.

Chapter 2: Problem statement, Justification, Objectives and Methodology

2.1 Problem statement

In India, access to health care is a big problem for individuals and families of low income group, particularly for those below poverty line (BPL). Currently, India has about 29.2 % of BPL population. This translates into more than 300 million persons living below 1.25 USD/day - the largest BPL population in the world (World Bank, 2016). The government spending on health is low at just 1.2 % of GDP, and out of pocket spending accounts for almost 70% of the total health expenditure of the country (MoHFW, 2014). Due to a lack of financial protection against health expenditure and reliance on out of pocket expenses, the poor are unable to access proper healthcare services and often at high risk to catastrophic expenditure leading to poverty (Garg and Karan, 2009). Studies show that in the country, ‘more than 40% of all patients admitted to hospital have to borrow money or sell assets, including inherited property and farmland, to cover expenses, and 25% of farmers are driven below the poverty line by the costs of their medical care.’(Berman, 2010). According to the latest draft health policy of 2015, an estimated 63 million people in India suffer catastrophic expenditure on account of healthcare related costs – thereby being pushed into poverty (MoHFW, 2015). Needless to say, those living below the poverty line are the most vulnerable to such a situation.

To address the above and to mitigate and prevent financial hardships from healthcare related expenditures, and in pursuit of universal access to health, government of India introduced its flagship health insurance programme, the Rashtriya Swasthya Bima Yojna (RSBY) scheme in 2008 for those below the poverty line. The main objective of the RSBY is to provide financial protection against catastrophic health expenditure for the BPL population and thereby improve their access to health services. The scheme currently has enrolled 37 million families belonging to the BPL population. As one of the largest government funded health insurance in the world, the scheme has received high praise from the World Bank and the ILO. However, it has also received a fair share of criticism from agencies such as the Council for Social Development in India finding the scheme ineffective against its objectives and OXFAM finding that the scheme has actually ended up leaving its target beneficiary- the poor, behind (Averil and Marriot 2013; Council for Social Development, 2014). Although the scheme is now in its 6th round of operation and rolled out in 25 states of India, only 19 states have active enrolment data of at least 1 year available on the RSBY portal, and some states have not continued with the scheme with Maharashtra, Tamil Nadu and Andhra Pradesh

opting out of RSBY, and instead establishing their own state-level schemes (Thakur, 2015).

2.2 Justification

While the government of India moves towards a policy of public health insurance schemes such as the RSBY as a key instrument towards achieving universal health coverage in India, there is a need to locate the RSBY within the wider goal of universal health coverage. This necessitates a proper understanding of the progress, performance and criticisms of RSBY as a health insurance model across the different states where it is being implemented. For instance, a tax-financed system is traditionally accepted as the most cost-effective option. In light of this, a High Level Expert Committee (HLEG) set up by the Planning commission in India has also included as an option a universal health package financed through tax revenues (NHP 2015). However, at present an insurance based system with RSBY and similar state level schemes appear to be the preferred option. This can be seen from the last National Health Policy of 2002 where a social health insurance funded by the government and provided through the public sector, complemented by a growing private insurance sector catering to secondary and tertiary cover was seen as viable option for India (Rathi et al 2012; Sharan n.d.). Since the introduction of RSBY in 2008, budgetary allocation for the scheme has also increased from 4800 million (USD 70 million) in 2009-10 to 11410 million (USD 168 million) in 2013-14. The current target beneficiary has also been expanded to other unorganized sector workers with the state government paying the premium as an RSBY ‘top –up’ in the states of Chhattisgarh, Kerala and Himachal Pradesh.

The RSBY is a substantive and redistributive type of public health policy with the broader objective of improvement in welfare and bringing basic social and economic changes of the lowest section of society through the process of reducing impoverishment due to healthcare. This study therefore seeks to critically examine the design, implementation, and performance of the RSBY scheme. Further, the literature will also be reviewed with a view to propose improvements to better respond to the needs of the target population.

2.3 Objectives

Objective 1: To critically review and analyse the existing literature on the performance of the Rashtriya Swasthya Bima Yojna (RSBY) of India, to identify gaps in its current design and implementation approach.

Objective 2: To propose evidence informed approaches from India and internationally to improve the RSBY to better respond to the needs of the target population.

2.4 Methodology

The RSBY is primarily a public policy intervention to provide health related financial risk protection for the most vulnerable segments of the Indian population. The above objective of critically examining the design, implementation, and performance of the RSBY, thus entails the conduct of a public policy analysis.

2.4.1 Analysing public policies

2.4.1.1 Public policy: A brief mapping of the concept

Public policy has been defined as “a purposive course of action followed by government in dealing with some topic or matter of concern” (Anderson, 1975). Public policy refers to the rules, regulations, and guidelines formulated by governments for the purpose of achieving certain social goals. Governments devise policies aimed at solving problems that have an impact on the society and the general public. A policy is operationalized through legislation, programmes, projects, regulations, taxes and other operations of the instruments of government. In India, the Sarva Shiksha Abhiyaan is a government program to achieve the policy of free and compulsory education for all children between the ages of 6-14 that was established through the Right to Education Act, 2009. Other examples can be the policy for poverty alleviation, Integrated Rural Development program, Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), 2005 etc.

The development of public policy analysis began as an American phenomenon which spread out and became adopted as a specialization in Canada and other European countries such as Netherlands and Britain. Moreover, in Europe a growing number of scholars have made important contributions to the development of the field (Fischer & Miller, 2006).

Public policies are usually classified into various types on the basis of their functions and objectives:

- 1) Substantive public policies – that which are concerned with the general welfare and

development such as education, employment opportunities, law and order, anti-pollution laws etc. catering to all of society.

2) Regulatory public policy – trade regulations, business, public utilities, road safety etc. performed by independent bodies working on behalf of the government.

3) Distributive Public Policy – that which are meant for specific segments of society such as the BPL etc. Examples are public assistance and welfare programmes, adult education programme, food relief, social insurance, vaccination camps, public distribution systems

4) Redistributive Public Policy – that which are concerned with rearrangement of policies concerned with bringing basic social and economic changes. To enable equitable distribution and to ensure that certain assets and benefits are not located disproportionately amongst certain segments of society, or it lies as surplus, redistribution is done to reach the needy.

5) Capitalisation Public Policy - that which are related to financial subsidies given by the Centre to state and local governments and central and state business undertakings etc. and are only indirectly linked to public welfare unlike the others. eg. Infrastructural and development policies for government business organisations

6) Constituent Public Policy- that which are related to constituting new institutions/mechanism for public welfare

7) Technical Public Policy- policies on procedures, rules and framework

The RSBY, with its welfare objectives of health coverage and eradication of medical impoverishment for the BPL group, can be classified under both the substantive and redistributive type of public policy

2.4.1.2 Public policy analysis: A brief overview

Public policy analysis describes investigations that produce accurate and useful information for decision makers (Chochran and Malone, 2005). According to Dunn (1981) policy analysis is “an applied social science discipline which uses multiple methods of inquiry and arguments to produce and transform policy-relevant information that may be utilized in political settings to resolve policy problems.” Policy analysis aims to provide a systematic evaluation of the technical and economic feasibility and the political viability of alternative policies, strategies for implementation and consequences for political adoption. In creating knowledge of policy-making processes policy analysts investigate the causes, consequences, and performance of public policies and programs with the objective to reduce uncertainty and provide information for decision makers in the public arena (Dunn, 1981). Public policy

analysis is useful to evaluate a current policy, to assist in determining whether it should be continued or to identify its weaknesses that may be corrected (Morestin, 2012).

2.4.1.3 Methodology of Public Policy Analysis

The methodological core of policy analysis today can broadly be characterized as a form of critical multiplism (Cook, 1985), and this is mostly due to the nature of policy analysis and the way it is understood. Policy analysis can be understood as both normative and also partly descriptive. It is normative to the extent that an additional aim is the creation and critique of knowledge claims about the value of public policies for past, present, and future generations (Dunn, 2015), and it is descriptive to the extent that it is an analysis that draws on traditional disciplines that seek knowledge about causes and consequences of public policies (Morestin, 2012). Policy analysis seeks to create knowledge that improves the efficiency of choices among alternative policies, and therefore the methodology of policy analysis aims at creating, critically assessing, and communicating policy-relevant knowledge. It has come to represent a systematic methodology for problem solving in the face of complexity, an aim that runs directly counter to misguided notions that policy making involves well-informed calculations to economically, politically or organizationally “rational” actors who seek, respectively, to maximize economic utility, political power, or organizational effectiveness (Morestin, 2012).

As the epistemological foundations upon which policy analysis as a discipline rests differ from those of the disciplines of which policy analysis is composed, policy analysis is therefore often taken as an applied social science discipline that is able to employ multiple methods of inquiry to solve practical problems. In that light, the methodology of policy analysis draws from and integrates elements of multiple disciplines: political science, sociology, psychology, economics and philosophy. (Dunn, 2015). Many frameworks have been proposed for the analysis of public policies. As the nature and objectives of public policies differ, the frameworks for analysis of these policies differ. This puts a constraint on the development of a common framework thus limiting the comparability of similar policies. For the present study the framework proposed by the National Collaborating Centre for Healthy Public Policy (NCCCHPP) 2012 is applied.

2.4.1.4 Conceptual framework of the study

This study uses the framework for analysing public policies from the National Collaborating Centre for Healthy Public Policy (NCCHPP) 2012. To analyse public policies in the field of public health, an evidence-informed approach to decision making is favoured. The emphasis for this approach involves examining the effectiveness of the policy option being considered and identification of issues related to the implementation of a public policy so that its chances of success can be assessed. Accordingly, a two-pronged analysis is done, which focusses on two axes namely (a) the effects of the policy being studied and (b) the issues surrounding its implementation. This framework identifies six analytical dimensions within the two axes of effects and implementation that influence decision making on public policies. These six dimensions are effectiveness, unintended effects, equity, cost, feasibility and acceptability (table 1).

Table 1: Dimensions for analysing the RSBY scheme


Effects	Effectiveness	What effects does the policy have on the targeted health problem?	Durability
	Unintended effects	What are the unintended effects of this policy?	
	Equity	What are the effects of this policy on different groups?	
Implementation	Cost	What is the financial cost of this policy?	
	Feasibility	Is this policy technically feasible?	
	Acceptability	Do the relevant stakeholders view the policy as acceptable?	

Source: NCCHPP 2012

Effectiveness of the RSBY is analysed by examining the extent to which the policy achieves its objectives. As ultimate objectives are often difficult to judge and take time to be observed, and published evidence linking the cause and effect relationship of public policies and their ultimate effects are scarce, there is value in taking into account intermediate effects. One way to deconstruct the chain of expected events between the public policy and the targeted problem is by representing it using a logic model (Morestin, 2012). Using the analytical framework, one can create a logic model of the public policy i.e. RSBY with its intermediate

and ultimate effect objective. Thus we have the intermediate effect of awareness leading to enrolment and utilization to the ultimate effect objective of reduction of OOP and medical impoverishment. With a logic model that represents the theory and the expected effects, it allows the analysis to see to what extent these effects are produced in reality

Figure 2; Logic model for effect of RSBY

Public policy	Intermediate effect			Ultimate effect on the problem
	Health access			
RSBY health insurance for the BPL population	Awareness	Enrolment	Utilization	Reduction in OOP & medical impoverishment
				

Next, unintended effects, if any, will be analysed, identified and articulated. Unintended effects are part of the effects produced in the implementation of a public policy but are unrelated to the objective pursued. Unintended effects can be positive or negative (Rychetnik et al, 2002)

Equity, the third dimension is analysed by looking if there is any differential effects of the policy on different heterogeneous groups or if there is the likelihood of creating, increasing or correcting inequalities in the distribution of a targeted problem (Morestin, 2012). It is necessary to take equity into account and not just effectiveness because often public policies improve overall average in response to a problem but can also deepen social inequalities (Potvin et al, 2008).

The implementation effect of RSBY is analysed using three dimensions namely cost, feasibility and acceptability as provided in the framework. The analysis of cost involves looking at the source of financing and its sustainability. The feasibility of the policy is analysed by looking at the technical feasibility involving design, administrative mechanisms, and availability of required resources around the policy. Acceptability is then assessed by looking at literature on how the policy is judged by stakeholders. The analysis of the policy from all stakeholders' perspective will help in better understanding the applicability as well as feasibility of the policy.

2.4.1.5 Study Approach

The study utilised a literature review to achieve the study objectives, and to arrive at suggestions and recommendations. The literature reviewed includes both published and unpublished (grey) literature as well as secondary data from the RSBY online portal.

Search strategy

The literature for the thesis was searched through Google scholar, PubMed, Google and VU library for published articles. These articles were screened by reading the abstracts, looking at relevance to the study and leaving out the one that does not suit the thesis. Bibliographies of the relevant articles were also used. The grey literature was collected using google search engine to find out the various websites of WHO, World Bank, Ministry of health, economic and political weekly magazine. Information from books, factsheets, policy documents, standard guidelines and protocols were retrieved from the respective institutional websites. The keywords were mostly used in combination or separately to find the information needed.

Exclusion and Inclusion Criteria:

Studies were included only if they addressed the topic of RSBY and health insurance. Studies were excluded if – a) there was no access to full text available, b) not in the English language,

The following table illustrates the search words used to find the literature

Table 2: Search table

Source	Search words used by objective		
	Objective 1	Objective 2	
Pubmed, google scholar , VU e-library	RSBY, performance, analysis, enrolment, utilization, OOP, public policy, public policy analysis	Health insurance for the poor, universal health cover, RSBY, Health insurance, India, public policy analysis	
Website of RSBY, ministry of health India	Enrolment, utilization		
Website of WB, WHO			

Chapter 3: Study Results and Findings

3.1 Analysis of the Rashtriya Swasthya Bima Yojna (RSBY) scheme's performance

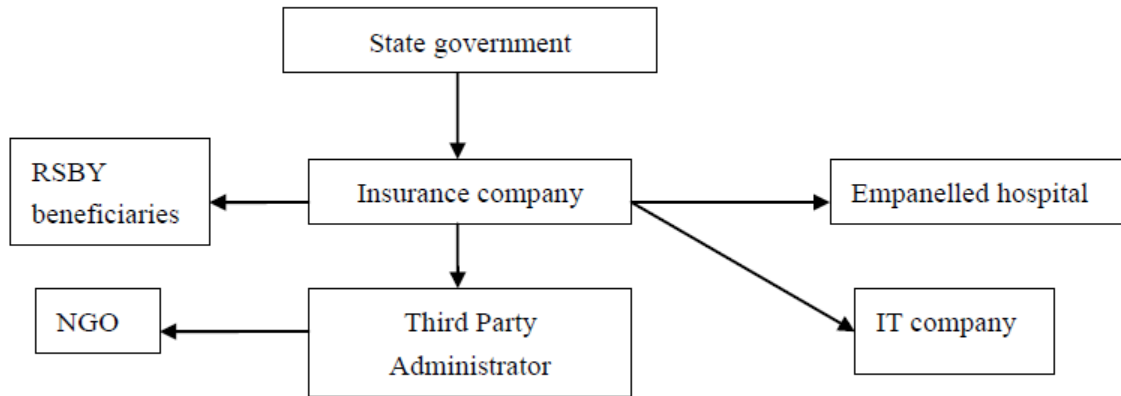
Brief Overview of RSBY

With the enactment of the Unorganized Workers Social Security Act in 2008, the government of India introduced the RSBY scheme in April 2008 as a demand side financing instrument, with the acceptance that supply side financing on health alone was unable to reduce out of pocket expenditure on health in India. The RSBY therefore has two objectives namely a) to provide financial protection against catastrophic health costs by reducing OOPs for hospitalization and b) to improve access to quality health care for BPL families and other vulnerable groups in the unorganized sector. Under this scheme, the beneficiaries can avail hospitalization coverage upto a maximum limit of Rs.30000 (\$ 600 US) per annum on a floater basis. To be more precise, the scheme covers a) hospitalization defined as that requiring hospital admission for 24 hours or more inclusive of pre-existing diseases, b) a list of day care surgeries, c) all maternity expenses for both normal and caesarean deliveries and finally a transportation charge of Rs.100 paid to the beneficiary for every hospitalization with a maximum limit of Rs.1000 during the policy period. The RSBY scheme entitles upto a maximum limit of 5 members of a household as beneficiaries. A minimal amount of Rupees 30/- (< US\$ 1) as registration fee is charged per household.

The premium bracket is set at a maximum of 750 Rupees (\$11.12 US) per household per annum. However, the premium differs from district to district as each state government selects insurance companies through a competitive bidding process and technically qualified with lowest bid is selected. The premium is paid by the centre and state governments on a 75:25 % cost sharing in all states except in JK and NE states at 90:10. The RSBY policy period is a year. An important feature of the RSBY is the smart card which enables cashless transactions at the empanelled hospitals.

Institutional structure of the RSBY

The RSBY has been designed as a business model, which differentiates it from most of the other existing schemes, in a public-private partnership with the Central government, the State government, Insurance and private health providers playing a role with incentives built in for all stakeholders and an extensive use of technology or IT systems to administer the scheme.




For the RSBY, each state has a State RSBY Nodal Agency which selects an insurance agency for every district through a competitive bidding process. The insurance company then agrees a contract with empanelled hospitals, both public and private health service providers in the districts. The role of the insurance agency includes processing of claims and monitoring of the empanelled hospitals against fraud and malpractice, awareness generation and enrolment of BPL households, installation and setting up of IT facilities through an IT company at the empanelled hospitals including biometric card reader etc. However, the insurance agencies also outsource part or all of these activities to third party administrators (TPA), like an insurance intermediary, who are also selected by competitive bidding process. In certain places, the TPA further outsources awareness generation of the RSBY scheme to local NGOs.

3.2 Effectiveness

The first analytical dimension used to assess the performance of a public policy is its effectiveness in achieving its objectives (Salamon, 2002). The RSBY has been in operation since 2008 and has the objectives to a) provide financial protection against catastrophic health expenses by reducing OOP and b) to improve access to quality health care for the BPL population. Using our logic model from the conceptual framework, we look at awareness, enrolment, utilization and reduction of OOP to measure effectiveness in this section.

Figure 2; Logic model for effect of RSBY

Public policy	Intermediate effect			Ultimate effect on the problem
	Health access			
RSBY health insurance for the BPL population	Awareness	Enrolment	Utilization	Reduction in OOP & medical impoverishment
				

3.2.1 Low awareness

To enable RSBY to have an effect on utilization, awareness of RSBY would include information about eligibility, enrolment process, benefits of the scheme as well as the empanelled hospitals under the scheme. Since its inception in 2008, studies have looked at awareness as a determinant of enrolment and utilization of the RSBY scheme often with discouraging findings. A study in Maharashtra in 2013 for instance, revealed that there was very low awareness of the scheme with just 29.7 % of 6000 sample households aware of the scheme. Not surprisingly enrolment was also low at just 21.6 %. Of the enrolled, the depth of awareness was lacking with only 22.3 % feeling that they had received adequate information while over 77 % had incomplete information of the scheme's benefits, the sum assured and the list of empanelled hospitals (Thakur, 2015). Another study of the 7 RSBY implementing districts in Delhi also reported very low awareness of the scheme with just 5 % of the target BPL households aware of the services and the benefit package even though various IEC campaigns such as radio and health camps were organised (Nair, 2013). Limited awareness of the scheme was also found to be the most important reason for non-enrolment and non-utilization amongst enrolled households in Gujarat (Sheshadri et al, 2012) In the states of Himachal Pradesh and Uttar Pradesh, majority of the households were aware about their eligibility and the registration fees for enrolment. However, the level of awareness was low when probed on the benefits, insured amount per year, maximum eligibility of five members in a family, transportation allowance etc. (RSBY, 2010). These findings were similar to Karnataka state where 85 % of eligible households responded 'yes' to having heard of RSBY, yet many were still unaware about where and how to obtain treatment under the scheme

(Rajashekhar et al, 2011)

3.2.2 Gap between actual and target for enrolment

Low enrolment is a recurring theme in many of the studies reviewed. Even after 8 years of implementation and in its 6th round of operation, the RSBY scheme is yet to have its presence in all the districts of the implementing states. The gap between eligible households (Target) and actual enrolment in 2016 can be seen from table 3 below.

Table.3: Implementation status of the RSBY

RSBY Implementation data					Data as on 30/3/2016	
	States	Total target families	Total enrolled	Empanelled private	Empanelled public	% enrolled
1	Assam	2371950	1421104	40	132	59.91
2	Bihar	13822582	6899144	930	135	49.91
3	Chhattisgarh	3724030	3442749	578	365	92.45
4	Gujarat	4396654	1876628	1083	483	42.68
5	Haryana	1229850	437850	420	33	35.60
6	HP	877763	480588	21	153	54.75
7	Jharkhand	3607741	1682894	287	173	46.65
8	Karnataka	11346934	6731881	512	268	59.33
9	Kerala	2221283	2021572	178	209	91.01
10	Manipur	120237	70925	7		58.99
11	Meghalaya	479743	256138	15	167	53.39
12	Mizoram	212572	152983	19	79	71.97
13	Orissa	6158498	4462959	173	408	72.47
14	Punjab	452979	232352	142	162	51.29
15	Rajasthan	3829760	2769097	306	420	72.30
16	Tripura	771225	492022	2	77	63.80
17	UP	5301377	1464242	784	611	27.62
18	Uttarakhand	728216	285229	67	94	39.17
19	WB	11100347	6150716	733	459	55.41
	Total	72753741	41331073	6297	4428	56.81

Source: www.rsby.gov.in

As can be seen from table 1.1, in 19 of the RSBY implementing states where MIS data is available, the average enrolment is about 57 % against target beneficiaries in 2016. This is a small improvement from 47 % enrolment in 2011, five years ago. RSBY enrolment performance varies across states; states such as Uttar Pradesh have enrolment of 28 % even

after 4-5 years of implementation and Haryana has an enrolment of 36 % after 5 years of implementation. In Gujarat, 45.3 % of the eligible households were enrolled in 2011-12, whereas in 2016, it has actually decreased to 43 % according to the RSBY portal. A study by Sun (2011) on enrolment patterns found wide variations in enrolment rates across villages, regions and demographic groups with all eligible households enrolled in only 2.5 % of the sample villages studied. It is noteworthy that the two outlier states of Kerala and Chhattisgarh where enrolment is at the highest at 91 % and 92 % respectively are the states where the state governments have expanded the RSBY by topping up the scheme and including non-BPL populations, namely RSBY CHIAK (comprehensive health insurance agency of Kerala) in Kerala and RSBY Plus in Chhattisgarh.

Looking at the factors behind low enrolment, a lack of awareness of the scheme, a lack of prior information of the enrolment schedule is reported in majority of the studies reviewed (Sun, 2011; Rathi et al, 2012). Awareness generation is clearly inadequate, with a low number of health camps, and camps organized only at the taluk headquarters, at the gram panchayat level where practices cannot be controlled (Seshadri et al, 2012; Narwade, 2014; Rathi et al 2012). Another big factor behind low enrolment is the short and rigid time frame for enrolment with the TPA. An annual enrolment is conducted for about 2-3 days from 10 AM to 6 PM where biometric information such as thumb fingerprints and passport photo of the head of household are taken. Several studies have revealed that eligible households were not present during the enrolment visits by the TPA as they had to attend to their daily wage work or in the fields. In Maharashtra, a study has revealed that over 60 % of eligible target households were not present on the enrolment dates of the TPA (Rathi et al, 2012). This is similar to findings in Delhi and Faridabad, Haryana and Karnataka (Wu, 2012). In many cases, households were of the impression that they would be able to enrol in the late evening after coming back from work or the following day, which was not the case (Rajasekhar et al, 2011). TPAs were found to be unwilling to extend the time frame for enrolment or set up permanent enrolment camps as the costs would be too high (Wu, 2012). Another factor reported is a geographic discrimination based on costs of enrolment by the insurer and cream skinning or the deliberate enrolment of healthier households (Sun, 2011) This was also reported in Amravati, Maharashtra where larger villages closer to district headquarters were selected for enrolment while the remote tribal blocks even with the maximum number of poor households were not enrolled (Rathi P et al, 2012). This social exclusion by insurance agencies is also reported in other studies (Thakur & Ghosh, 2013). Other factors include a problematic BPL list, erroneous names, and refusal to enrol due to head of household missing

due to illness or death even though another member is provided for in the guideline (Rajasekhar et al, 2011)

3.2.3 Gap between actual and target utilization

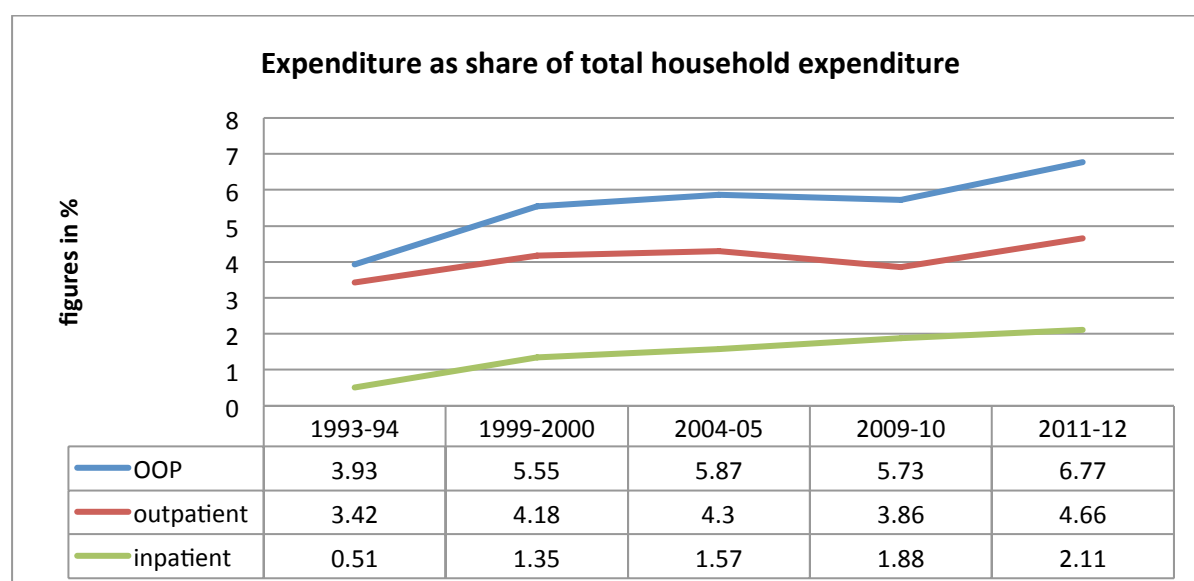
In 2016, of the 19 states with available enrolment data in the RSBY portal, the data shows an average hospitalization for 28.6 % of the total enrolled. Even in states with high enrolment such as Chhattisgarh at 92 % in 2016, overall hospitalization for the state is at 16 %. In Gujarat with 43 % enrolment, the hospitalization is at a low 3 % while for Karnataka with 59 % enrolment the percentage of hospitalization is just 1.5 %. Kerala with a high enrolment of 91 % in 2016 has a hospitalization percentage of 17 %. The factors behind the low utilization are varied. Insufficient knowledge about the details of the scheme such as the sum insured, where and how to obtain treatment is reported in a number of studies (Thakur, 2015; Rajashekhar et al, 2011). Awareness generation is clearly inadequate, with a low number of health camps, and camps organized only at the taluk headquarters (Kumar, 2010; Narwade, 2014). Another important factor is the delay in issuance of smart cards. Both Wu in Delhi and Rajashekhar in Karnataka noted extreme delays lasting beyond 6 months in issuance of smart cards even though the policy was only for a 12 month period and the scheme guidelines provide for smart cards on the spot at registration. In Karnataka for instance, a large majority did not receive smart cards, with gram Panchayat linking delivery of smart cards to payment of house and water tax, and local officials demanding money for the smart card leaving BPL households disinclined to pay extra money for the smart card (Wu 2012, Rajasekhar et al 2011). This is similar to a study finding in Chhattisgarh where it took an average of 29 days to receive the Smart Card and for 96 % (4 % receiving on the same day) time taken to receive their cards ranged from 2 to 150 days. Further, a study found in 99 % of studied cases, the RSBY brochure was not given; consequently, respondents were without the list of empanelled hospitals at the time of enrolment (Nandi et al, 2012). Provider side deterrents were also prevalent with the refusal of treatment and delay of treatment by hospitals to RSBY card holders, and a lack of empanelled hospitals in the catchment area (Wu, 2012; Kumar, 2010). In Karnataka for instance, a survey of 39 empanelled hospitals revealed that most of the hospitals were refusing to treat RSBY card holders for two reasons viz. problems with the smart card technology and delays in reimbursement (Rajashekhar et al, 2011) Further the hospital reputation, behaviour of registration staff and responsiveness of hospital staffs to RSBY card holders were found to affect utilization (Kumar, 2010; Rajashekhar et al 2011). OOP expenses were also a factor with distance to empanelled hospital, transport costs and

non-availability of medical supplies in empanelled hospitals reported as a deterrent to low utilization. In Orissa for instance, extra expenses were borne during treatment by RSBY patients. Further, with the scheme only covering 5 days of hospitalisation, patients continued to incur expenses long after the treatment. (Rathi et al 2012; Rajashekhar et al 2011; Kumar, 2010)

3.2.4. Extent of OOP mitigation

An impact study of the RSBY found that despite high enrolment in some states, the RSBY has failed to reduce catastrophic health expenditure, having little or no impact on medical impoverishment in India. Comparing the trends on OOP expenses for medical care from 1993-94 to 2011-12 (Figure 2) the study found that hospitalization expenditure and the percentage of household expenditure on OOP have steadily increased in the last two decades, while there is a rise in catastrophic headcount, showing that RSBY and other GSHIS have failed to provide any significant financial risk protection. (Council for Social Development, 2015)

Figure 3: Trends in OOP (1993- 2012)



Source: India Social Development report, 2014

These findings are in line with the smaller scale studies in the districts. A household survey in Patan district, Gujarat reported the near absence of financial protection from the scheme as its most significant finding. According to the study, out of the total cases of hospitalization, only 15 % had a cashless experience. The median OOP expense of the remaining 95 % was 7000 rupees, which was similar to the OOP expenses of those who were not enrolled in the RSBY scheme. (Seshadri et al, 2012). Another study in Delhi reported that a third of all patients

incurred OOPs expenses. While the average claim amount was Rs.3700, the average OOP was Rs.1690 (Grover and Palacios, 2011). In a study in Maharashtra, 70 % of OOP was on medicine costs while 18 % was on transport and diagnostics. In this study, 70 % of study sample reported incurring OOP expenses on medicines after discharge (a maximum period of 5 days) with an average of Rs.1190 per disease episode. (Rathi et al, 2012). Another study in Chhattisgarh reported about 37 % of beneficiaries incurring OOP expenses with a higher percentage (58 %) in private hospitals at an average of Rs.1079 and 17 % in public hospitals at a cost of Rs.309 (Nandi et al, 2012). Elsewhere in Karnataka an impact evaluation study in (2010-2012) analysed the incidence and intensity of catastrophic health expenditure (CHE) in two rounds of RSBY implementation. The study found that CHE increased in round II from round I at all threshold levels for both RSBY and non-RSBY households highlighting the ineffectiveness of RSBY to offer financial protection to the poor (Aiyar et al, 2013)

3.3 Unintended effects

Unintended effects are part of the effects produced in the implementation of a public policy but are unrelated to the objective pursued and which can be either positive or negative (Rychetnik et al, 2002). In the case of the RSBY, few unintended effects have been identified from literature, such as a) social exclusion/a geographic discrimination based on costs of enrolment by the insurer and b) cream skinning or the deliberate enrolment of healthier households (Sun, 2011) This was also reported in Amravati, Maharashtra where larger villages closer to district headquarters were selected for enrolment while the remote tribal blocks even with the maximum number of poor households were not enrolled (Rathi et al, 2012). This social exclusion by insurance agencies is also reported in other studies (Thakur & Ghosh, 2013). The effect of exclusion is also found to arise from errors in the BPL list itself. In Chhattisgarh, the government recognizes 74% of its population as poor and provides subsidized grain. However, central government has fixed the percentage of BPL in the State at 46%. Hence, there is a huge population of poor people who have not been even considered eligible for the RSBY scheme (Nandi et al, 2012; Mazumdar et al, n.d.). Even though the RSBY is meant for the poor, several studies found poor performance of RSBY in delivering health services especially in rural India. (Narayana, 2010; Rajashekhar et al, 2011; Rathi et al, 2012) while an all India study reported that the RSBY was used mostly by those who had better access to healthcare and the most marginalised were excluded further (Council for Social Development, 2015). In majority of the cases, empanelled hospitals tend to be placed near district headquarters raising costs of access for poor. It also encouraged hospitals to treat

simpler and less complicated disease. Another study also suggested that in the context of publicly funded insurance schemes such as RSBY with third party payment made to private providers, supply-side moral hazard appears to be loaded heavily in favour of private providers (Reddy et al, 2011) Such effects have been confirmed by various complaints of fraudulent practices leading to the RSBY issuing an advisory for de-empanelment of hospitals in May 2011. (Trivedi & Saxena, 2013)

3.4 Equity

This dimension looks at any differential effects of the public policy on different social groups and the likelihood of creating, increasing or correcting inequalities in the distribution of a targeted problem (Morestin, 2012). In this respect, several studies have reported deliberate discrimination against some BPL households by insurance companies during enrolment process. Accordingly, poor households in some areas were not enrolled where the risk or cost to enrol was deemed too high for the insurers viz. geographic discrimination and selective enrolment of healthier villages (Sun, 2011; Wu, 2012). However, a study in Chhattisgarh did not find any issue of cream skimming (Nandi et al, 2012). Another study on social exclusion and RSBY in Maharashtra reported mixed findings. This study reported that even though RSBY was expected to decrease social exclusion, there was evidence for both whereby a) in some cases, RSBY increased social exclusion, e.g., hamlets located outside villages were usually not visited for the enrolment purpose, and these people (mainly SC / ST etc.) are also lack awareness and information and b) In some cases, RSBY decreased social exclusion, e.g., within households – since only 5 members per family can be enrolled, families usually covered elderly and young children rather than adults (Thakur & Ghosh, 2013).

3.5 Costs

The RSBY is funded on a costs sharing basis between Union government and individual states at a 75:25 ratio (except for the north-east states and Jammu and Kashmir at 90:10). Currently, all BPL population and certain other unorganised worker groups are eligible with full premium subsidy. Gradual increase in budget allocation is seen since its launch in 2008 from 70 million USD in 2009-10 to 168 million in 2013-14. However, according to a study, based on 2011 premium rates, RSBY is expected to cost minimum 3,350 crore rupees (\$500 million USD) per year as just the Union government share to cover the entire BPL population and the current amounts allocated can barely meet universal coverage of basic services (Dror and Vellakkal, 2012). The RSBY is designed as a demand side financing scheme in which the financing function is

left to the government and/or contribution from employees, intermediated by an insurer or other financing intermediaries and healthcare is purchased by the intermediaries from both the public and private providers. Demand-side financing, is therefore, expected to lead to “money follows the patients”, approach (Hsiao, 2007) and provide a thrust to market forces and competition. There is considerable uncertainty surrounding the sustainability of the scheme in the medium and long term and RSBY would need to attract premium paying APL households.

3.6 Feasibility

According to the analytical framework feasibility can be assessed by assessing the extent to which existing administrative mechanisms are able to manage the implementation of the existing policy. Feasibility of a public policy is also assessed by asking the question whether the government promoting a given policy will be the one to implement it or will implementation fall to other actors. According to Salamon (2002), implementation builds in complication with increasing number of actors, as it requires negotiation with these different actors to ensure their involvement and commitment to act towards the desired objective. It then becomes necessary to question whether those spearheading the public policy, in this case the government can rely on an appropriate system of incentives and sanctions to guide the activities of the other actors involved in implementation (Sabatier & Mazmanian, 1995).

In this respect, the RSBY has been designed as a business model and implemented by different actors with incentives built in for each stakeholder. According to Wu (2012), the institutional design of the RSBY is based on a set of contracts and low enrolment and utilization rates can be attributed to a contracting party’s poor performance and the flaws in the design. Such flaws also indicate that preconditions necessary for the contract’s normal operation are not satisfied. Further, because various contracts are interlinked, failure in any contract follows a typical chain reaction. From the literature reviewed we can summarise some of the main issues surrounding feasibility.

3.6.1 Misaligned incentives and low premium

Rajashekhar et al (2011) suggests that many of the issues with RSBY are attributable to a misalignment of incentives. With respect to utilization, as a business model, a low claims ratio turns it into a profitable business for the insurance agencies. Therefore, there is no incentive for the insurance company to promote utilization, to deliver cards without delay or incorrect details, or even to ensure complete information about the package, benefits, list of empanelled hospitals is received by the beneficiary. There is also no incentive to check that hospitals are prepared and ready to receive the beneficiaries. In

an ideal scenario, encouragement and promotion of utilization should be conducted by actors who will directly benefit from increased utilization. Thus, if the treatment package rate is attractive, this role can be taken by the hospitals.

With respect to enrolment, insurance agencies are incentivised to gain from higher enrolment, however for private insurance companies, there was no incentive to increase enrolments in many cases as sometimes the enrolment costs were higher than the premium. During enrolment, TPAs were unwilling to extend the timeframe or set up permanent enrolment camps as the costs would be at a loss for them. Similarly, TPAs were unwilling to enrol households in more remote terrains as the costs involved was higher than what TPAs would receive from the insurance company. This can also be blamed at the failure to have an annual enrolment target and a penalty provision for breach in the contract.

3.6.2 Problematic BPL list

The RSBY was often let down by a problematic BPL list at enrolment. The BPL lists often had erroneous names of household members, and in cases where the head of the household was missing due to death or other reasons, the entire family was refused enrolment. Further, the BPL list/records used by the planning commission at the central level and the state would not match creating bottlenecks (Rajashekhar et al, 2011; Wu, 2012) For instance, in Chhattisgarh, the government recognized 74% of its population as poor and provides subsidized grain. However, central government had fixed the percentage of BPL in the State at 46%. Hence, there is a huge population of poor people who have not been even considered eligible for the RSBY scheme (Nandi et al, 2012; Mazumdar et al, n.d.)

3.6.3 Public-Private choices

The RSBY by empanelling both public and private providers is expected to bring the facilities of both private sector and public sector as options to the beneficiary, with both sectors competing and giving the card holder a freedom of choice which was not available before. However, a study looking at the design issues of RSBY has found that choice is in reality dictated by the provider and options are restricted to the services that a hospital is willing to provide. The study found that private hospitals provided a narrow and selective range of services, picking the more profitable packages. Private hospitals also elected to treat simple conditions and referred complicated cases to the public sector (PHRN, 2012).

3.6.4 Pricing of packages

For private hospitals, the RSBY packages were unattractive as they were priced much lower than the market rates offered at the hospitals to non-BPL patients. This often led to undesirable effects such as hospitals preferring hysterectomies which offered better rates rather than caesarean section and irrational rise in cataract surgeries (Nandi et al, 2013; NHRC, 2012; Shukla et al., 2011). For private hospitals, the RSBY ceiling of 30,000 rupees (\$ 445 USD) was considered too less for major surgeries (Basu, 2010). Owing to this inadequate package, medical conditions requiring longer stays or expensive medications such as poisoning or burns, snakebite, were not treated under RSBY (Dasgupta et al, 2013). Private hospitals also claimed that in around 15-20% of cases, additional procedures needed to be done which could not be charged to the RSBY. For the public hospitals as well, the low packages meant the RSBY did not lead to increased revenues. Only in the case of not for-profit institutions, the RSBY package rates were higher than their usual rates and thus increased their income. However, even these hospitals had to face “losses” in case they needed services from specialists (especially surgeons/obstetricians) from outside their staff (PHRN, 2012).

3.6.5 Technology

Though the use of technology in RSBY is considered innovative, most of the studies have mentioned problems surrounding the use of technology even leading to refusal of treatment and rejection of claims, indicating inadequacy in administrative infrastructure to fully support the RSBY. Issues mentioned were poor internet connectivity in PHC and CHCs, inadequate training on the use of IT, improper installation, inability to work offline, malfunctioning of IT, incorrect information stored on some cards, storage of low quality etc. (Rajasekhar et al, 2011). The claim of portability of the smart card was also rendered invalid as card holders on the move could only use it with the local TPA of their enrolment (Wu, 2012)

3.6.6 Settlement of claims

Another major bottleneck reported is the delay in settlement of claims. The design of the RSBY failed to provide penalty provisions for delay in settlement of claims, and delays in reimbursement of claims which created difficulties for both providers and patients. The RSBY guidelines provide for 21 days, now extended to 30 days to settle a claim. However, studies have observed that settlement of claims in the hospitals extended from 6 months to 2 years, with about 10-15 % of claims rejected (PHRN, 2012; Dasgupta et al, 2013). This was also

reflected in the data given presented on the state RSBY website, which showed that only 17.2 per cent of the total claims were settled within 21 days till July 2012. (PHRN, 2012). Further, the continuously decreasing premium due to competition between insurers forces them to select the TPA with lowest quotation, often in the form of low scale, inexperienced agencies to deal with empanelled hospitals leading to delays in reimbursements and processing of claims.

3.6.7 Grievance redressal and monitoring

The absence of a grievance redressal mechanism for hospitals and insurance agencies was mentioned by most of the studies (Rathi et al, 2011; Nandi et al, 2010; Rajasekhar et al, 2011). Inadequate to non-existent monitoring is also reported by studies with an instance of RSBY funds being used to pay salaries of NRHM staff recruited in government hospitals (Basu, 2010; Rajasekhar et al, 2011). A pressure to increase utilization was also seen to lead to irrational hospitalizations and prescriptions in the health facilities (Nandi et al, 2013). As per the RSBY official data, more than 250 hospitals have already been de-empanelled due to fraud related activities (IDFCF, 2014). The RSBY by design has a real time data monitoring able to produce data on morbidity, disease patterns etc. but is seriously short-staffed with just about 10 staffs at the centre and 100 at the state level for 80 million population compared to 5000 staff for 70 million population in the Rajiv Arogyashri (Reddy et al, 2011)

3.6.8 Narrow coverage

According to Sharan (n.d.), the RSBY is unable to make significant headway into universal health coverage for India for 3 reasons – firstly, it only covers inpatient care for specific procedures, secondly continuing problems with the BPL list, and thirdly, the scheme is heavily dependent on the private sector, which is primarily profit oriented. The Social Development Report of 2014 notes that the RSBY's major design flaw is that it has a narrow focus only on inpatient care coverage which is expected to be low volume, high value financial transactions. However, the study notes that to enable protection from catastrophic health shocks and household impoverishment, evidence has shown the opposite holds true with regards to catastrophic expenses. (Council for Social Development, 2015). Another study also notes the major design flaw of RSBY and the other state insurance programmes is their narrow focus on secondary and tertiary hospitalisation (Selvaraj & Karan, 2012). Kalita & Mor (2015) argue that in any given year, fewer than 2.50 % of patients will require hospitalisation. Therefore for India to achieve universal health coverage, in terms of financial

feasibility and its well-being goals, 97.5 % of all conditions would require to be treated at the primary care level.

3.6.9 Lack of hospitals

The low enrolment and utilization of RSBY in part has been pointed towards a lack of empanelled hospitals in the catchment area. The availability of hospitals in remote areas continues to be a major challenge though the initial problems of severe shortage of hardware in RSBY have been reasonably streamlined (Basu, 2010). The proportion of empanelled hospitals is highly skewed towards the private sector who are located in urban areas (Narayana, 2010; Rajasekhar et al., 2011).

3.7 Acceptability

This dimension looks at the stakeholder's opinions and perspective of the policy and is therefore focussed on the subjective judgements of stakeholders (Swinburn et al, 2005). For the RSBY policy, the stakeholders include the BPL beneficiaries, insurance company and the service providers.

3.7.1 Providers

According to a study by Trivedi and Saxena (2013), majority of the public and the private service providers perceived a power imbalance created by the 3 stage procedure of de-empanelment in favour of the insurance companies and felt a constant threat of being de-empanelled by the insurance company. Set up in 2011 in response to several complaints of supply side moral hazards, the three step procedure for delisting the empanelled hospital involves (a) placing the hospital on 'watch list' at any instance of doubt, (b) suspension and (c) commencement of a detailed investigation and claim by the insurance company, that can lead to de-empanelment. According to the hospitals, this gives absolute power to the insurance company as the procedure for suspension can be put up solely by the insurance company, and the investigation and de-empanelment process involves deliberation only between state authorities and the insurance company. For the hospitals they can only initiate their redressal from the district level agencies. As per the hospitals, this has created a power imbalance whereby the insurance provider can unilaterally initiate suspension that can go unopposed for at least 30 days. Although set up as a guard against malpractices, it has the potential to be abused by insurance companies in collusion with the State Nodal Agency against hospitals that are not conducive for profit maximizing and. In Gujarat's Patan district,

a frequent change of insurance company was found and many service providers complained of the outgoing insurance companies negotiating a lower settlement claim amount than actual which providers had to accept for fear of losing entire claims. Another complaint by service providers was the delay in settling of claims by the insurance companies (Trivedi & Saxena, 2013).

3.7.2 Card holders

For the BPL beneficiaries, it has been a mixed response to the RSBY scheme and if acceptability is linked to enrolment and utilization, the RSBY has not received an enthusiastic response as might have been envisaged by the policy makers. Major complaints from the beneficiaries have been difficulties in enrolment, delays of several months to issue the smart cards, poor knowledge of how and where to utilise the scheme, the hospitals not equipped to use card reading technology, non-portability of the smart card, month long delays in reimbursement (Rajashekhhar et al, 2011). Lack of the list of empanelled hospitals and brochure not provided is also reported in Chhattisgarh (Nandi et al , 2012) In other instances, some empanelled hospitals delay and deny treatment in some cases in Odisha, and amongst slum dweller in Delhi because the insurance company always delayed payments to the hospital (Kumar, 2010; Wu, 2012). Transparency was also a factor, with a percentage of beneficiaries often found in studies complaining of not being informed of the amount deducted from their cards after treatment, not told the balance or not being provided a receipt by the hospitals (Nandi et al, 2010; Chaupal, 2013). According to a TPA administrator in Delhi, migrant populations regard the smart card as useless, as even though it is supposed to be portable, it is not possible for them to get treatment in an empanelled hospital other than their hometown as reimbursement is difficult with the TPA and Insurance company in the smart card different from the local ones, there is no automatic transaction and no data tracking (Wu, 2012).

3.7.3 Insurance and TPAs

Insurance companies reported delays of 6 months in premium payment from the state government. The insurance agencies also complained about the low premium rates which were lower than the enrolment costs for far flung areas making it unprofitable. The continuously falling premium rates due to competition between insurers also affected the prices offered to TPAs, with some TPAs unable to renew their contract due to the low prices offered (Wu, 2012).

Chapter 4: Discussion of Findings

4.1 Evidence informed approaches to improve RSBY

In chapter 3, I have analysed the RSBY looking at both effects and implementation using 6 dimensions. Findings from the preceding chapter suggest that the RSBY needs to be improved in many areas including better policy design, stronger support systems, and awareness among beneficiaries etc. In order for these to happen, there is a need to identify additional steps the policy needs to adopt. In this section, looking at evidences from India and abroad, I try and address objective 2 of the study which is to identify and propose evidence based approaches that may facilitate significant improvement of the scheme.

4.1.1 Primary care, outpatient treatment and medicines:

One of the main limitations of the RSBY mentioned in various studies is the weak nature of the pro-poor targeting mechanism of RSBY. In resource limited settings studies have shown that insurance coverage focusing on expensive hospital care is not always the most effective way of providing financial risk protection. Specifically, insurance schemes such as the RSBY need to focus on the disease profile and health expenditure pattern of the population to increase its effectiveness in protecting the population from medical impoverishment. Currently, health insurance schemes in India except for the ESIS scheme are disproportionately targeted at specialists and hospital-care, especially on tertiary care. Evidence in developed countries has shown this to offer poor value for money. The examples of universal health coverage in middle-income countries such as Brazil, Chile, Thailand has seen a transition from the earlier hospital centric focus to primary care, on its way towards achieving universal coverage (WHO, 2008).

Across the globe, several countries have included in their insurance coverage outpatient treatment as a critical component, especially the re-imburement of drugs. Beside several high income countries, Thailand as a lower middle income country has included re-imburement of drugs in its successful health insurance program (Reddy et al, 2011). Thailand is often cited as a development success story which is reflected in various health indicators such as life expectancy of 74 years and neonatal mortality rate of 7.9. (World Bank, 2016) In 2013, its out-of-pocket expenditure, as a percentage of total expenditure on health, was approximately 11%. Thailand's number of impoverished households also decreased from 3.4% in 1996 to 0.8-1.3% between 2006 and 2009 much of which is attributed to the Universal health coverage scheme. In India currently, only the CGHS and

ESIS discussed earlier, provide medicine re-imburement. Considering that household medical impoverishment is primarily on account of outpatient costs, especially costs of drugs, the examples of countries such as Thailand are worth considering. Further, the packaging of the rates and procedures can be improved by taking care of complications or unforeseen intervention that can arise with an illness needing longer hospitalisation or expensive medication. The policy can also introduce the possibility of revising diagnosis and increasing the limit of beneficiaries to more than five members. Here, the Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) can be another example. Providing a benefit of Rs.150000 per family per year, available to each and every family member, it also provides free follow up consultation, diagnostics, and medicines under the scheme up to 10 days from the date of discharge, with claims settlement set at 15 days.

4.1.2 Awareness generation

Low awareness levels have been identified in the preceding chapter as a primary roadblock hindering higher enrolment and particularly greater utilization. The role of the TPAs and the insurance companies in this regard needs to be examined. Even though they are incentivised to enrol, the findings have shown instances of cream skinning and geographic discrimination where profit margins are at stake. In the case of utilization, they are certainly not incentivised to encourage utilization. The incentives system should be revised with sanctions/penalty for not enrolling all eligible beneficiaries or not issuing the smart cards. Procedures regarding number of days for enrolment, venue of enrolment and number of enrolment camps can be revised.

4.1.3 Claims processing:

One of the major issues with the RSBY is the delay in claims settlement. In typical insurance, the responsibility of claims processing is given to the insurance agency. With the RSBY, the responsibility of processing claims lies with the TPA enrolled by the insurance company and is done through a representative at the empanelled hospital through an elaborate pre- approval authorisation process. In the case of the ESIS and CGHS schemes, though a similar procedure is followed, there is no involvement of a TPA in approval of services. Once it is approved by a doctor or ESIS/CGHS representative, beneficiaries can access services. The bills are sent for re-imburement to ESIS/CHGS by the empanelled hospitals and reimbursement done through electronic transfers to the hospitals. In such cases where insurance companies are involved throughout the process, the time required has been seen to be much lesser.

4.1.4 RSBY PLUS:

There have been suggestions around integration of the major public health insurances in India, namely the three central government schemes CGHS and now RSBY run by the Ministry of Health and Family Welfare and ESIS under the Ministry of Employment and Labour. While the RSBY provides secondary care to BPL/informal populations, the CGHS focusses mainly towards tertiary care for civil servants, and the ESIS provides all three levels of care and referrals to organized/formal sector workers. The integration of the three schemes would immediately enlarge the fund pool and the risk pool enabling efficient allocation and utilization of funds. The RSBY and the CGHS would be able to share the large network of hospitals and dispensaries under the ESIS, which is largely underutilized. ESIS would also offer the gatekeeping function of referral systems.

4.1.5 Fiscal sustainability:

Currently the government is bearing the dual financial burden of funding the public infrastructure and the national insurance, the RSBY. The risk pool for this scheme comprises of the BPL population with least ability to contribute. By extending the scheme to other segments of society, namely Above Poverty Line (APL) populations and others who are able to pay premium, the RSBY can expand its benefit package to a more comprehensive package attractive to the majority while expanding its risk pool and enrollee base. By expanding the beneficiary contribution, as in the case of typical health insurance where the rich subsidise the poor, the sustainability of such a scheme can be enhanced. The state of Kerala is able to provide universal health insurance by extending the RSBY to contributing segments namely the APL population who pay full premium and a category of poor (not included in the RSBY) defined by the state and not the planning commissions criteria who pay Rs.100 as compared to Rs.30 in RSBY. Another example can be the Yeshavini scheme in Karnataka with 40 % subsidy by the state.

Chapter 5: Conclusion and recommendations

5.1 Conclusion

This study examined the RSBY scheme looking at two axes of effects and implementation using the framework developed by NCCHPP. The findings show that the RSBY is currently struggling to achieve its objectives. Effectiveness against its objectives as measured by enrolment shows low to moderate results with minor improvements from previous years while utilization rates continue to be low overall. Despite the fact that the RSBY has brought health insurance to the BPL population, OOP mitigation remains a far cry with studies showing a rise in OOP expenditure. It is clear that to progress towards mitigation of OOP, the packages of RSBY would require expansion beyond inpatient care, from high risk, low frequency to low risk, high frequency conditions. The option of medicine re-imburement as followed in several countries appears to be a viable addition to the RSBY. The success of any policy depends on acceptability by the beneficiaries and the concerns raised in the literature by all stakeholders regarding acceptability are worth revisiting by policy spearheads.

In spite of the grand scale of the scheme, the RSBY clearly has some limitations in both the design and operations. On the question of feasibility, it is clear that due to the numerous actors involved in implementation, the management has become complicated. The question of feasibility on whether there exists a reliable system of incentives and sanctions to guide the activities of all actors remains valid. The limitations certainly also arose from the broader constraints around institutional capacity that has plagued health system in India. The lack of empanelled hospitals in peripheral areas, incapacity of providers to perform certain procedures and consequent refusals, issues with IT operations etc. are all evidence of a lack in supportive administrative mechanisms for the successful operation of the policy. Overall, it is clear that most of the improvements needed for RSBY to meet its desired objectives will necessitate a determined approach and political will by the policy makers.

5.2 Recommendations

The RSBY is a welcome step towards universal health coverage in India, particularly for its focus on the BPL populations. Many of its limitations have been discussed in the preceding chapters. Following are some recommendations to improve the RSBY.

- (a) The role of the TPAs and Insurance companies in awareness generation needs to be monitored as clearly inadequate awareness is affecting both enrolment and utilization. The incentives system can be revised with sanctions/penalty for not enrolling all eligible beneficiaries or not issuing the smart cards. Time period of enrolment of 2-3 days, venue of enrolment and number of enrolment camps should be revised.
- (b) An improved grievance redressal mechanism with the government playing a greater role can be initiated
- (c) Likewise, an increase in administrative manpower, administrative support systems including IT to enable better monitoring and management
- (d) A greater focus on primary care and reimbursement of medicines cost as part of the benefits package to move toward universal health coverage
- (e) Revision of enrolment period above 1 year as in the Kalaighner and CGHS schemes
- (f) Expansion of RSBY with more attractive package and inclusion of contributing higher income populations to enable cross-subsidization and universality.
- (g) Convergence of RSBY and the other two public schemes- CGHS and ESIS

5.3 Study limitations

This study has several limitations which can be pursued by further research. Firstly, although the NCCHPP analytical framework allows for the use of various data collection methods, this study was able to utilise only literature review to analyse the RSBY. As the study did not use primary data, analysis was possible only to the extent available in the studies reviewed. Secondly, as studies were not available for all states (even for the 19 states with enrolment data in the RSBY online portal), this paper is unable to provide a more detailed findings and analysis, the scope of which is beyond this present study. Finally, as the study only utilised the analytical dimensions provided in the NCCHPP framework, there is a possibility of missing out on certain other aspects of RSBY that might require addressing.

References

Articles

Ahuja, R. (2004). Health insurance for the poor in India. *Indian Council for Research on International Economic Relations (ICRIER)*, 1-24.

Aiyar, A., Sharma, V., Narayanan, K., Jain, N., Bhat, P., & Mahendiran, S. (2013). Rashtriya Swasthya Bima Yojana: a study in Karnataka. *Centre for Budget and Policy Studies (CBPS), Bangalore, India.*

Baru, R., Acharya, A., Acharya, S., Kumar, A.S., & Nagaraj, K. (2010). Inequities in access to health services in India: caste, class and region. *Economic and Political Weekly*, 49-58.

Basu, R. (2010). Rashtriya Swasthya Bima Yojana: pioneering public private partnership in health insurance. *New Delhi: Department of Political Science, Jamia Millia Islamia.*

Berman, P., Ahuja, R., & Bhandari, L. (2010). The impoverishing effect of healthcare payments in India: new methodology and findings. *Economic and Political Weekly*, 65-71.

Cook, T.D. (1985). Postpositivist critical multiplism. *Social Science and Social Policy*, 21-62.

Dasgupta, R., Nandi, S., Kanungo, K., Nundy, M., Murugan, G., & Neog, R. (2013). What the good doctor said: a critical examination of design issues of the RSBY through provider perspectives in Chhattisgarh, India. *Social Change*, 43(2), 227-243.

Devadasan, N., Seshadri, T., Trivedi, M., & Criel, B. (2013). Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. *Health Research Policy and Systems*, 11(1), 1.

Dror, D. M., & Vellakkal, S. (2012). Is RSBY India's platform to implementing universal hospital insurance? *The Indian Journal of Medical Research*, 135(1), 56-63. <http://doi.org/10.4103/0971-5916.93425>

Garg, C.C. & Karan, A.K. (2009). Reducing out-of-pocket expenditures to reduce poverty: a disaggregated analysis at rural-urban and state level in India. *Health Policy and Planning*, 24(2), 116-128.

Grover, S. & Palacios, R. (2011). The first two years of RSBY in Delhi. *Palacios, R, Das J, Sun, C (2011) India's health insurance scheme for the poor: Evidence from the early experience of the Rashtriya Swasthya Bima Yojana. New Delhi, India: Centre for Policy Research*, 153-188.

Hsiao, W.C. (2007). Why is a systemic view of health financing necessary?. *Health Affairs*, 26(4), 950-961.

Kalita, A. & Mor, N. (2015). Social Health Insurance as a Complementary Financing Mechanism for Universal Health Coverage in India. *Available at SSRN 2607180.*

Loh, L.C. , Ugarte-Gil, C., & Darko, K. (2013). Private sector contributions and their effect

on physician emigration in the developing world. *Bulletin of the World Health Organization*, 91, 227-233.

Morestin, F. (2012). A framework for analysing public policies: a practical guide. *National Collaborating Centre for Healthy Public Policy*.

Narwade, S.S. (2014). Coverage Performance of Rashtriya Swastha Bima Yojana. *Scholars Journal of Economics, Business and Management*, 1(3), 90-92.

Nair, K.S. (2013). Rashtriya Swasthya Bima Yojana (RSBY)-hospitalised families in national capital territory of Delhi, *Artha Vijnana*, LV(1), 71-88.

Nandi, S., Nundy, M., Prasad, V., Kanungo, K., Khan, H., Haripriya, S., & Garg, S. (2012). The implementation of RSBY in Chhattisgarh, India: a study of the Durg district. *Health, Culture and Society*, 2(1), 40-70.

Narayana, D. (2010). Review of the Rashtriya Swasthya Bima Yojana. *Economic and Political Weekly*, 13-18.

Potvin, L., Ridde, V., & Mantoura, P. (2008). Évaluer l'équité en promotion de la santé. *Les inégalités sociales de santé au Québec*, 355-378.

Rathi, P., Mukherji, A., & Sen, G. (2012). Rashtriya Swasthya Bima Yojana: evaluating utilization, roll-out and perceptions in Amravati district. *Economic & Political Weekly*, 47, 57-64.

Rajasekhar, D., Berg, E., Ghatak, M., Manjula, R., & Roy, S. (2011). Implementing health insurance: the rollout of Rashtriya Swasthya Bima Yojana in Karnataka. *Economic and Political Weekly*, 46(20), 56-63.

Reddy, K.S., Patel, V., Jha, P., Paul, V.K., Kumar, A.S., Dandona, L., & Lancet India Group for Universal Healthcare. (2011). Towards achievement of universal health coverage in India by 2020: a call to action. *The Lancet*, 377(9767), 760-768.

Rychetnik, L., Frommer, M., Hawe, P., & Shiell, A. (2002). Criteria for evaluating evidence on public health interventions. *Journal of Epidemiology and Community Health*, 56(2), 119-127.

Shukla, R., Shatrugna, V., & Srivatsan, R. (2011). Aarogyasri healthcare model: advantage private sector. *Economic and Political Weekly*, 46(49): 38-42.

Selvaraj, S. & Karan, A.K. (2012). Why publicly-financed health insurance schemes are ineffective in providing financial risk protection. *Economic & Political Weekly*, 47(11), 61-68.

Swinburn, B., Gill, T., & Kumanyika, S. (2005). Obesity prevention: a proposed framework for translating evidence into action. *Obesity Reviews*, 6, 23-33.

Taneja, P.K. & Taneja, S. (2016). Rashtriya Swasthya Bima Yojana (RSBY) for universal health coverage. *Asian Journal of Management Cases*, 13(2), 108-124.

Thakur, H. (2015). Study of awareness, enrollment, and utilization of Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme) in Maharashtra, India. *Frontiers in Public Health*, 3, 282.

Thakur, H. & Ghosh, S. (2013). Case study report on social exclusion and (RSBY) Rashtriya Swasthya Bima Yojana in Maharashtra. *Health Inc, School of Health Services Studies*.

Trivedi, M., & Saxena, D.B. (2013). Third angle of RSBY: service providers' perspective to RSBY-operational issues in Gujarat. *Journal of Family Medicine and Primary Care*, 2(2), 169.

Books

Anderson, J.E. (1975). *Public policymaking*. New York: Praeger.

Cochran, C.L., & Malone, E.F. (2005). *Public policy: perspectives and choices*. Lynne Rienner.

Council for Social Development. (2015). *India social development report 2014: challenges of public health*. India: Oxford University Press.

Dunn, W.N. (1981). *An introduction to public policy analysis*. Englewood Cliffs.

Dunn, W.N. (2015). *Public policy analysis*. Routledge.

Fischer, F. & Miller, G.J. (Eds.). (2006). *Handbook of public policy analysis: theory, politics, and methods*. crc Press.

Infrastructure Development Finance Company Foundation. (2014). *India infrastructure report 2013-14: the road to universal health coverage*. New Delhi: Orient Blackswan Private Limited.

Salamon, M.L., & Elliott, O.V. (2002). *The tools of government: a guide to the new governance*. New York: Oxford University Press.

Sabatier, P.A. & Mazmanian, D. (1995). A conceptual framework of the implementation process. In S.Z. Theodoulou & M.A. Cahn (Eds.), *Public policy: the essential readings*. Upper Saddle River: Prentice Hall.

Schieber, G., Baeza, C., Kress, D., & Maier, M. (2006). Financing Health Systems. In D.T. Jamison, J.G. Breman, AR Measham, G Alleyne, M Claeson, D.B. Evans, P Jha, A. Mills & P. Musgrove (Eds.), *Disease control priorities in developing countries*, (p. 225). World Bank Publications.

Dissertations

Wu, Q. (2012). *What cause the low enrolment rate and utilization of Rashtriya Swasthya Bima Yojana: a qualitative study in two poor communities in India* (Doctoral dissertation, Liverpool School of Tropical Medicine).

Chaupal Gramin Vikas Prashikshan Evum Shodh Sansthan (Chaupal). (2013). *Study on status of public health services at various levels in Chhattisgarh*. Unpublished manuscript.

Newspapers

Mehra, P. (2014, December). Just 17% of Indians have health coverage. *The Hindu*.

Basu, K. (2007, July 25). India's demographic dividend. *BBC News*, Retrieved from http://news.bbc.co.uk/2/hi/south_asia/6911544.stm.

Reports

Averil, C., & Marriott, A. (2013), Universal health coverage: why insurance schemes are leaving the poor behind. *Oxfam International, Oxfam Briefing Papers*.

Kumar, S. (2010). Awareness accessibility and utilization of RSBY in Puri district Odisha. Xavier Institute of Management, Bhubaneshwar (Independent research project report).

Mazumdar, S., Singh, P.K., Shukla, S.K., & Kumar, A. (n.d.). Impact Assessment Study on Rasthriya Swasthya Bima Yojana (RSBY). *Population Health and Nutrition Research Programme, Institute for Human Development, New Delhi*.

Reddy, K. S., Selvaraj, S., Rao, K. D., Chokshi, M., Kumar, P., Arora, V., & Ganguly, I. (2011). A critical assessment of the existing health insurance models in India. *Public Health Foundation of India*, 1-115.

Seshadri, T., Trivedi, M., Saxena, D., Soors, W., Criel, B., & Devadasan, N. (2012). Impact of RSBY on enrolled households: lessons from Gujarat. *BMC Proceedings*, 6(5), 1. BioMed Central.

Sun, C. (2011). An analysis of RSBY enrolment patterns: preliminary evidence and lessons from the early experience. *India's health insurance scheme for the poor: evidence from the early experience of Rashtriya Swasthya Bima Yojana*. New Delhi: Centre for Policy Research.

Web Documents

Central Bureau of Health Intelligence, Government of India. (2015). National health profile. Retrieved from <http://www.cbhidghs.nic.in/writereaddata/mainlinkFile/NHP-2015.pdf>

Ministry of Rural Development, Government of India. (2011). Socio-economic and caste census in rural India. Retrieved from <http://rural.nic.in/netrural/rural/index.aspx>

Ministry of Health and Family Welfare, Government of India. (2014). National health accounts estimates for India 2013-14. Retrieved from <http://nhsrcindia.org/NATIONAL%20HEALTH%20ACCOUNTS-%20Estimates%20for%20India-2013-14.pdf>

Ministry of Health and Family Welfare, Government of India. (2014). National health policy 2015 draft. Retrieved from <http://www.mohfw.nic.in/showfile.php?lid=3014>

National Human Rights Commission. (2012, July). Media reports rampant uterus-removal surgeries in Chhattisgarh: NHRC issues notice to the State Government. Retrieved from <http://www.nhrc.nic.in/disparchive.asp?fno=2618>

Public Health Resource Network. (2012). Design Issues in RSBY: Mapping Provider Perspectives. Initial Findings. Presentation to Director, Health Services and State Nodal Agency-RSBY, Chhattisgarh, 20th March 2012 [Powerpoint slides]. Retrieved from <http://webcache.googleusercontent.com/search?q=cache:IKCDGBmngvQJ:phrsindia.org/wp-content/uploads/2016/02/5RSBY-design-issues-of-RSBY.pptx+&cd=1&hl=en&ct=clnk&gl=in>

Rashtriya Swasthya Bima Yojana. (2010). Evaluation Study of Rashtriya Swasthya Bima Yojana in Shimla & Kangra Districts in Himachal Pradesh. Retrieved from <http://www.rsby.gov.in/documents.aspx?ID=14#sub72>

Sharan, M.R. (n.d.) RSBY in the context of universalizing healthcare in India. Retrieved from http://www.academia.edu/10735990/RSBY_in_the_context_of_universalizing_healthcare_in_India

United Nations Development Programme. (2015). Human Development Report 2015: work for human development. Retrieved from report.hdr.undp.org

United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: data booklet 2015 revision. Retrieved from https://esa.un.org/unpd/wpp/publications/Files/WPP2015_DataBooklet.pdf

World Bank. (2016). Poverty & equity data: India. Retrieved from <http://povertydata.worldbank.org/poverty/country/IND>

World Health Organization. (2008). World health Report 2008: primary health care (now more than ever). Retrieved from <http://www.who.int/whr/2008/en/>