HEALTH FINANCING & DELIVERY IN INDIA:

AN OVERVIEW OF SELECTED SCHEMES

Kalpana Jain

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Glossary

AP	Andhra Pradesh
BPL	Below Poverty Line
CGHS	Central Government Health Scheme
CHC	Community Health Center
ESIS	Employees State Insurance Scheme
GDP	Gross Domestic Product
HBS	Harvard Business School
HRW	Human Rights Watch
ICDS	Integrated Child Development Scheme
IMR	Infant Mortality Rate
IT	Information Technology
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
NCEUS	National Commission for Enterprises in the Unorganized Sector
NFHS	National Family Health Survey
NHRC	National Human Rights Commission
NHSRC	National Health Systems Resource Centre
NIOH	National Institute of Occupational Health
NMCH	National Commission on Macroeconomics and Health
NRHM	National Rural Health Mission
NSSO	National Sample Survey Organization
PHC	Primary Health Center
PHFI	Public Health Foundation of India
RDPR	Department of Rural Development and Panchayati Raj
RSBY	Rashtriya Swasthya Bima Yojana
SEWA	Self Employed Women's Association
TB	Tuberculosis
UP	Uttar Pradesh

UPA	United Progressive Alliance
WHO	World Health Organization
WSJ	Wall Street Journal

Abstract: India has taken several innovative steps recently to introduce social security measures for informal workers and below poverty line population. The Central government recently launched the national health insurance scheme, the Rashtriya Swasthya Bima Yojana (RSBY), which is getting implemented across the country alongside several state governments schemes. Until recently, most of this population did not have access to any form of health insurance. Only 10 percent of Indians were covered by health insurance, that too highly inadequate.

This paper analyzed four health insurance schemes – the RSBY, Vimo SEWA, Yeshasvini and Rajiv Aarogyasri in terms of their benefits, coverage and access. The objective was to look at the strengths and weaknesses of the schemes as well as to critically assess how best they were able to protect the poor and informal sector workers against the impoverishing effects of health costs. Based on desktop research, the paper analyzed the schemes for their inclusiveness, quality of services, awareness amongst the intended beneficiaries, ease of access for women and their impact on reducing out -of - pocket expenditure on healthcare.

Over 80 per cent of health expenditure in India comes out- of-pocket and a quarter of those hospitalized fall below the poverty line as a result of the costs. Until recently, Central government schemes provided health insurance only to formal sector workers whereas 93 percent of the workforce in India comprises informal workers, majority of whom are poor. The National Commission for Enterprises in the Unorganized Sector (NCEUS) estimates about 836 million or 77 percent of the population, who constitute most of India's informal economy, are living below USD 0.4 a day (NCEUS, 2007).

In little over three years, the RSBY has provided hospital-based insurance cover to about 100 million people. State-based schemes have further expanded this coverage. While the achievement of RSBY in such a short period of time is commendable, the findings of this study show much of the government effort is directed towards providing inpatient care. RSBY, for instance, does not cover the cost of drugs or outpatient visits.

In fact, almost all schemes focus primarily on inpatient care, whereas evidence points to higher household expenditure on outpatient care. Only Vimo SEWA takes a comprehensive health care approach, making highly targeted interventions and assisting patients in accessing primary care through its own network of SEWA health. But Vimo SEWA operates on a much smaller scale. The larger schemes are focused mainly on provision of secondary and tertiary care.

Inclusion too is a problem, as under RSBY the criteria is based on a below poverty line list, which itself is faulty and does not even exist in some states. The current design risks missing out migrant workers. Moreover, the barriers to access for the poor could range from access to information to rude behavior of hospital staff. It is mainly Vimo SEWA that makes efforts to specifically address these barriers while working towards equity. Women's access to healthcare remains limited.

Quality is an area of concern as in the absence of a robust public health system, the schemes are highly dependant on the private sector, which functions in India without any protocols or regulations. In the absence of a strong quality monitoring mechanism, in

many places the poor get exploited with unnecessary surgeries. Finally, with state governments launching their own schemes, such as Rajiv Aarogyasri, there is an urgent need for a more cohesive and comprehensive national strategy to avoid this duplication and use the schemes to reduce out-of-pocket expenditure more efficiently.

1.Introduction:

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

Recognizing this, several state-based and Central health insurance initiatives have been launched in recent years. The largest of these initiatives is the Central government's national health insurance scheme, the Rashtriya Swasthya Bima Yojana (RSBY) which was launched in April 2008 and is being implemented in 25 of India's 28 states and 7 union territories(http://www.rsby.gov.in/Documents.aspx?ID=14). As a cashless scheme, it provides healthcare services to a family of up to five beneficiaries[1] through a smart card, enabled with the help of information technology. The scheme has achieved a wide

[1] Average family size as per the Census was 5.3 in 2001. In rural areas the family size was 5.4 and in urban areas 5.1 (http://censusindia.gov.in/Data_Products/Data_Highlights/Data_Highlights_link/data_highlights_hh1_2_3.pdf)

breadth of coverage, quickly issuing 23.5 million smart cards and providing coverage to some 100 million people, by the end of June 2011, across India. (Anil Swarup, 2011)

The scheme is significant as it is the first serious national effort at a health insurance for informal sector workers and those living below poverty line (BPL). The scheme aims to provide coverage to groups of informal workers such as construction workers, street vendors, *beedi* (a local cigarette) workers, beneficiaries under the Mahatma Gandhi National Rural Employment Act (MNREGA) who have worked for more than 15 days in the preceding financial year and approximately 4.75 million registered domestic workers. (http://www.rsby.gov.in/Documents.aspx?ID=14)

Before the launch of this scheme, the Central government provided health insurance only to formal sector workers through two large Central government health insurance schemes even though the informal sector in India constitutes almost its entire workforce. Ninety three per cent of the total work force in India (NCEUS, 2007) is in the informal sector and accounts for 60 percent of its Gross Domestic Product (Chen, 2003). A vast majority of this workforce comprises the absolute poor.

A recent report by the National Commission for Enterprises in the Unorganized Sector (NCEUS), an overarching advisory body and watchdog for the informal sector, constituted by the Indian government on September 20, 2004, highlighted that despite India's rapid economic growth, there was widespread poverty in this group. In its report, the NCEUS pointed out that at the end of 2004-05, about 836 million or 77 per cent of the population, who constituted most of India's informal economy, were living below

USD 0.4[2] a day (NCEUS, 2007). What is worse is, a majority of these workers work in hazardous conditions without any social protection (NCEUS, 2007).

Based on NCEUS' recommendations, the Indian Parliament passed a landmark legislation, the Unorganized Sector Workers' Social Security Bill in December 2008 to provide life, disability, health, and old age insurance to informal workers (NCEUS, 2007). Only 0.4 per cent of the unorganized sector workers in India receive any social security benefits (NCEUS, 2007).The Commission submitted its first Report on Social Security for Unorganized Workers on May 16, 2006 recommending the creation of a national minimum social security for all the eligible informal workers.

The National Health Insurance Program or the Rashtriya Swasthya Bima Yojana (RSBY) was announced under this new legislation. The RSBY is the first national health insurance scheme in India, which provides approximately USD 634 (Rs 30,000) to families to cover medical expenses at participating hospitals (http://www.rsby.gov.in), on a floater basis, which would mean the total insurance amount could be used for meeting health expenses of one person or jointly with other members of the family.

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

[2] The conversion rate used for the paper is 1USD equivalent of Rs 47.32

poor were being able to access these facilities. (Rajasekhar et al, 2011).

This paper will analyze RSBY and three states based schemes to find out their impact on providing protection from health costs to the poor and to informal workers. Amongst the schemes being implemented in different states, the paper will analyze Rajiv Aarogyasri in Andhra Pradesh, Yeshasvini in Karnataka and Vimo SEWA, now active in nine states in India. Rajiv Aarogyasri, launched as a scheme for the absolute poor, has expanded to provide health coverage to about 85 percent of the state's population. Yeshasvini has been providing secondary and tertiary health care to agricultural workers in Karnataka with the help of cooperative societies, which have a strong culture in the state. SEWA has been involved for over two decades, initially in the state of Gujarat and now in eight other states as well, in providing health insurance to poor, informal women workers and their families. Vimo SEWA has the longest learning experience amongst all these schemes and of working closely with women in the informal workforce. But it is RSBY that is being watched with a great deal of interest by researchers, development agencies and policy makers, both nationally and internationally. The scheme has connected a vast IT-enabled network of hospitals across India and is expanding rapidly to provide health insurance coverage to more and more people.

The paper will focus on five key aspects of the schemes in this analysis: inclusiveness and access for informal workers; quality of services being provided; awareness of the scheme amongst its intended beneficiaries; access for women and their impact on reducing out of pocket expenditure on healthcare. Health insurance schemes designed for informal workers need to take into consideration the various barriers to access. For instance, access may be difficult if wait times are too long or facilities are not in their

neighborhood. Informal workers risk losing a day's wage if the place is too far or services too time-consuming. These problems get all the more aggravated for women workers, trying to balance their responsibilities at home, along with work. Women account for a third of this informal workforce and often remain invisible (Chen, 2003; Sudarshan, 2009).

Women workers have special needs and poor health: Their work hours are long and income small. Moreover, their working conditions are such that their health deteriorates over time. It could be long hours of needlework or collecting hazardous waste. Worse still, there are no additional work-related benefits nor are they protected under any labor laws. Mothers-to-be often work until the time their labor pains start and return to work soon after delivery (Lund, 2009) The risk of accidents and occupational health hazards is high because of the hazardous nature of their jobs. SEWA found a high claims rate for fractures and accidents (Desai, 2009). As informal workers, these accidents are not covered for medical benefits by their place of employment.

Poverty exposes them to unsanitary living conditions and lack of access to basic living requirements, such as clean water. As a result, their risk profile for contracting preventable illnesses is high. In addition, these women are also responsible for household work, such as collecting water everyday, which puts additional strain on their bodies. Often these women suffer from health problems, but do not see a doctor, which only worsens their condition. Family needs take priority and when it comes to allocating resources, the health of a male or a child takes precedence over their own (Shah 2008). Marginalization and lack of education often prevents access to information. So, even when such schemes are available, access remains poor due to lack of awareness.

Quality is another major concern as India's health systems function without any regulations and the poor are often victims of apathy and neglect, especially when care is free or subsidized. It is in this context that it is imperative to study each of these schemes to know how best these schemes are meeting their stated objectives; what is the quality of care being provided and what may be the future policy direction for RSBY.

The paper is divided into three sections: Part I of the paper provides background information of the challenges of India's health care system, its public health infrastructure and its demographic and health challenges. It is critical to know the environment in which any of these schemes operate to fully comprehend the challenges of implementation and scalability. Part II of the paper discusses the structure, financing and benefits extended under the four schemes listed above and analyzes their performance. Part III of the paper presents its conclusions and recommendations.

PART II

2 : Overview of Healthcare and Demographic Profile in India

2.1 Healthcare in India

One of the big challenges of the India's healthcare system is the financial burden it puts on households in terms of out-of-pocket spending. The share of out-of-pocket spending on private healthcare is highest in India, in comparison with other developing countries except Pakistan (Berman et al, 2010). It remains one of the main causes of impoverishment as more than three-quarters of the health care expenditure is met by households (Balarajan et al, 2011). About 39 million additional people fall into poverty each year as a result of this expenditure (Balarajan et al, 2011). While most health insurance schemes focus on providing coverage for hospitalization, studies have shown

that it is the outpatient care that leads to more impoverishment than in-patient care (Berman et al, 2010).

Figure 2.1

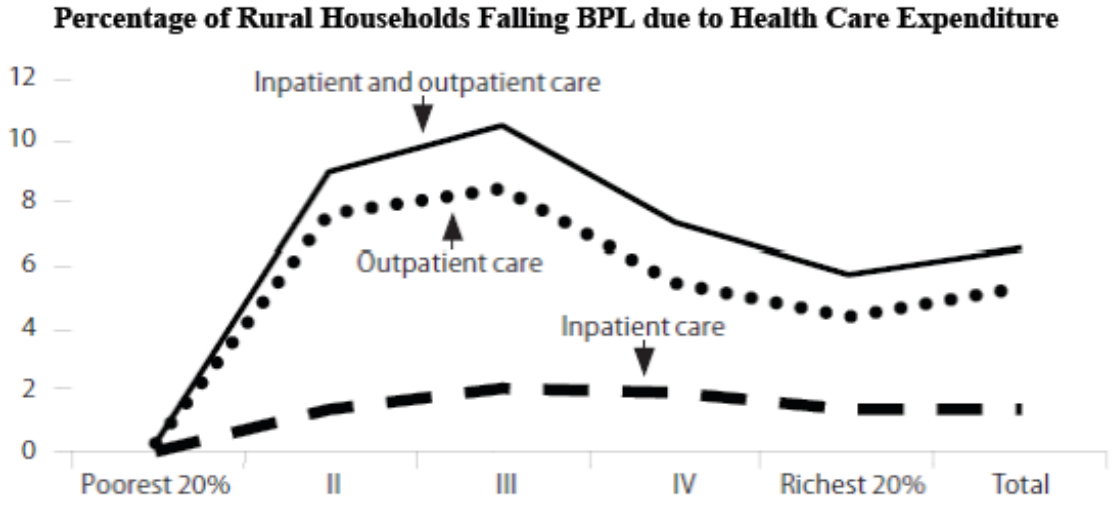
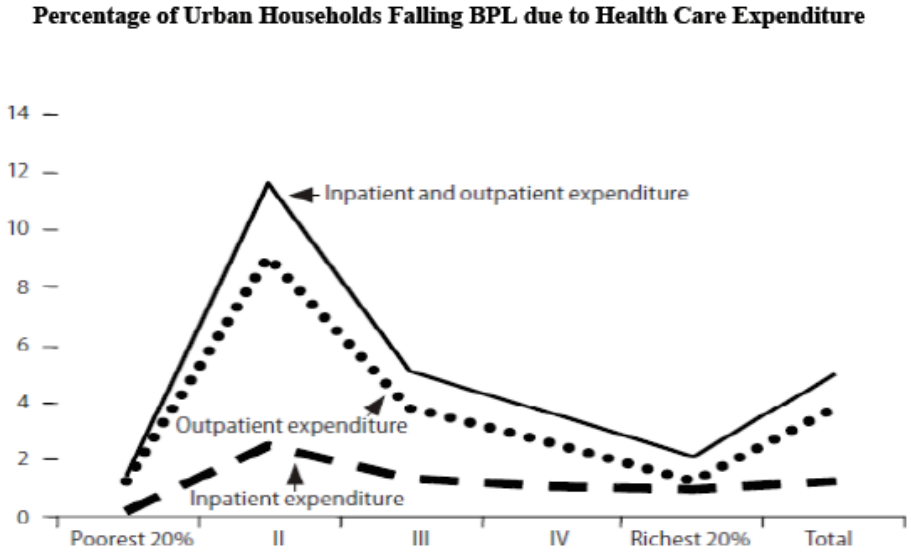


Figure 2.2



Source: Berman et al, 2010:67

2.1.1 ***Institutional Structure of Public Healthcare in India and Challenges:*** India's

health care system was carefully structured at the time of Independence by a committee led by P C Bhore to provide primary healthcare within a reasonable distance even in remote, rural areas. It was envisaged as a three-tiered system, with a vast network of primary health centers with referral linkages to secondary and tertiary care. Sub centers were set up for providing health care to every 5,000 population in the plains and to every 3,000 in hilly and tribal areas. Primary Health Centers (PHC) were set up for every 30,000 population in the plain areas and for every 20,000 population in hilly and tribal areas. Community Health Centers were set up to provide more specialized health services (Duggal; Gangolli, 2005).

A district-based system of secondary care was the next level of care and the last and final tier was the tertiary care. The system was meant to take preventive and curative healthcare to every remote, rural area. The vast network of sub centers and primary health centers were especially designed to address people's healthcare needs as close to them as possible (Nundy, 2005).

However, the system did not function as envisaged. Several studies and data from the ministry of health show how several sanctioned posts remained vacant as doctors were reluctant to go into far-flung rural areas. Often times essential medicines too were in short supply and people were dissatisfied with the services. Studies show that people had to walk a long distance to the PHC only to find that the doctor was not available (Garg, 1998). Apathetic attitude of staff, mismanagement, long waiting hours and unavailability of emergency equipment and life saving drugs, led to people seeking health care from private providers (Garg, 1998; Nandraj,1997). A report of The National Commission on Macroeconomics and Health (2005) points to serious shortage of specialists at

Community Health Centers alone. As a result, a large number of people, both in urban and rural areas, started to go to private providers.

2.1.2 ***Quality of Private Sector:*** The private sector filled in the gaps but the quality of this care is highly varied. In rural and poorer urban areas, people with no medical degrees also set up practice to fill in the huge vacuum for services. This private sector now provides most of health care services and it is where the bulk of manpower and infrastructure rests: approximately 80 percent of all doctors, 75 percent of all dispensaries, and 60 percent of all hospitals in India are now in the private sector (Narayan et al, 2003). But the quality of private sector is highly varied and much of it is concentrated in urban areas.

The National Commission on Macroeconomics and Health, after a survey of eight districts in India, found that the distribution of the health services was highly skewed, with 88 percent of urban areas having health facilities compared with 24 percent of rural areas. Two-thirds of the doctors were in urban areas (NCMH, 2005). There was an absence of uniform standards, treatment protocols, or even regulations (NCMH, 2005).

The private sector health care is provided on the basis of fee-per-service and for profit. Private corporate hospitals, registered under Indian Companies Act are owned by shareholders and are run like any other private limited company. Their motive is profit and they operate on fee-for-service basis. They could also be offering their services for a premium paid to them directly or through medical insurance companies (Garg, 1998).

At the same time, the entry of high-end private medical centers pushed up the overall costs of healthcare. A billion dollar industry emerged in India thanks to the quality of this

health care, known commonly as medical tourism[3]. Government hospitals, unable to compete with the resources of this high-end private care, suffered a further setback, as the best in the teaching faculty, specialists and other medical staff, left for better infrastructure, work environment and remuneration in the private sector.

2.1.3 *Quality of Public Sector*

The quality of public sector services and infrastructure has, thus, been steadily declining in many states. There are variations though, depending on the administrative infrastructure of the state and the political leadership. The northern state of Bihar seems to be worst hit on quality, which is reflected in how few people visit any of the public sector facilities. In Bihar, 93 percent of people do not use public sector health facilities (NFHS 3, 2005-06) although the situation is vastly opposite in Sikkim where only 8 percent people do not want to use government facilities.

Overall, government healthcare is seen as being poor quality and only when people cannot find or afford private healthcare, do they go to a government hospital. In many places, this may be the accurate view as well, even though private healthcare too may not be good quality. There is a complete lack of accountability with people having little by way of recourse to any form of redressal for cases of neglect or negligence. Often times, highlighting their plight through the media is the only recourse, which, otherwise, would go unnoticed.

This case here would help illustrate the plight of the poor, even after the launch of RSBY. In July 2011, media reports brought to attention the deaths of at least 18 children

[3] . In 2004, the market for medical tourism was estimated at US$333 million. It is predicted to generate US$2 billion a year business opportunity by 2012 (Hazarika 2006).

within 48 hours in a state-run hospital in Kolkata, the capital city of West Bengal, a state in Eastern India. All these were poor people, who had traveled long hours with critically sick babies before they could get to a health care facility. The tertiary care hospital did not have adequate infrastructure to provide the necessary critical care, which may have led to a large number of these deaths (Daily Bhaskar, 2011). The Wall Street Journal (WSJ), while commenting on India's healthcare, recently said in a front-page article: "Overall, the nation's vast, government-run health system can be a dangerous place. Hospitals are decades out of date, short-staffed and filthy. Patients frequently sleep two to a bed (WSJ, July 30, 2011). The launch of the various health insurance schemes have done little to change the state of healthcare for the poor.

Widespread poverty and the poor social status of vulnerable groups creates additional barriers in access to healthcare at public sector hospitals where the staff has often been known to be rude and uncooperative, especially with the poorer patients.

This state of the public sector has affected the performance of large-scale government programs. A review of the performance of the National Rural Health Mission, a flagship program of the UPA government launched in May 2005 to improve access and availability of quality care in rural areas, offers a glimpse into the challenges a national scheme is likely to face, given the weak state of the public sector. While much has been achieved under the scheme, rural areas still suffer from huge shortfalls.

Studies by Human Rights Watch (HRW), which conducted a field review of the facilities in the northern state of Uttar Pradesh, also pointed out serious quality issues. The HRW found Uttar Pradesh had 583 fewer community health centers than the 1,097 required by Indian public health standards. Fewer than a third had an obstetrician or

gynecologist; about 45 percent did not have funds for an ambulance; equipment was not available for emergency cases and only 100 had a blood storage facility (Varia, 2009).

Other studies too have noted serious deficiencies in manpower and infrastructure despite sustained and targeted focus at improvements. Five years after the launch of NRHM, shortages for doctors, various specialists, lab technicians and radiographers at community health centres were between 50 percent to 70 percent. Absenteeism continued. And around 10 percent to 15 percent primary health centers were without water supply and electricity (Mahal et al, 2011).

2.1.4 ***Mismanagement in Healthcare:***

One of the questions that has been raised is how judiciously does India utilize her healthcare budget? Is the health outcome poor in India due to budgetary constraints or mismanagement of resources? Why does India have such poor outcomes on its public health facilities? These are important questions to consider given the size of the national health insurance program, whose success, in part, will depend on how well resources are managed.

Clearly, one reason is the low spending. Overall India spends very little on healthcare. Public spending on healthcare in India by 2004-05 was only about 0.9 percent of the GDP, ranking India 171 among 175 nations on healthcare spending. The UPA government has managed to raise this spending to only 1.4 percent of the GDP (WHO, 2008)

But an additional reason could well be in the way resources are managed and distributed. Researchers have pointed out how the distribution of resources is skewed

toward salaries and other consumption expenditure and very little towards capital expenditure on buildings, machinery and equipment. About 97 percent of the public health expenditure in India is used for consumption expenditure. While about 60 percent of the consumption expenditure is spend on wages and salaries, only 35 percent is allocated towards materials and supplies, drugs, and transport. This eventually leads to poor services and lack of availability of drugs and equipment at health care facilities (Garg, 1998).

Countries such as Bangladesh and Indonesia spend about USD 14 and USD 19, respectively, per capita on health, which is relatively less than the per capita spending by India (USD 23) but the health outcomes in terms of child mortality are considerably better in these countries -- 74 for Bangladesh and 45 for Indonesia compared to 93 for India (World Bank, 2003; NMCH, 2005: 242).

It may be important to point out here that health is considered to be a sector leading in corruption in India, which could have serious implications for large publically-funded schemes. Transparency International India pointed out that health, which has the maximum public interaction, is also the second most corrupt sector, after the police. The Karnataka Lok Ayukta (ombudsman) estimated that at least 25 percent of the budget in health care was siphoned through corrupt practices. Studies that analyzed the Lok Ayukta's report found the corruption in the system so pervasive that all categories of government health functionaries, from lower level sanitation staff to nurses, doctors and specialists, were involved (NMCH, 2005: 54).

The level of corruption is not limited to concern on unethical financial transactions but also to safety in healthcare settings, many of which will mostly involve the lives of poor

and marginalized groups. The Lok Ayukta's report, for instance, found unlicensed manufacturers of drugs and blood bank operators had been given large orders and no action seemed to have been taken against suppliers of spurious drugs. In the private sector patients were exploited through unnecessary tests. This may be a major area to work on for the health insurance schemes, where there have been reports of unnecessary surgeries and other malpractices (NMCH, 2005: 54). Better standards of monitoring and accountability need to be set up.

2.1.5 *Financing of India's Healthcare Systems:*

In India, health is primarily the responsibility of the states, even though the Centre is a major source of financing, which explains why the quality of the public sector is so varied. The Central government finances curative services in Central government hospitals and clinics and also provides support for disease control programs. However, the responsibility of implementation of the programs rests with the states. The states are required to fund their own hospitals and primary health care centers. Programs are funded with the help of general tax and non-tax revenues. These include grants and loans received from both internal and external agencies (Garg,1998).

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

most of the public sector employees and employees of the autonomous bodies (Garg, 1998).

2.2 India's Demographic and Health Indicators:

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

The three rounds of NFHS found children in India suffering from severe malnutrition manifesting through stunting, underweight and wasting. Forty eight per cent of children under five years of age were found to be stunted and 43 percent were underweight, twice as high as the average percentage of underweight children in sub-Saharan Africa. Seven out of every 10 young children were found to be anemic. Despite government schemes, such as the Integrated Child Development Scheme (ICDS), malnutrition continued to be high amongst children (NFHS, 1992 –2006).

The third round of NFHS pointed to the increasing disparities in the health condition of the different groups of the population in the same city, an indicator of the vastly different access of these groups to healthcare. In NFHS-3, the under-five mortality rate was 73 for every 1,000 live births among the urban poor, compared with the average of 48 among all city dwellers in India. This finding may be of particular interest to this study as the majority of the informal workers would either be part of the urban or rural poor (NFHS 3,

2005-06).

Similar disparities were noticed in the rural and urban indices. India's infant mortality rate too declined from 129 deaths per 1,000 live births in 1971 to 53 in 2008. However, IMR in rural areas continues to be much higher. Currently, the urban IMR is 36 as compared to the rural IMR of 58 (National Health Systems Resource Centre NHSRC).

Adding to its challenges, India continues to have extensive poverty. A 2007 estimate of poverty in India by Abhijeet Sengupta, economist and member of the government's Planning Commission, shows 77 percent of Indians living on less than USD 0.4 (Rs 20) a day. An official government panel, known as the Tendulkar Committee, revised the estimate of poverty in India for 2004-05 to 37.2 percent from 27.5 per cent and for rural India to 41.8 percent from 28.3 percent, over the existing official averages (Srinivasan 2010). However, even when revised, these figures represent large numbers for a country with a population of 1.2 billion. And in the absence of affordable and accessible systems, the poor, a majority of which are informal workers, are likely to be the most disadvantaged.

Low-income people are at higher risk of getting TB as it spreads in crowded places. TB kills more women in India than any other infectious disease and causes more deaths among women than all causes of maternal mortality combined (Dua, 2005). With about two to three million cases per year, the reported incidence of malaria too is high (Dua, 2005: 18). At the same time, the burden of non-communicable diseases in India is expected to double with cardiovascular diseases and diabetes showing a steep increase. Increasing cases of cancers and tobacco use are adding to India's challenge.

2.3. Gender Disparity: Gender bias remains a serious concern in India where preference

for sons leads to sex-selective abortions. Despite India introducing legislation against determining sex of the fetus, such abortions are increasing with the 2010 Census data showing a worsening of the sex ratio, with 914 girls per 1,000 boys. The last census in 2001 had also seen a sharp decline over the previous one – it had dropped from 945 girls in 1991 to 927 girls per 1,000 males in the 0 -6 age group (Guardian, 2011).

The bias towards the girl child expresses in various ways and has a serious impact on her quality of life, access to health and survival. NFHS 3 data shows how more girls, compared with boys, risk dying following the first month of life, even though biologically, mortality would be higher for male children. More girl children die in India beyond one month of life, whereas in most countries where infant and child mortality is driven by biology alone, male mortality is higher. In India, the mortality rate for girls, age 1–11 months per 1,000 live births, is 21, compared with only 15 for boys (NFHS 3, 2005-06).

This disparity, which begins at birth, translates into how women use and access resources. . Often, the awareness of what may be available for them does not exist. The national literacy rate for women in India is far below that of men: Forty one per cent of women and 18 per cent of men age 15 to 49 have never been to school. Fewer women have any exposure to any form of media as compared to men, which may limit their ability to get information. NFHS 3 found 35 percent of women had no regular exposure to newspapers or television, compared with 18 percent of men (NFHS 3, 2005-06). This may well point to the need for better targeted schemes for women.

PART II

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

Table 3.1 Overview of Schemes Being Reviewed

Schemes Reviewed	Rashtriya Swasthya Bima Yojana (RSBY) –	Vimo SEWA - Community Based Health Insurance Scheme	Rajiv Aarogyasri – – state government initiative	Yeshasvini- – Community Based Health Insurance – Private Sector Initiative
Scope	As a National Health Insurance Scheme, it is to be implemented all over India	Operational in nine states of India	Operational in the southern state of Andhra Pradesh	Operational only in the southern state of Karnataka
Targeted population	Below poverty line and certain categories of informal workers	Poor women workers in the informal sector and their families	Below poverty line population	Mostly agricultural workers who are members of cooperative societies in the state.

3.1. The Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme)

On April 1, 2008, the Indian government launched the Rashtriya Swasthya Bima Yojana (RSBY) to provide health coverage to informal workers and those living below poverty line (BPL). The scheme, first announced by the Indian Prime Minister, Manmohan Singh, on October 2, 2007, has since emerged as one of the largest health insurance schemes in the world (Reddy et al, 2011). The scheme is aiming at addressing the needs of different groups of informal sector workers such as building and other construction workers, street vendors, beedi workers, domestic workers and rickshaw pullers. The scheme design includes workers who may not have found employment for sometime but worked under

the Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA)[4]. So, those who worked for more than 15 days in a previous financial year would also be entitled to coverage under the scheme (http://www.rsby.gov.in/).

3.1.1 *Structure, Financing and Benefits package:*

The scheme is largely funded by the Central government, with the Centre financing 75 percent of the scheme while state governments putting in the remaining 25 percent, except for the North Eastern states where the contribution of Central government and state government is in the order of 9:1 respectively. The scheme covers hospitalization charges up to about USD 634 (Rs 30,000) for up to five members of a family, which include the head of household, spouse and up to three dependents. Pre-existing conditions are covered and there is no age limit. Beneficiaries of this scheme are required to pay only about USD 0.63 (Rs. 30) as registration fee while the government pays up to USD 16 (Rs 750) per family per year. The scheme also provides transport allowance, up to USD 21 (Rs 1,000) per year. However, the scheme does not cover outpatient care (http://www.rsby.gov.in/ or the cost of medicines.

The scheme works through a well-enabled IT system. Beneficiaries are issued a smart card that stores their name, age, photograph and thumb impression. This smart card needs to be presented to participating hospitals to avail treatment. Hospitals have been provided the technology to submit these transactions online to the insurance companies for reimbursement. (http://www.rsby.gov.in/) States have the flexibility to modify the scheme, its coverage, the package provided and even the cost of various procedures, to

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

their requirements. The Central government has worked out an initial package, but coverage is not limited to it. For instance, Kerala has decided to extend the scheme to above poverty line families as well. (RSBY Kerala evaluation paper. http://www.rsby.gov.in/Documents.aspx?ID=14) The initial package too is being revised to include more procedures, from 726 to 1100, based on feedback from insurance agencies (Reddy et al, 2011: 35)

Insurance companies are selected on the basis of bidding. Every State Government bids out coverage to public and private insurance companies. The scheme does not encourage competition at the level of the district, with only one insurance company allowed in a district. (http://www.rsby.gov.in/) However, an increasing number of insurance companies are entering the bidding process. From six, the number of insurance companies bidding for the roll out in 145 districts, has gone upto 11, an indication of the scheme's commercial viability (RSBY initial trends, 2011,http://www.rsby.gov.in/Documents.aspx?ID=14).

There is criticism though of handing over the responsibility for the enrolment of families and of tying up for services with public and private hospitals, to the insurance companies, along with smart card subcontractors, as it could have potential consequences in determining risk selection (Reddy et al, 2011).

Table 3.2 Salient Features of RSBY:

- Hospitalization coverage for up to Rs. 30,000 (approximately $ 634) for a family of five on a floater basis.
- Transportation charges up to a maximum of Rs. 1,000 (approximately $21) with a limit of Rs. 100 (approximately $2.1) per hospitalization.
- Pre and post hospitalization coverage up to 1 day prior to hospitalization and up to 5

days from the date of discharge from the hospital.

- All pre-existing diseases covered.
- No Age Limit
- IT enabled. Once a hospital is empanelled, a nationally-unique hospital ID number is generated so that transactions can be tracked at each hospital.
- Does not cover out patient expenses or cost of drugs

Source: Working Paper, Anil Swarup, Nishant Jain 2010)

3.1.2 *Performance of RSBY:*

With about 100 million people being provided health insurance under the scheme, the RSBY could be viewed as being highly successful in expanding the breadth of coverage . However, these results are not consistent across states. Data available from the ten states where one or more districts that have completed two years under the scheme, points to large variations in results between high performing states such as Kerala and low performing ones such as Uttar Pradesh. While Kerala and Delhi show a sharp increase in enrolments in the second year, the states of Haryana and Uttar Pradesh actually show a reduction in enrolment (RSBY Gets Going http://www.rsby.gov.in/Documents.aspx?ID=1) pointing to the difference in the level of interest taken by the state administration and the effectiveness of the implementation of the scheme and an indication, perhaps, of the quality of healthcare.

In terms of its coverage, the scheme provides only secondary level health care. Given that, health coverage of about USD 634 (Rs 30,000) is sufficient protection for most households in a given year (Rajasekhar et al, 2011). Studies from Karnataka show, on average, a poor household spends Rs 20,000 on hospitalization each year (Rajasekhar et al, 2011).

However, the big gap is a lack of provision of medicines or outpatient care, which has been shown to be a bigger reason for impoverishment when compared with in-patient hospital expenses (Peter et al, 2010). The main reason for keeping out drugs and outpatient coverage from RSBY is more to do with regulatory issues than actual needs. In the present health system, physicians can increase the number of patient visits and prescribe unnecessary and expensive medicines. In addition, prescription drugs can be easily obtained over-the-counter in India, which makes it more difficult to enforce any regulations (Reddy et al, 2011). But in the absence of a comprehensive coverage, the scheme risks continuation of high out-of-pocket expenses in these population groups that it seeks to protect against further impoverishment. The scheme is in its infancy and is grappling with various other issues of implementation as well.

3.1.3 ***Inclusion and Access for Informal Workers:***

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

works for people like us," Rajkumar told Mint. (2010).

But success stories such as this one, also need to be viewed in context of the larger structural problems with the process of inclusion. Legitimate beneficiaries have been left out of the scheme because of those problems. The Wall Street Journal (2008) reported the story of Vidhya Devi, the wife of a farm worker with two daughters, who could not get her entire family to be eligible for benefits as only her husband's name was on the card. These anomalies happen when the state fails to provide complete information to insurance companies. Getting this corrected is no easy task for a poor, illiterate farm worker, more so, if she is a woman. So, Vidhya Devi would need to write to the state and then present herself to the officials for a correction to be made.

The criterion for inclusion in the scheme is based on a Below Poverty Line (BPL) list of people drawn up through the Planning Commission of India. This BPL data is known to be ridden with problems. BPL is an economic benchmark the government uses to identify families in dire poverty. This data helps determine which families get aid under some of government's new welfare schemes. Here is where the problem arises: not only is the data is based on a survey conducted in 2002, but this list itself is stated to be faulty (Down To Earth, 2011).

A fresh survey has been postponed as the Central government is undecided on criteria to identify families below poverty line. It has been difficult for the government to determine the criterion by which to differentiate the poor from the absolute poor (BPL). And once again the performance of different states regarding this list has been varied. Kerala identified its own indicators for its BPL population. But several other states do not have a BPL list, which makes it difficult for the scheme to reach genuine intended

beneficiaries.

In some areas it led to social divisions and serious tensions where people felt they were unjustly left out, whereas their neighbors, with the same socio-economic background or even higher were included. In some rural areas, police had to be called to control the tensions. In many states, genuine informal workers are not on the list.

An evaluation from Karnataka, which describes the experience of implementing the scheme in detail in rural areas could explain the experience for informal workers (Rajasekhar et al, 2011). In the absence of a list for urban population, the state could not include the BPL population in urban areas. As a result, the scheme was implemented only in some select districts in rural areas. Here too, the BPL list was missing, but data was taken from another survey undertaken by the Department of Rural Development and Panchayati Raj (RDPR) in 2003. The state finally used the list of BPL ration cardholders, but the errors of inclusion persisted.

In addition, names of members in the list of eligible households were incorrect. In some cases, the name of the head of the household, required for issuing the smart card, was missing from the list. Such households were not allowed to register using another member as head of family. Thus, in families where the head of the household was ill or deceased, the members were unable to register.

Such errors led to clashes and tensions and at times the enrolment process had to be called off (Rajasekhar et al 2011). Angry people in these areas confronted enrolment officers when they found their names missing whereas the names of their neighbors or people considered being better off were being given the benefits. In such places, enrolment teams did not return to complete the process.

A newspaper report from Uttar Pradesh reveals a similar story where despite the presence of a BPL list, the enrolment teams could track only 50 percent names on the list. In the absence of these names, a private insurance company, ICICI Lombard, that was given the contract, was able to issue only 834,000 smart cards against a target of 1.924 million families in 15 districts (Indian Express, 2010).

Many of these families could be migrant workers and therefore not traceable. Moreover, the scheme requires families to register in their home states on the basis of BPL list (WSJ, 2008). This means that migrant workers, who have been unable to return home for long periods of time and therefore are not registered, cannot avail of the scheme even during times of illness. Thus, the design of the scheme risks missing out a large number of informal migrant workers.

An evaluation of RSBY by the ministry of labor also shows similar findings. In a paper on RSBY evaluation from Jaunpur in Uttar Pradesh, the evaluation acknowledges the gap between the BPL list and the BPL card holders. It acknowledges the huge "disconnect" between the BPL data between the State and the Planning Commission. (RSBY evaluation Jaunpur, 2010. http://www.rsby.gov.in/Documents.aspx?ID=14)

The Karnataka study (Rajasekhar et al, 2011) reveals other drawbacks too in the process. In almost all villages, enrolment took place either at the government school building or gram panchayat office. However, the location was not determined by what would be most convenient for people, but where the enrolment team felt they could target the maximum number of families. In many cases families had to go to another village to enroll, which was not most suited to the needs of the informal work force, who would suffer loss of wages.

Often times, there was no advance information given on when these registration camps would be held. Even the time and venue was not specified in advance. The Karnataka survey thus shows that 17 percent of households did not enroll even though they had heard of the scheme (Rajasekhar et al, 2011). So when the enrolment camps were organized many people were away on daily wage work or in the fields. In the absence of more information, many of these households believed they would be able to enroll in the late afternoon or the following day, which they could not. Others were unable to enroll because they were away from home on the day of enrolment for reasons such as the death of relative, hospitalization or attending a wedding. (Rajasekhar et al, 2011). The procedures require the presence of the head of the household for the smart card to be issued. In no case was this condition relaxed.

3.1.4 *Information and Awareness*: This is a critical part of the scheme if it is to reach the genuine beneficiaries. RSBY managers do acknowledge the need to create awareness for the success of the scheme. The RSBY website acknowledges that "inadequate awareness" amongst intended beneficiaries is often a common problem for many government initiatives. Under the scheme, state governments are responsible for creating effective programs for spreading awareness.

However, most states have handed over the function to insurance companies, who have a clear disincentive in doing so. More awareness would only lead to more claims and increase the chances of loss for insurance companies. District studies show that insurance companies are, in some districts, even forgetting to provide basic requirements to the customers: a list of network hospitals (Rajasekhar et al, 2011).

Much of the information that people received was through word of mouth. Studies

show that the most common way in which learnt of the scheme was through family and friends. The RSBY survey shows that 69 percent of RSBY patients first learnt of RSBY through a friend or family member and even learnt of about the hospitals that were empanelled through family members or friends. The survey shows this to be 61 percent (http://www.rsby.gov.in/Documents.aspx?ID=1).

3.1.5 *Quality* : The effectiveness of any health insurance scheme will depend on the quality of health infrastructure, whether in the public or private sector. As Part I of this study pointed out, there are large variations in the quality of healthcare and both public and private sector function without any accountability. The poor are more likely to suffer this lack of monitoring and free provision of healthcare may turn out to be only too costly for some. Here is an account of what The Wall Street Journal captured in a front-page article on July 30, 2011, which until then had gone unnoticed and unaccounted for. The WSJ profiled the death of Ruksana, an informal worker, who was given an IV infusion, later found to have bacterial growth in a government hospital in Rajasthan. Married at the age of 15, Ruksana, while caring for a household of seven, including an extended family of relatives, earned a total of less than $100 a month dyeing and ironing scarves and bed sheets from a nearby factory. Ruksana was just a number in a series of maternal deaths in this hospital until The Wall Street Journal followed up her story. The tragic case illustrates the quality of healthcare, as it exists for a vast majority of poor in many states of India, despite the launch of RSBY (WSJ, 2011). It may, thus, be worthwhile for RSBY to not focus exclusively on the number of smart cards that have been issued to judge the overall success of the scheme, but on the overall quality of health provisioning as well.

The ministry of labor is implementing the scheme with little involvement of the ministry of health. The focus of the scheme has been implementation, with no systems being set up on monitoring of its health component.

The private sector, as it is, has been functioning without any regulations. As has been discussed earlier, India's healthcare is highly privatized. It is not a surprise then that the majority of the hospitals empanelled by RSBY are in the private sector -- it has empanelled 4,923 private and 2,267 government hospitals (http://www.rsby.gov.in/Documents.aspx?ID=14).

This raises several concerns: One, from available studies, it appears the number of empanelled better private sector hospitals is much too low, which brings us back to the issue of quality of services. For instance, the evaluation from Kerala shows the number of private hospitals that had either better infrastructure or better facilities was low. This affected the quality of services, as many of the empanelled hospitals did not have many of the required specialist services. Only general medicine was found to be available at all of the empanelled hospitals in Kerala, forcing people to see private sector hospitals outside of the scheme. (RSBY evaluation Kerala, 2010.http://www.rsby.gov.in/Documents.aspx?ID=14).

The evaluation from Jaunpur in UP also shows the private sector was lacking in quality and several facilities were missing, forcing patients to seek care outside the network for non-reimbursable costs. (RSBY evaluation Jaunpur, 2010. http://www.rsby.gov.in/Documents.aspx?ID=14)

Two, the impact of long term impact on the public sector need to be considered if substantial resources continue to be channeled into the private sector. And three, its

impact on future health costs and further medicalization of health care, as a result, also need to be looked at. Hospital-based health coverage is only effective in reducing household expenditures when there is a robust, supportive primary health system that extends to under-served areas. In its absence, it may lead to increased hospitalization.

3.1.6 ***Out –of- Pocket Payments:*** A big part of healthcare expenses in India are out-of-pocket payments. About 79 percent of impoverishment is a result of outpatient care, which involves several small, but frequent payments and only 21 percent is a result of inpatient care. (Peters et al, 2010) Peters et al measured the impact of healthcare payments by calculating the number of households below the poverty line, before and after these expenditures. The household expenditures were "corrected for dis-savings or borrowings due to healthcare" Data from the National Sample Survey Organization for morbidity and healthcare survey was used for the study. Based on this, Peters et al estimated around 63.22 million individuals or 11.88 million households fell below the poverty line due to healthcare expenditures in 2004. In the absence of correction, the rate was much higher – 73.9 million individuals or 13.9 million households. Peters et al subsequently analyzed this impoverishing effect across states, urban and rural areas, incomes and between outpatient and inpatient care and found the costs of outpatient care responsible for much of the impoverishment. The outpatient care costs may be relatively small, but they involved frequent payments. Poverty line, in this study was calculated using the official Indian Planning Commission methodology. Poverty line numbers for 1999-2000 were updated for 2004, by inflating them. This was done both for the state level and for rural and urban areas. Peters et al used the international poverty benchmark of $1.08 per head per

day. Based on these results, Peters et al point out that "Schemes like RSBY have typically been designed based on strong assumptions and little evidence about the risks faced by poor households and the best approaches to addressing them." (Peters et al, 2010:70)
That being so, RSBY would have only a limited effect in reducing out-of-pocket payments. The benefit package under RSBY is mainly focused on the provision of secondary care. It does not include outpatient visits or cost of drugs.

If the primary health care system is functional and strong, the scheme can provide additional benefits through secondary care. In Tamil Nadu, for example, primary care and secondary care are already well provided by the public sector (Reddy et al, 2011). In states where the primary care is not so sound, Reddy et al state that insurance schemes must aim for better integration with the public sector through a referral system. The concept of cashless should imply that the patient is not incurring any out-of-pocket expenses, which is not the case (Reddy et al, 2011).

In the absence of coverage for outpatient visits or drugs, the scheme risks appearing to be a band-aid solution to a much larger problem. Studies have shown in the absence of coverage for outpatient visits, people delay going to a doctor for as long as they can. Research shows this to be one of the reasons for delay in seeking healthcare among informal workers. Such delays could not just lead to longer hospitalization but also income loss for informal workers. Often, the impact on women's health is more severe as they are the last to visit a doctor if they have to pay for the services.

3.1.7 *Gender Bias*: Given the gender bias in India, RSBY will need to do a lot more to make the scheme more accessible to women. RSBY's gender analyses available from the

145 districts shows the number of men among the families issued the smart cards, was far more than the number of women. In the districts that have completed one year, nearly 27 million were issued smart cards. However, of these persons, only about a third --- nearly ten million - were women. It is also possible that in many cases only the name of the man as the head of the household may be available thus skewing some of the results (RSBY initial trends, 2011. http://www.rsby.gov.in/Documents.aspx?ID=14). However, the picture is not too different even when looking at disaggregated level data, which shows women outnumbering men in only 6 out of 167 districts. There are large disparities between different states, which provide

valuable data on where more efforts need to be directed.

Some areas, with known gender bias, also reflect the same in the RSBY data. For instance, in Faridkot in Punjab, only 658 females were enrolled as against 4365 male members.. Encouragingly, there were some districts where women outnumbered men, but those were few. Trends from nine districts that have completed second year indicate more women may be accessing health services, which may be so as a result of more information being readily available (RSBY gender analysis, 2011. http://www.rsby.gov.in/Documents.aspx?ID=14).

3.2. Vimo SEWA Health Insurance Scheme

Launched in 1992, Vimo SEWA is a micro-insurance program, to help provide hospital-based coverage to poor women workers in the informal sector. Set up by the Self-Employed Women's Association (SEWA) a labor union of over 1.1 million women workers in the informal economy, Vimo SEWA has 200,000 members spread across

nine states of India (Shah, 2008). SEWA's members come from different areas of the informal work force: agricultural laborers, construction workers, street vendors or home-based workers. Ela Bhatt, who founded SEWA in 1972, made special efforts to study the issues around the health of women workers in collaboration with the National Institute of Occupational Health (NIOH) Ahmedabad, which provide an important learning for health insurance schemes wanting to reach informal workers.

As mentioned earlier, women workers have special needs as their health deteriorates over time due to the long hours or hazardous nature of their work. They have a higher rate of fractures and accidents (Desai, 2009). Unsanitary living conditions and a heavy load of household work adds to the strain on their bodies. Family needs take priority and they often do not seek treatment for their own medical needs.

SEWA tries to integrate these needs into working towards better health. For instance, SEWA makes interventions to make water more accessible to these women, as a way to lessen the strain on women's bodies (Lund, 2009; Shah, 2008). SEWA's approach to their health is tailored to their needs and aims at reducing the barriers to access. Vimo SEWA started initially by partnering with the United India Insurance Company (a subsidiary of the Government Insurance Company). However, it soon realized that insurance companies do not have any experience in insuring the poor, which requires a different approach. Eventually, in 1994, SEWA decided to run Vimo SEWA by itself. It was a new challenge but eventually SEWA did learn how to administer the scheme in a sustainable way. It also learnt that it could improve its membership by improving the quality of its services (Shah 2008).

3.2.1 ***Structure, Financing and Benefits Package:*** Vimo SEWA provides life, hospitalization and asset insurance as an integrated package. Membership is voluntary. Women, between 18 to 55, can join the scheme as principal members of Vimo SEWA. Women need to be the primary members to buy insurance for their husbands and children. These members remain eligible for hospitalization benefits until 70 years of age, provided they remain insured every year after the age of 55 (Ranson et al, 2006).

SEWA's team of trained community based health workers, called *aagewans*, interact on a regular basis with the community, while providing information on how to prevent diseases as well as how to access services and file claims. The *aagewans* are grassroots level workers who come from the community itself (Tara Sinha et al, 2005).

Since 2001, SEWA has implemented three different insurance policies. The most popular of these policies provides coverage of hospitalization expenses up to USD 42 USD (Rs. 2,000) per year. Other more expensive policies provide coverage between USD 116 (Rs 5,500) and USD 211 (Rs 10,000) per year. Hospitalization claims require 24-hour admission (http://www.sewainsurance.org/default.asp?iId=2749).

Vimo SEWA has, in recent years, moved to a cashless system. It has tie-ups with 37 hospitals – six of which are public, 25 charitable and six private – for providing quality care to its members (Chatterjee, 2007). Earlier, SEWA members had to mortgage assets, sell jewellery or go to a money lender to borrow money for healthcare. Often the poorest members were unable to file for claims.

Vimo SEWA members have an option of making a one-time fixed deposit in SEWA Bank, and the interest from this deposit pays the annual premium. Those who opt for this scheme get a one-time, flat rate payment for maternity, hearing aid, dentures, and

cataract surgery. SEWA exempts some diseases from coverage. These include chronic tuberculosis, certain cancers, diabetes, hypertension, piles and health problems related to alcohol and drug abuse. Vimo SEWA premiums are revised annually and collected in advance. Premiums could range from USD 3.6 (Rs 175) annually to USD 8 (Rs 375). (http://www.sewainsurance.org/default.asp?iId=2749) The premium is usually collected between October to December by SEWA's community based workers. Vimo SEWA puts in efforts at every step. Before the date of the premium collection, meetings are held at the village levels, door-to-door campaigns organized and materials distributed. (Devadasan, 2004).

While Vimo SEWA provides only hospital-based insurance, SEWA integrates the scheme with a broader, more comprehensive health care package. The reason SEWA does not include outpatient visits is because it believes it would not be an efficient use of its limited resources and processing of these claims would be difficult as there is no way to prove authenticity. In the comprehensive health care model of SEWA, its own health centres, SEWA Health, provide preventive and curative services in and around Ahmedabad and in nine other rural districts.

Table 3.3: Salient Features of Vimo SEWA*:*

- Insurance coverage is available to SEWA members. Husbands cannot enroll unless their spouse is an enrolled SEWA member.
- Covers hospitalization expenses from USD 42 USD (Rs. 2,000) per year to USD 211 (Rs 10,000) per year.
- Hospitalization claims require 24-hour admission. (http://www.sewainsurance.org/default.asp?iId=2749
- Premiums could range from USD 3.6 (Rs 175) annually to USD 8 (Rs 375).

- Women must be between 18 to 55 years of age to enroll for annual membership.
- Life insurance coverage terminates at age 64. However, the other coverage continues so long as the member pays premium till the age of 70 years.
- Conditions exempted from coverage include chronic tuberculosis, certain cancers, diabetes, hypertension, piles and health problems related to alcohol and drug abuse.

Source: http://www.sewainsurance.org/default.asp?iID=2759

3.2.2 *Performance of Vimo SEWA:*

SEWA has created a model of healthcare that has had significant success in improving access to healthcare for poor women working in the informal sector and their families. As a comprehensive health package, SEWA not only provides health insurance but works at providing primary health care, through 60 stationary health centers and mobile health camps. In addition, it conducts programs on health education and training; capacity building among local SEWA leaders and helps provide low-cost drugs through drug shops (Ranson et al, 2004). Health insurance then is part of a larger package of its approach to health care.

Vimo SEWA is a Community Based Health Insurance Scheme and therefore members themselves play a key role in shaping the scheme. SEWA Union works with the poorest women workers. And SEWA Health aims to provide services to the poorest among SEWA Union's members, particularly those who are living below the poverty line (less than US$1 per day) (Ranson et al, 2004).

SEWA's understanding of the community has enabled it to reach the poorest of the poor. Evaluations of SEWA suggest the following reasons for its success in reaching the poor: SEWA takes the services to the poor, rather than trying to bring the poor to the services; services are delivered by (or at least in part by) the poor themselves; services are generally combined with efforts to educate and mobilize the community. Prior to holding health camps, SEWA Health workers go door-to-door, educating people about the service and educating people (Ranson et al, 2004).

***3.2.3 Inclusion and Access for Informal Workers*:** SEWA believes strongly in equity and tries to make the scheme more inclusive for all of its members. Unlike RSBY, this is

a voluntary scheme and members need to pay their premium. SEWA works at ensuring access for its members. It worked towards ensuring claims submission before it became a cashless scheme.

SEWA did a study in 2003 that showed that the poor were able to enroll in the insurance scheme but not everyone was submitting claims. A study conducted by the World Bank also found that despite Vimo SEWA including the very poor, (Ranson, 2001) relatively few of those who were hospitalized, were reimbursed through the scheme. This study also noted that either women were not eligible for reimbursement, or the claims were not eligible, or the women were not submitting claims.

The problem was compounded in the poorest areas and in rural areas. For the poorest of SEWA members, a better access to services needed to include transport costs to the hospitals as well as admission charges. For the poorest of its members, it was even more difficult to get cooperation from the doctors and the staff. Seventy percent of SEWA members are in rural areas (Ranson et al, 2006). SEWA's team of trained community health workers or *aagewans* work actively with members to identify problems and intervene wherever necessary.

On the basis of the feedback, SEWA started cashless tie-ups with local hospitals in specific areas of Gujarat. Knowing that its members were unable to process the claim submission, the health workers help them with cashless claim submission. At the same time members were provided more education on prevention and early treatment of illnesses.

SEWA has worked pro-actively in working towards inclusion, even though there is more to be achieved. SEWA provides a good model for interventions to reduce barriers to

access to healthcare for informal workers, especially women.

3.2.4 ***Information and Awareness:*** SEWA learnt that the deep-rooted inequalities of the system also worked as barriers and prevented hospitalization amongst the poorest. It also learnt that women and communities needed to be empowered with information through a community-based model (Shah, 2008). In response to these findings, Vimo SEWA took several steps to improve awareness.

Between 1985 and 2000 about 200 SEWA members were trained as local health workers for their own villages and urban neighborhoods (Dayal, 2001 qtd Frances Lund, 2009). They help make referrals to hospitals and form a critical link between the members and the administrative staff.

As mentioned earlier, SEWA works actively with the community so they can see the benefits of health insurance. Vimo SEWA started in 1992 with a membership of 5,000, which increased to 30,000 by 2001 and tripled in a year's time to 90,000 (Acharya et al, 2005). Its current membership stands at 200,000, a demonstration of its awareness raising work with extremely poor women.

3.2.5 Quality**:** SEWA provides limited preventive and curative services to its members with the help of its own health centers, SEWA health. If necessary, health workers may refer women to a hospital and may even accompany women to the hospitals. Members themselves play a key role in the shaping of the scheme. At the same time, members are encouraged to use public healthcare facilities wherever possible and provided education on medical malpractices. Some of the studies indicate how under the existing systems of

health, the poor and vulnerable segments of informal women workers may be more exposed to medical malpractice.

For instance, Vimo SEWA found 43 percent of the claims submitted to it were for hysterectomies. Considering the age of hysterectomy claimants at times was as low as 22 years and the average age only 37 years, it led to concerns whether these were unnecessary surgeries (Desai, 2009). SEWA has been educating its members on such risks.

Despite SEWA's efforts, delay in seeking healthcare is fairly common among informal workers, which eventually leads to high hospitalization costs. The lack of an inexpensive good quality out patient services leads to a preference for hospitalization (Desai, 2009). Another reason is a lack of access to affordable care in the neighborhood (Desai, 2009). An analysis of Vimo SEWA's claims from 2007 to 2009 found over 40 percent of claims for preventable conditions or conditions that could be treated without hospitalization (Desai, 2009). SEWA found that easily preventable and treatable diseases constituted a high percentage of the claims. The highest claim rate was for water-borne diseases: diarrhea, gastroenteritis or typhoid (Desai, 2009) along with malaria and fevers.

3.2.6 Out-of -Pocket Payments: Affordable access to drugs in the public system was another challenge faced by SEWA members. Out-of-pocket expenditure on drugs formed a significant part of expenses on health care. Vimo SEWA has found that expenditure on medicines is the primary cost component of hospitalization claims (Desai 2009). Even at public hospitals, patients had to pay for drugs. Out-patient care is not covered under Vimo SEWA, although SEWA health provides limited support.

***3.2.7 Gender Bias*:** Even though Vimo SEWA focuses on informal women workers, the treatment seeking behavior, as evident from studies, reflects gender disparity. While women are the primary holders of Vimo SEWA, claim rates for men are slightly higher, followed by children and lastly women (Desai, 2009). SEWA has identified barriers to access to healthcare for poor women workers. Women workers need to consider the inconvenience that their absence in going to a health facility may cause to their family as they may not be able to prepare meals to look after the other family members. In a focused group interview conducted by Tara Sinha et al, an aagewan said: "Sometimes if the woman has to cook, prepare a tiffin (lunchbox), send her children to school, then she avoids getting admitted (to a hospital). She takes some pills and continues with her work . . . (Aagewan in a more-developed rural district)" women bear many responsibilities within the home, such as cooking, cleaning and childcare, which may hinder their ability to go for health care or hospitalization. Access becomes more difficult if the hospital is not in the neighborhood (Tara Sinha et al, 2005).

Women are least likely to seek healthcare if they have to incur out-of-pocket expenses. Therefore, in women, primary illnesses are often a cause of hospitalization. Eventually, it not only leads to higher costs of healthcare for these workers but also leads to income loss for workers in the informal sector (Shah 2008). In addition, women's access to health care is also limited by the deep-rooted biases, which makes women themselves allocate more resources to men. This again goes to underscore the need for a providing health care in their neighborhoods and for health insurance schemes to cover visits to doctors.

3.3. Yeshasvini Health Insurance Scheme

The Yeshasvini Health Insurance scheme, introduced in the southern state of Karnataka in 2003, demonstrated, for the first time, how it was possible to provide affordable health insurance, for secondary and tertiary care, to large numbers of informal workers, such as agricultural workers. Agricultural workers account for a majority of India's informal work force. Of the 395 million unorganized sector workers, agriculture workers account for 253 million (NCEUS, 2007).

The scheme was conceived by Dr. Devi Shetty, a well-known cardiac surgeon, who first demonstrated an efficient model of delivering high quality cardiac surgery within affordable means, through his hospital in Bangalore, Narayana Hrudalaya. Highly respected and influential, Dr Shetty was first approached by a milk cooperative for an endorsement of its product. From here, the idea of reaching middle to low income people through these clustered cooperatives was conceived in the form of Yeshasvini. The only institution in Karnataka that could connect rural farmers and rural **p**easants were cooperative societies. Karnataka has had a long history of cooperative movement. The first co-operative society was registered in the year 1905 in Kanaginahal village of Dharward District. Currently, there are over 31,000 cooperative societies. (Kuruvilla and Liu, 2007) All farmers that had been members of a cooperative for at least a year were eligible to participate, regardless of their medical history Yeshasvini provides free outpatient consultation as well as insurance cover for in-patient surgical procedures so as to prevent indebtedness as a result of catastrophic illnesses. Yeshasvini does not provide coverage for in-patient care without surgical procedure. Yeshasvini has three million

members, which constitutes 8.6 percent of the total rural population in the state of Karnataka (Aggarwal, 2010). Kuruvilla and Liu (2007) call it as "arguably, the world's largest health insurance scheme for the rural poor."

3.3.1 ***Structure, Financing and Benefits:*** Yeshasvini charges a small premium to insure its members for high cost surgeries. Currently, the annual premium is fixed at a flat rate of USD $2.53 (Rs. 120) per person. In addition, a 15 percent discount is offered on family packages for five members (Aggarwal, 2010). Members can get services at a network of 349 hospitals across 27 districts (Aggarwal, 2010) in the state. More than 1,600 surgical procedures are covered under the scheme. The maximum coverage provided for a participant is USD 4,226 (Rs 200,000). The rate for each surgery is fixed with the network hospitals.

Yeshasvini too is a cashless scheme and members are covered for all charges associated with any surgical procedure. This implies that all diagnostic tests required before a surgery are covered as well. Patients do need to incur transportation costs (Kuruvilla and Liu, 2007).

Premiums are collected through a network of state-run postal offices. They also track monthly payments and issue the Yeshasvini member card. In the first year, 9,000 people went through various surgical procedures and another 35,000 received outpatient treatment across the state. By early 2005, the scheme had covered a quarter of the cooperatives' 10 million members (HBS Case, 2005). By collecting the insurance fees upfront for a year, the Yeshasvini Trust (which was created to own the scheme) was able to minimize its initial need for funds.

The scheme receives considerable subsidy from the government. For the first year, the premium subsidy was USD 95,972 (Rs. 45,000,000). In the second year, the government budgeted a subsidy of USD 73,966 (Rs. 35,000,000). For the third year, a subsidy of USD 84,530 (Rs. 40,000,000) was agreed upon (Radermacher et al, 2005).

There are also hidden subsidies. The support of the government infrastructure cuts down on financial costs and support of the cooperative sector helps with its expansion. The program does have a large pool of resources. As of July 2008, the Trust had a fund of USD 10,566,356 (Rs. 500 million). The scheme started with 1.6 million members. By the end of February 2004, 7,352 surgical procedures had been done. Hysterectomies accounted for the largest proportion of surgeries (24.5 percent), closely followed by general surgical procedures (23 percent), and cardiac surgery for 7.35 percent of procedures (Aggarwal, 2010).

Table 3.4 Salient Features of Yeshasvini:

- Annual premium is a flat rate of USD $2.53 (Rs. 120) per person.
- Scheme is cashless and members are issued a Yeshasvini member card.
- The maximum coverage provided for a participant is USD 4,226 (Rs 200,000).
- Covers only surgical procedures for inpatients. More than 1600 surgical procedures are covered under the scheme.
- Free Out Patient consultation at all participating hospitals.
- Diagnostic tests required before a surgery are covered.
- Patients do need to incur transportation costs.
- Premiums are collected through a network of state-run postal offices.
- From 2006-07 the followingmedical benefits were included: Medical emergencies such as dog bite, snake bite, bull gore injuries, drowning, electric shock and other accidents occurred while operating agricultural implements. In addition, vaginal birth, neo natal

care and angioplasty procedures were also included.

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

3.3.2 Performance of Yeshasvini: Yeshasvini has made an impact in covering some high-cost procedures. Numerous studies have analyzed and commented on the financial protection against health risks that it has managed to provide to poor farm workers (Grossman, 1972 qtd by Aggarwal 2010).

Aggarwal states that as the scheme prevents delays in seeking care, treatment outcomes are expected to be better and recovery faster. This also reduces the risk of serious income loss for informal workers who need to be back at work early considering they rely mainly on their own labor and on assets such as livestock for income generation (Aggarwal, 2010). Yeshasvini has managed to overcome several obstacles in trying to reach the informal workers, especially agricultural laborers. These groups are often not a homogenous category, they are geographically dispersed and difficult to reach. They are often poor, without any income and in need of social security. Therefore, any work with this group was only taken up by non government organizations. The private sector had not ventured into leading a scheme for the agricultural workers (Kuruvilla and Liu, 2007).

Yeshasvini managed a highly successful partnership with the cooperative sector. The state government of Karnataka stepped in and the Department of Cooperation urged cooperative societies to get their members to join. When the scheme was launched, members had access to free treatment at 150 hospitals up to USD 2,113 (Rs 100,000) For USD 0.10 (Rs. 5) a month. What worked in support of the scheme was the state government's response. Yeshasvini was launched as a state government program with the

then chief minister S M Krishna taking deep interest. The government not only contributed towards half of the premium to be paid by the farmers but also provided support with the state infrastructure, which helped in cutting down costs.

There is some amount of disagreement on the long-term financial sustainability of the scheme. It does depend on state government subsidies. Aggarwal (2010) says Yeshasvini is not financially sustainable despite the large number of members as it provides high-cost surgeries at very low costs. However, a Harvard Business School case study looks at Yeshasvini as successful model which has demonstrated that it is possible to find large pools of communities for the low-cost insurance scheme to be able to function without incurring any losses. The HBS cast study says research by the Narayana Hrudalaya team estimated that only 8 percent of policyholders would require medical procedures. Thus the total funds collected would cover the costs of treatment. (HBS case study 2005: 10)

The scheme has been able to demonstrate how to make use of existing infrastructure to reduce costs. For instance, it found it did not have to create additional health centers. The state had enough beds. It found the average occupancy of hospitals in Karnataka to be only 35 percent before it was launched, mainly due to lack of affordability. The state had 30 private medical colleges, each with over 500 beds. (HBS Case 2005). As the HBS cast study points out, the scheme has shown how the private sector can step in and take some role in social responsibility.

3.3.3 ***Access and Inclusion for Informal Workers*** : The enrollment schedule has been kept long and flexible. It is spread across five months namely, from January to May. These are the months when cash crops such as cotton and sugarcane are harvested,

making it easier for farmers to pay the subscription. Finally, the mode of payment is also flexible; it is decided by the local cooperative societies depending on local conditions. The scheme demonstrates a strong component of community ownership, along with strong management, which has contributed to its success (Aggarwal, 2010).

However, the scheme still shows poor enrolment with only 35 percent of the target population being covered (Reddy et al, 2005:35) which points towards the necessity of actively doing awareness programs.

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

3.3.5 Quality: None of the research so far has pointed to problems of quality with the Yeshasvini scheme. Yeshasvini has its own system of evaluating hospitals before they can join the network. The hospitals enrolled in the scheme have at least 25 beds and are equipped with modern health facilities. Some of them are super-specialty hospitals. It seems the constraints of quality in the health system have not affected the services delivered through Yeshasvini (Aggarwal, 2010). This has been pointed out as one of the most innovative programs in community health financing in India. The scheme developed efficient partnership between the government, private, and cooperative sectors and made use of their respective strengths to provide quality healthcare to vulnerable groups and the hard –to-reach population of agricultural workers (Aggarwal, 2010).

The scheme has developed detailed procedures for enrollment, empanelment of

hospitals, treatment and claim settlement, and monitoring. To avoid the risk of unnecessary surgeries, Yeshasvini has a fixed rate, which is 40 to 50 percent below the market rate. These rates have not been modified since the scheme was launched, despite inflation. The scheme also excludes certain surgeries such as those requiring implants joint replacement surgeries, liver transplant surgeries, and follow-up investigations. (Aggarwal, 2010).

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

3.3.8 Gender Bias: As in the other schemes fewer women are able to get access and a more targeted approach needs to be devised so the benefits of these schemes can start to reach women in larger numbers. About 60 percent of Yeshasvini's members are men and only 40 percent women. Women often are not members of the cooperative even though Yeshasvini Trust covers members of the family as well. Most cooperative society members are men, even when 78 per cent of the population is connected through cooperative societies. Research shows the member is the first to enroll and family members may come later. Yeshasvini has started offering a reduced fee for the household to help with women's enrolment (Radermacher et al, 2005).

3.4. Rajiv Aarogyasri Health Insurance Scheme in Andhra Pradesh

Rajiv Aarogyasri was launched by the government of Andhra Pradesh in 2007 to provide health coverage to BPL population in the state. The scheme has now extended its mandate to include above poverty line families as well and is providing coverage to 20.4 million families, comprising about 85 percent of the total population of the state (Reddy et al, 2011:27).

The scheme was started as a pilot project in three of the most backward districts of Andhra Pradesh, before being extended to the entire state. The aim of the scheme is to reduce the indebtedness due to health care cost. Nearly USD 315 million was used from the chief minister's fund in 2004—2007 to help meet hospitalization expenses (Ravi et al, 2009).

3.4.1 ***Structure, Financing and Benefits*****:**

The scheme is run by a Trust, the Aarogyasri Health Care Trust, set up under the chairmanship of the Chief Minister and administered by a Chief Executive Officer, drawn from the Indian Administrative Service. A single insurance company, selected through competitive bidding administers the scheme, under the overall supervision of the state government (https://www.aarogyasri.org/ASRI/index.jsp).

The scheme provides health insurance for hospitalization up to USD 4,500 in a year at a network of 200 approved public and private hospitals. The scheme covers major tertiary care expenses, including expensive procedures such as a cochlear implant. The scheme covers immediate pre- and post-operative expenditure. The insurance coverage under the scheme is in force for a period of one year from the date of commenc ement of the policy. Patients can select the hospital they want to seek treatment at.

The entire scheme is cashless and the government covers the cost of the premium as

well. Upon enrollment, like the RSBY, beneficiary households receive a Rajiv Aarogyasri Health Insurance Card. Those holding a "white card" – given to BPL families – are readily provided with the Aarogyasri health card. There is no limit placed on the number of family members. Everyone in a household can be included under the scheme. The card has information about the family members, along with their pictures. The card, when presented at any of the network hospitals, facilitates cashless treatment.

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

The scheme has taken the help of health workers to help beneficiaries navigate the system. Aarogyasri has a team of 4,000 Aarogya Mithras, health workers, in each of the primary health centers across the state. These health centers are most often the first points of contact for most families seeking care. In addition, district hospitals and network hospitals also have help desks manned by Aarogya Mithras to facilitate smooth service delivery for Aarogyasri beneficiaries (http://www.jointlearningnetwork.org/content/rajiv-aarogyasri).

Under the scheme, all network hospitals are required to undertake a specified number

of village health camps in order to maintain their network status. The health camps help in screening for diseases as well as providing preventive care. Minor ailments are treated at the camp itself, whereas those that require further consultation are referred to network hospitals for free of cost treatment under their Aarogyasri benefits (http://www.jointlearningnetwork.org/content/rajiv-aarogyasri).

Table 3.5 Salient Features of Rajiv Aarogyasri

- The scheme is cashless. State government covers the cost of the premium.
- Covers major tertiary care expenses, including expensive procedures such as a cochlear implants.
- Provides health insurance for hospitalization up to approximately USD 4,500 in a year at a network of 200 approved public and private hospitals.
- Transport costs covered for the patient identified for surgery or treatment.
- Aarogyasri assistance counters at every network hospital.

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

With vast amounts of money being spent on running the scheme, long-term sustainability is an issue. The state is spending a total of USD 364,539,306 (Rs 17.25 billion) a year on the scheme, in addition to USD 206,043,825 (Rs 9.75 billion) as premium for health insurance to below poverty line families (Times News Network, 2011). Finding it difficult to sustain the cost, the state government had urged the Center

to share the costs, which was turned down. (Times News Network, 2011)

3.4.3 ***Inclusion and Access for Informal Workers:*** The scheme has been successful in providing tertiary care and it has reached a large number of beneficiaries. By September 2008, about 11 percent of the BPL population in AP was utilizing the scheme. (Mitchel et al, 2011). The most common conditions being treated are related to cardiac, cancer and neurological problems. Close to 90 percent reported improvement in their condition. An evaluation by Mitchel et al reports high satisfaction with the scheme as it had improved access for the BPL population for high-cost healthcare.

As the scheme does not categorize informal workers separately, it can only be assumed that a large number of its beneficiaries, particularly in the rural areas have been informal workers. About 87 percent of beneficiaries were from rural areas. BPL families were identified on the basis of the state's earlier existing ration card systems.

3.4.4 Information and Awareness**:** The scheme depends mainly on health camps to enroll people. Most people in the state are enrolled under the scheme. Health camps work as mobilizing centers for the scheme. Around 4,000 people go through health check ups every day. About 183 network hospitals are conducting approximately 500 camps in 13 13 districts (Ravi et al). Another point of outreach is the primary health centers and and government hospitals in the district, where the representative of the insurance compa ny has a Aarogyasri help desk. The help desk refers patients on the recommendation of the doctors to the hospitals in the network.

3.4.5 Quality: The state government is already finding ways of pruning costs. From

November 2011, it has decided to take away 133 procedures from the private sector. Only cancer, heart and some trauma cases will be attended to by the private sector. At the same time, there are media reports stating some government hospitals are not taking up Aarogyasri cases. In four years, at two hospitals at least, as per latest data released by Rajiv Aarogyasri Health Scheme, Warangal, during March 2010 to March 2011, no surgery has been performed, which means people living near these hospitals would be traveling to other cities for treatment. For every Aarogyasri surgery in government sector hospitals, 65 percent money goes to hospital and 35 percent goes to doctors. (Deccan Chronicle, 2011).

Medical associations point out that government hospitals in small towns and districts do not have the infrastructure to handle the surgeries that are being taken over from corporate hospitals. The government has decided that out of 938 procedures covered under Aarogyasri, around 100 are hardly used and these are likely to be pulled out (Flash News, 2011). A number of procedures such as hysterectomy, tonsillectomy, appendectomy and hernia have been much abused by private hospitals. Surgery was resorted to in thousands of cases that could have been treated conservatively. So, these procedures will now be conducted only in government hospitals (Flash News, 2011). Reddy et al too point out cases of hospital fraud reported in the Deccan Chronicle. Several hospitals have been blacklisted for unnecessary surgeries and the Director General of Vigilance has recommended removal of some of these hospitals from the list, as well as cancellation of their licenses. Many of these unnecessary surgeries (68 percent) were performed on women aged 21 to 40 (Reddy et al, 2011). It is not clear whether here too, as in the case of SEWA, unnecessary hysterectomies were being

performed on young women.

3.4.6 Out- of- Pocket Payments: As with other schemes, this evaluation too found that people were paying for various conditions that were not covered by the scheme, such as diarrheal diseases, often a result of the insanitary conditions where the poor live (IIPH-Hyderabad, 2009 as qtd in Reddy et al, 2011). In a survey conducted in Andhra Pradesh, 58 percent of the Rajiv Aarogyasri Scheme (IIPH, 2009) patients reported having incurred out-of-pocket expense with an average Rs. 3,600 (USD 76) per patient (Reddy et al 2011: 35).

More than one-half of the claims were in less than 10 percent of the participating network hospitals, primarily in AP's four large cities. There were wide variations in the claims paid for individual procedures covered under the scheme. (Mitchel et al, 2011).

A survey conducted by Mitchell et al reveals some important findings: households incurred out-of- pocket expenses not only for care at hospitals, but at all levels of health facilities and providers. Their findings seem to suggest that there has been little reduction in households' medical expenditure, even after Aarogyasri. They found that households holding the Aarogyasri card reported as high or higher treatment costs compared to those without. Mitchell et al concluded that care at these facilities is far from costless. "Reported costs of treatment ranged from around Rs 500 for those who sought care with RMPs (Registered medical practitioners), to over Rs 1,900 for those seeking care at private hospitals. Further, those experiencing protracted illnesses (that is, a duration of more than two weeks) faced costs upwards of Rs 4,300 at private hospitals" (Mitchell et al, 2011). However, studies do show that inpatient expenses during 2007-08 went down

by possibly as much as 20 percent (Fan et al, 2011; Mitchell et al, 2011).

3.4.7 Gender Bias: From available studies, it is not clear how many women are actually accessing health services. As the scheme does not impose any limitations, there is much more scope of women enrolling for the scheme, but data on usage of services by gender is not available.

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4. Part III:

4.1 Conclusions and Discussion:

Focus on Inpatient Care: It is evident from the study that the major focus of health insurance schemes in India is on hospital-based care. Most of the schemes do not provide coverage for outpatient care or the cost of drugs. This leaves a big gap in the schemes' stated objective of preventing impoverishment due to healthcare. Studies have pointed out that outpatient care leads to more people falling into abject poverty. Berman et al (2010) have shown it is outpatient care that leads to more impoverishment than inpatient care. In that case, the schemes may be having only limited impact in reducing household expenditure on healthcare.

This analysis also indicates that the focus on hospital-based coverage may also be leading to delays in treatment and incentivizing people towards going in for inpatient care. Experience from Vimo SEWA shows how the design and structure of health insurance schemes that focus more on hospitalization could act as a disincentive in seeking early care, more so for the informal sector workers. In the absence of affordable outpatient care, the poor often do not seek treatment until they are not able to work at all. As mentioned earlier, this is fairly common among informal workers. By the time they do

seek treatment, it may be more expensive and may translate into more wage loss due to their inability to be back at work during and after hospitalization (Desai, 2009).

The one drawback of RSBY is that it provides only secondary care, without a provision for outpatient services or coverage of cost of drugs. This is not to take away from the remarkable successes of the scheme. In little over three years, it has provided hospital-based insurance cover to about 100 million people in a challenging and complex political and administrative environment. This alone is no small achievement. For a large number of India's poorest, it has helped provide access to hospital-based care that they could not have earlier. An IT-enabled network of hospitals and insurance companies has ensured efficient and cashless delivery of healthcare to people below poverty line through the use of a simple card across the country. The schemes design has been well considered and well applicable to the needs of the poor. For instance, the RSBY's coverage for a family of five matches with India's average family size is 5.3.

However, for RSBY to be able to provide a more comprehensive healthcare that truly reduces the burden of health costs on poor households, some areas need to strengthened and gaps need to be addressed in moving forward. RSBY's focus on hospital-based secondary care only meets part of the objective of providing healthcare. Hospital-based coverage may work well in areas with a back up of a robust public health system with a strong primary healthcare component. As this paper explained in Part I, India's public health system is weak and primary care is amongst its weakest component. Hence, this leaves the poor to incur a substantial part of health expenditure.

Cost of Drugs: The cost of drugs, not covered through insurance, also imposes a high economic burden on impoverished households. The unregulated health sector

environment has dissuaded health insurance schemes from including drugs in their package: it is easy to purchase prescription drugs over the counter in India. A physician-pharmacist nexus too may drive up costs of unnecessary prescriptions. However, the government needs to regulate the system and bring in an essential medicines list as well, rather than take up the easy option (Reddy et al, 2011).

Focus on Tertiary Care: While large amounts of public money are being spent, both by the Centre and state, towards healthcare, much of it is only towards tertiary care. Reddy et al have collated, what they call " evidence from several sources" that suggests that a disproportionate share of government spending is going towards tertiary care. Over one-fifth of all government expenditure during 2009-10 went into tertiary care (Reddy et al, 2011). The overall spending in the country on hospital care works out to around 37 percent. In Delhi, Andhra Pradesh and Tamil Nadu over half of all government expenditure is on tertiary care. Delhi spends about 52 percent of its budget on hospital care (Reddy et al, 2011: 87). Judging by the efforts being made towards providing health insurance coverage to the poor, it is evident that governments, both at the level of Centre and states, recognize the urgent need. Such skewed spending then shows more of political expediency rather than an understanding of people's real needs.

SEWA's Comprehensive Approach: In a limited way, Vimo SEWA has shown how it is possible to provide a more comprehensive healthcare. Vimo SEWA provides access to primary care through a network of SEWA health centers. SEWA's comprehensive approach has a strong component of disease prevention and education. It also facilitates availability of high quality, low-cost drugs. However, Vimo SEWA is a community-based scheme, which works through highly motivated community-based workers and

may not be scalable to a national level. But there are important lessons in the Vimo SEWA model on working with the community and how best to make health insurance schemes more inclusive for the poorest of the poor. A considerable measure of Vimo SEWA's success has been its ability to reach the bottom percentile of the poor, a challenging task given their marginalization and inability to access information. The large numbers insured by the RSBY do not necessarily reflect equity and inclusiveness. Vimo SEWA model could provide some important learning here as well.

Gender Bias: There is also a high level of gender bias reflected in the usage of both RSBY and Yeshasvini. Again, Vimo SEWA has studied in detail the barriers faced by women in accessing healthcare. It actively works towards improving services to be able to get past some of the barriers. Given the poor state of women's health in India (as shown in Part I) the schemes do need to place special emphasis on how to improve their access. There is clear evidence, from RSBY, Vimo SEWA and Yeshasvini, that fewer women access healthcare.

Issues of Access: At the same time, another issue that the implementation of RSBY raises is that of access itself. Inclusion under RSBY is being determined on the basis of a list of people deemed as 'below poverty line'. There are question marks over the way people have been included in the list. There is also a bigger issue of the distinction between above and below poverty line people. Some of these issues will need to be worked through as RSBY achieves more breadth of implementation. The RSBY eventually intends to cover approximately 350 million below poverty line informal sector workers. This will still leave out a significant chunk of informal workers above poverty line, (Reddy et al, 2011: 19) an issue that will need to be addressed urgently.

Barriers for Migrant Workers: While RSBY is making efforts to remove barriers faced by migrant workers by allowing portability of smart card across states, media reports indicate, it may still be missing out on migrant workers in many places because of its design. Many of the families on the BPL list , who could not be traced, could be migrant workers. These families, who may have migrated for long periods of time to another state, will not be able to avail benefits under the scheme, until the time they get back and register on the basis of the BPL list in their home state (WSJ 2008). Thus, the design of the scheme risks missing out a large number of informal migrant workers.

Private Sector Involvement: Another area of concern emerging from this analysis is the proportion of private sector involvement. Except Vimo SEWA, which makes a concerted effort to get its members to avail services from the public sector, the other schemes, operated through commercial health insurance companies, have moved towards having 70 to 90 percent private providers (Reddy et al 2011:36). This may well be necessary in many areas due to the weak public sector, but as this selection has been left to commercial insurance companies, there is every possibility of a bias in such selection. This also raises several issues about its long term impact -- on the public health system, on the sustainability of the scheme and on escalation in healthcare costs.

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

Quality: The other concern the paper raises is the issue of quality. As mentioned earlier,

quality of private sector, is highly varied. It ranges from unqualified people practicing as doctors to world-class hospitals. As this study shows, in many places, such as Jaunpur in UP, private hospitals too are not well equipped to provide all services. Also, there is an urgent need to regulate the private sector, which so far has functioned without any protocols or standards.

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

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

Finally, it is time to get rid of a two-tier system of health care : world-class hospitals for the rich and poor quality hospitals for the poor, where deaths due to apathy and neglect, such as that of Ruksana, can go unchecked and unnoticed. As India becomes a

potential medical tourism hub, let us not lose sight of its poor. The RSBY holds a lot of potential and promise. It needs to build quality into it and integrate it with other state based schemes and work towards a comprehensive health care model, if it is to truly serve its intended beneficiaries.

Table 4.1

An overview of schemes reviewed :

Scheme	**Beneficiary contribution**	**Subsidies**	**Average Premium Rate**	**Coverage Universal/Targeted**	**Out-of-pocket payments**	**Benefit package**
Yimo SEWA	Yes	No	Rs 100 Rs 1000	Rs 2000 to Rs 10,000	Yes	Inpatient, secondary
RSBY	No	100%, State	Rs 440 to Rs 750	Rs 30,000 per family	Yes	Inpatient, secondary care only
Rajiv Aarogyasri Scheme	No	100% State	Paid by state government for BPL families. Rs 267 for Above poverty line	Rs 150,000 per family per year with additional buffer of 50,000	Yes	Inpatient, Tertiary care only
Yeshasvini	Yes	40%, State	Rs 150	Rs 200,000 per person	Yes	Inpatient, outpatient, secondary and some tertiary care

Source: Reddy et al. (2011)

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