India: Social Security for the Unorganised Sector - Non-Lending Technical Assistance
Final Report, December 18, 2009 (TA-P102561-TAS-BB)

1. The objective of this NLTA is to assist the GOI to formulate – and where relevant initiate implementation of - financially and administratively feasible policy responses to address the large gap in social security coverage that currently prevails in India. The ultimate objective of this policy would be to gradually expand financially sustainable income protection through social insurance for lower income households in the unorganized sector for major risks including health, disability, death and old age. The NLTA was initiated in response to a request from the Ministry of Labour, GOI and formally requested through a letter from DEA in late 2006. At the IMT review of the NLTA in 2007, the CMU requested periodic updates on progress and this note is the first of those.

2. Overall, the impacts of the NLTA to date have exceeded expectations at the time of the Concept Note. The rapid developments in GoI policies on expansion of social security in the period since the CN have increased the client demands from the NLTA. This has been particularly in the area of health insurance for the poor. The NLTA has been the key vehicle for an intensive involvement of the Bank in a key area of social policy reform. It has provided a rare opportunity to be involved upstream in the design of a new central scheme for the poor. The support to date under the NLTA has been explicitly acknowledged by both the Ministry of Labour and the Deputy Chairman of the Planning Commission as very useful and timely and a good example of GoI-Bank partnership. In addition, the overall progress on the other deliverables outlined in the CN for the NLTA has been good, with key deliverables completed or in advanced stages.

3. The sections below first outline the progress on specific deliverables outlined in the CN. These include outputs across a range of social insurance instruments for unorganized workers, including life/accident insurance, old age pensions, and health insurance. There is then more detailed discussion of the outputs of work under the NLTA on a large health insurance scheme for unorganized workers, the RSBY. The NLTA has involved inputs from Bank staff in the SP and health teams and from DEC. Bank team members on work to date have included Robert Palacios (TTL, working on all elements of the NLTA), Oleksiy Sluchinskyy (on ICT, database and micro-pension issues), Jishnu Das (on the RSBY scheme, including M&E, IEC and BPL data issues), Philip O'Keefe (international experience and RSBY policy and state work), Peter Berman (HI Task Force), Paolo Belli (HI issues), and Shonali Sen and Puja Dutta (informal sector data diagnostics). The Bank team has been supplemented by several consultant firms and individuals as outlined in RSBY discussion below.

(i) Studies, policy notes, and workshops on various social insurance instruments for unorganized workers:

4. The NLTA as described in the CN envisioned a series of small scale activities covering the major risks and types of social insurance mentioned above. The outputs were to include policy notes on Indian and international experience, workshops, surveys and analysis of existing survey data and close interaction with the counterpart staff at the Ministry of Labour and Employment as they prepared the design of pilot schemes and implemented them. The specific sub-tasks and progress to date under the NLTA are summarized in the table below. They involve a mixture of policy notes/studies and policy advisory produced by the core Bank team, and studies produced by consultants under the NLTA with close oversight of Bank staff. These have been filed in IRIS as completed or intermediate outputs produced. Most have fed in rapidly to evolving GOI policies on different types of social insurance for unorganized workers.

Activity/study	Objective	Status
Analysis of India's informal sector labor force	Differentiate within informal sector according to capacity and willingness to insure/save and other relevant household factors	Survey data acquired and initial descriptive tables produced. Final report expected FY09.
Survey of Rajasthan BPL households and life insurance coverage via new state government/LIC scheme for the poor (operating since October 2007)	Assess efficacy of GoR life insurance scheme by looking at BPL household awareness of coverage and knowledge of claims process, benefits	Special survey instrument produced; survey completed in January 2008. Data being processed to be submitted in May 2008. Report forthcoming.
Workshop on life insurance for the poor in India	Bring together government, insurance industry and relevant players (e.g. SEWA) to discuss lessons learnt from experience to date and implications for future policy of GoI.	Joint Government, industry, NGO and donor workshop held in 2007.
Study of micro-health insurance experience of SKS (a major MFI operating in southern states of India)	Assess pilot health insurance scheme and identify factors relevant for scaling up such as variable and fixed costs of administration, determinants of take up etc.	Randomized experiment and survey carried out and data generated. First draft submitted. Final draft expected June 2008.
Policy notes on international experience with extending social security to informal sector workers	Provide relevant international experience to GOI as it began to formulate its strategy in this area.	Policy note was shared with GoI (and published separately in Economic and Political Weekly and as chapter in Routledge edited collection). GOI officials stated that the report influenced policy thinking. Also participation in policy workshops of GOI. As part of Health Insurance Task Force (see below), Bank staff made presentations on international experience, filed in IRIS.
Participate in GoI Task Force on extending social security to unorganized sector set up with MOLE as GOI counterpart	Develop specific proposals for GoI on health insurance for unorganized sector workers	A GOI advisory Task Force including three Bank staff and one ILO representative formed and regular meetings from Spring 2007 to February 2008. TF submitted recommendations in March 2008. Bank staff provided regular written inputs and comments on evolving proposals, several of which had positive impacts on the final proposals of the TF.
Policy advice to GoI on possible approaches to implementing micro-pensions for Central Government administered Welfare Fund members.	Advise government on best practical approach to introducing pensions for Welfare Fund workers (beedi workers, miners, etc.).	NLTA team visited several Welfare Fund sites as inputs to policy notes and advice. Scheme parameters in line with advice have been determined and budget has been allocated for FY 2008-9.

Software (BEDVASP, EDVASP), revised website (look and interactive)
Presentations: Trivandrum (2), MIS workshop, Overview paper, Jishnu paper on BPL, Jishnu on Delhi, Xiaohui's presentation

(ii) Advisory and technical support to design and initial implementation of the RSBY health insurance scheme for BPL unorganized sector workers:

5. In late Spring 2007, a Joint Secretary in MOLE, Mr. Anil Swarup, was asked to lead an ambitious effort to provide health insurance coverage to roughly 60 million BPL households over a five year period starting in 2008. This is intended to deliver on GOI's commitment under the Common Minimum Programme to extension of social security coverage. This mandate resulted in a deepening of focus and resources at MOLE to design and implementation of the new scheme – Rashstriya Swasthya Bima Yojana or RSBY (National Health Insurance Scheme). The RSBY is a well designed scheme and has strong support from the highest levels of government. It is based on public-private partnership, market based incentives and empowerment of BPL beneficiaries. The scheme is described in Annex 1 and further information can be obtained from the Bank-financed website – www.rsby.in.

6. Given its ambition, there are a range of risks associated with the scheme which will undoubtedly provide major implementation challenges and can only be expected to be managed over the course of several years of "learning by doing". The risks and challenges include beneficiary identification; mobilization of awareness of officials and beneficiaries; institutional coordination and oversight challenges resulting from the innovative partnership arrangements of the scheme (with insurers, grassroots intermediaries, smart card providers, TPAs, and the overseeing state nodal agencies); logistical challenges in implementing the innovative ICT model of the scheme; and other issues. However, even the inevitable difficulties can provide lessons which will be relevant not only in the area of social insurance but also for many other areas of service delivery for the poor.

7. As a result of the high priority and fast track nature of the RSBY, the NLTA team was asked in mid-2007 to increase the intensity of engagement on health insurance for the poor. This new phase in the NLTA has continued through 2008 and has involved significant time from a number of Bank staff, several IT and survey firms and individual consultants/experts. Realizing that the resources available under the NLTA were not sufficient given the scale, scope and time horizon of the challenge, in January 2008 the GOI requested a technical assistance project (see attached request letter). In May 2008, the CMU cleared the request and the activity was initiated.

8. To date, an array of activities has been financed under the NLTA in response to the needs of GoI and selected states, with supplementary funding from a DFID Trust Fund. The specific outputs have been filed in IRIS and are available upon request. Overall, the activities can be grouped into several areas:

a. *Meetings, workshops and interaction on a frequent basis on design and implementation issues as they arise*. The meetings have been in some cases with GoI officials only, in others with GOI and specific groups of stakeholders (e.g. insurance companies, smart cards providers, NIC and IT/software firms), and in others with mixed groups (e.g. state level workshops with stakeholders from government, industry, health providers, NGOs and others). At least one member of the Bank team has attended an estimated 60-70 meetings over the course of the last year and had constant email/phone interaction with GOI staff as well as state government staff (including staff visits to several states rolling out the

scheme, including Rajasthan, Haryana, Bihar and UP). The advisory functions have included a variety of short presentations to meetings, written inputs and advice on design aspects of the scheme, and detailed comments on the draft policy and implementation documents for RSBY.

b. *Reviewing and providing written inputs to key RSBY policy documents*. Bank staff reviewed, commented on, and in several cases helped draft key documents that are an integral part of the program, including the RSBY Operational Guidelines, the draft MOU between states and the central government, smart card procedures and specifications, and draft tender documents.

c. *Data analysis.* The BPL database from several states was analyzed by Bank staff. These databases (which are maintained at the state level) are critical to the enrollment process for the scheme. Problems were detected that could severely undermine the RSBY enrollment process (e.g. double entry of households; incomplete household records; non-standard formats in entry of household information). In order to deal with this problem, data verification software was commissioned and produced and training provided for seven states has thus far been provided on its use. In addition, an on-line system for uploading data was designed and will soon be implemented.

d. *IT support, including software development and website design and hosting*. Under the NLTA, a firm was commissioned to produce a prototype enrollment software for the program. This was done and is now being utilized for enrollment. A second firm was contracted to design a website that serves two purposes. The first is to provide information to the public about the scheme and its operation (including two films that were financed by the Bank that demonstrate the enrollment process). The second purpose is to allow state governments and insurance companies to upload and download information/data through a secured and stand alone server.

e. *Survey design and implementation*. Two special surveys were conducted in Rajasthan and Delhi. The first has been done in one state and is about to be done in the second. It focused on communication and awareness of potential beneficiaries. The second has started will generate a baseline household data set that will be used to assess various aspects of the program as it is rolled out in these areas.

f. *Assistance to state governments in the implementation process (e.g., developing capacity to assess bids, understand data issues, etc.)*. Our staff and consultants have interacted closely with several state governments during the early roll out stage. This has involved regular visits to states to work with the nodal agencies responsible for the scheme, as well as regular distance communication and feedback, and participation in state level familiarization workshops, where a set of presentations have been developed for different stakeholders.

(iii) Next Steps:

9. The NPTA will continue with its dual focus on both the RSBY and other forms of social insurance. On the latter, this will involve completing analytical work in progress and disseminating findings with relevant stakeholders. It will also involve increased advisory work on the micro-pension schemes for selected central welfare funds. On RSBY, the NLTA will continue to respond to GOI and state level requests of a strategic nature, including providing the state-focused expert support initiated already in key start-up states. A further update on the NLTA will be provided in early CY 2009.

Annex 1: RSBY Health Insurance for Below Poverty Level Households

1. On August 15, 2007, Prime Minister Manmohan Singh in his Independence Day speech announced the creation of a new health insurance scheme; the Rashtriya Swasthya Bima Yojana or RSBY. This was following by his official launch of the scheme in October 2007, and initiation of implementation in selected districts from April 2008. There is a five year plan for rolling out the RSBY which allows each participating state to cover up to 20 per cent of their respective districts each year. By April 1, 2008, almost every large state government has expressed its intention of joining the scheme and many have already issued tender notices. Three states – Delhi, Haryana and Rajasthan – have begun enrollment. The initial response from beneficiaries has been very positive.

What is the RSBY and how does it operate?

2. The objective of RSBY is to provide financial protection to below poverty line (BPL) households from major health shocks that involve hospitalization through provision of a cashless insurance scheme. Specifically, BPL families are entitled to more than 700 in-patient procedures to a value of up to 30,000 rupees per annum for a nominal registration fee of 30 rupees. Pre-existing conditions are covered and there is no age limit. Coverage extends to the head of household, spouse and up to three dependent children or parents. Financing of the premium comes primarily from the central Government (75 percent of premium), with States contributing 25 percent of the premium and any administrative costs not built into the contract with the insurance provider.

Innovative features of the RSBY

3. The RSBY scheme is not the first attempt in India to provide health insurance to low income workers. To date however, these efforts (e.g. the Universal Health Insurance Scheme for BPL households) have failed to achieve a significant increase in health insurance coverage among lower income households at the national level. The RSBY scheme differs from these schemes in several important ways that may result in greater success. These include:

- the scheme provides the participating BPL household with choice between public and private hospitals and makes him a potential client worth attracting and keeping due to the significant revenues that hospitals stand to earn through the scheme. Uniquely, the scheme places control over significant resources in the hands of the beneficiary, empowering the BPL household and potentially creating an important source of competition for his business.

- unlike previous schemes, the insurers can be public or private and are subject to a tendering process and market competition for the health insurance business. Just as importantly, many implementation functions are the contractual responsibility of the insurer and its partners (e.g. hospitals, TPAs, grassroots intermediaries, smart card providers). While this introduces new demands on the state for oversight and regulation – and hence a new and significant set of risks – it reflects the lessons of prior failures that that public sector is incapable of performing all roles in a health insurance scheme.

- the design of the scheme involves incentives that are conducive both to the expansion of the scheme as well as long run sustainability. In the case of enrolment, the insurer is compensated for each household enrolled and issued a smart card. Hospitals also have an incentive to attract the BPL households as a potentially significant source of revenues. This is true even for public hospitals which are now being allowed to create 'societies' which will allow them to retain a share of the revenues that they collect.

Insurers, in contrast, have an incentive to monitor participating hospitals in order to avoid excessive claims through fraudulent or unnecessary procedures.

- the inclusion of intermediaries such as NGOs and MFIs which are tasked with mobilizing enrolment and facilitating use of services by BPL households addresses a key design flaw of previous schemes.

- the scheme involves innovative and "cutting edge" use of ICT applications in both beneficiary enrolment and use of health services and in the proposed MIS and oversight arrangements. A key platform is the smart card enrolment of all beneficiaries, with the card also acting as a debit card for cashless use of health services. The card can also be a "backbone" for beneficiaries in other targeted programs if desired, and some states are already exploring the possibilities for piggy-backing other program identification on the RSBY card. This has many advantages, though also introduces new risks in the management of the technology and ensuring the capacity of beneficiaries, service providers and insurers to support the functioning of the smart card system.

- to the team's knowledge, the RSBY is the first scheme in India for the poor which allows for portability of benefits across states, albeit on a selective basis to date. In this case, insurers are obliged to include network hospitals in states/cities where seasonal migrants from their states are most commonly found. This will naturally be partial in the early years, but is an important in-principle innovation of the scheme. The portability may also be accelerated for some states in practice by "back-to-back" network arrangements between insurers in different states.

- finally, the information gathered by government on a timely basis and reported publicly should allow both for mid-course improvements in the scheme as well as contribute to competition during subsequent tender processes with the insurers. More broadly, the MIS information on health service usage could be the first example in India of timely data on disease profile.

How it works

4. State governments engage in a competitive bidding process and select a public or private insurance company licensed to provide health insurance by the Insurance Regulatory Development Authority (IRDA). The technical bids submitted must include a number of elements as per GOI requirements. The insurer must agree to cover the benefit package prescribed by GOI through a cashless facility that in turn requires the use of smart cards which must be issued to all members. This requires that a sub-contract be arranged with a qualified smart card provider. The insurer must also agree to engage intermediaries with local presence such as NGOs, MFIs, etc. in order to provide grassroots outreach and assist members in utilizing the services after enrolment. The insurer must also provide a list of empanelled hospitals that will participate in the cashless arrangement. These hospitals must meet certain basic minimum requirements (e.g. size and registration) and must agree to set up a special RSBY desk with smart card reader and trained staff. The list should include public and private hospitals.

5. The financial bid is essentially an annual premium per enrolled household. The insurer is compensated on the basis of the number of smart cards issued, i.e., households covered. Each contract is specified on the basis of an individual district in a state and the insurer agrees to set up an office in each district where it operates. While more than one insurer can operate in a particular state, only one insurer can operate in a single district at any given point in time. The hardware and software specifications laid down by GOI imply inter-operability across districts and states. While this model is a major improvement on previous group-based schemes where insurers get lump sum premia from states whether or not beneficiaries are aware of being insured, it still retains the obvious risk that insurer incentives to ensure actual service provision (let alone decent quality of care) are weak after enrolment. This will be a major challenge for both public

oversight and for the performance indicators needed (and their collection and analysis through MIS) to assess the performance of insurers and their networked hospitals.

6. The operation of the system involves three stages: enrolment, hospital transactions and monitoring.

(a) Enrolment. An electronic list of eligible BPL households is provided to the insurer according to a pre-specified format. The list is posted in each village prior to the enrollment and the date and location is publicized in advance. Mobile stations are set up at local centers (e.g., public schools). These stations are equipped with the hardware required to collect biometric information (fingerprints) of the members of the household covered and to print smart cards with a photo. The smart card along with an information pamphlet describing the scheme and the list of hospitals is provided on the spot once the beneficiary has paid the 30 rupee fee. The process takes less than ten minutes.

Three individuals must be present at each enrollment: A district-level, state government officer is present and must insert his own, centrally-issued smart card to verify the legitimacy of the enrolment. (In this way, each enrollee can be tracked to a particular state government official). In addition, a smart card vendor and insurance company representative must be present. It would also be expected that the grassroots intermediary partner(s) of the insurer would be present, though this element is expected to take more time to put in place as comprehensively as the program Guidelines would suggest is required. At the end of the day of enrolment, the list of households issued smart cards is sent to the state government and centralized at the district level.

(b) Transactions at hospitals. The smart card entitles its bearer to a list of pre-specified in-patient services in the second month following enrollment. So, for example, someone enrolled in the month of February can use the card at designated hospitals as of April 1st of the same year through March 30th of the following year. (Provisions exist for pro-rata premium payments to the insurance company in the event of partial year enrolment subject to a minimum of six months.)

The transaction process begins when the member visits the participating hospital and his or her card is swiped. If a diagnosis leads to an inpatient procedure (or equivalent under day surgery), the appropriate prescribed package is selected in the software menu. Upon release, the card is again swiped and the pre-specified cost of the procedure is deducted from the 30,000 rupee total on the card. A receipt is printed and provided to the member. If the required procedure is not on the pre-approved list of RSBY procedures, the hospital will need to interact with the insurer or its TPA to get prior authorization of the procedure and a cost estimate. The frequency of such prior approvals will be an important factor to monitor in the initial years of the scheme, as the delays that may be involved present an important risk.

(c) Monitoring. Information on the transactions that take place each day at each hospital is uploaded through a phone line to a database on a district server. A separate set of pre-formatted tables are generated for the insurer and for the government respectively. This allows the insurer to track claims, transfer funds to the hospitals and investigate in the case of suspicious claim patterns through on-site audits. Governments are able to monitor utilization of the program by members and to some extent, begin to measure the impact of the program. (Rigorous M&E methods are being designed and may be supported by the World Bank.) Periodic reports would be made publicly available on the internet and through published reports.

Going forward

7. The Government of India, in cooperation with the participating state governments, will monitor the implementation experience of the scheme during the next few years. Adjustments will be made as the experience unfolds, always with the same objective in mind – to provide poor households with insurance against the costs associated with major illness.