Learning Journey

Health for all: RSBY Outpatient benefits pilot

ICICI Lombard General Insurance Company, Ltd.

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Project Basics

About the project

Rashtriya Swasthya Bima Yojana (RSBY) is India’s national health insurance programme for below the poverty line (BPL) families, most of whom are informal workers. It was launched in 2008 by the Ministry of Labour and Employment (MoLE). As of early 2013, RSBY has expanded to more than 487 of India’s 671 districts, now reaching more than 34 million families.¹ (You can find out more about the RSBY scheme in this video.)

RSBY was launched with an inpatient (IP) benefit package, a common approach for health insurance schemes whose long term goal is to provide comprehensive benefits to low income clients, but which commence by covering low frequency, high cost IP events. However, the costs of high frequency, low cost outpatient (OP) care represent a constant “dripping tap”² and result in significant out-of-pocket expenditures for RSBY’s BPL (below the poverty line) clients.³ This financial strain constrains treatment seeking, potentially leading to deterioration in health and eventual hospitalization.

In an effort to address demand for OP coverage, MoLE decided in 2011 to pilot the addition of OP benefits to complement RSBY’s existing IP benefit package. In partnership with ICICI Foundation for Inclusive Growth (IFIG) and the Facility, MoLE launched the pilot project in two districts in India: Puri in the state of Odisha and Mehsana in state of Gujarat.

The objectives of the pilot were to:

- Observe the effect of OP benefits on access to health care, treatment-seeking behaviour, client satisfaction with the RSBY scheme, health outcomes, out-of-pocket expenditure, and financial risks of households
- Test whether the inclusion of OP benefits decreases IP utilization, and therefore improves the overall viability of the scheme
- Improve health financing and delivery through public-private partnerships
- Test ways to efficiently deliver OP benefits at scale, using RSBY’s IT platform and biometric smart cards
- Understand the value proposition of OP care for health-care providers
- Create a single database about clients and their use of OP and IP services
- Inform and shape the future delivery and financing of OP benefits as part of a comprehensive benefits package in India
- Identify which factors affect prescription patterns and patient utilization of drugs

Stakeholders

This pilot was initiated in partnership with:

- The Ministry of Labour and Employment (MoLE) – sponsors the programme
- The ICICI Foundation for Inclusive Growth (IFIG) – provides the OP premium subsidy for the pilot period; serves as chief learning partner for the pilots

¹ICICI Foundation. 2013. Pilot Project Introducing Outpatient Healthcare on the RSBY Card – A Case Study, p. 10
²Freedom from Hunger’s Plan for better health: technical learning conversations facilitator’s guide. “These illnesses come regularly like dripping water—each drop of water is small but together the drops make a huge puddle. Each illness is not always serious, but together the illnesses make a lot of costs for her family.”

Learning Journey: March 2014
The International Labour Organization’s Microinsurance Innovation Facility (the Facility) – provided a grant to develop the OP software and related hardware, as well as the outreach material for awareness activities; supports knowledge management

An Oversight Committee was established under the guidance of MoLE. It provides oversight on project conceptualization, implementation, monitoring and evaluation. The committee also defines reporting systems for all project stakeholders. Members of the committee include:

- ICICI Foundation for Inclusive Growth
- Deutsche Gesellschaftfür International Zusammenarbeit (GIZ) – a technical service provider supporting the German government
- The World Bank
- International Labour Organization

**Project Design**
The pilot testing of OP benefits with existing RSBY IP benefits was designed in the following way:

- The complementary OP package is provided to all families enrolled in RSBY in the pilot districts
- The financial risk is borne by the insurer under contract in the pilot district. In the selected districts, Puri and Mehsana, the insurer is ICICI Lombard General Insurance Company
- A panel of private doctors, health care providers and public primary health centres (PHCs) will be developed in each pilot district. Providers will be selected based on a mapping study of existing health-care providers, with an aim to ensure convenient access to care
- The OP pilot will use the existing RSBY smart card platform to verify clients and register visits. All transactions are paperless and cashless.

On the ground, the pilots are implemented by:

- The State Nodal Agency (SNA) in each state
- ICICI Lombard General Insurer – contracted by MoLE as the insurer in the pilot districts
- Financial Inclusion and Network Operations (FINO) – developed and installed the technology components

Find out more details [here](#).

**Features of the OP cover**

- Up to ten outpatient visits per family per year in empanelled outpatient clinics; up to two of these visits can be to a specialist
- Medical consultation and medicine during OP visits are covered at no out-of-pocket charge to clients
- Additional OP services which may be required in follow up to an OP visit are covered for a period of 7 consecutive days
- Diagnostic tests and investigations are not covered, and clients must pay out-of-pocket for these (although MoLE is considering covering these in the future)

Existing features of RSBY which remain in place include:

- The fee charged to RSBY clients has not been increased with the addition of OP benefits, and clients do not sign up separately. Clients pay INR 30 per family to enrol to RSBY for a year, allowing them to access both OP and IP care
- Up to 5 members per family
- All pre-existing medical conditions covered
- Post-operative care delivered in an OP setting is covered under IP benefits

**Financing the scheme**

Premiums for OP benefits were set in accordance with expected costs, expected utilization, and the provider payment terms. Given the lack of historical data, the stakeholders agreed on an initial premium for each state. However, it was agreed that premiums would increase if provider payments increased or if additional benefits (open access to specialists or inclusion of diagnostic procedures, for example) were added.

Under RSBY, the national government pays 75 to 90 per cent of the IP premium, and the state government pays the remaining amount. However, for the OP pilots the premiums are not paid by the government, but by IFIG. Just as with IP premiums, OP premiums are administered through the SNA, which pays the insurer based on the number of households enrolled.

As OP benefits expand and scale up across India, it is expected that the central and state government will share the financing of the premium, in the same way that IP premiums are currently subsidized.

Please find more details [here](#).

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**Project Summary**

- **Project Name:** Health for all: RSBY Outpatient benefits pilot
- **Project Start Date:** October 2011
- **Duration:** 26 months (ending on the 31st Dec 2013)
- **Country:** India
- **Product:** Health
Project Updates

Key Indicators

All key indicators as of December 2013
Pilots began on 1st July 2011 in Puri and on 1st November 2011 in Mehsana

<table>
<thead>
<tr>
<th>District</th>
<th>Puri</th>
<th>Mehsana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total enrolment (no. of families)</td>
<td>180,371</td>
<td>76,929</td>
</tr>
<tr>
<td>Total enrolment (no. of lives)</td>
<td>647,043</td>
<td>298,446</td>
</tr>
<tr>
<td>Total number of claims to date (OP)</td>
<td>10,794</td>
<td>24,775</td>
</tr>
<tr>
<td>Total number of claims to date (IP)</td>
<td>2,338</td>
<td>7,834</td>
</tr>
<tr>
<td>OP Incidence (%)</td>
<td>2%</td>
<td>8%</td>
</tr>
<tr>
<td>IP Incidence (%)</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Number of OP claims over time - Puri

- Steep incline as providers were better incentivized to carry out OP consultations under RSBY after the provider payment was increased from INR 50 to INR 100.
- Sudden fall because of incompatibility of new 64KB RSBY smart cards.

Utilization initially grew slowly as it took time to build up awareness of the benefits and as more health facilities were gradually empanelled.
Number of OP claims over time – Mehsana

OPD utilization peaked as ICICI Lombard empanelled more hospitals and increased the provider payment from INR 75 to INR 100.

The OPD claims began to increase as the technology problems started to be resolved.

Sudden fall because of incompatibility of new 64KB RSBY smart cards.

Utilization initially grew slowly as it took time to build up awareness of the benefits.
What is happening?

Empanelling providers
It is the job of the insurer in each district to empanel health-care providers. They have to identify and contract potential providers, secure, install the RSBY hardware and software at the provider, and train the provider.

Each healthcare provider signs a memorandum of understanding (MoU) with the insurer stating their agreement to fulfil the scheme’s requirements which include providing OP care and dispensing medicines directly through nearby pharmacies at fixed rates. Alternatively, the district health authority can sign the agreement on behalf of all public providers in the district.

RSBY contracts both public and private health-care providers in order to provide care as close to communities as possible. A mapping exercise was carried out to plot the location of facilities and to determine which, and how many providers should be empanelled to provide adequate access throughout the pilot districts.

The response from health-care providers was better than expected in Puri and a network was empanelled relatively quickly (in just 2 and a half months). This was probably because some health-care providers were already participating in another scheme run by ICICI Lombard, and therefore were familiar with cashless schemes and had a level of experience and trust in dealing with the company. The response from public health-care providers was better than that of private health-care providers.

Mehsana is generally a more prosperous district than Puri. As a result, fewer OP providers in Mehasana were willing to participate in the pilot under RSBY, stating that the proposed payment was not high enough.

The provider payments were later increased for both districts. The provider payment in Puri was initially INR 50, and this was increased in April 2013 to INR 100. In Mehsana, the benefit package differed in that it allowed access to specialists for all covered visits. Additionally, provider fees were higher compared to those in Puri. Therefore providers in Mehsana were initially paid INR 75 per visit to a general doctor, and this was also increased to INR 100 in April 2013. For specialized doctors, the payment was INR 150 per visit.

Another approach taken to increase the number of participating OP providers was to recruit registered homeopathic doctors. This effort resulted in the addition of 6 providers in Puri, who were trusted and often used by the clients.

Please find more details here.

Training providers
All the empanelled providers are trained by ICICI Lombard on the scheme, its benefits, the technology, and the claims and reimbursement processes. The training is on-going and is conducted at several levels:

- Initial training, carried out by the technology partner, FINO, and ICICI Lombard’s customer service team during installation of RSBY OP technology
- District level workshops once every two months, done by ICICI Lombard and FINO. ICICI Lombard develops the content on the benefits package and FINO demonstrates the operation
of the RSBY hardware and software

- Practitioner-to-practitioner learning, conducted occasionally, in which a health-care provider is invited to learn by observing the operations at another health-care provider nearby under the guidance of FINO and ICICI Lombard

After the scheme had been running for a few months, it became clear that some providers were struggling to use the technology to register patients and to submit claims. It was therefore decided to conduct refresher training. Teams with representatives of each partner visited each provider, investigated the difficulties they were experiencing and addressed them with training.

Subsequently, it was decided to train each provider at least 2-3 times during the life of the project. Training visits were also available on demand for providers who were new to the technology. In addition, a team from FINO visits providers once a week to address any technical issues.

**Enrolling clients**

Under RSBY, the insurer is responsible for enrolment, but is supported by the SNA in each state. The SNA creates and maintains the population eligibility data for those who are BPL in an electronic format specified by the national government. Before the enrolment, the SNA provides a list of eligible clients, which is displayed in prominent locations in the village. Information is also provided to each household.

During enrolment a smart card is issued to each enrolled household. The insurer must reach each household member who is to be included, and authenticate their identity, register them, and issue them a card. The government then pays the insurer premiums based on the number enrolled in this way.

On a scheduled day, the insurer staffs an enrolment centre at a village. The enrolment process takes about ten minutes per household. Up to five family members provide fingerprints and have their photos taken and each household pays the standard INR 30 annual registration fee. Although modest, this fee is thought to increase a sense of ownership among clients.

One biometric smart card is provided to each newly enrolled household either on the spot or the day after registration. Clients must use this smart card to access healthcare through RSBY. This ensures that an eligible client receives services, limiting fraud and improving efficiency by providing the real-time, paperless encounter data. Along with the smart card, the client is given a booklet giving details of the scheme, benefits, available hospitals, key contacts, including the insurer’s call centre, and the complaints process.

An extra smart card can be created for migrant workers. In this case the coverage is split between this card and the household’s main card, and the migrant worker can access services using his or her card across India.

Enrolment in Puri began in June 2011, but was delayed due to the inaccuracy of the list of eligible clients provided by the SNA. As a result of this and further delays due to flooding in the district, enrolment was not finished in Puri until
November 2011. Around 132,000 households were enrolled, representing 53 per cent of eligible households.

FINO deployed 50-60 staff with 30 enrolment kits in each block. On average it took the team 15 days to enrol a block.

Enrolment in Mehsana followed that of Puri. Commencing in September 2011 and running for the designated 3 months, around 78,000 households were enrolled, representing 64 per cent of eligible households.

**Re-enrolling clients**

Policy renewals were delayed in both districts. In Puri this was a result of problems experienced by the state government when preparing the enrolment data. In Mehsana it was a result of delays in the SNA administering the insurance companies’ tenders, as well as the need to wait until after an election at the end of 2012. As a result, the existing policies had to be extended to cover clients until re-enrolment could be completed. The duration of the policy had initially been set at 1 year, with the option to change it at the discretion of MoLE, and with agreement of the SNA and the insurer. In the end the total policy period was extended to 37 months in Puri and 29 months in Mehsana.

Renewals began almost a year late in May 2013 in Puri. The problems with inaccurate data continued. Nonetheless, enrolment conversion rates in Puri showed a promising trend. ICICI Lombard was able to enrol 60 per cent of potential beneficiaries, compared to 53 per cent previously. This was partly because the SNA incentivized the Field Key Officers to participate by providing an incentive of INR 2 per family enrolled. In addition, the enrolment effort was better planned, with blocks most severely affected by rains enrolled before the monsoon season.

In Mehsana enrolment started in January 2013 and finished at the end of April 2013. Again outdated and inaccurate data hindered enrolment. In Mehsana the conversion rate was around 60 per cent, compared to around 64 per cent previously. This lower result was partly due to the introduction of new sources of beneficiary data, which overlapped with data already recorded for many existing beneficiaries.

The numbers of clients enrolled during each round of enrolments are below:

<table>
<thead>
<tr>
<th>Round 1</th>
<th>Policy start date</th>
<th>Puri</th>
<th>Mehsana</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy end date</td>
<td>31-Aug-2013</td>
<td>31-Mar-2013</td>
</tr>
<tr>
<td>Enrollment</td>
<td>Households</td>
<td>132,434</td>
<td>80,308</td>
</tr>
<tr>
<td></td>
<td>Lives</td>
<td>431,348</td>
<td>280,380</td>
</tr>
</tbody>
</table>

| Round 2 | Policy start date | 01-Sep-13 | 01-Apr-13 |
|---------| Policy end date  | 31-Mar-2014 | 31-Mar-13 |
| Enrollment | Households | 180,371 | 76929 |
|          | Lives | 647,043 | 298,446 |

Please find more details [here](#).
**Client Awareness**
Creating awareness among clients about the benefits and how they can access them is vital to ensure that they take advantage of them. Awareness campaigns were carried out by ICICI Lombard during the enrolment process to inform clients about the scheme.

Several approaches were tried in each area to see what worked best with each client population. There are considerable differences between the socio-economic backgrounds of Mehsana and Puri. Therefore, different awareness and literacy activities were planned for each district. In Puri dance and folk art were used in village centres and market areas, as well as posters and other displays in prominent areas. In Mehsana the awareness campaign included a radio jingle, dance nights during a festival season, displays, banners, a campaign vehicle, and kites (to coincide with a kite flying festival). Newspaper advertisements were also used, since, unlike in Puri, the majority of the population of Mehsana is literate.

As the pilot progressed, clients were not using the services as much as expected. In addition, feedback from the monitoring teams suggested that the awareness campaigns during enrolment were not sufficient. Therefore, the team carried out further awareness campaigns. These included celebration events at the health-care provider facilities, a vehicle specially designed to promote the scheme (see picture below), and information events and meetings.

However, even after these subsequent campaigns, the partners did not feel sure that awareness of the scheme, including the availability of OP benefits, was sufficient to achieve desired utilization levels.

Please find more details here.

**Claims**
The health-care provider receives a negotiated payment of INR 50-150 for each outpatient visit, depending on the district, and whether the health-care provider is a primary care doctor or a specialist. The rates were increased in both districts in order to persuade more health-care providers to become empanelled in RSBY provider network.

RSBY uses a smart card technology platform to deliver paperless, cashless transactions. When a visit takes place, a client’s identity is verified and the details of the visit are entered into the system. These details include patient demographics, diagnosis and treatment, and any follow-up required.

When these data are uploaded to the RSBY central system, the insurer is notified to pay the claim. Initially it was possible to upload health-care provider claims in two main ways. Where there is an
internet connection, the information is uploaded in real time, when the transaction takes place. Where the internet connection is intermittent, transactions are temporarily stored and uploaded later when there is a connection. If a facility has no internet connection at all, a representative of FINO collects the data in person on a data card. A mobile phone application was tested in August 2012 in Puri, allowing data to be transferred without an internet connection.

Once the data have been uploaded to the central system, FINO performs an initial data check. From this point, ICICI Lombard takes over to verify and process the claims. All OP claims are processed in house by ICICI Lombard; a third party administrator is not used.

Claims are settled with health-care providers through electronic fund transfer (EFT). It is mandatory to pay 95 per cent of the payments via EFT; the remainder can be made through cheques. The payment cycle usually takes 15 days once the claims data are received by ICICI Lombard. However, if ICICI Lombard suspects an error or possible fraud the health-care provider has 15 days to verify and resolve the claim.

Valid claims must be paid within 21 working days from the time the health-care provider enters the details of the encounter. There were some difficulties to achieve this because of problems with the data such as the bank details of the health-care providers. However, the vast majority are now processed within this time period.

Please find more details here.

Technology

Technology enables delivery of the insurance, and allows the scheme to operate on a completely cash-less, paper-less basis. When clients enrol, their biometric data are recorded and they are issued smart cards. Each OP provider authenticates the identity of the RSBY client using a single hardware unit, which contains a biometric card reader, a scanner, and a printer. The provider also uses a laptop installed with specific OP software, and records the details of the client’s visit here.

Each transaction on this platform documents that the service has been delivered to the client. The data are uploaded and synchronised with the central technology server, so that the health-care provider is eligible to claim payment for the visit (see section on claims for more detail). The technology partner, FINO, provides troubleshooting in case of technical problems. FINO also manages the central server to record claims upon receipt.
Below is an illustration of the technology-enabled process:

Over time, some adaptations to this core process were necessary. One change was to carry out the fingerprint matching only once, compared to twice initially, because the process was proving too time-consuming for clients. The single check now takes place after the data is entered into the OP software.

When the technology was installed at each provider, there were some problems. The biggest problem was that the providers struggled with unreliable or no internet connection. Data cards were used to help improve the internet connectivity, but issues with connectivity and with electricity persisted, slowing implementation. In addition, some of the devices stopped functioning after a few months, and required reactivation. While devices malfunctioned, claims had to be processed manually. This led to delays in claims payment, ultimately causing some providers to simply turn clients away. This led to a reduction in claims, and a loss of trust among those clients and health-care providers who were affected.

A mobile phone supported claims solution was later introduced, to help sidestep problems of limited internet connectivity. Seven health-care providers tested the mobile phone enabled system, with Bluetooth devices introduced in their clinics. These mobile devices provided a useful alternative to
submit claims, and were appreciated by providers. The extended battery life of the mobile and the Bluetooth enabled devices (10-12 hours compared to 3-4 hours for a laptop) allows providers to submit claims from more distant locations, which lack internet or power connectivity. Providers preferred the mobile phone method to the point of service (PoS) alternative and were able to increase OP claims to 3,100 transactions per month, up from 387 transactions per month (with PoS devices).

Please find more details here.

Change in biometric cards
The government was concerned that there was not sufficient space on the biometric cards to store all the data that might be required in the future, particularly to potentially accommodate multiple government schemes using the cards distributed originally for RSBY. It therefore decided to enhance the memory capacity of the cards from 32KB to 64KB.

However, this caused many problems for the OP pilot. The technology for IP RSBY comprises three devices and a laptop, whereas for the OP pilot integrated devices were installed in stand-alone OP clinics. The 64KB cards that were introduced were not compatible with these integrated devices. As a result, freestanding OP clinics could not access the RSBY technology platform. In the end it became clear that the hardware would have to be replaced, yet finalising the new software and installing it in the clinics took months. In the meantime, most private empanelled facilities, which are often the closest and most accessible for clients, simply began turning RSBY clients away or asking them to pay for services out-of-pocket. Freestanding public OP clinics could continue to provide consultations to clients for free, as they did before the scheme. But they were not able to offer medicines free of charge through RSBY, unless these were already available through other government provisions.

Considerable momentum and interest in the scheme had been built up through awareness activities and the experiences of clients. This disruption in service delivery has eroded the trust of clients, which may take significant effort to rebuild once the technology is operational again.

Action Research
Baseline research was conducted for Mehsana in September 2011. For Puri the first round of the research study was conducted in October 2012. For both the pilot locations end-line research will be conducted after the end of the policy period in each district.

Quantitative analysis of preliminary baseline data findings

An overwhelming majority of clients (more than 94 per cent in each district) were aware of RSBY from health-care providers and almost all (about 98 per cent in each district) knew about the cost of enrolment. On the contrary, the awareness about the benefits of the scheme was not as high. Less than half of the respondents (34.8 per cent in Mehsana) knew about hospitalization benefits. The majority of the household respondents did not know whether medical diagnostics (75.7 per cent in Mehsana) and medicines and drugs (59.9 per cent in Mehsana) expenses during hospitalization were covered.

Nearly all clients in Mehsana (93.9 per cent) incurred at least some health-care expenditure. A breakdown of out-of-pocket expenditure for treatment showed that the majority of out-of-pocket costs was for medicines (Mehsana - 89.9 per cent), transport (Mehsana - 60.6 per cent), and diagnostics (Mehsana - 50.2 per cent). In order to pay for out-of-pocket costs of OP treatment during the reference period, 32.6 per cent of households in Mehsana had to borrow money or take a loan.
Knowledge about how to access benefits was poor (only 18 per cent of clients understood the process in Mehsana). Lack of complete knowledge of how to access benefits was mentioned during in-depth interviews and in focus group discussions (discussed below). ICICI Lombard suspects that it may be the main reason for poor utilization of the OP benefits.

In-depth interviews and focus group discussions
Qualitative data were collected through in-depth interviews of key stakeholders and focus group discussions (FGD) with eligible clients to generate insight into the need for and perceptions of OP insurance.

All the participants in the FGDs were very positive about the expansion of the RSBY scheme to cover OP treatment along with IP treatment. In order to increase use of the scheme, the participants suggested:

- Detailed information about the scheme should be provided, preferably through Gramsabha (group meetings) separately for males and females (this was suggested by the female participants of Mehsana) and through public announcements
- Proper health-care facilities with qualified doctors in nearby health centres are important. The distance to facilities was brought up in particular in Mehsana
- The medicines prescribed by the doctors should be freely available in the health-care centres

Research into low IP claims
Since the start of the policy in Mehsana in November 2011, until February 2012, around 3,500 claims were submitted for IP benefits, compared to only 650 for OP benefits, contrary to the evidence that shows that OP services are accessed much more frequently than are IP services. Experience in the field suggested that this unexpected result was due to low awareness of OP benefits. IP was launched earlier, so there had been more time to build awareness and experience of IP benefits. It is also possible that fewer OP claims were recorded by public OP clinics than actual services delivered, since public clinics already offer free (cashless) OP services to beneficiaries, and may not therefore have recorded encounters on the RSBY system.

To understand why OP benefits were being underutilized a randomly chosen group of 50 clients were interviewed. Although the sample was limited, it yielded some interesting results. Around 87 per cent of those interviewed were aware of the IP benefits, compared to just 13 per cent who were aware of the OP benefits. Additionally, almost two thirds of those aware of OP benefits did not realize that medicines were included as part of the benefits offered for OP care. And among those aware of OP benefits, none of them had actually used them. They gave the following reasons:

- 40 per cent did not have any episode of illness requiring OP care
- 60 per cent went to doctors outside of the empanelled network, since they either did not know which doctors were empanelled or preferred to visit non-empanelled providers who might be more convenient or otherwise preferred.

In summary, it appeared that the large majority of clients were unaware of the OP benefits. When the team then explained the OP benefits available to interviewees, they were largely enthusiastic to make use of the OP benefits. This strongly suggests a need for a broad-based expanded awareness campaign on OP benefits.

Additional research, including the end-line findings will follow.
Other pilots
The pilot was also expanded to six other districts:
- Bathinda, Ferozepur and Rupnagar in the state of Punjab
- Rangareddy in the state of Andhra Pradesh
- Serchhip in the state of Mizoram
- Dehradoon in the state of Uttrakhand

You can see a summary of the pilots here, and the lessons learnt in them here.
Project Lessons

On empanelment of health-care providers

Empanelment of health-care providers is critical, and may require a mix of public and private health-care providers. The initial plan was to empanel only public health-care providers. It was subsequently realized that the geographic distribution of public health-care providers was not uniform, especially in Puri. Most of the public facilities were not accessible from remote areas. Public facilities also often lacked human resources, drugs, and other necessities. Therefore to provide more reliable OP services and decrease travel time for clients both public and private facilities were included in the network of health-care providers.

Increasing the utilization of public health-care providers can improve service and cost efficiency. ICICI Lombard’s experience and interaction with beneficiaries has suggested that clients are used to and comfortable using public facilities. Treating RSBY clients brings additional revenue to public providers, which can support improvements in the quality and reliability of their services. The programme can therefore contribute to strengthening the public health-care system.

Consider alternative medicine practitioners. Qualified alternative medicine practitioners are available in many areas, and are trusted and well-used by RSBY clients. Although a limited number of alternative practitioners have been empanelled so far, they have proven popular. Empanelment of additional alternative medicine practitioners is therefore being considered, especially in areas where not enough other qualified practitioners are available.

Health-care providers are more likely to be convinced to become and remain contracted health-care providers by someone from their own community. Local representatives, typically from the government, are more trusted by health-care providers and more in-touch with the local context. Local representatives can also help address on-going issues with health-care providers and persuade them to improve their infrastructure and services.

Different approaches should be used to empanel public and private health-care providers. Public health-care providers are managed by state governments. Private health-care providers, on the other hand, operate independently and are often willing to work directly with insurers if given sufficient financial incentives. It is therefore necessary to collaborate with state governments to engage public health-care providers, whereas insurers must recruit private health-care providers with appropriate incentives. In all cases, general awareness campaigns through workshops and other means should be used to inform medical practitioners about the scheme and stimulate their interest before direct attempts are made to empanel them.

New technology may discourage health-care providers from participating in a scheme. Initially private health-care providers were reluctant to consider becoming a participating provider for the RSBY OP pilot. ICICI Lombard made several visits to explain the concept and recruit them. One of the major reasons was the technology. The majority of the health-care providers in both districts were not very comfortable with computers and most operate using paper-based systems. Furthermore, they believed
that the smart card technology and need for data entry would increase the time they spent on each patient, decreasing the number of patients they could see in a day. Public health-care providers worried that additional staff might be needed to handle the technology-based transactions.

Health-care provider compensation must equal, or come close to, market rates, at least initially. RSBY expects to achieve cost savings using volume-based pricing. However, initial utilization was low and providers did not experience a significant rise in visits. As a result, many health-care providers, both private and public, did not see the increased volumes that might have persuaded them to provide services below market rates. Public hospitals that also offered OP services generally believed that they should focus on IP services, which yield higher revenue. Thus it was difficult to contract sufficient numbers of OP health-care providers. For many providers the payment was lower than the amount they were already charging in their clinics. They were persuaded to take part in the scheme because of its potential to bring high volumes of clients, even at a lower payment per visit. However, after empanelment one health-care provider in Puri and two in Mehsana terminated because their footfall did not increase as they had hoped, and they found the rates to be too low.

Health-care provider payments are defined by the government. ICICI Lombard proposed a combination of higher payments and additional coverage for diagnostics, which would allow health-care providers to charge the scheme for additional services, while also providing enhanced benefits to clients. The inclusion of diagnostics is still being considered, but the provider payments have already been increased. As a result the there was an instant increase in the numbers of claims. In Mehsana, there were 12,500 claims in July 2012, compared to 1,100 claims in June 2012.

On training health-care providers
It is necessary to train providers on site to ensure that they receive training. Providers felt that they did not have time or sufficient notice to attend training. Time and money was therefore wasted on trainings that were not attended. As a result, training was instead carried out at the clinics, with an invitation for further training in a more central location.

On claims
Prompt claims payment and good communication around claims is important to maintain health-care provider engagement. Sometimes claim payments took longer than the 21 day turnaround service standard due to problems with the claims data or health-care providers’ bank account details. These delays demotivated the health-care provider. Measures taken to address these problems include rigorous checking of health-care providers’ bank details and better communication around any delays in claims payments. The turn-around-time is now greatly improved, and the vast majority of claims are paid within the targeted time.

On technology
Plan for hardware security before installation. Since many hospitals do not have locker/storage facilities, security of the hardware becomes an issue. It would have been better to anticipate this need in advance to avoid last-minute solutions or loss of equipment.

It is important to make administrative processes efficient for clients and health-care providers. Initially, the finger print matching to validate the cardholder’s identity was done twice per OP visit, once during registration for the visit and a second time after entering the diagnosis and treatment data. This
double validation took 15-20 minutes per patient, leading to complaints of bottlenecks and duplicate work by health-care providers. Now finger print matching is done only during data entry.

Additionally, the list of symptoms, diagnoses, and drugs on the menu within the OP software application was very long and it took too much time for the OP health-care provider to choose an entry from the list. Later, the billing software was updated with a series of pre-formulated lists of common drugs, diagnoses, and symptoms that replaced the longer list so that the health-care providers could more quickly select an appropriate response. It would have been better to have tested the user-friendliness of the paperless billing process at clinics and to have made improvements earlier in the development process.

**New technology should be integrated into the existing work flow of users.** The terminology used in the OP software often did not match that already used by health-care providers for symptoms and diagnoses. Additional and more commonly used terms were subsequently added to the software to better fit user needs. There is also a plan to provide printed lists (symptoms, diagnoses, and drugs) to the doctor, who could mark them as required and hand them over to other staff to enter into the system.

**It is important to understand IT infrastructure limitations at the health-care providers, and to adapt systems to limited internet connectivity and power supply.** Continuous challenges were experienced to access electricity and internet, which is required to install the OP software through a series of data downloads from the central server to the health-care provider laptop/computer. To prevent delays and allow the system to function during just a brief period of internet connection (just 20-30 minutes was enough) the amount of data to be downloaded was decreased. Another option was also introduced, where the FINO representative would bring the data for installation on a CD or a data card so that the installation could proceed without an internet connection.

Once the technology had been installed, the health-care providers continued to have problems uploading claims data using the OP software. A system to make transactions offline was therefore developed, but initially a maximum of ten transactions could be made offline, after which the transactions had to be uploaded before the next transaction could occur. The maximum number of transactions allowed offline has now been increased to 100. If the empanelled facilities have no internet connection at all, a representative from FINO can collect the transaction data in person with a data card. Finally, since many rural areas have erratic power supply, a mobile phone transaction application in place of the web application has been developed.

**There is a need to proactively ensure that public health-care providers comply with administrative procedures, including billing requirements.** Salaried public health-care providers may lack sufficient incentive to report challenges with the technology or the scheme in general. For example, three public health-care providers in Puri stopped providing OP care to RSBY clients after a few months when their systems malfunctioned because their PoS devices needed to be reactivated. Although the health-care providers knew about the issue for a long time, they never came forward to resolve it. ICICI Lombard’s regional team had to intervene and persuade the health-care providers to reactivate the devices and continue providing the service.

**On enrolling clients**

**Start with clean enrolment data.** ICICI Lombard found that the quality of the data for BPL households was often poor. The data, taken from the 1997 and 2001 censuses, contained errors including
duplications, missing records, and outdated information on deaths, births, marriages, and migration. There were discrepancies in about 10 to 15 per cent of the data which sometimes led to resentment in villages, followed by lower enrolment. The pre-enrolment data should have been examined carefully and updated to ensure more accurate enrolment of eligible households.

Enrolment should begin 2 months before the planned effective dates for policies, to allow for delays caused by the weather and difficult access. The challenges of intermittent electricity and connectivity were compounded by a lack of proper roads and transport infrastructure, which in turn were exacerbated by the arrival of the monsoon season with heavy rain. Due to the rain several enrolment kits broke down and many households did not turn up for enrolment. Due to floods in some blocks, enrolment was completely stopped for about 15-20 days.

On client awareness
Awareness building must be on-going to promote long-term understanding of RSBY benefits. Initial awareness campaigns were successful in creating a buzz about RSBY OP benefits, but they were too complex, and did not result in sufficient understanding of the benefit package among the health-care providers or clients. In particular, many clients misunderstood the fact that the OP benefits included a range of common drugs prescribed during an OP visit, at a specified level per visit. Instead, they thought that they were entitled to receive the total benefit amount for drugs over the allowed number of OP visits per year. Though clients’ initial impression held appeal, their misunderstanding later caused confusion and resentment when they found out that the benefits were not as expansive.

It is important that clients understand their benefits so that they can demand them from health-care providers. Some health-care providers did not understand that their payment covered both the consultation and a defined set of common drugs in a single rate per visit, regardless of which or how many covered drugs were prescribed. In some cases health-care providers thought that the RSBY payment was a fee-for-service reimbursement for the charges for the visit plus charges for drugs, and therefore prescribed drugs based on the fee amount remaining after the consultation was deducted. When clients also did not fully understand that they were entitled to drugs prescribed free of charge with each visit, they were likely to face extra charges or forego a prescription if it was not affordable.

Awareness will not spread by word of mouth until a critical mass of clients experience the benefits of the cover. ICICI Lombard found that information did not spread as quickly as hoped, due to low utilization of the product. This problem was compounded by health-care providers’ poor understanding of the benefits. Health-care providers were therefore unable to give the clients accurate information, causing confusion even where information did spread through word of mouth.

Many communication channels, including mass media, are unsuitable for rural populations in India. Rural communities are not very well connected to most media sources. Radio and newspaper advertisements only reach a limited number of households. However, approaching people in person can also be problematic, especially women who were often reluctant to engage with local campaigners. ICICI Lombard used wall paintings, but later found that these were not well received by the population because they were not placed in suitable locations, or that they had been painted over with other information. Written materials were unpopular and quickly discarded by clients.

The problems in the most rural areas were bought into focus by ICICI Lombard’s different experiences in the two pilot areas, Puri and Mehsana. The areas vary considerably in terms of demographic and socio-economic status. Puri is a highly conservative society, whereas Mehsana is relatively modern and
literate. Transport access and media penetration are also more advanced in Mehsana than in Puri. ICICI Lombard faced far greater resistance to convince rural providers in Puri to use computers for OP claim transactions since most of them were not comfortable with the technology and took some time to learn to use it. Again, when the mobile application was later introduced, they resisted the change in technology. However, it was gradually accepted with extensive training, and many preferred the mobile application in the end.

**On OP claim patterns**

**Most claims were for infectious diseases.** The most common symptoms reported in OP claims were fever, pain, and inflammation. The most commonly prescribed medicines were anti-inflammatories, painkillers, antipyretics, and antibiotics. The high incidence of infectious diseases is likely to be a result of poor living conditions and hygiene. These diseases should be highly preventable with increased availability of safe drinking water and better hygiene practices. Promotion of these could reduce the disease burden and related claims.

**Occupational injury also poses a hazard to the populations of these areas.** Ten per cent of claims were for injuries. Since traffic accidents are generally low in rural areas, these are likely to reflect the higher vulnerability of the rural population to injuries while working.

**Better claims data are required to improve analysis of claims experience.** Hospital claims data require significant time and effort to sort and code to obtain a more useful analysis. To improve the consistency and accuracy of the data, symptoms and diagnosis options should be more carefully aligned in the system. For example, it is currently difficult to identify the diagnosis when the doctor simply records “fever”, which could be related to many different causes.

The health-care providers wanted the drugs and disease master lists within the billing software to be simplified. Taking this into consideration, the technology team reduced the number of choices available to record the client’s symptoms, diagnosis, and prescriptions.

**It is essential to analyse health claims on a frequency and cost basis per family to uncover what is really driving results.** Trends can be more easily observed and data are more comparable by looking at the frequency and unit cost of claims on a per-person or per-family basis.

**On client value**

**Time can be as important to clients as money.** If the processes are too slow, a product will not provide sufficient value to clients. Clients often did not find a value in using their RSBY cards to access OP care if health-care providers asked them to wait due to technology challenges with RSBY systems (such as a lack of internet connectivity, inability to use the technology platform when the operator is absent, non-matching finger prints, lack of electricity, and so on).
Poor clients in particular may have many health-care problems when they visit a health-care provider, and providers may ration care. Health-care providers struggled to prioritize which condition they should treat. The single fee for the visit plus any drugs prescribed created an incentive to ration care since the payment per visit is capped.

Interaction with clients provides useful information on the barriers they experience to access health care and benefit from the scheme. Focus groups revealed some of the problems clients faced in accessing healthcare through the RSBY OP scheme. For example, many reported problems related to long treatment processes, distant locations of health care centres, and inactive smart cards, which often led to doctors refusing treatment.
Next Actions

As of February 2014, around 220,000 clients in Puri and 78,150 clients in Mehsana have used RSBY OP services under the pilot. There are now plans to scale-up OP benefits as part of RSBY. MoLE will make it mandatory for insurers to include OP benefits in the benefit package as districts bid or re-bid in 2014.

In the meantime, the following actions are planned for additional pilot testing under RSBY:

- The government is considering including diagnostic services such as laboratory tests to complement consultations and prescriptions in the OP cover. This could provide additional financial benefits for health-care providers, as well as enhanced healthcare and reduced out-of-pocket expenditure for clients. This has been proposed to the state governments.
- Further development and testing of the mobile application, and wider deployment, to alleviate constraints to access the technology platform.
- Experimentation with different provider payment methodologies such as capitation, or use of a “gate-keeper” function whereby clients must access specialist services with a referral from a primary care provider.