Origin of the concept and design

Pilot project - Providing out patient healthcare to complement Rashtriya Swasthya Bima Yojana (RSBY)

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Introduction

ICICI Foundation for Inclusive Growth (ICICI Foundation), Rashtriya Swasthya Bima Yojana (RSBY) and International Labour Organisation (ILO) are experimenting new mechanisms to provide outpatient health care to the poor. A pilot project to provide out patient healthcare is being implemented in two districts in India - Puri district in Odisha and Mehsana district in Gujarat beginning June 2011. Provision of out patient health services is based on expanding the current RSBY inpatient benefit package to include outpatient healthcare services to complement the existing RSBY scheme with the primary objectives of

- To improve the health seeking behavior among BPL population.
- To ensure delivery of quality outpatient services by healthcare providers (both public and private) nearer to the community.
- To provide financial access to out patient healthcare among BPL population

This document is prepared in connection with the documentation of outpatient healthcare pilot project. The narrative presented here reflects the process of envisioning the concept and design of the pilot project. It reflects the ideas, expectations, initial discussions/series of events and plans of implementing partners. Documenting this process captures the aims and objectives of each of the partners and the complexity in evolving a design considering each of those.

Triumph Health Enhancing Systems (agency contracted for documentation) conducted interviews using a semi-structured questionnaire with each of the implementing partners. The exercise dated from 7th May to 28th June 2012.

*It is advised that the document must be read with an understanding of the context and design of the pilot and be used/shared judiciously only to interpret findings/learning’s if any with in such context. These case studies neither reflect a generalized view of implementation or impact of the pilot nor supplement systematic research already being conducted.*

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**Context**

Government of India since 2004 made heavy investments in development of the health system through significant supply and demand side interventions. The National Rural Health Mission (NRHM) launched in 2005, is working towards revitalizing the existing primary health care system in rural areas providing access to preventive and primary care (Ministry of Health and Family welfare, India 2010). Though there has been progress, the health status of disadvantaged groups (poor, tribal and informal sectors) is still a concern. Equally worrying is the growing reliance on high out-of-pocket expenditure on health as a proportion of total household expenditure, reaching catastrophic proportions at times (i.e. equal to or greater than 40% of a household’s non-subsistence income).

The tax financed health insurance programs introduced by the central and state governments since 2007 are targeted at reducing out-of-pocket expenditures to protect the poor from catastrophic health expenditures. Currently over 302 million, about a fourth of India’s population are covered under such programs (PHFI, 2010). Implemented in partnership with public/private insurers and health care providers by prepayment risk pooling mechanisms, these programs allow below poverty line (BPL) and informal sector population a wider access to receive secondary or tertiary health care without any payments for health services.

Rashtriya Swasthya Bima Yojana (RSBY) by Government of India introduced in 2008 is one such program to reduce burden of health care spending on inpatient healthcare for the households of BPL population and unorganized workforce (informal sector). RSBY, based on insurance and public private partnership model focuses on improving the effectiveness of both public and private health service delivery by empowering people to choose among the providers. RSBY currently covers 30.4 million households across India.

While providing a financial cover related to inpatient healthcare is an important step to reduce catastrophic health expenditures, recent evidence reveals that expenditure on out patient health care has a greater impoverishing effect than on inpatient care and also impacts health seeking behavior as it deters poor from utilizing the health services when ill. It is estimated that an individual in India when ill, spends on an average Rs.257 (Rural) and Rs.306 (Urban) on outpatient care that includes doctors consultation fee, diagnostics and medicines.

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1. PHFI 2011, A Critical Assessment of the Existing Health Insurance Models in India
2. RSBY website (www.rsby.gov.in) accessed on 30th June 2012
This high expenditure for outpatient healthcare coupled with the uncertainty to access quality care (soon after the illness is perceived) nearer to their place of residence, keeps millions of poor away from seeking healthcare. Thus it is necessary to find alternative financing mechanisms to provide outpatient healthcare especially for the poor to achieve universal coverage and reduce the reliance on household out-of-pocket spending.

**Illustrative example**

*Rumi Bai is a 40-year-old married women with two children. Rumi and her husband work as daily wage laborers in a remote village in the state of Odisha, India. In winter of 2010, she had two episodes of pain abdomen followed by profuse bleeding per vaginum...*

It is not hard to imagine millions of women like Rumi Bai and their families living in the less developed pockets of India, where it is uncertain if Rumi Bai would seek any medical help in the first instance. If the symptoms persist,

(1) She might consult a traditional healer or an informal healthcare provider from the village where she can pay in kind or when ever she has the money. It is highly unlikely that she would approach the nearest qualified physician as the health facility with a qualified doctor might be located far from where she lives. Even if she decides to travel, she would loose a day’s wage and needs the money for travel and treatment.

(2) If she decides to visit a health facility, at a private clinic she would pay for the consultation, diagnostics and medicines while at a public health facility, expected to provide services free of cost, the doctor might not be available or might not have the diagnostics and medicines to diagnose/treat her complaints.

(3) She might wait for a few months to save enough money or take a loan to visit a popular private clinic in the town. In the bargain to get healthy, she would lose all her savings to cover the costs of travel and treatment, indebted her for life and pushing her further into poverty.

*Amidst the uncertainties surrounding Rumi Bai’s family and other characteristically poor, illiterate families living in rural India, the impinging question is how to assure every one of them quality health services nearer to their place of residence, accessed at first instance of illness without paying any out-of-pocket expenses?*
Origin of the pilot project

ICICI Lombard is the largest private insurance company in India and a major player in Financial Inclusion programs using the insurance platform. It also implements RSBY\(^4\) in several districts across India since 2008. Inspired by the success of RSBY in providing inpatient healthcare services to the poor through insurance mechanism, in 2010 the company started to work towards creating mechanisms on similar lines as RSBY to deliver out patient healthcare services.

Towards the end of 2010, the company came up with a concept where the existing RSBY benefit package would be expanded to include out patient healthcare services. It believed that delivering out patient services through RSBY would be beneficial as it would utilize the RSBY technology platform developed for functioning of the scheme with built in mechanisms for fraud control. A detailed concept note was developed. The focus was to use the RSBY as a platform and it was identified that a special software augmenting the existing RSBY technology was to be developed to perform functions related to delivery of out patient healthcare services. The company envisioned developing the new software and piloting the same in any of the districts implementing RSBY.

During the same period, the company came across Micro Insurance Innovation Facility's (Facility) 'Call for Innovation Grants.' Housed at the International Labour Organization's Social Finance Programme and launched in 2008 with funding support from the Bill & Melinda Gates Foundation, one of the main activities of the facility is to provide grants to institutions to devise and test innovative approaches to providing better insurance products to the low-income market in developing countries. In 2010 the focus of micro innovation facility was on health insurance and a call for proposals was made.

ICICI Lombard submitted a detailed project proposal to the Facility explaining its interest to design and pilot an out patient health insurance product for low-income households to be offered in conjunction with RSBY’s inpatient scheme in two district of India. The request for funding was granted and Lombard was promised USD 400000 for the following components of the project – software development, hardware infrastructure and out reach materials. The costs related to implementation, rollout and monitoring of the out patient product were to be borne by ICICI Lombard. Primary focus of the grant was to fund technology to develop innovative ways of service delivery pigging back on the RSBY IP platform. Secondly a small amount is catered to project management,

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\(^4\) Rashtriya Swasthya Bima Yojana, India’s National Health Insurance Scheme - a tax funded health insurance program covering inpatient treatments for the low-income households especially the informal sector workers. More info at www.rsby.gov.in
implementation support – ground salaries, operational costs, hardware for OP clinics etc. The funding could not cover the cost of premium for the out patient health insurance product in the districts, research and documentation of the pilot project – necessary components to test and advocate scale up of such product across the country.

ICICI Lombard approached ICICI Foundation for inclusive growth (ICICI Foundation) to fund the rest of the components as the foundation worked with the objectives of improving health outcome amongst poor and marginalized communities under their mandate to strengthen primary health care in India. The Foundation agreed to fund the rest of the components and participate in conceptualization, development and implementation of the out patient product. ICICI foundation formally informed its participation to the 'Facility' at ILO in April 2011 and this saw the emergence of supporting partners for the pilot and its implementation.

As the concept of providing out patient healthcare entirely depended on RSBY, and an overarching need to guide the design of project plan, its implementation and review was needed, the ‘Facility’ in April 2011 formally requested Ministry of Labour and Employment (MoLE), that oversees RSBY the following (excerpt from the original letter from Micro Insurance Innovation Facility to Ministry of Labour and Employment):

The Facility is keen to support a pilot project in 2 districts in India where an outpatient insurance product will be offered to complement the Rashtriya Swasthya Bima Yojana’s (RSBY) inpatient scheme. We will work with the ICICI Foundation for Inclusive Growth (ICICI Foundation), which is willing to fund the insurance premium for the outpatient product and serve as the project’s learning partner for research and documentation.

The project is of high interest to ICICI Foundation and us because of the potential to learn valuable lessons on strategies to enhance value to RSBY clients in the form of outpatient benefits and improve overall health financing and delivery through public private partnerships. Some of the potential efficiencies to test could include but not be limited to the success to administer the outpatient product on the RSBY’s IT platform, use of a common member identification card and creation of a single database with member data and utilization experience (both outpatient and inpatient).

This pilot project will run for at least 2 years and require alignment of interests and commitment, and a high degree of collaboration and support from a number of stakeholders, and most significantly from MoLE. We wish to seek your permission on the following activities:

1) Since the outpatient product will be offered in conjunction with the RSBY inpatient scheme, the pilot project will need to be implemented on the existing RSBY technology platform and will require access to this platform.

2) Since the outpatient product will be offered to all BPL clients of RSBY in 2 districts in India, the project will also require access to the RSBY member databases for the pilot locations.

3) For the successful implementation of this pilot project, we also recommend that a Oversight Committee be established with the following members:
   a. ICICI Foundation for Inclusive Growth, Ms. Pompy Sridhar
We expect that this Committee, under the guidance of the MoLE will provide oversight on project conceptualization, implementation, monitoring and evaluation. The Committee will also clearly define reporting systems for all project stakeholders and take necessary course corrections.

Internal discussions and consultations were held at RSBY before it confirmed its participation. When the RSBY IP was designed, including OP services was considered but due to concerns of moral hazard the idea was dropped. But there was a belief that providing all three levels of care - primary, secondary and tertiary was necessary to provide the beneficiary with good health. Preventive primary care would also reduce the burden of IP health services and the related costs. By 2010, the RSBY IP had more or less stabilized and provision of primary care soon became part their core discussions from early 2011. However, there was a wide recognition that expanding services to primary care was not an easy task. There were detailed discussions as to how one can manage the high patient load in delivery of OP services, improve the processing time taken by the existing technology platform and claims reimbursement (as number of providers would certainly increase), methods to cap moral hazard and detect fraud etc. As the thought process was on, initial discussions with ICICI Lombard representatives on the proposed pilot project gave RSBY’s ideas new shape. After considering the initial design and internal discussion, RSBY finally gave its nod to experiment the idea of OP pilot and await the results. In second week of May 2011, MoLE officially confirmed its acceptance to set up the oversight committee, enable the use of existing RSBY technology platform and provide necessary data for the pilot project. With this gesture, the entire project governance structure was established. The roles and responsibilities of the implementing partners were discussed and work on the product design, project implementation plan, technology development started.
Initial concept and product design

Initial discussions between ICICI Lombard and ICICI Foundation brought about a concept note on the pilot project in March 2011. This was the first comprehensive note prepared culminating several discussions on design of the out patient insurance product, the technology that needed to be developed and the partner for development, selection of pilot districts, partners involved for research, documentation etc. It also recognized various partners, their roles a broad implementation plan. This concept was presented to ICICI Foundation’s Management committee for appraisal and approval to participate in the Project.

Excerpt from the concept note on the aim and product design is as follows:

This project attempts to improve the efficiency of health spending in India by creating affordable and reliable options for outpatient care. Specifically, the project will offer outpatient insurance in conjunction with RSBY’s inpatient scheme in 2 districts.

The project aims to:

- Design and implement India’s first outpatient insurance for low income households
- Document and assess technical and financial feasibility of offering outpatient insurance
- Improve availability and quality of outpatient care
- Strengthen links between health spending and health outcomes
- Assess the impact of a comprehensive healthcare package on health seeking behavior and client satisfaction

The outpatient product:

The outpatient product will complement RSBY’s inpatient coverage. To this extent, it will be offered to the same households that are eligible for RSBY’s inpatient scheme, in the project locations. Enrollment for both products (inpatient and outpatient) will be done at the same time, and enrolled beneficiaries will be issued a RSBY smart card that will allow them to access inpatient and outpatient services.

Similar to the inpatient product, the outpatient product will:

- Cover up to 5 members per family
- Cover all pre-existing medical conditions
- Support cash-less transactions through a smart card

Additionally, the outpatient product will:

- Cover up to 10 outpatient visits in empanelled outpatient clinics (public and private) per year per family. Each visit will allow beneficiaries to access the outpatient clinic for a period of 7 consecutive days, should there be a need for follow up.
- Cover consultation fees and cost of drugs (for all drugs on World Health Organization’s prescribed list). Diagnostic services are not part of the product.

It is important to note here that without actual utilization levels for outpatient insurance; it is not possible at this stage to state which product features (including the number of
visits per family and type of services covered) best suit the target population. Data emerging from the rollout and implementation of this product will allow us to verify these assumptions and further improve the outpatient product. However, by including the cost of drugs in the outpatient coverage, we acknowledge the various national and micro studies that confirm that most of the out of pocket expenditure is on drugs (from both inpatient and outpatient episodes).

The product will be rolled out in 2 districts, and in order to maximize learning and price discovery, the product features may be modified when rolled out in the second district. This is to allow for variations in outcomes including utilization levels, experience and claims data. For example, the project may consider introducing co-payment in the second district, where beneficiaries pay a specified amount to access outpatient healthcare and the insurer pays the remaining costs. This modification will allow us to prevent unnecessary usage of services and assess its impact on project viability.

Service delivery:

The empanelled outpatient clinics will have a smart card reader to identify beneficiaries. The medical practitioner at the clinic will provide medical services (consultations, drugs etc) to the beneficiary after biometric identification. At the time of visit, the medical practitioner will have one of the following options:

- Review patient and prescribe drugs or request a follow up after a certain period, or
- Request additional diagnostic tests for the patient and request patient to return after completing tests
- Identify urgency and suggest the need for hospitalization

If the medical practitioner prescribes drugs to the beneficiary, he/she will be able to avail these without any extra charges at the clinic or at another facility that has a tie-up with the clinic. Details of the visit (nature of illness, medical advice, drugs prescribed etc) will be captured at the clinic through hardware and software developed for the project. This software will integrate data from both inpatient and outpatient services. If the number of visits by a patient exceeds 10 per year, then the patient will be requested to pay consultation fees and cost of drugs to the outpatient clinic directly.

Outpatient clinics in Puri will be paid Rs 50 per visit by ICICI Lombard for every visit (up to 10 visits) that a beneficiary makes to the clinic. Beyond the 10 visits, beneficiaries will directly pay consultation fees and cost of drugs to the outpatient clinics. In District 2, the project may consider modifying the amount paid by insurers to providers per visit.

Puri was selected as the first district and the second district was to be selected after 6 months of implementation in Puri. The overall project cost of designing, implementing and evaluating the outpatient insurance product in 2 districts is Rs.102 million out of which Rs.75 million were pledged by ICICI Foundation and the rest by the Facility (Rs.18 million) and ICICI Lombard (Rs.9 million).
The partners in the project were recognized as follows:

1. ICICI Foundation for Inclusive Growth (funding premium, research, documentation)
2. Micro Innovation Insurance Facility - International Labour Organisation (funding the development of technology, hardware infrastructure, IEC materials)
3. ICICI Lombard General Insurance Company (Implementation, Monitoring)
4. RSBY team in the Ministry of Labour and Employment (Over all guidance)
5. RSBY State Nodal Agency (State level implementation support)
6. Network of outpatient providers (out patient service delivery)
7. FINO (Technology development, implementation and trouble shooting support)
8. Agency to develop outreach and communication materials
9. GfK Mode (Research)
10. Independent Documentation Agency
11. DCOR Consulting Private Limited (Facility Mapping in the districts)