See Hindi Version of the Query
See Hindi Version of the Summary (available from 07 May 2010)

Decentralization Community

Solution Exchange for the Decentralization Community
Consolidated Reply

Query: Effectively utilizing Rashtriya Swasthya BimaYojana - Experiences, Advice

Compiled by Joy Elamon, Resource Person and Tina Mathur, Research Associate
Issue Date: 03 May 2010

From Vipin Varma, THOT Consultants, New Delhi
Posted 12 March 2010

I work as Director of a health and development consultancy - THOT based in New Delhi. We provide strategic planning, advocacy, training, project monitoring and communication services. We are currently engaged in providing civil society partnerships to state governments in the Rashtriya Swasthya Bima Yojana (RSBY) scheme (www.rsby.in) launched in April 2009. It is a smart-card based health insurance system.

There are numerous cases where Below Poverty Line (BPL) families have been financially wiped out because of a health related catastrophe, such as an accident, a problem pregnancy, or any other severe medical condition. While universal access to healthcare is the responsibility of the government and is the desired scenario, in the absence of the same, affordable health insurance for all assumes even greater importance. Health insurance is one way of providing protection to poor households against the risk of health spending leading to perpetual poverty. The objective of the scheme is to protect BPL households from major health-shocks that involve hospitalization. RSBY is currently the most inclusive and comprehensive national health insurance scheme, especially for a section of society for whom quality healthcare forever seemed out of reach. At a one-time enrolment fee of merely Rs 30/-, the scheme provides coverage to five members of the family, up to an annual total coverage of Rs 30,000. The scheme covers most serious illnesses and procedures that require hospitalization.

The scheme is currently running in 22 states and some states are entering its second phase. However, given the vastness of the country and the levels of literacy in the country, the utilization of the scheme has not been as much as desired. Even if enrollment is satisfactory, beneficiary utilization is not necessarily optimal. In a population with relatively low literacy and poor understanding of healthcare processes, the beneficiaries lack the support and guidance to utilize the benefits of this unique scheme to their maximum advantage.

It is also important to note that many of the components coming under the broad premise of primary health care like family welfare, health and sanitation, women and child development,

social welfare, including welfare of the handicapped and mentally retarded etc and poverty alleviation programmes are subjects transferred to rural local governments as per the Eleventh Schedule of Article 243 G of 73rd Amendment to the Constitution of India, though the actual situation might vary from State to State.

Members may also note that the Union Budget 2010-2011 has announced that the Rashtriya Swasthya Bima Yojana (RSBY) benefits would be extended to all such Mahatma Gandhi NREGA beneficiaries who have worked for more than 15 days during the preceding financial year. This is also important as Panchayats play a major role in the implementation of NREGS.

In this context, we request inputs from members on the following:

- What are the special institutions, systems, etc which are needed at the village and block levels to increase utilization of such RSBY by BPL population?
- Could you share experiences in awareness generation and increased utilization of RSBY or similar schemes among the identified population by PRIs?
- Is there a need for building any specific capacity/capability in the PRIs for improving utilization of RSBY among the BPL population and other NREGS beneficiaries with the aid of PRIs? Recommended and/or proven strategies for the same would be invaluable.

Your inputs will help us in sharing with the State governments the possibilities of improving the utilization of the Scheme. The identification of NGO or civil society partners will further help to forge future partnerships with State Government to increase uptake and utilization of the scheme.

Responses were received, with thanks, from

1. **Joe Varghese, Sree Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram**
2. **Jos Chathukulam, Centre for Rural Management (CRM), Kottayam (Response 1; Response 2)**
3. **Lolichen PJ, The Concerned for Working Children, Bangalore**
4. **Vipin Verma, THOT Consultants, New Delhi**
5. **Mukti Bosco, Healing Fields Foundation, Hyderabad**
6. **Kris Dev, Life Line to Citizen, Chennai**
7. **Ashok Kumar Pathak, Development Consultant, Uttar Pradesh**

Further contributions are welcome!

Summary of Responses

Members discussed the issues related to the implementation of Rashtriya Swasthya Bima Yojana (RSBY) with regard to the role of Panchayats. The query was also discussed in the context of the Union Budget 2010-2011 where it was announced that the RSBY benefits would be extended to

all such Mahatma Gandhi NREGS (MGNREGS) beneficiaries who have worked for more than 15 days during the preceding financial year. Members suggested the institutional mechanisms required at thee local level, awareness generation leading to increased utilization and the need for capacity building at the local level.

Institutional mechanisms

Respondents recognized that the governance of RSBY is very crucial as it faces a set of serious challenges including awareness building, acceptability and attractability, confidence building, preparation and distribution of 'smart cards' on time and empanelling of private institutions and private insurance companies who are willing to participate in the scheme. Improvement of delivery of the public health systems and other public local institutions is another area of intervention, especially when there is 'demand overload'. RSBY envisages a paradigm shift from a public sector domain to a public private partnership domain and it is here that the governance system requires more attention.

Members were categorical that the Gram Panchayats and the Primary Health Centres (PHCs) would be the focal points of scheme operationalization at the local level. However, there is a need for a trained local facilitator who facilitates access in the hospitals as well as other processes including paper work. One RSBY worker per 50,000 population as the facilitator at the networked hospital could be a good option, members suggested. This person can report to the health committees, which are already set up at the village level. Members also mentioned that there is no need for a new structure as there is a large network of ASHAs under the National Rural Health Mission (NRHM). They could be provided some incentives to facilitate RSBY among targeted families. However, a district level customer service centre is a must for proper implementation of the scheme.

One of the most important aspects is identification of marginalized families, which can be done through the involvement of Panchayats, members suggested. A one time exercise can be done with the help of Civil Society Organizations and independent professionals with Panchayats for identification of beneficiaries. Tools such as wealth ranking in Participatory Rural Appraisal may be quite useful for the effort. Considering the long term scope of the scheme, members suggested that instead of a card for a family, RSBY could be integrated with UID Smart card for every citizen from birth to death and proper tracking needs to be included. There was also a suggestion to introduce Multi Purpose Biometric Smart Card cum Bank Debit Card based transaction, make it mandatory and track all transactions for transparency and accountability.

Awareness generation and increased utilization

Members shared a few examples of how some of the States have tried to make a difference in the implementation of RSBY. The way Tamil Nadu's health department synergistically organizes two of its health programmes is noteworthy. The State organizes regular health camps at PHC level called 'Varumun Kappam' in close collaboration with Panchayats. Such camps are popular with the participation of political leaders and the mobilization of bureaucracies from different line departments.

The Arogyasri scheme of Andhra Pradesh was successful in awareness generation and increased utilization, though the role of Panchayats is minimal. There is also the VIMOSEWA scheme where awareness of the members is high but product and utilization is not upto the mark. But this scheme is limited to VIMO's members only.

In Kerala, the major actors at the village level are the Gram Panchayat, Kudumbasree units (women's SHG network working closely with the Panchayats) and the Insurance Company. However, the local units of all the major political parties and Kerala State General Insurance

Employee's Union (a trade union of the above insurance company) are also supporting the campaign at the village and block level.

Members shared the experience of Health Insurance Fund, a donor agency in Africa piloting a health insurance scheme where the local NGOs, MFIs, Hospitals as well as the local governor is involved in the programme. The first step was in understanding and building awareness in a targeted manner. This coupled with facilitators could potentially become the answer towards making it successful.

Building Capacities

Members pointed out that merely transferring subjects to PRIs alone will not be sufficient. Training in terms of how to administer schemes effectively, democratizing the information base not only to officers at the State and district levels, but at the PRI and Gram level is vital. They recalled that in many places, nobody knew about the RSBY scheme or how enrollment is to be done, including labour officials. Knowledge needs to be built in a focused manner, as was done in the MFI targeted training, the ASHA worker training, the immunization programme etc. This also requires the involvement of PRIS and other stakeholders like local NGOs, PDS system and other media channels.

MNNREGS and RSBY

The Union Budget 2010-2011 has announced that the RSBY benefits would be extended to all such Mahatma Gandhi NREGA beneficiaries who have worked for more than 15 days during the preceding financial year. However, members said that not even higher level officials are aware of this. Regarding covering MNREGS workers under the scheme, there is no provision to register and provide job cards only to BPL families. So, the real target groups for the RSBY scheme might be sidelined.

Members pointed out that the involvement of PRIs has impacted awareness generation regarding schemes like MNREGS to a large extent. Moreover, involvement of PRIs ensures ownership of the programme at grassroots level. Members concluded that the convergence of Health, Education, ICDS, Rural Development and Revenue departments, PRIs and involvement of Media and Civil Society Organizations/ CBOs will certainly help in implementation of the RSBY scheme effectively.

Comparative Experiences

Tamil Nadu

Varumun Kappam works with political and bureaucratic Support *(from Joe Varghese, Sree Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram)*

Tamil Nadu organizes regular health camps at PHC level called 'Varumun Kappam' in collaboration with Panchayats. Such camps are popular with participation of political leaders and different line departments. District Collector directly monitors the activities. The cases identified are taken to district level medical colleges for further screening and diagnosis. These cases are then referred for procedures under the 'Chief Minister's free health Insurance scheme'.

Related Resources

Recommended Documentation

Rashtriya Swasthya Bima Yojana and Comprehensive Health Insurance Scheme - Implementation of the schemes in all the 14 districts of Kerala (*from Jos Chathukulam, Centre for Rural Management, Kottayam; response 2)*
Government Order; Labour & Rehabilitation (J) Department, Government of Kerala, Thiruvananthapuram; 4 July 2008
Available at ftp://ftp.solutionexchange.net.in/public/decn/cr/res12031001.pdf (PDF; Size: 38 KB)

Contains the directives for the implementation of the Rashtriya Swasthya Bima Yojana and Comprehensive Health Insurance Scheme in the State of Kerala

From Tina Mathur, Research Associate

Rashtriya Swasthya Bima Yojana Guidelines
Guidelines; Ministry of Health and Family Welfare, Government of India, New Delhi; 03 March 2008
Available at ftp://ftp.solutionexchange.net.in/public/decn/cr/res12031001.pdf (PDF; Size: 84 KB)

Provides the household eligibility criteria and other guidelines for operationalization of the Rashtriya Swasthya Bima Yojana

RSBY-What Have the State Governments to Do
Guidelines Ministry of Health and Family Welfare, Government of India, New Delhi; 19 May 2008
Available at ftp://ftp.solutionexchange.net.in/public/decn/cr/res12031003.pdf (PDF; Size: 1.3 MB)

Provides guidelines on the role of State governments in implementation of the Rashtriya Swasthya Bima Yojana

Rashtriya Swasthya Bima Yojana -Providing health insurance cover to the poor
Country Paper-India; by Anil Swarup, Ministry of Labour and Employment, Government of India, New Delhi; Asia-Pacific Regional High-Level Meeting on Socially-Inclusive Strategies to Extend Social Security Coverage, International Labour Organization; 19-20 May 2008
Available at http://www.ilo.org/public/english/region/asro/bangkok/events/sis/download/paper39.pdf (PDF; Size:)

Outlines the details of Rashtriya Swasthya Bima Yojana including its design, benefits, coverage and process flow

Recommended Organizations and Programmes

Comprehensive Health Insurance Scheme (CHIS), Kerala *(from Jos Chathukulam, Centre for Rural Management, Kottayam; response 1)*
Government of Kerala, Thiruvananthapuram; Details at http://india.gov.in/citizen/health/viewscheme.php?schemeid=1437

Implemented by Government of Kerala to cover the non- RSBY population, extending to all families other than BPL (Absolute Poor) as per the Planning Commission's guidelines

From Mukti Bosco, Healing Fields Foundation, Hyderabad

Arogyasri, Andhra Pradesh
http://www.aarogyasri.org/ASRI/index.jsp

Provides financial protection to families living below poverty line upto Rs. 2 lakhs in a year for the treatment of serious ailments requiring hospitalization and surgery

VIMO SEWA, Ahmedabad, Gujarat
Chanda Niwas, Opposite Karnavati Hospital, Ellis Bridge, Ahmedabad-380 006; Tel: 079-26580530; social@sewass.org

An integrated insurance programme to provide social protection for SEWA members to cover their life cycle needs and risks through self managed insurance organization

From Vipin Varma, THOT Consultants, New Delhi

Rashtriya Swasthya Bima Yojana
Ministry of Labour and Employment, Government of India, New Delhi; http://www.rsby.in/

A comprehensive insurance scheme to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization

Mahatma Gandhi National Rural Employment Guarantee Act 2005
http://nrega.nic.in/rajaswa.pdf (Size: 5.29 MB)

Provides for enhancement of livelihoods security of rural households by providing 100 days guaranteed employment in every financial year; RSBY would extend to beneficiaries

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Responses in Full

Joe Varghese, Sree Chitra Tirunal Institute for Medical Science and Technology, Thiruvananthapuram

The way Tamil Nadu's health department synergistically organizes two of its health programmes, may throw some light on a potential strategy to tackle this issue. The State organizes regular health camps at PHC level called 'Varumun Kappam' in close collaboration with Panchayats. Such camps are popular and highly politicized events (in positive sense) with the participation of political leaders and the mobilization of bureaucracies from different line departments. District Collector him/herself directly monitors the activities. The cases identified in such camps are taken to district level medical colleges (transportation is also provided by the state) for further screening and diagnosis. These cases are then referred for procedures under the 'Chief Minister's free health Insurance scheme'.

I have observed these camps in several places during my recent trips to the state in connection with another research. A systematic assessment is required to identify the success of this in terms of utilization rates. The larger lesson is the need to create channels for political dividends for our political class at all levels that can easily come with such curative care programmes. In this case, Chief Minister's name attached to the insurance scheme ensures a higher level commitment and bureaucratic support. Likewise, the camp approach provide space for local leader's involvement and participation

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Jos Chathukulam, Centre for Rural Management, Kottayam *(response 1)*

Recently Kerala has launched a state wide Comprehensive Health Insurance Scheme (CHIS). This scheme builds on Rashtriya Swasthya Bima Yojana (RSBY) of Central Government to address BPL workers as per the definition of the National Planning Commission. This is a direct cash transfer system through 'smart card'. What the Kerala Government has intended to do, apart from the 'poor' (11.79 lakhs families) as defined by the Planning Commission, it adds another category of 'poor' (10 lakhs families) which is defined by the State Government. The Kerala Government also has to address the APL families under the scheme. As per the estimation of the State Planning Board, Government of Kerala, the scheme will cover a total population of 1.1 crore. No doubt, the governance of the scheme is going to face a set of serious challenges including awareness building, acceptability and attractability of the scheme, confidence building, preparation and distribution of 'smart cards' in time, empanelling of private institutions and private insurance companies who are willing to participate in the scheme. Improvement of

delivery of the public health systems and other public local institutions is another area of intervention which involves certain amount of issues related to 'demand overload'. In addition to this, there may be other ideological and political economy questions related to the paradigm shift from a public sector domain to a public private partnership domain. It is also a fact to look into the Approach Paper to the Eleventh Five Year Plan prepared by the present Planning Board of the Government of Kerala. The approach paper is strongly against the system of health insurance and it strongly favours a free health care system.

In this context, it is interesting to look at the governance issues of comprehensive health insurance scheme of Kerala in detail. However at present, no empirical study is available to suggest for you. The budget document 2010-2011 for the Govt. of Kerala says, "The Health Insurance Scheme being implemented in Kerala has gained national attention. The scheme will be free from all teething troubles and will be fully operational in 2010-2011. The decision that the insurance receipts need not be remitted to the treasuries and the health institutions can utilize it for their development will be a major boost to the initiatives for strengthening the health sector. It is expected that Hospital Development Societies will get Rs.40 crore on this account in 2010-2011."

As far as your first issue is concerned, the major actors at the village level in Kerala are the Gram Panchayat, Kudumbasree units(women's association life under SHG network with the patronage of State Government) and United India Insurance Company Ltd. However, the local units of all the major political parties and Kerala State General Insurance Employee's Union (a trade union of the above insurance company) are also supporting the campaign at the village and block level.

Lolichen P J, The Concerned for Working Children, Bangalore

Currently RSBY is implemented in 5 districts of Karnataka; it is proposed to cover all the districts of the State from 2010-11. One needs to wait and see. The Gram Panchayats and the local Public Health Centres (PHCs) would be the best focal points to publicize this programme and to enroll families into this programme.

One of the challenges of the scheme that I foresee is it applicability strictly to BPL card holders. In most of our cities, there is a huge number of migrant populations engaged in the informal sector, most of them unskilled, engaged in odd jobs, construction labour or coolie labour. However, most of them do not have BPL cards; and therefore they will be denied this facility.

One of the proposals that we have made to the Labour Department in Karnataka is to consider extending this scheme to all those workers who have taken membership of the Building and Other Construction Workers Welfare Board, so that large number of the poor, even if they do not have the BPL cards can take advantage of this scheme.

Vipin Varma, THOT Consultants, New Delhi

Thanks to Joe for the great insight shared with all regarding the Tamil Nadu (TN) approach to generate political dividends and motivating platforms with the engagement of local leaders as well as bureaucracy. RSBY can definitely use similar models for grassroots awareness as well as utilization enhancement. We shall also explore further data with regard to the TN initiatives.

We are also very thankful to Jos for the details regarding Kerala Comprehensive Health Insurance Scheme (CHIS) and the various issues highlighted. The APL family inclusion and the retention of insurance remittances for hospital improvement seem like very well-meaning innovations that can be adopted by other States too. It would be further helpful if we could be directed to some references, web links or other sources of information on the planning proposals and reports,

etc mentioned by the community members responding to the query, as we can then be sure of accessing the details quickly and accurately.

We look forward to further such experiences and insights from the Decentralization Community members.

Mukti Bosco, Healing Fields Foundation, Hyderabad

I have been travelling in Bihar and UP, enrollment is a question mark in terms of who and how it is being done. From what I have seen nobody knew about the RSBY scheme, including labour officials and how enrollment is done- none had a clue. Only the Deputy DMO of the district hospital seems to know, and what he knew was what he has been told. His hospital is networked and already the biometric scanner is in place but there are no patients as nobody has a clue where and when and who has been enrolled even though the website seems to show the districts. The local NGO's/MFI's have been trying to talk to different officials there is complete ignorance.

As for utilisation, one would definitely require a **facilitator** who is trained to understand and facilitate access in the hospitals as well as in terms of processing the papers is vital for the programme to be of any use.

Just transferring subjects to PRIs alone is not the answer, training in terms of how to use it effectively, **democratising the information** base not only to officers at the state and district levels, but at the PRI, gram level is vital. This is somehow being missed. Information needs to reach grassroots, to the common man about the different schemes so that they can effectively use it and ask for it.

Regarding the fact that the Union Budget 2010-2011 has announced that the Rashtriya Swasthya Bima Yojana (RSBY) benefits would be extended to all such Mahatma Gandhi NREGA beneficiaries who have worked for more than 15 days during the preceding financial year, not even higher level officials are aware of this. They say they have seen it in the newspapers and that is it. NREGS schemes in many places is at the discretion of the Pradhan and that too the payment is according to what he/she wants to disburse.

On the specific questions, my comments are:

- **What are the special institutions, systems, etc. which are needed at the village and block levels to increase utilization of such RSBY by BPL population?**

A people's representative, PRI, possibly information disseminated by a local NGO, in Anganwadi centres, schools, etc could be a possible way out. Public Distribution System (PDS) cards, MFI registrations could be some alternatives. But information dissemination should be the first step without which there would be just fake enrollments and lack of utilization. Maybe a RSBY worker per 50,000 population who also is the facilitator at the networked hospital could be a good option. This will ensure not only information disseminated to the grassroots but also if monitored appropriately could become an effective change agent in terms of health seeking behaviour. This person can report to the health committees, which are already set up at the village level.

- **Could you share experiences in awareness generation and increased utilization of RSBY or similar schemes among the identified population by PRIs?**

The Arogyashri scheme could come close to awareness generation and over utilization in terms of certain diseases. Of course there is a lot of misuse in terms of private providers but awareness in some rural areas, semi-urban and urban areas are high. Awareness in remote areas is still questionable and negligible.

There is also the VIMOSEWA scheme where awareness of the members is high but product and utilization is not upto the mark. But this scheme is limited to VIMO's members only.

Health Insurance Fund, a donor agency in Africa is piloting a health insurance scheme where the local NGO's, MFI's, Hospitals as well as the local governor is involved in the programme. The first step was in understanding and building awareness in a targeted manner. This coupled with facilitators could potentially become the answer towards making it successful. The process needs to be transparent and information available in public places, radios, TV's, Papers, Schools, Anganwadi centres, MFI's, Sub centres etc.

- **Is there a need for building any specific capacity/capability in the PRIs for improving utilization of RSBY among the BPL population and other NREGS beneficiaries with the aid of PRIs? Recommended and/or proven strategies for the same would be invaluable.**

Yes, in terms of capacity in creating awareness, facilitation for enrollment as well as at the hospital will go a long way. In some areas even NREGS is not functional or awareness is extremely low. If one is to tie up with NREGS, knowledge needs to be built in a focused manner, like the MFI targeted training; like the ASHA worker training: like the immunization programme. Make is simple, easy to understand and involve other stake holders, local NGO's, PRI's, PDS system, and other media channels. Before rolling out across states the first step is building awareness- not only in terms of enrollment, but also in terms of access. Without this the scheme may not be successful.

Hope this is useful and let me know if there is anything that we can help in planning or implementing the scheme.

Kris Dev, Life Line to Citizen, Chennai

Vipin's observations are very good and valid. But making RSBY or NREGA or any other welfare scheme of the GoI or State Governments effective is not easy because it is not citizen centric and mired in corrupt practices.

I am well aware of the resistance of people to pay Rs. 30 for a card to get a RSBY card as they feel it would be another waste of their money, mainly to benefit others (TPAs, Insurance Companies, Registered Hospitals, etc).

It is observed, whenever we as individuals or organizations or government or public sector employees claim medical reimbursement, invariably hospitals inflate the rates, charge high fees, saying, after all the reimbursement is from other agencies and why should the patient bother. There is no fixed service fee. Invariably patients are admitted and many unwanted high cost tests / scans are undertaken to fleece to the maximum. It is time that there is a cap on the limit of money a hospital can take subject to rendering genuine service. This is where the catch is. Who is to judge as to what is a genuine service?

Instead of a card for a family, RSBY should be integrated with UID Smart card for every citizen from birth to death and proper tracking needs to be included. Every citizen should get uniform good service. It should not be, you name the person, and I shall tell you the type of treatment we extend.

I can cite one example -that of Cancer Institute, Chennai, a non-profit, mainly charity organization. Here the Doctors are de-linked from the Administration. There are only 2 categories - payment and free categories. If the monthly earnings of an individual or family is above Rs. 1,000, then it is payment. Else it is totally free. The payment is the same, irrespective of if you are rich or poor. The treatment is also the same, irrespective of if you are rich or poor. To my knowledge, there is no visible corruption or favoritism in treatment.

From my observation, in many villages, the Village Nurse would give importance only if the family is politically connected or is rich enough to influence the community leaders. The health registers and stock of medicines is not updated even for years and there is no system of checking!

Many PRIs are steeped in corruption. The only way we can make people get truly benefited is to de-link the service providers and service seekers. Introduce Multi Purpose Biometric Smart Card cum Bank Debit Card based transaction mandatory and track all transactions for transparency and accountability. Eliminate the cancer of corruption, through a major surgery, if we want the benefits to genuinely reach the poorest of the poor. No cosmetic change can improve the systems.

I am sorry to sound extremely negative; but unfortunately that is the fact of the matter. Unfortunately, most service providers including NGOs prefer to fish in troubled waters and keep the water agitated and deny the common man their rightful dues, so that they can survive! That is how the rich are getting richer and the poor are getting poorer and the gap is widening day by day. Apparently some benefits are shown to reach the poor. But at what cost to the nation is not seen, as electoral aims have come to play a major role and are seen to be more important than citizen welfare in a democracy!

Ashok Kumar Pathak, Development Consultant, Uttar Pradesh

Rashtriya Swasthya Bima Yojana (RSBY) scheme has a big role to play for the benefits of poor. Regarding number of Below Poverty Line (BPL) families in Uttar Pradesh, it is a debatable issue. So, we would be missing many marginalized families to bring them under the purview of RSBY.

Regarding covering MNREGS workers under the scheme, there is no provision to register and provide job cards only to BPL families. So, we are missing the real target groups for the RSBY scheme. Provision of healthcare facilities to all the households, especially the marginalized, is a very important issue. There must be a provision of identification of marginalized families, through the involvement of Panchayats, to be included in the beneficiary list of RSBY. One time exercise can be done with the help of Civil Society Organizations and independent professionals to help the Panchayats in identification of beneficiaries. The tools like wealth ranking in Participatory Rural Appraisal may be quite useful for the effort.

No new structure would be required to be created at the grassroots level to implement the scheme, as there is a large network of ASHAs under NRHM programme. ASHAs can play the role of counselors effectively, as they are already involved in the same kind of job. They have also undergone several training packages, so a little orientation about the RSBY scheme will work. They can be provided some incentive to facilitate the targeted families. But district level customer service centre for the RSBY is a must for proper implementation of the scheme.

Involvement of PRIs has impacted awareness generation regarding MNREGS, though debatable, to a large extent. Involvement of PRIs will ensure ownership of the programme at grassroots level. Convergence of Health, Education, ICDS, Panchayati Raj, Development and Revenue departments and involvement of Media and Civil Society Organizations/ CBOs will certainly help in implementation of the RSBY scheme effectively.

Jos Chathukulam, Centre for Rural Management (CRM), Kottayam *(response 2)*

Government of Kerala issued a government order on 4 July 2008 on the implementation of the Rashtriya Swasthya Bima Yojana and Comprehensive Health Insurance Schemes in all the 14

districts of Kerala. I hope the above said GO may give some working details on the RSBY in Kerala. Please see ftp://ftp.solutionexchange.net.in/public/decn/cr/res12031001.pdf

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Many thanks to all who contributed to this query!

If you have further information to share on this topic, please send it to Solution Exchange for the Decentralization Community in India at se-decn@solutionexchange-un.net.in with the subject heading "Re: [se-decn] Query: Effectively utilizing Rashtriya Swasthya Bima Yojana – Experiences, Advice. Additional Reply."
