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RAJASTHAN GOVERNMENT HEALTH SCHEME (RGHS): COMPREHENSIVE POLICY ANALYSIS AND EVIDENCE-BASED REFORM BLUEPRINT

Dr Madan Lal Moond — Deputy CMHO, Rajsamand, Rajasthan, India

Dr Sharda Choudhary — Senior Resident, Pathology RUHS CMS, Jaipur

Dr Vaseem Naheed Baig — Senior Professor and Head, Department of Community Medicine, RUHS CMS, Jaipur, Rajasthan, India

ABSTRACT

Background: The Rajasthan Government Health Scheme (RGHS), launched in September 2021, is a cashless, IT-enabled health benefit programme covering over 65 lakh state government employees, pensioners, and constitutional functionaries across 22 beneficiary categories. Despite its comprehensive design, the scheme has been beset by large-scale financial fraud, a chronic provider payment crisis, and governance deficits that have undermined its intended mandate. **Objectives:** This paper aims to (1) document the structural failures, fraud patterns, and systemic bottlenecks afflicting RGHS from 2023 to 2026; (2) benchmark RGHS against five globally successful public health insurance models; and (3) propose a realistic, evidence-based reform blueprint applicable within Rajasthan's administrative and financial context. **Methods:** A comprehensive policy analysis was conducted using government audit reports, registered First Information Reports (FIRs), media investigations, hospital association statements, and official RGHS circulars. Five international health schemes-Taiwan's National Health Insurance, South Korea's NHIS, Germany's Statutory Health Insurance, the Netherlands' regulated private insurance model, and Thailand's Universal Coverage Scheme were examined for transferable best practices. **Results:** Documented frauds totalling over 100 crore, 19 FIRs, 64 suspensions, and crores in unpaid hospital dues as of July 2025 reflect five interconnected root-cause domains: a frozen CGHS rate structure (unchanged for 11 years), single-TPA processing bottlenecks causing 7–9 month payment delays, exploitable OTP-based digital authentication, reactive rather than proactive fraud governance, and low beneficiary awareness. International benchmarks consistently demonstrate that annual rate revision, biometric smart-card technology, AI-based real-time fraud analytics, ring-fenced funding, and graduated provider action protocols are associated with high system performance and provider satisfaction. **Conclusions:** RGHS's failures are implementation failures, not design failures. A targeted reform package encompassing a ring-fenced RGHS Corpus Fund, mandatory ABHA-linked biometric authentication, AI-powered preventive analytics, multi-TPA deployment with enforceable 30-day payment SLAs, annual Rajasthan Medical Inflation Index-linked rate revision, and district-level Nodal Officers can structurally resolve the current crisis and position RGHS as a national model for state government health schemes.

KEYWORDS : Rajasthan Government Health Scheme, RGHS, Health Insurance Fraud, CGHS Rates, Cashless Healthcare, Health Scheme Reform, Universal Health Coverage, TPA, Biometric Authentication, Health Policy India

1. INTRODUCTION

The Rajasthan Government Health Scheme (RGHS) is a comprehensive, cashless, IT-enabled health benefit programme launched by the Government of Rajasthan in September 2021.[1,2] It was introduced under the Finance (Insurance) Department and replaced the earlier fragmented medical reimbursement system under multiple separate rules. RGHS is administered by the Rajasthan State Health Assurance Agency (RSHAA) and managed through the State Insurance and Provident Fund (SIPF) Department.[1,4]

1.1 Vision and Mandate

The scheme aims to provide universal, accessible, and paperless cashless medical care to all eligible state government employees, retirees, and constitutional functionaries. The Governor's notification introduced RGHS to cover indoor treatment, day-care procedures, outdoor treatment, investigations, and Ayurveda/Homeopathy/Unani treatment, replacing eight separate rules/schemes that previously governed medical facilities for different beneficiary categories.[2]

1.2 Beneficiary Categories

RGHS covers 22 categories of beneficiaries,[1] including:

- Ministers and Cabinet Members of the Government of Rajasthan
- All India Service (IAS/IPS/IFoS) Officers posted in Rajasthan
- Members of Legislative Assembly (MLAs) — serving and ex-MLAs
- Serving Judicial Officers and Retired Judicial Officers
- Serving State Government Employees (7th Pay and 6th Pay Commission)
- Pensioners and Family Pensioners of State Government
- Employees and Pensioners of Autonomous Bodies, Boards, and Corporations (SAB)
- Panchayati Raj employees and Urban Local Body employees
- Accredited Journalists (under separate notification)
- Dependent family members of all above categories[1,4]

1.3 Financial Coverage Structure

Table 1: Financial Coverage Under RGHS

Benefit Category	Annual Coverage	Remarks
IPD / Hospitalization	₹5,00,000 per family (floater)	Includes OPD up to ₹20,000
Catastrophic Illness	Extra ₹5,00,000 per family	For specified critical illnesses
OPD Medicines	₹20,000 (within floater)	Cashless at CONFED / empanelled pharmacies
Diagnostics & Imaging	Covered within floater	MRI, CT, Doppler under CGHS rates
AYUSH Treatment	Covered	Ayurveda Day Care included (2026 guidelines)
Maternity & Child Care	Covered under IPD	As per CGHS package rates
Mental Health	Covered	Consultations and medications at approved centres

Source: RGHS official portal and 2026 guidelines.[1,3]

1.4 Key Features

The scheme's key features include:[1,5]

- **Fully Automated IT Platform:** Seamless SSO-based registration, HCNP empanelment, Transaction Management System (TMS), claim settlement, and grievance redressal entirely paperless.[1]
- **Self-Printing of RGHS e-Card:** Beneficiaries print their own card through the RGHS portal (rghs.rajasthan.gov.in) using SSO login.[1]
- **Electronic Medical Records:** Each beneficiary has an EMR for tracking medical history across empanelled hospitals.
- **CGHS-Aligned Package Rates:** All procedures billed at CGHS rates no provider-defined billing.[1]
- **Pre-Authorization:** Most major surgeries require TID (Transaction ID) and pre-authorization from the portal.
- **Outside-State Treatment:** Permitted at select multi-specialty hospitals with prior approval; emergency exception exists.
- **RGHS Connect Mobile App:** Available on Google Play Store for beneficiary access, hospital search, and claim tracking.[5]
- **Ayurveda Day Care and Diagnostic Imaging:** Included as per the 2026 guidelines for Ayurveda Day Care therapy and OPD booking of MRI, CT Scan, and Colour Doppler.[3]

1.5 Operational Workflow — Beneficiary Journey

The RGHS beneficiary journey proceeds as follows: (1) SSO Portal login and self-registration with family member upload; (2) DDO/HoD verification and RGHS e-Card generation within 3–7 working days; (3) identification of an empanelled HCNP (hospital, pharmacy, or diagnostic centre); (4) for OPD prescription upload and cashless medicine dispensing; for IPD/surgery hospital raises TID, treatment proceeds, and discharge summary is uploaded; (5) TPA reviews the claim and releases payment to the hospital within the stipulated SLA of 60 days (actual turnaround in 2025–26: 7–9 months); and (6) the beneficiary tracks status on the RGHS portal, with grievance cell recourse if needed.[1,21]

2. Documented Problems, Challenges and Frauds in RGHS

This section presents a data-driven review of structural failures, systemic fraud, and administrative bottlenecks plaguing RGHS drawn from government audit reports, FIRs, media investigations, and hospital association statements from 2023–2026.

2.1 Massive Financial Frauds and Scams

2.1.1 The Alwar ₹100+ Crore Scam (2025)

A government audit exposed one of the largest frauds in RGHS history a ₹100+ crore scam involving multiple doctors posted at health centres across Alwar district.[11] The modus operandi was a sophisticated three-way collusion: doctors deliberately misdiagnosed patients and prescribed expensive medications for ailments the patients never had; patients were directed to specific medical stores with which the doctors had a financial arrangement; fake medical reports were prepared to justify prescriptions and inflate billing; medicines were sometimes not even dispensed only billed through RGHS; and patient safety was directly compromised by both unnecessary prescriptions and fraudulent documentation.[11]

2.1.2 Alwar ₹26 Lakh Scam-Doctor-Pharmacy Collusion (2025)

An FIR was registered against Mittal Hospital and Rajasthan Pensioners Association Medical Store in Alwar after investigation revealed nine individuals suspended two Ayurveda doctors, three allopathy doctors, and four government employees.[12] A single beneficiary's health card was used to generate fake OPD slips and claim ₹26 lakh in one year. False prescriptions and fabricated treatment records were used to siphon government funds. The pharmacy sold materials beyond prescribed medicines to inflate bills. Investigation revealed three-way collusion between the beneficiary, the doctor, and the pharmacy store.[12]

2.1.3 Sikar- Doctor Suspensions (February 2026)

Seven doctors were suspended from Sikar district following a Finance Department audit: Associate Professors of Orthopaedics and General Medicine were implicated, along with doctors at Community Health Centres and S.K. Hospital.[13,14] FIRs were registered against Bharatpur Nursing Home and Bothra Diagnostic and Imaging Centre, Bikaner. Bothra Diagnostic had subjected patients to medically unjustified tests (HbA1c, RA Factor, Procalcitonin). Kashish Pharmacy was found colluding with Bharatpur Nursing Home to generate fake claims. The hospital had obtained SSO IDs and passwords of employees to generate fraudulent TIDs.[13,14,15]

2.1.4 Jaipur Hospital Operator Arrest-Document Forgery (2025–2026)

A private hospital operator in Mansarovar, Jaipur was arrested after forensic evidence confirmed document manipulation: patient records had been repeatedly marked as 'discharged and readmitted' before RGHS portal upload; consent forms had altered dates and critical details changed; cash was collected from RGHS beneficiaries without proper receipts (double-charging); billing records showed discrepancies with essential documents missing or in altered form.[16] A Special Investigation Team (SIT) probe was launched and forensic examination confirmed tampering.[16]

2.1.5 PBM Government Hospital-Forged Doctor Signatures

Prescriptions were found carrying forged signatures and seals of doctors who were on leave or not posted in OPD. Some prescriptions were issued in the names of doctors not even posted at the hospital. Investigation revealed a systemic vulnerability in paper-based prescription verification.[15]

2.2 Cumulative Action Statistics (As of February 2026)

Table 2: Cumulative Enforcement Actions Under RGHS (as of February 2026)

Action Taken	Count / Amount
FIRs Filed	19
Personnel Suspended	64
Beneficiary Cards Blocked	~500+
Hospitals — Payment Blocked	39+
Hospital Officials Blocked	Officials of 33 hospitals
Amount Recovered from 8 De-empanelled Hospitals	₹32+ Crore
Pharmacies Officials Blocked	212+
Amount Recovered from Pharmacies	₹5+ Crore
Largest Fraud Estimate	₹100+ Crore (Alwar audit)
Pending Hospital Dues (RAHA Report, July 2025)	₹980 Crore for 701 hospitals

Source: Government notifications and media reports, 2025–2026.[13,14,15,16]

2.3 Hospital Payment Crisis and Boycotts

A systemic payment crisis has plagued RGHS from its early years. The Rajasthan Alliance of Hospital Associations (RAHA) reported outstanding dues of ₹980 crore owed to 701 hospitals as of July 2025.[17,18,19] The crisis escalated through several stages; by August 2025, the government disbursed over ₹850 crore yet some hospitals continued to refuse RGHS services.[17,18] The IMA boycott following the arrest of a private hospital director further disrupted RGHS services.[20]

2.4 CGHS Rate Freeze-The Root Cause of Provider Discontent

Critical Structural Problem: CGHS package rates which form the basis of RGHS reimbursement were frozen from 2014 to October 2025 (11 years without revision). The Central Government revised CGHS rates on October 13, 2025. However, Rajasthan's RGHS continues to operate on the older rates framework, making private hospital participation financially unviable in many specialties.[21]

- This rate freeze means hospitals receive reimbursement at 2014 prices for 2025 medical costs.[21]
- NABH-accredited hospitals receive 15% more than non-NABH still insufficient for many tertiary procedures.
- SLA for payment: 60 days (contractual). Actual: 7–9 months (media reports, 2025–26).[17,21]
- Under-reimbursement is the primary justification used by private hospitals for non-compliance and fraud.
- Quality hospitals withdraw from RGHS panel, reducing access for beneficiaries particularly in tier-2 and tier-3 cities.[21]

2.5 Single TPA Bottleneck

- RGHS relied on a single Third Party Administrator (TPA) for claim processing.
- Single-point processing created massive backlogs claims taking 7–9 months instead of the 60-day SLA.[17,21]
- Hospital associations demanded expansion to 4 TPAs, agreed in principle by July 2025.
- As of 2026, expansion to multiple TPAs is still being implemented.
- The TPA bottleneck directly incentivizes fraud as hospitals seek to 'recover' costs through other means.

2.6 Digital Vulnerabilities and IT Security Gaps

- Fraudsters obtained employee SSO IDs and passwords to generate fraudulent TIDs.[13,16]
- Paper prescriptions remain part of the system easily forged with fake doctor signatures.[15]
- Patients repeatedly 'discharged and readmitted' digitally to inflate room rent claims.[16]
- No real-time validation of doctor presence at the hospital against the prescriptions they sign.
- OPD prescription upload system exploited to generate fake medicine claims without actual dispensing.
- Lack of biometric verification at pharmacy dispensing points card sharing rampant.

2.7 Governance and Implementation Challenges

- Beneficiary awareness gap: Many employees are unaware of OTP security; they share RGHS cards with non-beneficiaries.
- No district-level Nodal Officers for grievance redress a primary demand of employee organizations.
- The scheme excludes treatment outside Rajasthan (except emergencies), creating hardship for patients needing specialized care.
- Dental surgeries, certain cosmetic procedures, and experimental treatments are excluded policy clarity is needed.
- Political economy: Hospital operator arrest triggered IMA boycott the debate around criminal versus administrative action remains unresolved.[20]

3. Global Benchmarks-five Successfully Running Health Schemes

A rigorous examination of five internationally acclaimed health insurance schemes reveals consistent success factors: single-payer or tightly regulated multi-payer models, smart-card technology, regular rate revisions, transparent provider payment systems, and strong anti-fraud mechanisms.[22,23,24,25,26,27,28,29,30]

3.1 Taiwan — National Health Insurance (NHI)

Global Ranking: #1 (CEOWORLD Health Care Index 2025–26) | Score: 158.2 | System: Single-Payer, Universal[22,23]

- Launched 1995; achieves near-universal coverage (99%+) across 23 million population.[26,27]
- Single-payer system funded through payroll contributions (employee + employer) and government subsidies.
- Comprehensive benefit: Preventive care, prescription drugs, dental, Chinese medicine, home nurse visits, maternity.
- **Smart Health Card:** Taiwan's NHI smart card tracks complete medical records across all clinics, hospitals, and pharmacies eliminating duplication and enabling real-time fraud detection.[26,27]
- Regular office visits: Co-payment as low as US$5.
- **Anti-Fraud:** Real-time prescription monitoring duplicate prescriptions flagged instantly across providers.
- Short wait times, high patient satisfaction 96% of citizens approve of NHI.
- Providers paid using DRG (Diagnosis Related Groups) and global budget incentivizes efficiency over volume.
- Annual NHI global budget reviewed and updated no multi-year rate freezes.[22,23]

Table 3: Taiwan NHI — Key Success Architecture and Lessons for RGHS

Element	Taiwan NHI Design	Applicable Lesson for RGHS
Funding	Payroll deduction + govt subsidy	Dedicated corpus fund -not general budget
Rate Setting	Annual review with DRG methodology	Annual CGHS-linked revision, not 11-year freeze
Technology	Smart card- real-time cross-verification	Biometric e-card replacing paper prescriptions
Fraud Detection	Real-time duplicate detection	AI-based prescription analytics
Provider Payment	Global budget + fee-for-service	SLA enforced-payment within 30 days
Coverage	Universal-no exclusions by geography	Cross-state coverage for RGHS beneficiaries

Source: CEOWORLD Health Care Index 2025–26 and published reports.[22,23,26,27]

3.2 South Korea — National Health Insurance Service (NHIS)

Global Ranking: #2 (CEOWORLD 2025–26) | Score: 151.3 | System: Universal, Technology-Driven[22,23]

- Universal coverage through NHIS funded by employer contributions, employee contributions, and government subsidies.[24,26]
- Covers hospital care, prescription drugs, and traditional Korean medicine (Hanbang).
- **DUR System:** Drug Utilization Review provides real-time drug-drug interaction checks at the point of prescribing prevents unnecessary and dangerous prescriptions.[22,29]
- **Technology:** Fully digitized claims, mandatory e-prescriptions, and biometric authentication at hospitals.[22]
- Extensive use of Big Data analytics to identify billing anomalies and provider fraud.
- Patient co-payment model: Citizens pay a percentage (not flat rate) that scales to service intensity.
- **Anti-Fraud Unit:** Health Insurance Review and Assessment Service (HIRA) a dedicated agency reviewing 100% of claims.[22,23]
- Fast payment turnaround: Most claims settled within 14–21 days of submission.[22,23]

3.3 Germany-Statutory Health Insurance (SHI / GKV)

System: Multi-Payer Non-Profit (>100 Sickness Funds, regulated) | Consistently ranked among the world's top five healthcare systems[24,26,29]

- Joint Funding: Employee (7.3% of salary) and Employer (7.3%) equal contribution; government covers low-income individuals.[24]
- Approximately 88% of Germans covered by SHI; the remaining 12% have private insurance.
- **Regulated Competition:** Over 100 non-profit 'sickness funds' (Krankenkassen) compete, but under strict government regulation.
- Citizens can freely change funds annually quality and service competition without profit motive.
- Comprehensive coverage: Hospital care, specialist treatment, prescription drugs, preventive care, dental, mental health.
- **Rate Setting:** Federal Joint Committee (G-BA) sets rates using evidence-based benefit assessments, updated regularly.[24]
- Strong data transparency: All funds must publish financial reports; fraud triggers immediate regulatory action.

3.4 Netherlands-Mandatory Private Insurance with Government Regulation

Global Ranking: #4 (CEOWORLD 2025–26) | Score: 144.3 | System: Compulsory Regulated Private Insurance[22,23]

- All residents must purchase basic health coverage from tightly regulated private insurers.
- Government provides risk equalization: Insurers with sicker patients receive higher compensation no cherry-picking.
- Healthcare allowance (zorgtoeslag) subsidizes premiums for lower-income residents.
- Residents choose insurers freely creates healthy competition driving innovation.
- **DBC System:** Diagnosis-Treatment Combination bundled payment for complete treatment episodes.[26,27]
- Extremely low administrative costs through standardized digital claims processing.[29]
- **Regulation:** Independent Dutch Healthcare Authority (NZa) regulates tariffs and market conduct.[26,27]

3.5 Thailand Universal Coverage Scheme (UCS / 30-Baht Scheme)

System: Government-Funded, Capitation-Based[25,28]

- Launched 2002; initially required 30 Baht (~$1) co-payment per visit now free (co-payment removed 2006).[25]
- Coverage: 99.5% of all Thai residents insured (only 75% in 2000).[24,28]
- Funded from national budget; allocated on a mixed per-capita basis by the National Health Security Office (NHSO).
- **Community Health Workers:** Approximately one million community workers support delivery at the grassroots level.[25,28]
- In 2016, Thailand became the first Asian country to eliminate mother-to-child HIV transmission.[25]
- Published research confirmed that UCS patients paid zero out-of-pocket in the vast majority of visits, even through COVID-19.[30]
- Capitation payment to primary care units incentivizes prevention over cure.[28]

3.6 Global Comparison Matrix

Table 4: Global Comparison of Health Insurance Models vs. RGHS

Parameter	Taiwan NHI	S. Korea NHIS	Germany SHI	Netherlands	Thailand UCS	RGHS (Current)
System Type	Single-payer	Universal NHIS	Multi-payer	Regulated Private	Govt-funded	Quasi-public + TPA
Coverage	99%+	100%	88%+	100%	99.5%	~65 Lakh target
Rate Revision	Annual	Regular	Annual/ Evidence	Annual	Annual	Frozen 11 years
Payment Turnaround	14–30 days	14–21 days	14 days	Prompt	14–30 days	7–9 months
Anti-Fraud System	Real-time NHI IC	HIRA 100% review	Fund audits	NZa oversight	NHSO monitoring	Reactive (FIR-based)
Technology	Smart IC card	DUR + Big Data	Standardized digital	Standardized digital	Integrated	SSO portal (OTP risk)
Provider Satisfaction	High	High	High	High	Moderate–High	Low (boycotts, 2025–26)

Source: Compiled from published international healthcare rankings and programme reports.[22,23,24,25,26,27,28,29,30]

4. Root Cause Analysis- Why RGHS Struggles

Based on official reports, audit findings, and news investigations, the problems afflicting RGHS can be organized into five interconnected root-cause domains:

Table 5: RGHS Failure Analysis- Five Root Cause Domains

Root Cause Domain	Core Problem	Impact
1. Financial Architecture	No ring-fenced corpus; rate frozen 11 years; single TPA	Provider exodus, payment crisis, ₹ crores in dues
2. Technology & Security	OTP-based SSO vulnerable; paper prescriptions forgeable	₹100+ crore fraud; forged signatures; record manipulation
3. Provider Relations	Adversarial crackdown without fair process; no timely rate revision	IMA shutdown; hospital boycott; beneficiary access loss
4. Governance & Monitoring	No district Nodal Officers; reactive audit; no real-time AI	Fraud detected months/years later; ₹100 crore losses
5. Beneficiary Awareness	Card sharing; OTP disclosure; unawareness of rights	500+ cards blocked; fraud using genuine cards

Source: Compiled from government audit reports, FIRs, and media investigations.[11,12,13,14,15,16,17,20,21]

The root causes interlock in a reinforcing causal loop: the 11-year CGHS rate freeze led to under-reimbursement for hospitals,[21] prompting quality hospitals to exit RGHS; remaining providers faced financial pressure, creating incentives to game the system; fraud and overbilling led to government crackdowns (FIRs and arrests),[11,12,13,16] precipitating hospital boycotts and reduced access to care;[17,20] media attention and partial payment releases provided only short-term relief, allowing the cycle to repeat in the absence of structural reform.

5. Realistic Reform Blueprint (Solution Framework)

The following reform recommendations are based on: (a) documented RGHS failures, (b) lessons from five globally successful health schemes, and (c) feasibility within Rajasthan's administrative and financial context. Each recommendation is mapped to a specific problem and a global precedent.

5.1 Financial Architecture Reforms

5.1.1 Create a Ring-Fenced RGHS Corpus Fund

- Immediately separate RGHS funding from the general state budget into a dedicated corpus similar to Taiwan's NHI premium fund.[22,23]
- Contributions from employee salary deductions, employer

(government) contributions, and pensioner deductions should directly credit this corpus.
- The corpus should be managed by an independent board with quarterly financial disclosures.
- **Global Precedent:** Germany's sickness fund model contributions are ring-fenced and cannot be diverted to other government purposes.[24]
- Immediate impact: Elimination of the dues crisis that destabilizes the provider network.

5.1.2 Annual Rate Revision-Link to Medical Inflation Index
- The 11-year CGHS rate freeze is the single most destabilizing structural flaw.[21] Implement mandatory annual rate revision.
- Create a Rajasthan Medical Inflation Index (RMII) using data from major hospitals' cost audits.
- Rates should be revised every April, linked to RMII, to prevent both under-reimbursement and windfall profits.
- Differential rates: NABH Accredited > NABH Non-Accredited-incentivizes quality accreditation.
- **Global Precedent:** Netherlands DBC (Diagnosis-Treatment Combination) rates revised annually by the Dutch Healthcare Authority (NZa).[26,27]

5.1.3 Multi-TPA Model with 30-Day Payment SLA Enforcement
- Implement the planned 4-TPA model immediately each TPA allocated a geographic zone (North, South, East, West Rajasthan, or 7 zone-wise TPA providers).[17]
- Introduce automatic penalty clauses: TPA pays 1% interest per month on delayed payments beyond 30 days.
- SLA dashboard: Real-time public tracking of average claim settlement time per TPA on the RGHS portal.
- **Global Precedent:** South Korea HIRA settles 95% of claims within 21 days; payment automation is mandatory.[22,23]
- Expected impact: Reduction of average settlement time from 7–9 months to 30–45 days within 18 months.

5.2 Technology and Security Reforms
A three-layer security model is proposed for the reformed RGHS: (1) Beneficiary Authentication ABHA-based biometric RGHS smart card (fingerprint and face recognition), replacing OTP-only SSO, with Aadhaar-linked real-time verification at hospital entry; (2) Provider Authentication Doctor Digital Signature (DSC) on all e-prescriptions, real-time NMC registry cross-check, and duty roster integration (prescription valid only if doctor is on duty); and (3) AI Fraud Detection Engine real-time analytics to flag unusual prescription patterns, duplicate billing, and outlier test ordering, with automated alert to a quality control unit for investigation.

5.2.1 Mandatory e-Prescription with Doctor DSC
- Eliminate paper prescriptions entirely all prescriptions to be digitally signed by licensed doctors.
- Integration with NMC (National Medical Council) registry: The system auto-validates whether the prescribing doctor is licensed and posted at the hospital.
- Duty roster linkage: Prescription is invalid if the doctor is not scheduled on duty eliminates forged signature fraud.[15]
- **Global Precedent:** South Korea's DUR (Drug Utilization Review) real-time prescription validation has been mandatory since 2010.[22]

5.2.2 Aadhaar-Linked Biometric Smart Health Card
- Replace SSO OTP system with an ABHA-based, Aadhaar-linked biometric card fingerprint verified at hospital check-in.
- Card sharing and proxy treatment become technically impossible with biometric authentication.
- Offline functionality for rural hospitals: Card stores basic health data locally and syncs when online.
- **Global Precedent:** Taiwan NHI IC card tracks all medical encounters, prescriptions, and payments in real time.[22,26,27]
- Implementation: Pilot in one or two zones initially.

5.2.3 AI-Powered Fraud Detection Analytics Unit
- Establish a permanent RGHS Quality Control and Preventive Analytics (QCPA) Unit under RSHAA.
- AI model flags: (a) prescription outliers a doctor prescribing 10× the district average; (b) the same patient admitted 5+ times in a month; (c) diagnostic tests with zero clinical correlation to diagnosis; (d) medicines billed without dispensing scan confirmation.
- Proactive investigation: QCPA generates monthly watchlists for field verification.
- **Global Precedent:** South Korea HIRA reviews 100% of claims using AI algorithms, reducing fraud from 12% to below 3% of claims.[22,23]
- Immediate priority: Pharmacy dispensing scan (barcode) confirmation mandatory before claim generation.

5.3 Provider Relations and Governance Reforms
5.3.1 Graduated Response Protocol-Not Criminal First
- **Tier 1 Administrative Warning:** Written show-cause, voluntary correction, fine (₹1–10 lakh range).
- **Tier 2 Enhanced Scrutiny:** Enhanced audit, payment hold (partial), QCPA supervision.
- **Tier 3 Criminal Action:** Reserved for clear forensic evidence of deliberate large-scale fraud only.
- Create an RGHS Medical Disputes Tribunal a quasi-judicial body with a 30-day resolution mandate.
- Appeal mechanism before de-empanelment: Hospital receives 14-day notice and an opportunity to present evidence.
- **Global Precedent:** Netherlands NZa graduated regulatory action with formal appeal process; criminal referral only for proven intent.[26,27]

5.3.2 District-Level RGHS Nodal Officers
- Appoint dedicated RGHS District Nodal Officers (DNOs) in all 50 Rajasthan districts, reporting directly to the CMHO.
- Role: Beneficiary grievance resolution (7-day turnaround), field verification of hospital compliance, pharmacy spot audits, and employee awareness programmes.
- DNOs to submit weekly fraud-risk reports to RSHAA grounded, real-world intelligence.
- **Global Precedent:** Thailand's approximately one million community health workers creating grassroots accountability.[25,28]

5.3.3 Hospital Quality Tier System
- Create three-tier hospital classification under RGHS: Tier A (NABH Accredited), Tier B (State Quality Certified), Tier C (Basic Empanelled).
- Differential reimbursement rates: A > B > C directly incentivizes quality accreditation.
- Fast-track empanelment for Tier A hospitals reduced documentation burden as a reward for quality.
- Annual quality review: Hospitals move between tiers based on outcome data, patient complaints, and audit results.
- **Global Precedent:** Germany's mandatory hospital quality reports (Qualitätsberichte) public disclosure enabling informed beneficiary choice.[24]

5.4 Beneficiary Empowerment Reforms
5.4.1 RGHS Awareness and Literacy Campaign
- Launch a statewide 'RGHS Samajhein-Apna Haq Paayein' (Understand RGHS Claim Your Rights) campaign.
- Content: OTP safety, card sharing consequences, grievance filing, and services covered or excluded.
- Channels: Employee department meetings, pension office displays, RGHS Connect app push notifications,[5] and Rajasthan Doordarshan.
- Special focus: Pensioners most vulnerable to card misuse and pharmacy fraud.

5.4.2 Real-Time Claim Tracking and Transparent Status Portal

- Beneficiary dashboard: Live status of every claim submitted / under review / approved / paid / rejected with reason.
- SMS/WhatsApp alerts at each claim stage no more 'black box' processing.
- Grievance with SLA: All grievances resolved within 7 working days; DNO escalation if unresolved.
- Annual RGHS Report Card for each beneficiary: Summary of treatments used, amount claimed, and balance remaining.

5.5 Implementation Roadmap

Table 6: RGHS Reform Implementation Roadmap

Timeline	Action Items	Responsible Agency	Priority
0–3 Months (Immediate)	1. Activate 4-TPA model 2. Implement 30-day SLA with penalties 3. Appoint District Nodal Officers 4. Mandate ABHA-based e-Prescription pilot in 1-2 zones 5. Establish QCPA anti-fraud unit	RSHAA + Finance Dept + Health Dept	CRITICAL
3–6 Months (Short-term)	1. Revise RGHS rates to align with CGHS Oct 2025 revision 2. Graduated Response Protocol notified 3. RGHS Awareness Campaign launched 4. Hospital Tier classification published 5. AI analytics engine procured	Health Dept + SIPF + Finance	HIGH
3–9 Months (Medium-term)	1. ABHA-based Aadhaar-linked biometric smart card 2. Doctor DSC integration with NMC registry 3. Duty roster integration into TMS 4. Ring-fenced RGHS Corpus Fund established 5. Real-time Beneficiary Dashboard live	RSHAA + IT Dept + NMC	HIGH
9–12 Months (Long-term)	1. Full biometric card rollout (statewide) 2. Annual RMII-linked rate revision mechanism operational 3. RGHS Medical Disputes Tribunal constituted 4. Cross-state hospital empanelment expanded 5. RGHS Quality Report Card published annually	Govt of Rajasthan + Finance + Health	MEDIUM

6. Integrated Reform Architecture

Table 7: Reformed RGHS (End-to-End System Design)

Layer	Current State	Proposed Reform	Global Model
Beneficiary Entry	SSO OTP → card sharing risk	ABHA-based Aadhaar biometric smart card	Taiwan NHI IC Card
Prescription	Paper/Electronic → easily forged	Mandatory Doctor DSC + NMC validation	S. Korea e-Rx + DUR
Hospital Admission	TID on SSO → easy unauthorized access	Biometric check-in + duty roster cross-check	Taiwan NHI real-time
Claim Processing	Single TPA → 7–9 month delay	4 TPAs + 30-day SLA + auto-penalty	S. Korea HIRA 21-day
Fraud Detection	Reactive (audit after fraud)	AI QCPA real-time analytics engine	S. Korea HIRA 100% review
Rate Setting	Frozen 11 years (2014 CGHS)	Annual RMII-linked revision	Netherlands NZa annual
Provider Action	Immediate criminal action → boycott	Graduated 3-tier response protocol	Netherlands NZa tiered
Payment Fund	General budget → delayed arbitrarily	Ring-fenced RGHS Corpus Fund	Germany sickness funds
Governance	No district-level monitoring	District Nodal Officers (50 districts)	Thailand CHWs model
Beneficiary Info	Poor awareness → card misuse	Awareness campaign + real-time dashboard	All 5 global models

Source: Adapted from international health system benchmarks.[22,23,24,25,26,27,28,29,30]

7. CONCLUSION AND KEY TAKEAWAYS

RGHS is a conceptually sound, comprehensive health scheme that has improved access to cashless treatment for over 65 lakh beneficiaries in Rajasthan.[1,2] Its failures are not inherent to the scheme's design they are implementation failures rooted in financial under-provisioning, technology gaps, and governance deficits that have accumulated over five years.

Documented frauds exceeding ₹100 crore,[11] 19 FIRs, 64 suspensions,[13,14] and a ₹980 crore payment backlog owed to 701 hospitals[17,18] underscore the severity of the current crisis. The 11-year CGHS rate freeze is the foundational structural flaw,[21] while the single-TPA bottleneck, OTP-based authentication vulnerabilities, and absence of district-level governance have compounded the problem.

Comparison with Taiwan,[22,23,26,27] South Korea,[22,23] Germany,[24] the Netherlands,[26,27] and Thailand[25,28,30] consistently reveals that annual rate revision, biometric technology, AI-driven fraud prevention, ring-fenced funding, and graduated enforcement are the hallmarks of high-performing health insurance systems.

A reformed RGHS incorporating a ring-fenced Corpus Fund, ABHA-linked biometric smart cards, an AI-powered QCPA unit, a multi-TPA model with 30-day SLA enforcement, annual RMII-linked rate revision, and 50 district-level Nodal Officers can structurally resolve the current crisis and position RGHS as a national model for state government health schemes.

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