India

Area	3,287,263 km²
Population[i]	1,173,108,018
Age structure	
0-14 years	31.3%
15-64 years	61.3%
65 years and over	7.4%
Infant mortality rate (per 1,000 live births) both sexes[ii]	52
Life expectancy at birth (years) female	65
Life expectancy at birth (years) male	62.1
Maternal mortality ratio (per 100,000 live births)[iii]	450
GDP per capita	
Current US$[iv]	1,017
PPP (current international $)[v]	2,946
Constant local currency	31,663
Per capita total expenditure on health (PPP current international $)[vi]	109
Private expenditure on health as percentage of total expenditure on health	73.8
Unemployment rate[vii]	10.7%
Labour force	467 million
Percentage of workforce in informal economy	94%
Human development index (HDI) rank[viii]	134
HDI poverty indicators – Human poverty index rank	88
HDI health indicators – Life expectancy at birth rank	128
HDI education indicator – Adult literacy and gross enrolment in education	120

Rashtriya Swasthya Bima Yojana

Anil Swarup
Nishant Jain

11
India

Summary

Target group:	Population below the poverty line.
Target population:	300 million by 2012.
Benefits:	Coverage of ₹s 30,000 (US$650) for a family of five for one year; Transportation charges of ₹s 1,000 (US$22) per year; Pre-existing diseases covered from day 1; One day pre-hospitalization and five-day post-hospitalization covered; No age limit.
Funding:	Central and State governments pay the premium to the selected insurer; Beneficiary pays ₹s. 30 as the registration fee per year.
Delivery process:	Each enrolled beneficiary is provided with a biometric smart card; Beneficiary can visit any empanelled hospital across India; Beneficiary is provided cashless treatment; Hospital submits paperless claims to the insurance company.

Information on the Author

Anil Swarup, Director General Labour Welfare, Developing and Implementing Labour Welfare Schemes, Ministry of Labour and Employment.

Nishant Jain, German Agency for International Cooperation (Deutsche Gesellschaft für Internationale Zusammenarbeit, GIZ), India.

Background

There has been a growing belief among decision makers that the absence of a meaningful social security arrangement was not merely a problem for individual workers; it had wider ramifications in the economy and society. Consequently, definite initiatives were taken towards inclusive growth wherein marginalized sections of society could participate in as well as benefit from development. Providing social security to the entire workforce, especially unorganized workers, emerged as one of the major concerns in the country.

The high growth rate (averaging around 8 per cent per annum during the past couple of decades) provided an opportunity to undertake various social protection initiatives for the population. It also created the necessary fiscal space for taking such steps. The Unorganized Workers' Social Security Act, 2008 was legislated to provide a framework for social protection to this huge workforce segment (430 million). The initiatives also included facilities such as life and disability insurance, employment guarantee, and pension.

Health care in India is financed through various sources, including individual out-of-pocket payments, central and State government tax revenues, external aid and profits of private companies. National Health Accounts data from 2004-2005 show that central, State and local governments together account for only about 20 per cent of India's total health expenditure. More than 78 per cent of the health expenditure comprised unpooled, out-of-pocket expenditures – one of the highest rates in the world. External aid to the health sector accounted for a negligible 2 per cent of the total health expenditure.

The Government of India recognized inequities in its health delivery and financing infrastructure and introduced various measures to overcome them. One measure was to increase the budgetary allocations for health care. The Government is planning to increase its spending on health care from the current 1.1 per cent of gross domestic product (GDP) to 3 per cent of GDP. However, increasing the budget for health care is not a solution in itself. There are indeed limitations in the absorptive capacity of the public health-care system apart from the manner in which these funds are used.

WHY RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)?

In the last four to five years, the governments in India have introduced various demand-side financing mechanisms to provide financial security for vulnerable segments of society. Examples are health insurance schemes such as the Universal Health Insurance Scheme (UHIS) launched by the Ministry of Finance in 2003 and State-level health insurance schemes launched by the States of Punjab, Kerala and Assam. However, most of these central or State government-funded schemes have had problems due to poor policy design, lack of clear accountability at the State level, lack of sustained efforts in implementation, weak monitoring and evaluation, unclear roles and responsibilities of different stakeholders, and poor awareness about the schemes among beneficiaries. However, there are exceptions such as the Arogyasri scheme in the State of Andhra Pradesh.

The national government felt that there was a need for a national-level health insurance scheme in the country that would provide financial security to society's vulnerable segments. Learning

from the experiences of other major government and non-government health insurance schemes in India, it decided to launch a health insurance scheme that later came to be known as Rashtriya Swasthya Bima Yojana (RSBY). The population below the poverty line was considered the first target of this scheme. Understanding the characteristics of the target group was imperative. At the outset, since the targeted beneficiaries were poor, they could not be expected to pay cash in advance and take reimbursement later. Therefore, the scheme had to be cashless. Second, the beneficiaries were largely illiterate. Hence, they were not in a position to be involved with documentation. The scheme therefore needed to be paperless. Third, some members of the target population were migratory so they required a scheme that was able to provide benefits anywhere in India. The scheme therefore had to be portable across the country.

What is Rashtriya Swasthya Bima Yojana?

Rashtriya Swasthya Bima Yojana (RSBY) is a health insurance scheme that was launched on 1 April 2008 by the central Ministry of Labour and Employment. The primary objective of RSBY is to provide financial security to beneficiaries below the poverty line for hospitalization-related expenses and improve access to quality health care. Another objective is to empower the beneficiaries by giving them the choice to select any public or private health-care provider for treatment. The scheme aims to cover all the people below the poverty line, estimated to number approximately 300 million, by 2012. The families below the poverty line are estimated through a rural household survey conducted by different States.

RSBY provides hospitalization coverage up to ₨30,000 (approximately US$650) per annum for a family of five on a floater basis. Transportation charges are also covered up to a maximum of ₨1,000 (approximately US$22) per year, with a limit of ₨100 (approximately US$2.20) per hospitalization. In addition to these benefits, pre- and post-hospitalization expenses incurred one day before hospitalization and up to five days from the date of discharge from the hospital are covered. Another special feature of the scheme is that unlike general health insurance schemes where pre-existing diseases are excluded, all pre-existing diseases under RSBY are covered from day one. There is also no discrimination against the elderly since there is no age limit for eligibility under the scheme.

RSBY uses smart-card technology to enrol beneficiaries. A biometric smart card is given to each family below the poverty line, which enables the members to avail themselves of the benefits under the scheme throughout India. All the States and the Union Territories are likely to be covered in a phased manner by 2012.

A beneficiary enrolled under RSBY can visit any hospital that is part of the network of health-care providers. This network is being created across India

through empanelment based on predefined criteria. As of July 2010, around 6,000 hospitals (more than 70 per cent are private) comprised the RSBY delivery network. Providers are empanelled by the State-selected insurance company. A health-care provider empanelled by any of the insurers in RSBY is automatically empanelled by all the other insurers. For empanelment, hospitals must agree to install necessary hardware and software to be able to transact business through the beneficiary smart card. They must also set up a dedicated RSBY desk with trained staff. Once a hospital is empanelled, a nationally unique hospital identification number is generated so that transactions can be tracked at each hospital. Each empanelled hospital is connected to the district server of the insurance company. This facilitates transfer of data relating to hospitalization on a daily basis.

RSBY Process Flow

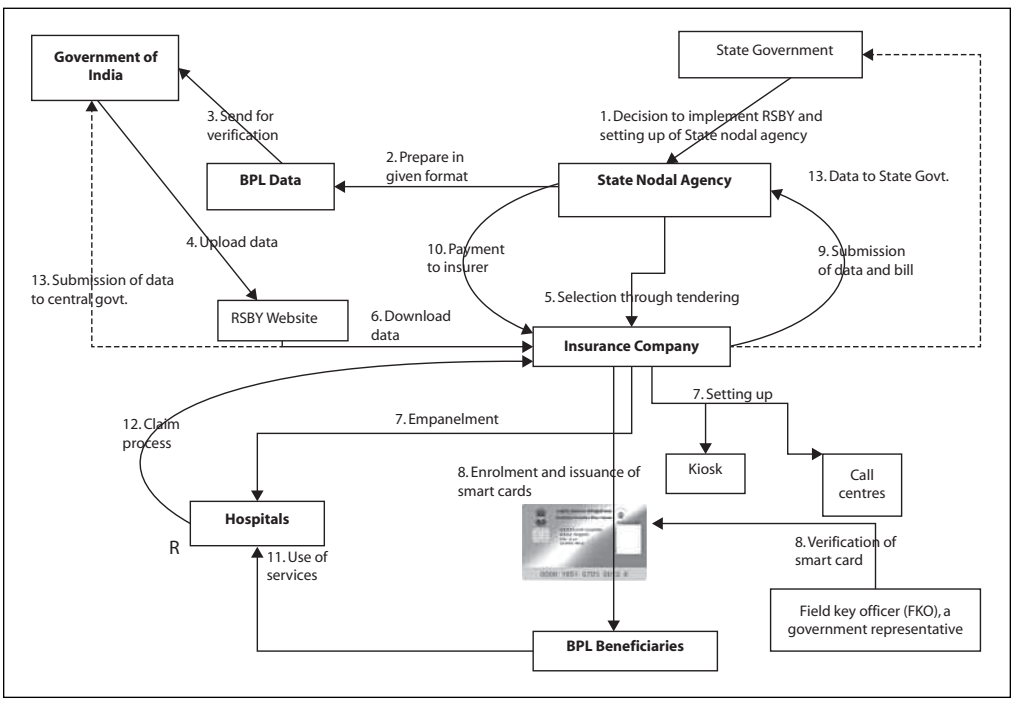
RSBY involves a set of complex but well-defined processes (fig. 1). The process flow for RSBY is as follows:

- Once the decision to implement RSBY is taken by a State government, an independent body, a State nodal agency, is set up.
- The State nodal agency collects/prepares below-the-poverty-line data in the specified RSBY format.
- Once these data have been prepared, an insurance company is selected through an open bidding process.
- Annually, an electronic list of eligible below-the-poverty-line households is provided to insurers by the State. An enrolment schedule for each village, along with dates, is prepared by the insurance company with the help of district officials. The insurance company is given a maximum of four months to enrol below-the-poverty-line families in each district.
- Insurance companies are required to hire intermediaries to reach out to the beneficiaries before the enrolment. In addition, the list of below-the-poverty-line families is posted in each village at the enrolment station and in prominent places prior to the enrolment camp. The date and location of the enrolment camp are also publicized in advance.
- Mobile enrolment stations are established at local centres (e.g., public schools) in each village at least once a year. These stations are equipped by the insurer with the hardware to collect biometric information (fingerprints) and photographs of the members of the household covered and a printer to print smart cards with photo. The smart card, along with an information brochure describing benefits, hospitals in network, etc., is provided to all enrollees once they have paid the ₹s30 (US$0.70) registration fees. The

process normally takes less than 10 minutes.

- A government official from the district (field key officer, FKO) needs to be present at the camp and must insert his own government-issued smart card and provide his fingerprint to verify the legitimacy of the enrolment. In this way, each enrollee can be tracked to a particular official. In addition to the field key officer, an insurance company/smart card agency representative is present at the enrolment camp.
- At the end of the enrolment camp, a list of enrolled households is sent to the State nodal agency by the insurer. The list of enrolled households is maintained centrally.
- Before commencement of the enrolment process, the insurance company empanels both public and private hospitals. Each empanelled household is provided with Hospital Authorization Cards (HACs) in the form of smart cards with unique identification numbers.
- A beneficiary, after receiving the smart card and after the start of the insurance policy, can visit any empanelled hospital across the country to avail himself/herself of benefits.

Figure 1 | RSBY process flow.



Use of Technology under RSBY

The use of technology under RSBY is one of the highlights of the scheme. RSBY is perhaps one of the few schemes in the developing world where technology has been leveraged for delivering social-sector benefits.

A smart card is given to each family below the poverty line at the time of enrolment in the scheme. The smart card is prepared and printed on the spot in the village by the insurer and handed over to the beneficiary. As noted earlier, this card can be used by the beneficiary in any empanelled hospital across India to obtain treatment. In addition to the smart card, biometric technology is used to provide more protection from fraud and to improve targeting. Fingerprints of all beneficiaries are collected during enrolment at the village level. One thumb impression of each of the household beneficiaries is stored in the smart card. This fingerprint is used to verify the identity of the beneficiaries at the hospital.

Another technology used to provide a secure environment for smart-card issuance and use is the key management system, which helps to reduce fraud and improve accountability. A government officer called a field key officer needs to be present at the enrolment station; his role is to verify each beneficiary family using his own smart card and fingerprints. This ensures that only the correct beneficiary is issued the card by the insurer. Similar key cards are used at each place where a smart card is used.

RSBY has been able to position itself as a paperless scheme with the help of technology. Claims are submitted online by the hospitals, and insurers can make online payments to the hospitals. In addition, a robust back-end data management system is being developed for RSBY that will ensure the smooth flow of data from across India to both the State and central governments in real time.

The aim of the scheme is to use technology not only for controlling fraud and monitoring but also to find innovative solutions. For example, enrolment software has been designed to ensure that the wife is necessarily included in the list of those insured in the family.

Funding of RSBY

RSBY is a government-funded scheme where the premium is paid from general revenues. The funding for the premium comes jointly from central and State governments: 75 per cent of the premium (90 per cent in the case of Jammu and Kashmir and Northeastern States) is contributed by the central government while 25 per cent of the premium (10 per cent in the case of Jammu and Kashmir and Northeastern States) is contributed by the respective State government. The insurance premium is determined at the State level. Registered insurers compete in the open bidding process.

It was also decided by the Government that the beneficiaries will also pay the

small amount of ₨30/ US$0.70 as a registration fee. This was done so as to increase the sense of ownership of the scheme among the beneficiaries. This ₨. 30 is aggregated at the State level and is used to take care of the administrative cost.

RSBY Data

After two years of operation, RSBY has been able to move from 2 States to 23 States in the country. The highlights of the performance of the scheme by the end of July 2010 are presented in table 1.

Table 1 | Highlights of the performance of the RSBY scheme by the end of July 2010.

RSBY Data	
Number of families enrolled	Approx. 18 million
Number of persons enrolled	Approx. 70 million
People covered as a percentage of total target population	24%
Number of States where RSBY is being implemented	23
% of States that have started RSBY implementation	80%
Number of hospitals empanelled	5,945
Number of persons who have received treatment	850,000
Average hospitalization rate	3%
RSBY Economic Data	
Total expenditure on premium subsidy of RSBY until 31 July 2010	₨8,000 million US$174 million
Expenditure on RSBY premium as a percentage of GDP	0.013%
Administrative expenditure on RSBY by Government of India	₨50 million US$1.09 million

Source: Ministry of Labour and Employment.

Stakeholders and Their Roles

RSBY is an example of how a scheme can evolve successfully through the cooperation of different stakeholders. In the initial stages of the scheme, there were organizations such as the World Bank and the German Agency for International Cooperation (GIZ) that supported the development of the design and processes. There are six primary stakeholders in the scheme: the central government, State governments, State nodal agencies, insurance companies, hospitals and non-governmental organizations (NGOs). The roles of each of these stakeholders are clearly defined in the scheme (table 2).

Table 2 | Roles of stakeholders in RSBY.

	Central Govt.	State Govt.	State Nodal Agency	Insurer/ Third-party Administrator (TPA)	NGOs/ Other Partners	Providers of Care
Oversight of scheme	X		X			
Setting up of nodal agency		X				
Financing scheme	X	X				
Setting parameters (benefits package, empanelment criteria, below-poverty-line criteria)	X	X				
Hardware specifications (e.g., systems, smart card)	X					
Contract management with insurer			X			
Accreditation/Empanelment of providers				X		
Collecting registration fees				X		
Enrolment			X	X	X	
Financial management/planning	X		X			
Actuarial analysis				X		
Setting rate schedules for services/reimbursement rates	X		X			
Claims processing and payment				X		
Outreach, marketing to beneficiaries			X	X	X	
Service delivery						X
Developing clinical information system for monitoring/evaluation	X		X			
Monitoring State-level use and other patient information	X		X	X		
Monitoring national RSBY information	X					
Customer service				X	X	X
Training	X		X	X		

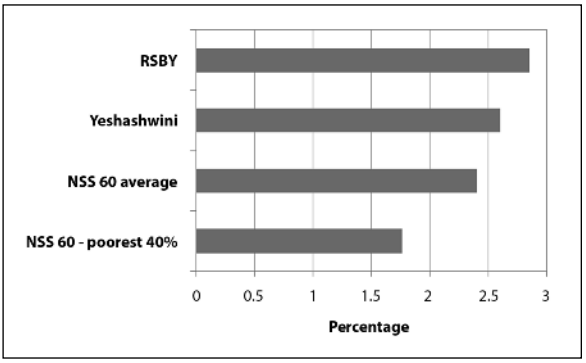
Initial Impact

RSBY has been in operation for just over two years but the impact is clearly visible. Data from RSBY and many external evaluations have revealed the following:

- **improvement in access to health care**. Access to health care for the targeted segment of RSBY has improved considerably in the past two years. Data from the studies show that the hospitalization rate in the initial 92 districts of RSBY is 2.8 per cent while it is only 1.75 per cent for the poorest-of-the-

poor population otherwise (as per the National Sample Survey Organization (NSSO) 60th Round Survey) (see graph). Evidence is also emerging that an increasing number of women are accessing such facilities, in some districts outnumbering men.

Percentage of RSBY members hospitalized.



- **reduction in out-of-pocket expenditure on health.** One of the objectives of the introduction of RSBY was to reduce the out-of-pocket expenditure on health by the poor population. Survey results of RSBY in Kerala State show that non-RSBY poor patients spend on average six times more money in the hospital than RSBY beneficiaries.
- **setting up of health infrastructure in rural areas.** Evidence is emerging that the private sector is finding value in setting up health-related infrastructure in regions that had hitherto been unserviced. This is largely because RSBY is creating a demand for health services in the rural areas, which has provided an incentive for private players to set up hospitals.
- **high level of satisfaction.** Different surveys in the States of Kerala and Delhi have shown that more than 90 per cent of the beneficiaries who have taken treatment under RSBY are satisfied with the treatment and the services provided in the hospitals.

Challenges Faced

Various challenges needed to be met in establishing the RSBY:

- **stakeholder buy-in.** The first major challenge before implementing RSBY was to obtain the buy-in not only of officials within the central and State governments but also of the insurance and smart-card industries. Intensive meetings were organized with all the stakeholders to explain the scheme design and to obtain their agreement to it;
- **a supply of necessary hardware and software.** RSBY needed a supply of smart card-related equipment in large quantities. These machines were not available in the required quantities. The buy-in of the industry helped in its responding to the demand and importing the equipment to match the demand;
- **development of a key management system.** One of the main

features of the RSBY design was to provide a foolproof secure system to prevent any fraud or misuse. Therefore, it was a huge challenge to develop a key management system that could provide necessary security at different levels;

- **enrolment and awareness.** The printing and issuance of smart cards in the village constitute one of the most challenging aspects of RSBY. The smart cards are to be issued on the spot and in difficult terrain. Once the smart cards are issued, another challenge is to improve the awareness of the beneficiaries regarding their use; and
- **lack of capacities at different levels.** Building capacities at each level to implement a complex scheme such as RSBY was another challenge. These capacities were to be built among all the stakeholders, which included government officials, insurance companies, hospitals and NGOs.

Success Factors

Factors responsible for the success of RSBY are as follows:

- **partnership approach.** Right from the designing of the scheme, attempts were made to take the stakeholders into confidence. A partnership approach was adopted with all the private players;
- **standardization.** A national scheme such as RSBY required a high degree of standardization so that it could work uniformly across India. In addition to all the key documents, all the software and hardware were standardized and guidelines were issued regarding their preparation, use and certification;
- **flexibility.** RSBY has evolved continuously since its inception. Different provisions and processes of the scheme have been revised in response to the realities on the ground;
- **attention to detail.** Each process and each step relating to the implementation of the scheme have been documented. Similarly, the roles of each stakeholder and their relationship with others have been clearly defined so as to avoid any ambiguity;
- **empowerment of the beneficiaries.** The beneficiaries, in this context the poorest of the poor, were empowered since they were now being given a choice of hospitals, public and private, across the country;
- **business model.** This was perhaps the first-ever business model on this scale for a social-sector scheme with insurance companies and hospitals finding "fortune at the bottom of the pyramid".

RSBY saves a life and many more...

Sudhir lives in a small village near Bijnor in Uttar Pradesh. He has a son, Santosh, who is mentally challenged. Santosh met with an accident and his left leg was severely burned. Sudhir, being a daily-wage worker, could barely make both ends meet, let alone afford treatment for his son in a good hospital, which forced him to settle for treatment with a local doctor who could do little to alleviate his son's misery. Santosh continued to suffer.

Being mentally challenged, Santosh could not even express his agony and discomfort. He turned into a lifeless being. The family had no option but to helplessly watch the suffering of Santosh, who could be crippled for life owing to the non-availability of timely treatment. Selling the small hut that they owned or taking a loan would have brought greater misery.

RSBY came to their rescue. When Sudhir was informed about the scheme, he was initially apprehensive. However, once he understood what a smart card could do, he enrolled himself. The scheme fortunately also covered the pre-existing conditions.

Not only did Santosh get quality treatment at Beena Prakash hospital, a private hospital situated in the small town of Bijnore in western Uttar Pradesh, with just the flash of the RSBY smart card, but he also did not have to pay a single penny for the treatment. In fact, he was paid ₹s100 (US$2.20) as reimbursement for travel expenses. The son recovered in due course. RSBY came as a saviour.

Today the general ward of Beena Prakash hospital and many other similar hospitals are bustling. Locals claim that this heightened buzz of patients is "unprecedented". What is even more unusual is that most of the patients belong to the population living below the poverty line. RSBY has made it possible for these people to visit these hospitals and obtain cashless treatment through the smart card.

---

[i] National estimates, 2010.

[ii] WHO, Global Health Observatory, 2008.

[iii] WHO, UNICEF, UNFPA and World Bank, Global Health Observatory, 2005.

[iv] World Bank, *World Development Indicators* 2008 and *Global Development Finance* 2008.

[v] Ibid.

[vi] Government of India budget, 2009.

[vii] National estimates, 2009.

[viii] UNDP, *Human Development Report* 2009.