Health Insurance for the poor
India’s Rashtriya Swathya Bima Yojana

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Ministry of Labour and Employment
Government of India
STRUCTURE OF THE PRESENTATION

• The Indian context.
• Why social security?
• Why health insurance?
• What is the scheme?
• The initial challenges.
• What has happened so far?
• How has the scheme been perceived?
• What is the potential of the smart card platform?
• What are the lessons for other countries?
Workforce In India

• 460 million workforce in India

• More than 94% of workers are in the informal sector

• India's unorganized sector is one of the largest in the post-industrial world
OUR BELIEF

• Absence of a meaningful social security arrangement is not merely a problem for individual workers, it has wider ramifications in the economy and the society.
• From an economic point of view, it debilitate workers’ ability to contribute meaningfully and efficiently.
• Low earning power, coupled with vulnerabilities, lead to poverty that also reduces aggregate demand.
• Socially, it leads to disaffection and dissatisfaction, especially when a small segment of the society is well endowed and seen as prospering.
• Government of India is working towards providing social security to the workers
## ECONOMIC GROWTH IN INDIA

...Some Indicators

<table>
<thead>
<tr>
<th></th>
<th>50-51</th>
<th>90-91</th>
<th>03-04</th>
<th>08-09</th>
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</thead>
<tbody>
<tr>
<td><strong>Food Grains</strong> (Million Tonnes)</td>
<td>50.8</td>
<td>176.4</td>
<td>212.2</td>
<td>233.88</td>
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<tr>
<td><strong>Finished Steel</strong> (Million Tonnes)</td>
<td>1</td>
<td>13.53</td>
<td>36.9</td>
<td>57.16</td>
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<tr>
<td><strong>Electricity Generation</strong> (Billion KWH)</td>
<td>5.1</td>
<td>264.3</td>
<td>565.1</td>
<td>842.5</td>
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<tr>
<td><strong>Foreign Exchange Reserves</strong> ($ Billion)</td>
<td>1.9</td>
<td>2.2</td>
<td>107.4</td>
<td>251.98</td>
</tr>
<tr>
<td><strong>Exports</strong> ($ Bn)</td>
<td>0.15</td>
<td>8</td>
<td>73.3</td>
<td>105.15</td>
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<tr>
<td><strong>Life Expectancy</strong> (years)</td>
<td>32.1</td>
<td>58.7</td>
<td>65.3</td>
<td>63.4</td>
</tr>
<tr>
<td><strong>Literacy rate</strong> (% of population)</td>
<td>18.3</td>
<td>52.4</td>
<td>65.4</td>
<td>66</td>
</tr>
</tbody>
</table>
Major Needs of Unorganised Sector workers

• Employment Security
• Health Security
• Maternity Security
• Old Age Security
Major Initiatives

• Employment Security through National Rural Employment Guarantee (NREGA)
• Health and Maternity Security through Rashtriya Swasthya Bima Yojana (RSBY)
• Unorganized Workers’ Social Security Act, 2008
Financial Commitment

• Though the financial commitment is a small percentage of GDP it has a multiplier effect

<table>
<thead>
<tr>
<th></th>
<th>Value (Rs. Million)</th>
<th>Value ($ Million)</th>
<th>% of GDP</th>
<th>% of Total Plan Outlay</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP</td>
<td>61,641,780</td>
<td>1284203.8</td>
<td></td>
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</tr>
<tr>
<td>NREGA</td>
<td>401,000</td>
<td>8354.2</td>
<td>0.6505%</td>
<td>10.78%</td>
</tr>
<tr>
<td>RSBY</td>
<td>3,500</td>
<td>72.9</td>
<td>0.0057%</td>
<td>0.09%</td>
</tr>
</tbody>
</table>

Source: Budget of Government of India
OOP = 83% of total health spending in India

Data for All - India 2004
<table>
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<tr>
<th></th>
<th>Average OOP Payments made per hospitalization in Govt. facilities</th>
<th>ALL INDIA</th>
<th>POOREST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>70</td>
<td>54</td>
</tr>
<tr>
<td>2.</td>
<td>Average OOP Payments made per hospitalization in private facilities</td>
<td>158</td>
<td>115</td>
</tr>
<tr>
<td>3.</td>
<td>%age of people indebted due to OP Care</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>4.</td>
<td>%age of people indebted due to IP Care</td>
<td>52</td>
<td>64</td>
</tr>
</tbody>
</table>

*Source: NSSO, GOI*
TYPES OF HEALTH FINANCING

• Supply Side Health Financing
  – Government funds public hospitals directly
    • No accountability of hospitals
    • Most of the fund is tied
    • No choice for beneficiaries
    • No incentive to improve performance
    • Often mismatch between demand and supply of funds

• Demand Side Health Financing
  – Government pays to the hospitals (public and private) based on services provided either directly or through intermediation of an insurance company
## Insurance Vs. Direct Payment

### Insurance Company
- Insurance Company carries the risk
- Liability of Government is only up to premium payment
- Insurance Company has professional expertise of managing fund
- Experience in handling these issues
- Insurance Company has business interest to reduce cost and improve efficiency
- Insurance Company has field level offices to monitor the hospitals
- Insurance Company is bound by IRDA regulations so more control
- Public Private Partnership improves the effectiveness of payer-provider relation
- Low overheads results in low-cost

### Government
- Government carries the risk
- Government liability is unlimited as per the usage by beneficiaries
- Generally professional expertise is missing
- There is no interest to reduce the cost of usage and improve efficiency
- No dedicated presence to monitor the performance of the hospitals at the field
- No regulation to control the performance
- A nexus can potentially come between payer and provider
- High overheads
RASHTRIYA SWASTHYA BIMA YOJANA
CHARACTERISTICS OF UNORGANIZED SECTOR WORKERS

• Poor
• Illiterate
• Migratory
RASHTRIYA SWASTHYA BIMA YOJANA

The Scheme

• Total sum Insured of Rs 30,000 (U.S. $ 650) per BPL family (a unit of five) on a family floater basis

• Pre-existing diseases covered

• Coverage of health services related to hospitalization and certain procedures which can be provided on a day-care basis
RASHTRIYA SWASTHYA
BIMA YOJANA

Benefits

• Cashless coverage for hospitalization with few exceptions.
• Provision of Smart Card.
• Provision of pre and post hospitalization expenses.
• Transport allowance @Rs.100 (U.S.$ 2.2) per visit up to a ceiling of Rs. 1000 (U.S. $ 22) as part of the benefits.
FUNDING

• Contribution by GOI : 75% of the estimated annual premium.
• Contribution by the State Governments: 25% of the annual premium.
• Additional benefits can be provided by the State Government but the cost has to be borne by the State.
• Beneficiary to pay Rs. 30 (U.S.$ 0.65) per annum as Registration Fee.
• Administrative cost to be borne by the State Government.
• Cost of Smart Card to be borne by the Central Government @ Rs.60 (U.S.$1.30) per beneficiary
SMART CARD

Rashtriya Swasthya Bima Yojana

XXXX
XXXX (English)
AGE: 42 yrs.
GENDER: MALE

0000 1651 0700 0012 6

Issued: Jan. 2008
INITIAL CHALLENGES

- Acceptability by the States and other Stakeholders
- Earlier experience with Health Insurance Schemes
- BPL Data
- Increasing Hospitalisation
  - Awareness
  - Availability of Hospitals in rural areas and their willingness to join
- Availability of hardware and software to support
- Capacity of Government and Private players.
- Moral Hazard
- Evolving a win-win situation for everybody
Some other challenges

• Insurance related.

• Information Technology related.

• Marketing of the Scheme.
HOW IS RSBY DIFFERENT?

• IT used to reach the poor on a large scale.
• The BPL families are being empowered with a choice. They can choose from among several hospitals (both public and private) for treatment.
• A ‘business’ model for a social sector scheme. (Fortune at the bottom of the pyramid)
• Key Management System (KMS) to make the scheme foolproof.
• Simple front end but extremely complex back end.
• Paperless.
• Validity of the smart card throughout the country.
ENROLMENT KIT

- Web Camera: for Photograph
- Optical Biometric Scanner: for Fingerprints
- Data Masters: Based on State’s BPL data
- Battery Power Back-up: for Undisrupted Enrolment
- Dye-Sublimation Printer
WHERE DID IT ALL BEGIN?

EXPANSION OF RSBY ACROSS INDIA (Mar 08- Jul 08)
Current Status of RSBY Implementation in India

- Cards issued – App. 32.4
- People enrolled – App. 110 million
- Number of People benefitted till now – App. 4.3 million
- Number of Hospitals Empanelled – App. 12,100
- States where Service delivery has started – Twenty Six
- Number of Insurance Companies Involved – Fourteen
INITIAL TRENDS AND IMPACT

- Improvement in access to Healthcare. Health infrastructure being set up in remote areas by the private sector.
- Public Sector hospitals competing and improving performance to gain access to flexible funds and incentives.
- Penetration in the areas affected by extremist activities.
- Marked improvement in utilization by women in the scheme.
- For expenditures beyond Rs. 30,000 (US $650), State Governments linking with other schemes
- States funding premium for certain categories above poverty line.
- Independent Groups paying the entire premium to ride the RSBY platform
- Below Poverty Level (BPL) lists improving on account of exposure
- Disease profiling in each District
Utilization rates for RSBY members suggest increased access to hospital services

Note: Estimate based on monthly hospitalizations; includes multiple procedures within same household in case of RSBY
Hospitalisation Ratio

- Access to hospitals have increased for RSBY beneficiaries
- Districts which have finished two years have higher hospitalisation
- There is huge variations across different States
Male/ Female Hospitalization Ratio

Overall Hospitalization Ratio
- Round 1: 3.01
- Round 2: 3.83

Male Hospitalization Ratio
- Round 1: 2.79
- Round 2: 3.89

Female Hospitalization Ratio
- Round 1: 3.36
- Round 2: 3.76
Public sector hospitals must play key role in RSBY and can benefit from RSBY as well

In Kerala government hospitals, revenue from RSBY is used for:

- 75% earmarked for KMC to fill critical gaps
  - Improving hospital environment
  - Providing additional consumables and maintaining equipments
  - Building and acquiring capacity
  - Covering operational expenses of ambulance service
- 25% on incentivizing staffs

Outcome:
- Better equipped to provide more patient friendly services and to compete with private hospitals
PREMIUM TRENDS in RSBY
295 Districts where One Year Completed

Burnout Ratio for 295 Districts

- Balance with Insurance Company: 27%
- Expenditure by Insurance Company: 73%

95 Districts where Two Years Completed

Round 1
- Balance with Ins Co.: 12%
- Expenditure by Insurance Company: 88%

Round 2
- 125.98
- -25.98
Satisfaction Level of Beneficiaries from RSBY

Himachal
- Excellent: 26%
- Very Good: 4%
- Not Satisfied: 70%

Haryana
- Satisfied with scheme: 77%
- Not satisfied with scheme: 23%

Chhattisgarh
- Excellent: 18%
- Very Good/Good: 60%
- Average: 3%
- Not satisfied: 19%

Gujarat
- Satisfied: 83%
- Not satisfied: 17%

Kerala
- Excellent: 65%
- Very good: 26%
- Good: 5%
- Average: 4%
- Not satisfied: 19%
August 26, 2008

India's Poor Get Health Care in a Card
Credit Plan Gives Nation's Neediest the Funding for Medical Treatment -- and Tool for Charging It
By JACKIE RANGE
August 26, 2008; Page A10

"For poor people, it's great," says Mr. Kumar.

"It's the best scheme India has, I think, and real welfare for the poor," he says.
Finally, a lifeline for India's poor

Nothing causes as much anxiety in a family as when someone falls sick. Nearly 65% of India's poor get into debt and 1% fall below the poverty line each year because of illness, according to National Sample Survey Organisation (NSSO) 2004. The answer, of course, is health insurance, but only 6% of India's workers have it. Free public hospitals are not an option as two out of five doctors are absent, and there is a 58% chance of receiving the wrong treatment, according to Ashish Dash and Jeffrey Hammer's study. This tragic state of affairs is, however, set to change dramatically with Rashtriya Swasthya Bima Yojana (RSBY), a visionary national health insurance scheme, which provides Rs 30,000 in patient health benefits at a premium of Rs 600, which the government pays if you are poor. A brainchild of an IAS office, Anil Swarup, this scheme will succeed when others have failed because of choice competition and a magical 'smart card'. A patient can choose from almost 1,000 private or government hospitals. States can choose from 38 public or private insurance companies. Insurers have the incentive to recruit the poor as they earn premiums by doing so. Hospitals will not turn away the poor because they don't want to lose the Rs 30,000 in potential revenue. The poor have a choice to exit a bad hospital, something that only the rich can do today. Competition between hospitals will improve the quality of healthcare and new hospitals will open up because there is now money in catering to the poor. The insured carry a smart card with a photo, fingerprints of the family, and an official's 'key' who is accountable. It makes transactions cashless and paperless for the 745 pre-agreed medical procedures. The card contains Rs 30,000 and it tracks expenses day to day in the hospital and the money is deducted automatically after each procedure. No need for pre-approval or reimbursement. Since the poor are migratory birds, the smart card empowers a Bhari to use a hospital in Gujarat. Smart cards are designed to prevent fraud because of 11 unique types of embedded software.

So far 40,000 cards have been issued in six months covering 2.5 million people. Most states have agreed to the scheme because the centre foots 75% of the premium. Haryana and Gujarat are the most enthusiastic states. Uttarakhand and Orissa are dragging their feet. Kerala is offering it to everyone as long as the non-poor pay their own premium. Thus, it has become a universal product of the insurance company. Only Madhya Pradesh and the North-East states, to their disgrace, have not joined. If all goes according to plan, 30 crore people or one third of India will be covered in five years at an annual cost of Rs 650 crore — a tiny sum compared to the money wasted in dozens of other schemes. Previous state health insurance schemes failed because they insisted that people use public hospitals and public insurers - with predictable results. This one will succeed because in insurance companies, hospitals, and patients all have 'skin in the game'.

Smart cards can dramatically cut corruption in all our social programmes. India spends 14% of GDP on subsidies for the poor, which is more than enough to wipe out poverty. But poverty persists because subsidies leak out through corruption. Smart cards can also carry data on payments for rations (PDS) or earnings from employment schemes (National Rural Employment Guarantee Scheme) and it can expose corruption very quickly. Despite the Left's strident rhetoric, middle class Indians do not resent income transfers to the poor as long as the benefits reach the poor. Our problems in India are of the 'how', not of the 'what'. The smart card addresses the 'how', and we know it is powerful because corrupt officials and politicians are trying hard to kill it. For the nation, it is the best Diwali present amidst all the gloom in the marketplace.

“For the nation, it is the best Diwali present amidst all the gloom in the marketplace”
"A plastic square has given Husain the power to save his wife's life."

The Rashtriya Swasthya Bima Yojana (RSBY) has transformed the life of over 65 million people in the unorganised sector.
It’s a government effort and it seems to be working.
The biggest change that this card has brought about is that it has brought money into hands of people. So no hospital, public or private, can afford to ignore even the poorest of patients.
The government seems to have a winning model with the first market driven welfare scheme where all the players, the insurance companies, hospitals and patients get to benefit.
Extension and Expansion of RSBY

RSBY

Below Poverty Line (30%)

Fully Subsidised

Partially Subsidised/ Non-Subsidised

Other Occupational Groups e.g Taxi drivers

B&C Workers

Domestic Workers

Street Vendors

NREG S Workers

Private Insurance

Government Employees

Tertiary Care

Secondary Care

Primary Care/ Outpatient

Curative Continuum
Future of RSBY Smart Card.......?

<table>
<thead>
<tr>
<th>Common Storage Area</th>
<th>Family demographic details</th>
<th>Biometric details of RSBY family</th>
</tr>
</thead>
<tbody>
<tr>
<td>RSBY related data</td>
<td>Health Card related data</td>
<td>PDS Data</td>
</tr>
<tr>
<td>XXXX (Local Language)</td>
<td>XXXX (English)</td>
<td>AGE: 42 yrs.</td>
</tr>
<tr>
<td>0000 1651 0700 0012 6</td>
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</table>
SOME RECENT DEVELOPMENTS

• Experimental projects for OP at Puri (Orissa), Mehsana (Gujrat) and Rangareddy (A.P.)
• Decision to use RSBY Smart Card for Financial Inclusion, Life and Disability Insurance related information and for “Swawlamban”
• Chattisgarh has decided to use RSBY smart card for PDS
• Countries like Bangladesh, Pakistan, Maldives, Nepal, Nigeria and Vietnam show interest in the scheme
• Setting up a forum, Network for Social Security, “NeSSt” for exchange of information and to facilitate proliferation of social security schemes in the developing world
Lessons for other Countries

• Health insurance can be an instrument for providing health care.............but it is extremely complex.
• The framework has to be designed carefully in the context of ground realities.
• Technology can be leveraged.
• All stake holders have to be on board.

There is so much to learn from each other
the journey so far has been tough but extremely exciting and fulfilling