

2006 | ASIAN DECENT
2015 | WORK DECADE



International
Labour
Organization

**Asia-Pacific Regional High-Level Meeting on
Socially-Inclusive Strategies to Extend
Social Security Coverage**

New Delhi, India, 19 –20 May 2008

COUNTRY PAPERS

INDIA

RASHTRIYA SWASTHYA BIMA YOJANA

Providing health insurance cover to the poor

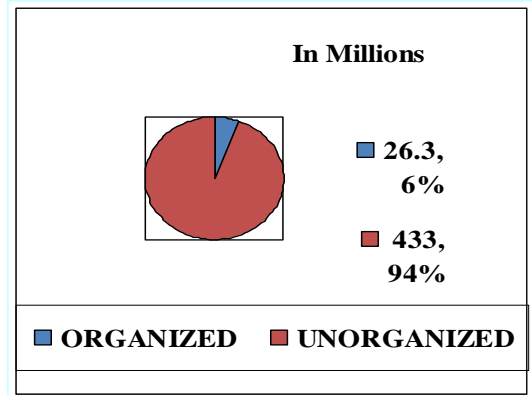
*-Anil Swarup
Ministry of Labour and Employment
Government of India*

INTRODUCTION

One of the most urgent and vexing problems in the developing world, more so in India, is how to finance and provide health care for more than two billion persons, most of whom are impoverished or belong to low income group. This is brought out clearly in the World Development Report 2000/2001. In most Asian countries, health care is financed by out-of-pocket (OOP) payments by individuals. These expenditures result in jeopardizing an equitable health system in developing countries. In the absence of financial risk pooling, the poor have to meet the costs of health care from their own pocket, pushing them further down the abyss.

THE INDIAN CONTEXT

In India, around 94% of the total workforce is in the unorganized sector. In absolute terms too, the numbers (around 433 million) are mind boggling. One of the major insecurities of these workers and their families is the frequent incidence of illness and need for medical care and hospitalization. Despite expansion in the health facilities, illness remains one of the most prevalent causes of human deprivation.



It has been clearly recognized that health insurance is one way of providing protection to poor households against the risk of health spending leading to poverty. However, most efforts to provide health insurance in the past have faced difficulties in both design and implementation. The poor are unable or unwilling to take up health insurance because of its cost or lack of perceived benefits. Organising and administering health insurance, especially in rural areas, is also difficult.

The common dilemma facing policy makers is with regard to the need for a Government sponsored health insurance cover when health services are being provided 'free' by the Government itself. However, the fact is that the 'free' government health services are not meeting the needs of the community. This is the reason why a lot of out-of-pocket expenses are still taking place which in turn lead to indebtedness, as is evident from table below. It is also evident that the poorest bear the brunt of it.

Out of pocket payments and indebtedness in some States in India (Rural)

	All India	Poorest	Low Income	Middle Income	High Income
% of people who do not use health services	18	24	24	18	11
% of people who use government services for OP	22	30	26	22	18
% of people who use government services for IP	42				

Average OOP payments made for OP (Rs)	257	191	237	243	426
Average OOP payments made for OP in Government facilities	11	9	19	9	12
Average OOP payments made for OP in private facilities (Rs)	246	163	190	211	377
Average OOP payments made per hospitalization (Rs)	5695				
Average OOP payments made per hospitalization in Government facilities (Rs)	3238	2530	2950	3017	6374
Average OOP payments made per hospitalization in private facilities (Rs)	7408	5431	5777	6781	10749
% of people who are indebted due to OP care	23	21	31	32	20
% of people who are indebted due to IP care	52	64	65	60	52

Source: NSSO 60th round 2004. Govt. of India

THE SCHEME

Target Group

The unorganized sector workers below poverty line (BPL) and their families are proposed to be covered under Rashtriya Swasthya Bima Yojana (RSBY) during the next five years (2008-09 to 2012-2013).

Understanding the characteristics of the target group was found to be absolutely imperative in evolving a scheme that could have a meaningful impact. An analysis of this group reveals that they are primarily:

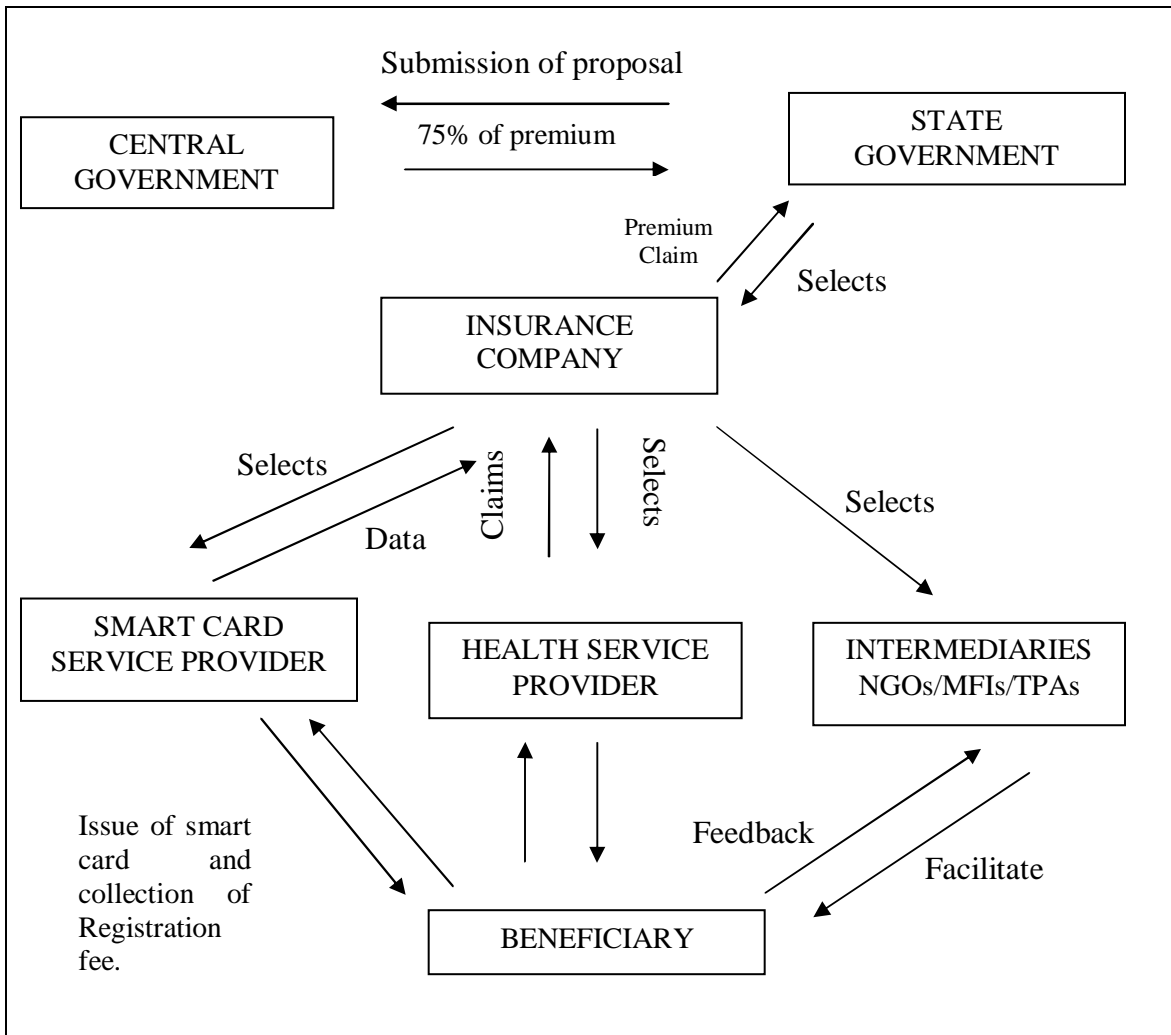
- Poor
- Self employed
- Illiterate
- Migratory, and
- Unskilled

Thus, the scheme, had to be cashless, because there was no way in which the beneficiary could raise the financial resources and then claim reimbursement from any agency. The reimbursement process itself is normally so cumbersome that it would have been virtually impossible for those below poverty line, even if they could raise the resources upfront, to claim the benefit.

A large number of workers in India migrate from one State to the other in search of employment. So far, none of the health insurance schemes, for that matter any other scheme, addresses this aspect. An added complexity emerges when only some in the family migrate and rest of them stay back.

On account of illiteracy, repeated documentation cannot be resorted to and, in this sense, the cashless system was the only alternative.

SCHEME DESIGN:



Benefits

The beneficiary, under RSBY, is eligible for the following minimum benefits:

- Total sum insured of US \$750 per BPL family per annum on a family floater basis. (A family would comprise the household head, spouse and upto three dependents)
- Pre-existing conditions to be covered, subject to minimal exclusions.
- Coverage of health services related to hospitalization and services of a surgical nature which can be provided on a daycare basis. (Though OPD facilities are not covered under the scheme, OPD consultation is free)
- Cashless coverage of all health services in the insured package.

- (e) Provision for pre and post-hospitalization expenses for one day prior and 5 days after hospitalization.
- (f) Provision for transport allowance (actual with limit of US \$2.5 per visit) but subject to an annual ceiling of US \$25.

Funding

- (a) Contribution by Government of India: 75% of the estimated annual premium of US \$19, subject to a maximum of US \$14 per family per annum. Additionally, the cost of the smart cards to be borne by the Central Government @ US \$1.5 per card.
- (b) Contribution by the respective State Governments: 25% of the annual premium, as well as any additional premium in cases where the total premium exceeds US \$19.
- (c) The beneficiary would pay US \$0.75 per annum as registration/renewal fee.
- (d) Any administrative and other related cost of administering the scheme in each State, not otherwise included in the premium cost, shall be borne by the respective State Governments.

Proposed Coverage and Allocation for the Scheme

An estimated 60 million BPL families (300 million persons) in 600 districts of the country will be covered in the next five years as follows:

	2008-09	2009-10	2010-11	2011-12	2012-13
Number of BPL workers to be covered (in million)	12	24	36	48	60
Proposed Expenditure (Million US \$)	190	357	527	697	881

ROLL-OUT OF THE SCHEME

Process Flow:

The process flow under RSBY is given in *Annexure.1*.

After the identification of the Districts to be taken up in a particular year, the State Governments are required to select one or more health insurance service providers on a periodic basis according to a tender process which would take account of both the price

of the insurance package and technical merit of the proposal. The tender is open to both public and private insurers who meet the standards fixed by Insurance Regulatory Development Authority (IRDA).

The selected insurance company has to have back to back arrangement with:

- a) Health service providers
- b) Smart card service providers
- c) Intermediaries

Only such health service providers would be empanelled by the insurance company as are able to meet the predefined criteria. The idea here is to ensure that though an attempt would be made to keep the number as large as possible to facilitate competition and easy access, some minimum standards are adhered to. The hospitals have also to agree to a predetermined package of medical and surgical procedures and the costs thereof to obviate subjectivity. No preauthorization is required in case of predetermined packages. Majority of the ailments will fall within these packages. However, in case the ailment does not fall in such packages, the procedure for preauthorization has been prescribed.

Information Technology Application:

Smart Card is central to RSBY, as it would enable cashless transaction as well as inter-operability in network hospitals throughout the country. It would also enable foolproof biometric identification of the beneficiary.

The smart cards will be issued by the smart card service provider on behalf of the Insurance Company to the beneficiary. However, ownership of the card will remain with the Central Government for its use in subsequent years and for other purposes. The card is to be personalized on the spot and



delivered there itself. The cost, if any, would be borne by the insurance company as a part of the overall bill.

The smart card cannot be issued in the absence of head of the family as his photograph has to appear on the face of the card. However, it can be issued in the absence of other members, provided the head of the family is present. Their details can be added subsequently at the district kiosk, to be maintained by the insurance companies.

In view of the possible migration of BPL workers, there is a facility of split card under the scheme. These cards can be split at the time of first issue or subsequently at the district kiosk. Split value can be decided by the head of the family, provided the total

amount on both the cards is equivalent to the total amount available on the primary card before the split. The insurance company will authorize issue of these cards.

A new card can be issued in case of loss of smart card. However, the beneficiary will have to bear the cost of duplicate card. As the details of the family would be available in the database, the card could be issued at the district kiosk.

The hospitals are mandated to possess necessary hardware of predetermined specifications to read and operate the data on the smart card. A transaction software, based on the specifications, is to be prepared by the service provider for use in the hospitals.

A back-end data base management is to be put in place for transmission from hospitals to a designated server and for electronic settlement of claims to make the scheme not only cashless but also paperless. An elaborate MIS is being developed for close supervision and monitoring at various levels.

As indicated in Annexure.2, in all, 11 sets of softwares are proposed to be used for effective use of smart cards under RSBY.

Security:

With a view to imparting security to the entire process of issuing and use of smart card, an elaborate key management system (KMS) has been evolved by the National Informatics Centre (NIC). A Central Key Generation Authority (CKGA) has been set up for creating root keys and to manage the entire key management system at the Central level. The district keys will also be generated by CKGA. Thereafter, the keys for field key officers (FKOs) will be generated at the district level. The district keys will be transferred by the CKGA to the district key managers. An elaborate training schedule has been worked out for the field key officers. On the occasion of district level workshop, the FKO cards would be issued to them, using the DKMA software developed by NIC.

Role of Intermediaries:

The Intermediaries between the insurance companies and the beneficiary have a very important role in carrying the scheme to such beneficiaries. These intermediaries could be in the form of TPA, NGOs, MFIs, Panchayat Raj Institutions or a combination of these depending upon the requirement in each region and the capacity and capability of the intermediaries. However, without such 'social aggregators' it would be virtually impossible to roll out the scheme.

The intermediaries can leverage existing network of beneficiaries and existing infrastructure in the administration of the product, thereby reducing the overall administrative cost. The intermediaries, specially the local NGOs, would know the people in the area and their language. This would help them prepare an effective communication plan for awareness generation which would result in a greater

participation of beneficiaries in the scheme and its better understanding. Such intermediaries can also provide advice to beneficiary households wishing to avail health facilities.

Monitoring and Evaluation

Monitoring of the progress under the scheme will take place at various levels (District, State and National) by respective Governments and Insurance Companies. The parameters for monitoring would relate to:

- (a) Cards issued
- (b) Visits to the hospitals
- (c) Admissions and deaths while admitted
- (d) Claims made by the hospitals and settlement thereof by the insurance companies
- (e) Payment of premium

A robust IT enabled back-end database management is being evolved to facilitate monitoring.

The scheme also entails evaluation and impact analyses. The World Bank has already engaged an external agency to carry out a bench mark survey which would be used subsequently for evaluating the scheme as well as for undertaking an impact analyses.

MARKETING OF THE SCHEME

The complex nature of the scheme, the commitment required in terms of time and finances and the preconceived notion about the social sector being an exclusive domain of the government threw up major challenges in terms of marketing of the scheme amongst the States. Similarly, on account of negative perception about government schemes and in view of upfront investments in procuring hardware, in developing software and putting in place the required manpower, there was initial reluctance on the part of insurance, smart card and health service providers in coming on board. Hence, the scheme had to be marketed through a well defined strategy amongst each of the stakeholders.

Personal visits by senior officials to the States, to market the scheme, organizing video conferences to provide on-the-spot clarifications and dispelling misapprehensions and prompt response to queries, lending a helping hand, both in terms of understanding the technology as well as in organizing sensitization workshops and standardization documents and templates went a long way in providing comfort to the States. They have gradually come to 'own' the scheme.

The scheme has been sold as a business model to the other stakeholders as there was an in-built business opportunity for them. A series of interactive sessions facilitated in conveying this message as also the fact that government meant business.

RSBY GETS GOING

The response of the State Governments and other stakeholders has been very encouraging. Till 30.4.2008, 15 State Governments had advertised to seek quotes from Insurance companies. Six proposals have already been approved and, out of these, smart cards have started rolling out in three of them. By the end of April, 2008, 25,000 cards have already been issued.



Some of the complex IT applications have been put into operation and are gradually stabilizing.

UNIQUE FEATURES OF THE SCHEME

1) IT tools for poorest of the poor:

In all 60 million cards will be issued under RSBY during the next five years. This will be the biggest ever exercise involving IT applications for BPL families in India or anywhere else in the world. So far, IT applications had been used primarily in the urban areas. The smart card is now traveling to rural areas on such a large scale.

2) Empowering Below Poverty Line families:

Unlike the previous Government sponsored schemes, where the beneficiaries did not have option to select the service delivery point, under RSBY, the beneficiary can choose the hospitals from a list of network hospitals, including private hospitals, for seeking treatment.

3) RSBY operates on a business model:

In view of the numbers and the fund involved, there are business opportunities for all the key players, like Insurance Companies, Hospitals, Smart Card Service Providers and the Intermediaries. On an average, around Rs.70 million will be pumped in each district. This would create the business opportunity as there would be incentive for private sector health providers to set up health related infrastructure. Similarly, on account of sheer volumes, smart card service providers will have the incentive to deliver the cards even in the rural areas. The insurance companies obviously can also make decent money on account of the proposed volumes.

4) Security of Cards:

A key management system has been evolved by National Informatics Centre to ensure that the smart cards are fully secure. There would be no scope of cards being duplicated or being misused. The smart card also envisages use of biometrics (finger print verification).

THE CHALLENGES AHEAD:

The front end of the scheme is quite simple but the back-end, specially in the context of Information Technology applications, is quite complex involving a number of players, both in the public and private sector domains. Vertical and horizontal coordination poses the biggest challenge even after the stabilization of a variety of softwares that are being used to roll out the scheme.

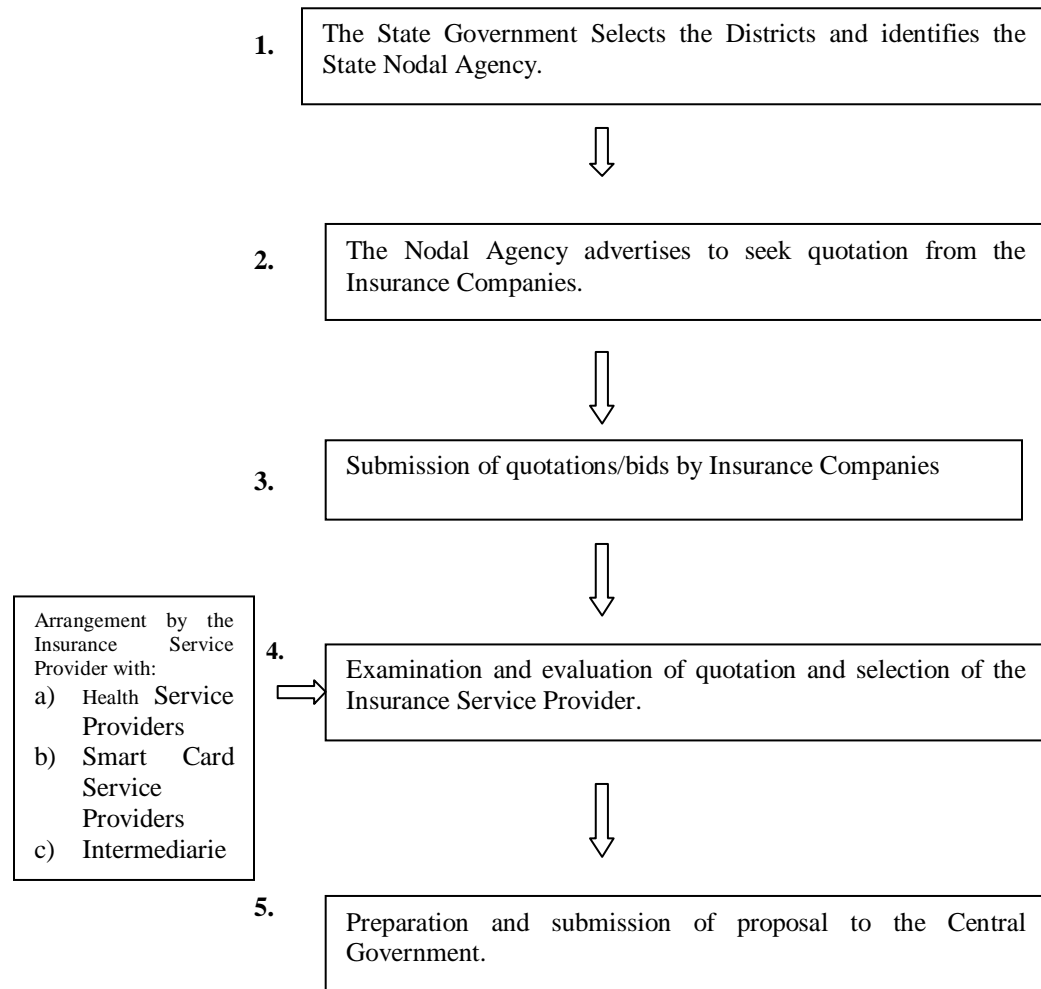
The back-end data base management throws up a different challenge in terms of developing the structure and putting in place the hardware. There are some issues yet to be resolved: Who will own and manage these structures? Who will own and manage this database?

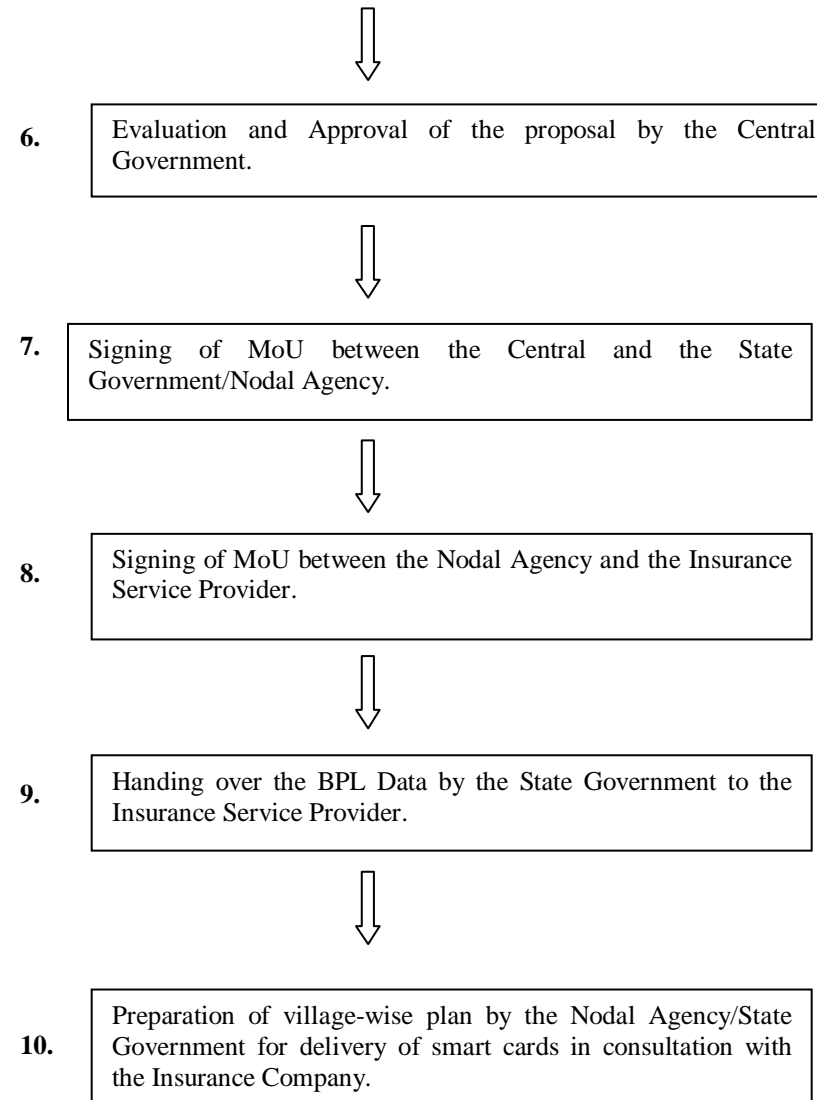
Reaching out to such huge numbers in far flung areas is a stupendous task. Evolving communication modules and delivering them on such a scale will test the capacity and capabilities of the Insurance Companies whose task is to sell this product.

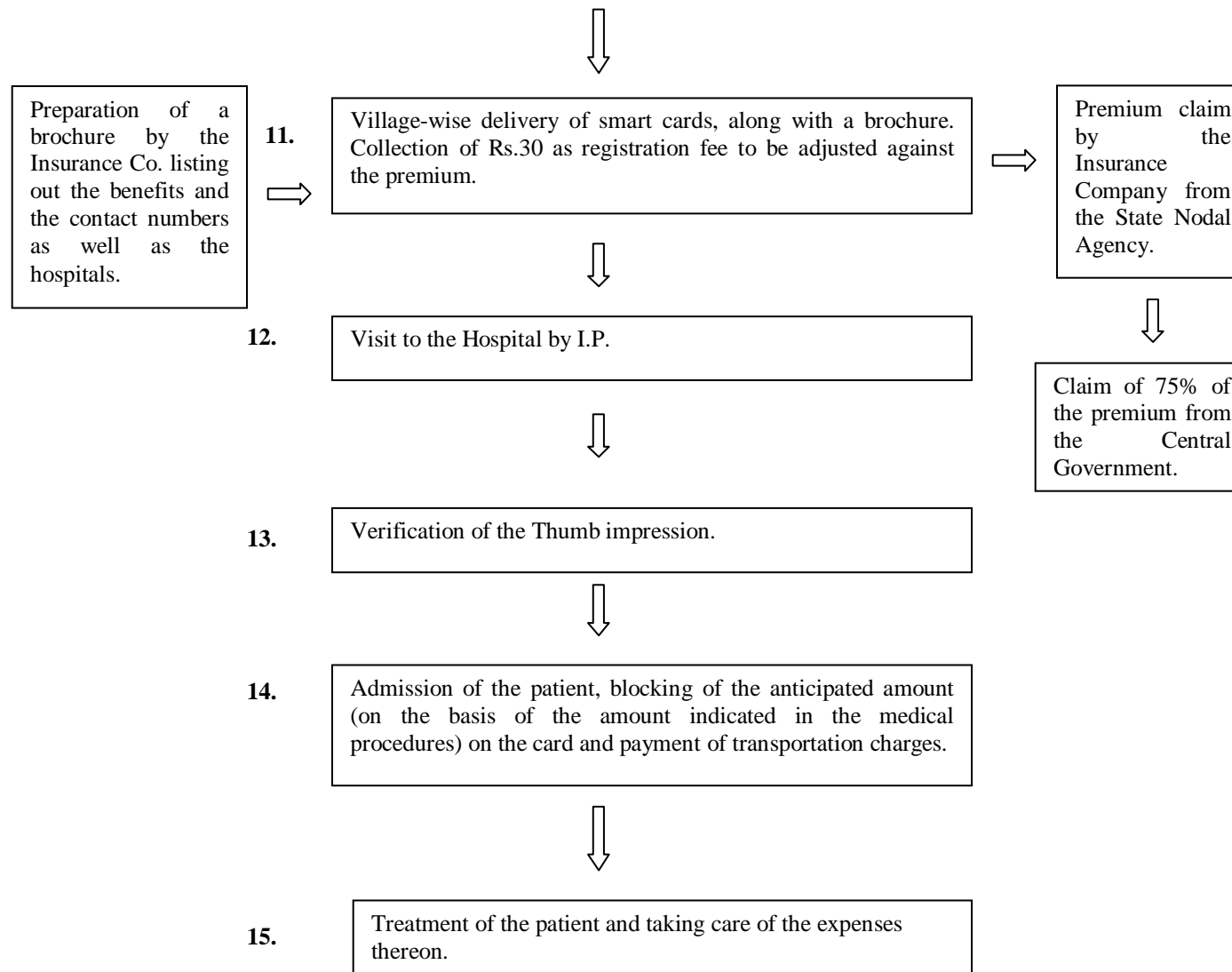
And finally, the challenge is not merely of quantity but also of quality of service by various service providers.

The journey has just begun..... there are huge challenges ahead.

PROCESS FLOW









16. Discharge of the patient and debiting of the final amount from the smart card



17. Lodging of claims by the Health Service Providers from the Insurance Company.



18. Settlement of claims.

