Rashtriya Swasthya Bima Yojana: Pioneering Public-Private Partnership in Health Insurance

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Abstract

With the introduction of Rashtriya Swasthya Bima Yojana (RSBY) from April 2008 India has pioneered a public private partnership model to provide health insurance to the poor. RSBY has several stakeholders – the central government, the state governments, the insurance companies, the public/private health care providers and the below poverty line (BPL) families – who will all benefit from the new scheme which is the first government social sector scheme to embrace a business model of profit. National health accounts data reveal that the government sector (centre, state and local) together accounted for only 20% of all health expenditures and 78% took the form of out-of-pocket payments – one of the highest percentages in the world. This new scheme is meant for the Indian workforce (about 300 million) working in the informal sector who do not have any kind of access to health protection benefits. The central and state governments will jointly bear the premium of providing quality health care to the poor in all districts of India through RSBY. In less than 3 years the RSBY has enrolled more than a third of India's BPL families – the target is to enroll 300 million poor by 2012-13 through this innovative scheme. This is an IT enabled scheme and will provide for healthy competition among public and private health care providers leading to real improvements in health infrastructure specially in rural areas. Despite severe initial challenges RSBY is today considered a successful public/private partnership model in terms of outreach and sustainability and may well become a precursor to other schemes in the social sector.

Introduction

India is one of the fastest growing economies in the world today which can reap ample benefits from a "demographic dividend" that demographers claim spurs economic growth. India is presently in the intermediate stage of demographic transition characterized by declining fertility and declining mortality, which has resulted in the largest population in the 15-25 age group (about 500 million) residing in India[1]. Since we have the largest share of working age population in the world we have to determine what kind of policies pertaining to employment, health and education should be put in place so that India can benefit by this one time demographic window of opportunity. The National Rural Health Mission launched in 2005 by the Government of India has also brought in focus the role of adequate healthcare in changing the quality of life, specially amongst the underprivileged and the unorganized sector.

Health care in India is financed through individual out-of-pocket payments, central and state government tax revenues, external aid, private sector profits and other sources. National health accounts data reveal that the government sector (central, state and local) together account for only 20% of total health expenditures, external aid via the voluntary sector account for 2% and 78% take the form of – out-of-pocket payments – one of the highest percentages of the world[2].

Despite a government owned free health care delivery chain, 64% of the poorest population in India are indebted every year to pay for the medical care they need. 85% of the Indian workforce working in the informal sector do not have any kind of insurance and lack access to effective social protection schemes[3]. The government realized that there are three main characteristics of their target audience (BPL families) that needed to be taken into consideration in this scheme: the

population is poor and therefore cannot pay cash first, is largely illiterate, therefore cannot fill out registration forms and largely migrant, therefore they would need transportable benefits. RSBY was launched in 2008 and is being implemented by all state governments targeting universal coverage of the entire BPL population in India (approx. 300 million) by 2012-13.

Rashtriya Swasthya Bima Yojana (RSBY) is India's first social security scheme that embraces a profit motive, and is a good example of public-private partnership in the social sector. The insurer (public or private) is paid premium for each household enrolled for RSBY. Therefore, the insurer has the motivation to enroll as many households as possible from the BPL list. A hospital has the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. Insurers in contrast, monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims. Moreover the scheme provides for the inclusion of intermediaries such as NGOs which have a greater stake in assisting in the search for BPL households since they are paid for their services. The government by paying a maximum sum upto Rs.750/- per family per year, allows access to quality health care to its BPL population fulfilling its commitment to one of the important Millennium Development goals.

In 26 months (by June 2010), RSBY had enrolled 60 million people in 22 states, in the next year this should move to 100 million[4]. This is the first time, India's IT technology prowess has been used to run a national social security programme. There is a five year plan for rolling out the RSBY which allows each participating state to contract 20 percent of their respective districts each year. By April 1, 2009 almost every state government had expressed its intention of joining the scheme. In the two and a half years since its operation some ground realities have emerged which

can create problems in the future e.g. Rs.30,000 is considered a paltry sum for major surgical interventions in the private health care sector. OPD medication which also can be expensive is excluded from RSBY. If BPL coverage becomes 100% premiums may go up which may need more financial commitments by state governments.

The strength of the scheme lies in the fact that it is a social welfare scheme with the profit made by the various stakeholders acting as a catalyst. Cases of corruption and fraud can be tracked by the stakeholders themselves. RSBY provides the participating BPL household with freedom of choice between public and private hospitals and makes him a potential client (with Rs.30,000/- on his card) worth attracting on account of the significant revenues that hospitals stand to earn through the scheme. If RSBY succeeds, this model of public private partnership in the social sector will become a precursor to other schemes. Today, in less than 3 years of operation, it is being considered as one of the most successful government funded social protection schemes in India in terms of outreach and sustainability.

Keywords **–** health insurance, social sector scheme, public private partnership, outreach and sustainability.

What is RSBY?

RSBY has been launched by the Ministry of Labour and Employment, Government of India to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage upto Rs.30,000/- for most of the diseases that require hospitalization. Government has even fixed the package rates for the hospitals for a large number of interventions. Preexisting conditions are covered from day one and there is no age limit. Coverage extends to five members of the family which includes the head of a household, spouse and upto three dependents. Beneficiaries need to pay only Rs.30/- as registration fee while the central and state governments pay the premium to the insurer selected by the state government on the basis of a competitive bidding.

The RSBY scheme is not the first attempt to provide health insurance to low income workers by the Government in India. The scheme, however differs from the earlier schemes in several important ways.

Who are the stakeholders?

The majority of the financing, about 75 percent is provided by the Government of India (GOI). In the North-eastern states and Jammu and Kashmir GOI's contribution is 90 percent. GOI also lays down the benefit package and detailed information on the electronic data format for BPL families. The central government standardized all implementation documents such as contracts between state governments and insurance companies. Software and hardware were standardized and the rates for surgical interventions were finalized by the central government.

State Governments

State governments provide 25% of the financing in all states except North Eastern states and Jammu and Kashmir where the financial commitment is only 10%. State governments engage in a competitive public bidding process and select a public or private insurance recognized by the Insurance Regulatory Development Authority (IRDA) or enabled by a Central Legislation. RSBY provides health insurance for the enrolled BPL families from each district upto a maximum number of households based on the definition and the figures provided for each state by the Union Planning Commission. State governments alone are responsible for the accuracy of their BPL lists. Each state must establish an independent body, the State Nodal Agency, to implement the scheme in that state through insurance companies. The Central Government provides the regulatory framework and bulk of the financial support.

Insurance Companies

An electronic list of eligible BPL households is provided to the insurer using a pre-specified data format. An enrolment schedule for each village alongwith dates is prepared by the insurance company with the help of district level officials. The smart card, along with an information pamphlet describing the scheme and the list of hospitals is provided on the spot once the beneficiary has paid the 30 rupee fee. This list of enrolled households is maintained centrally and is the basis for financial transfers from the Government of India to the state governments. Empanelment of hospitals is done as soon as the insurer gets the contract. The insurer shall empanel enough hospitals in the district (public or private) so that beneficiaries need not travel very far to get the health care services. Information relating to transactions is sent through a phone line to a district server. This allows the insurer to track claims, transfer funds to hospitals and investigate.

The Health Care Providers

These hospitals install necessary hardware and software so that smart card transactions can be processed. After rendering the service to the patient, the hospitals need to send an electronic report to the Insurer. The Insurer after going through the records information will make the payment to the hospital within a specified time period which has been agreed between the Insurer and the hospital. At present more than 3200 private hospitals and 1100 public hospitals across India are RSBY empanelled. RSBY has thus opened up a new market for private sector hospitals whose services were never afforded by BPL families.

The Beneficiaries

The transaction process begins when the member visits the participating hospital. After reaching the hospital, the beneficiary will visit the RSBY help desk where his identity will be verified by his photograph and fingerprints stored on his/her smart card. If a diagnosis leads to hospitalization the beneficiary can get his expenses covered upto Rs.30,000 yearly. Any hospital which is empanelled under RSBY by any insurance company will provide cashless treatment to the beneficiary anywhere in India choosing from 700 in-patient medical procedures. OPD facilities are not covered under this scheme, though OPD consultation is free. However it is important to remember that the RSBY scheme is in addition to facilities being provided at pre existing government hospitals in every state.

RSBY – Coverage so far

The response of the state governments and other stakeholders has been very encouraging. The scheme became operational from 1.4.08. So far, 26 out of 29 state governments have initiated steps to implement the scheme. Smart cards have started

rolling out in 22 of them. By 20.7.10 more than 17 million cards, providing health insurance cover to around 70 million persons have already been issued. Around 700,000 persons have already availed of free hospitalization facilities. Unlike the previous Government sponsored schemes, where the beneficiaries did not have the option to select the service delivery point, under RSBY, the beneficiary can choose any hospital (public or private) from a list of network hospitals for seeking treatment.

On an average Rs.50 million is being pumped in each district every year. This has created business opportunity as there would be incentives for private sector health providers to set up health related infrastructure. Similarly on account of sheer volume, smart card service providers will have the incentive to deliver the cards even in the rural areas. The insurance companies can make decent profits. Beneficiaries can now avail of nearly free quality health care from a choice of hospitals. RSBY is India's first social security scheme that embraces a profit motive, involving 20 insurance companies, private and public hospitals, state governments and the centre, each acting as a check on the other. This business model design is conducive both in terms of expansion and sustainability. By paying only a maximum sum upto Rs.750/- per family per year, the government is able to provide access to quality health care to the below poverty line population. It will also lead to a healthy competition between public and private providers which in turn will improve the functioning of the public health care providers.

A decision has been taken to extend the scheme to categories beyond BPL. Thus the benefits have now been extended to the building and other construction workers. The Finance Minister of India in his 2010 Budget speech has also announced extension of RSBY benefits to such MNREGA beneficiaries as have worked for 15 days or more during the previous year. The Railway Minister in the same year

announced similar benefits for railway coolies and vendors. The scheme has come in for appreciation from the World Bank, UNDP and other developing countries[5].

If all goes well, according to plan, 30 crore people or one third of India will be covered in five years (2008-13) through the RSBY scheme. In other words, health of both the financial and labour markets are positively co-related. In a country like India where 86% of the total labour force exists in the unorganized sector and contributes around 50% to the national GDP. (NCEUS Report 2008); health of the labour force becomes a vital area of investment for private and public sector stakeholders. This becomes even more imperative when just about 2% of the total population of India is covered by health insurance (Chandra Shekar Hemalatha 2009) and public spending is just 0.9% of the GDP.

It is estimated that around 4% of BPL population requires hospitalization every year and cost per episode (at 1995-96 prices) was estimated at Rs.2,100 (Ahuja, ICRIER 2004). Currently total expenditure on health in India is around 6% of the GDP. Government spending is less than 25% against the average spending of 30-40% in other developing countries. Indian health insurance industry stands at INR 5125 crores with only a small section (2%) being covered so far. The health insurance sector has the potential to become a Rs.25,000 crore industry by 2012 (Health insurance sector estimates 2010).

Challenges and problems of RSBY

Only about one third of the total number of Indian districts has seen the enrolment of the poor. About eight states (U.P., Maharashtra, Punjab, Haryana, Chhattisgarh, Gujarat, Bihar and Kerala) account for over 85% of all enrolled districts. The rest of the 20 Indian states and union territories have been slow in enrolment of BPL families in RSBY. Thus a large geographical area and about two

third of total districts are still outside RSBY coverage. In Kerala, one of the better performers, the variation in enrolment of BPL families is between 60% in Idukki and 100% in Kottayam, as well as 97% in Ernakulam. There is large inter district variation in states[6]. Overall, just about 50% of the poor in selected districts have been enrolled in RSBY. The exception is Kerala which reported 80% coverage with some districts enrolling almost the entire number of poor households.

The share of private sector hospitals is 95% in Kanpur, 87% in Amritsar, 90% in the Dangs and 100% in Karnal – all the high hospitalization districts[7]. In Kerala, which is the only state with about 45% of the empanelled hospitals in the public sector, the hospitalization rate does vary with the share of hospitals in the private sector. It is also time for the state governments to understand the way premiums are set. It might be the case that the states are complacent as the central government doles out the bulk of the premium amount. But the situation could rapidly change as more private players get into the scheme and hospitalization rates go up. A careful analysis of hospitalization and costs cannot be avoided if premiums have to be kept under control.

Before RSBY, no central-government-funded health sector scheme had been successful at reaching beneficiaries. A further complication was that no IT enabled government project had been taken up on this scale so far. Thus RSBY faced major challenges both before and during implementation:

Marketing of the scheme

- Since RSBY was not mandatory for state governments, the central government had first to convince state governments of the scheme. RSBY could succeed only if all state governments bought into the idea whole-heartedly.

Availability of hardware

- Since the smart cards are printed and issued locally, in the villages, the support hardware necessary for production in sufficient numbers had to be made available. When the scheme was first launched, there was a severe shortage of hardware such as smart card printers and fingerprint scanners.

Increasing enrolment and utilisation

- Initially, there were problems registering BPL people because of migration, death and inaccurate data, and because people were simply unaware of the scheme and its possibilities, utilisation rates were low.
- State governments and insurance companies worked together to improve awareness within the target group. Tools like health camps, engaging NGOs and awareness events in schools are used to increase awareness and bring beneficiaries to the hospitals.
- The availability of the hospitals in remote areas is another major challenge in increasing utilisation of the scheme. New demand demonstrates that RSBY fosters the establishment of additional hospitals even in these areas.

Capacity development of stakeholders

- To successfully implement a complex scheme like RSBY, capacity building is necessary at all levels. Building the managerial and conceptual capacities of the organisation and individuals involved has proved to be a major challenge.
- At the central government level, RSBY is still being operated by the Ministry of Labour and Employment. Successful models from around the world indicate that the Government of India needs to create an independent institutional structure at the national level to operate the scheme in future.

Conclusion

One of the most urgent and difficult problems in the developing world, more so in India is how to finance and provide health care for more than a billion persons, a third of them impoverished and belonging to the low income groups. This is brought out clearly in the World Development Report 2000/01. In most Asian countries health care is financed by out-of-pocket payments by individuals. These expenditures jeopardize an equitable health care 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 resulting in severe indebtedness. The common dilemma facing policy makers is with regard to the need for a government sponsored health insurance cover despite health services being provided 'free' in government hospitals. However, the fact is that the 'free' government health services are not meeting the needs of the community. Moreover 85% of the workforce in India are in the unorganized sector and still do not have the desired social security scheme. In most states, cards are issued on BPL lists made in 2002. According to National Sample Survey Organisation 2004, nearly 65% of India's poor get into debt and 1% fall below the poverty line each year because of illness. Even today (despite RSBY) only 6% of India's workers have got the benefits. Besides, ceiling of Rs.30,000 may prove too less for major surgeries in private hospitals. The medical college hospitals have to contend with delays in insurance payments. The government hospitals, including the medical college hospitals, used to have the services of additional doctors and paramedical staff appointed on contract by the National Rural Health Mission. With the Mission trying to streamline its funds utilisation the hospitals sometimes have been reported to meet the salary expenses from the RSBY funds.

Comprehensive compiling of data on BPL families as a population group has revealed to many state governments remediable deficiencies in their existing BPL data. A few states such as Kerala and Tripura have already revised their BPL data based on their experience with RSBY. This optimisation of BPL data will not only assist further RSBY implementation and operation but will also improve the targeting and outreach of many other social protection schemes. Within 2 plus years of operation, RSBY is considered one of the most successful government funded social protection schemes in India in a public-private partnership mode. It may be considered a precursor to other social protection schemes in the country in future.

Table 1

Selected Demographic and Health Statistics, India 2006

	India (2006)
Gross national income per capita (PPP international $)	2460
Population (in thousands) total	1,151,751
Per capita total expenditure on health (PPP int. $)	109
Private expenditure on health as percentage of total expenditure on health	80.4
Infant mortality rate (per 1,000 live births) both sexes	57
Life expectancy at birth (years) female	64
Life expectancy at birth (years) male	62
Maternal mortality ratio (per 100,000 live births)	450

Table 2

Policy features of RSBY

Eligibility : BPL Criteria

Beneficiary : Self + Spouse + 3 Dependents

Sum Insured : Rs.30,000/- (Family Floater)

Only Cashless benefit policy.

Coverage:

It's a hospitalization benefit policy which covers the hospitalization for any illness which requires minimum 24 hrs stay in hospital.

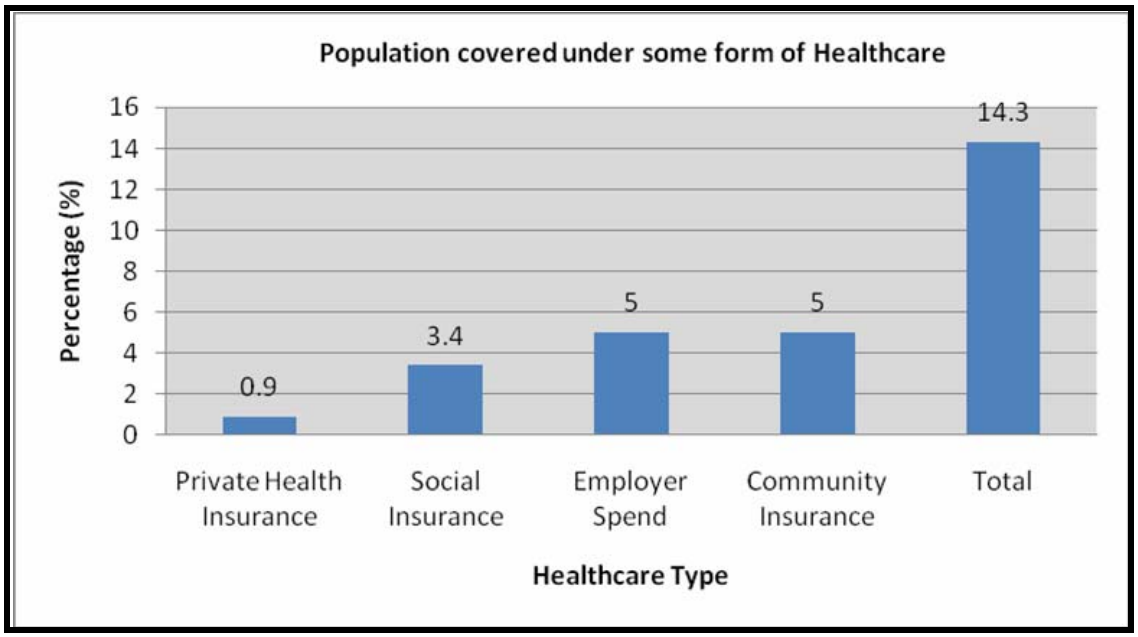
Additional Coverage:

- Pre-existing disease cover.
- Maternity cover – 4500/- with day 1 child cover
- Day care treatment covers for specified illness.
- Expenses of 1 day prior to the admission & 5 days post the date of discharge from hospital would be covered.
- Transportation Cost (per visit Rs.100 & overall limit of Rs.1000/-)

Source: www.rsby.in

Table 3

Health Insurance : Scope



Source: www.rsby.in

Table 4

Enrolment of the Poor in RSBY in the selected Districts

State	Total No. of Districts	No. of Districts Enrolment Complete	No. of Selected Districts*	BPL Households (Lakhs)	No. of Households Enrolled (Lakhs)	No. of Enrolled
Bihar	38	10	6	18.46	8.93	48.40
Gujarat	27	10	9	9.30	5.65	60.83
Haryana	21	20	20	11.47	6.91	60.26
Kerala	14	14	14	14.56	11.73	80.59
Maharashtra	35	27	11	15.07	5.90	39.12
Punjab	21	19	5	1.48	0.60	40.42
Uttar Pradesh	70	58	13	19.58	8.30	42.36

** Selected by the availability of data for at least 12 months.*
http://www.rsby.in/accessed 3-6 June 2010.
Source: EPW Article – July 17, 2010, Vol.XLV, no.29.

Table 5

Hospitalisation Coverage under the RSBY in the Selected States

State	Hospitalisation Rates Per 1,000 Persons during the Previous 365 days				Public Hospitals Empanelled (%)
	NSSO	Average-RSBY (District)	Maximum-RSBY (District)	Minimum-RSBY (District)	
Bihar	10	5.97	7.42 (Gaya)	4.96 (Saharsa)	16.87
Gujarat	29	24.78	196.41 (The Dangs)	9.07 (Kachchh)	25.39
Haryana	32	13.12	22.17 (Karnal)	1.69 (Rohtak)	4.59
Kerala	101	26.17	50.47 (Ernakulam)	6.29 (Wayanad)	45.86
Maharashtra	30	9.33	22.89 (Amravati)	0.57 (Thane)	0
Punjab	30	3.91	17.55 (Amritsar)	0.07 (Jalandhar)	23.19
Uttar Pradesh	13	12.30	64.00 (Kanpur Nagar)	0.77 (Gonda)	27.61

http://www.rsby.in/accessed 3-6 June 2010
Source: EPW Article – July 17, 2010, Vol.XLV, no.29.

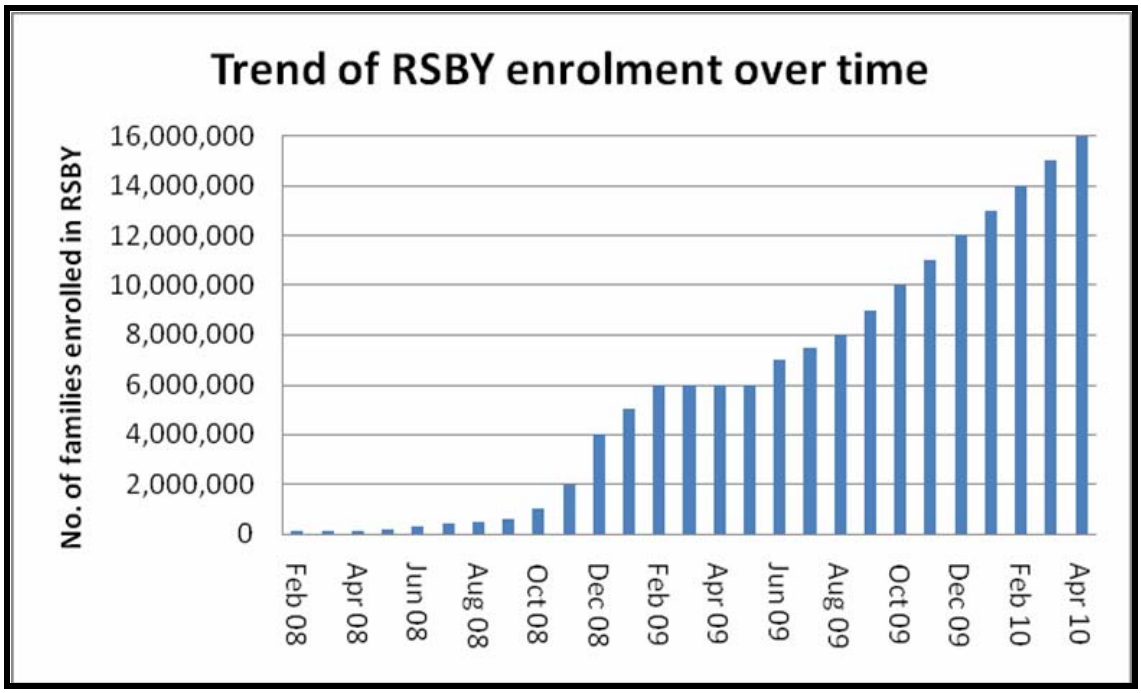
Table 6

Some Aspects of Value of Hospitalisation

State	Share of the Top Two Districts (in %)				Margin of the Insurance Company
	Average Value of Hospitalisation (Rs.)	Enrolled Households	Value of Hospitalisation	Empanelled Hospitals	
Bihar	3,856	46.26	49.97	40.96	72.74
Gujarat	3,433	34.69	44.70	39.63	21.10
Haryana	4,862	13.02	27.04	10.38	41.40
Kerala	3,101	19.78	24.20	23.45	16.48
Maharashtra	5,001	29.15	65.12	37.85	43.65
Punjab	6,606	36.67	89.86	50.00	71.70
Uttar Pradesh	5,089	7.24	34.46	43.55	26.95

Margin is computed as, premium paid minus value of hospitalisation divided by premium paid.
http://www.rsby.in/accessed 3-6 June 2010
Source: EPW Article – July 17, 2010, Vol.XLV, no.29.

Table 7



Source: http://www.rsby.in

References

1. World Health Organisation National Health Accounts, India, 2006.
2. Ministry of Health & Family Welfare, National Health Accounts, New Delhi: Government of India, 2006: pp.1-79.
3. National Sample Survey Organisation. Morbidity, Health care and condition of the aged. New Delhi: Government of India, 2006: pp.1-482.
4. Ministry of Health & Family Welfare, National Rural Health Mission: Mission document, New Delhi: Government of India, 2005: pp.1-17.
5. Devadassan N, Jain Nehal, An inventory of health insurance products in India, Bangalore: Institute of Public Health; 2008: pp.1-136.
6. For more information check website www.rsby.in
7. Narayana D, Review of the Rashtriya Swasthya Bima Yojana EPW, July 17, 2010, Vol.XLV, No.29.

Endnotes

1. Projection of the UN Population Division as quoted in The World Youth Report 2003.
2. Source: www.rsby.in
3. Source: Ministry of Health and Family Welfare, National Health Accounts, New Delhi, Government of India, 2006, pp.1-79.
4. Source: www.rsby.in
5. Another major visible RSBY impact is a reduction in out-of-pocket expenditures on health. A comparison of data from the NSSSO on this and RSBY surveys show that non-members spend six times more (Rs.3000) than holders of RSBY smart cards (Rs.500) for hospital visits.
6. New private hospitals are being set up in rural areas because of the business potential. Both private and public health care providers have improved infrastructure and the competition created by added RSBY holders demand also fosters improvements in quality.
7. See D. Narayana, Review of the Rashtriya Swasthya Bima Yojana, EPW, July 17, 2010 Vol.XLV, no.29.