

# RSBY: Extending social health protection to vulnerable population by using new technologies



International  
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## India

**By effectively integrating technology into the design of its scheme, RSBY has significantly extended health protection to vulnerable and informal workers and is becoming one of the main platforms to deliver social protection.**

When it was launched on 1 April 2008, RSBY had two main objectives: (1) to increase access for informal economy workers to quality health care and (2) to reduce out-of-pocket expenditures on hospitalization costs.

RSBY is now implemented in 28 states and union territories of India. As of April 2014, 37.2 million families are enrolled in the scheme and around 7.16 million hospitalization cases have benefitted from the scheme. Initially targeted at the Below Poverty Line (BPL) population, the programme now covers more categories of unorganized workers.

RSBY's information technology (IT) platform is now successfully used to administer other social security schemes. These standardization efforts could lead to greater efficiency and transparency of social security schemes in India.

National social protection floors (SPFs) guarantee access to essential health care and basic income security for children, persons of working-age, and older persons.

185 countries have adopted the Social Protection Floors Recommendation, 2012 (No. 202), an approach to achieve universal social protection.

This brief presents a successful country experience of expanding social protection.



### Main lessons learned

- Social health protection schemes should be user-friendly with beneficiaries at their centre. RSBY—a paperless, cashless, and portable scheme—is adapted to its beneficiaries who are primarily poor, often illiterate, and largely migrant.
- A comprehensive communication strategy with customized messages for target groups should be prepared at the start of any social health protection scheme. Being aware that poor families often have little or no knowledge about insurance, particular emphasis should be placed on making the beneficiaries aware of the scheme, its benefits, and their eligibility.
- A national social protection scheme can function smoothly only if there is a certain degree of standardization in terms of the tools and technology being used across the country. At the same time, the technology used should be adapted to the conditions on the ground.
- Advanced technology, such as the use of smart cards, can contribute to expanding coverage and give access to health-care services for populations that are illiterate and without identity documents.

**Social Protection in Action:**  
Building Social Protection Floors

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## **1. An affordable health insurance that provides financial protection to the poor, unorganized workers, and their families.**

Health care in India is financed through various sources, including individual out-of-pocket payments, central and state government tax revenues, private companies' initiatives, social contributions, and external aid. National Health Accounts data from 2004-05 show that combined expenditures of central, state, and local governments accounted for only about 20 per cent of total health expenditures in India while households accounted for nearly 60 per cent.

To reduce out-of-pocket expenditures and extend health coverage to the uncovered, the federal Government launched the Rashtriya Swasthya Bima Yojana (RSBY) on 1 April 2008 under the responsibility of the Central Ministry of Labour and Employment (MoLE). The objectives of RSBY are to reduce financial barriers to access hospital care and eliminate catastrophic health-care costs for the poor population, some categories of unorganized workers, and their families. In addition, the programme is tasked with improving the availability of health services and service delivery, as well as empowering beneficiaries by giving them a choice to select the empanelled hospitals where they wish to seek treatment.

RSBY is structured as a public-private partnership. It is led by the central Government, but implemented by authorities in India's states and union territories in cooperation with insurance companies, hospitals (public and private), and civil society organizations.

The scheme is financed from states' and the central Government's budgets and operated by insurance companies that are selected in each state through an open bidding process. The premium for the scheme is shared between the central Government and state governments at a ratio of 75:25, and 90:10 for north-eastern states. Additionally, the central Government bears the cost of the membership cards at a rate of 60 Indian rupees (INR) per card.

INR30 registration fees are collected at the state level and used to cover administrative costs. The overall cost incurred for issuing a card (including its production cost of about INR30, awareness activities carried out by the insurer for enrolment, the cost of the hardware to print the card, human resource training, among other costs)

varies between INR75-100 depending on the location where the membership card is issued.

RSBY had to answer to the constraints and characteristics of its beneficiary group. First, it was clear from the outset that since the targeted beneficiaries are poor, they could not be expected to pay cash up-front and receive reimbursement later. Therefore, the scheme had to be cashless. Second, the beneficiaries are largely illiterate and unable to read documentation. The scheme, therefore, needed to be paperless. Third, some of the target population are migratory in nature, making it necessary for beneficiaries to access benefits across many locations. Thus, the scheme needed to be portable across India.

## **2. An insurance scheme that is cashless, paperless, and portable**

RSBY aims to cover the entire BPL population—estimated to be approximately 70 million families comprising 350 million persons—and many categories of unorganized workers by 2017. The BPL families are identified through household surveys conducted by state administrations, while various government departments prepare lists of unorganized workers. Starting in 2011, eligibility for RSBY was extended to new categories of informal workers, including street vendors, domestic workers, rag-pickers, taxi and rickshaw drivers, and mine workers.

RSBY provides insurance coverage for selected hospitalization expenses and outpatient procedures up to INR30,000 (approximately US\$500) per annum for a family with a maximum of five members on a floater basis<sup>1</sup>. Transportation charges are covered up to a ceiling of INR1,000 per year with a limit of INR100 per hospitalization. In addition to the hospitalization itself, insurance coverage starts up to one day prior to hospitalization, covering tests and medication leading up to the hospitalization. The insurance also covers medicines and other assistance required by the patients up to five days after the date of discharge from the hospital. RSBY covers all pre-existing diseases from day one and does not have an age limit.

In order to be cashless, paperless, and portable, the scheme relies on the use of membership cards. Each family pays a fee of INR30 to join the scheme and provides the first and last names of the household head,

<sup>1</sup> Floater basis means that total amount can be used by one person or jointly with other members of the family.

spouse, and up to three other designated beneficiaries. All family members enrolling in the scheme must be present on the day of enrolment to be photographed and fingerprinted. Using a laptop, scanner, and card printer, the registration team generates an RSBY membership card on the spot. Insurance company representatives provide the families with information about their benefits and a list of empanelled hospitals where they can receive services. Beneficiaries under RSBY can seek treatment at any one of the 10,000 public or private empanelled hospitals. Upon admission, the hospital verifies the patient's identity by checking their fingerprint. If the fingerprint matches one of the prints stored on the card and sufficient funds from the INR30,000 annual allowance remain on the family card, the patient receives cashless treatment.

The development of this genuine identification system based on a membership card was necessary in a country that lacks a national civil database and identity papers covering the whole population. A government officer is always present at the enrolment station in order to verify the identities of potential beneficiaries and make sure they meet the eligibility criteria. After delivering services, the hospital uses the RSBY-specific transaction software, which records all information on card bearers, the care they received, and the costs involved, to send a paperless claim to the insurance company and a record to the state and central governments. After reviewing the claims, the insurance company settles them directly through online transactions with the hospital.

### **3. The scheme is successful in improving effective access to health care**

Access to health care among the RSBY beneficiary population has improved considerably in the past five years. According to an internal evaluation survey, hospitalization rates in RSBY districts have increased to three times those found in the National Sample Survey data for the poorest 40 per cent of the population (5.04 per cent versus 1.75 per cent). Additionally, 90 per cent of the beneficiaries who have received treatment under RSBY are satisfied with the treatment and services provided by the hospitals.

One of the objectives of RSBY was to minimize out-of-pocket payments. A survey carried out in the states of Jharkhand, Maharashtra, and Punjab shows that while 90 per cent of the RSBY enrolled patients did not spend

anything upon treatment, poor patients who were eligible but not enrolled in RSBY spent on average INR17,000 per year for hospitalization (Ghosh, 2012). However, another evaluation from Gujarat concluded that “nearly 60 per cent of insured patients had to spend about 10 per cent of their annual income on hospital expenses, despite being enrolled” (Narayanan et al., 2013). Access to health services is also limited by the annual ceiling of INR30,000 per family, which may prove too little for major surgeries. However, this ceiling may be raised to INR50,000 in the coming years.

Due to an unequal distribution of the health workforce and infrastructure in India, many people, especially in rural areas, lack access to health care. According to internal surveys, RSBY is creating demand for health services in rural areas, which has in turn created an incentive for private players to set up hospitals. It is of interest to further document the required conditions (notably in terms of regulation) for these private initiatives to result in increasing effective access to health care for vulnerable populations without increasing inequities.

### **4. What's next?**

RSBY is gradually demonstrating that it is not only able to effectively deliver health insurance to poor and vulnerable sections of society, but has also created an IT platform which can deliver other social security benefits.

Other ministries and departments have shown interest in delivering their own social security schemes through the RSBY platform. The Department of Financial Services has decided to use the RSBY platform to deliver a life and disability insurance called Aam Aadmi Bima Yojana. Similarly, the Ministry of Rural Development has decided to deliver the National Social Assistance Programme (which also targets BPL) through the RSBY platform.

Learning from RSBY will help the Government of India to develop an effective model to achieve its goal of universal health coverage. Areas which may require further attention include: (1) extending coverage to all informal economy workers, (2) revising the benefits package to reflect increasing costs of treatment, as well as out-patient and tertiary care services, (3) strengthening existing systems for identifying fraud and addressing grievances, and (4) improving the quality of health services provided under RSBY.

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