



# WIEGO Women in Informal Employment Globalizing and Organizing

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## Health Insurance in India: The Rashtriya Swasthya Bima Yojana Assessing Access for Informal Workers

**Kalpana Jain<sup>1</sup>**

**N**inety three percent of the workforce in India comprises informal workers, the majority of whom are poor. Informal women workers have special needs and poor health. Their work hours are long and income small. Their health deteriorates over time due to their working conditions which may involve long hours of needlework in poor light and ventilation, or the collection of hazardous waste. As informal workers, they do not get any work-related benefits or protection under labor laws. Family needs take priority and when it comes to allocating resources, the health of a male or a child takes precedence over their own (Shah 2008). As a result, women workers do not see a doctor even when they suffer from health problems, which often worsens their condition. Moreover, informal workers are often not able to access care if the health facility is too far, and if the queues are long, as they

risk losing income. Their lack of education and marginalization may prevent access to reliable information about available health care.

The National Commission for Enterprises in the Unorganized Sector (NCEUS) estimates about 836 million or 77 percent of the population, who constitute most of India's informal economy, are living below USD 0.4 a day (NCEUS, 2007). Yet, one of the big challenges of India's healthcare system is the financial burden it puts on households in terms of out-of-pocket spending. The share of out-of-pocket spending on private healthcare is very high in India compared to most other developing countries (Berman et al, 2010). About 39 million additional people fall into poverty each year as a result of this expenditure (Balarajan et al, 2011). Until recently, only 10 percent of Indians had some form of



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<sup>1</sup> Kalpana Jain was a health editor at the largest circulating daily newspaper in India: The Times of India where she reported on development issues and exposed many concerns in the public health sector through her articles. She is currently based at the Harvard Kennedy School, and is also a senior fellow at Brandeis University, USA. Email: findkjain@yahoo.co.in.

medical insurance and that too was highly inadequate (National Rural Health Mission Document 2005-2012).

In the past, central government schemes provided health insurance only to formal sector workers. Recognizing this gap, several state-based and central health insurance initiatives have been launched in recent years. The largest of these initiatives is the national health insurance scheme, the Rashtriya Swasthya Bima Yojana (RSBY) which was launched in April 2008 and is being implemented in 25 of India's 28 states and seven union territories. It is the first serious national effort at health insurance for informal workers and those living below poverty line (BPL).

The scheme is largely funded by the central government, with the centre financing 75 percent, and state governments putting in 25 percent. The scheme covers hospitalization charges up to about USD 634 (Rs 30,000) for up to five members of a family for a year. Beneficiaries are required to pay only about USD 0.63 (Rs. 30) as registration fee while the government pays up to USD 16 (Rs 750) per family per year. The scheme also provides transport allowance, up to USD 21 (Rs 1,000) per year. However, it does not cover outpatient care or the cost of medicines. The scheme works through a good IT system. Beneficiaries are issued a smart card that stores their name, age, photograph and thumb impression. This smart card needs to be presented to participating hospitals to avail treatment.

Health insurance schemes designed for informal workers need to take into consideration the various barriers to access. This case study, based on a desktop review, examines how the RSBY scheme has worked so far for informal workers, especially poorer women. The complete case study covers two



**Inclusion procedures can result in many families existing below the poverty line being excluded from the RSBY scheme's BPL lists.**

other state schemes. It compares them with the Vimo SEWA scheme, active in nine states, that was built by SEWA (the Self-Employed Women's Association), a labor union of over 1.1 million women workers in the informal economy.

In the three years since its launch, the RSBY has helped provide access to hospital-based care to a large number of poor, informal sector workers. By the middle of 2011, 23.5 million smart cards had been issued, and these covered 100 million people with health insurance (Swarup, 2011). An IT-enabled network of hospitals and insurance companies has ensured efficient and cashless delivery of healthcare. The scheme's design has been well considered and well applicable to the needs of the poor. For instance, the RSBY's coverage for a family of five matches with India's average family size of 5.3. Overall, RSBY has performed commendably in providing health insurance coverage to extremely poor people. At this stage, the focus has been on expanding coverage and rightly so. However, it is also a good stage now to assess where informal workers face barriers to accessing healthcare. This case study identified the following barriers:

*1. Inclusion procedures risk leaving out many BPL workers:* The criterion for inclusion in RSBY is based on a BPL list of people drawn up through the Planning Commission of India. BPL is an economic benchmark the Indian government uses to identify families in dire poverty. However, the BPL list has several problems and in many places BPL families have been left out. Some states do not have the list. States had to devise their own criteria for inclusion in the scheme. In some areas, people felt they were unjustly left out, while their neighbors with the same or higher socio-economic status were included. This led to social divisions and serious



tensions. In some cases, the name of the head of the household, required for issuing the smart card, was missing from the list. Such households were not allowed to register using another member as head of family. In families where the head of the household was ill or deceased, the members were unable to register. These rules make the scheme beyond the reach of the poorest workers, who need it most.

Moreover, the scheme requires families to register in their home states on the basis of the BPL list (Range, 2008). This means that migrant workers, who have been unable to return home for long periods of time and therefore are not registered, cannot avail of the scheme even during times of illness.

*2. High cost of out-of-pocket payments:* A big part of healthcare expenses in India are out-of-pocket payments. About 79 percent of impoverishment through health service use is a result of outpatient care, which involves several small but frequent payments, and only 21 percent is a result of inpatient care (Peters et al, 2010). The benefit package under RSBY is mainly focused on the provision of secondary care. It does not include outpatient visits or the cost of drugs.

In the absence of coverage for outpatient visits, people delay going to a doctor for as long as they can. Such delays could not only lead to longer hospitalization but also income loss for informal workers. The impact on women's health is more severe as they are the last to visit a doctor if they have to pay for the services.

*3. Fewer women avail services:* RSBY's data from 145 districts shows that far more men than women were issued the smart cards: of the nearly 27 million cards that were issued, only about a third, or nearly ten million, were women.



**It is difficult for informal workers to access good information on the RSBY scheme. A recent survey showed that 69 per cent of first time users learned of the scheme through word of mouth.**

*4. Information dissemination is inadequate:* Available literature shows that much of the information that people received was through word of mouth. The RSBY survey shows that 69 percent of RSBY patients first learnt of RSBY through a friend or family member and even learnt of about the hospitals that were empanelled through family members or friends.





**Despite the proven importance of good primary care to the lives and livelihoods of informal workers, the RSBY scheme concentrates on the provision of secondary and tertiary level healthcare and does not provide for primary care.**

Under the scheme, state governments are responsible for creating effective programs for spreading awareness. However, many states have handed over the function to insurance companies and there is a gap in terms of a clear and effective strategy of information dissemination. In Karnataka, the question of how to create awareness was left to the district administration.

*5. Lack of regulations and varied quality:* There are large variations in the quality of healthcare, and both the public and the private sector function without much accountability. The poor are more likely to suffer from this lack of oversight of the quality of care. The scheme is being implemented by the ministry of labor, with little involvement of the ministry of health that would or should have more expertise in quality issues. Some studies show the

number of empanelled high quality private sector hospitals is low and in some places patients had to seek services outside of network hospitals (RSBY evaluation Jaunpur, 2010, sourced from <http://www.rsby.gov.in/Documents.aspx?ID=14>).

As mentioned earlier, RSBY is in its early stages of implementation and has achieved remarkable success in a relatively short period of time. RSBY cannot be expected to fix the larger problems of the health system in the short term. However, this study has identified key areas where action could be initiated over the short term. Some of the lessons for RSBY can be drawn from the experiences of other schemes such as Vimo SEWA, Yeshasvini or Rajiv Aarogyasri.

*1. Process of issuing smart cards:* RSBY issues the smart card in the field itself, but the head of the household needs to be present. This has led to lower enrolments in areas where either the name of the head of the household was incorrect or he was not present, as he was at work. Informal workers would find it difficult to give up a day's wage to be available at a certain place. In many places, people were not given adequate information in advance, which again led to poor enrolment. This process could be streamlined. The government has already ensured smart card portability across states. It should also look at making the process of issuance of the card easier for informal and migrant workers. In Rajiv Aarogyasri's system, smart cards can be issued on the spot.

*2. Provide primary care coverage:* Benefits under RSBY are mainly focused on providing secondary care coverage. Primary care is not provided under the scheme. This case study found how the poor often do not seek treatment for minor illnesses if

they have to pay for it. Coverage of outpatient visits may require much larger investments by the government at this stage. However, RSBY could take some learning from Vimo SEWA in the way it integrates the scheme with a comprehensive health care package, providing preventive and curative services through its health centres. RSBY too could integrate the scheme with voluntary or not for profit health centres for primary health centres, in places where primary care is weak.

*3. Better information dissemination:* The RSBY could strengthen the process of information dissemination, which, in some places, has been left to insurance companies, who may have an interest in better enrolment, but not necessarily in more claims. In this initial phase of the scheme it needs a much stronger information dissemination system to reach the poorest people. In the case of Vimo SEWA, dedicated community health workers have been very effective. RSBY could also do so. This may also encourage a better participation of women and help reduce the gender gap.

*4. Set up mechanisms for quality monitoring:* Adequate quality monitoring mechanisms are yet to be set up by health insurance schemes in India. It is especially important to do so when the poor population are involved and the risks of medical malpractice may be high (Vimo SEWA for example found a high rate of hysterectomies being performed on very young women). RSBY could start this process by building in inspections and quality monitoring mechanisms.

*5. Coverage for cost of drugs:* There is no simple answer to the complex issue of providing for the cost of drugs, especially in countries such as India where all medicines can be purchased over the counter.

However, this is an important issue and does require some thought on how best insurance schemes can cover the cost of essential medicines, especially for the poorest population.



**Disseminating information on health schemes to informal workers is important if they are to benefit from these schemes. The RSBY scheme could learn important lessons on how to do this from the VimoSEWA team.**



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**WIEGO POLICY BRIEFS** offer information on policies and organizational practices that affect the informal economy. This series supports advocacy processes and disseminates better practices and ideas, contributing to a worker- and livelihood-centered approach to development.

**THE SOCIAL PROTECTION PROGRAMME OF WIEGO** aims to investigate and highlight the risks faced by the working poor in the informal economy, and particularly the risks faced by women workers. It aims to identify, document and promote innovative approaches to providing social protection to informal workers, and ultimately to promote a new approach to social protection that integrates informal workers into social insurance schemes as well as social assistance.

**ABOUT WIEGO:** Women in Informal Employment: Globalizing and Organizing is a global research-policy-action network that seeks to improve the status of the working poor, especially women, in the informal economy. WIEGO draws its membership from membership-based organizations of informal workers, researchers and statisticians working on the informal economy. For more information see [www.wiego.org](http://www.wiego.org).