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Review Article

PHARMACEUTICAL FINANCING FOR BELOW POVERTY LINE THROUGH MICRO HEALTH INSURANCE: "HEALTH FOR ALL"

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ABSTRACT

The health risks probably pose the greatest threat to lives and livelihoods of poor households (Jutting, 2004). A short-term health shock can contribute to long-term poverty and continuation of vicious circle of poverty. In this paper we tried to highlight key features of Rashtriya Swasthaya Bima Yojana (RSBY), an innovative Public Private Partnership (PPP) model for pharmaceutical financing, initiative of Government of India to eradicate the healthcare problems and poverty of population living below poverty line (BPL) in rural and urban India. The study show that scheme is not only providing free health care to poor households but also giving them chance to improve their standards of living by giving them access to quality healthcare through empanelled private players.

Keywords: Pharmaceutical financing, Health Care , Public Health, Micro Health Insurance, Public Policy, BPL, Poverty.

INTRODUCTION

Health security is increasingly being recognized as integral to any poverty eradication plan. Typically, a when a poor household experiences a health shock, their medical expenses rise and their contribution to household income and routine household expenditure declines (Wagstaff and Doorslaer, 2003; Gertler, Levine & Moretti, 2009; Gertler and Gruber, 2002). Approximately 150 million people around the world experience financial catastrophe i.e. they are obliged to spend on health care more than 40% of the income available to them after meeting their basic needs (WHO Factsheet N°320, 2007). This low (nil) income and high medical expenses can also lead to debt, sale of assets, and removal of children from school in poor families. Thus, a short-term health shock can contribute to long-term poverty (Van Damme et al, 2004; Annear et al, 2006). Due to scarcity and low income, these households generally forego high-value care and often opt for low quality health care (Das, Hammer and Leonard, 2008), which further leads to poor health outcomes and poverty.

Health insurance for poor people in the form of micro health insurance[1] has addressed some of these problems in various developing countries (Escobar and Panopolou 2003; Knaul and Frenk 2005; Obermann et al. 2006; Liu and Rao 2006; Wagstaff et al. 2007). By covering the cost of care after a health shock, health insurance cover does help to smooth consumption, reduce asset sales and new debt, increase the quantity and quality of care sought, and to improve health outcomes (Levine, 2008). Like several other developing (and industrialized) countries Government of India has started a new health insurance scheme naming Rashtriya Swasthaya Bima Yojana (RSBY) for the Below Poverty Line (BPL) families in the unorganized sector from April 1, 2008. The main objective of RSBY is to provide the insurance cover to below poverty line (BPL) households from major health shocks that involve hospitalization (www.rsby.in). In this paper we have tried to highlight the unique features, pharmaceutical financing mechanism & impact on healthcare utilization by BPL under RSBY scheme. The impact of RSBY Scheme on Healthcare Utilization has been studied with help of the secondary data available on the website of RSBY and other reports:

HEALTHCARE SYSTEM IN INDIA

The healthcare industry in India, comprising hospital and allied sectors, is projected to grow 23 per cent per annum with the estimated size of US$ 35 billion in year 2009 and is expected to touch a size of US$ 77 billion by 2012 (IBEF, 2010). India's expense on health care sector comprises 5.25% of the GDP and is the highest amongst developing countries (Economy Watch, 2010). The Health sector in India has

[1] **Micro Health Insurance** is a risk transfer device which refers to health insurance characterized by low premium and low caps or low coverage limits, sold as part of atypical risk-pooling and marketing arrangements, and designed to service low-income people and businesses not served by typical social or commercial insurance schemes.

registered a growth of 9.3% between 2000-2009, comparable to the growth rate of other emerging economies such as China, Brazil and Mexico (IBEF, 2010).

The government's share in the healthcare delivery market is 20 percent while 80 percent is with the private sector (Government of India, 2010).

After gaining independence in 1947, Government of India (GOI) envisaged a national health system in which the state would play a leading role in determining priorities and financing and would provide services to the population (Government of India, 2005). The health care system in India is characterized by multiple systems of medicine, mixed ownership patterns and different kinds of delivery structures which ranges from world class hospitals to a one room shacks. Public sector responsibility is divided between central and state governments, municipal and *Panchayat* local governments. Public sector health facilities include teaching, hospitals, secondary level hospitals, first-level referral hospitals {Community Health Centres (CHCs) or rural hospitals}, dispensaries; primary health centres (PHCs), sub-centres, and health posts. Other than above public health facilities also include selected occupational groups like organized work force Employee State Insurance (ESI), Defence, Central Government Employees Health Scheme (CGHS), Railways, Post and Telegraph and Mines among others (WHO, 2004). The Union Ministry of Health and Family Welfare (MoHFW) is responsible for the implementation of national programmes and sponsored schemes on healthcare as well as providing technical assistance. There are three major department works under MoHFW viz: Department of Health, Department of Family Welfare, and Department of Ayush. Department of Health that looks after health-related activities include various immunization campaigns, control over various health bodies including National Aids Control Organization (NACO), National Health Programme, Medical Education and Training, and international cooperation related to health issues. Department of Family Welfare takes care of maternal and child health services; information, education and communication rural health services; non-governmental organizations and technical operations, policy formulation, statistics, planning, autonomous bodies and subordinate offices, supply of contraceptives; international assistance for family welfare and urban health services, administration and finance for the health and family welfare department. The functional areas of Department of Ayush includes up-gradation of standards of education in the Indian systems of medicines and homoeopathy colleges in the country, strengthening of existing research institutions and ensuring a time-bound research programme for identified diseases for which these systems possess an effective treatment, drawing up schemes for promotion, cultivation and regeneration of medicinal plants used in these systems, evolve pharmacopoeia standards for Indian systems of medicine and homoeopathy drugs (www.mohfw.nic.in).

In year 2005, in government healthcare service, there were 22,271 primary healthcare centers and 137,271 sub-centers

in rural areas; 1,200 PSU (public sector units) hospitals, 4,400 district hospitals, and 2,935 community healthcare centers in smaller towns and cities; and 117 medical colleges and tertiary care hospitals. The private healthcare providers mainly include private practitioners, for profit hospitals and nursing homes, and charitable hospitals. These private healthcare providers are numerous and fragmented. In the absence of a national regulatory body, some private providers practice without minimum standards and the quality of treatment varies from one provider to another. The average size of private hospitals/nursing homes is 22 beds, which is low compared to other countries (International Trade Administration, 2009).

Government of India has launched 7 Year National Rural Health Mission (NRHM) (2005-12) in April 2005 aiming to improve the quality of life of rural citizens and carry out the necessary architectural correction in the basic health care delivery system. NRHM seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure, with a commitment to rise public spending on health from 0.9% of GDP to 2-3% of GDP. Table 1 shows the key developments in Indian Healthcare System under NRHM from 2005 to 2009 (http://www.mo hfw.nic.in/NRHM.htm).

Table 1: Contributions of NRHM to Indian Healthcare System (2005-2009)

Activity/Intervention	Gain from NRHM
Human Resources	7.49 lakhs Accredited Social Health Activists (ASHA) (community health workers) selected 7.05 lakhs ASHA trained up to 1st module and 5.65 Lakhs up to 4th Module; 5.20 lakhs ASHAs with drug kits in villages.
	8,624 MBBS Doctors , 2460 Specialist, 46,690 ANMs, 26,793 staff nurses, 7692 AYUSH Doctors , 3160 AYUSH paramedics added to the system under NRHM
Physical Infrastructure	9144 new health Sub Center buildings, 8997 up-gradation of Sub Centre buildings, 1009 new PHC buildings, 2081 up-gradation of PHC buildings, 435 new CHC buildings and 1255 up gradation of

Activity/Intervention	Gain from NRHM
	CHC building , 57 new District Hospitals and 387 up-gradations of District Hospitals have been taken up under NRHM.
Untied Grants for maintenance and local action.	All Health Sub Centers, PHCs, CHCs, Sub District and District Hospitals are provided untied grants to improve the facilities under the supervision of Panchayati Raj Institution and Rogi Kalyan Samitis at the facility levels. This has considerably improved the maintenance of facilities all over the country.
Pregnant Women Safety Scheme Janani Suraksha Yojana (JSY)	Considerable progress has been made in JSY. From 7.04 Lakhs women covered under JSY in 2005-06, the coverage in 2008-09 was 86.22 Lakhs, and 78.41 in 2009-10 so far, which is nearly one third of all deliveries in India every year
Mobile Medical Units	1031 MMUs under NRHM are working to provide diagnostic and outpatient care closer to hamlets and villages in remote areas
Emergency Medical transport and Ambulance systems	States have used NRHM funds to provide a variety of emergency transport systems and ambulances to improve timely attention hospital referral from households.
Doctors, Drugs and Diagnostics	NRHM has added doctors and paramedics on large scale leading to more care for patients. Availability of resources for drugs and diagnostics has improved with NRHM support to states.

(Source: Adapted from The Journey So far, NHRM, Ministry of Health and Family Welfare, March 2010)

No doubt that India's overall expenditure on health is comparable to most developing countries; but India's per capita healthcare expenditure is low due its large billion plus population and low per capita income. At the same time healthcare infrastructure in India is still dominated by government hospitals; merely 15% of population is covered through pre paid insurance scheme. medical claim schemes have less than 3.5 million members; only 3.4% population is covered through ESI Scheme; only 5% population is covered by employer schemes; and 5% population is covered through community insurance schemes (www.mediminds.com). According to an estimate of World Bank (2005), 42% of India falls below the international poverty line of $1.25 a day (PPP, in nominal terms INR 21.6 a day in urban areas and INR 14.3 in rural areas). This means that a third of the global poor now reside in India (The Hindu, 2008). This scenario was not likely to improve because of rising healthcare costs and India's growing population (estimated to increase from 1 billion to 1.2 billion by 2012). The Government of India has taken a landmark initiative to address these issues relating to poverty, access of public health systems especially for the vulnerable sections of the society by launching micro health insurance for naming RSBY for the BPL families in the unorganized sector.

RASHTRIYA SWASTHYA BIMA YOJANA (RSBY)[2]

RSBY has been launched by Ministry of Labour and Employment, Government of India to provide health insurance coverage to 60 million people living Below Poverty Line (BPL). The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. RSBY brings together the Centeral (Federal) Government, State government, public and private hospitals, as well as insurance companies. Beneficiaries under RSBY are entitled to hospitalization coverage up to approximately USD 667 (INR 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. Pre-existing 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 household, spouse and up to three dependents. Beneficiaries need to pay mere less one USD (INR 30) as registration fee while 75% of the premium is paid by Central Government and remaining premium is paid by respective State Government. The selection of the insurer (A public or private insurance company licensed to provide health insurance by the Insurance Regulatory Development Authority[3] (IRDA)) for a district or cluster districts is done by the respective State Government on the basis of a competitive bidding. The insurer is expected to cover the benefit package prescribed by Government

[2] The details of RSBY scheme given here is taken from official website of RSBY i.e. http://rsby.in/Index.aspx

[3] Established by Parliament of India to protect the interests of the policyholders, to regulate, promote, and ensure orderly growth of the insurance industry in India. For more details logon to www.irdaindia.org

of India through a cashless facility that in turn requires the use of smart cards which must be issued to all members. Insurance companies usually take help of qualified smart card provider in the form of sub-contract to offer this service. The insurer is required to engage intermediaries with local presence such as NGOs etc. in order to provide grassroots outreach and assist members in utilizing the services after enrolment. The insurer is also required to provide a list of empanelled hospitals (both public and private hospitals) that will participate in the cashless arrangement. These hospitals are expected to meet certain basic minimum requirements (e.g., size and registration) and must agree to set up a special RSBY desk with smart card reader and trained staff. The financial bid is essentially an annual premium per enrolled household. The insurer is compensated on the basis of the number of smart cards issued, i.e. households covered. Each contract is specified on the basis of an individual district in a state and the insurer agrees to set up an office in each district where it operates. While more than one insurer can operate in a particular state, only one insurer can operate in a single district at any given point in time.

The scheme has provided the participating BPL household with the freedom of choice between public and private hospitals. The scheme has been designed as a business model for a social sector scheme with incentives built for each stakeholder that make the scheme expand and sustain in long run. The insurer 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. This results in better coverage of targeted beneficiaries. A hospital has the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. Even public hospitals have the incentive to treat beneficiaries under RSBY as the money from the insurer is flowing directly to the concerned public hospital which they can use for their own purposes. Insurers, in contrast, monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims. The intermediaries such as NGOs and MFIs, which have a greater stake in assisting BPL households, get paid for the services they render in reaching out to the beneficiaries. Overall by paying only a maximum sum up to 17 USD[4] (INR 750) per family per year, the Government is able to provide access to quality health care to the BPL population with healthy competition between public and private providers.

The scheme has used IT applications for the, in the rural setting, for social sector on such a large scale. Every beneficiary family has been issued with a biometric enabled smart card containing their fingerprints and photographs. All the hospitals empanelled under RSBY are IT enabled and connected to the server at the district Level. This will ensure a smooth data flow regarding service utilization periodically. However, the OPD facilities are not covered under this scheme, but OPD consultation is free. Beyond consultation, if any expenditure is incurred in the OPD, which does not lead to

[4] The exchange rate assumed for purpose of the study is 1 USD = INR 45

hospitalization, it will be met by the beneficiaries. The scheme also includes transportation cost of approx. 2 USD (INR 100) per visit with an overall limit of approx 22 USD (INR 1,000) per annum. The scheme does not cover diseases that do not require hospitalization, like congenital external diseases, drug and alcohol induced illness,sterilization and fertility related procedures, vaccinations, war/nuclear invasion, suicide and naturopathy, *Unani, Siddha, and Ayurveda.* However, the aforementioned are only indicative in nature and it has been specified in the guidelines that there should be minimum exclusions and the list of exclusions would be negotiated between State and the Insurers and would be subject to assessment by the Approval and Monitoring Committee to ensure that it is not overly wide. So far out of 29 states (including State of Delhi) in India, 26 States have initiated the RSBY programme and 15,718,261 smart cards have been issued by May 31, 2010.

With a view to provide security to the beneficiaries in terms of the charges levied for a particular treatment and standardize the cost of each medical procedure, the listing of the medical procedures and the cost thereof have been set by GOI. However, the cost of each medical procedure is not mandatory for the State which can negotiate it separately with the insurance company who in turn would enter into a contract with the network hospitals accordingly. However, the States have been mandated to fix some cost. Therefore, there is no uniformity maintained throughout the country but the cost has been fixed in each State with consideration to the suggestions given by the Central Government. Information on the transactions that take place each day at each hospital is uploaded through a phone line to a database on a district server. A separate set of pre-formatted tables are generated for the insurer and for the government respectively. This allows the insurer to track claims, transfer funds to the hospitals and to investigate the case of suspicious claim patterns through on-site audits. Governments are able to monitor utilization of the program by members and to some extent, begin to measure the impact of the program. Periodic reports are made publicly available on the internet and through published reports.

Information Technology Application:

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

Unique Features of the Scheme

The Key unique feature of the scheme is as follows:

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) 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

3) 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).

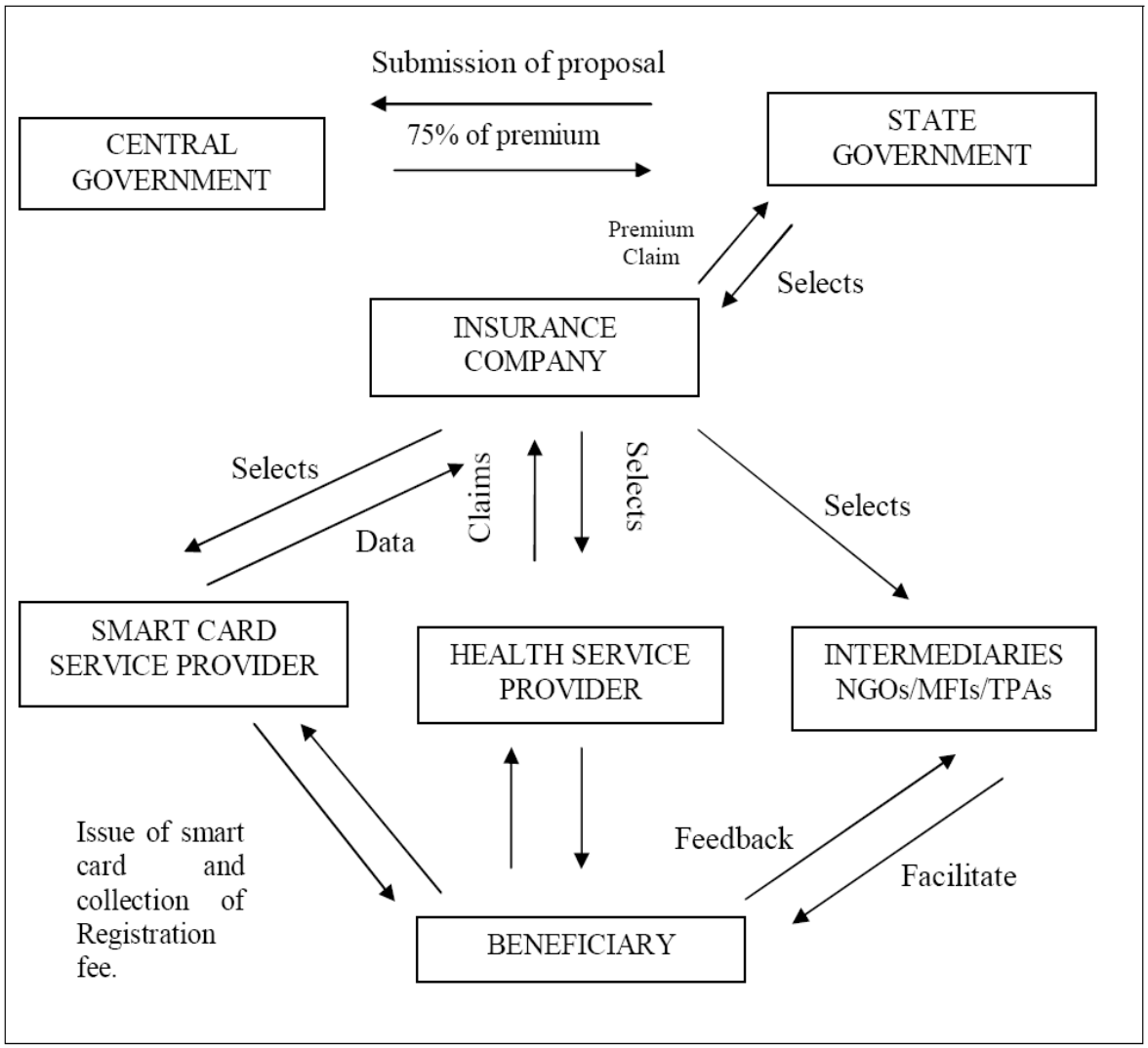

Figure1: A Public Private Partnership Model of RSBY, Adapted from Swarup, 2008

IMPACT OF RSBY ON HEALTHCARE UTILIZATION

Penetration of RSBY Scheme

Since initiation of RSBY Scheme so far, 26 States including 1 union territory (Arunachal Pradesh, Delhi, Rajasthan, Gujarat, Haryana, Bihar, Uttrakhand, Kerala, Punjab, Chhatisgarh, Karnataka, Maharashtra, Manipur, Sikkim, Tamilnadu, Uttar Pradesh, West Bengal, Jharkhand, Himachal Pradesh, Nagaland, Goa, Assam, Orissa, Tripura, Chandigarh and Meghalaya) have advertised about it. So far out of these 26 states, the enrollment process and empanelment of hospital has been started in 22 states. Out of total 631 districts in India, BPL families residing in 399 districts have been selected

for offering RSBY cover (Table 2). Enrollment process of the scheme has been completed in nearly 50% of selected districts. Here, it is important to note that states in which enrollment process has been completed, the total BPL families enrolled out of selected BPL population are about 57% only. This shows the penetration of the scheme is not very high as expected. This might be due to very low level of awareness and education (Chankova et al., 2008; Gine et al., 2007) among the masses about the benefits of the scheme or complicated procedural or lack of sincerity in implementation of the scheme. This requires to be further researched in future endeavors. No doubt just with in 2 years of initiation, out of nearly 52 million Indian BPL families, 29.49% BPL families has been covered with RSBY scheme but still there is long way to go.

Utilization of Health care Facility under RSBY Scheme

RSBY scheme has used public private partnership (PPP) model for empanelment of hospitals in the scheme. Hence both public and private health care providers have been empanelled under the scheme. So far more than 4000 hospitals (out of which 75% hospitals are private hospitals) have been empanelled and more than half million population has got treatment in these hospitals. The high level of participation of private hospitals shows the success and acceptance of scheme among private hospitals. The utilization of healthcare facilities under RSBY scheme is highest in the state of Kerela and lowest in case of state of Assam (Table 3). The empanelment of the number of hospital for BPL families in each state is widely unequally distributed. In the state of Assam, after every 21,177 BPL families enrolled, a hospital is available whereas in state of Punjab same is so after every 369 BPL families. Here, it can be opinioned that state of Assam and Punjab can not be compared due wide diversity in terms of geographical location, socio-cultural, economic development etc. But this is not so in state of Meghalaya which is located in near vicinity of Assam, which has similar environment, a hospital is available for every 1367 BPL families.

TABLE 2: PENETRATION OF RSBY SCHEME AMONG BELOW POVERTY LINE HOUSEHOLDS IN INDIA

S. No.	State/UT	Number of Districts				BPL Families				
		Total #	Selected*	Enrollment Complete*	Enrollment in Progress*	in All Districts^*	In Selected districts*	Enrolled *	%age of BPL families Covered in state	%age of Targeted BPL families covered
1	Andhra Pradesh	23	0	0	0	2864400	0	0	0.00%	-
2	Arunachal Pradesh	16	0	0	0	40700	0	0	0.00%	-
3	Assam	27	4	1	3	1050300	371346	127064	12.10%	34.22%
4	Bihar	37	37	10	9	5578450	5578450	2577171	46.20%	46.20%
5	Chhattisgarh	18	16	13	3	2220717	2220717	974701	43.89%	43.89%
6	Delhi	10	10	1	0	539471	539471	218055	40.42%	40.42%
7	Goa	2	2	2	0	6953	6953	3505	50.41%	50.41%
8	Gujrat	27	27	10	0	1130034	1130034	682354	60.38%	60.38%
9	Haryana	20	20	19	1	1146942	1146942	691197	60.26%	60.26%

S. No.	State/UT	Number of Districts				BPL Families				
		Total #	Selected*	Enrollment Complete*	Enrollment in Progress*	in All Districts^*	In Selected districts*	Enrolled *	%age of BPL families Covered in state	%age of Targeted BPL families covered
10	Himachal Pradesh	12	12	2	9	286924	286924	218202	76.05%	76.05%
11	Jammu and Kashmir	15	0	0	0	92100	0	0	0.00%	-
12	Jharkhand	24	8	5	3	2124000	1630491	553260	26.05%	33.93%
13	Karnataka	28	6	0	5	2787700	338931	78103	2.80%	23.04%
14	Kerala	14	14	14	0	1767205	1767205	1173388	66.40%	66.40%
15	Madhya Pradesh	50	0	0	0	4646800	0	0	0.00%	-
16	Maharashtra	35	29	27	2	6558000	3461175	1515561	23.11%	43.79%
17	Manipur	9	0	0	0	69600	0	0	0.00%	-
18	Meghalaya	7	5	1	0	83100	50997	27330	32.89%	53.59%

S. No.	State/UT	Number of Districts				BPL Families				
		Total #	Selected*	Enrollment Complete*	Enrollment in Progress*	in All Districts^*	In Selected districts*	Enrolled *	%age of BPL families Covered in state	%age of Targeted BPL families covered
19	Mizoram	8	0	0	0	23800	0	0	0.00%	-
20	Nagaland	11	4	3	0	66800	49970	39301	58.83%	78.65%
21	Orissa	30	12	2	4	3813500	704717	418929	10.99%	59.45%
22	Punjab	21	21	19	2	451935	451935	170191	37.66%	37.66%
23	Rajasthan	33	33	4	0	2295700	0	0	0.00%	-
24	Sikkim	4	0	0	0	24600	0	0	0.00%	-
25	Tamilnadu	31	31	2	0	454736	454736	149520	32.88%	32.88%
26	Tripura	4	4	1	3	303335	303335	211238	69.64%	69.64%
27	Uttar Pradesh	70	70	58	11	9717452	9717452	4651461	47.87%	47.87%
28	Uttarakhand	14	14	2	0	117940	117940	53940	45.74%	45.74%

S. No.	State/UT	Number of Districts				BPL Families				
		Total #	Selected*	Enrollment Complete*	Enrollment in Progress*	in All Districts^*	In Selected districts*	Enrolled *	%age of BPL families Covered in state	%age of Targeted BPL families covered
29	West Bengal	19	19	4	2	1913767	1913767	879002	45.93%	45.93%
30	Andaman and Nicobar (UT)	3	0	0	0	21200	0	0	0.00%	-
31	Chandigarh (UT)	1	1	1	0	8000	8000	5407	67.59%	67.59%
32	Dadra and Nagar Haveli (UT)	1	0	0	0	18800	0	0	0.00%	-
33	Daman and Diu (UT)	2	0	0	0	5300	0	0	0.00%	-
34	Lakshadweep (UT)	1	0	0	0	1900	0	0	0.00%	-
35	Puducherry (UT)	4	0	0	0	55700	0	0	0.00%	-
	India	**631**	**399**	**201**	**57**	**52287861**	**32251488**	**15418880**	**29.49%**	**47.81%**

Source: # www.districts.nic.in/dstats.aspx **,** ^ State-wise Estimated Number of Below Poverty Line (BPL) Households in India, (As on 01.10.2006), available at http://www.indiastat.com/economy/8/incidenceof poverty/221/stats.aspx, * RSBY website as on May 31, 2010, http://rsby.in/Overview.aspx.

Table 3:Utilization of Healthcare Facilities for RSBY Scheme

S. No.	State	No. of Empanelled Hospitals				No. of Hospitalization
		Private Hospitals	Public Hospitals	Total Hospitals	Enrolled BPL Families Per Hospital*	
1	Assam	1	5	6	21177	0
2	Bihar	204	14	218	11822	40,093
3	Chandigarh	8	3	11	492	17
4	Chhattisgarh	84	174	258	3778	4,952
5	Delhi	77	-	77	2832	14,268
6	Goa	2	-	2	1753	7
7	Gujarat	259	94	353	1933	81,615
8	Haryana	403	21	424	1630	51,703
9	Himachal Pradesh	23	122	145	1505	2,053
10	Jharkhand	86	32	118	4689	16,630
11	Karnataka	23	43	66	1183	4
12	Kerala	157	133	290	4046	157,887
13	Maharashtra	654	8	662	2289	36,504
14	Meghalaya	5	15	20	1367	31
15	Nagaland	5	-	5	7860	1,765

16	Orissa	47	17	64	6546	160
17	Punjab	316	145	461	369	3,649
18	Tamilnadu	32	-	32	4673	4,842
19	Tripura	-	15	15	14083	4,174
20	Uttar Pradesh	767	227	994	4680	112,418
21	Uttarakhand	20	37	57	946	1,117
22	West Bengal	106	-	106	8292	13,326
	India	**3279**	**1105**	**4384**	**3517**	**547,215**

Source: www.rsby.in as on May 31, 2010; * Enrolled BPL Families per Hospital = No. of BPL Families enrolled in a state/ No. of hospital empanelled.

IMPLICATION & CONCLUSION

No doubt, health insurance cover can not change the probability of an adverse event, but it can mitigate the financial consequences of a health shock especially incase of a poor household (Stone, 2002). Access to health care in form of micro health insurance is boon for the people living in chronic poverty, where a short-term health shock can contribute to never-ending vicious circle of poverty. The success of an effective micro health insurance scheme for poor is depends on its ability to reach to the target population and its utilization. RSBY model in India is not only facilitating the overall social-economic development of the poor households but also giving huge business opportunity to all key stakeholder i.e. insurance companies, hospitals, smart card service provides and others. Under RSBY scheme around Rs. 70 million/year is pumped in each district by state and central government in the form premium paid for health insurance (Swarup, 2008). Just with in two years of initiation, the realized outcomes of the RSBY scheme in terms of subscription rate, utilization of health services, and mitigation of economic burden for medical expenditure are beyond expectations. These outcomes are not only helping to improve health outcomes but also assisting to achieve goal 1 of MDGs by reducing health expenditure burden of poor. The model is able to achieve all this due to its uniqueness to make both public and private players participate, transparent system, and usage of information technology for the welfare of poor. Therefore, we can safely conclude that RSBY Model can be one of the much needed, innovative model of pharmaceutical financing mechanism which can also replicated in other developing nations as well.

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