



## THE SWASTHYA SATHI SCHEME AS A STATE WELFARE POLICY IN WEST BENGAL: A CRITICAL ANALYSIS

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### RESEARCH ARTICLE



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#### Abstract

This research meticulously analyses the Swasthya Sathi (SS) plan, West Bengal's foremost social health insurance program, contextualising it within the paradigm of Indian welfare policy and Universal Health Coverage (UHC). Founded in 2016, SS distinguishes itself by a unique universalist framework, offering comprehensive yearly health coverage of ₹5 lakh per family and operating on a totally state-funded, no-contribution approach. A key element is its commitment to localised woman empowerment via the issuance of the smart health card in the name of the eldest female family member. The initiative has achieved significant size, covered around 2.5 crore people and successfully reducing Catastrophic Health Expenditure (CHE) by 18% among participating households. Nevertheless, the effort faces considerable sustainability and implementation challenges. The extensive state funding mechanism exposes it to considerable financial risk, while persistent operational shortcomings undermine its cashless promise; empirical data reveals that 33.03% of beneficiaries still incur out-of-pocket (OOP) charges. Furthermore, pricing conflicts and alleged payment delays have cultivated adversarial relations with the private hospital network, leading to access barriers for beneficiaries. This analysis indicates that while Swasthya Sathi effectively demonstrates inclusive financial protection, its long-term viability requires immediate legislative reforms focused on sustainable finance, efficient provider management, and the elimination of residual out-of-pocket expenses.

**Keywords:** *Swasthya Sathi (SS), West Bengal, Universal Health Coverage (UHC), Social Health Insurance Scheme (SHIS), Catastrophic Health Expenditure (CHE), State Welfare Policy, Ayushman Bharat (PM-JAY), Financial Protection*

#### Introduction

The worldwide initiative for Universal Health Coverage (UHC) underscores the importance of organised health financing systems, particularly social health insurance/assurance schemes (SHIS), aimed at protecting individuals against financially debilitating medical costs. In India, Out-of-Pocket (OOP) expenditures are exceedingly high, making health problems a major contributor to poverty. Consequently, state action is crucial to alleviate financial risk and improve access to quality treatment. The implementation framework in India is marked by a fragmented federal structure, wherein local states frequently devise indigenous health plans that can complement or, in certain instances, supplant central initiatives. These state-sponsored initiatives demonstrate specific localised welfare concerns and political agendas related to health governance.

The Swasthya Sathi (SS) scheme was formally inaugurated by the Government of West Bengal in December 2016.<sup>1</sup> The program first focused on particular demographic categories, including low-income workers and volunteers involved in various state-administered initiatives, aiming to offer them collective health coverage. Three Over time, the scope of Social Security increased significantly, seeking universal health protection for all residents of the state not already encompassed by specialised governmental programs. Three The fundamental objective of SS is the progressive expansion of healthcare coverage towards Universal Health Coverage (UHC). Three The primary objective of the initiative is to diminish out-of-pocket healthcare costs, especially for financially onerous secondary and tertiary care, via a completely cashless and paperless delivery system.

#### Methodology

This paper does a critical evaluation of the Swasthya Sathi plan, analysing its policy framework, implementation effectiveness, and socioeconomic consequences as a significant state welfare initiative. The analysis combines an examination of the scheme's distinctive design principles, including universal eligibility and complete state funding, with actual data on financial protection,

usage patterns, and identified operational challenges. Moreover, the research examines the scheme's function within the overarching political economy of Indian health financing, including its interplay with the central government's health efforts.

### **Policy Framework**

Swasthya Sathi is distinguished for its exceptionally comprehensive design. The program provides extensive health coverage of up to ₹5 lakh per family yearly for secondary and tertiary care hospitalisation. Three A defining feature is its nearly universal eligibility, granting benefits to all permanent inhabitants of West Bengal, as long as they are not included in other existing state-sponsored programs. Four The design is unequivocally inclusive of family structure, imposing no limitations on the number of covered family members. The policy encompasses parents from both the recipient and the spouse, guaranteeing extensive protection for extended families. Three The policy encompasses all pre-existing diseases and disorders from the moment of enrolment, guaranteeing prompt access to critical treatment without any waiting period.

### **Financial Mechanism**

The financial framework of Swasthya Sathi is designed to guarantee no financial burden on the recipients at any point of the process. The initiative functions on a zero-contribution model, indicating that beneficiaries are not obligated to pay any premiums or fees for the issuing of the smart health card. The West Bengal State Government covers the full expense of the premium, encompassing the operational costs of the smart cards. This pledge solidifies the scheme's identification as a genuine welfare program designed to offer extensive financial protection up to the coverage limit.

The state government's decision to assume 100% of the financial burden is not simply an administrative action; it constitutes a significant political declaration ensuring optimal access and asserting complete political recognition for the welfare initiative. This structure concurrently subjects the program to a significant and distinct fiscal risk. The program currently encompasses nearly 90 million individuals across 25 million families, with the state expending approximately Rs 13,156 crore since its inception. This concentration of financial responsibility solely on the state budget renders the scheme particularly susceptible to variations in state revenue and overarching macroeconomic pressures. This financial structure is significantly affected by intergovernmental relations, especially budgetary conflicts with the central government, which may jeopardise the program's long-term sustainability and stability if revenue sources are undermined.

### **Gender Empowerment through Card Ownership**

A procedural aspect of Swasthya Sathi holds considerable societal significance: the compulsory issuing of the smart health card in the name of the eldest female family member, designating her as the head of the household for health assurance purposes. This procedural designation converts the smart card from a mere identity document into a concrete tool for localised gender empowerment.

The state legitimises the woman's authority over essential health decision-making inside the home by granting her control over access to the family's health resources, a significant financial asset valued at ₹5 lakh yearly. This approach aims to directly affect home power relations, potentially enabling female family members, who have historically encountered obstacles to accessing care, to utilise cashless facilities more easily. This emphasis on women's autonomy is a strategic initiative aimed at enhancing healthcare-seeking behaviour and equity outcomes inside the domestic sphere.

### **The Digital Framework and Implementation Efficiency**

- A. Architecture of the IT Platform and Smart Card System:** The Swasthya Sathi scheme's operational foundation is its sophisticated IT platform, which guarantees a paperless, cashless, and entirely transparent service delivery approach. The solution is entirely cloud-based, enabling online monitoring and rapid service delivery, therefore conserving time and resources. The smart card system is fundamental to this digital architecture. Every beneficiary family is issued a 64Kb biometric smart card that contains digitally encrypted data. This card functions as the exclusive credential for accessing services. The initiative mandates fingerprint verification from any enrolled family member to proactively combat fraud and prevent misuse when seeking treatment at an empanelled facility. The card is valid indefinitely and undergoes automatic renewal each year.
- B. Operational Objectives and Claims Processing Framework:** The initiative is underpinned by particular operational requirements designed to guarantee swift and reliable service provision. All medical procedures and treatments have mandatory pre-authorization. The stipulated Turnaround Time (TAT) for the entirely online pre-authorization procedure is set at 24 hours. To ensure financial efficiency, the reimbursement claims to empanelled hospitals are required to have a turnaround time of 30 days. Thirteen The policy stipulates that interest will be applied to payments that are delayed over the 30-day period. Thirteen Operational accountability is upheld by a 24/7 toll-free call centre, an online complaints tracking system, and a real-time alert mechanism intended to identify any fraudulent activities.
- C. Hospital Accreditation and Classification:** Swasthya Sathi employs an extensive, diverse network of healthcare providers, including both governmental and private institutions. As of early 2021, the program encompassed 2,082 operational hospitals, consisting of 508 public institutions and 1,574 private establishments. All accredited hospitals are subject to a transparent evaluation process. Hospitals receive grades (A, B, C, and R) based on scores derived from the physical assessment of their facilities and infrastructure. This grading system enables beneficiaries to make educated decisions about

their treatment options. The specifics of these amenities, along with the network roster, are available on the official website and a specialised mobile application.

**Welfare Impact: Financial Safeguarding, Utilisation, and Equity Results**

Since its establishment, Swasthya Sathi has exhibited a successful expansion in service provision and demographic outreach. The program encompasses around 25 million families. This significant degree of penetration has resulted in widespread utilisation, with the program officially reaching the milestone of over 10 million hospitalisations. Data indicate a consistent, incremental rise in annual hospitalisation rates since 2017. This trend indicates a transformation in health-seeking behaviour, reflecting a “enhanced attitude and conduct of economically disadvantaged patients to utilise hospital services on a cashless basis,” thereby dismantling financial obstacles to getting care.

**A. Empirical Evidence Regarding the Mitigation of Catastrophic Health Expenditure (CHE):** The principal aim of the initiative is to offer financial safeguarding against medical emergencies. Scholarly research validates the program’s efficacy in this domain. Research assessing the impact of Swasthya Sathi from 2016 to 2021 revealed that the program significantly decreased Catastrophic Health Expenditure (CHE) by 18% among participating households. Fifteen This research confirms the scheme’s effectiveness in preventing financial disaster for beneficiaries. The study indicates that the inclusive aspect of Swasthya Sathi—encompassing both the middle class and families below the poverty line—reduces the likelihood of exclusion errors typically linked to narrowly focused programs, hence augmenting the overall protective impact.

**B. Disaggregated Analysis: Dependence on Public versus Private Sector:** An examination of claims data uncovers significant trends concerning resource distribution and beneficiary inclinations. Despite government hospitals serving a substantial percentage of patients (35.28% of beneficiaries), they represent merely 13.80% of the total claim amount distributed.

The inverse of this conclusion is that the private sector obtains the predominant majority (86.2%) of the asserted monies. This pattern suggests that recipients predominantly use SS coverage to obtain specialised, high-cost secondary and tertiary treatment in private institutions. The inclination towards private sector engagement for high-value claims indicates a structural imperative: either the public health system is deficient in specialised capacity, necessitating the transfer of high-risk cases (such as intricate cardiac or cancer treatments) to the private sector, or beneficiaries regard private care as superior in quality or more accessible. The state’s financial risk concerning private providers is greatly increased by this utilisation bias, rendering the scheme’s fiscal stability strongly dependent on the operational efficacy and cost control inside the private network. The extensive use of private hospitals for critical care treatments, including heart surgery, has compelled the state to enhance public infrastructure, as demonstrated by the rise in catheterisation laboratories throughout the state.

**C. Implications for Expensive and Prolonged Treatment:** Swasthya Sathi has demonstrated its significance in the management of chronic and expensive diseases. Cancer treatment is the most requested procedure under the scheme, accounting for a significant portion of the annual budget, estimated at around Rs 500 crore. The program’s coverage has directly enhanced treatment completion rates for severe illnesses. A research on breast cancer patients revealed that 92% of participants successfully finished their treatment under Swasthya Sathi, indicating that the financial support offered by the system mitigates dropout from prolonged and costly medical regimens.

**Table 1: Swasthya Sathi: Principal Performance Metrics and Financial Implications**

Metric	Figure/Finding	Significance
Families Covered	Approx. 2.5 Crore	High population penetration.
Total Hospitalizations	Over 1 Crore (as of Oct 2022)	Demonstrated high utilization.
CHE Reduction	18% (2016–2021)	Confirmed success in financial protection against major health shocks.
Total State Expenditure	Rs 13,156 Crore (since inception)	Indicates significant fiscal commitment.
Claim Share: Government Hospitals	13.80% of total claim amount	Highlights reliance on the private sector for higher-value claims.

**Comparative Political Economy: The SS vs. PM-JAY**

**A. The Ideological Divide: Universalism vs. Targeting:** The existence of Swasthya Sathi is intricately connected to the complicated, competing dynamics between state and central governments on health welfare policies. West Bengal significantly opted out of the central government’s premier initiative, Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY). The state government justified this choice by claiming that SS is superior and inherently more inclusive. The critique directed against PM-JAY focusses on its targeted methodology grounded in Socio-Economic Caste Census (SECC) criteria, which frequently results in the exclusion of recipients due to asset possession. In contrast, the universal strategy of Swasthya Sathi is advocated as equitable, guaranteeing coverage for both deserving middle-class individuals and BPL families, thus reducing the likelihood of exclusion errors.

**B. Political Justification for Government-Implemented Health Assurance:** The choice to finance Swasthya Sathi solely with state funds, bypassing the conventional 60:40 central-state sharing model, provides the West Bengal government with

total administrative and financial authority over the initiative. This financial autonomy enables the state to assert unequivocal political recognition for the substantial welfare accomplishment. By implementing a universal coverage strategy, the state government effectively reduces the political risk linked to exclusion errors present in targeted programs such as PM-JAY. A universal program optimises the political benefits of social spending by diminishing the probability of public discontent arising from perceived unjust exclusion. The intergovernmental discord about health policy is exacerbated by persistent economic disagreements, as the state government has explicitly expressed apprehensions about withholding federal cash, including GST compensation, so deepening the political divide over welfare services.

- C. Comparative Analysis of Financing, Coverage, and Provision:** A direct comparison of Swasthya Sathi and PM-JAY reveals significant structural differences that contribute to the political friction. Swasthya Sathi encompasses a broader demographic, covering over 1.5 crore people, whereas the PM-JAY’s targeted list includes 1.12 crore families in the state, many of whom are already beneficiaries of the state system. Financially, SS is entirely state-funded, whereas PM-JAY functions on a cost-sharing model (generally 60% Centre, 40% State). Furthermore, the SS smart card is provided at no expense, in contrast to PM-JAY, where beneficiaries may face a little fee (e.g., Rs 30 per individual) for identity document reproductions. The program incorporates a robust gender equity element by requiring the smart card to be issued to the female head of the household, a provision not included in PM-JAY.

**Table 2: Swasthya Sathi vs. Ayushman Bharat (PM-JAY): A Comparative Policy Analysis**

Aspect	Swasthya Sathi (West Bengal)	Ayushman Bharat (PM-JAY)	Significance for Welfare
<b>Funding Ratio</b>	100% State Government	60% Centre, 40% State (in most states)	Determines state fiscal autonomy and burden.
<b>Eligibility/Approach</b>	Universal (All residents not covered by other state schemes)	Targeted (Based on SECC data/deprivation criteria)	Extent of inclusion/exclusion error reduction.
<b>Gender Empowerment</b>	Card issued in the name of the woman head of family	No specific, parallel arrangement noted	Policy integration of gender equity and control.
<b>Delivery Mechanism</b>	64Kb Smart Card (Paperless)	Often relies on printed identity details/card	Speed and efficiency of service initiation.

**Critical Assessment**

Despite its notable success in expanding coverage and reducing CHE, Swasthya Sathi faces critical implementation gaps that threaten its long-term integrity and efficacy.

- A. The Continuation of Out-of-Pocket (OOP) Expenditure:** A notable structural inconsistency in the scheme’s execution is the continued occurrence of OOP expenditure, which contravenes the essential cashless directive. Empirical research reveal that 33.03% of beneficiaries reported incurring supplementary out-of-pocket expenses during their hospital stay for necessities such as needed medications, equipment, or diagnostic testing. The ongoing leakage indicates two main causal factors: either the negotiated package rates paid to hospitals by the scheme are insufficient or incomplete, compelling providers to unlawfully solicit additional payments from patients; or, the package rates do not encompass all essential consumables, transferring the financial burden onto the beneficiary. This leakage compromises the fundamental assurance of financial safety offered by the scheme.
- B. Provider Relations Crisis: Disputes Over Rates and Delays in Payments:** The connection between the state government and the private hospital network is often contentious. Private providers frequently assert extensive delays in claim reimbursements, with some claiming that the state owes them arrears ranging from Rs 150 to 200 crore. Consequently, hospitals frequently devise methods to deny or limit admission for SS patients. These strategies encompass establishing extensive waiting lists for scheduled admissions, denying emergency cases under the SS quota, or using other justifications for rejection.
- The contention revolves around the sufficiency of rates. The government claims that its established rate charts are essential to deter private hospitals from presenting “exaggerated invoices”. In contrast, private hospitals contend that the government’s established costs for procedures are financially unsustainable, prompting them to limit the number of beds designated for SS patients. The continuous failure or reluctance of premium private institutions to fully collaborate undermines the scheme’s commitment to providing universally high-quality tertiary care. The friction may transfer the entire specialised healthcare burden on public hospitals, which could already be overwhelmed, thus leading to inferior quality or significantly delayed outcomes for SS beneficiaries in comparison to privately paying patients.
- C. Quality of Care and Administrative Deficiencies:** Operational oversight indicates persistent administrative deficiencies. Notwithstanding the official policy directive of a 24-hour Turnaround Time (TAT) for pre-authorization, delays in pre-authorization approval were documented by 8.26% of beneficiaries, rendering it the predominant factor

contributing to time delays in the hospitalisation process. The disparity between policy formulation and actual implementation reveals operational impediments, frequently at the hospital or Third Party Administrator (TPA) level. Moreover, deficiencies in informational transparency exacerbate patient susceptibility. A mere 24.77% of beneficiaries indicated that they received sufficient guidance from the hospital's registration desk throughout the treatment process. This knowledge asymmetry renders patients significantly reliant on medical personnel, heightening the risk of financial abuse or administrative disarray.

- D. Systemic Vulnerabilities:** The vast financial magnitude of the initiative requires rigorous supervision to prevent fraud. Audits have shown recurrent occurrences of systemic corruption, encompassing the filing of fraudulent claims and exaggerated invoices by empanelled suppliers. Furthermore, misuse is not limited to the private sector. Authorities have indicated instances of government physicians participating in illicit private practice and purportedly exploiting the SS program, indicating a necessity for comprehensive regulation and enforcement measures within the public health framework. The IT framework depends on online triggers and alerts to identify potential fraud; nonetheless, these mechanisms require ongoing investigation and enforcement to protect financial integrity.

### Conclusion and Policy Recommendations

The Swasthya Sathi scheme in West Bengal is a largely successful health assurance model that has achieved near-universal coverage, empowered women as cardholders, and reduced Catastrophic Health Expenditure (CHE) by 18% for enrolled households. However, it faces challenges related to financial governance and provider management, particularly concerning state funding's long-term sustainability, OOP expenditure leakage of 33.03%, and adversarial relationships with private providers due to rate disputes and payment delays.

Recommendations for improving the scheme include establishing a dynamic rate revision mechanism involving evidence-based negotiations with private providers to make rates viable, and enforcing strict adherence to the 30-day turnaround time (TAT) for claims reimbursement to restore trust and participation from healthcare providers. Additional strategies focus on enhancing beneficiary protection and operational efficiency, such as mandating comprehensive coverage of treatment packages that include pre-hospitalization diagnostics and post-discharge medications, and instituting real-time audits to address delays in pre-authorization, which affect 8.26% of beneficiaries. The implications for sub-national health policy in India suggest that while Swasthya Sathi's success offers lessons for universal health insurance models, its challenges emphasize the need for regulatory capacity and sustainable fiscal management to ensure quality care and access are effectively delivered.

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