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NAVIGATING HEALTH FINANCING AND INSURANCE OPTIONS FOR URBAN POOR IN INDIA

August 2017
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It was prepared by Ramesh Bhat for the Health Finance and Governance Project

The Health Finance and Governance Project

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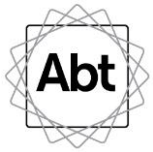
Photo: Men at work in the streets of Kolkata, India.



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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.

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ACRONYMS

BPL	Below-Poverty-Line
CAGR	Compound Annual Growth Rate
CBHI	Community-Based Health Insurance
CGHS	Central Government Health Scheme
CHF	Community Health Fund
EPP	Empanelled Private Provider
ESIC	Employees' State Insurance Corporation
ESIS	Employees' State Insurance Scheme
FGP	Family Group Practices
FHF	Family Health Fund
GDP	Gross Domestic Product
GSHI	Government-supported Health Insurance
HIO	Health Insurance Organization
HSRP	Health Sector Reform Program
IRDA	Insurance Regulatory and Development Authority
MOH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MOHP	Minister of Health and Population
NCD	Non-Communicable Diseases
NCMS	New Rural Cooperative Medical Scheme
NGO	Non-Governmental Organization
NHI	National Health Insurance
NHM	National Health Mission
NHP	National Health Policy
NLEM	National List of Essential Medicines
NPPA	National Pharmaceutical Pricing Authority
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
NUHM	National Urban Health Mission
OOP	Out-of-Pocket

PPP	Public-Private Partnership
PPS	Prepayment Schemes
PVHI	Private Voluntary Health Insurance
RSBY	Rashtriya Swasthya Bima Yojana
SECC	Socio-Economic and Caste Census
UT	Union Territory
WHO	World Health Organization

One lakh = 100,000

One crore = 10,000,000 = 10 million

Currency conversion used: US$1 = Rs 65

EXECUTIVE SUMMARY

India has one of the world's highest rates of out-of-pocket (OOP) spending on health. OOP spending in India accounts for 67.1 percent of total health spending, whereas the global average is 29 percent. In contrast to this high level of private financing of health, India's public spending on health of 1.15 percent of its gross domestic product (GDP) is much lower than the global average of 5.4 percent and one of the lowest in the world. Data from the recent National Sample Survey Office (NSSO) household expenditure survey (round 71) and National Health Accounts support concern about the ongoing high OOP spending, the bulk of which (63.5 percent) is on outpatient services. The growing incidence of non-communicable diseases (NCDs) and introduction of new medical technologies may exacerbate the OOP spending problem.

India's urban population has grown over the years. The latest census estimates an urban population of 430 million, 33 percent of the total population. It also estimates that about 27 percent of the urban population is poor, surviving on a daily consumption expenditure of Rs 47 or less. Census projections show that by 2030, another 250 million people will come to the cities. More than 60 percent of GDP is being generated from Indian towns and cities, making urban health and health care a significant issue.

The high OOP spending on health puts a financial burden on poor and vulnerable families by presenting a barrier to utilization (first-time and continuity of treatment and care); it can affect the health-seeking behavior of those who cannot afford to pay. Those poor families who do seek care may have to forgo spending on other basic necessities such as food, clothing, housing, and education; in many cases, the family is pushed into poverty. With India's urban population growing, urban OOP spending also is growing, at much faster rate than rural OOP spending.

To mitigate the burden of OOP spending on health, health financing policies in India over the years have created a series of independent risk pools led by initiatives from central and state governments, employers, communities, and voluntary contributions from individuals. It is estimated that all these schemes put together cover about 42 percent of the population, leaving 58 percent without any financial cover for health risks. However, utilization under each scheme varies considerably due to targeting, product design, and coverage issues. Also, these multiple initiatives - and risk pools - mean that the insurance landscape of India is extremely fragmented, and this has a number of efficiency and equity implications.

Recently, the government has proposed policies to strengthen the public health system and strategic purchasing so as to offer a low-cost package of services. For example, the National Health Policy (NHP) 2017 envisages increasing public health spending to 2.25 percent of GDP by 2025. This would require governments (at central and state levels) to budget higher allocations to health. The recent financial devolution to states is likely to shift more financing to the states, but more allocations to health depends on their making health spending a priority. On the supply side, the NHP has proposed to expand public provision of services, subsidizing low-cost interventions and strategic purchasing.

Given the current system of reliance on OOP spending on health and its effect on the urban poor and the inefficiency of highly fragmented risk pools, India needs a comprehensive health financing response, especially one to cover the urban population. Key strategies toward this may be:

- Expanding existing government health insurance schemes to other groups of population,
- Scaling up community/mutual based insurance schemes, and
- Making existing private voluntary health insurance schemes affordable and attractive for the urban poor.

Achieving these opportunities will require a multi-pronged approach. This report discusses key elements of this approach:

- Collaborative arrangements among various stakeholders
- Targeting strategies
- Coverage and product design

The government could shape the implementation of policies using (a) organization and strengthening institutional structures, (b) financing and payments, (c) information and persuasion, (d) improving access and availability, (e) pricing, and (f) regulation.

Many countries across the globe have implemented innovative approaches, using experimentation and pilots before scaling up the proposed initiatives. Government, insurance companies, and health care providers need to come together and develop collaborative arrangements to understand the many unknowns in a complex process and develop health protection measures for the urban poor.

1. INTRODUCTION AND OBJECTIVES

India has shown consistent improvements in the population's health status over the years. Maternal mortality and under-five mortality have declined significantly from 556 (per 100,000 women) and 167 (per thousand births) in 1990 to 167 and 49 in 2013. HIV prevalence among adults also has declined, from 0.34 percent in 2007 to 0.26 percent in 2015. Polio has been eradicated, a very important achievement. However, many challenges remain and many new challenges are emerging. For example, inter- and intra-state variations remain significant. Non-communicable diseases (NCDs) have surpassed communicable and infectious illnesses as the main cause of the illness burden. NCDs currently account for about 60 percent of the burden, and NCDs and injuries together account for 72 percent. Also, it is well recognized that rapid economic growth, lifestyle issues, and climate change including biological and environmental factors are significant determinants of health outcomes.

In addition, in India there is a high degree of inequity in access to health care. Marginalized and vulnerable populations may fear incurring catastrophic health expenses, which leads to their avoiding health seeking and creates inequity in health outcomes. The health finance implications of such experiences are critical. Government has responded to these challenges. In 2005, the government implemented programs through the National Rural Health Mission (NRHM) to address health problems of the rural population. In 2014, the government established the National Urban Health Mission (NUHM), focused on the urban poor and health capacities of urban areas. Management of the NUHM was subsumed into the existing structure and governance mechanisms of the NRHM to create the National Health Mission (NHM). Among the NHM's aims is addressing various health finance challenges.

At the same time, the government of India at both the central and state levels has implemented various health insurance schemes for different segments of the population. For example, the implementation of national health insurance for families living below the poverty level has aimed at reducing the financial burden of spending on hospitalization. Private voluntary schemes at the community level and private individual level have also been part of initiatives to address health finance challenge in India.

The objective of this paper is to review the health financing challenge in India by presenting the findings of National Sample Survey Office (NSSO Round 71) data on out-of-pocket (OOP) spending on health. The paper specifically discusses the rural-urban differences in OOP spending and implications thereof. Given the complexity and challenges of health system in India and the rural-urban differences, the responses need to be contextual and may differ. The paper then reviews the government response and landscape of health insurance and presents an opportunity map where health insurance options can be expanded. The paper describes broad strategies to develop a comprehensive health protection response to meet the health protection needs of urban India.

2. HEALTH FINANCING SCENARIO: OUT-OF-POCKET SPENDING

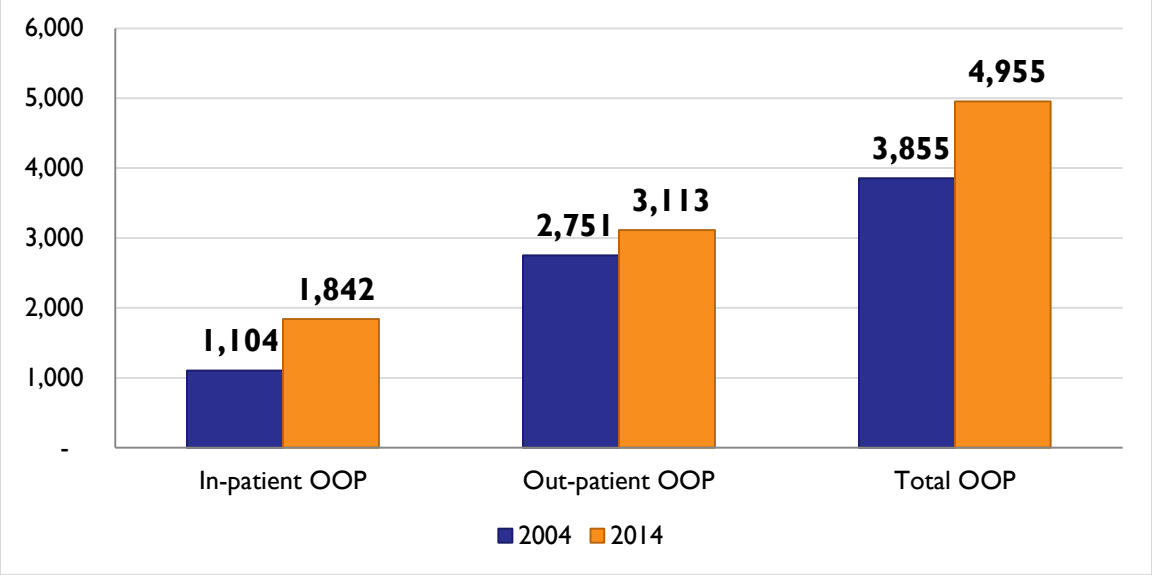
India has one of the world's lowest rates of public spending on health. The government spends about 1.15 percent of GDP on health, much less than the global average of 5.4 percent. The public spending accounts for 28.6 percent of total health expenditure on health – about Rs 1,042 per capita per annum (US$16[1]) at current prices (Ravi et al. 2016). With this level of public allocation, coverage of the entire spectrum of health care needs remains a financing challenge.

In contrast to the government's share of total health expenditure, OOP spending on health makes a significant contribution to health financing. OOP spending includes all direct household payments on health – payments to health providers, on drugs and pharmaceuticals and diagnostics, and on other goods and services for improvement in the health of individuals. The OOP spending on health was 67.74 percent of total health expenditure (MoHFW 2016). Data collected by the recent NSSO household expenditure survey (round 71) and National Health Accounts support the concern about high OOP spending. NSSO survey findings show that OOP spending on health accounts for over two-thirds (67.1 percent) of total health spending in India, one of the highest proportions in the world, and far more than the global average of around 20 percent. While this ratio has declined marginally from a high of about 70 percent a decade ago with the introduction of the NHM and other government-supported insurance schemes, analysis of expenses in real terms indicates a significant increase in overall OOP spending between the two rounds of NSSO data (2004 and 2014). The growing incidence of NCDs and introduction of new medical technologies may further worsen the OOP spending problem.

A disaggregation of the NSSO data at household level shows that the bulk (63.5 percent) of OOP spending is on outpatient treatment and care (see Figure 1). This is 1.7 times OOP spending on inpatient care. Further, the NSSO round 71 data suggest that an overwhelming 75 percent of outpatient treatment and care happens in the private sector; this number is 55 percent for inpatient care. Such a large proportion of outpatient care taking place in the private sector makes OOP spending a much bigger health financing challenge.

[1] Using exchange rate of US$1 =Rs 65.

Figure 1: OOP Spending on Health per Household (inflation adjusted)



Source: Ravi et al. 2016

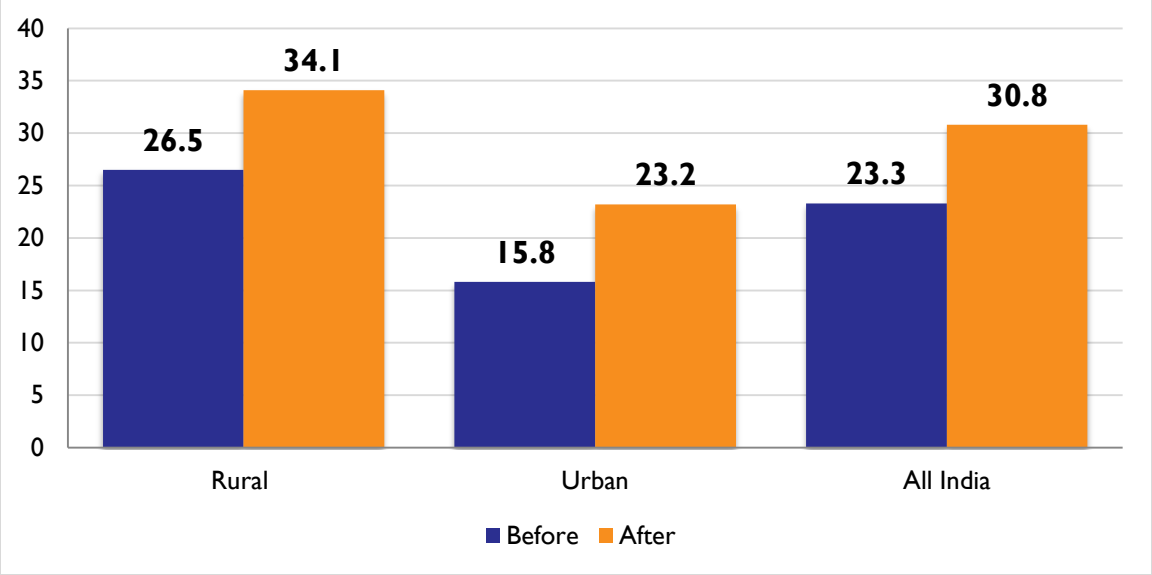
The private health care sector is highly fragmented and consists of various types of providers. Some of these are informal providers and less-than-qualified providers. So again, with the large proportion of outpatient care taking place in the private sector, the variation in quality across private providers is a major concern from the health systems perspective.

India's economic growth has been good in the recent past, but high fiscal deficits have prevented increasing government allocations to health. Overall government revenue critically depends on tax collections, and the tax-paying population has not expanded with the economic growth. States' fiscal space also has remained constrained. Government in the past proposed increasing health allocations to 3 percent of GDP, but as noted above the allocations have remained significantly less, in the range of one percent. The low budget allocations and low public spending on health forces people to spend out of pocket. As the health finance literature points out, this high OOP spending on health puts a financial burden on families, leading to consequences such as the following:

- Inadequate health seeking, both first-time utilization and continuing treatment, for those who cannot afford to pay.
- Some who do choose to seek care – despite having to pay out of pocket for it – must forgo other basic family needs such as food, clothing, housing, and education; in some cases, the health spending pushes the family into poverty.
- Decisions that force incomplete/partial treatment and compromise quality of care, which has implications for efficiency.

More than 60 million persons are pushed into poverty every year due to health care costs (Government of India MoHFW 2017). As per World Health Organization (WHO) estimates, each year, approximately 150 million people experience financial catastrophe, meaning they are obliged to spend on health care more than 40 percent of the income available to them after meeting their basic needs (WHO 2007). And about 100 million persons are driven below the poverty line. Using the Tendulkar poverty line estimation, the estimates suggest that the below-the-poverty-line (BPL) population will increase from 15.8 percent to 23.2 percent after the health expenditures are adjusted from the consumption (see Figure 2). This is a significant increase of 47 percent (Ravi et al. 2016), and it indicates that OOP spending on health has exceeded 10 percent of consumption in a significant number of cases.

Figure 2: Percent of Population Below the Poverty Line Before and After Deducting Health Expediture from Consumption



Source: Ravi et al. 2016

3. INDIA'S URBAN SCENARIO

India's urban population has grown over the years. The latest census estimates an urban population of 430 million, 33 percent of the total population. It also estimates that about 27 percent of the urban population is poor, surviving on a daily consumption expenditure of Rs 47 or less. Census projections show that by 2030, another 250 million people will come to Indian cities.

Urban India has witnessed significant changes in addition to growth. There has been a transition toward a market-based economy, most of which is in the informal (unorganized) sector – informal employment, which includes casual or short-term contractual or irregular workers in the formal sector, accounts for 67 percent of urban non-agricultural workers (Mitra 2014). Also, the role of the urban sector in economic growth and poverty reduction has undergone a major change. For example, gross value-added growth in the informal manufacturing sector including own-account manufacturing enterprises (household enterprises) was 9.65 percent between 2005/06 and 2010/11 (Mitra 2014). As a result, more than 60 percent of India's gross domestic product (GDP) is being generated from towns and cities.

A recent Lancet report (Anjana et al. 2017) on India indicated that states with higher per capita GDP seem to have higher prevalence of diabetes and the prevalence of diabetes is higher in urban areas (11.2 percent) than in rural areas (5.2 percent). In urban areas of some of the more affluent state such as Chandigarh, Maharashtra, and Tamil Nadu, diabetes prevalence is higher in people with lower socio-economic status (Anjana et al. 2017). Given that NCDs and injury are significantly higher in urban areas, there is a growing urban health finance challenge.

To cope with the massive health care-related needs that have arisen with rapid urbanization, it has become imperative to draw up a strategy for health protection, the leading cause of impoverishment. Based on experiences with implementation of the Jawaharlal Nehru National Urban Renewal Mission and its successor programs, the government has envisaged investing US$20 billion over a seven-year period in a city-modernization plan. Citizen participation, increased delegation of powers, higher devolution of resources, project prioritization, and an area-based approach are some key aspects of improving urban governance to achieve project outcomes. The need for public-private partnerships (PPPs) is now widely appreciated.

Estimates of the percentage of the urban population living below the poverty line[2] range from 13.7 percent using the Tendulkar Committee's methodology (2011/12) to 26.4 percent using the Rangarajan expert panel's formula. However, data from the 2011 Socio-Economic and Caste Census (SECC) estimate that about 35 percent of urban Indian households qualify as poor. The SECC estimates of deprived or poor households are based on door-to-door enumeration of defined parameters of exclusion such as government employment, income tax status, ownership of two-wheelers or refrigerators, and farming of at least five acres of irrigated land. The SECC data are thus likely to capture vulnerability much better than rigid poverty line parameters such as monthly per capita consumption expenditure of Rs 1,407 in urban areas (at 2011/12 prices). However, there may be a tendency for respondents to understate income and asset ownership or, alternatively, overstate deprivation.

[2] The most widely held and understood definition of extreme poverty (earning less than US$1.90 a day) was established by the World Bank and uses strictly economic terms.

The government recognizes that estimating vulnerability is important, but equally important is developing mechanisms and policy initiatives to address the consequences of vulnerability. The conventional interventions of subsidizing various goods, for example through ration shops,[3] have been found to not benefit the persons in need. Also, the cost of such programs is high, and the diversion of supplies to private markets has led to distortions in the market. As a result, the government has come to focus on ways of using direct cash transfers to the unique identification number (Aadhaar[4])-linked bank accounts of identified beneficiaries. For example, cash transfers to subsidize liquefied petroleum gas supplied to residences are working satisfactorily, gradually weeding out those not deserving the benefit. Of course, concerted efforts such as adoption of the "GiveItUp" campaign[5] have contributed to the objective of targeting the subsidy correctly. The government plans to extend such schemes to food and fertilizer subsidies, education, and other welfare programs. There is a significant potential to link health insurance schemes through the direct cash benefit mechanism.

[3] As part of a food security program, the government of India distributes subsidized food and non-food items to India's poor under a Public Distribution System through a network of fair price shops (also known as ration shops) established in several states across the country.

[4] The Aadhaar number is a 12-digit, unique-identity number issued to all Indian residents based on their biometric and demographic data.

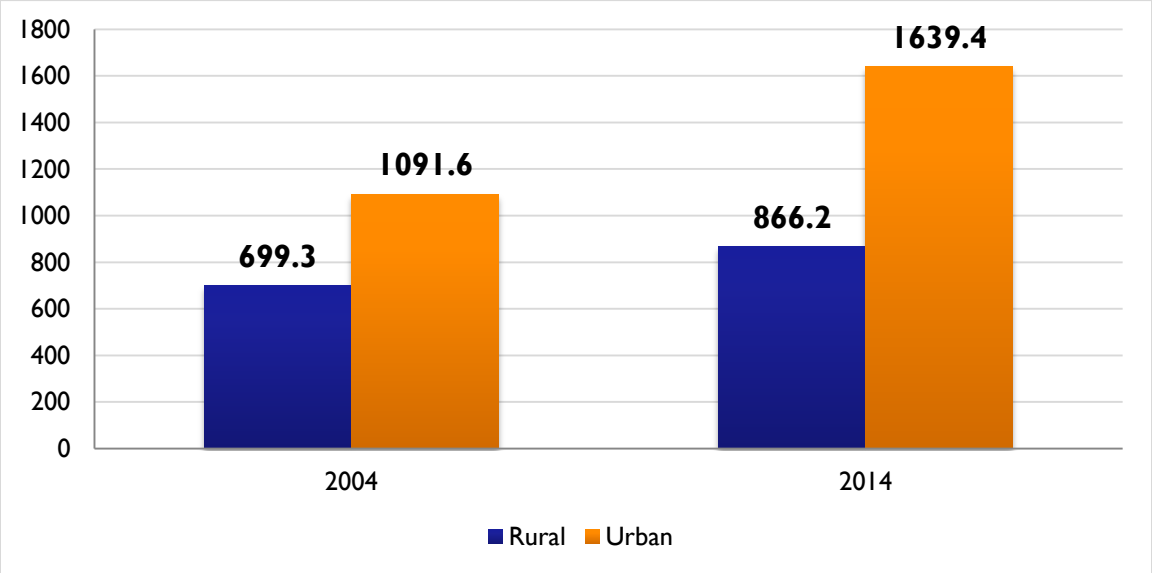
[5] "GiveItUp" campaign is a movement urging those who can afford to buy liquefied petroleum gas at market price to give up their subsidy.

4. URBAN OOP SPENDING ON HEALTH

The NSSO survey findings suggest that annual OOP spending on health has not only increased, but also more OOP is being spent on outpatient care. For example, at the individual level, annual OOP spending on health has increased by 37 percent, from Rs 799 per capita (US$12) to Rs 1,098 (US$17), over the 10-year period from 2004 to 2014 (Ravi et al. 2016). At the household level, OOP spending on outpatient care is more than what is spent on inpatient care. However, the comparison between OOP spending on outpatient and in-patient care need to be done with care as OOP spending particularly on inpatient care may be under-spent or truncated. It is possible many families do not seek care or seek limited care because they cannot pay, and therefore OOP spending on inpatient care is less.

In real terms, average annual urban OOP spending on health increased from Rs 1,092 to Rs 1,639 over the 2004 to 2014 period (see Figure 3), an increase of about 50 percent, whereas rural OOP spending increased only 23 percent, from Rs 699 to Rs 866 (Ravi et al. 2016). OOP expenditure per case has also been 32 percent higher for urban consultations as compared with rural cases. The findings also suggest that OOP spending per case in urban areas has been growing at a higher rate than in rural areas. Urban households used to pay Rs 41 more per out-patient case than rural households in 2004. And 10 years later, the urban households are paying Rs 93 more per out-patient case than rural households (Ravi et al. 2016).

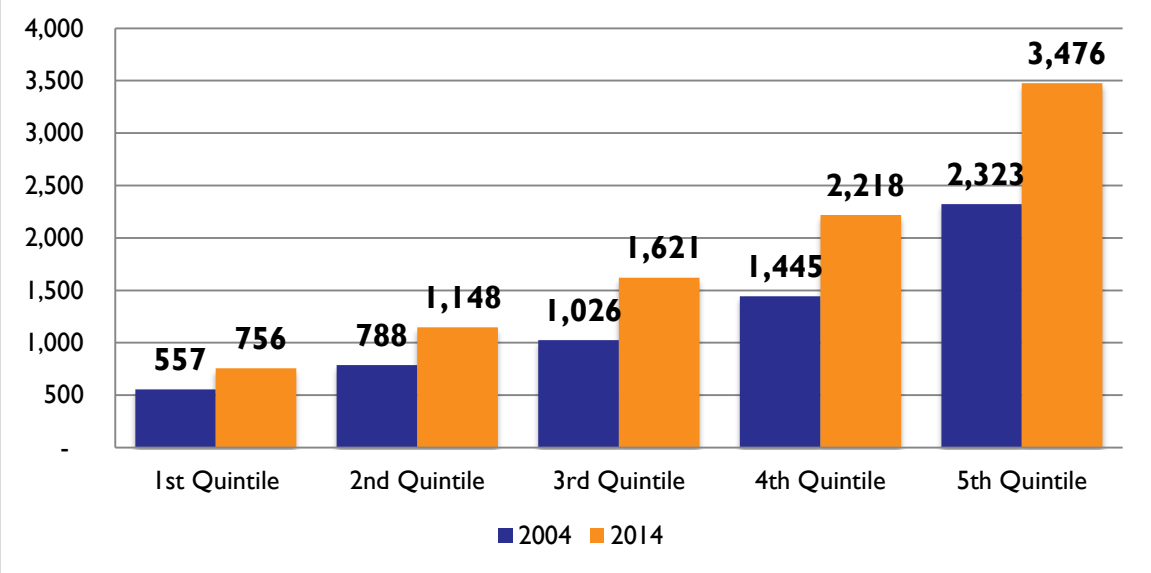
Figure 3: Urban-Rural Increase of OOP Spending on Health



Source: Ravi et al. 2016

NSSO data show that urban households saw a fivefold increase in their diagnostic expenses as compared with rural households. This disparity has increased over the past decade as new medical technologies were introduced and the incidence of NCDs increased. Using consumption expenditure quartiles as a proxy for income, the OOP spending increase in poorest quintiles (4th and 5th quintile groups) was 36 percent and 46 percent during the period 2004 to 2014 (see Figure 4).

Figure 4: Consumption Quintile Differences in Urban OOP Spending on Health



Source: Ravi et al. 2016

Regarding protection from the financial burden, the NSSO data suggest that in urban areas, only 17.8 percent of residents were covered by some form of government insurance (11.9 percent), employer support (2.4 percent), or other risk-pooling mechanism including private voluntary insurance (3.5 percent). Insurance coverage by consumption quintile indicates that in the poorest (1st) quintile, only 9.7 percent were insured as compared with 36.4 percent in richest (5th) quintile. These data suggest that private insurance is more used by richer urban groups whereas public insurance is evenly distributed across all groups. The data also show significant inter- and intra-state variations in insurance coverage and, as a result, OOP spending on health.

Most health insurance programs are not comprehensive, as they do not cover outpatient care. Improving access to comprehensive health care and providing financial protection to the urban poor is therefore increasingly viewed as critical for improving health outcomes.

In summary, the findings from NSSO data show that health-seeking behavior and dependence on private providers and resultant OOP spending on health (and in particular on outpatient care) are major health financing challenges, because only 18 percent of the urban population is covered under any health insurance scheme, and most of the schemes do not cover outpatient care. As discussed above, one consequence of high OOP spending on health is to push the individuals in lower-income groups to below the poverty line, leading to impoverishment. Similar to the geographic variations in insurance coverage and OOP spending on health, there are variations in the implication for impoverishment. Improving access to comprehensive health care and providing financial protection to the urban poor is increasingly viewed as critical for improving India's health outcomes.

5. GOVERNMENT POLICY RESPONSE

During the past decade and particularly in the recent past, the government of India has implemented a spate of policy initiatives toward protection from catastrophic OOP health expenses. The urban-rural difference in the increasing OOP expenditure burden is consistent with implementation of the government-supported NRHM, NUHM, and other national health programs for poor segments of the population. These government responses have been at two levels: the programmatic level (supply-side response) and through health financing and insurance initiatives (demand-side response). The following are government-supported policy responses:

- **National Health Mission:** The NHM is the largest public health program in India with the objective to strengthen the supply side of health care. The NHM has two sub-missions: the NRHM and the NUHM. The NHM started with a focus on mother and child health. Now, an important component of the program is strengthening the management and infrastructure of urban health. The National Health Policy (NHP) 2017 proposes on-scale assured interventions, organized primary health care delivery, and referral support for the urban poor. It is also developing collaborative mechanisms with other sectors to address wider determinants of urban health. There are opportunities to develop initiatives to focus on reducing the urban poor's OOP spending on health. The total budget allocations to the NHM for 2016-17 is Rs 19,437 crore, 79 percent of which is allocated to the NRHM.
- **National Disease Control Programs:** The National AIDS Control Programme and Revised National Tuberculosis Control Programme are two national health programs implemented by the central government. Both have a component of engaging with the private sector to strengthen services, care, and delivery. The government-allocated budget of these two programs is about Rs 3,000 crore per annum.
- **Price Regulations of Essential Drugs and Procedures:** The government's National Pharmaceutical Pricing Authority (NPPA) maintains a National List of Essential Medicines. Recently, NPPA put price controls on cardiac stents, and it plans to bring various procedures such as pacemakers, lenses, catheters, implants, and valves under price controls. These controls have significant implications for bringing down OOP expenses for health. The government has also proposed to implement a policy that would bind doctors to prescribe generic medicines.
- **National Free Diagnostic Services Initiative:** Among the NHP's other initiatives to reduce OOP spending on health is the National Free Diagnostic Services Initiative, which has been implemented as a part of the NHM. Under this initiative, the Ministry of Health and Family Welfare (MoHFW) has prepared details for essential diagnostics packages tailored to various levels of care, the process of engaging private providers through PPPs in public facilities, an implementation framework for ensuring the availability of basic diagnostic services, and alternative models using innovative technologies the states can adapt to their local conditions. The initiative aims at bringing down OOP expenses on belated/irrational treatment of diseases/ disabilities (many of which are incurable and become highly debilitating), and avoidable pressure on the health system on account of their management.

- **Free Screening of Critical Risks:** To achieve the NHP 2017 goals of universal and comprehensive health care, the government plans to start universal free health screening for key health risks under the NHM. To begin, a set of free essential diagnostic services at each facility level has been identified that would be provided free of cost in an assured mode. The tests encompass hematology, serology, bio-chemistry, clinical pathology, microbiology, radiology, and cardiology. States are allowed to add to the list based on epidemiological considerations and available financial resources. Also, a "Test and Treat Initiative" has been proposed to be implemented in 100 districts across various states.
- **Public-Private Partnership Plan:** Niti Aayog, along with the MoHFW and World Bank, has proposed a PPP model to augment NCD treatment facilities in smaller cities. Odisha announced this year that it had engaged a private health care provider to operate and manage a cardiac care hospital in Jharsuguda on a pilot basis, while Karnataka and Andhra Pradesh have devised elaborate insurance schemes that make use of private health care facilities for surgical procedures. The Niti Aayog proposal also aims at addressing issues of pricing, monitoring and oversight, and quality of care.

6. DEMAND-SIDE INSURANCE RESPONSE AND ITS LANDSCAPE

The government of India at both the central and state levels has introduced health financing protection measures for different segments of the population. At the same, a number of community-based organizations including mutuals have developed and implemented health insurance programs to meet the needs of their communities. The public and private general insurance companies and stand-alone health insurance companies also offer health insurance products that individuals can buy from the market on a voluntary basis. Many employers assume health risks of their employees by either directly owning a health facility/ies or creating a tie-up with local health service providers or by reimbursing the OOP health spending of their employees. These interventions can be broadly classified as follows (see Annex A for details on each scheme):

- Central Government Health Scheme (CGHS)
- Employee State Insurance Scheme (ESIS)
- Government-supported health insurance (GHIS) such as Rashtriya Swasthya Bima Yojana (RSBY) and Chief Minister's State-Level Health Insurance Schemes such as RSBY+ (state-supported schemes)
- Community- and Mutual-based Health Insurance (CBHI)
- Private Voluntary Health Insurance (PVHI)
- Employed-based Risk Retention (employer-based schemes)

6.1 Central Government Health Insurance Scheme

The MoHFW started the CGHS in 1954 with the objective of providing comprehensive medical care facilities to central government employees, pensioners, and their dependents. CGHS covers about 3.67 million beneficiaries. The scheme is financed mainly through central government tax revenues. Employees contribute a share of their salaries to the program; their annual contributions are tied to the salary scale. However, these employee contributions account for only about 5 percent of CGHS revenue, whereas the government contribution is 95 percent. The total expenditure on this scheme was Rs 18 billion in 2015, which translates into a per capita expenditure of Rs 5,000.

6.2 Employees' Social Insurance Scheme

The ESIS is a flagship social insurance providing multidimensional social and health security protection to workers and their dependents. The ESIS applies to workers in factories and other enterprises (including on construction sites) that have 10 (in some states 20) or more employees drawing wages of less than Rs 21,000 per month. The scheme applies to 783,000 establishments covering 21.3 million families having total beneficiaries of 82.8 million. This social insurance program is financed by contributions from employers (4.75 percent of the wages payable to employees) and employees (1.75 percent of the wage). Employees having wages of Rs 100 or less are exempted from this contribution. State governments contribute 1/8th of the expenditure of medical benefits within a per capita ceiling of Rs 1,500 per insured person per annum.

6.3 Publicly Funded Government Health Insurance Schemes

Recognizing the challenges faced in adopting a supply-side health financing approach only, the government of India and various state governments have launched many publicly funded health insurance schemes targeted at poor and vulnerable families. Most of these schemes were fully subsidized by the government. Through the schemes, an attempt has been made to use a demand-side health financing approach to protect people from catastrophic health expenses. The government initiated one of the major policy reforms by launching RSBY in 2008. Various state governments have implemented this scheme with their additions and extended the coverage and scope. As per the Insurance Regulatory and Development Authority, the total number of persons covered by government-financed insurance schemes is 273.3 million. The total premium paid to these schemes by the government was Rs 2425 crore (US$373 million) during 2015/16.

6.4 Community- and Mutual-Based Health Insurance Schemes

The government health insurance schemes focus on the BPL segment. As a result, a large percentage of the population remains without financial protection. Those left out include people just above the poverty line, members of credit societies, urban labor networks of migrants, and informal, micro, small, and medium business clusters that are not eligible for GHIS. Insurance regulations in 2005 made reference to recognizing mutual aid cooperatives as partners in growth and development of the insurance sector focused in particular on vulnerable and economically weaker sections of society and bringing in the "micro-insurance" approach. The partner-agent model has been used by commercial insurance companies in India to meet their mandatory requirement of reaching out to vulnerable groups of the population. Many CBHI schemes in India have taken this route. At the same time, some communities follow the mutual model. The broad estimates suggest that total coverage under community/mutual models is in the range of 25 million people, of which the mutual model covers 4 million.

6.5 Private Voluntary Health Insurance

PVHI is provided by:

- Public sector non-life insurance companies
- Private sector non-life insurance companies
- Stand-alone private sector health insurance companies

The total number of persons covered under PVHI in 2015/16 was 85.74 million, who contributed a total gross premium of Rs 220 billion (US$3.4 billion). Public sector companies are market leaders having a market share of 64 percent. The current market share of private and stand-alone entities is 22 percent and 14 percent, respectively. The PVHI market consists of following product segments:

- Group PVHI (market share of 53 percent)
- Individual PVHI (market share of 47 percent)

PVHI has registered a compound annual growth rate (CAGR) of 19 percent in the past five years. The market share of Group PVHI is higher than the Individual PVHI, but the Individual segment is growing at a CAGR of 22 percent as compared with 18 percent for the Group segment. Recent amendments to insurance legislation recognized health insurance as a class of business, enabling the incorporation of stand-alone health insurance companies. The legislation defined the health insurance business as "effecting of contracts which provide for sickness benefits or medical, surgical or hospital expense benefits, whether in-patient or out-patient, travel cover and personal accident cover." The market share of stand-alone health insurance companies is increasing: in past three years, it has gone up from 11 percent to 14 percent.

6.6 Other Insurance and Health Protection Schemes

Many organizations in India, such as railways and large public and private sector organizations, have created their own health infrastructure and cover their employees. Many other employers assume the health insurance risk of their employees and cover their health costs through reimbursement schemes. There are no estimates on how many individuals are covered directly by employers and we put a very broad estimate of such coverage in the range of around 10 million individuals.

The total number of persons covered under all the types of insurance discussed above is nearly 552 million, 42 percent of the population. The landscape of insurance suggests that 675 million people, about 58 percent of the population, remains uncovered and thus pay their health care expenses out of pocket (see Figure 5, page 16).

It is important to note that actual utilization under each scheme, however, varies considerably due to targeting, product design, and coverage issues.

As discussed earlier, the financing of outpatient health care is a much bigger challenge than the financing of inpatient care, because no insurance scheme covers outpatient care. In addition, any health insurance coverage is only 17.8 percent in urban areas. Looking at insurance coverage by consumption quintile indicates that only 9.7 percent of people in the poorest quintile were insured whereas 36.4 percent in the richest quintile were. Richer urban groups use private insurance more whereas public insurance is evenly distributed across all groups. Improving access to comprehensive health care and providing financial protection to the urban poor, therefore, is increasingly viewed as critical for improving health outcomes.

The insurance landscape of India also suggests that the risk pool is extremely fragmented. Many schemes cover a particular segment of the population based on specific eligibility criteria of the pool. These independent risk pools include initiatives of the central and state governments, employers, communities, and voluntary contributions from individuals. A review of all these schemes showcases the following characteristics (see Annex C):

- Eligibility criteria of each risk pool are different; overall they are mutually exclusive although there are some overlaps. For example, members of a community-based pool may also be eligible for RSBY and members of various pools may buy voluntary insurance.
- Pools vary in terms of revenue base and its sources.
- Some pools have voluntary membership, whereas in others membership is mandatory. Even the mandatory pools have targeting issues.
- The health system does not insist that every member has to be part of some pool. Therefore 58 percent of people do not have any cover.
- The nature of employment and income levels play an important role in defining eligibility criteria.
- Each risk pool has a highly variable population size and per capita premiums and expenditures on health are different.

The existence of diverse pools and the variation in membership and expenditures have implications for risk-pool efficiency and equity. For example, variations in size, need, and use of a type of service provider can lead to variation in insurance premiums. In many situations, premiums (whether paid by the government or individuals) are influenced by the claims ratio and therefore premiums may be driven by considerations other than efficiency. As a result, pools with more vulnerable populations may be at a disadvantage and need to charge a higher premium to be sustainable.

At the same time, supply-side responses in the health sector are evolving. Efforts are increasing and attempts are on to strengthen the public health systems and strategic purchasing so as to offer a low-cost

package of services. To achieve this, for example, the NHP 2017 envisages increasing public health spending to 2.25 percent of GDP by 2025.

Figure 5. Health Insurance Landscape India

Income	Population	CGHS	ESIS	GSHI	State Supported	CBHI	PVHI	Others	Total	%
H							85.7 Million		100	8%
I		3.67 Million								
G							Opportunity	10 Million		
H								Opportunity	UNINSURED	58.4%
M										
I										
D						Opportunity				
D										
L					Opportunity					
E			82.8 Million						104	8%
				Opportunity		25 Million				
									348	26%
					75 Million					
				B						
				P						
				L						
L										
O				273.3 Million						
W										
	1327	3.67	82.80	273.3	75	25	85.7	10	556	100%
% Of Population Insured		0.3%	5.9%	20.6%	5.7%	1.9%	6.5%	0.8%	41.6%	

CGHS	Central Government Health Scheme	Not Operated Through Commercial Insurance Companies
ESIS	Employee State Insurance Scheme	Not Operated Through Commercial Insurance Companies
GSHI	Government Supported Health Insurance	Operated through Commercial Insurance Companies
State Supported	CMs State Level Schemes	Not Operated Through Commercial Insurance Companies
CBHI	Community Based Health Insurance	Some Operated Through Commercial Insurer Some Mutual
PVHI	Private Voluntary Health Insurance	Operated through Commercial Insurance Companies
Other	Employed Based Risk Retention	Not Operated Through Commercial Insurance Companies

OPPORTUNITY TO EXPAND INSURANCE

7. OPPORTUNITIES AND APPROACHES TO COVER URBAN POOR

Given that OOP spending affects the urban poor and highly fragmented risk pools are driven by considerations that do not ensure efficient operations, India needs a comprehensive health financing and insurance response. There are challenges to addressing the health protection needs of the urban poor and policymakers need to consider and focus on these while developing innovative approaches. These challenges are:

- Affordability
- Aggregation (targeting)
- Channel and Distribution
- Instituting Primary Care
- Technology
- Financial Literacy
- Supply-side Challenges

Figure 5 provides key opportunities for expanding existing schemes; they are:

- Expanding existing government health insurance schemes
- Scaling up community/mutual-based insurance schemes
- Making PVHI schemes affordable and attractive to the urban poor

Tapping these opportunities will require a multi-pronged strategy, the key elements of which are:

1. **Collaborative arrangements among stakeholders.** Collaborative arrangements among key stakeholders, which include insurers, providers, and aggregators, can be leveraged as resources. New arrangements and opportunities need be explored, and key groups that should be engaged need to be identified. Government, regulators, and other stakeholders need to facilitate review of key approaches that will help the formation of effective collaborative arrangements. The leadership role in resolving key institutional and system issues is critical to foster such arrangements.
2. **Targeting strategies.** One of the major challenges in expanding health insurance coverage of the urban poor lies in targeting and aggregating schemes to ensure that the cost of aggregating, distributing, and channelling the products is efficient and effective. To do this, we need to define who the urban poor are and develop approaches to target them, such as the following approaches:
    - Focus on micro-enterprises and micro-credit institutions in urban communities
    - Develop mechanisms of bringing together the migrant communities and developing health protection mechanisms

- Use technology to integrate urban communities
- Understand the urban communities and their health-seeking behavior
- Develop innovative approaches and pilots to test provision of coverage
- Ensure the affordability and economic logic of the programs and schemes

The role of aggregators in the process of developing comprehensive programs needs to be harnessed. The affordability and economic logic of the programs and schemes will be a key challenge and government support through direct cash transfers or other effective ways of ensuring the affordability of insurance needs to be worked out. Technology and lessons learned can be used to address many of these challenges.

3. **Coverage and product design.** India now has some history of developing and offering voluntary health insurance products to the population. Some pools such as CGHS and ESIS remain outside the purview of using insurance companies as vehicles for underwriting and, as a result, knowing how much coverage clients should receive and how much they should pay for insurance may not be clear. Insurance companies have collaborated with community-based organizations to offer insurance products under the "partner-agent" model. Lessons from this can be scaled up to increase coverage and work out product designs for targeted population segments. These initiatives may also be initiated as pilots.

The government could shape the implementation of approaches aimed at increasing access and providing financial protection using various health policy instruments. For example, information and persuasion may be used to improve the awareness, literacy, and knowledge of various health services including financial protection schemes because the lack of awareness is considered to be a major barrier to health service utilization. Similarly, the policy instruments such as organization and strengthening of institutional structures can be used to strengthen the management implementation of various schemes. Making the primary and preventive services accessible to larger population can make the financial protection focusing on hospitalization care effective. Pricing instrument can be used to influence the market for ensuring and developing insurance products that are affordable.

8. INNOVATIVE AFFORDABLE INSURANCE SOLUTIONS

The recent insurance regulations of 2016 introduced the concept of "pilot products" aimed at encouraging innovations in the design for covering risks. To this end, preliminary discussions with insurance regulators in India have suggested that they would like to encourage insurers to collaborate in designing and implementing pilot products.

The complexity of health systems and unknowns about the context make pilots advisable for initiating and testing reforms and developing innovative approaches. Over the years, many countries including India have designed and implemented pilots to test interventions before rolling them out. Some examples are as follows (these are discussed in greater detail in Annex B):

- South Africa: National Health Insurance Pilots in 11 districts, 2012
- India: Pilot Project Introducing Outpatient Healthcare on the RSBY Card in Odisha, Gujarat, Punjab, Andhra Pradesh, Mizoram, and Uttarakhand, 2011
- Gujarat, India: Chiranjeevi Scheme Pilot in five districts
- Tanzania: Community Health Fund (Rural Health Insurance), 1995-2001
- Rwanda: Prepayment Scheme in three districts with a population of 1.08 million, 1999-2000
- Almaty, Kazakhstan: Primary health care fund holding, 1997
- Thailand: Health Card Scheme (Rural Insurance) 1984-1997, roll-out in 1998
- China: Rural Health Insurance in 40 townships, 1990
- Philippines: Provincial Health Insurance Program in three municipalities with over 1 million population, 1993-1999
- Ghana: Willingness to pay for health insurance pilot
- Alexandria, Egypt: Family Health Fund pilot
- Issyk-Kul, Kyrgyzstan: Pilot to demonstrate the feasibility of a mandatory health insurance scheme, 1994

The role of pilots in general in health system strengthening has been well documented in the literature. Given the complexity and multi-dimensional linkages, pilots are preferred to understand the unknowns of the situation, test the feasibility of the proposed scheme, and evaluate its early impact. This helps in refining the strategy and various implementation decisions before scaling up. The global experience in implementing pilots to promote health insurance initiatives suggests that insurance companies and providers, while designing the pilots, need to consider:

- Key goals and objectives of the pilot
- Size, scope, and scale of the pilot
- Contextual factors such as capacity, complexity, and involvement of stakeholders
- Targeting, coverage, product design, and affordability issues of the proposed pilot and implementation vehicles to be used

- Life of the pilot, scaling and phasing of activities, and the economic logic
- Understanding if the pilot could be rolled out and, if not, the constraints and challenges
- Expected pilot outputs such as evidence from monitoring and evaluation and from experience, political momentum, demand for reform, and building capacity
- Technical assistance required to design, develop, and implement the pilot; in particular the need for the pilot to conform to existing health insurance regulations.

The government, insurance companies, and providers need to come together and develop collaborative arrangements to understand the 'many unknowns' in a complex process and initiate programs and interventions focusing on developing health protection measures for the urban poor.

9. SUMMARY AND CONCLUSION

India's urban population has expanded greatly over the years. Approximately 430 million people now live in urban areas and about 27 percent of them are poor. A disaggregated analysis of household health expenditure data suggests that OOP spending in urban areas has been growing at a much faster rate than in rural ones.

It is well known that high OOP spending on health is a financial burden for the poor, impacting not only their health-seeking behavior but also their cutting expenditures on other basic family needs such as food, clothing, housing, and education. In many cases, spending on health pushes the family into poverty.

Health financing policy responses in India over the years have led to the creation of initiatives by central and state governments, employers, communities, and voluntary contributions from individuals. Together these schemes are estimated to cover about 42 percent of the population with some sort of insurance, leaving uncovered the remaining 58 percent without coverage.

Given that the OOP spending is a burden on the urban poor and the fragmented risk pools are inefficient, India needs a comprehensive health financing response. The landscape of opportunities suggests areas where existing schemes can be expanded to cover urban residents. The key opportunities are: (a) expanding existing government health insurance schemes to other population groups, (b) scaling up community/mutual-based insurance schemes, and (c) making existing PVHI schemes affordable and attractive to the urban poor.

Implementing these opportunities will require a multi-pronged strategy. The key elements of the strategy discussed in the report are: (a) developing and fostering collaborative arrangements among various stakeholders, (b) developing and designing effective targeting strategies, and (c) focusing on coverage and product design to ensure offering are attractive and affordable. The government could shape the market implementation of policies using (a) organization and strengthening institutional structures, (b) financing and payments, (c) information and persuasion, (d) improving access and availability, (e) pricing, and (f) regulation.

Many countries across the globe have implemented innovative approaches, using experimentation and pilots before scaling up the proposed initiatives. Government, insurance companies, and health care providers need to come together and develop collaborative arrangements to understand the many unknowns in a complex process and develop health protection measures for the urban poor.

ANNEX A: VARIOUS HEALTH INSURANCE SCHEMES IN INDIA

Central Government Health Scheme

The Central Government Health Scheme (CGHS) was started under the Indian Ministry of Health and Family Welfare (MoHFW) in 1954 with the objective of providing comprehensive medical care facilities to central government employees, pensioners and their dependents residing in CGHS covered cities. Started in Delhi, currently the scheme operates in 27 cities of India (CGHS Website 2017).

In 2015, the most recent year for which figures are available, CGHS was providing facilities to a large beneficiary base of about 3.67 million. The scheme has an open-ended and comprehensive approach of providing health care using the dispensary model as its mainstay. Facilities available under CGHS include outpatient treatment including dispensing of medicines, specialist consultation at polyclinic/government hospitals, indoor treatment at government and empanelled hospitals, investigations at government and empanelled diagnostic centers, cashless facility for pensioners, reimbursement of expenses for emergency treatment accessed in government/ private hospitals, reimbursement of expenses incurred for purchase of hearing aids, artificial limbs, appliances, etc. as specified, and family welfare, maternity, and child health services (CGHS Website 2017). All beneficiaries and their dependents are provided with individual photo ID plastic cards. The CGHS is financed mainly through the central government's tax revenues; the annual per capita expenditure for CGHS is more than Rs 5,000. Though beneficiaries do contribute a share of their wages toward the premium depending upon their pay scale, this accounts for just about 5 percent of the total expenditure. The government accounts for the remaining 95 percent. The gradual increase of total expenditure has increased up to Rs 1,800 crore in 2015 as compared to Rs 747 crore in 2006/07 (Kumari et al. 2016).

Employees' State Insurance Scheme

Employees' State Insurance Scheme (ESIS) of India is a multidimensional social security system that provides socio-economic protection to workers and their dependents covered under the scheme (ESIC Website 2017). An integrated measure of social insurance as well as health care embodied in the Employees' State Insurance Act, 1948, ESIS protects `employees' against the impact of incidences of sickness, maternity, disablement, and death due to employment injury. It provides medical care to insured persons and their families (dependents' benefit). Other benefits include confinement expenses, funeral expenses, vocational rehabilitation, physical rehabilitation, unemployment allowance, skill up-gradation training, and a 24x7 Helpline. Systems of medicine recognized for treatment include Allopathic, Ayurveda, Unani, Sidha, Yoga therapy, and Homeopathy. The apex body for managing ESIS is the Employees' State Insurance Corporation (ESIC).

The ESIS applies to factories and other establishments (road transport, hotels, restaurants, construction sites, etc.) that employ 10 (in some states 20) or more persons. Employees drawing wages up to Rs 21,000 (formerly Rs 15,000) a month are entitled to social security cover (ESIC Website 2017). Currently, over 830 centers in 31 states and union territories (UTs) having ESIS coverage are serving over 7.83 lakhs factories and establishments across the country, benefiting about 21.3 million insured

family units through 151 hospitals and 42 hospital annexes for inpatient services and about 1,418 ESIS dispensaries, 140 AYUSH units, and 1,017 panel clinics for primary and outpatient care. The total beneficiary base stands at over 82.8 million and the government is working to cover all states/UTs under the 2nd Generation Reforms Agenda named "ESIC-2.0," which was launched in August 2015.

The ESIS is financed by contributions from employers (4.75 percent of the wages payable to employees) and employees (1.75 percent of the wage). Employees earning up to Rs.100 a day are exempt from making any contributions. State governments contribute 1/8th of the expenditure of medical benefits within a per capita ceiling of Rs 1,500 per insured person per annum.

There are few studies that have evaluated the utilization of ESIS across states; however, most point to the need for urgent revamping of services and service quality to improve beneficiary satisfaction (Shingade and Madhavi 2016, Divya and Pillai 2014).

Publicly Funded Government Health Insurance Schemes

The government of India and various state governments have launched many publicly funded health insurance schemes targeted at poor and vulnerable families. Most of these schemes were fully subsidized by the government. Through these schemes, an attempt has been made to use a demand-side health financing approach to protect people from catastrophic health expenses.

The central government initiated one of the major policy reforms in India by launching Rashtriya Swasthya Bima Yojana (RSBY) in 2008. Many state governments have implemented this scheme with their additions and extending the coverage and scope, while others chose to implement their own schemes. As per the Insurance Regulatory and Development Authority (IRDA), the total number of persons covered by the government-financed insurance schemes is 273.3 million. See the states and their status in terms of RSBY and other health insurance scheme implementation in the table below.

Table A.1: Status of States in Implementing Health Insurance and RSBY

	Through Insurance Company	Through Trust	Through Insurer and Trust	Total States	States
States/ UTs with only RSBY	9	NA	NA	9	Bihar, UP, Assam, Haryana, Tripura. Manipur, West Bengal, Uttarakhand, Jharkhand
States/ UTs with RSBY and state top-up tertiary care schemes	4	NA	6	10	Odisha, Rajasthan, Chhattisgarh, Meghalaya, Gujarat, Karnataka, Kerala, Punjab, Himachal Pradesh, Mizoram
States/ UTs with only their own scheme	7	3	0	10	Tamil Nadu, Maharashtra, Arunachal Pradesh, Goa, Dadra & Nagar Haveli, Andaman & Nicobar Islands, Daman and Diu, Andhra Pradesh, Telangana, Puducherry
States/ UTs without any insurance scheme	NA	NA	NA	7	Madhya Pradesh, Delhi, Jammu & Kashmir, Sikkim, Chandigarh, Nagaland, Lakshadweep

Source: Jain, forthcoming 2017

Community-based Health Insurance and Mutuals

Community-based health insurance (CBHI) has emerged as an alternative demand-side financing option in settings where OOP spending on health was high. CBHI schemes are designed to ensure that adequate resources are available for the community members to access effective health care (Daher 2001). Contributions are accumulated and managed to spread the risk of payment for health care among all scheme members. Moreover, these organizations are staffed by local members who experience first-hand the needs within their neighborhoods.

There are various forms of CBHI, including mutual health organizations, medical aid societies, and micro-insurance schemes. All are voluntary and apply the basic principle of risk sharing. (Carrin et al. 2005). A mutual, mutual organization, or mutual society is an organization based on the principle of mutuality. CBHI organizations such as mutuals raises funds from its members, and these funds are then used to provide common services to all members of the organization or society. Any excess revenue is adjusted by lowering the cost of policies or by investing in improving services or supporting their community, as the members decide. A mutual is therefore owned by, and run for the benefit of, its members, and it has no external stakeholders.

While there are a number of community-based organizations in India, their potential for health insurance provision remains largely untapped. There are only about 25 million people who are covered by CBHI (including mutuals). Health mutuals are present but their numbers are few and hardly enough to cater to India's huge population base. The authors of this paper estimate that there are about 21 health mutuals (big and small) having close to 3.1 million community people (Bhat et al. 2017a and 2017b). Some of the best-known health mutuals in India include those run by Annapurna Pariwar, Uplift India Association, Dhan Foundation (Peoples Mutual), SKDRDP, and Grameen Koota. It is interesting to note that most of these organizations offer microfinance services in the form of credit, insurance, pension, etc. Their members have integrated the health mutual into their ongoing work over a period of time due to the felt needs of community. It is also observed that many NGOs and microfinance institutions have developed a hybrid approach to deal with multiple facets of health needs. For example, the Self Employed Women's Association (SEWA) uses the partner-agent model for hospitalization needs and mutual model for wage loss. SKDRDP follows the mutual model for outpatient care and partner-agent model for hospitalization services. Thus, insurance products are offered both on the principle of health mutual or community-based model, and on the partner-agent model in partnership with the commercial insurance companies.

Most of the mutuals and CBHI organizations are concentrated in a few states of western and southern India. The absence of regulations for mutuals and community-based organizations for health insurance by IRDA presents a challenge to its recognition and scalability. As outlined in the 2010 IAIS Issues Paper on the Regulation and Supervision of MCCOs, their member-based nature raises a number of issues that may require a dedicated regulatory and supervisory response while they work to increase access to insurance market (Bhat et al. 2017a). Other than regulations, some challenges faced by these organizations are: (1) the new risk-based regulatory capital standards (globally) that can put some organizations at a competitive disadvantage compared with better-diversified insurers, (2) finding a balance between good governance and the unique characteristics, which form the pillars of their cooperative model, (3) keeping pace with technological innovations, and (4) difficulties associated with scaling up and ensuring sustainability (Bhat et al. 2017).

Private Voluntary Health Insurance

The growth of corporate sector insurance has been substantially influenced through the introduction of mediclaim hospital insurance policy in 1983 by the four public sector general insurance corporations with a provision of tax exemption. Today there are five stand-alone insurance companies and 24 general insurance companies providing health insurance (IRDA 2016) and covering about 85.7 million people. Many key performance indicators indicate the growth of the PVHI sector: The stand-alone health insurers registered a growth rate of 41.12 percent in 2015/16 against a 31.07 percent growth rate in 2014/15. The gross health insurance premium collected by general and health insurance companies was Rs 24,448 crore in 2015/16, and Rs 20,096 crore in the previous financial year. The premium collection in the health segment continued to surge ahead at Rs 27,457 crore in 2015/16, from Rs 22,636 crore in 2014/15, an increase of 21.30 percent. The market share of health segment has increased to 28.49 percent from 26.73 percent in the previous year (IRDA 2016). The PVHI sector has seen growth not only in individual insurance business but also in group insurance business.

Private insurance can bridge financing gaps by offering consumers value for money and helping them avoid waiting lines, low-quality care, and under-the-table payments for health care in hospitals. However, experience from other countries suggests that the entry of private firms into the health insurance sectors, if not properly regulated, does have adverse consequences. These include increased cost of care, problems of inequity, consumer dissatisfaction, fraud, and moral hazard (Anita 2008). The IRDA must ensure that this sector develops rapidly and that the benefit of insurance goes to the consumers.

Employer-Based Health Protection Schemes

Employers in the private sector adopt multiple ways to take care of the health needs of their employees. While most companies with more than 20 employees enroll their employees under the government's Employees' State Insurance Scheme (ESIS) (Anita 2008), a major limitation is that ESIS covers only low-income workers. Moreover, ESIS services are time consuming and sometimes lack in the quality of care provided. Hence, the corporate sector has to look for other ways to provide health protection to their employees, especially those employees who cannot be covered under ESIS.

Some public and private sector employers opt for taking group medical insurance for their employees from public or private insurance companies. Others cater to the health protection needs on their own by providing lump-sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, or a fixed medical allowance. Some larger entities even create their own health care infrastructure for employees. The Railways, Defence and Security forces, and the Plantation and Mining sectors run their own health services for employees and their families. Some of the facilities include:

- Empanelment: Some employers develop a panel of private hospitals and clinics or practitioners' offices where employees are encouraged to seek care and which, in return for being recognized as approved providers, offer discounted rates.
- Direct Provision of Services: Many large plants/units have on-site emergency services and dispensaries.
- Pluralistic Payment Arrangements: Some corporations use multiple payment arrangements, such as reimbursements and arranging health check-ups.
- Allowances and Reimbursements: Many employers provide for medical care of their employees under collective agreements in the form of allowances or otherwise. Most employers today pay their employees a medical allowance either at a fixed rate or as reimbursement of the expenses incurred by the employees for health care.

- Contributions for Medical Care: Some companies take contributions from their employees to meet their medical costs.
- Free Medical Check-Ups: Some companies provide free annual medical check-ups, particularly for employees who are middle aged.
- Post-Retirement Health Care Benefits.

ANNEX B: GLOBAL EXPERIENCE IN PILOTING HEALTH INSURANCE

1. **Kyrgyzstan:** One of the first pilots in Central Asia was established in 1994 in Issyk-Kul oblast (province or state) in Kyrgyzstan, covering population of 253,000 people. Context was provided by the delay in implementation of two health reform laws, including one on medical insurance, due to poor macroeconomic performance, a low tax revenue base, and a lack of technical capacity within the health sector. The initial objective of the pilot was to provide the Kyrgyz government with a demonstration of a planned social health insurance model. Technical assistance was provided by USAID. During the design phase, the pilot quickly evolved into a broader health reform effort aimed at strengthening the primary care sector and downsizing an inefficient hospital sector to increase health system efficiency. Key activities included restructuring of primary health care in Issyk-Kul, including development of new family group practices, introduction of family medicine, open enrollment, development of new provider payment and health information systems, and introduction of mandatory health insurance. Lessons from this pilot fed into the development of a national health reform strategy (Partners for Health Reformplus 2004). Over time, this strategy provided the top-down political support necessary for continuing, strengthening, and rolling out of pilot activities in the oblast. Even though the Issyk-Kul pilot project was never rigorously evaluated, the model that was tested was modified and refined based on implementation experience, rolled out to two additional oblasts after two years with assistance from a World Bank loan project, and eventually rolled out nationally, covering over 85 percent of the population by 1996 under family group practices. Experience and lessons learned in Issyk-Kul were used to establish a national Mandatory Health Insurance Fund in January 1997. National capacity-building efforts also resulted in the creation of a cadre of highly qualified reform experts. Based on this experience, the Ministry of Health (MOH) thereafter piloted a continuous quality improvement program, a single-payer financing model, an outpatient drug benefit for the insured, and new models of providing emergency care and ambulance services. Evaluation and implementation experience led to refinement and phased implementation of a number of these "second generation" pilots.
2. **Rwanda:** The utilization of primary health care services in Rwanda had gone to an all-time low in the late 1990s due to increased poverty and incapacity to pay user fees for health services, which were costly. The MOH chose to initiate a pilot of prepayment schemes (PPS) for community-based health insurance (CBHI) in 1998. At that time, health systems management was decentralized, and it was felt that health financing reforms were inevitable, and reform elements needed to consist of community-based PPS. The pilot was conceptualized to resolve complex design and operational questions and to build capacity for a national program, before large-scale implementation of CBHI could be launched (Partners for Health Reform*plus* 2004).

The principal actors in the design and development of the pilot at the national level were the MOH, USAID, and, through USAID, the Partnerships for Health Reform project. A steering committee was formed to guide the implementation of pilot. The committee was responsible for the selection of the three districts that would be the pilot sites and the two control districts. Capacity building was an integral part to the pilot design, and heavily focused on establishing capacity at the local level. Monitoring of performance was central to pilot operations, with monthly feedback on performance provided to all stakeholders for discussions of findings and revisions to improve performance.

The pilot was implemented in three districts (with a population of about 1.08 million) from July 1999 through the end of September 2000. The PPS established an insurance program that entitled beneficiaries to preventive care services, maternity benefits, and selected curative care services at a health center linked with the program and designated by the beneficiary. People paid an annual premium (either for a family of up to seven members, or on an individual basis) that allowed beneficiaries access to these health care services for a full year, having minimal co-payment at the time of service delivery. The pilot featured community participation at the local level through gatherings of the general assemblies of PPS members that were responsible for selecting governing rules and regulations, and overseeing the financial and administrative management of the schemes.

As a result of the pilot process, specific policy recommendations were developed that contributed to planning for health policy reform in Rwanda. In terms of financing strategy for the Rwanda health sector, it was recommended that prepayment with providers paid by capitation be endorsed as a financing alternative to out-of-pocket user fees. However, the national roll-out faced problems due to time constraints, lack of funds to support a national program, and limited MOH capacity to oversee and regulate.

3. **Thailand:** The Thai health card scheme, a government-run scheme providing voluntary health insurance for rural communities without formal sector employment, started in 1983 on a small scale in 18 villages as a pilot on community financing and primary health care in maternal and child health (Pannarunothai et al. 2000). The scheme later started receiving a matching subsidy from the government. Over the course of the next 15 years, the scheme was gradually rolled out in phases, with frequent evaluations. While initial goals of the pilot were primarily to determine the feasibility of the overall approach, later phases of piloting focused more on fine-tuning the design of the scheme and developing capacity for further roll-out.

   Scheme coverage has experienced u-shaped behavior: it started at 5 percent of the total population in 1987, declined to 3 percent in 1992, and then rose to 14 percent in 1997. The upturn was an outcome of the new focus on universal coverage, together with reformed fund management. The component of the provincial fund covered basic health, basic medical, referral, and accident and emergency services. The central fund was earmarked to manage cross-boundary services and high-cost care (a kind of reinsurance policy).

   On average, the utilization rate of the voluntary health card was higher than that of the compulsory (social security) scheme. And among three variants of health cards, the voluntary health card holders used health services two to three times more than the community and health volunteer card holders. Cost recovery was low, especially in the provinces with low coverage. In the province with highest coverage, cost recovery was as high as 90 percent of the non-labor recurrent cost. Today, the Thai government has merged resources from the Medical Welfare Scheme and the Health Card Scheme under its universal health coverage scheme.

4. **South Africa:** A National Health Insurance (NHI) pilot was launched in 2012 in 11 districts of South Africa. The idea behind starting this pilot was to focus on the most vulnerable sections of society across the country, reduce high maternal and child mortality through district-based health interventions, and strengthen the performance of the public health system in readiness for the full roll-out of NHI (Fusheini and Eyles 2016).

   The objectives of the pilot included testing the ability of the districts to assume greater responsibilities under the NHI, and to assess utilization patterns, and costs and affordability of implementing a primary care service package. As a health financing system, the NHI is designed to pool funds to provide access to quality, affordable personal health services for all South Africans irrespective of their socio-economic status. Thus, the NHI was intended to ensure that the use of health services does not result in financial hardships for individuals and their families

   The pilot was implemented and rolled out over a 15-year period, with the first phase ending in 2017. Over its next phases, the pilot will further assess whether the health service package, primary health care teams, and strengthened referral system will improve access to quality health services, particularly in rural and previously disadvantaged areas of the country.

   The NHI is planned to have a single-payer mandatory prepayment mechanism where resources are pooled in a single fund to cover for the health needs of the entire population via a strategic purchaser. This involves eliminating various forms of direct payments such as user charges, co-payments, and direct out-of-pocket payments to accredited health service providers. The implementation plan of the NHI identifies potential sources for funding the scheme as including: direct and indirect taxation, payroll tax, and collection of premiums or membership contributions from employees or informal sector (Department of Health, Republic of South Africa 2015). The program has yet to decide how much premium is to be paid. In terms of cost, a preliminary estimates suggest that the NHI will cost R255 billion (about US$30 billion) per year by 2025, if implemented as planned over the 15-year period (Fan and Silverman 2012).

5. **India:** Rashtriya Swasthya Bima Yojana (RSBY), India's national health insurance program, provides cashless inpatient health care services for workers in the unorganized sector and the below-the-poverty-line population since 2008. To address the burden of high expenditure for outpatient health care and improve health-seeking behavior among the poor, the Outpatient Health Care Pilot project under the RSBY was conceived. The pilot project began in July 2011 in the Puri District of Odisha and from November 2011 in the Mehsana District of Gujarat. It introduced the delivery of cashless outpatient health care services in these districts to all households enrolled in the RSBY. The same insurance company was contracted for both inpatient and outpatient services in order to contain costs and maintain scalability, but a separate annual premium was paid for the outpatient services component. New information technology software, similar to software for RSBY inpatient services, was developed and installed to handle the delivery of outpatient health care services. The RSBY team in the Ministry of Labour and Employment partnered with the Microinsurance Innovation Facility of the International Labour Organisation and the ICICI Foundation for Inclusive Growth (ICICI Foundation) for this pilot project. The case study on this pilot suggests that until February 2013, more than 83,000 beneficiaries in Puri and around 45,000 in Mehsana had utilized RSBY outpatient services; family-level utilization stood at 60 percent. Initial analysis showed that there was a reduction in average inpatient health care claim size of about 14 percent in Puri and 15 percent in Mehsana, after introduction of the outpatient health care services. The enthusiasm generated by the outpatient health care pilot and the comfort from the initial findings and observations encouraged other states like Punjab, Uttarakhand, Mizoram, and Andhra Pradesh to carry out similar experiments (ICICI Foundation 2013).

6. **India:** The Chiranjeevi Scheme, based on the public-private partnership (PPP) model to deliver reproductive health care services, was launched as a one-year pilot project in December 2005 in five backward districts of Gujarat: Banaskantha, Dahod, Kutch, Panchmahals, and Sabarkantha. In 2007, the scheme was rolled out in the entire state, based on the success of the pilot. When the scheme was initiated, the pilot districts were selected based on remoteness and included regions with the highest rate of infant mortality. The private medical practitioners (mainly obstetricians) in these districts were empanelled in the scheme by the government to provide cashless delivery-care services to women below the poverty line by introducing voucher scheme. Under the scheme, the private providers would be reimbursed after presenting the voucher provided by the government. Moreover, eligible women were also entitled to receive Rs 200 toward transport costs and Rs 50 for the accompanying person. The objective of the scheme was to remove financial barriers for the poor in accessing qualified private providers. Any private qualified gynecologist with basic facilities like a labor and operating room and access to blood and an anesthetist was enrolled under the scheme. These empanelled private providers (EPPs) had to agree to perform free delivery for women designated below the poverty line. EPPs were paid Rs 179,500 for every 100 deliveries including caesarean sections and complicated deliveries (Acharya and McNamee 2009). To discourage unnecessary caesarean sections, there was no separate or additional payment for them. The remuneration package was designed by a group of experts in which all possible complications (15 percent of all cases) were included. To overcome working capital problem of the EPPs, they received an advance payment of Rs 15,000 while signing an agreement with the state government.

   The government noticed that maternal as well as neonatal deaths were substantially reduced under the scheme (Acharya and McNamee 2009). Another study (Bhat et al. 2009) showed that the Chiranjeevi Scheme had provided financial protection against the cost of delivery and emergency operational costs to the marginalized section of the population. The Chiranjeevi Yojana was considered to be a successful PPP model and it has also received the prestigious Asian Innovations Award, given by the Wall Street Journal. It has been a flagship scheme of the Gujarat state ministry of health and family welfare and has been recommended for scaling up at the national level.

7. **Tanzania:** The Community Health Fund (CHF) started in 1996 with a pilot scheme in Igunga district of Tanzania. It was later expanded to other councils with the expectation of covering the whole country (MOH, Tanzania 1999). The scheme was identified as a possible mechanism to improve access to health care for the poor and vulnerable groups. The CHF was a form of pre-payment scheme designed for rural people in Tanzania (Munishi 2001). It was based on the concept of risk sharing whereby members would pay a small contribution on a regular basis to offset the risk of needing to pay a much larger amount in health care user fees if they fell sick. According to the Community Health Fund Act of 2001, the objectives of the CHF were: (i) to mobilize financial resources from the community for provision of health care services to its members; (ii) to provide quality and affordable health care services through sustainable financial mechanism; and (iii) to improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contributing on matters affecting their health (URT 2001). Membership in the CHF was voluntary and the household was the unit of enrollment. The majority of districts set their contribution rate to between US$4.2 and US$12.7 per year, as agreed by members of the community themselves, and members were given a health card (URT 2001).

CHF members registered at public health facilities where premiums were also collected and member households were subsequently eligible for free primary care at the selected facility. In some districts, limited referral health care services were also covered. After collection, the funds were deposited into a cost-sharing or CHF account at the council level (Stoermer et al. 2012). In some districts, a percentage of the funds went back to the facility and could be used for drug purchases and minor repairs. The government matched member contributions through a matching grant. A system of exemptions aimed at ensuring free access to public health services among vulnerable groups such as children under five years of age, pregnant women, and people with chronic diseases like HIV/AIDS also existed (Mtei and Mulligan 2007).

Even after more than 10 years of roll-out of the scheme, national CHF coverage remained very low at about 7.1 percent of the total population (Humba 2011), compared with the population of informal sector workers and their dependents, which represent more than 70 percent of the entire population. The reasons for this were varied and included perceptions that the quality of services in government facilities was poor; the benefits package was limited; and doubts existed over the local management of the scheme. Substantial challenges in implementation remained, particularly around management and accountability of the scheme, and also in ensuring that the poorest groups were not excluded. Despite these issues, there were also clear examples where councils had been able to overcome difficulties and introduced innovative solutions. On the whole, the government was committed to extending coverage through the CHF (Borghi et al. 2013).

8. **Kazakhstan:** Primary care reforms in Zhezkazgan in the late 1990s were accompanied by an effort to increase the population's involvement through increased information and choice. After the initial stages of the reform process, during which reform goals and approaches were debated and modified, a public information campaign was implemented intensively for several months. Information was provided to the public by the Oblast Health Department and health providers through the newspaper, television, and radio, as well as through special health promotion events. The first stage of the public information campaign culminated in open enrollment in December 1997, in which the population of Zhezkazgan city was given the opportunity, for the first time ever in Kazakhstan, to choose their primary care provider. More than 75 percent of the population visited the enrollment points throughout the city to actively enroll in the Family Group Practice (FGP) of their choice. In mid-1998, Satpayev city also conducted an open enrollment campaign (Abzalova et al. 1998).

   The primary care capitated payment system was introduced in Zhezkazgan, which was a transition to a partial primary care fundholding payment system, in which the capitated payment received by the FGP was increased, and the FGP was responsible for purchasing or providing all outpatient specialty services for its population. The goal was to strengthen the incentives for FGPs to reduce inappropriate referrals and to invest more of their resources in preventive care and health promotion. Under the capitated payment system, FGPs that were able to attract more enrollees also attracted a larger share of primary care financing. While the pilot was initiated in 1997, political opposition and severe budgetary constraints prevented long-term implementation and roll-out of the pilot (Partners for Health Reformplus 2004).

9. **China:** In the last six decades, China has made significant advances in health system strengthening and improving health outcomes, despite suffering setbacks including political and socio-economic crises. The development of a health insurance system for rural residents has been an important means of expanding access to essential care. The New Rural Cooperative Medical Scheme (NCMS) in China was established in 2003, as a flagship policy aimed at rural populations. It expanded rapidly, with coverage increasing from 9.5 percent to 98.9 percent of rural residents in 2003-2013 (Meng and Xu 2014). During the time it was launched, pilots were a crucial part of the implementation process. In the technical guidance document issued by the central government, there was no detailed design specifying the contents of scheme (premiums rate, provider payment mechanism, benefit package, etc.), but it was required that provinces select at least two or three counties to pilot their schemes prior to full-scale implementation. There was the expectation that the pilots would be evaluated, with any policy scale-up to all counties drawing on the evaluation outcomes. From 2003 to 2005, NCMS pilots were conducted in approximately 300 counties, and in 2006 a large-scale evaluation of already implemented NCMS was conducted (Lin et al. 2011). All these pilots and evaluations helped to inform the final design of the NCMS, which is currently being implemented.

10. **Egypt:** Historically, the Egyptian health care system emphasized inpatient, institutional care. Reform efforts introduced by the Egyptian Ministry of Health and Population (MOHP) shifted this emphasis toward outpatient, high-quality primary health care. Alexandria governorate was chosen as the site for the pilot effort for the Health Sector Reform Program (HSRP). Activities started with some service delivery pilot sites in the Montazah district and eventually expanded to the entire district and thereafter to the entire governorate. Four types of provider facilities participated in the pilot: MOHP, Health Insurance Organization (HIO), private, and nongovernmental organization (NGO). The Alexandria pilot project comprised the following three components:

    a. A health care model that provides high-quality primary care services at sites comprehensively staffed with family practice physician/nurse teams and with the administrative capability to manage patient intake and establish and collect user payments.

    b. A financing component administered by a quality-contracting agency called the Family Health Fund (FHF) that would pay performance-based incentives to providers, and

    c. A regulatory component of reforms for finance, accreditation, information, and contract management that each participating health care agency and provider must meet.

    The FHF that was the brainchild of the MOHP was an innovation in health financing in Egypt. It was developed by 1999 but implemented around 2000-2001. It started with acting as a payment center, located in each of the five pilot governorates where HSRP was implemented, starting with Alexandria. The FHF is responsible for providing insurance coverage to beneficiaries through contracting and purchasing primary health care services from Family Health Units and Family Health Centers that are owned by public sector or HIO providers and have fulfilled the family medicine accreditation requirements. By 2005, the aim was to establish FHFs in each governorate of the country (WHO 2006).

Broad learning from the review of pilots:

- Political will and ownership is most crucial for the successful design and implementation of a pilot in any country.
- Participation, sustained commitment, and capacity strengthening of all stakeholders is crucial for smooth implementation of a pilot.
- Pilots take time to implement and evolve. A short time frame imposes time constraints and can hamper functioning. It also deters impact evaluation, which is crucial for taking a decision on eventual roll-out.
- In pilots like those on health insurance, awareness generation in the community and capacity strengthening, as well as transferring ownership, takes substantial time, sometimes even years, and has to be factored in the overall timeframe of the study.
- While pilots are planned for up scaling by the policymakers, they are likely to involve new partner NGOs, policymakers, and other institutions as they are implemented in the field or rolled out in newer areas. This needs to ensure that enthusiasm in other areas and among stakeholders is as high and sustained.
- Many pilots are donor driven. They cease to exist when funding stops for various reasons. This trend has to be safeguarded against. Human and financial resources are crucial for pilot implementation.

ANNEX C. KEY CHARACTERISTICS OF HEALTH INSURANCE SCHEMES IN INDIA

Scheme	CGHS	ESIS	GSHI	State Supported	CBHI / Health Mutuals	PVHI	Other
Name of the Scheme	Central Government Health Scheme	Employee State Insurance Scheme	Government Supported Health Insurance	CMs State Level Schemes	Community-Based Health Insurance	Private Voluntary Health Insurance	Employed Based Risk Retention
Started in Year	1954	The ESI Act was enacted in 1948 and came into effect from 24 February 1952	Rashtriya Swasthya Bima Yojana: 2008	2005 onwards in different states. Rajiv Aarogyasri was launched in 2007 in Andhra Pradesh (AP)	Started in India in 1950's.	Grew rapidly for 1983 onwards.	Corporate Entity Specific
Sources of Revenue	Central Government, Employee Contribution (marginal)	Employee (1.75 %), Employer (4.75 %) and State Government's share is 1/8th, central government's share is 7/8th	Central Government (60%) and State Government (40%)	State Government Budget	Communities Premium	Voluntary Premium	Corporate Entities Internal Accruals
Membership	Mandatory	Mandatory	Mandatory, but targeting an issue	Mandatory, but targeting an issue	Mandatory and Voluntary for Members of Community	Voluntary	Varies
Operations Through	Not Operated Through Commercial Insurance Companies	Not Operated Through Commercial Insurance Companies	Operated through Commercial Insurance Companies (some operated by state governments)	Some schemes are Operated Through Commercial Insurance Companies	Some Operated Through Commercial Insurer/ Some Mutual	Operated through Commercial Insurance Companies	Not Operated Through Commercial Insurance Companies

Scheme	CGHS	ESIS	GSHI	State Supported	CBHI / Health Mutuals	PVHI	Other
Risk Retention	Government	ESIS	Health Insurance Companies, Both Public and Private	Health Insurance Companies, Both Public and Private and some cases State Government	Health Insurance Companies, in Health Mutual Cases Communities	Health Insurance Companies, Both Public and Private	Corporate Entities
Providers Engaged	Public and Private	Largely Owned Facilities but also Public and Private	Public and Private	Public and Private	Largely Private, Public Facilities	Private	Private
Coverage	Comprehensive, both Hospitalization and Outpatient Care	Comprehensive, both Hospitalization and Outpatient Care	Hospitalization Only	Hospitalization Only	Hospitalization Only	Hospitalization, Some Insurers have started integrating Outpatient Care	Hospitalization
Eligibility Criterion	Central Government Employees, Pensioners and their dependents	Worker population and their dependents. Establishment wherein 10 (20 in some states) employed drawing wages up to Rs 21,000 a month	Below Poverty Line	Below Poverty Line Plus Extension to other Vulnerable Groups of Population	Community Membership	Voluntary, depends upon benefit package desired/ selected	Corporate Employees
Average Expenditure/ Premium	Annual per capita expenditure is over Rs 5000. Total expenditure was Rs 1800 crore in 2015	Medical Benefit Expenditure was Rs 3008 crores in 2011-12, Cash Benefit expenditure Rs.621 crores and Administrative Expenses was Rs 724 crores	A nominal registration fee of Rs 30 is charged per household. Total premium paid to RSBY in 2015–16 was Rs 1500 cr.	Differs from state to state. For Rajiv Aarogyasri, expenditure was 24.4% of total health expenditure in 2009-2010***	Varies, depending upon mutual consent of members involved	The premium collection in health insurance segment was Rs 220 billion in 2015-16 **	Varies
Number of Persons Covered (in millions)	3.67	78.9	273.3	75	25	85.7	10

Scheme	CGHS	ESIS	GSHI	State Supported	CBHI / Health Mutuals	PVHI	Other
Governing body/ Stewardship role	Ministry of Health and Family Welfare	Employees' State Insurance Corporation (ESIC)	Ministry of Health and Family Welfare	Department of Health of respective state or trusts formed for the scheme.	Committees formed by members for running the scheme	Insurance company	Corporate entity
Insurance premiums vary across different schemes and identical individuals in different risk pools pay different premiums							
There is significant variations in the package of care and the differences in the benefit package from risk pool to risk pool are significant							
The provider mix varies across pools and results in qualitative differences in health care received by members of different risk pools (for example, ESIS Hospital vs Private Hospitals)							
There are significant differences in the out-of-pocket charges to individuals in different risk pools							
*Source: http://esic.nic.in/NewsnEvents/summary080612.pdf							
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ANNEX D. REFERENCES

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