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ROLE OF GOVERNMENT-FUNDED AND COMMUNITY-BASED HEALTH INSURANCE SCHEMES IN MOVING TOWARD UNIVERSAL HEALTH COVERAGE IN INDIA

August 2017
This publication was produced for review by the United States Agency for International Development.
It was prepared Dr. Nishant Jain for the Health Finance and Governance Project

The Health Finance and Governance Project

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August 2017

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: Jain, Nishant. August 2017. *Role of Government-funded and Community-based Health Insurance Schemes in Moving toward Universal Health Coverage in India.* Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

Photo: A farmer plows his field using livestock at a village in Dhar district, Madhya Pradesh, India.

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ACKNOWLEDGEMENTS

A work of this nature would not have been completed without the support of many people. I want to thank representatives of various state governments who are running their health insurance/protection schemes. My sincere thanks also go to the representatives of the Ministry of Health and Family Welfare and the Ministry of Labour and Employment who provided their insights regarding Rashtriya Swasthya Bima Yojana (RSBY) and the proposed scheme.

My gratitude goes to Lysander Menezes for always telling me to keep the macroeconomic picture in mind. I am also thankful to Jeanna Holtz, who asked pointed questions that helped in preparing and structuring the report clearly. I am thankful to Vinita Satija for providing excellent editorial support. Last but not least, this report may not have been completed without the guidance of Professor Ramesh Bhat, who has always pushed me to expand boundaries.

EXECUTIVE SUMMARY

India has substantially improved health outcomes, especially those related to maternal and child survival. However, there remains a high degree of health inequity in health outcomes and access to health care services. The Indian government spends only 1.15 percent of gross domestic product (GDP) on health, one of the lowest percentages in the world. This low public expenditure is one of the reasons for very high out-of-pocket (OOP) expenditures on health, and it results in 40-60 million persons being pushed below the poverty line. The high OOP expenditure on health is an outcome of over-reliance on the private sector for both inpatient and outpatient health services. In spite of major investments in improving public-sector providers, data show that dependency on the private sector is increasing. India's high dependence on the private sector may not be a problem per se, but in the absence of financial protection and inadequate regulation of the sector, particularly in areas of quality assurance and cost management, the undesirable consequence of such dependence for some groups of the population is a serious health finance problem.

Recognizing the challenges faced in adopting only a supply-side health financing approach, the Government of India and various state governments launched health insurance schemes targeted at poor and vulnerable families. The government has fully subsidized most of the schemes. These government-funded health insurance schemes (GFHIS) have attempted to use a demand-side health financing approach.

GFHIS have evolved over time. The first generation of schemes was launched between 2004 and 2007. Based on lessons from their scheme design and implementation models, the next generation of schemes was designed starting with Andhra Pradesh's Rajiv Aarogyasri in 2007. The Aarogyasri design inspired many states such as Karnataka, Tamil Nadu, and Maharashtra, which launched their own schemes. One common feature of all of these schemes was a focus on tertiary care. The Ministry of Labour and Employment launched Rashtriya Swasthya Bima Yojana (RSBY) in 2008. It focuses more on secondary care and is currently the largest GFHIS. It uses a biometric smart card platform. Many states have expanded RSBY either in terms of benefit cover and/or target population at their own cost, while others are implementing only their own health insurance schemes. GFHIS have been able to scale up very fast and have been able to improve access and reduce OOP expenditure to an extent, but they face the challenges of fragmentation, overlapping benefits, weak institutions, low awareness, and absence of linkages with primary care.

At the same time, several community-based health insurance (CBHI) schemes operate in India with the purpose of meeting the health needs of community-based organizations. They aim to address the gap in health protection needs of communities and tackle high OOP spending on health. The introduction of GFHIS like RSBY had some impact on existing CBHI schemes, some of whose clients were below the poverty line and therefore eligible to enroll in GFHIS/RSBY. Nevertheless, most CBHI clients were above the poverty line and therefore ineligible to migrate to RSBY, so they continued to be enrolled in CBHI. This may change due to the proposed launch of the National Health Protection Scheme (NHPS), which is likely to increase benefits and enroll a much larger population. The NHPS aims at increasing the health insurance benefit cover of existing GHIS and proposes to enroll a much larger population based on socio-economic census data.

CBHI schemes have faced issues of limited benefit cover, difficulties in scaling up, and unsustainably high administrative costs. The advent of GFHIS has compounded these challenges. To remain relevant in the changing health care environment and carry out their task of strengthening access to health care, CBHI schemes must work to redesign their vision and strategy. This can involve having a closer look at their target population, benefit cover, and/or implementation framework. For example, as most GFHIS do not cover primary care, this might become the purview of CBHI schemes. However, providing this cover on a stand-alone basis without any linkage with inpatient services might be tricky due to moral hazard and high costs. In reinventing their role and strategy, CBHI schemes could consider learning from and adopting GFHIS strengths in implementation and management. A good way to share and transfer these lessons would be for CBHI schemes to develop a partnership or linkage with GFHIS. Various CBHI schemes could also come together to pool their technical expertise and financial resources.

Non-poor or near-poor families are not covered by GFHIS, including RSBY. But these families can be covered by CBHI schemes. Currently they might not be enrolling in CBHI either because they see the schemes having scale-up issues or failing to be a part of the country's larger health system. However, if CBHI schemes can enhance their internal capacities and align with GFHIS, they will be more attractive to new families. GFHIS have developed comprehensive empanelment criteria for health care providers, package rates for treatment, robust IT systems, and effective monitoring systems. CBHI schemes can either adopt many of these aspects or they can enter into a partnership with the government to get access to them. For benefits that are not part of GFHIS, CBHI schemes may need to develop the know-how and systems on their own or in partnership with other CBHI schemes to achieve a critical mass.

There is a policy debate on whether government should invest resources in strengthening the public health systems or use the health insurance financing mechanism to buy services from the private sector. The National Health Policy (NHP) of 2017 proposes focusing on increasing the public spending on health with emphasis on strengthening public health provision. At the same time, given the significant presence of the private health sector, the NHP 2017 proposes to use existing GFHIS to develop options for strategic purchasing.

Health insurance schemes bring some predictability regarding health expenditures at the individual or household level. Besides its function of distributing the risk, it also provides service-provider options for beneficiaries. Public facilities would have an incentive to improve quality if they are allowed to retain the claims received within their facilities. These resources can improve the provider's infrastructure and services. In addition, a defined percentage of claim revenue provides a financial incentive to public provider staff to augment their salaries.

One of the biggest challenges to the Indian health care sector is a lack of regulatory controls over quality, pricing, manpower, and so forth. GFHIS have been able to influence the behavior of the private sector to some extent in terms of price control through package rates, incentivizing quality, defining human resource requirements, and collecting data. Health insurance through GFHIS and CBHI schemes could further this, with scheme purchases influencing the pricing, quality, and service delivery of both public and private sectors. In this way, health insurance has a potential to go beyond just providing financial protection and also contribute to health systems strengthening.

Even though insurance schemes have the potential to answer the above-mentioned challenges, they are constrained by fragmentation and suboptimal use of their potential as a lever for health sector reform. Data from the latest household survey by the National Sample Survey Office suggest that only 12-14 percent of the population is covered by health insurance, largely for secondary and tertiary care only. This leaves a large percentage uncovered for any level of care. Therefore, India needs a health protection policy response that delivers comprehensive health protection.

The powerful role health insurance can play in India's journey to universal health coverage is undeniable. How strong this role will in fact be will depend on how far and how soon the different players can converge on intent and implementation. Linkage of reformed primary care delivery through the National Health Mission with health insurance is imperative to address gaps in access to health care. As a start, the government must actively engage different stakeholders to create a unified vision of health care for the country, one that defines the place of each funding mechanism, stakeholder, and type of care. Government will also need to decide whether to subsidize only poor or make coverage universal.

1. INTRODUCTION AND BACKGROUND

India is the world's third largest economy in terms of its gross domestic product (GDP) in purchasing power parity terms.[1] Even though India has been able to improve substantially some of its health outcomes, especially those related to maternal and child survival, there is high degree of inequity in health outcomes and access to health care services (MOHFW 2014).

According to the World Health Organization (WHO), India has one of the lowest public health expenditures in the world. Total health expenditure is 4.02 percent of GDP; government expenditure on health is only 1.15 percent of GDP. Approximately 67 percent of total health expenditure is by households, and most of that, 64 percent of total health expenditure, is out-of-pocket (OOP) spending (MOHFW 2016). Even in government facilities, which are supposed to be completely free, people have to spend a lot OOP (Rs 6,120 (US$94) per hospitalization episode) (National Sample Survey Office [NSSO] 71st round 2015). The low level of government expenditure on health as a percentage of GDP leads to high dependence on the private health care sector, which results in high levels of OOP spending on health.

High OOP expenditure on health is worrisome. Various studies have shown that 40-60 million households in India are pushed below the poverty line every year due to health-related expenditures (Berman et al. 2010; Shahrawat and Rao 2012; Garg and Karan 2005). This creates a huge strain on the economy and can negate other government poverty alleviation efforts in two ways. First, families become poor due directly to catastrophic health expenditures; second, illness and other health conditions reduce people's productivity, which affects their income generation capacity and can further affect their poverty status (Savedoff and Schultz 2000; Saha 2013).

In spite of all the investments the central government (in programs such as the National Health Mission) and state governments have made to improve primary and secondary health care delivery, the public health sector is not able to cope with the rising health care-related demands of the population. As a result, dependence on the private health sector is steadily increasing, even for primary care. Compounding matters is the growing dual burden of disease and rapid transition of health epidemiology in India. While communicable diseases still affect the population, the burden of non-communicable diseases is increasing. Overall, communicable diseases contribute to 28 percent of the entire disease burden, while maternal and neonatal ailments contribute to 13.8 percent. Non-communicable diseases (60 percent) and injuries (12 percent) now constitute the bulk of the country's disease burden (MOHFW 2014).

Data show the high reliance on the private sector for care. Up to 71.7 percent of outpatient cases opted for private facilities in rural areas and 78.7 percent did in urban areas (NSSO 2015). Even for inpatient care, 58.1 percent of urban hospitalization cases and 68 percent of rural cases were treated in the private sector (NSSO 2015). Such reliance on the private sector and consequently high OOP expenditures on health are lower in most countries. India's high dependence on the private sector may not be a problem in itself, but in the absence of any kind of financial protection and inadequate regulation of the sector, in particular weak self-regulation, information asymmetry may lead to exploitation of patients. Often in countries with better health systems, the private sector self-regulates even in the absence of a strong formal regulatory mechanism; in India, self-regulation is not adequate.

[1] http://data.worldbank.org/data-catalog/GDP-PPP-based-table (accessed on 05th November 2016)

To address the gap in government provision of health care and to tackle high OOP spending on health, several community-based health insurance (CBHI) schemes were launched in India. Many of these schemes started long before the advent of government-financed health insurance schemes (GFHIS). The CBHI schemes have tried to provide financial protection (though on limited scale) to their target populations. The schemes have varied target populations such as members of a cooperative/trade union or non-government organizations (NGOs). Some schemes were for families taking credit from microfinance institutions. Since all these CBHI schemes were contributory, very poor families were excluded by design since they do not have the financial capacity to pay even a small premium (Ekman 2004; Lahkar and Sundaram-Stukel, 2010). It is important to note that while almost all GFHIS have focused on poor and economically weaker populations, the target segments for CBHI schemes vary, though most are above the poverty line.

With the introduction of GFHIS, it is time for the CBHI schemes to assess whether their benefits and/or target beneficiaries are complementing or duplicating those of GFHIS. There are various ways in which CBHI schemes can complement GFHIS, and both types of schemes can work in tandem with each other. Complementarity can be with respect to target population, benefit cover, and/or community participation.

2. OBJECTIVES OF THE STUDY AND METHODOLOGY

The objective of this study is to analyze the evolving scenario of GFHIS and CBHI schemes in India. The paper assesses the evolution of GFHIS and their impact on CBHI schemes with respect to innovation and implementation experience. The aim is to identify lessons from GFHIS that can have impact on the functioning of CBHI schemes. The paper makes recommendations on fitting together these health insurance schemes in the larger health care domain in the country.

This qualitative analysis is based largely on the experience of the author working in various capacities in the design and implementation of several GFHIS in India and many other countries. The sources of additional data about experience in India and beyond included:

- A literature review, which included both published research and unpublished research and other materials such as conference presentations (see Annex F)
- Telephonic and in-person key informant interviews with representatives of select state governments that are implementing Rashtriya Swasthya Bima Yojana (RSBY) and other schemes
- Additional interviews with representatives of research institutions and other organizations working in this area

More data on international experience came from a literature review and first-hand interaction with representatives of select countries that are managing their own health insurance schemes.

3. INDIA'S EXPERIENCE WITH GFHIS

Recognizing the limitations of focusing on only the supply-side health delivery and financing model, in the last decade, the Government of India and various state governments have introduced demand-side financing mechanisms to provide financial security for vulnerable segments of society. Several state governments, including Goa, Punjab, Kerala, and Assam, launched health insurance schemes between 2005 and 2007. Most of these early schemes were not able to achieve the desired objectives and were closed after one or two years. Though the schemes' intention to provide health insurance was laudable and much needed, the schemes were not successful for many reasons:

- Their basic model was to contract out the implementation of the health insurance scheme to an insurance company and pay the company a lump-sum premium based on the estimated number of families to be covered. Implementation of the scheme was the responsibility of the insurance company. Without rigorous oversight and control from the state governments, the companies had minimum incentive to inform beneficiaries of scheme benefits and procedures, including how to use benefits. In most states, insurance companies made a substantial profit while too many people went without care, which led to bad publicity not only for these schemes but for the concept of health insurance.
- As alluded to in the preceding paragraph, the state government had no dedicated institution responsible for scheme management. Without a dedicated scheme manager that could oversee enrollment, the states paid the premium for the estimated targeted population, not for the families actually enrolled. This lack of oversight continued with other implementation processes.
- Since the beneficiary families were automatically enrolled in the scheme if they had a below the poverty line (BPL) card/ration card, etc., awareness generation was not done. The low claim ratios of many of these schemes indicated that most people were not even aware of their insurance coverage.
- The benefits package was not always appropriately designed. For example, in one state, severe degenerative diseases such as Alzheimer's and Parkinson's were included, but common, simple diseases were not.

The lessons that emerged from this initial set of schemes were that:

a. Setting up a dedicated institution to manage the health insurance scheme is imperative for success

b. Outsourcing the implementation to an insurance company only is not sufficient. Government should provide strong oversight

c. The benefit package should be designed appropriately

d. Preferably there should be an enrollment process. If not, intensive awareness activities need to be carried out to inform beneficiaries about the scheme

States began to launch a second wave of health insurance schemes in 2007. Some of the more salient schemes are discussed below in Section 3.1. These initiatives incorporated lessons learned from the earlier schemes and were aimed at providing health insurance to the state's vulnerable, BPL population. An interesting observation here is that even though all these schemes focused on the BPL population,

the definition of BPL varied by state. For example, in Gujarat's Mukhyamantri Amrutum scheme, people with an income up to Rs 120,000 per year were considered poor, while in Tamil Nadu's Chief Minister's Health Insurance scheme, this limit was Rs 72,000. Some of the newer schemes have influenced schemes in other states.

3.1 State GFHIS

3.1.1 Rajiv Aarogyasri

In 2007, the government of Andhra Pradesh[2] launched a health insurance scheme for poor families called Rajiv Aarogyasri. The government made two very critical decisions at the time of designing and launching the scheme, which had huge implications for the design of similar schemes launched by other states:

- The first decision was to cover mostly defined tertiary care procedures. The rationale for this decision was that primary and secondary care services were being effectively provided by the government facilities and the insurance scheme would cover services that are not easily available in government facilities. Even though the benefits package was revised later to include some secondary care conditions, it still predominantly consists of tertiary care packages and most claims are for tertiary care conditions.
- The second decision was regarding the target population. Even though the scheme was technically offered to poor families, families having a white ration card were eligible, which meant that approximately 80 percent of population of the state was considered poor and was covered under the scheme.

Rajiv Aarogyasri started with an insurance company implementing the scheme and a dedicated trust providing management and oversight. Setting up a dedicated trust to manage the scheme was a crucial step (based on lessons from earlier schemes) as this body had experts able to manage the scheme through the insurance company. As time passed, the trust built its capacities to manage the scheme on its own, and after four years, the state government decided to implement the scheme directly through the trust without insurance company intermediation. This shift was done in a phased way in 2011 and 2012. Now, the scheme is managed and implemented at the state level by the Aarogyasri Health Care Trust.

Initially, in 2007/08, the scheme covered 163 treatments under the banner Aarogyasri-I with a budget of Rs 500 million (US$7.7 million). In 2008/09, under Aarogyasri-II, it added 533 (389 surgical and 144 medical) procedures and 79 procedures in the specialities of obstetrics, eye, ENT, cardiology, trauma, and critical care. The scheme also expanded to cover the entire state. In 2011, the Aarogyasri scheme had approximately 80 million beneficiaries.

The state approached the scheme professionally with the help of a well-designed IT system. There is no doubt that Aarogyasri was instrumental in inspiring many states such as Karnataka, Tamil Nadu, and Maharashtra to launch similar schemes.

Critics have argued that though Aarogyasri has achieved success, the priorities of the state government are misplaced. A disproportionately large percentage of the health budget goes to a scheme providing only tertiary care (Reddy and Mary 2013). In 2007/08, expenditure on Aarogyasri was six percent of the state's total health expenditure; it increased to 24.4 percent in 2009/10 (Reddy and Mary 2013). The scheme has revised its benefits package to include some secondary care diseases, but it continues to face

[2] In 2014, Andhra Pradesh was split into two states, Andhra Pradesh and Telangana.

challenges such as provider-induced demand, targeting, and increasing costs. Andhra Pradesh is spending a much higher percentage of its health budget on tertiary care than on primary and secondary care (Reddy et al. 2011).

The fact that Aarogyasri benefits are mostly limited to tertiary care, and simple secondary care conditions were not covered, has been a limitation. It does not cover hospitalization related to simple medical needs such as fever, diarrhea, and minor surgeries, which are relevant for the poor and vulnerable. In addition, Aarogyasri's benefits are not recognized outside state boundaries. Persons covered by a state scheme can get the benefit only within the state. They remain vulnerable outside the state.

Even though part of the motivation behind the Aarogyasri scheme may have been political, this scheme was able to gain huge popularity quickly and was able to fill a big gap related to accessibility of tertiary care for families in the state. For these reasons, it is considered one of the important health insurance schemes in the country.

3.1.2 Other State-level GFHIS

Aarogyasri and later RSBY (discussed below) inspired many other state governments such as Karnataka, Tamil Nadu, Maharashtra, Gujarat, and Himachal Pradesh to establish similar schemes between 2008 and 2015. Many more states/union territories (UTs) have joined this movement. Currently, 24 states/UTs are implementing their own schemes, either on their own or as a top-up to RSBY.

The main feature of most of these health insurance schemes is that they follow a Public-Private Partnership (PPP) model. They are completely funded by the government, and they pay a premium to insurance companies on behalf of beneficiaries. The insurance companies enroll the beneficiaries, empanel the hospitals, manage claims, and bear the financial risk.

In some schemes, however, for example Karnataka's Vajpayee Aarogyasri scheme and Gujarat's Mukhyamantri Amrutam scheme, the state government implements the insurance program through a government-owned trust instead of a partnership with an insurance company. The trust implements the scheme, including informing the beneficiaries and contracting with public and private hospitals for claim payments.

As we have seen, in one approach, which most of the states use, the risk is borne by the insurance company. Government liability is limited to premiums paid to the insurance company. In the second approach, financial risk and full responsibility of implementation lies with the trust/society. State/UT governments have set up these trusts/societies as independent bodies to manage and implement the health insurance schemes. Both approaches have advantages and challenges; Annex B compares the models.

There are also variations in the benefit packages of these schemes. States implementing their own schemes to supplement RSBY have either expanded RSBY eligibility to more categories of beneficiaries at the cost of state government and/or they are providing additional top-up benefits (mostly tertiary care) to supplement RSBY benefits. In addition, some states have decided to implement their own health insurance schemes. There are still few states that are not implementing any health insurance scheme. The summary of approaches as of March 2016 is provided in Table 1.

a. 10 states were implementing schemes as a top-up to RSBY
b. 10 states were implementing independent schemes
c. Nine states were implementing only RSBY
d. Seven states were not implementing any demand-side health insurance/protection scheme

By implementation model:

1. 20 states are implementing their schemes entirely through an insurance company
2. Three states are implementing their schemes entirely through a trust
3. Five states are using a combination of insurance company and trust

Table 1: RSBY and Other Health Insurance Implementation Approaches across India, 2016

	Through Insurance Company	Through Trust	Through Insurer and Trust	Total States	State or Union Territories
RSBY only	5	NA	NA	5	Bihar, Tripura. Manipur, Nagaland, Uttar Pradesh
RSBY and state-sponsored top-up tertiary care scheme	6	NA	5	11	• Assam, Chhattisgarh, Meghalaya, Odisha, Punjab, West Bengal • Gujarat, Himachal Pradesh, Karnataka, Kerala, Mizoram
State/UT-sponsored scheme only	9	3	0	12	• Andaman & Nicobar Islands, Arunachal Pradesh, Dadra & Nagar Haveli, Daman and Diu, Goa, Maharashtra, Rajasthan, Tamil Nadu, Uttarakhand • Andhra Pradesh, Telangana, Puducherry
No GFHIS*	NA	NA	NA	8	Chandigarh, Delhi, Haryana, Jammu & Kashmir, Jharkhand, Lakshadweep, Madhya Pradesh, Sikkim

Source: Author's data collection

* As per latest information, States of J&K, Haryana, and Jharkhand are also planning to start RSBY and/or their own health insurance schemes

3.2 Central Government-Sponsored Health Insurance Schemes

Even though health is a state responsibility in India, the central government has launched various health insurance schemes in the past decade and a half. One of the first major initiatives of the central government was a 2003 Ministry of Finance health insurance scheme called Universal Health Insurance Scheme (UHIS).[3] This scheme covered beneficiaries to a cap of Rs 30,000 and was implemented by public sector insurance companies. This scheme focused on a family as a unit and was available in three forms: (i) R 1.0 per day per year for an individual; (ii) Rs 1.5 per day per year for a family of up to five members; and (iii) Rs 2.0 per day per year for a family of up to seven members. In all these options, the government provided a fixed subsidy of Rs 100 to BPL families only, whether it was an individual who bought insurance or a family of five or seven. After realizing that enrollment in this scheme by BPL families was low, the government in July 2004 raised the subsidy to Rs 200 for an individual, Rs 300 for a family of five, and Rs 400 for a family of seven. Thus, the revised premium for BPL families worked out to be Rs 165, Rs 248, and Rs 330, respectively (Gumber and Arora 2006). This scheme never built much momentum due to weaknesses in both design and implementation structures. In 2005/06, the scheme

[3] http://pib.nic.in/newsite/PrintRelease.aspx?relid=78863

attracted a meagre 68,296 families.[4] One reason for this low uptake was that in UHIS, all implementation was left to insurance companies without any active role of the government. A low level of awareness about the scheme also contributed to its low utilization. UHIS was gradually phased out after the introduction of RSBY in 2008.

The central government started another scheme in 2007. The Ministry of Textiles launched Rajiv Gandhi Shilpi Swasthya Bima Yojana (RGSSBY). It provided a moderate cover of Rs 15,000 per year for handicraft artisans.[5] In the same year, the Ministry of Textiles launched a health insurance scheme for handloom weavers that was part of "Handlooms Weavers Comprehensive Welfare Scheme," with a cover of Rs 15,000. One feature that differentiates these two schemes from all other GFHIS is inclusion of an outpatient component of Rs 7,500 per year within the overall cover of Rs 15,000. Insurance companies implemented both of these schemes. In 2013, the Ministry of Textiles decided to integrate the schemes into the RSBY. This decision meant that benefits would increase from a maximum of Rs 15,000 to Rs 30,000 per year to match those of RSBY[6]; however, the outpatient benefit of Rs 7,500 continues to be provided.

3.2.1 Rashtriya Swasthya Bima Yojana

3.2.1.1 Scheme Background

Around the time that Rajiv Aarogyasri launched in Andhra Pradesh started producing early encouraging results, the Government of India started discussing the design and launch of a national health insurance scheme to provide benefits across the country.

It is interesting to note that government entrusted the responsibility of design and launch of this scheme to the Ministry of Labour and Employment (MoLE) instead of the Ministry of Health and Family Welfare (MoHFW). MoLE was implementing the Employee State Insurance Scheme, a social protection insurance scheme for formal sector workers. There was growing demand from informal sector and unorganized workers for their own health protection scheme. At that time, MoLE had no experience with managing health insurance schemes for poor and unorganized workers. In hindsight, the decision to assign the task of scheme design and implementation to MoLE was beneficial to the scheme. MoLE's lack of experience working with health insurance for poor and unorganized workers enabled the ministry to think innovatively while designing the scheme.

RSBY was launched in April 2008 with the objective of providing financial security to the poor. It identified categories of unorganized workers and their families for hospital expenses, thus reducing OOP expenditure on health. Another objective was to improve access to quality health care by providing access to private hospitals in addition to public ones. Available data show that in 2015/16, RSBY was covering 41.2 million beneficiary families across the country.[7]

[4]Government of India, Lok Sabha Unstarred Question No.2667, dated 17.3.2006. Parliament of India. 2006

[5] http://www.oneindia.com/2007/05/20/textile-ministry-launches-insurance-scheme-to-cover-60-lakh-artisan-1179657278.html

[6] http://www.craftmark.org/rajiv-gandhi-shilpi-swasthya-bima-yojana

[7] http://pib.nic.in/newsite/PrintRelease.aspx?relid=144960

3.2.1.2 Scheme Design

While designing the RSBY, the government considered three main features (Jain 2014).

- Targeted beneficiaries were poor, and they could not pay for treatment even if they were reimbursed later; therefore, the scheme needed to be cashless.
- A large percentage of the targeted beneficiaries were illiterate; therefore, an attempt was made to make the scheme paperless. This important feature was to avoid embarrassing beneficiaries with insurance paperwork.
- People have to travel within the country for various reasons and most of the government schemes are not portable. Lack of automatic portability has been a characteristic of almost all the government schemes, e.g., the Public Distribution System (PDS) and Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS). Because health needs can arise at any time, the proposed scheme needed to be portable across the country.

The design of RSBY addressed these issues through a smart card-based biometric system that enabled the scheme to be cashless, paperless, and portable.

Unlike Aarogyasri, the focus of RSBY was on secondary care conditions (including simple medical conditions such as malaria and dengue) that required hospitalization and not on less-frequent critical care conditions. Since RSBY was launched as a national scheme, the basic assumption was that even for secondary care services, beneficiaries should have a choice between public and private health care providers. The reason is that public facilities are not always able to provide all the needed services or might not be accessible due to overcrowding or other reasons.

Although more families incur OOP expenses for outpatient care than for inpatient care, the Government of India decided after many discussions that RSBY would cover only hospitalization. One reason for this was that the NSSO 60th Round (2004) data showed that the percentage of people who go into debt due to health care-related events is much higher for inpatient care than for outpatient care, particularly for the poor. Another concern was that it would be more difficult to control fraud and abuse in outpatient services due to moral hazard; it is very difficult to check on the spot as outpatients spend very little time at the health facility. In contrast, inpatients are admitted to the hospital, which allows time for an on-the-spot audit/verification and early control of potential fraud.

Another major RSBY innovation was the design of the benefit package. Before RSBY, the state schemes used a "positive" list to state explicitly all the covered conditions. In contrast, RSBY relied on a "negative" list of explicit exclusions, with anything not on this list covered. To control costs, RSBY developed a list of commonly used service packages with a single rate established for each package. Covered services not included in a package rate. For example, surgical conditions had rates fixed between the hospital and insurance company. For medical conditions, the hospital received a per day fixed rate.

The main features of RSBY are:

a. **Target Population:** RSBY covers the entire BPL population, estimated to be approximately 300 million individuals in 2008 according to the Planning Commission of India. In India, household surveys help generate a BPL family estimate from which state governments prepare the final BPL list based on a cut-off score. However, active field enrollment in RSBY exposed problems in the quality and reliability of the BPL list, where many false positive and false negative errors were discovered. This forced the government to rethink the strategy of targeting only the BPL population. As a result, the government decided to expand the scheme to beneficiaries of the MGNREGS. To ensure that only true MGNREGS workers were able to avail RSBY

benefits, only families who had worked for at least 15 days under MGNREGS in the preceding financial year would be eligible to enroll in RSBY (Jain 2014).

BPL and MGNREGS lists were more effective in rural settings. Urban areas required a different strategy. To improve targeting in urban areas and reach unorganized workers in addition to BPL and MGNREGS workers, the government of India progressively added the following categories of unorganized workers for eligibility in RSBY between 2008 and 2013:

- Building and other construction workers
- Licensed railway porters
- Domestic workers
- Street vendors
- Beedi workers
- Auto and taxi drivers
- Rickshaw pullers
- Rag pickers
- Mine workers
- Sanitation workers

Even though the intent of the government was good in bringing these categories under RSBY, as workers in these categories are the most vulnerable, the biggest challenge is the lack of any available list of workers belonging to these categories. Therefore, even though in theory these workers are eligible for RSBY, their enrollment is subject to preparation of a database of these workers by the state governments. This has been challenging, as RSBY data obtained from the MoHFW (which assumed responsibility from MoLE for the scheme in 2015[8]) show that most of the enrolled families in RSBY are still from BPL and MGNREGS categories only.

b. **Benefits:** RSBY provides hospitalization benefits of up to Rs 30,000 per annum for a family of up to five members. The family has been defined as head of the family, spouse, and any other three members as identified by the head of the family and who are in the RSBY beneficiary family list. RSBY covers transportation charges up to a maximum of Rs 1,000 per year with a limit of Rs 100 per hospitalization. In addition, RSBY covers costs up to a day prior to hospitalization (e.g., diagnostic tests done at the hospital), and up to five days from the date of discharge (e.g., medicines) (Jain 2014).

   In terms of product design, RSBY differs from private health insurance products in many aspects. Two key differences are (1) there is no age limit or restriction, and (2) all pre-existing diseases are covered immediately. There is no waiting period.

c. **Technology:** The use of technology is a highlight of the scheme. RSBY is perhaps one of the few schemes in the developing world with large scale technology use for delivering social sector benefits. At enrollment, each beneficiary family receives a smart card, which contains fingerprint, photograph, and demographic data. The insurer prepares and prints it on the spot and hands it to the beneficiary. Fingerprints of all beneficiaries are collected on the spot. A thumb impression of each beneficiary is stored in the card and is used to verify the beneficiary's identity at the

[8] http://pib.nic.in/newsite/PrintRelease.aspx?relid=117875

hospital. Biometric verification is also done by a government officer to authenticate the identity of the beneficiary for enrollment in the scheme to ensure that card is delivered to the right beneficiary. At the time of treatment, cashless treatment is provided once the fingerprint stored in the smart card verifies the presenting patient's identity.

The IT system ensures that the scheme is portable and the beneficiary can access treatment at any of the empanelled hospitals across the country. All insurance companies working with RSBY have signed an agreement that a hospital empanelled by one is empanelled for all the insurance companies for RSBY purposes. RSBY mandates that empanelled hospitals carry out the transaction electronically and send electronic data to servers of both the government and the respective insurance company. The software works in both offline and online mode and transfers data whenever there is connectivity. Therefore, electronic hospital transaction data are available to the government on a daily basis. The data are then analyzed for monitoring and other purposes.

d. **Funding of RSBY:** RSBY is fully subsidized by the government where the cost of the premium is shared between the central and state governments in the ratio of 60:40 (it was 75:25 at the time of launch of the scheme). For northeastern states and three Himalayan states, the ratio is 90:10. To generate ownership of the scheme among the beneficiaries, government charges a nominal registration fee of Rs 30 per household. The fee could function as an indicator of satisfaction. Beneficiaries will come back for renewal and pay the registration fee again only if they are satisfied with the scheme. This amount is aggregated at the state level and is used for the administrative cost of the State Nodal Agency (SNA). Therefore, the functioning of the SNA becomes self-sustainable.

e. **Institutional Structure for RSBY:** RSBY mandates that states/UTs set up an SNA under a trust/society to implement RSBY. This was done to avoid challenges faced by UHIS and other earlier schemes, where no dedicated agency existed at the state level. The SNA is responsible for implementation of the scheme in the state, including carrying out the tendering process and selection of insurance companies to implement the scheme. The agency is financially independent as the registration fee of Rs 30 per family per year, paid by the beneficiaries, is used for its administrative and other expenses. This arrangement has brought a seriousness to implementation of the scheme at the state level, where full-time dedicated staff work for RSBY.

f. **Public-Private Partnership:** The scheme is based on a PPP in which the state government contracts an insurance company through an open tendering process to implement the scheme for three years. The assumption behind engaging a commercial insurance company is that these companies have the necessary technical skill and business interest to implement the scheme efficiently. However, the government still has an important role in supporting the insurance company and overseeing the scheme. Similarly, private hospitals are empanelled to provide services under the scheme to complement public hospital services and provide a choice of facilities to beneficiaries.

3.2.1.3 Challenges

RSBY is considered one of the most successful initiatives in the world in terms of quick scaling up and targeting. However, like any other health insurance scheme, RSBY faces many challenges, some related to policy design and others to implementation. The main challenges are as follows:

A. Policy Challenges

a. ***Limited Benefits:*** RSBY covers only Rs 30,000 per family per year. This level of coverage is inadequate to provide financial protection for tertiary care conditions such as cardiac conditions, cancer, and trauma. Non-communicable diseases and injuries now constitute the bulk of the India's disease burden, and therefore families may end up spending OOP for treatment of such conditions. The announcement of the National Health Protection Scheme (NHPS) by the Union Finance Minister during the 2015/16 budget presentation proposed to increase benefits to Rs 100,000 per family. The final decision to implement this is pending.

b. ***No Linkage with Preventive and Primary Care:*** RSBY provides benefits for hospitalization only. There is no linkage with preventive and primary care services that the government provides. This emphasis on hospitalization while ignoring outpatient care prevents a continuum of care.

c. ***Use of Old BPL List:*** Most of the states make use of the 2002 BPL list for RSBY. Since these lists are old, much of their information is inaccurate and therefore only 50-60 percent of targeted beneficiaries are being enrolled in RSBY. In states such as Himachal Pradesh and Kerala, which have been able to update the BPL list, the enrollment percentage is much higher, 70-90 percent.

d. ***Absence of National-level Independent Body to Manage the Scheme:*** Even though states are mandated to set up an SNA to implement the scheme, there is no equivalent agency at the national level. At that level, the MoHFW manages the scheme directly. This results in limited institutional capacity at the central level to manage the scheme. Bureaucratic bottlenecks may delay decision making, and financial constraints may prevent the scheme from hiring experts.

B. Implementation Challenges

a. ***Enrollment:*** Enrolling beneficiaries and printing and issuing smart cards at the village level is one of the most challenging tasks under RSBY. The smart cards are to be issued on the spot, which is difficult in areas where electricity is unreliable. There are huge variations among the states with respect to the enrollment conversion rate (percentage of targeted families enrolled). The governments need more accurate data with duplications removed across the eligible categories of RSBY to get the correct figure. The average enrolled family in RSBY is just above three members while the census puts the number at approximately five. Correcting the number of family members enrolled is a major challenge. Incentives and disincentives need to be designed in such a way that insurance companies enroll up to five members in each family.

b. ***Low Utilization:*** One purpose of a health insurance scheme is that beneficiaries use the covered health services when they need the care. Though national-level hospitalization rates have increased over the years with RSBY, there are huge variations in use by state (Jain 2014), and therefore there is a need for further improvement. Low awareness about the scheme and how to use benefits is a main reason for the low hospitalization rate in some places. There is a need to identify reasons for low hospitalization rates, and based on them determine actions needed to increase utilization.

c. ***Low Awareness of Scheme:*** Studies (Rana et al. 2015; CBPS 2015) have found that people's awareness of and knowledge about the scheme and its processes are limited. Better scheme enrollment and hospitalization rates will require focused awareness creation activities involving field functionaries.

d. ***Availability of Empanelled Hospitals:*** Convincing hospitals to empanel was a major challenge during the first years of the scheme as private hospitals were skeptical about the scheme and public hospitals saw no need to be empanelled as they already provided free services. The scheme held discussions with private hospitals and health departments in the states to stress the benefits empanelment meant for the hospitals. Hospitals gradually were convinced to join the scheme and by 2015/2016, more than 10,000 hospitals were empanelled. Approximately 60 percent are private hospitals and 40 percent are public.

   To ensure that the hospitals remain in the scheme, package rates offered need to be regularly updated and claims need to be settled on time. Hospitals have asked that rates be revised more frequently. Claim settlement is a challenge in many states; delayed payment of claims discourages hospitals from continuing with the scheme.

e. ***Lack of Capacities at Different Levels:*** Building capacities needed at each level to run a health insurance program so complex as RSBY has been a challenge. Required capacities include managing health care providers, building awareness, controlling fraud, and doing data analytics. Many states lack a full-fledged SNA to implement the scheme.

f. ***Fraud and Abuse:*** Fraud and abuse challenge health insurance schemes worldwide. Providing unnecessary treatments, up-coding treatments, converting outpatient days to inpatient days, and filing claims without having provided treatment are common types of health insurance fraud. Newspapers have reported on cases of fraud and abuse in RSBY.910 Availability of data ensures that RSBY is well positioned to tackle this. Data provided by MoLE through the RSBY website show that out of more than 10,000 hospitals empanelled till now, more than 250 have been de-empanelled due to fraud-related activities. Such instances mar the reputation of the scheme and create perverse incentives.

g. ***Weak Monitoring System:*** Though a lot of data have been generated under RSBY, use of the data is not effective. The government should develop a much stronger monitoring system with automatic triggers and red flags to identify quickly deviations and potential fraud. The goal is more effective monitoring of the performance of insurance companies and hospitals to measure the extent to which the scheme is able to reach its objectives.

[9] http://indiatoday.intoday.in/story/up-hospitals-misusing-rsby-treating-men-for-gynaecological-diseases/1/110828.html

[10] http://timesofindia.indiatimes.com/city/lucknow/Duplicate-cards-fraudulent-users-pose-challenge-to-Rashtriya-Swasthya-Bima-Yojana/articleshow/19521096.cms

3.2.1.4 Suggestions

- Increase the benefit cover from the current Rs 30,000 per family per year. The announcement of the proposed NHPS is a step in the right direction. The family cap of five members should be removed because it might result in exclusion of women and the elderly.
- Provide a linkage with primary cover to make the cover comprehensive.
- Improve empanelment by bringing more private and public hospitals into the network. In a few states, public hospitals are still not empanelled and it is critical to include all eligible public health care providers because, in many areas, no private hospitals are available.
- Improve beneficiary families' awareness about the scheme and the process of accessing benefits.
- Strengthen SNAs to better manage the schemes. The government of India should issue clear guidelines regarding SNA staffing for the states to adopt. RSBY is a complex scheme; it needs specialized people in each state to implement it effectively.
- Revise package rates on a periodic basis. Even through rates have been revised a few times in the past eight years, there needs to be a more systematic structure for revision.
- Develop a structured framework for tackling fraud and abuse to ensure the success of the scheme. IT systems should be able to detect anomalies and potential fraud automatically so they can be tracked closely in real time.

3.3 Community-based Health Insurance Schemes

CBHI schemes are health financing mechanisms that aim to protect low-income households from health-related risks. CBHI schemes are particularly important in developing countries, where the government cannot afford to provide all health care services, and where low-income families and workers in the informal sector incur burdensome OOP expenses for health or forgo health care.

CBHI schemes rely on a pooling of health risks and contributions from community members in the way of prepayment premiums, although the design or implementation may differ across contexts.

Since the late 1990s, CBHI schemes at the village level have been proposed as an alternative approach to increase access to insurance, replacing informal risk-pooling approaches. Many studies suggest that CBHI schemes involved clients in governance and in establishing scheme rules, benefits, and procedures (Dror and Jacquier 1999; WHO 2000; Wiesmann and Jutting 2001; Ahuja 2005; NCMH 2005; ILO/STEP 2006; Bhat and Jain 2006; UNDP 2007; Dror et al. 2009). This has led to the implementation of a number of CBHI schemes in several developing countries, including India (Dror et al. 2007; Gautham et al. 2011).

In India, CBHI schemes have been implemented for more than 15 years. In 2005, the International Labour Organization (ILO) listed an inventory of 51 microinsurance schemes in India. CBHI schemes have played a role in the expansion of health insurance in India as they introduced the concept of health insurance to the low-income (but not very poor) people who are the target segment of these schemes. Even though CBHI extends the coverage to sectors of the population otherwise ignored, one criticism of it is that these schemes fail to reach the most vulnerable. In the data for India, Ranson (2003) found evidence that suggests that there is demand for insurance among the poor, but that there is no evidence that CBHI covers the poor. A possible reason for this is financial constraints; the poor cannot afford to pay CBHI's modest insurance premium, even though it is already lower than premiums charged by private insurers.

Regarding access to and utilization of services, the evidence is inconclusive. Some studies do not find any impact of health insurance on utilization of hospital services while other studies find that schemes have a positive impact on hospitalization. Ranson (2004) found no significant relationship in frequency of hospitalization and membership in the Self-employed Women's Association (SEWA) scheme. Aggarwal (2010) found a positive impact on utilization of health care (use and intensity) in the Yeshasvini scheme in the state of Karnataka. Desai et al. (2014) found strong evidence of a positive relationship between insurance and hospitalization. Also, the hospital choice differed between insured and uninsured women. For the ACCORD-AMS-ASHWINI (AAA), Devadasan et al. (2007) also found higher hospitalization among the insured.

Ranson et al. (2004) found that the SEWA scheme is inclusive of the poor; however, enrollment access and claims are differentiated by socioeconomic and geographic conditions. Whereas in urban areas the scheme seems to be equitable, poor people in rural areas tend to have less access and fewer claims for inpatient care.

Ranson (2002) found that in the SEWA scheme, women who made claims were much poorer than the general population. The same study suggests that the scheme has the capacity to protect poor households against the uncertainty of medical expenses. However, it points to a trade-off between the financial protection of the households and the sustainability of the schemes.

Furthermore, even if the poor have access to insurance, this does not guarantee access to health care, because the inability to pay additional OOP expenses can hinder access. Ranson's 2002 study of the SEWA scheme found that the financial burden is reduced for persons who claimed reimbursement; however, the costs paid were still catastrophic for some individuals. Sinha et al. (2006) also found that one of the barriers to seeking treatment was lack of money to pay for treatment upfront even though reimbursement is available later.

In a study of the Yeshasvini insurance scheme in the state of Karnataka, Aggarwal (2010) found that the scheme offers financial protection to the households by decreasing OOP expenditures on health.

Before RSBY was launched, a large number of CBHI schemes were being implemented in India, but there was not much evidence available of new CBHI schemes being launched since RSBY was introduced. There is a strong possibility that many of the existing schemes providing only inpatient benefits and having BPL members as their clients could have been adversely impacted in terms of penetration or growth due to the launch of RSBY. This could be due to the fact that BPL families have to pay a much higher premium for these schemes than for RSBY. Premiums range from Rs 100 to Rs 300 in CBHI schemes for less benefit cover than with RSBY). RSBY costs only Rs 30 per family per year as registration fee. So it is likely that the BPL families may opt for the almost-free GFHIS with more benefits than a scheme where they have to pay a premium for fewer benefits, as under CBHI schemes.

Moreover, the focus of research has shifted away from CBHI schemes post-RSBY. Many papers evaluating aspects of CBHI schemes were available before 2008, and fewer papers after 2008, the year that RSBY launched. Since 2008, there are many papers evaluating various aspects of RSBY and many other GFHIS.

In India, there are more than 50 CBHI schemes, but the existing evidence is restricted to a few schemes: SEWA, Yeshasvini, ACCORD, and Uplift Mutuals.

Overall, there is mixed evidence of a positive impact on the utilization of health care services in the different CBHI schemes in India, as shown by the studies described above. Even where there is an impact, its extent differs by scheme. Also, there is no conclusive evidence that such programs reach the poorest households.

One fallout of the advent of RSBY and other GFHIS is their impact on the design and implementation of new CBHI schemes and on the sustainability of existing CBHI schemes. One study tried to analyze this issue: Panda et al. (2013) found that access to RSBY does not hamper uptake in CBHI schemes. However, this study looked at this effect from an individual perspective, where gaps in the RSBY benefit package were being filled through a CBHI scheme and therefore beneficiaries were open to a new scheme that provided outpatient benefits not available in RSBY. But the same will not hold true if the CBHI scheme provides the same or fewer benefits than the GFHIS.

Therefore, one of the main lessons that comes through strongly is that CBHI schemes need to be more aware of the impact of GFHIS on enrollment under CBHI schemes, and they may need to reorient themselves either in terms of target beneficiary or benefit cover.

4. STRENGTHENING HEALTH INSURANCE INITIATIVES IN INDIA

As GFHIS were being conceptualized and designed, they benefited from lessons, especially related to implementation, from CBHI schemes, the only schemes targeting poor families. Otherwise aspects of GFHIS were designed independently as per the requirements of the national and state governments.

In discussions, various CBHI scheme owners mentioned that RSBY and other GFHIS are impacting BPL member enrollment in CBHI schemes. In this scenario, CBHI schemes need to examine their strategies to complement other insurance programs in India. This may require examining their benefit packages and target segments. Even where the CBHI schemes focus on BPL population targets, their benefit cover needs to be either better than or complementary to GFHIS. If the benefit cover is not very different, the schemes should differentiate themselves in terms of target segment, aiming to cover families that are not covered under GFHIS.

The government of India recently announced its plan to replace RSBY with the proposed NHPS sometime in 2017. The NHPS aims to increase the benefit package to Rs 1 lakh per family per year (compared with the current Rs 30,000 per family per year) and to cover a larger population in all states/UTs. Families that currently are covered under CBHI schemes and are not part of RSBY may become eligible for the proposed NHPS. If this happens, there is a strong possibility that families may opt out of CBHI and into the more generous, free benefits of NHPS. *However, if the benefit package and/or target segment of CBHI becomes complementary to that of NHPS, then CBHI schemes will be very relevant even in the new scenario.*

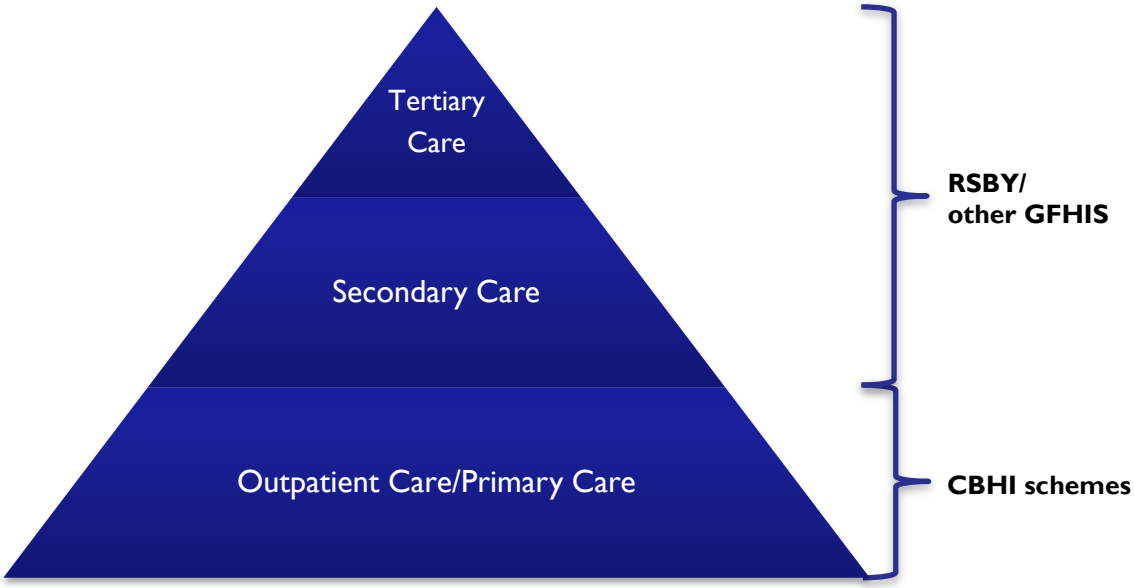
Even though the approach of RSBY and other GFHIS is very different from that of CBHI schemes in India, there are lessons (both positive and negative) that may be relevant to strengthen the CBHI schemes. This section analyzes lessons from GSHIS in terms of such aspects as product design, governance, institutional mechanism, implementation structure, provider payment mechanism, IT systems, and monitoring plan.

A. **Benefit Package Design:** RSBY and other GFHIS cover only inpatient expenses and day care surgeries. This means that they do not cover simple consultations, medicines, and diagnostics that do not require or lead to hospitalization. NSSO data from various rounds clearly show that families spend more on more common and more frequent outpatient treatment, yet GFHIS have decided to cover only catastrophic high-cost conditions. The National Health Mission's focus on improving primary health care could be linked with inpatient GSHIS to create a continuum of care.

   One option that CBHI schemes could explore is to design their benefit packages to complement benefit packages of RSBY and other GSHIS (see Figure 1). The proposed NHPS can provide both secondary and tertiary care. Could CBHI complement this by covering outpatient services? Existing CBHI schemes have not had much experience in handling outpatient insurance. Providing outpatient day cover through health insurance is very challenging for reasons such as high premiums, potential adverse selection, higher chances of fraud and abuse, and so forth. Nevertheless, CBHI schemes are in a better position to manage the issue of adverse selection due to their linkage with the community and in some cases even a contractual relationship (microfinance-linked insurance). Their links with the community and peer pressure also mean they can identify and handle fraud and abuse

better. And if a focused outpatient service package is defined, premiums can be kept low enough for families to afford.

Figure 1: Possible Benefit Tiers between CBHI and GFHIS



Source: Prepared by Author

However, there are two challenges to this approach: (1) beneficiaries will need to be enrolled in both GFHIS and CBHI schemes separately, and (2) the population groups that are not covered by GFHIS will be covered only for services offered by CBHI schemes. Regarding the latter, GFHIS decisions to allow these groups to enroll by paying a premium or to provide a full subsidy to a non-BPL group can resolve this challenge. For example, the Himachal Pradesh government recently announced that an above-poverty-line (APL) family can buy coverage by paying an annual premium of Rs 365, and the government will subsidize the rest.[11] And Chhattisgarh and Meghalaya universalized RSBY and the state top-up scheme. However, the first issue can be resolved only if a mechanism can be developed whereby a beneficiary family can be enrolled in both GFHIS and CBHI schemes through the same enrollment process. This will require a formal arrangement between the CBHI scheme and GFHIS.

B. **Target Population:** RSBY is a targeted scheme that allows a government subsidy to reach poor and vulnerable families. However, the BPL lists are not kept up to date, resulting in inclusion and exclusion errors that affect the quality of enrollment. As per data available from the MoHFW, in 2015/16, the enrollment conversion ratio in RSBY was only 56 percent, which means that 44 percent of targeted beneficiaries are not covered. The inaccuracy of the BPL list is a main reason for this low ratio. Therefore, there must be a better targeting mechanism under GFHIS.

   The lesson for CBHI schemes is that since they are not restricted to the BPL list, they can target families that are otherwise left out of GFHIS. This will fill a much-needed gap in population coverage.

[11] https://www.myhealthcareindia.com/himachal-pradesh-universal-health-protection-scheme.html

C. **Gender Equity:** A voluntary health insurance scheme has potential for gender inequity. The gender bias may lead to preferential enrollment of males in the scheme. This effect may be greatest when the scheme limits the number of beneficiaries per household, as RSBY does (five per household). Additionally, enrollment in a scheme often takes place at a location away from the house; this can potentially be a barrier to women's enrollment, as their mobility is often limited, especially in rural areas.

   Although policymakers anticipated that gender inequity would be a big challenge, the data show a somewhat different story. RSBY data show that in absolute numbers, over time more women started taking benefits under the scheme. By 2013, the data showed 54 percent of utilization was by women and 46 percent by men (Jain 2014). Some of the measures taken by the government in designing RSBY may have contributed to this outcome. For example, the RSBY enrollment software requires enrollment of a spouse listed in the family database. Initial RSBY awareness generation activities highlighted that the spouse and girl children should be enrolled. In West Bengal, the state government designates female members as head of the household for RSBY enrollment purposes, thereby ensuring their enrollment.

   The lesson for CBHI schemes is to create mechanisms so that females receive equal treatment with respect to enrollment and utilization. In the majority of CBHI schemes reviewed for this study (except some like SEWA), they did not have any specific measures targeting women, implying that CBHI schemes could learn from RSBY's efforts to support gender equity.

D. **Institutional Structure:** Most CBHI schemes continue to operate at a smaller scale. Capacity to manage the scheme and availability of necessary institutions is one of the reasons for lack of CBHI scale-up. RSBY defined clear institutional structures and skill sets needed to manage the scheme in states such as Kerala, Meghalaya, and Chhattisgarh. States that could not set up similar institutions, such as Bihar and Jharkhand, struggled with the implementation of RSBY. Even on the state level, government-funded schemes that set up strong institutions, such as Karnataka, Tamil Nadu, Maharashtra, Andhra Pradesh, and Telangana, have done well.

   The lesson for CBHI schemes is that they need to develop essential institutional capacities to operate the scheme. For example, they need a skilled professional staff that can manage the hospitals, control fraud and abuse, conduct costing, prepare treatment protocols, and so on. Scheme success also will depend to a large extent on the type of institutional structure and governance mechanisms the scheme sets up.

E. **Implementation Model:** A health insurance scheme can be implemented through various models depending on the internal capacities of the scheme. Table 2 profiles the implementation models being deployed in India.

Table 2: Implementation Models for Health Insurance Schemes

S. No.	Impl. Model	Financial Risk Carrier	Operations	Monitoring and Control	Example
a.	Self-managed	Scheme	Scheme	Scheme	State schemes: Vajpayee Aarogyasri in Karnataka, Aarogyasri in Telangana etc.
b.	Fully outsourced (risk-sharing and operations) Completely managed through insurance company	Insurance company	Insurance company	Scheme	RSBY State schemes: Maharashtra, Tamil Nadu
c.	Shared risk and operations Partly managed through insurance company	Up to certain threshold – scheme Beyond that threshold – insurance company	Scheme and insurance company	Scheme	
		Up to certain threshold – insurance company Beyond that threshold – scheme	Insurance company and Scheme	Scheme	State schemes: Himachal Pradesh, Kerala etc.
d.	Outsourced operations	Scheme	Implementation support agency	Scheme	State schemes: Himachal Pradesh (one of its schemes)

Source: Prepared by Author

a. **Self-managed**–The scheme employs experts to manage enrollment, hospital empanelment, awareness generation, monitoring, and claims, including fraud control. This complete control of both policy and operations is one advantage of this model. However, the model requires the scheme management agency to possess specific skills (e.g., data analysis, product design, contracting, case management) and to have adequate human resources to carry them out. Importantly, the scheme bears full financial risk for its performance. If the scheme runs a deficit in any period, it will need to have sufficient reserves, access to additional capital, or some kind of reinsurance arrangement to cover the deficit. When there is a surplus, the scheme is able to retain it. Some of the state-government health insurance schemes (e.g., Aarogyasri in Telangana and Vajpayee Aarogyasri in Karnataka) use this model.

b. **Fully outsourced (risk-sharing and operations)**–In this model, implementation is completely outsourced to an insurance company. The financial risk is borne by the insurance company. The company—not the scheme--covers any deficits due to high claims. The scheme needs to develop capacities to monitor the performance of the insurance company partners and provide oversight effectively. Examples of a fully outsourced scheme include RSBY and many state GFHIS such as those in Maharashtra, Tamil Nadu, and Rajasthan. In fact, some community organizations also offer health insurance that is outsourced through what is known as a partner-agent model. The community organization, often a microfinance institution, serves as a distribution channel for an insurance product that an insurance company develops and manages. The community "agent" does not bear any financial risk.

c. **Shared risk and operations** – Some schemes are willing and able to accept some but not all financial risk. In this case, they share risk with a partner, usually an insurer to reinsure them, meaning that the insurer will share the cost of claims based on a pre-established formula and method. For example, the scheme pays claims up to a certain amount; above this threshold, the insurer bears the cost. In a shared-risk model, the insurance partner will typically be involved in certain operations such as pricing and claims audits since it bears some financial risk. As with the self-managed model, a scheme with more limited financial risk also needs to build its capacity to manage the scheme's operations. Some CBHI schemes have adopted this model.

   Another version of a shared-risk model is a reverse arrangement where risk up to a certain amount (i.e., the first layer) is borne by the insurance company. The scheme accepts financial risk for claims that exceed that level (i.e., the second layer). In the first layer, there are higher numbers of claims and uncertainty; there are fewer cases in the second layer, and so the organization directly manages the risk. In many states, the benefit cover provides protection for both secondary and tertiary care services. In these cases, states use the insurance company to provide secondary care cover while the state government directly manages the tertiary care cover. States such as Himachal Pradesh, Gujarat, Kerala, and Mizoram use this model.

d. **Outsourced operations** – In some cases, schemes realize that they do not have the internal capacity to manage the scheme on their own, but they have financial capacity to manage the risk. In this case, they hire a third party to manage and implement the scheme but bear the financial risk. For example, in Himachal Pradesh, the state government has hired an agency to manage one of its health insurance schemes. The author of this study knows of no case where a CBHI scheme has outsourced management.

Whether CBHI schemes are newly designed or redesigned, they can learn from the experiences of GFHIS in terms of implementation models. Even in RSBY or some state schemes where insurance companies implement the scheme in full or in part, experience shows that internal organizational capacity is imperative to monitor insurance companies effectively. RSBY experience has clearly shown that states that were able to build better internal capacities for data analysis, claims management, monitoring, capacity building, field structures, and so forth were more able to manage the insurance companies they engaged to support scheme implementation.

Therefore, an important lesson for CBHI schemes is that insurance schemes need internal management capacity to implement schemes effectively, even when financial risk and operations are outsourced to an insurance company**.** If CBHI schemes do not develop effective internal capacities to manage the insurance companies, they may not be able to provide the best services to their beneficiaries.

F. **Active Enrollment and Issuance of Health Insurance Card:** RSBY includes an active enrollment process with issuance of a family smart card to each enrolled family in the scheme. Even though enrolling millions of households is challenging at the field level, this aspect of the design has been considered a salient feature of RSBY. Issuance of a card to the family is proof of their entitlement and empowers beneficiaries to exercise their rights under the scheme. However, there are some CBHI schemes, especially those linked with microfinance or livelihood programs, where the premium is bundled with other fees and enrollment is mandatory. Banerjee et al. (2014) in their review of a microfinance scheme where mandatory health insurance was introduced, found that the loan renewal rate dropped by 16 percent within one year of introduction of mandatory health insurance. Because health insurance had a negative effect on the microfinance scheme, it was later made voluntary.

G. **Empanelment of Hospitals:** All GFHIS have used clear empanelment criteria for hospitals. These criteria have been developed based on input from subject matter experts and public and private health care providers. The criteria include the availability of facilities, infrastructure, human resources, specialties, and other services. CBHI schemes that aim to provide an inpatient benefit package can use the same empanelment criteria or can take lessons for defining their own criteria.

   Another option for some CBHI schemes could be to tie up with RSBY or with a GFHIS so that they can ride on their empanelled hospitals. This will enable these schemes to gain quick access to a network of qualified health care providers.

H. **Payment through Package Rates:** For provider payment, all the GFHIS including RSBY use case-based, pre-defined package rates that are fixed by the government. These rates include all the costs related to each covered treatment (e.g., hernia repair) including pre- and post-hospitalization expenses. The use of diagnosis-related groups (DRGs) (e.g., hernia) instead of case rates may be a more advanced option for these schemes. DRGs link better with the health status of the patient, rather than the procedure the patient received. However, enough granular data was not available for these schemes at the time of launch to design a DRG-based payment schedule.

   CBHI schemes can potentially use the same payment rates developed by GFHIS by contracting with a GFHIS to access the GFHIS's provider network and payment platform, including the contracted rates. However, if the hospitals do not agree to the same payment schedule for CBHI schemes that deliver much lower patient volume, the CBHI schemes may need to negotiate a slightly higher rate than the GFHIS preferred rate – but still achieve more competitive payment rates than it would have been able to negotiate independently.

I. **Use of IT Systems:** Starting with Aarogyasri, RSBY and most other GFHIS have used IT extensively to deliver health insurance to target beneficiaries. Effective use of IT systems not only improves implementation effectiveness but also provides strong monitoring tools for cost containment. IT can also facilitate the task of scaling up. While some CBHI schemes have adopted IT effectively, more widespread use of extensive IT systems can bring down the cost for CBHI schemes. Monitoring will become more robust. Paperwork will decrease. A smaller staff can manage the scheme. And IT can help control fraud faster and more effectively.

   There are costs involved with development of IT systems, and a single CBHI scheme may not be able to afford them. However, if a few schemes collaborate, they can jointly develop a robust IT system that all of them can use. They also can provide assistance to other CBHIs if necessary.

J. **Awareness Generation:** Various studies have shown that one of the biggest challenges to schemes such as RSBY is lack of awareness among the beneficiaries about the scheme. RSBY and other GFHIS are primarily top-driven schemes, and therefore at the field level they need intensive awareness activities. If these activities are not carried out effectively, the schemes face a barrier for the beneficiary families to access benefits. Insurance companies initially had the responsibility for creating awareness about RSBY, but that later shifted to state government for a post-card issuance period. This may have helped to improve awareness, but lack of a comprehensive awareness strategy resulted in low awareness about the scheme.

   CBHI schemes are by definition community-based, and therefore it is plausible to assume that awareness levels will be much better in these schemes. In addition, since families pay the full premium OOP, there is greater chance that they would be aware of scheme benefits. However, the issues related to insurance illiteracy, lack of understanding of benefits, and so forth apply even to CBHI.

Since awareness generation has been one of the weak points of RSBY and similar GFHIS, CBHI schemes can make conscious attempts to learn from this. They need to develop a clear awareness strategy so that beneficiaries are not only knowledgeable about scheme details but also about how to use benefits and whom to approach and how if they have a complaint. Field-level staff can be provided performance-based incentives to improve awareness. This will be especially true with schemes in which enrollment is mandatory. However, merely making people aware about the insurance scheme may not result in their enrolling, as many other behavioral, demographic, and cultural factors may impede enrollment (Bhat and Jain 2006; Adebayo et al. 2015).

K. **Strong Monitoring Mechanism, Claims Management, and Fraud/Abuse Control:** RSBY and other GFHIS have created a robust monitoring mechanism that is critical to the success of these schemes. Data from all the hospitals serving patients flow daily to the servers of the government and/or insurance companies; intelligent systems analyze the data to detect patterns and anomalies that suggest fraud and abuse. The IT system also ensures that only genuine beneficiaries are able to get treatment under the scheme. A strong IT-based monitoring and fraud control mechanism is important even for small schemes and is imperative for the larger GFHIS. For example, RSBY has a list of triggers/alerts gleaned from Indian and international experiences that it uses to identify potential fraud and abuse. This has enabled it to de-empanel more than 250 hospitals from the scheme for fraudulent activities ranging from conversion of outpatient days to inpatient ones, providing unnecessary treatments, charging for higher-cost treatments, and colluding with beneficiaries.

   CBHI schemes can learn from these RSBY and other GFHIS mechanisms of monitoring, which have been instrumental in identifying patterns and fraud and thus in controlling costs. CBHI schemes have the advantage of being much smaller in terms of population covered and therefore can have closer control on fraud and abuse. Community monitoring also is an excellent tool for this purpose.

L. **Linkage with GFHIS:** One of the ways in which CBHI schemes can quickly access economies of scale is by linking with the larger RSBY and state health insurance schemes. Such economies could include negotiated (lower) provider payment rates, more empanelled hospitals and hospital networks, and IT monitoring systems. This linkage, if properly designed and integrated, can actually benefit both the GFHIS and the CBHI scheme. Government programs may appreciate enabling a larger population to be covered while CBHI schemes will be able to access the advantages listed above.

   This has not been tried formally but could be a game changer in terms of CBHI scale-up and success. A formal agreement can be signed between a state government and CBHI scheme in that state whereby the state agrees to provide the scheme access to package rates, IT systems, empanelled hospitals, and so forth. In return, the scheme may aim to cover leftover beneficiaries, and provide complementary benefits and/or support in awareness generation activities.

M. **Collaboration Possibilities:** The Government of India has announced that it will launch a new scheme called the National Health Protection Scheme as a successor to RSBY. A major focus of the NHPS will be to use a single platform to bring convergence between various existing GFHIS implemented by both central and state governments.

   This step could be an important example for CBHI schemes. Their linking with each other, such as pooling resources on one IT platform as discussed earlier, can greatly improve their efficient functioning and sustainability. Schemes that now manage risk on their own could potentially share risk with each other.

Table 3 shows a number of opportunities for collaboration to strengthen the insurance landscape in India. Initial linkages could lead to total integration in the long run. This will need a concerted effort

from both GFHIS and CBHI schemes as currently they operate independently without any linkages with each other.

Table 3: Possible Avenues of Collaboration between CBHI Schemes and GFHIS

Parameter	RSBY/ GFHIS	CBHI Schemes	Potential Collaborations
Benefit package	Inpatient care only	Inpatient and some outpatient services	CBHI schemes' benefits complement GFHIS if targeting the same population
Target population	BPL and defined categories of unorganized workers	Near poor families that are able to pay the premium	Families not covered by GFHIS can be targeted by CBHI
Financing	Fully subsidized by government	Contributions by beneficiaries	No linkage in financial matters
Institutional structure	Clearly defined institutions and human resources with specialized insurance skill sets	Varied structures and often not clearly defined	Learning for CBHI schemes on defining institutions and human resources with specialized skill sets
Implementation mechanism	RSBY and most state schemes – through insurance companies Few state schemes – through a trust	Various models with and without insurance companies	Developing internal capacities to manage the insurance function or to manage the whole scheme
Empanelment of hospitals	Clearly defined criteria by subject matter experts from government and insurance companies	Criteria often defined internally or with insurance companies	CBHI schemes can adopt criteria of GFHIS CBHIs can tie up with GFHIS to access their empanelled hospitals
Case rates	Case-based package rates are defined by team of experts, and hospitals are paid based on these rates only	Mostly use pre-agreed fee for service	Case-based package rates developed by GFHIS can be used as base
IT systems	Well-developed IT systems used effectively at both front and back ends	Basic IT systems	Can learn from IT systems especially in enrollment and monitoring In a collaborative arrangement, IT resources can be shared by providing access to the same IT systems, and those can be used for beneficiaries of other schemes
Awareness generation	Weak awareness mechanism in general	Comparatively better awareness mechanisms due to linkage with the community	Focus more on awareness especially in schemes where premium is deducted automatically Joint awareness campaign with GFHIS can be developed

Parameter	RSBY/ GFHIS	CBHI Schemes	Potential Collaborations
Monitoring and fraud and abuse control	Robust monitoring framework	Fraud and abuse control used to be a major challenge	Lessons from monitoring and fraud and abuse control systems of GFHIS can be drawn in terms of triggers/ alerts
Linkage with other schemes	RSBY is an independent scheme. States are implementing top-up schemes. Many of those states are using the RSBY IT platform However, all the independent state-funded schemes are being implemented independently without any linkage to each other	Most CBHI schemes are implemented independently, without any linkage with each other or GFHIS	CBHI schemes can use the systems of GFHIS, and field-based strength of CBHI can be used for GFHIS CBHI schemes can also attempt to link with each other to pool risk and develop common products and procedures especially related to IT systems, monitoring, etc.

5. SELECTED INTERNATIONAL EXPERIENCES AND LESSONS FOR INDIA

Numerous countries worldwide have moved toward health insurance models where health care is being purchased instead of being provided free of cost through supply-side financing. If we identify a few countries where there is a large informal sector, we have examples of Thailand, Philippines, South Korea, Mexico, and Ghana as the countries that have launched national health insurance schemes and are moving toward UHC (see Annex A). Rich experiences gained by these countries may have many lessons for India, especially in the areas of:

- Design of benefit packages
- Targeting and reaching informal workers

These two areas are critical for India as the government is aiming to scale up schemes and reach a larger number of citizens with comprehensive coverage. The following paragraphs contain lessons on these two issues from a few relevant countries.

A. Benefit Package Design

Numerous countries are providing a comprehensive benefit package under their health insurance program.

- In the Philippines, the Philippine Health Corporation covers a comprehensive package of services, inpatient care, catastrophic coverage, ambulatory surgeries, and deliveries. Outpatient treatment for malaria and tuberculosis are included. Outpatient primary care is offered for indigents in public facilities.
- The number of interventions included in the benefit package for the Mexican health insurance scheme called Seguro Popular has increased over the years. It started in 2003 with 78 health interventions, and by 2009 it covered 266 interventions. These cover most causes of primary care visits and around 95 percent of all causes of hospitalization.[12] A special benefits package for catastrophic expenses (the Protection Fund Against Catastrophic Expenditures) covers defined interventions, such as treatment for HIV/AIDS and some types of cancer such as childhood, breast, and cervical.
- The National Health Insurance in South Korea includes most inpatient and outpatient services, dental care, traditional medicine, prescription drugs, and preventive services (Soonman 2015).
- In Thailand, the Universal Coverage Scheme provides benefits for inpatient and outpatient care, surgery, and drugs. Preventive health care is also offered. Health promotion and disease prevention is done mainly through physical check-ups, immunization, and so forth. Additional benefits such as treatment for HIV/AIDS and renal replacement therapy are given (Evans et al. 2012).

[12] http://www.jointlearningnetwork.org/countries/mexico accessed on 25 July 2017

- Countries in Africa have also taken a lead in providing comprehensive financial protection. For example, Ghana's National Health Insurance Scheme offers an extensive benefits package, which intends to cover 95 percent of disease conditions in Ghana (Blanchet and Acheampong 2013). The services included are outpatient and inpatient, oral health, eye care services, and maternity care.

A review of international experience suggests that primary care is an integral part of the comprehensive insurance programs implemented by several countries. Indian GFHIS and CBHI schemes focus on inpatient coverage; outpatient coverage is not part of the package. As the GFHIS and CBHI programs evolved, it was perhaps prudent to start with only inpatient services as they are expensive and are more easily monitored for fraud and moral hazard than are outpatient services. However, after gaining some experience, the government may consider including outpatient services and making insurance schemes comprehensive in terms of coverage. The government can either consider bringing these services under its insurance schemes or link inpatient health insurance with outpatient services and create a referral chain. However, to do either of these, primary care reforms may also need to be carried out as in many countries (e.g., Thailand) due to the fact that the current system of delivery of primary care of India is not able to achieve the desired impact.

B. Targeting and Reaching Informal Workers

Most of the international experience reviewed for this study suggests that the health insurance programs aim to cover the entire population. Another common feature is that contributions of the poorest families are subsidized. People with higher incomes pay mandatory/voluntary contributions that the government sometimes subsidizes. In countries with a significant unorganized sector and a large percentage of informal workers, there are no good examples of a government's success in implementing an insurance program in which it collects premiums from these workers. An alternative way to get them covered is to subsidize all or much of their premium, an approach that Thailand and Mexico have adopted. Thailand subsidizes approximately 70 percent of the population that is not covered though formal sector schemes. Mexico provides them massive subsidization through Seguro Popular. In Ghana (NHIA 2013) and the Philippines, premiums paid by informal workers do not represent a significant proportion of the cost of coverage, and therefore the schemes are near-fully subsidized.

With India aiming to expand coverage through health insurance schemes, a lesson from all the countries above is that they are implementing UHC by providing insurance cover to everybody. India also needs to move toward UHC even if the government currently has a targeted approach that covers only poor families. It is also important to note that India has a very high percentage of informal workers, more than 80 percent of the workforce (Srija and Shirke 2014).

6. IMPLICATIONS

There have been debates internationally as to whether health insurance is an effective health financing mechanism or whether the government should instead invest only in strengthening the public health care system. This debate differs when the role of health insurance is limited to financial risk protection as opposed to when it is broader. In a country with very strong governance systems, regulations, and control over the private sector, the first role and more limited role of providing financial risk protection will be sufficient. However, in a country like India, with weak regulations and almost no control over the private sector, health insurance may be able to play a larger role.

6.1 Role of GFHIS and CBHI Schemes in Health Reforms in India: Beyond only a financial protection tool

Governments in India have implemented tax-financed health insurance to provide financial protection from high OOP expenditures on health to BPL families. Community-based organizations have implemented CBHI schemes to provide their members financial protection at low and affordable premiums. In short, both these public and private schemes seek to provide financial protection and to improve access to health care. Major benefits of these programs are discussed below.

A. **Empowering Beneficiaries:** Schemes have empowered their members by providing them access to both public and private hospitals. This means the members decide which hospital will receive how much money.

   For poor and vulnerable populations, this is a choice they never had before. Prior to being enrolled in a scheme, they had to seek treatment either at a government facility where the treatment was supposedly free or at a private facility where they had to pay for care OOP from their savings, by borrowing, or by selling assets.

B. **Reducing OOP Spending on Health:** A main objective of GFHIS is to reduce OOP expenditure on health. Schemes achieve this albeit with some major limitations. For example, the schemes cap the amount they will cover, and they cover only inpatient services, whereas more OOP spending is on outpatient services than on inpatient care (NSSO 2015 and 2004). Nonetheless, there are some encouraging examples of OOP expenditure reduction: In the Vajpayee Aarogyasri scheme in Karnataka, OOP spending dropped by 64 percent (Sood et al. 2014). A study of an RSBY scheme in Himachal Pradesh found that beneficiaries experienced a significant reduction in OOP spending in comparison with people not enrolled in the scheme (Gupt et al. 2016). Better implementation of these schemes can further reduce OOP expenditure. For example, RSBY guidelines obligate empanelled facilities to arrange for insured patients to obtain covered medicines and diagnostic tests from another source without cost if the facility is unable to provide them on site. However, studies (Johnson and Kumaraswamy 2012, Devadasan et al. 2007) have shown that people are paying for medicines and diagnostics that are not available at the empanelled facility. The Rs 30,000 limited benefit cover and limit on family size may also lead to OOP spending on health. Removing these limitations will reduce this spending.

C. **Improving Access:** GFHIS have been able to improve substantially beneficiaries' access to care by empowering them to choose where to seek care and by eliminating financial barriers when seeking care. Data from various studies have shown that beneficiaries covered under RSBY and other GFHIS have higher hospitalization rates than families of the same income status who are not covered under these schemes (Gupt et al. 2016).

D. **Political Tool:** Another important reason to launch these schemes has been political. Ever since Rajiv Aarogyasri was launched in Andhra Pradesh, many states have seen health insurance schemes as a way of conveying that the government is concerned about the health and financial protection of the population and is trying to empower them through health insurance.

   In fact, this trend has gained so much momentum that benefit covers are increasing across states but in ways that do not always necessarily match the disease burden. And benefit limits are not necessarily appropriate. For example, the tertiary care benefits states provide vary from Rs 70,000 in Kerala to Rs 300,000 in Rajasthan.

   On the other hand, it is heartening to see that health care is coming on to the political agenda in India as well as internationally. Political commitment ensures that the schemes get funds and that reform continues.

6.2 GFHIS and CBHI Schemes as Lever for Health Care Reforms

The benefits mentioned above may be sufficient to encourage health insurance reform. However, India will miss a huge opportunity if these GFHIS schemes and the political momentum generated through them are not used to trigger broader health care reform that will actually improve health care delivery in India. The broader view also can be used to improve stewardship of the private sector and influence its behavior through the strategic purchasing of its services by the government.

Health insurance through GFHIS and CBHI schemes can be a lever for large health care reforms in the following ways:

A. **Strengthening the Public Health Care System:** Although the government has launched the National Health Mission to improve the public health care system, studies show gaps still exist. Even now, a majority of the population seeks inpatient and outpatient care at private health facilities (NSSO 2015 and 2004).

   When the GFHIS were launched, experts questioned the necessity of including government health care facilities in these schemes. They argued that government facilities were already providing free services. However, NSSO data showed that people were incurring substantial OOP expenses even in public facilities, especially for medicines and diagnostic tests.

   By allowing public hospitals to retain claims revenue, the government can help the facilities strengthen their service delivery by using the revenue to improve their infrastructure and services. In addition, a defined percentage of this revenue (e.g., 25 percent for RSBY) can be paid out as incentives to the staff to supplement their salaries. States such as Kerala and Chhattisgarh have used RSBY claims revenue to improve services of public hospitals and to provide staff incentives. RSBY data show that while claims from public hospitals comprised only four percent of total claims in 2008, they had increased to more than 40 percent in 2013.

   When public facilities improve service provision, better services are available not only for insured patients but for everybody who seeks care at the facility.

B. **Improving Quality:** Public hospitals have instituted initiatives such as Indian Public Health Standards to improve quality, but these are not fully complied with, and there is lots of room to improve quality. In private health facilities, in the absence of strong regulatory mechanisms, the options to influence quality of care are limited.

   There have been debates internationally on using health insurance as a lever to improve quality of health care because without addressing quality, expanding access will have limited impact on health outcomes (Spaan et al. 2012). Experts argue that insurers, as payers of health care, should influence the quality of care they purchase for their beneficiaries.

   GFHIS are influencing quality by adopting a system in which hospitals are graded on quality parameters. For example, in Tamil Nadu's Chief Minister's Health Insurance Scheme, hospitals graded more highly are paid more for the same treatment than are hospitals at a lower grade. While this approach might seem to increase costs, the experience of many countries has shown that quality improvement actually can reduce overall costs by lowering the infection rate, reducing readmissions, and so forth. GFHIS provide a unique opportunity to improve quality of care because government, as a large purchaser, can influence quality; for example, it can mandate that claims will be paid only if a hospital follows the Standard Treatment Guidelines.

C. **Controlling Prices:** To ensure that hospitals are paid standard rates for the same treatment across the state and that they do not overcharge, all GFHIS have negotiated package rates for various surgical and medical conditions. Fixing of these rates has enabled the government to contain the price of the packages. Since often these rates are much less than the market rate, the effective cover of these schemes is much higher, that is, with the same cover, more treatment can be provided.

   Even though these rates apply only to scheme beneficiaries and hospitals can charge market rates to uninsured patients, evidence shows that in a few states (e.g., Andhra Pradesh), private hospitals have started charging the lower rates even to uninsured patients.

D. **Expanding Access to Standardized Data for Decision Making:** One of the challenges that Indian policymakers face is lack of accurate data. Some data are collected from public providers, but little information is available from private providers. Some data are available through periodic surveys.

   GFHIS, through their IT systems, have standardized data received on a daily basis from empanelled hospitals. This provides the government access to data from both public and private hospitals on an almost real-time basis. These data can be analyzed to see the disease pattern, caseload, gender breakdown, and so forth. Availability of real-time data also helps in quickly identifying and controlling epidemics.

E. **Influencing Behavior of Private Sector:** In the absence of strong regulation of the private sector, governments in India have little or no control over the sector. Government can neither ask for data nor influence pricing mechanisms in the private sector. However, since a majority of people seek treatment in the private sector, there is a need to ensure provision of good-quality care at a reasonable price. The purchasing power of these schemes means they have the potential to influence the behavior of the private sector in terms of rates, quality, and availability of services.

F. **Indirectly Strengthening the Supply of Health Care:** Anecdotal evidence suggests that the private sector has established new hospitals in areas where current public sector capacity is insufficient to serve GFHIS beneficiaries. Although the private sector's actions reflect their profit motive, this also improves the supply of health care in remote areas that can be harnessed with sufficient oversight.

Controlling Fraud/ Abuse: GFHIS can be an important tool to control and minimize fraudulent practices such as provision of unnecessary treatments or charging for services not rendered. Not only do these schemes get data in almost real time from the hospitals, but they also have trained people who look for fraud and abuse. Hospitals know that the schemes have teams working to identify and minimize fraud. In this way, the schemes play a critical role in reducing fraud in the Indian health care sector.

G. **Generate Additional Funds for Government Hospitals:** Using the health insurance mechanism, government can redistribute funds. It need not find only new funds to support the health insurance program. In reality, a significant portion of health insurance funds may come back to the government system itself. Annex C describes a scenario showing that overall financial returns from health insurance may be higher than the expenditure.

In summary, there is an opportunity for the government to use GFHIS for broader health sector reform through strategic purchasing of care from both public and private health care providers.

7. CONCLUSION AND WAY FORWARD

Challenges to supply-side financing and delivery of health care in India have opened the door to innovative demand-side health insurance models. India's GFHIS purchase health care from both public and private sector health care providers for targeted poor and vulnerable families with the objective of mitigating the financial burden that high OOP expenditures on health put on these families. During the last decade, more than 24 GFHIS have been implemented by the national and states/UT government. Along with these GFHIS, CBHI initiatives are being implemented in various parts of the country. There is some overlap in the coverage of these schemes but more often they are complementary because their eligibility criteria differ. There is, therefore, a need to look at these schemes in a comprehensive manner and find whether they can be merged or aligned to provide a comprehensive response to the high OOP expenditure on health and access to health services. It is well known that the fragmentation of individual, unlinked approaches and schemes results in financial inefficiencies, overlapping benefits, duplication of resources and efforts, and waste.

The government should aim to move toward UHC, whose objective is to cover everybody for most health care services. The government certainly needs to bear the full cost for those who are poor and vulnerable. For the rest of the population, the government can either finance premiums through its tax revenue or those who are better off can pay through prepaid pooling mechanisms such as insurance. Benefits should not be only inpatient services. Primary health care should be part of the package or linked with the package. This gradually will reduce unnecessary hospitalizations, and costs, once the scheme becomes widespread. It may also help in strengthening public health facilities as the claims will be related to the performance of the health facility.

In terms of population groups, there is no denying that for the poorest and poor population groups, government will need to bear the cost of health care as the groups are not able to pay a premium in advance or an OOP payment at the time they seek treatment. GFHIS target these segments currently, and they should continue to do so. CBHI can target families that are less poor than the above groups and so not eligible for GFHIS, but not well-off enough to pay for the high premiums of private commercial health insurance. Because most of this population segment consists of unorganized and informal sector workers, aggregating them and collecting premiums from them is a major challenge. Experience suggests that community-based organizations that have developed capacity in health insurance can effectively target these families for their schemes.

Two recent state government-level initiatives are trying to universalize coverage by aiming at covering everybody and not only BPL families. In both Meghalaya and Chhattisgarh states, the government uses tax revenue for full subsidies of the premium for all the families, regardless of socioeconomic status. Various countries have adopted this model as it is very difficult to collect premiums on a regular basis from informal workers in a voluntary system. If the taxes are mobilised properly, even the financial sustainability of these initiatives can be maintained over the coming years.

Karnataka state has adopted another model, which offers the tertiary care health insurance scheme to both BPL and APL families. For BPL families, the scheme is completely free. APL patients incur a co-payment at the hospital at the time of treatment. In late 2016, Himachal Pradesh announced its intention to cover APL families (not covered in current fully subsidized health insurance scheme) through a contributory scheme to which these families pay a premium of Rs 365 per year to join. The rest of the cost (if any) will be borne by the state government. In this approach, the state government has opened

the government insurance scheme platform to non-poor families, allowing them to enroll in the scheme by paying the premium. The advantage of this model is that there is less financial burden on the government; a possible disadvantage is that adverse selection can be a serious issue if enrollment is voluntary.

The central government, however, has not taken steps to expand population coverage beyond expanding RSBY to 11 more categories of informal workers. Even though the government is talking about expanding the RSBY target population in the proposed NHPS, it seems the NHPS is likely to remain only a targeted – not universal – scheme.

Health insurance will play a critical role in India in moving toward UHC. Various forms of health insurance schemes that are being implemented in a fragmented and parallel manner need to converge. GFHIS and CBHI schemes also need to create synergies and complementarity with each other as this will help in providing better, more efficient coverage. The Government of India will need to create a vision of health care that defines the role of each funding mechanism, stakeholder, and type of care as the nation moves toward universal health coverage.

ANNEX A: KEY LESSONS FROM SELECTED COUNTRIES FOR INDIA

	Benefit Package	Provider Payment	Quality	Targeting
Thailand	The Universal Coverage Scheme (UCS) provides both inpatient and outpatient care benefits. Preventive health care is also offered.	Capitation, Diagnostic Related Groups (DRG), and global budgets	To ensure quality of health services provided, the National Health Security Office accredits facilities; there are some audits and assessments of the quality of services.	All population is targeted through three major schemes. 70% of families are covered under UCS and subsidized by government.
Philippines	PhilHealth has a comprehensive package of services, inpatient care, catastrophic coverage, ambulatory surgeries, and deliveries; outpatient treatment for malaria and tuberculosis are included.	Capitation and per case basis	To ensure quality of health services, the providers accredited by PhilHealth are required to take part in quality assurance, utilization review, and other assessment programs.	PhilHealth coverage is available to the entire population. The local government determines who is poor and enrolls them; for employees enrollment is mandatory, and for the rest of the population enrollment is voluntary.
South Korea	The National Health Insurance includes most inpatient and outpatient services, dental care, traditional medicine, prescription drugs, and preventive services.	Fee for service	Health Insurance Review and Assessment Service (HIRA) was established as an independent agency. HIRA is responsible for reviewing medical fees and assessing the quality of health care services.	All the population is targeted
Mexico	The benefits package of Mexico's Seguro Popular covers most causes of primary care visits and around 90% of all causes of hospitalization. Furthermore, there is a special benefits package for catastrophic expenses.	Capitation and per case basis	Along with Seguro Popular, government and other key stakeholders launched the National Crusade for Quality in Health Care. The National Health Care Award was given as part of the Crusade.	Seguro Popular is offered for all Mexican citizens who are not covered by a social security scheme. Families belonging to the four lowest income deciles do not have to pay a contribution.

	Benefit Package	Provider Payment	Quality	Targeting
Ghana	Ghana's National Health Insurance Scheme offers an extensive benefits package that is intended to cover 95% of disease conditions in Ghana. The services included are outpatient and inpatient, oral health, eye care services, and maternity care.	Capitation and DRGs	Credentialing is done to ensure that health care providers can provide basic quality health services in accordance with the National Health Insurance Program. It promotes quality improvement in health care delivery, nurtures healthy competition among service providers, and instills public confidence in the health system.	The scheme aims to cover all residents of the country.
Lessons for India	India is providing only inpatient care through GFHIS but most countries with UHC also cover outpatient and primary care services.	India is currently using a system of package rates but learning from the experience of other countries suggest alternative approaches such as DRG-type system for inpatient services and capitation model for primary care.	Countries have used health insurance purchasing as a lever to improve quality of care, and India can learn from these experiences.	Most of the countries have taken a UHC approach where they are targeting coverage of all citizens. India has taken a targeted approach. There are separate schemes for formal sectors. An important lesson that emerges from comparison with other countries is that India needs to create a vision for UHC where every citizen is covered.

ANNEX B: COMPARISON OF TRUST/SOCIETY OPERATED MODEL VS. INSURANCE COMPANY OPERATED MODEL

S No.	Parameters	Trust/ Society Model	Insurance Company (IC) Model
1.	Carry of financial risk	Financial risk is borne by the government	Financial risk is borne by the insurance company (IC)
2.	Claim liability of government	Claim liability of government is unlimited	Liability of the government is limited to the premium paid to the IC
3.	Administrative cost	No definite data on administrative costs of trust/ society but it should be less than 10%	As per information available from various ICs, their administration cost is in the range of 10%
4.	Experience of claim management	Initially no experience but that can be gained	Experience in managing health insurance policies and dealing with hospitals, claims, etc.
5.	Institutional capacity	Initially no institutional capacity, but it can be built slowly by hiring and training human resources	Generally the UC has institutional capacity to manage health insurance programs
6.	Incentive to keep cost low	There is no business incentive to keep cost low as profit and loss do not matter to trust	There is a business incentive to keep cost low. However, if not controlled, this can lead to unnecessary rejection of claims
7.	Potential of fraud	Less experience with managing hospital fraud In addition, fraud by hospital can potentially increase if some persons from trust/society collude with the hospitals	More experience with managing various types of hospital fraud. As an institution there is incentive to minimize fraud
8.	Quality of services	Quality of services will depend on the governance capacities in the state and capacities of the trust/society	Quality of services will depend on the capacity of the team of IC in the state
9.	Regulation	There is no regulation per se of trusts/societies and they are governed by the acts under which they are registered	ICs are strongly regulated by the Insurance Regulatory and Development Authority (IRDA) in each aspect of their functioning
10.	Role of state government	State government has to carry out all the activities for scheme implementation, including enrollment of beneficiaries, empanelment of hospitals, claim management, medical audits, field audits, fraud control, and awareness generation	The main role of the IC will be claims management, medical audits, and fraud control State will carry out enrollment, hospital empanelment, and awareness generation

S No.	Parameters	Trust/ Society Model	Insurance Company (IC) Model
11.	Profit motive	There is no profit motive of the trust/society as all the money remaining from one year can be used for next year	There is a strong profit motive However, GFHIS can have a provision that IC administrative costs and profits cannot be more than 20 percent, and rest will be returned to the government
12.	Flexibility to change	Can be done and implemented with immediate effect if state level health agency has capacity	Will take some time if there is implication for premiums
13.	Outsourcing of activities	Trust/societies can outsource activities to Third Party Administrators (TPAs) as per IRDA guidelines	ICs can hire TPAs for various defined activities

ANNEX C. CASE STUDY ON INVESTMENT IN HEALTH INSURANCE AND RETURNS

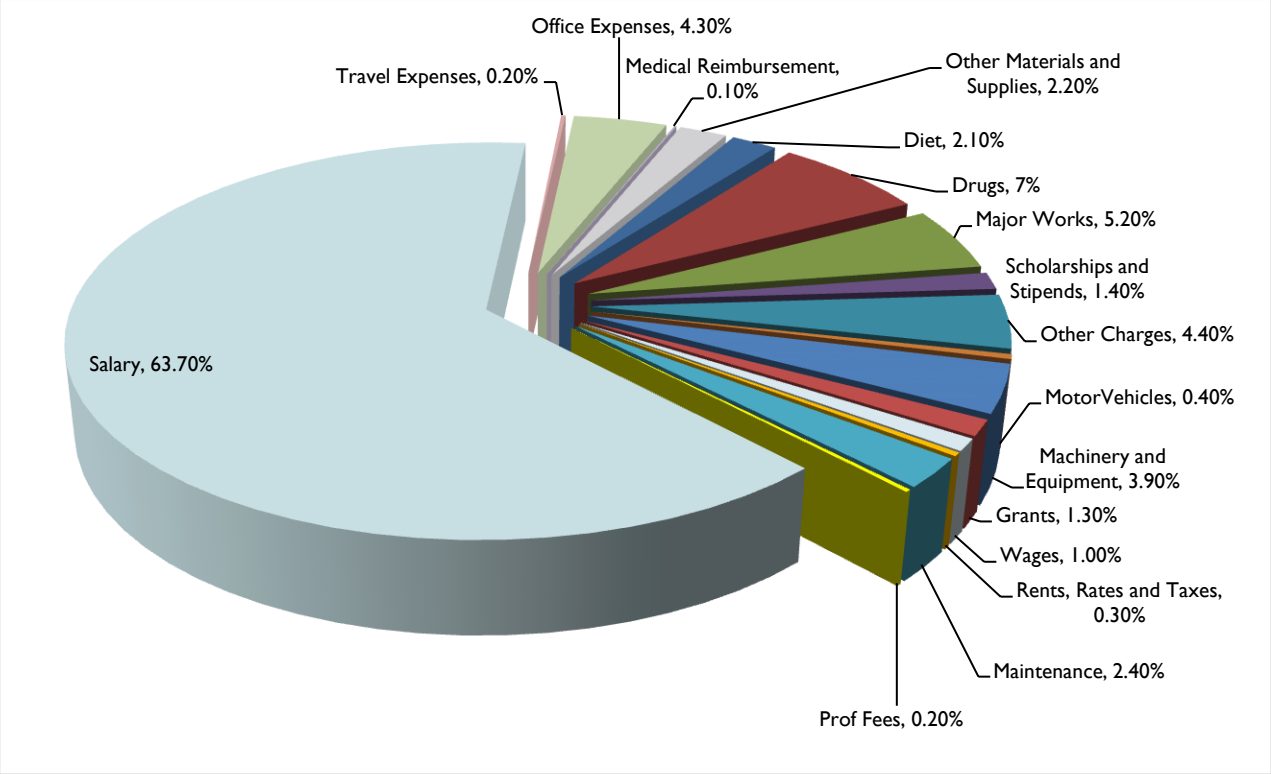
This case study takes the example of a state in India where the state government is planning to introduce the National Health Insurance Scheme.

On the face of it, establishment of such a scheme looks like the government will spend additional monies on health, most of which will flow to the private sector. Many experts have criticized such expenditure.

However, if the government takes a holistic approach, planning the scheme well including taking into account the context, the scheme might actually save money overall. Following are data points from the state:

- Total population – 100 million
- BPL population – 25 million
- BPL families – 5 million (assuming five members per family)
- Insurance premium – Rs 500/ family/ year
    - Central government (Rs 300 per family per year)
    - State government (Rs 200 per family per year)
- Total state health care budget – Rs 16,340 million

If we analyze the state government's data, we see that the largest share of the health budget goes to salaries (63.7%). The remaining 36 percent goes to many different items, as shown in the figure.



When health insurance is introduced, the state's public hospitals will receive claims reimbursement from the insurance company/trust. The hospitals can use this money for whatever purposes they want; meanwhile, government should ideally reduce some amount from the budget line item that is allocated to public hospitals. For the purpose of this case study, four have been identified and are shown in the following table with the proposed percentage cut in the budget.

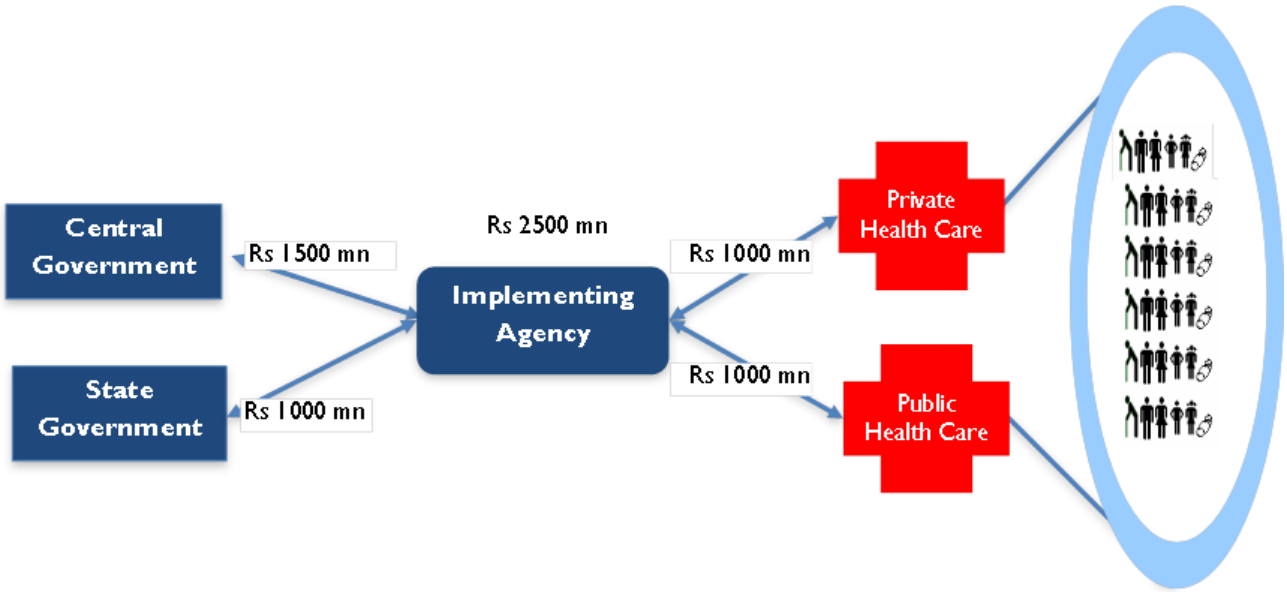
Reallocation of Health Budget

Heads	Current Budget	Proposed Cut (%)	Savings (Rs)
Drugs	1140 million	33%	377 million
Other Charges	720 million	25%	180 million
Maintenance	392 million	33%	130 million
Other Materials and Supplies	360 million	20%	72 million
Total			760 million

We see from the table that a budget cut of 25-33 percent will save approximately Rs 760 million.

If the premium is Rs 500 per family per year, then the total premium will be Rs 2,500 million for 5 million families. With the ratio of 60 percent to be borne by the central government and 40 percent by state government, the state share will be Rs 1,000 million per year.

Rs 2,500 million will be paid to the implementing agency, either an insurance company or a trust/society. If that insurance company/trust spends 80 percent of claims (Rs 2,000 million) and half of it is paid to the public hospitals, then those hospitals will earn an additional Rs 1,000 million through the health insurance scheme.



From the table below we see that the state will receive Rs 1,000 million back to public hospitals through payment for services and in addition Rs 760 million will be saved through reduction in line item budget costs.

In this state, OOP spending on hospitalization is Rs 1,220 million. If we assume that 75 percent of this spending is saved after the introduction of the health insurance scheme, then a further notional saving of Rs 92 crore will be realized. Therefore for an investment of Rs 2,500 million by the government, Rs 2,680 million will be realized as saving.

	Expenditures (Rs million)	Returns (Rs million)
Insurance premium	2500	
Claim payment to govt. providers		1000
Savings in health budget		760
Potential OOP savings		920*
Total	2500	2680

These monetary benefits are in addition to other benefits such as improved quality and access, as mentioned in the main document.

ANNEX D. PROFILE OF HEALTH INSURANCE AND PROTECTION SCHEMES ACROSS STATES/UTs

(1 lakh = 100,000)

	Andhra Pradesh	Telangana
Name of the Scheme	Dr. N.T.R Vaidya Seva (from 2015) Erstwhile Rajiv Aarogyasri	Aarogyasri (from 2015)
Year of Launch	2007	2015
Implementing Agency	Trust	Trust
Target Population	BPL families as enumerated and photographed in White Ration Card	BPL families as enumerated and photographed in White Ration Card
Benefit Cover	Up to Rs 2.50 lakh per family per annum on floater basis	Rs 1.50 lakh + replenishment cover of Rs 50,000 on family floater basis
Type of Cover	Free outpatient screening and consultation, secondary care, tertiary care, and follow-up packages	Free outpatient screening and consultation, secondary care, tertiary care, and follow-up packages

	Tamil Nadu	Maharashtra
Name of the Scheme	Chief Minister's Comprehensive Health Insurance Scheme	Rajiv Gandhi Jeevandayee Arogya Yojana
Launch Year	2012	2012
Implementation Mode	Insurance company	Insurance company
Target Population	Families with annual income below Rs 72,000; members of 26 welfare boards	BPL families + APL families (income up to one lakh)
Coverage	Rs 1 lakh coverage **+** Rs 50,000 for critical care on family floater	Rs 1.5 lakh + Rs 2.5 lakh for kidney transplant on family floater
Benefit Package	Secondary care, tertiary care, and follow-up packages	Secondary care, tertiary care, and follow-up packages

	Karnataka	Gujarat
Name of the Scheme	Vajpayee Arogyashri (VAS) Rajiv Arogyabhagya (RAB)	Mukhyamantri Amrutum (MA) Yojana MA Vatsalya (MAV) Yojana
Launch Year	2009-10 (VAS), 2015 (RAB)	2012 (MA) &2014 (MAV)
Implementation Mode	Trust for both	Both are directly implemented by state
Target Population	VAS – BPL families RAB – APL families (Co-payment based)	MA – BPL families MAV – APL families with annual income less than Rs 1.2 lakhs
Coverage	Rs 1.50 lakh + Rs 50,000 buffer RAB – Co-payment by beneficiary of 30% in General Ward and 50% in Private/ Semi-Private Ward respectively	Rs 2 lakh per family on floater
Benefit Package	Tertiary care and follow-up procedures	Critical care and follow-up

	Kerala	Meghalaya
Name of the Scheme	Comprehensive Health Insurance Scheme (CHIS) and CHIS Plus	Megha Health Insurance Scheme
Launch Year	2008	2012
Implementation Mode	CHIS – Insurance company CHIS Plus – Trust	Insurance company
Target Population	CHIS – State BPL families not covered by RSBY (fully subsidized) and identified APL families (premium to be paid by beneficiaries) CHIS Plus – RSBY + CHIS families	All the citizens of the state of Meghalaya excluding state and central government employees
Coverage	CHIS – Rs 30,000 (RSBY cover) CHIS Plus- Rs 70,000 per family on floater	Cover A – Rs 30,000 (RSBY) Cover B – Rs 30,000 (replenishment cover for RSBY) Cover C – Rs 1,40,000 (for critical and follow-up care)
Benefit Package	CHIS- Hospitalization and day care surgeries (RSBY cover) CHIS Plus – Tertiary cover	Hospitalization and day care procedures plus critical care

	Chhattisgarh	Rajasthan
Name of the Scheme	Mukhyamantri Swasthya Bima Yojana (MSBY)	Bhamashah Swasthya Bima Yojana
Launch Year	2012	2015
Implementation Mode	Insurance company	Insurance company
Target Population	All left out resident families (ration card holder) not covered under RSBY	Benefits for the National Food Security Scheme beneficiaries and RSBY beneficiaries (as RSBY is proposed to be taken over by Health Department from Oct. 15).
Coverage	Rs 30,000 per family on floater	Health insurance cover of Rs 30,000/- for general illnesses and Rs 3.00 lakh for critical illnesses shall be given to a family on floater basis in one year for IPD procedures.
Benefit Package	Secondary care	Secondary and tertiary care packages

	Himachal Pradesh	Odisha
Name of the Scheme	RSBY Plus & Mukhya Mantri State Health Care Scheme (MMSHC)	Biju Krushak Yojana
Launch Year	2012 (RSBY plus) and 2016 (MMSHC)	2013
Implementation Mode	Both are implemented by trust	Insurance company
Target Population	RSBY Plus – All RSBY and MMSHC enrolled families MMSHC – State identified 9 categories including senior citizens above 80 years, persons >= 70% disability and single women among others	Farm families
Coverage	RSBY Plus – Rs 1.75 lakh per family on floater MMSHC – Rs 30,000 per family on floater	Rs 70,000 (for RSBY beneficiaries) Rs 1.00 lakh (non RSBY Beneficiaries)
Benefit Package	RSBY Plus – Critical Care MMSHC – Secondary Care	RSBY List + Critical Procedures

	Mizoram	Punjab
Name of the Scheme	Mizoram State Health Care Scheme (MSHCS) as a top up to RSBY	Bhagat Puran Singh Sehat Bima Yojana (BPSSBY) & Bhai Ghanhya Sehat Sewa Scheme (BGSSS)
Launch Year	April 2008	2015
Implementation Mode	State government	BPSSBY - Insurance company BGSSS – Managed by trust, implemented by Insurance
Target Population	RSBY BPL and APL card holder	BPSSBY – BPL & other poor families identified by the state BGSSS – Cooperative members
Coverage	Total health insurance cover of Rs 3 lakhs (MSCHS – Rs 2.7 lakh + RSBY – Rs 0.3 lakh), also covers APL families with a cover of Rs3 lakh for identified critical Illness (encompassing more than 100 illness/conditions)	BPSSBY- Rs 50,000 for secondary care BGSSS- Rs 2 lakh family floater
Benefit Package	Specified list of day care (OP) services, secondary and tertiary care procedures	BPSSBY- Secondary care and personal accident BGSSS- Secondary and tertiary care

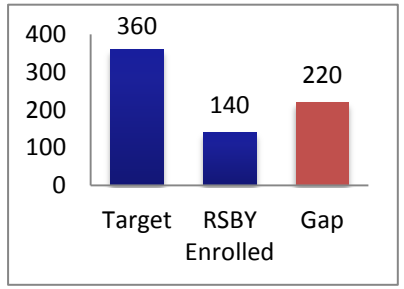
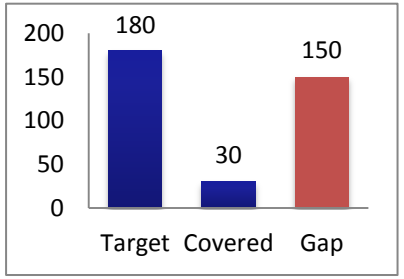
	Uttarakhand	Puducherry
Name of the Scheme	Mukhyamantri Swasthya Bima Yojana (MSBY)	Puducherry Medical Relief Society
Launch Year	2015, Second Phase – August 2016	2003
Implementation Mode	Insurance company	PMRS /State government
Target Population	All the citizens of the state are entitled, excluding state and central government employees	BPL families - Income ceiling of Rs 75,000 per annum as prescribed by the government for economically weaker section family
Coverage	Cover has been increased from Rs 50,000 to Rs1.75 lakh in the second phase	Up to Rs 2 lakh per family per year
Benefit Package	Secondary and tertiary care procedures	Tertiary care

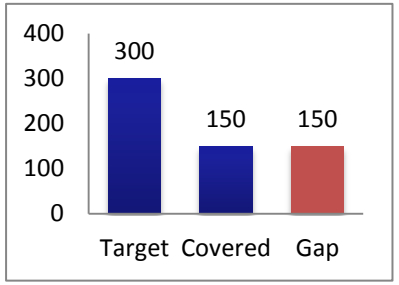
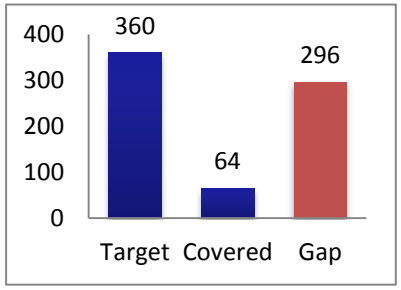
	Goa	Daman and Diu and Dadra Nagar Haveli
Name of the Scheme	Din Dayal Swasthya Seva Yojana	Sanjeevani Swasthya Bima Yojana
Launch Year	2016 (May, 2016)	2013
Implementation Mode	Insurance Company	Insurance company
Target Population	All resident families of Goa staying for more than five years, excluding families of government employees	Absolute poor family – BPL as per government census. Domicile APL, BPL, APST, non-APST, state government employees, their dependents, all age group, and all genders, excluding families of office of profit, central government employees, and Group-B and above categories of contractors. Families whose family income below 1 lakh – per annum. Any other resident families
Coverage	Rs 2.5 lakh for families up to 3 member, Rs 4 lakh for families with four or more members	Up to Rs 2 lakh per family per year
Benefit Package	Secondary and tertiary care	Medical and surgical inpatient treatment; death insurance, including accidental death benefit of Rs 1 lakh/ individual.

	Arunachal Pradesh	Andaman and Nocobar Islands
Name of the Scheme	Chief Minister's Universal Health Insurance Scheme	Andaman and Nicobar Islands Scheme for Health Insurance (ANISHI)
Launch Year	2014 (September, 2014)	2015 (January, 2015)
Implementation Mode	Insurance Company	Insurance Company
Target Population	APL, BPL, APST, non-APST, state government employees, their dependent family members, all age groups, and all genders, including transgender, excluding families of office of profit, central government employees, and Group-B and above categories of contractors	1. All persons holding BPL/AAY cards 2. Retired government servant settled in Andaman and Nicobar Islands 3. Permanent residents of Andaman and Nicobar Islands and their dependents family members with family income up to 3.00 lakhs per annum (Who are not govt. servants.)
Coverage	Up to Rs 2 lakh	Rs 5.0 lakh per patient per illness
Benefit Package	Medical and surgical treatment (except outpatient facility)	Both inpatient and outpatient Critically ill patients, if referred under the scheme to travel by flight, will be entitled to reimbursement of the air ticket for the patient and one attendant. Travel expense for patients with one attendant shall be reimbursed (Bunk class fare)

Source: Compilation through public sources

ANNEX E. CURRENT STATUS OF FUNDING AND COVER UNDER HEALTH INSURANCE IN INDIA

	Level of Care	Current Source of Funds	Current Funding Mechanism	Current Coverage Estimate*	Covered under GFHIS
Below Poverty Line (Bottom 30% of population)	Preventive	Government	Direct funding		Secondary Tertiary
	Promotive		Direct funding		
	Primary	Beneficiary	Direct funding by govt. Out of pocket		
	Secondary		Direct funding Central and state GFHIS		
	Tertiary		Out of pocket		
Near Poor (30-45% of population)	Preventive	Government	Direct funding		Part Secondary Tertiary
	Promotive		Direct funding		
	Primary	Government	Direct funding		
		Beneficiary	Out of pocket		
	Secondary	Government Beneficiary	Direct funding State GFHIS		
	Tertiary		Out of pocket		

	Level of Care	Current Source of Funds	Current Funding Mechanism	Current Coverage Estimate*	Covered under GFHIS
Middle Income (45-70% of population)	Preventive	Government	Direct funding		Part Secondary Tertiary
	Promotive		Direct funding		
	Primary	Government	Direct funding		
		Beneficiary	Out of pocket		
	Secondary	Government	Direct funding, state GFHIS		
		Beneficiary	Out of pocket		
	Tertiary	Government	Direct funding, state GFHIS		
		Beneficiary	OOP and premium		
	High-end tertiary	Beneficiary	OOP and premium (private insurance)		
High Income	Preventive	Government	Direct funding		NA
		Beneficiary	Out of pocket		
	Promotive	Government	Direct funding		
	Primary	Government	Direct funding		
		Beneficiary	Out of pocket		
	Secondary	Government Beneficiary	Direct funding, OOP, and premium		
	Tertiary				
	High-end tertiary				

* Source: Current coverage estimate has been prepared by author based on various separate databases

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