State Level Strategies for Health Insurance and Health Care

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Introduction

While the total expenditure on healthcare is about 4.1% of GDP, India spends only about 25% of this (or 1% of GDP) from government resources[2]; the rest is met by families and individuals seeking health care on an out-of-pocket-at-point-of-service[3] basis. The HLEG has estimated that in order to provide universal healthcare this number has to go up to 2.5% if UHC has to be offered[4] (recent research suggests numbers closer to 3.8% of GDP[5]). On an absolute basis the HLEG has estimated that between an Rs.1,500 to Rs.2,000 per capita would be required to deliver Universal Health Care[6]. The Planning Commission's Twelfth Plan document indicates that between the Centre and the States only 1.87% will be made available by the end of the plan period (2017) with the Centre providing 33% of this total[7]. There is additionally some concern that even if the Centre is able to provide for its share of this expenditure not all the States would be able to do so.

Ideally all the States need a universal healthcare scheme that delivers on the entitlement of every resident of the State to receive a good package of health care which includes:

a. A strong emphasis on a very broad range[8] of preventive, promotive, and curative care at the Sub-Centre[9] and Primary-Health-Centre level combining both broad-passive- curative efforts with targeted –active-preventive-early-treatment measures[10]; with more than 70% of the total healthcare investment going at this level[11].

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[2] Twelfth Fiver Year Plan (2012-2017), Social Sectors (Volume III), Pages 2-3.
[3] This has to be contrasted with pre-paid healthcare which could also be charged on an out-of-pocket basis (instead of paid by the government through taxes for example). Even voluntary insurance is paid for on an out-of-pocket basis. Out-of-pocket-at-the-point-of-service is however the most damaging because of the non-postponable nature of healthcare and can often require emergency sales of physical assets or even very high cost borrowings, with the potential to bankrupt even middle and upper-middle income households and drive them towards poverty.
[4] HLEG Report, Page 97 (http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf).
[5] http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0030362
[6] http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf, Point number 3, Box 1, Page 105.
[7] Twelfth Fiver Year Plan (2012-2017), Social Sectors (Volume III), Page 18.
[8] Current focus of government provided healthcare is principally Maternity and vaccinations.
[9] Often governments regard the Primary Health Centre (PHC) as the first point at which healthcare can be accessed. The High Level Expert Group on Universal Health Coverage (www.uhc-india.org) disagreed with this point of view and has argued that the PHC must be thought of more as a secondary care centre and the sub-centre as the first point of contact with the staffing and other support services to make it effective as the first port of call (http://www.uhc-india.org/reports/hleg_report_chapter_5.pdf, Pages 190-194).
[10] The sub-centre design work of the IKP Centre for Technologies in Public Health could be useful to examine here (http://www.ictph.org.in/downloads/ICTPH%20Model%20for%20the%20Provision%20of%20Primary%20Care%20at%20the%20Village%20Level.pdf).
[11] The number of 70% is drawn from the report of the High Level Expert Group (http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf, Recommendation 8, Page 108)

b. Strict gatekeeping[12] at the sub-centre level for all higher levels of care with an effort to ensure that more than 95% of the patients are fully cared for at this level and only a small number[13] are required to seek higher levels of care[14];

c. Adequate[15] supply of higher levels of care.

d. Strong performance pressure at all levels of the health delivery system, driven both by vertical (internal, hierarchical) as well as horizontal (demand side, community based) accountability mechanisms such as capitation payments, purchaser-provider splits and / or independent regulatory mechanisms; and regular health outcomes assessments at the population level by the government[16].

e. A complete absence of any user fees, co-pays, or deductibles, at all levels[17] with strong gatekeeping at the sub-centre level being used to ensure that there is rational and controlled use of higher levels of care.

f. Free universal availability of all essential drugs in both public as well as privately owned facilities including pharmacies[18].

g. Strong cost control measures using district-level-capitation payments so that the entire healthcare system participates in the risks as well as rewards of poorly / well run systems and works actively to address the burden of disease[19].

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[12] That is, no patient will receive treatment at a higher level of care without explicit referral from the lower level of care.

[13] A quick examination of the pricing of the RSBY scheme (at Rs.750 for Rs.30,000 of maximum cover) suggests that only about 2.5% of the insured should require this level of cover and that of Rajiv Arogyasri scheme (at Rs.300 for Rs.200,000 of maximum cover) suggests that only about 0.15% of the insured should require this level of cover for the schemes to be viable. If one assumes that between them RSBY and RAS fully cover the secondary and tertiary healthcare needs of the population, these numbers are consistent with the view that more than 95% of the patients should be dealt with at the primary care level with no onward referrals.

[14] One of the more successful healthcare systems is the one in Thailand. Here under the Universal Healthcare System (UHC): "Each person must register with a public health unit (that is, a health centre or community [public] hospital) in his or her residential area and use it as a primary point of contact before getting a referral for secondary care (that is, at a provincial hospital). This primary care unit functions as a gatekeeper and helps control the cost of medical care". This is similar to the system employed by the National Health Service in the UK Page 458. Damrongplasit, Kannika and Melnick, Glenn A, "Early Results from Thailand's 30 Baht Health Reform: Something to Smile About", *Health Affairs*, 28, no.3 (2009):w457-w466. (http://content.healthaffairs.org/content/28/3/w457.full.html). See also the excellent 10 year review of Thailand's UC scheme http://www.social-protection.org/gimi/gess/RessShowRessource.do?ressourceId=28441

[15] What is adequate is highly debatable but this is a very important area of debate.

[16] For an excellent review of the literature on this subject refer Khaleghian, Peyvand and Monica Dasgputa, "Public Management and the Essential Public Health Functions", World Development Vol. 33, No. 7, pp. 1083–1099, 2005. It very broadly concludes that in the context of health care "New Public Management" tools such as purchaser-provider splits and decentralisation have not lived up to their early promise and that there is a strong case for revisiting "Old Public Management".

[17] Refer: "Universal Healthcare and the Removal of User Fees", Robert Yates, Lancet 2009, 373: 2078–81. The core points of the article are that even small user fees have a dramatic impact on usage of primary care services; that often they are more expensive to collect than the revenues they imply; and they can themselves constitute a significant source of hardship.

[18] Brazil for example offers free blood pressure and diabetes medicines to all valid prescription holders directly at the pharmacy, even without the need to go to a public facility: http://www.bbc.co.uk/news/world-latin-america-12361366.

h. A strong emphasis on universality so that the very vulnerable middle-class is not left out and receives the benefit of pre-payment even if it has to pay an additional surcharge on income or on salary[20]; the benefits of the performance pressure that such patients can bring to bear is available to the low-income population; and a large, parallel, apparently superior, fee-for-service health system does not evolve for the middle class which is envied by those receiving care within the universal healthcare system[21].

However, as mentioned earlier, there appears to be real doubt if there is indeed room in either the State or the Central budgets for the enhanced levels of expenditure required for such a system and, even if the money were to become available, bringing about all these changes is likely to take a great deal of time. There may be a need therefore to think in two frames of reference – a near term one and a longer term one and to find a pathway in which the longer term evolves naturally from the shorter-term measures that are implemented.

At the present time, State governments seem to be facing two, potentially competing, choices:

a. Strengthening of the health delivery infrastructure at all levels, but particularly at the sub-centre; public health centre; and the community health centre levels – made extremely difficult given the severe shortage of funds and the non-availability of trained manpower.

b. Roll-out of State level insurance schemes for secondary and tertiary care, using either insurance companies or public trusts to discharge the function of purchasing healthcare, using resources provided to them by the government.

Starting with these two, there are actually several permutations and combinations that present themselves as choices in front of State governments as they think about the way forward for themselves. These include maintaining the status quo; rolling back the insurance schemes; merging the state owned delivery apparatus into the insurance schemes; or developing a hybrid solution in which the state owned delivery infrastructure co-exists with the insurance schemes in a tightly coordinated manner. The following paragraphs discuss each of these options in some detail.

Maintain Status Quo

Maintaining status quo implies a pathway in which both these schemes with some variations are pursued independently of each other with each being funded from a different part of the budget and being managed by a different ministry. The potential benefit of such a plan would be that citizens are able to access hospital facilities in both the private and the public sector as they wish. This allows them to benefit from the available supply of private hospitals and introduces a measure

[19] Thailand uses this system actively (see detailed discussion of how the capitation rate is calculated: http://www.jointlearningnetwork.org/sites/jlnstage.affinitybridge.com/files/Capitation_Thailand_Netnapis.pdf).

[20] http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf, Recommendation 3, Page 101.

[21] It is also important to note that the countries that appear to be doing best in achieving UHC goals are those that are prioritising population coverage (sometimes over the size of the benefit package). This goes for the recent UHC success stories of Mexico, Brazil, Sri Lanka, Thailand, and, most recently, China. Furthermore it would appear to be political pressure that is driving this push for full population coverage. See the Savedoff paper in the recent Lancet special series: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61083-6/fulltext. Raising expectations for improved coverage from as many people as possible is a good way to pressurise the system to deliver more and better services.

of accountability in the public hospitals and "double funding"[22] which could be used to strengthen these facilities as well act as a performance incentive for the physicians and other members of the team. Primary healthcare and government hospitals would continue to see improvements as and when funds become available from their part of the budget.

The key downside is that given the large unaddressed burden of disease on the ground, over a period of time, the usage of secondary care facilities would be much higher than was desirable or affordable by us as a country and potentially tax resources that could have been used to strengthen primary care provision would get spent to support more hospital infrastructure thus further exacerbating the problem of the already high levels of secondary and tertiary healthcare expenditure. Over the medium term this entire process would lead to an irreversible situation in which "excess" hospital capacity[23] would be created with, at least in relative terms, an increasingly underfunded and underperforming primary healthcare infrastructure not getting an adequate amount of resources and thus not able to bring down the burden of disease.

The insurance schemes are perceived[24] to be very effectively addressing the immediate financial protection challenges associated with the high costs of hospitalisation in India and are therefore seen by the political establishment as very popular and enjoy a great deal of support. An under-funded primary care network is struggling to cope even with basic goals relating to the delivery of children and is unable to address any other health concerns and is therefore seen not be very popular. An uncoordinated approach towards growing both these schemes would also serve to exacerbate this problem to the detriment of the health levels of the entire population.

Roll Back All Insurance Schemes and their Budgets into State Healthcare Budgets

Rolling back all the insurance schemes is potentially another option in front of the government and is also the preferred position of the HLEG[25]. In this even the extra money from the Ministry of Labour would be made available to the relevant health ministries to continue to invest in public healthcare systems and in contracting-in the services of the private sector where it was felt that the public sector did not have adequate capacity. Under this option it is still possible that there could be private sector provision but the model of quality control would be through Administrative (or Vertical) Accountability.

The anxiety here is that in a severely under-funded healthcare system any incremental amounts of money added to the budget would simply get absorbed within the system without necessarily any results becoming visible – there appears to be an explicit desire to partition the two pools of funds so that immediate relief and financial protection may be provided to the citizens for their hospitalisation expenses and access to an adequate level of hospital facilities from the private sector. There is also the concern that the ability of health ministries to contract-in secondary and tertiary care facilities is weak[26] and that it would be best to set up independent purchasers such as

[22] Where the public hospitals get paid by the government both from their normal budgets as well as via the insurance schemes.

[23] See the US debate on this:http://www.dartmouthatlas.org/downloads/reports/Capacity_Report_2009.pdf;

[24] Research on this subject is ongoing.

[25] HLEG Document, Recommendation 9, Page 108 (http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf).

[26] CGHS which does its own contracting on a fee-for-service basis within India and the CSMBS in Thailand (http://www.nationmultimedia.com/national/Govt-aims-to-cut-cost-of-civil-servant-scheme-30195882.html) both suffer from very high per episode levels of expenditure and very high levels of cost-inflation. In a conversation with the HLEG the Director of Healthcare within Tamil Nadu also expressed a concern that his ability to contract in Tertiary care would be weak and that he preferred to deal with these politically powerful providers on an arm's length through the insurance companies.

Trusts or Insurance Companies to do this on behalf of the government so that the added level of skills and ability to exert control on expenditures that these entities bring, would be available to the government.

Roll the State Healthcare Budgets into the Insurance Schemes

Rolling the State health budgets into the Insurance framework is yet another alternative that is available. As in the case of Thailand the funds could be transferred to a Trust[27] or the services of one or more insurance companies could be employed to "purchase" or "commission" healthcare services from the ministry of health or the private sector. This would be akin to the classic "purchaser-provider" split that has underpinned many of the successful Universal Health Care (UHC) schemes around the world, including Thailand[28]. The benefit of such an approach would be that entire infrastructure of primary, secondary, and tertiary care would be available potentially on an integrated basis and the scheme would then require only those with integrated infrastructures to bid for participation – this is the Thai model. One of the suggested solutions under this option is to create Healthcare Social Enterprises[29] which would be integrated networks of primary, secondary, and tertiary care which would be paid on a capitation basis. In many ways this approach is preferred to the fragmented purchasing of secondary and tertiary care and the HLEG took the view that if indeed insurance as a purchasing route had to be pursued (i.e., purchaser-provider splits fully implemented) this would also be their recommendation[30]. Under this option it is still possible that there could be public sector provision but the model of quality control would be through Customer (or Horizontal) Accountability.

However, this approach is fraught with many risks and was clearly not the preferred choice of the HLEG. The implementation of such an approach, even on a pilot basis requires the availability of the complete level of funding needed to ensure UHC. And, even if the funds are available, despite the global view that this could result in substantial improvements in the quality of care provided by both public and private provider and would prove to be cost effective, in the Indian context the HLEG did not favour this model for the delivery of UHC for several reasons[31].

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[27] "The National Health Security Act promulgated in November 2002 mandated the establishment of the NHSO and its governing body, the National Health Security Board (NHSB). The NHSB is chaired by the Minister of Public Health, and is responsible for setting policy, making decisions on the benefits package, deciding on appropriate provider payment methods, and setting rules and guidelines. The NHSB's 29 other members include representatives from various stakeholder groups: government officials (8), local governments (4), NGOs (5), health professionals (4), private hospitals (1), and experts in insurance, medical and public health, traditional medicines, alternative medicines, financing, law, and social science (7). The NHSB also has 11 subcommittees that assist in policy development". (Page 51) "Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010)", Nonthaburi, Thailand: Health Insurance System Research Office, 2012.

[28] In 2002 all major MOPH programme budgets (provincial, district and sub-district health services, and subsidies for the Medical Welfare and Voluntary Health Card Schemes) were pooled, making available a total budget of 26.5 billion baht. The estimated shortfall of about 30 billion baht needed to start nationwide implementation of the new scheme was allocated by the Government. Although this entire sum was initially managed by the MOPH, the capitation-based UCS budget passed via the CUPs to the provider facilities, which meant that the MOPH's annual supply-side budget allocation dried up completely. ". (Page 57) "Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010)", Nonthaburi, Thailand: Health Insurance System Research Office, 2012.

[29] Refer note and presentation by Dr. Shiban Ganju.

[30] HLEG Document, Page 110, Point "h" (http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf).

[31] See the discussion in the HLEG Document, Pages 109-110 (http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf).

A very high level of monitoring would be needed by the purchaser to ensure that the terms of contract are being met. This would require both human capacity and a very high level of expenditure. Hospital based expenditures are potentially controllable through DRG style payment structures and for primary care or entire networks through capitation style payments. However, issues such as quality of care that is provided, and denial of appropriate levels care by networks that are paid on a capitation basis are serious concerns that need a high level of supervision. In the absence of these levels supervision there are very real dangers of mismanagement and "capture" of the system by the providers and it is not at all clear that the governmental and regulatory apparatus would in a position to exercise this level of oversight[32]. And, much of the infrastructure for primary care needs to be constructed and given the paucity of resources that will be available even under the UHC framework the networks that are created on the ground would be in the nature of monopolies and national interest may be better served if these networks are in public hands.

Build a Hybrid Solution

Given all the challenges and concerns associated with maintaining the status quo or with choosing either one of the "pure" options, another approach would to develop a hybrid approach which seeks to find a middle path. It would require us to simultaneously strengthen health systems; universalise health insurance coverage with a focus on secondary and tertiary care; and integrate the insurance system with the health system, giving priority to the poorest districts. Annexures I and II provide a set of ideas that could be considered as a part of this hybrid approach. A possible approach could involve taking the following steps:

1. Universalise the Insurance Schemes using Trust or Insurance Companies as purchasers. It is indeed possible to offer almost universal health insurance for secondary and tertiary care within existing funding available with the central and state governments[33], particularly if the covered conditions are defined with care and strong expenditure caps are placed. As the capacities of the ministries of health develop these purchasing arrangements could then be transferred over to them as envisaged in the UHC.

2. Impose a requirement on all tax payers to pay a health protection surcharge. The proceeds from this surcharge would go to pay for extending the coverage of health insurance to the non-BPL populations. This surcharge in the medium-term could then be pooled to contribute the additional sums needed to fund the UHC.

[32] In the Indian context there would be a concern that: "Functions such as surveillance are so complex and spread out that monitoring a private contractor would be a costly exercise—however good the indicators chosen—and might lead to principal–agent related efficiency losses such as those observed when hard-to-monitor services are decentralized. Effective monitoring also requires a high level of technical capacity within government, without which contractors will take advantage of their informational advantages vis-a` -vis the government and fail to be held accountable. Even for more straightforward services like curative care, the monitoring function often proves difficult to design and sustain in the long term. A common argument for contracting out to the private sector because capacity is low in government in developing countries is therefore flawed: for contracting to work well, capacity needs to be high. Governments with a low capacity are likely to have a low ability to write, monitor, and enforce contracts for complex services. Contracting should therefore be approached with care and not as a substitute for strengthening the capacity of government itself. Given the high transaction and monitoring costs involved, efficiency gains are unlikely." (Extracted from Khaleghian, Peyvand and Monica Dasgputa, "Public Management and the Essential Public Health Functions", World Development Vol. 33, No. 7, pp. 1083–1099, 2005).

[33] Refer La Forgia and Nagpal (2012) for more discussion on this.

3. As discussed in the Annexures I and II take several steps to link the insurance schemes strongly with the currently available publicly provided primary healthcare infrastructure. Some of these steps would include:

    a. Modernisation of sub-centres, primary healthcare centres, and community hospitals by using them for enrolment into insurance schemes, maintenance of patient records, and as gatekeepers.
    b. Take steps to address the burden of chronic disease, specifically CVD, using presumptive treatment approaches. This would go a long way towards reducing the need to seek higher levels of care and hospitalisation expenses.
    c. Including Maternal and Child Care being provided at the sub-centres, PHCs, and CHCs into the insurance schemes.
    d. Universal availability of free generic essential medicines even outside the public sector, particularly for CVD so that it does not get constrained by the poor quality of public health infrastructure.

4. Introduce formal licensing of hospitals based on a CON (Certificate of Need) process and a national set of norms so that "excess" supply does not build up in the system, particularly those funded by RSBY and RAS type schemes. This is often the path through which insurance led systems build up a curative focus – by creating excess hospital / bed capacity in the system[34]. This approach would also ensure that wherever high quality public or private empanelled hospitals are already present no other hospitals are able to compete with them.

5. Use the purchasing power of the Government or the Trust and tools such as Aadhar put in place strong quality control measures such as:

    a. Universal usage of EHRs in hospitals and at all levels of health facilities within the State.
    b. Development of a national Quality Index which would be based on performance of hospitals on issues such as readmission rates, CLABSI rates, and five-year event-free survival rates.

6. Strongly imposed spending caps on expenditures on secondary and tertiary care and on the maximum premium that may be paid for any of the insurance schemes.

Conclusion

For most States It is clear that given the level of financing that is available for the provision of healthcare, it would not be possible to offer universal healthcare no matter what method of purchasing (Supply side or Demand side) is used or whether the private sector or the public sector emerge as the principal providers. For these States, given the fact that the resources are not immediately available, the question is how to ensure that, as they gradually acquire the financial capacity; build the political will; and begin to put in place the human resources and the physical infrastructure required for UHC, the immediate healthcare and financial protection needs of the population are addressed in manner such that in trying to address immediate needs it does not start to move in a direction opposite to the one that is best suited for the achievement of the UHC goal even in the longer term. As discussed earlier the current fragmented approach presents a number of urgent challenges that need to be addressed and has the real danger that it will make the goal of UHC unattainable even in the longer run because of the creation of excess hospital capacity, populations getting used to free-market choice structure for seeking health services, and continued relative under-funding of primary healthcare leading to larger and larger unaddressed burdens of

[34] See the US debate on this:http://www.dartmouthatlas.org/downloads/reports/Capacity_Report_2009.pdf;

disease. For these States the hybrid option outlined about would appear to offer the best way forward:

1. Universalise the Insurance Schemes using Trust or Insurance Companies as purchasers[35]. It is indeed possible to offer almost universal health insurance for secondary and tertiary care within existing funding available with the central and state governments, if the covered conditions are defined with care and strong expenditure caps are placed. As the capacities of the ministries of health develop these purchasing arrangements could then be transferred over to them as envisaged in the UHC.

2. Impose a requirement on all tax payers to pay a health protection surcharge. The proceeds from this surcharge would go to pay for extending the coverage of health insurance to the non-BPL populations. This surcharge in the medium-term could then be pooled to contribute the additional sums needed to fund the UHC.

3. As discussed in the Annexures I and II take several steps to link the insurance schemes strongly with the currently available publicly provided primary healthcare infrastructure. Some of these steps would include:

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    c. Including Maternal and Child Care being provided at the sub-centres, PHCs, and CHCs into the insurance schemes.
    d. Universal availability of free generic essential medicines even outside the public sector, particularly for CVD so that it does not get constrained by the poor quality of public health infrastructure.

4. Introduce formal licensing of hospitals based on a CON (Certificate of Need) process and a national set of norms so that "excess" supply does not build up in the system, particularly those funded by RSBY and RAS type schemes. This is often the path through which insurance led systems build up a curative focus – by creating excess hospital / bed capacity in the system[36].

5. Use the purchasing power of the Government or the Trust and tools such as Aadhar put in place strong quality control measures:

    a. Universal usage of EHRs in hospitals and in all the levels of facilities within the entire system.
    b. Development of a national Quality Index which would be based on performance of hospitals on issues such as readmission rates, CLABSI rates, and five-year event-free survival rates.

6. Strongly imposed spending caps on expenditures on secondary and tertiary care and on the maximum premium that may be paid for any of these schemes.

[35] Whether a State owned Trust is used or insurance companies are used would entirely depend the administrative capacities of the State and the independence with which the Trusts would be able to operate.
[36] See the US debate on this:http://www.dartmouthatlas.org/downloads/reports/Capacity_Report_2009.pdf;

However, there will be a number of States that are expected to have the necessary resources to provide Universal Healthcare even without any additional support from the Central Government[37]. These would include States such as Haryana, Maharashtra, Mizoram, Sikkim, Uttarakhand, Delhi, Pondicherry, Arunachal Pradesh, and Goa. For these States the recommendation would be to:

1. Carefully make a choice between using Supply side methods (administrative accountability within the State apparatus) or Demand side methods (customer accountability and competitive forces) to control the quality of provision of healthcare. As has been pointed out earlier, the HLEG has strongly recommended using Supply side methods to control quality of provision within healthcare. However most of the countries that have proceeded towards Universal Healthcare have favoured Demand side methods[38]. Based on the answer to this question one of the two "pure" options discussed earlier would suggest themselves.

2. Once the answer to the above question is clear these States would need to roll back all fragmented Insurance schemes. If they wished to go with Demand side accountability then with the help of insurance companies or Trusts or directly from the ministries of health, contract with integrated networks or Health Social Enterprises to purchase care on a capitation basis. If on the other hand they preferred Supply side accountability then they would proceed as outlined in the HLEG document.

3. In either case the State would need to ensure that 70% of the healthcare expenditure is reserved for primary care.

4. Impose a requirement on all tax payers to pay a health protection surcharge. The proceeds from this surcharge would go to pay for extending the coverage of health insurance to the non-BPL populations. This surcharge in the medium-term could then be pooled to contribute the additional sums needed to fund the UHC.

5. Introduce formal licensing of hospitals based on a CON (Certificate of Need) process and a national set of norms so that "excess" supply does not build up in the system[39].

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    b. Development of a national Quality Index which would be based on performance of hospitals on issues such as readmission rates, CLABSI rates, and five-year event-free survival rates.

[37] By the end of the twelfth plan these States would have the required amount of funds available with them for implementing a full UHC. Refer UHC Document, Page 106-107 (http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf).

[38] At the end how the administrative system of monitoring in the public system work relative to customer accountability in the private, moderately regulated system, is an empirical one and should States choose to adopt different strategies it would throw up very interesting insights.

[39] See the US debate on this:http://www.dartmouthatlas.org/downloads/reports/Capacity_Report_2009.pdf;

Annexure I
Strengthening of Health Systems

Public health systems are chronically under-funded and even relative to the funding that they receive, they are often under-performing. This section explores some ideas for strengthening public health systems that are independent of the fact that an insurance scheme is also in the offing, but seek to benefit from its arrival.

1. **Set-up Tracking Mechanisms at all Levels**: With the arrival of insurance schemes since there is likely to be a great deal of investment in technology[40], take this opportunity to set up electronic usage-tracking mechanisms at all facilities, including sub-centres[41]. Also use the technology budgets and the drive to enrol patients in the insurance scheme to build a GPS[42] map of every household in the State and to provide the Auxiliary Nurse Midwife (ANM) with mobile phone / tablet based technological capabilities to simplify and make much more efficient her routine data collection tasks[43]. Use both these efforts to set up strong district level performance tracking capabilities which are well advertised so that the users / NGOs / local politicians are kept well informed about the relative performance of various health systems and district level health managers[44]. There is also the possibility of setting up attendance tracking by posting a simple question on each health centre and a mobile number to which people can send an SMS[45].

2. **Free-up Supply Constraints at the Primary Care Level**: Arrival of insurance would imply that privately owned hospital infrastructure would start to grow because it can now benefit from both government-financed patient flow as well as its own fee-for-service / private insurance patients – making it much more viable. Explore similar ways of unlocking supply constraints at the primary-health-centre and the sub-centre level using the PPP route[46] and perhaps as a part of the empanelment process for the insurance schemes (discussed later).

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[40] While there has been a great deal of design input from Government of India's Labour Ministry and the World Bank the RSBY systems are largely managed by technical organizations such as FINO Paytech (www.finopaytech.com). These companies would be very happy to offer similar platforms to State governments for a wider implementation.

[41] Given the size of the country and the remoteness of many of these locations there is always a concern relating to the maintenance and operation of the hardware. Commercial organisations such as Wipro have successfully demonstrated their capability to do this all across the country in extremely remote areas and guarantee up-times.

[42] http://www.gps.gov/

[43] There are a number of platforms that now enable this. One example is listed here: http://www.who.int/ehealth/resources/compendium_ehealth2012_9.pdf

[44] Here simple service output indicators can be extremely useful for example numbers of outpatient consultations, immunisation coverage and deliveries in health units. Not only are these a function of the availability of key inputs (e.g. HR, facilities, medicines, etc.) but they also measure whether people think they are sufficient quality to consume them. Many health people often try and establish complicated quality monitoring systems but these basic indicators could also be very powerful.

[45] Platforms such as www.ushahidi.com allow the real-time tracking of such SMS messages. Also see this video: http://www.youtube.com/watch?v=EhT3co2qNAA. UNICEF has successfully scaled up these innovations in Uganda on a nationwide basis: http://www.unicef.org/uganda/9903.html -- see the sections on mTRAC and U-Report.

[46] Within the activist community while these seems to be a broad acceptance of the role of the private sector in secondary and tertiary care there is a strong resistance to their entry in any form in primary care. This is hard to comprehend given the reality that as a consequence of the entry of the private sector the supply of secondary and tertiary care facilities is growing rapidly relative to primary care facilities. Additionally within the government each of these facilities is seen as a large infrastructural project whereas the reality is that it is the human resources dimension that is most important. The use of small rented facilities could easily

3. **Move Care Closer to the Patient**: Even independently of the arrival of the insurance scheme there is an opportunity to move care closer to the patient so that it both lowers costs as well as is easier to access. A good example of this effort would be to move routine Deliveries to the sub-centre[47] with the PHC acting more as an Emergency Obstetric Care centre with a blood bank[48] in place. The ANM could be trained to carry out these routine deliveries either by assisting at the PHC and / or by using training tools such as Mama Natalie[49].

4. **Focus on Chronic Disease**: This is a growing burden of disease[50] that is also directly linked to the propensity to seek secondary and tertiary care. Paying attention to this disease burden could therefore have a very large beneficial impact on the wellbeing of the population as well as ensure that the insurance premiums do not rise precipitously over time – it is also possible to include the early diagnosis and treatment of these conditions (carried out at the sub-centre) within the insurance plan. Carrying out CVD risk assessment of the entire population[51] or at least of those being insured using simple markers[52] such as Waist-Hip-Ratio; Body-Mass-Index; and Blood Pressure is easy to do[53] and then potentially a follow up treatment plan could either include a series of additional diagnostic tests such as OGTT (Oral Glucose Tolerance Test) followed by treatment[54] or, if that is thought to be infeasible, a presumptive treatment plan with a suitably designed multi-drug cocktail[55].

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substitute for the large and expensive facilities that the government builds at these levels – most of which remain under-utilized.

[47] See the discussion on Type B sub-centres in the revised IPHS Guidelines for sub-centres (http://health.bih.nic.in/Docs/Sub-Centers-(Revised)-2012.pdf)

[48] Poor availability of power can become an impediment for the establishment of a high quality blood bank. Use of solar powered refrigerators or maintaining a live registry of local healthy donors for each blood type could prove to be effective substitutes.

[49] http://www.laerdal.com/in/mamaNatalie; http://www.youtube.com/watch?v=-mj7oaLmBlQ. This approach is being implemented by CARE India (http://www.careindia.org/healthcare#4) as a part of its work with the Government of Bihar.

[50] The Lancet Global Burden of Disease for 2010 finds that for South Asia High Blood Pressure, High fasting plasma glucose, and high total cholesterol are among the most important risk factors accounting for the total burden of disease in the sub-continent (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61766-8/abstract).

[51] Given the unwillingness of people to demand these services and practitioners to supply them it might be necessary to introduce financial incentives to both to increase the consumption of these preventive health measures similar to the Janani Suraksha Yojana (JSY).

[52] See the WHO STEPS guidelines on this approach: http://www.afro.who.int/en/clusters-a-programmes/hpr/health-risk-factors/diseases-surveillance/surveillance-country-profiles/step-survey-on-noncommunicable-disease-risk-factors.html.

[53] Also see a post on an implementation of such an approach at the sub-centre level by ICTPH (http://ictph.org.in/blog/health-technology/the-launch-of-mobile-phone-based-rapid-risk-profiling-of-our-populations/).

[54] ICTPH (www.ictph.org.in) is designing and testing these strategies in its field site in Thanjavur, Tamil Nadu.

[55] There are a number of studies that demonstrate the efficacy of various combinations of drugs within the Polypill. The TIPS study was carried out in India: "Effects of a polypill (Polycap) on risk factors in middle-aged individuals without cardiovascular disease (TIPS): a phase II, double-blind, randomised trial", *Lancet* 2009; 373: 1341–51. A more recent study was published in PLoS ONE by Wald DS, Morris JK, Wald NJ (2012): "Randomized Polypill Crossover Trial in People Aged 50 and Over".

Annexure II
Design of Health Insurance Schemes

Health insurance schemes, as currently designed, unlock the supply constraint at the higher levels of care by allowing residents to access private healthcare facilities in addition to the hospitals owned by the government. What is also needed is an unlocking of the supply constraint at the primary care level coupled with strong gatekeeping and strict constraints on the increases in hospital capacity at the secondary and tertiary care levels. Otherwise there is a concern that, over time, a pure secondary-tertiary care focus could result in very high levels of health care spends in the state without the concomitant improvements in healthcare[56]. It is not the use of insurance as a tool or the use of insurance companies but the fact that it is a fragmented secondary and tertiary care scheme that is the concern. This section explores some ideas that attempt to address this concern and to find a way to get the best possible outcomes from the schemes.

1. **Empanelment of Hospitals**: Since the insurance schemes are likely to emphasise in-patient services, explore moving public hospitals to entirely becoming insurance financed; reducing or ideally eliminating budget based payments to them; and require them to receive payments in exactly the same manner as private hospitals. Since these hospitals have historically been under-funded they are likely to initially suffer as a consequence of this move since patients may prefer to by-pass them and move to privately owned facilities. Therefore to give them time to adapt there may be a need to continue to fund them from the budget for a defined period of time; and require that all hospitals (not just public ones) be given a defined geographical territory over which they have sole access by automatically and exclusively linking patients with them based on geographical proximity (easy to compute once GPS codes for registered households are made available) and strong primary care networks[57] which, even though not covered by the insurance scheme, act as gatekeepers. This would have the effect of incentivising even non-governmental healthcare providers to make longer-term investments in their infrastructure and tie-up with primary care providers in order to participate in the bidding exercise. This move will serve to increase performance pressure on public hospitals; free up more departmental resources that could be used to improve the provision of primary care at the

[56] There is often a concern expressed that by including the private sector hospitals as service providers these insurance schemes have permitted a great deal of fraudulent behavior by these hospitals which is financed by public resources. The evidence on the ground is however that the aggressive use of technology by these schemes has led to an unprecedented level of fraud control. The schemes are designed as cash-less and pre-approved because it both reduces costs and considerably enhances the patient experience. However, under such an approach while it is almost impossible to track fraud on an ex-ante basis (such as the widely reported hysterectomies in Bihar), the technical infrastructure underlying the schemes has allowed them to identify and penalize and de-empanel those hospitals that have exhibited consistent fraudulent behavior (see list of de-empanelled hospitals from the RSBY site: http://www.rsby.gov.in/Hospitals.aspx?id=2). In the absence of data it is hard to establish whether the extent of fraud and corruption in an entirely publicly run system is higher or lower than within these schemes.

[57] This method of empanelment was used extensively in Thailand and as a consequence: "Although the NHSO can contract with private providers, few private hospitals and almost no private clinics or pharmacies in the provinces are capable of providing the comprehensive range of services in the benefits package. As a result, the vast majority of UCS members receive services from provider networks linked to MOPH district hospitals. In larger cities other public and private hospitals are able to serve as contractor providers, and some catchment populations have been allocated to these networks. In 2010, 54.6% of the 3.7 million members living in Bangkok were registered with private clinics and hospitals (see Table 5), but the national average was far lower: only 5.7% of UCS members were registered with private-sector networks in 2010". Page53. "Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010)", Nonthaburi, Thailand: Health Insurance System Research Office, 2012.

sub-centre level; and ensure that excess capacity does not build up at the secondary and tertiary care levels resulting in unhealthy competition[58].

2. **Payment Systems**: Allocate the money set aside for the insurance scheme on a capitation basis and refund the excess between the bid and the capitation state-wide allocation to the primary care providers so that there is an incentive to the primary care provider to keep claims low[59].

3. **Include PHCs and Sub-Centres in the Scheme**: Generally health insurance schemes are characterised by the inclusion only of low-frequency-high-cost conditions in order to keep the premium low. This keeps the utilisation low and builds strong late-stage curative orientation into the system and drives healthcare seeking behaviour towards expensive, less cost-effective interventions. It would be useful to include moderate frequency and moderate cost events such as maternity[60] into the scheme and include public systems such as PHCs and sub-centres into the design so that such care can be provided to residents in a proximate manner, even under the insurance scheme.

4. **Gatekeeping**: Typically gate keeping functions inside insurance schemes are performed by TPAs (Third Party Administrators) whose principal task is to check unnecessary and expensive hospital procedures. Most well-designed universal healthcare schemes, on the other hand, give gate keeping functions to primary care providers. The State government could explore doing something similar gate keeping capabilities inside sub-centres and PHCs and paying them a small fee for it from the insurance premium. This gate keeping function could provide an added level of incentive to the primary care providers to keep the burden of disease under check and would benefit the government, the insurer, and the community[61]. It may be useful to carry out the

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[58] Even in a free market healthcare system such as the US, hospitals are required to establish that there is indeed a need for a new hospital through a "Certification of Need" (CON) process: http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx.

[59] "The UCS approach to closed-end provider payment brought radical changes to how the budget was spent. Prior to UCS, apart from staff salaries, operating budgets and resources were allocated to health facilities through the Provincial Health Office (PHO) based on utilization rates and number of beds, which could be easily influenced by politicians. Under the UCS, the outpatient budget is allocated based on age-adjusted capitation and the total number of UCS members in a locality, with some adjustments to ensure the financial viability of the contract provider network in remote areas, the size of the catchment area and the number of health centres in the network. There is a fixed cost for district hospitals and more recently a fixed cost for small general hospitals. For inpatient services, a global budget is calculated for each of the 13 public health regions (Bangkok is one region and each of the other regions cover five to six provinces), and inpatient expenditure is reimbursed based on the cost weight of the Diagnosis Related Groups† (DRGs) generated by each hospital but capped by the regional global budget. In 2001 DRGs were already being used by MOPH hospitals in a pilot exercise for the Medical Welfare Scheme: as this was not a new mechanism there was little resistance from health providers". (Page 46) "Thailand's Universal Coverage Scheme: Achievements and Challenges. An independent assessment of the first 10 years (2001-2010)", Nonthaburi, Thailand: Health Insurance System Research Office, 2012.

[60] Maternity is covered in RSBY (http://www.rsby.gov.in/faq_medical.aspx#7). There may be a feeling that since JSY already covers Maternity it would be a duplication of effort to also include it within insurance. If the goal is indeed that 100% of the deliveries should happen in institutional settings and that high emergency obstetric care should also be made available, then it should instead be seen as a strengthening of the public-provider network for a high priority service rather than as a duplication. Since a mother cannot obviously deliver the same baby twice, including this under the insurance programme would ensure that gaps in areas such as emergency care would be more naturally filled in through the insurance mechanism while routine deliveries take place at the sub-centre with a clear referral protocol for any signs of complications.

[61] In Thailand, for example, "Each person must register with a public health unit (that is, a health centre or community [public] hospital) in his or her residential area and use it as a primary point of contact before getting a referral for secondary care (that is, at a provincial hospital). This primary care unit functions as a

enrolment under the insurance scheme at the sub-centres and the PHCs as well so that the skills are built up there and the contact with the patient initiated.

5. **Enrolment Procedures and Starter Packs**: When the insured are being enrolled it would be useful to do a rapid risk assessment of CVD and other illnesses for them. If they are found to be at-risk then they could either be started on a full diagnostics path or Starter Packs could be given to them with all the medicines and instructions on how and when to consume them[62]. The price of these Starter Packs could be included in the insurance premium. The risk status of the individual could then eventually be matched to the nature of treatment that she has been offered in secondary and tertiary care settings so that sharper early diagnosis and treatment pathways could be evolved[63].

6. **Quality Control Measures for Hospitals**: Use the purchasing power of the Government or the Trust and tools such as Aadhar to put in place strong quality control measures which would include:

    c. Universal usage of EHRs in hospitals.
    d. Development of a national Quality Index which would be based on performance of hospitals on issues such as readmission rates, CLABSI rates, and five-year event-free survival rates.

7. **Specific Features of the Schemes**: There are several debates on the manner in which insurance schemes may be designed:

    a. Pre-approved cashless (as in RSBY) versus post-authorisation Reimbursement: The schemes should be designed to be pre-approved and cash-less for all payments that are moderate in size and for conditions where there is less of a concern of fraud and misuse. Technology platforms developed for RSBY could be used which provide a high level of ex-post electronic and audit control without inconveniencing the citizens on an ex-ante basis by making them run from pillar-to-post to get approvals – the experience in private insurance markets is that this is the cause of the maximum hardship.

    b. District versus State Level Bidding: District level bidding would provide a much larger set of options for the state government[64], particularly if it chooses to go with insurance companies as purchasers of healthcare instead of a State level Trust. The burden of disease is very different from district-to-district and since potentially different insurers would win in each district, it would be feasible for the State to give them longer term (five to ten year) contracts with stringent performance clauses but yet not be tied-in to them if they do not perform[65].

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gatekeeper and helps control the cost of medical care". Page 458. Damrongplasit, Kannika and Melnick, Glenn A, "Early Results From Thailand's 30 Baht Health Reform: Something To Smile About", *Health Affairs*, 28, no.3 (2009):w457-w466. (http://content.healthaffairs.org/content/28/3/w457.full.html

[62] In addition to appropriate CVD medicines the Insurance Starter Packs could also contain other items such as ORS packets for diarrhoea, Iron Sprinkles packets for children, and Iron and Folic Acid tablets for young women.

[63] It would be important to ensure though that these individuals are not systematically excluded by the insurer on account of their higher risk status.

[64] This is the current RSBY design.

[65] It is also important to bear in mind that given the importance of creating big risk pools and reducing fragmentation, a case could be made for State Level bidding. If might be worth looking at the Chinese experience, where they are struggling to manage 3600 risk pools at the county level: http://uhcforward.org/blog/2012/aug/28/china-next-steps-path-universal-coverage. Perhaps a minimum

c. Universal Coverage**:** As discussed earlier, there is a great deal of value in making the scheme universal in coverage recovering, if necessary, an additional health surcharge along with sales tax or other State level taxes to ensure that the rich contribute an additional sum to the scheme but do get the benefit of no out-of-pocket payments at the point-of-service. If only the poor are sought to be included there may be a case to still include all the elderly in the scheme – 60 years and above – a great deal of in-home poverty observed in practice even inside households that are nominally above the poverty line.

d. Use of Public Trust versus Public / Private Insurer: Both models have been used to deliver Universal Healthcare within developed and developing countries and no one approach seems to be universally preferred. Within the Indian context, the Public Trust structure, particularly if the intent is to benefit from a purchaser-provider split, may prove to be insufficiently "distant" from the State and from political pressures. And, if there is already a shortage of talent within the public sector the creation of a Public Trust would further stretch the available talent pool.

population size would need to be agreed so that the level of fragmentation is not excessive but that the State also has a choice of insurance providers to work with.