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Pathways to Universal Health Coverage: Lessons from Government-sponsored and Community-Based Health Insurance Schemes in India

India's health sector continues to be challenged by overall low levels of public financing and disproportionate reliance on private resources. High out-of-pocket (OOP) spending by households, almost 60 percent of total health expenditure,[1] restricts access to quality health care for many low-income families and threatens to impoverish them.

Supporting the Expansion of Financial Protection and Improving Access to Health Care is a Focus of the USAID-funded Health Finance and Governance (HFG) Project in India.

The current national government has shown political will to implement major health sector reforms in pursuit of universal health coverage (UHC). Demand-side financing, where money follows the patient, through government-funded health insurance (GFHI) schemes is a key vehicle of this pursuit. To this end, the Ministry of Health and Family Welfare is preparing to roll out, in 2017, an expanded version of Rashtriya Swasthya Bima Yojana (RSBY), the government's flagship health insurance scheme that covers about 34 million below-poverty-line (BPL) households, or about 119 million people.[2] The new National Health Protection Scheme (NHPS) will cater to a substantially greater number of people.

Several state governments have also launched GFHI schemes for poor and vulnerable families. Some state schemes, such as the Aarogyasri scheme launched by the Andhra Pradesh government in 2007, have gained significant popularity, going on to expand and inspire others. Currently, 20 states are implementing their own schemes, either to complement RSBY or as a standalone scheme.

At the local level as well, several community-based health insurance (CBHI) schemes are functioning as community-led health financing and risk-pooling programs providing financial protection to members. Such micro-insurance schemes precede the launch of GFHI schemes in India, and have contributed to the expansion of health insurance in the country, providing a buffer to low-income households not covered by government schemes for the poor.

This brief presents the key insights from a qualitative review of GFHI and CBHI schemes in India. Its aim is to identify lessons that could contribute to expansion of financial protection for Indians below or near the poverty line.

[1] Ministry of Health and Family Welfare (MoHFW). Draft National Health Policy 2015. Government of India.
[2] MoHFW. Press Information Bureau Release – March 24, 2013.

Key Observations

This section summarizes the findings of a qualitative review by HFG, which analyzed the evolving scenario of GFHI and CBHI schemes in India. The review drew on the experience of subject matter experts directly engaged with design and implementation of several GFHI schemes in India, a literature review, and discussions with various stakeholders. The exercise has lent vital insights, presented below, on the design and implementation experience of health insurance schemes (see Figure 1, Figure 3); the possible lessons from and linkages with GFHI schemes that can impact the functioning of CBHI schemes (see Figure 2), and the health financing imperatives to accelerate progress toward UHC.

Financial risk protection is a key component of UHC.

UHC aims to enable all to access quality health services without financial hardship. India's focus in the last decade on supply-side financing to strengthen the public health system has yielded results but crucial gaps remain, evident from high OOP expenditure and increasing dependence on the private sector. Health insurance schemes have a big role to play here, providing their beneficiaries financial risk protection and empowering them to access quality health care, purchased from public and private health care providers. As many of the schemes, GFHI schemes in particular, target poor and vulnerable families, they are also creating equity in access to health care. Importantly, the government is able to spend its money in a targeted manner, delivering a subsidy to intended recipients. Various studies also attest to the positive impact GFHI schemes have on reducing inpatient OOP payments, a major cause of indebtedness due to health care-related events.

India must explore options to provide a comprehensive benefit package.

Several countries across the world are providing a comprehensive benefit package covering inpatient and most outpatient services. For India, there are important lessons from the schemes launched by countries such as Thailand, Mexico, South Korea, Philippines, and Ghana as they move toward UHC. Most GFHI and CBHI schemes in India provide only inpatient coverage, and simple consultations, medicines, and diagnostics that do not lead to hospitalization are not covered. In the beginning, it may have been prudent to cover only inpatient services, as the potential abuse/fraud can be better monitored for inpatient services, and the frequency of claims is much lower. However, the government must now consider options to expand financial protection from the cost of outpatient services. One option would be to expand insured inpatient benefit plans to

Figure 1. Review of Government-funded and CBHI Schemes in India*

	What's There?	What's Missing?
GFHI Schemes	+ Health insurance for poor and vulnerable populations	− No coverage for non-poor/near-poor populations
	+ Coverage for inpatient expenses (hospitalization) and day surgeries	− Weaknesses in targeting due to poor quality of BPL data
	+ Use of quality-based accreditation criteria for providers	− No coverage for primary care/outpatient services
	+ Well-defined system of package rates to pay providers	− Lack of a comprehensive awareness strategy on the ground
	+ Use of IT systems, such as smart card-based biometric system	
	+ Availability of hospital transaction data, enabling effective monitoring and fraud detection	
CBHI Schemes	+ Financial protection for above-poverty-line (APL) population who are ineligible for GFHI	− Lack subsidies to target the poor who cannot pay premium
	+ Strong awareness generation and community participation	− Most only provide benefits for inpatient services
	+ Community audit systems, providing a measure of monitoring and fraud control	− Lack of capacity to manage and scale up schemes
	+ Some schemes provide wage loss cover to RSBY-enrolled families during hospitalization	− Diminishing relevance with the advent/expansion of GFHI schemes

What May Accelerate Progress Toward UHC?

- Expansion of benefits to more comprehensively address health care needs and reduce OOP payments
- Linkages and complementarity between GHFI and CBHI schemes to address gaps, widen reach, and bolster impact

* The information on GFHI schemes largely pertains to RSBY and some state government-funded schemes like Rajiv Aarogyasri. The information on CBHI schemes is gleaned from a literature review covering different micro-insurance schemes, key among them being SEWA, Yeshasvini, and ACCORD. The review did not cover health insurance/protection schemes for formal workers. Omission of any health insurance scheme from this review does not in any way deny its existence, importance, or utility. The review does not claim to be thematically and geographically comprehensive.

include outpatient services. A more modest option would be to create a referral mechanism that can improve continuity of care and service and possibly offer discounts for uninsured outpatient services that complement insured inpatient services. However, either option requires that primary care reforms are carried out, as has been done by countries such as Thailand.

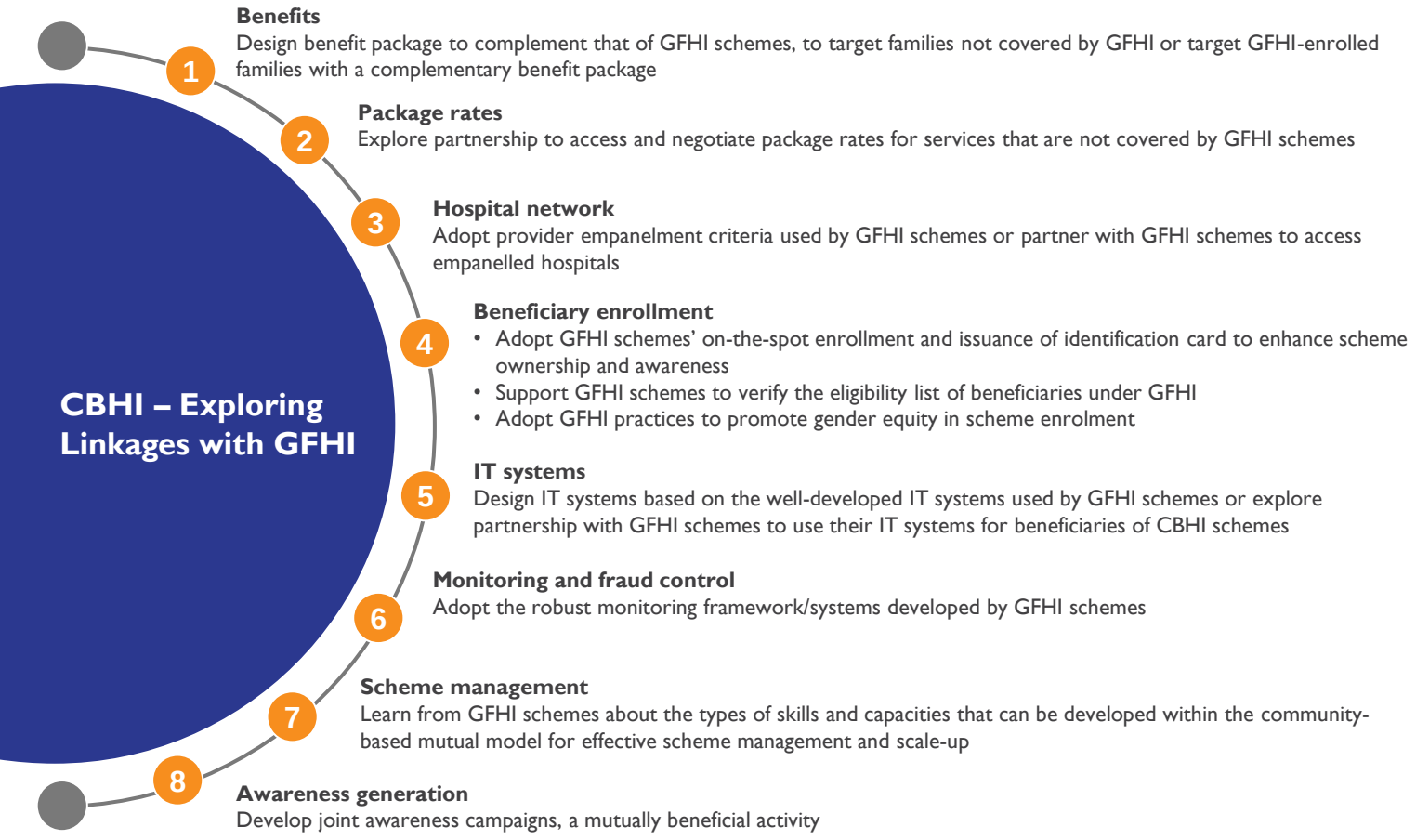
Aiming for UHC necessitates expanding enrollment of non-BPL households.

Most countries mentioned earlier are attempting to reach UHC by subsidizing poor families, while voluntarily and/or mandatorily getting higher income households to pay premium contributions. In India, the government uses a targeted approach, covering only BPL families, yet a significant percentage of eligible beneficiaries are not enrolled due to reliance on inaccurate BPL eligibility lists (see Figure 3). The next step for India to advance toward UHC could be to allow the not-so-poor to pay a premium to enroll in the scheme. However, it is important to note that India has a very high percentage (92 percent of total employment) [3] of informal workers, from whom premium collection has proved a challenge worldwide. India could draw lessons from countries such as Thailand that have subsidized a large percentage of informal workers, but such a decision would have considerable economic and political ramifications.

There is a compelling case for reinvention of CBHI schemes.

The introduction of GFHI schemes such as RSBY has affected existing CBHI schemes, especially those with BPL clients who are eligible for RSBY. Some CBHI schemes that had members with incomes above-the-poverty-line have continued to do well. However, the proposed launch of NHPS is likely to expand the benefit package and enroll a much larger population. This may cause families currently covered by CBHI but not enrolled in RSBY to become eligible for subsidized benefits under NHPS. These families may be prompted to not renew membership in their CBHI scheme, posing a new challenge to the scheme. CBHI schemes should explore complementarity with GFHI schemes to retain their relevance and continue to provide financial risk protection. For example, CBHI schemes could offer complementary benefits or target different population groups. More specifically, CBHI schemes could provide value added services that improve access to primary care, which most GFHI schemes do not cover. In reinventing their role, CBHI schemes could consider learning from GFHI schemes that excel in implementation and management. A good way to share and transfer lessons learned would be for CBHI schemes to partner with GFHI schemes (see Figure 2), to leverage each other's strengths. CBHI schemes could also pool their technical expertise and financial resources.

Figure 2. Possible Linkages CBHI Can Explore with GFHI



[3] International Labour Office (ILO). 2016. India Labour Market Update.

Figure 3. RSBY in Focus: What Challenges Encumber India's Flagship Health Insurance Scheme for the Poor?

Policy-related Challenges

- **No linkage with preventive and primary care services:** Hospitalization-only benefits not linked with preventive and primary care services offered at public health facilities
- **Use of old BPL lists:** Reliance on dated BPL lists in most states limiting enrollment of eligible beneficiaries
- **Absence of a national-level management body:** Limited institutional capacity at the central level to implement the scheme

Implementation-related Challenges

- **Issues in enrollment and issuance of smart cards:** Infrastructure gaps and poor quality of data adversely affect number of targeted families enrolled
- **Low awareness:** Top-down driven scheme with inadequate awareness building at the field level impacting access by beneficiaries
- **Availability of health infrastructure:** Unavailability of private hospitals in many areas; keeping private hospitals empaneled requires prompt claims settlement and regular updating of rates
- **Lack of robust scheme management in some states:** Inadequate capacity in State Nodal Agencies in many states hinders scheme implementation
- **Weaknesses in the monitoring system:** Improvement needed in use of data for monitoring and fraud detection

Fragmented health insurance space warrants convergence.

Notwithstanding the myriad of schemes in India—over 20 center- and state-funded GFHI schemes and about 50 CBHI schemes[4]—almost 68 percent[5] of the population is not covered by health insurance. Multiplicity of health insurance schemes with minimum convergence is resulting in overlapping beneficiaries, duplication of benefits, cost inefficiencies, and resource wastage. There is need for a unified vision and integration in design and implementation, aimed not only at convergence between various GFHI, CBHI, and private insurance schemes but also between supply-side and demand-side initiatives. Convergence would serve to widen impact and reach, crucial for India's UHC aims, and also, importantly, help the government allocate its resources with better planning and consideration of the long-term impact of each investment.

Demand-side financing can be a lever of health sector reform.

Health insurance can envisage a bigger role than that of a financing tool alone. With government as the strategic purchaser, GFHI schemes provide a unique opportunity to improve service quality of both public and private health care providers. Going forward, the use of globally accepted diagnosis-related group (DRG) system, a mechanism for classifying hospital cases into groups for the purpose of payment, may be explored to improve transparency, efficiency, and quality in hospitals. Making the claims payment to hospitals based on DRGs will encourage hospitals to maintain quality standards and treat patients efficiently.

In the current system, money from claims received by public hospitals remains with the hospitals and can be used to improve hospital infrastructure and services and incentivize staff. This provides public hospitals the inducement to improve services to attract potential clients (beneficiaries). Further, in a country like India, with weak regulation and almost no control over the private sector, such financing mechanisms can, as GFHI schemes have demonstrated to some extent, influence the behavior of the private sector by fixing prices for services through package rates, incentivizing quality care, and strengthening monitoring through collection of treatment data. This data can also provide critical inputs for policymakers.

The Way Forward

The powerful role health insurance will play in India's journey to UHC is undeniable. How strong the progress is will depend significantly on innovation and preparedness of different players to come to agreement on intent and implementation. The new regulation issued by India's Insurance Regulatory and Development Authority (IRDA) for introduction of insurance products on a pilot basis is aimed at encouraging innovation in product design for risks not covered before, such as wellness and primary care. Efforts to holistically address gaps in health care access would also require linkage of reformed primary care delivery with health insurance. Overcoming low health insurance penetration must also be a priority. The government could address this imperative either through subsidies or by collecting premiums, where the digital platform of the Unique Identification Authority of India (UIDAI), or Aadhaar, could be leveraged for better targeting, enrollment, and claims management. As a start, the government must actively engage different stakeholders to create a unified vision of health care in the country that defines the place of each funding mechanism, stakeholder, and type of care.

[4] ILO. 2005. India: An Inventory of Micro Insurance Schemes.
[5] MoHFW. Press Information Bureau Release – May 06, 2016.

The Health Finance and Governance (HFG) project works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. Designed to fundamentally strengthen health systems, the HFG project improves health outcomes in partner countries by expanding people's access to health care, especially to priority health services. The HFG project is a five-year (2012-2017), $209 million global project funded by the U.S. Agency for International Development under Cooperative Agreement No: AID-OAA-A-12-00080.

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