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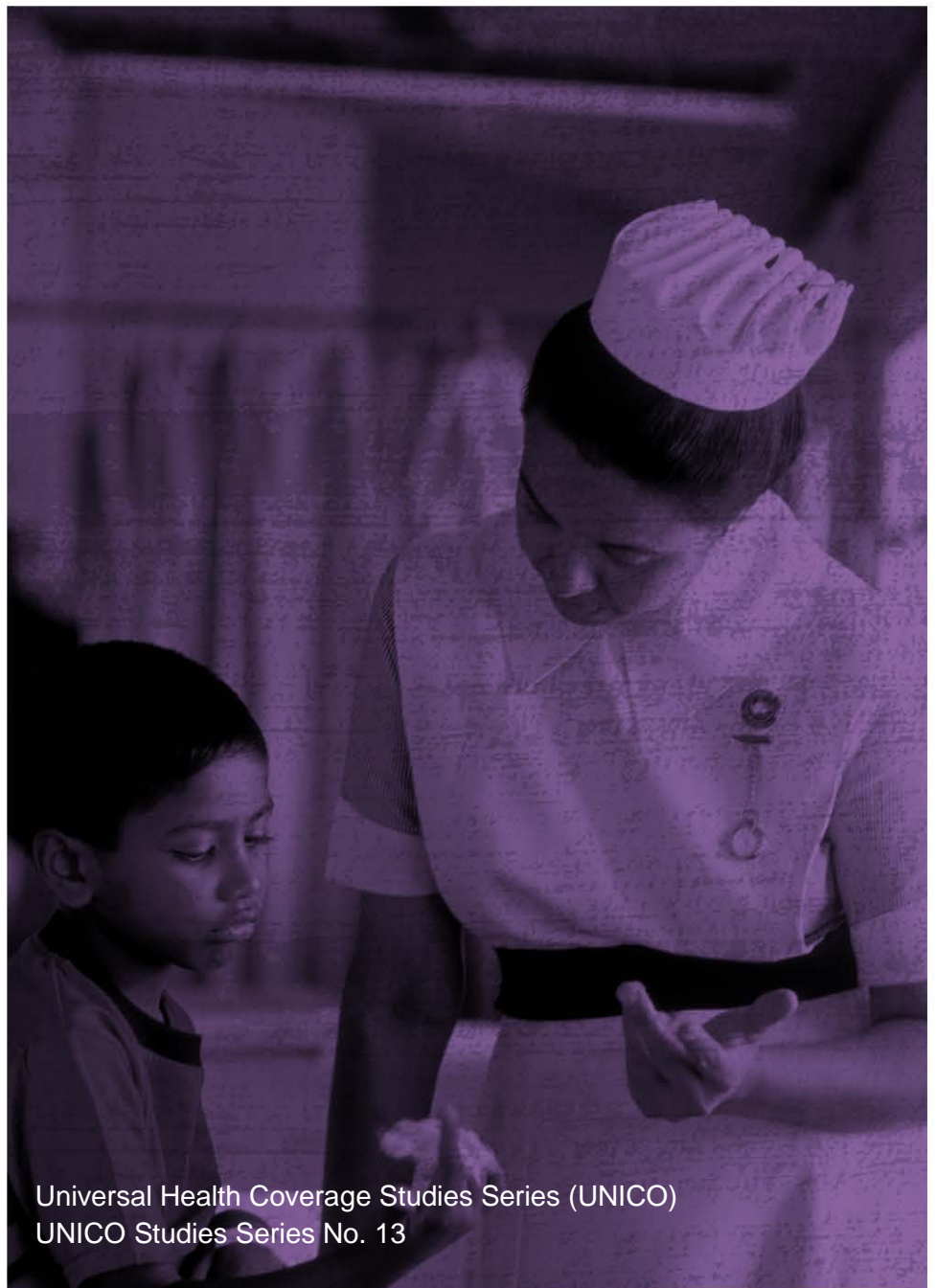
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Expanding Health Coverage for Vulnerable Groups in India

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Human Development Network



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¹ Several sections of this case study are adapted from La Forgia and Nagpal (2012).

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The World Bank’s Universal Health Coverage Studies Series (UNICO)

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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Abbreviations

ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
DLHS-3	District Level Household Survey, Round 3
GDP	Gross Domestic Product
GSHISs	Government Sponsored Health Insurance Schemes
HCP	Health Care Program
MOHFW	Ministry of Health and Family Welfare
MOLE	Ministry of Labour and Employment
NRHM	National Rural Health Mission
NSS	National Sample Survey
RA	Rajiv Aarogyasri
RSBY	Rashtriya Swasthya Bima Yojana
SIP	System to Identify the Poor
WHO	World Health Organization

Executive Summary

India's health sector continues to be challenged by overall low levels of public financing, entrenched accountability issues in the public delivery system, and the persistent dominance of out-of-pocket spending. In this context, this case study describes three recent initiatives introduced by the central and state governments in India, aimed at addressing some of these challenges and improving the availability of and access to health services, particularly for the poor and vulnerable groups in the country. This includes two federal schemes introduced by the Government of India—the National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare and the Rashtriya Swasthya Bima Yojana (RSBY) of the Ministry of Labor and Employment—and the Rajiv Aarogyasri scheme launched by the state government of Andhra Pradesh. The three schemes discussed in this case study were designed and implemented by different agencies almost in parallel, over the same time period, and used different financing and delivery approaches. A discussion of the mechanics and operational features of these programs has been undertaken to unravel the underlying complexities, interactions, and interdependencies of these programs within the country's health system.

Introduced in 2005, the NRHM has led to several service delivery innovations and to significant, though still inadequate, increases in central government investments in health, especially for public health interventions and primary care. Since 2007, the new wave of Government Sponsored Health Insurance Schemes (GSHISs), such as RSBY and Rajiv Aarogyasri, has introduced a new set of arrangements to govern, allocate, and manage the use of public resources for health, including an explicit (and delivered) package of services, greater accountability for delivering services, and a bottom-up design to reach universal coverage by first achieving coverage of the poor. Targeting is, however, not without its challenges, and incidence of false positives and false negatives may be high, but this targeting is managed largely outside the domain and influence of these health programs. Nevertheless, the bottom-up design for expansion of health coverage, starting with coverage of the rural and the poorest segments of the population first, and the rapid scale-up of population coverage in a short period of time, are unique facets of the “India story.”

Several achievements of these programs are unprecedented and have far-reaching implications. NRHM, for example, managed to create significant flexibility in financial management rules for the public health system—the financial autonomy to retain and flexibly spend funds at public health facilities is unique in the country's public financial management system. GSHISs have enabled the purchasing of health services from the private sector at a scale never before seen.

However, the early successes of these programs have not been without their share of challenges, and the unfinished agenda remains. For example, not much progress has been made toward performance-based payments or alignment of incentives for mainstream health sector workers. Several operational, capacity, and monitoring challenges surround all programs. Coordination among the programs is not common, and often linkages to the wider health system are weak or even absent. Debate continues about whether the country can continue with expansion on both the supply and demand side in the long term, the prioritization of investments between primary and inpatient care, and between the extension of population coverage versus expansion of the benefits package, especially when resources are limited.

The areas of focus of each of the three schemes discussed in this case study are clearly delineated—primary care in the case of NRHM, secondary care in the case of RSBY, and tertiary care in the case of Rajiv Aarogyasri. Although this distinction in focus was due to their respective evolutionary factors and was not planned, an interesting complementarity exists. Thus, if these programs could further evolve in close coordination and with similarly defined populations covered, and with smooth linkages, they could potentially contribute to seamless, comprehensive coverage for primary, secondary, and tertiary care, drawing upon their respective strengths and synergies.

There is considerable scope, for example, for NRHM-strengthened primary care facilities serving as effective gatekeepers for the secondary and tertiary health insurance programs and for contributing to effective follow-up care after these patients are discharged. Preventive interventions and effective case management for noncommunicable diseases at the primary care level will contain costs for inpatient programs. The lessons from the demand-side financing schemes in aligning facility-level incentives for inpatient care can be used to introduce a performance-based remuneration system for public facilities providing primary care. Together, this could be the promising foundation for a reformed health finance and delivery system, catapulting forward India's march toward universal health coverage.

1. Introduction

Despite its relatively large disease burden of communicable and noncommunicable diseases (MOHFW 2005a; WHO 2010), India has traditionally been a low spender on health care, allocating approximately 4.1 percent of gross domestic product (GDP), or US\$40 per capita in 2008–09 (MOHFW 2009).³ In terms of India's share of global health expenditure, the country, with over 16 percent of the world's population, manages with less than 1 percent of the world's total health expenditure. The share of health spending has also not kept pace with the country's dynamic economic growth in the first decade of this millennium⁴ (India's total health spending accounted for a much higher 4.8 percent of GDP in 2001–02 and has reduced its share since then). Public spending on health as a share of GDP has varied little over the same decade, hovering at about 1 percent, even though policy pronouncements have sought to raise this share for several years. Government (central, state, and local) is the source of about one-fifth of spending, while out-of-pocket payments represent about 70 percent—one of the highest percentages in the world,⁵ impoverishing an estimated 63 million Indians every year (Berman Ahuja, and Bhandari 2010).

India is significantly below its global comparators in terms of public expenditure on health as a share of GDP among countries with similar levels of income (GDP per capita in current U.S. dollars). At its current level of income, most countries exhibit higher public spending on health as a share of their GDP than India. India also falls short in terms of health impact achieved from its health spending. Compared to the country's level of income and total health spending per capita, India has not performed as well as its income comparators on lowering maternal mortality, and performance is just about average for infant mortality (La Forgia and Nagpal 2012). Large disparities in health outcomes are still evident across states and social groups, and improvements have not been shared equally. Public subsidies for health disproportionately favor the richer segments of society (Mahal et al. 2002). Peters et al. (2002) estimated that in the late 1990s, for every 1 rupee spent on the poorest income quintile, the government spent an estimated 3 rupees on the richest quintile. Budgets bear little or no relation to volume, quality, or efficiency of care. Staffing and budget norms—often related to civil service, budgetary legislation, or public health codes—restrict managers' freedom to marshal resources to improve quality or achieve efficiency.

In theory, the public health system of the country does provide comprehensive, full-spectrum health services, and is open to everyone at free or near-free pricing. However, it is also a fact that an overwhelming 80 percent of ambulatory care and as much as 60 percent of inpatient care continues to be obtained outside the public health system. Considerable inter-state variation exists, especially in inpatient utilization (Mahal, et al., 2001) and there are significant sub-national disparities across various dimensions of vulnerability. The publicly financed, owned and delivered health service is also the single largest health sector subsystem, where each state runs its own providers and infrequently purchases services from others. Though higher facilities are designated as referral facilities, the gatekeeping and referral systems are not strong and even tertiary hospitals receive a large number of primary care cases in their outpatient facilities.

³ Provisional estimations from 2005–06 to 2008–09.

⁴ However, the literature on the income elasticity of health spending being above one is not very conclusive.

⁵ Among Asian countries, this was exceeded only by Pakistan, Cambodia, Myanmar, and Afghanistan in 2008 (*World Health Statistics 2010*).

It is within this context, and given the current structure of the country's health system as discussed in detail at Annex 1, that this case study describes three recent initiatives introduced in the last few years by the central and state governments in India, aimed at addressing some of these health system challenges and improving the availability of and access to health services, particularly for the poor and vulnerable groups in the country. This includes two federal schemes introduced by the Government of India—the National Rural Health Mission (NRHM) of the Ministry of Health and Family Welfare (MOHFW) and the Rashtriya Swasthya Bima Yojana (RSBY) of the Ministry of Labor and Employment—and the Rajiv Aarogyasri scheme launched by the state government of Andhra Pradesh. NRHM is the flagship initiative of the MOHFW and represents MOHFW's efforts to rejuvenate and reshape state health systems, aimed at strengthening India's public health delivery infrastructure and improving service delivery, especially in rural areas and with a focus on primary care. In contrast, RSBY and Rajiv Aarogyasri are demand-side schemes aimed at improving public purchasing of inpatient services for the poor and are focused on providing secondary and tertiary care, respectively.

Taken together, the bottom-up approach of prioritizing coverage and financial protection for vulnerable beneficiaries first, innovative design features of the programs, and the successes and challenges of these new schemes, and the apparent dichotomy in financing approaches (supply side versus demand side), with yet the potential complementarity in focus, creates a unique Indian story—one that appears to provide a promising foundation for a reformed health finance and delivery system.

The remainder of this case study on India's march toward universal health coverage focuses on three recent, prominent programs, and includes a discussion on the institutional structure of these programs and their interactions within the country's health system, their mechanisms for beneficiary targeting and enrolment, the benefits packages covered by them, accompanying innovations in public financial management, and their information environment. Annex 1 presents an overview of the health system and health financing in India, and Annex 2 discusses the evolutionary context of India's Government Sponsored Health Insurance Schemes. The discussion of the mechanics and operational features of these programs has been undertaken to unravel the underlying complexities, interactions, and interdependencies within these programs. The case study also aims to contribute to the ongoing debate within the Indian health sector, with opinions divided between investments in traditional input-based health spending for publicly managed health facilities versus demand-side financing, purchasing of care, and involving private providers and intermediaries in delivering services financed by public money. The case study also aims to share how the lessons learned by one program can be applicable more widely within the Indian health system and beyond.

2. Overview of the Three Schemes included in this Case Study

India's health sector continues to be challenged by overall low levels of public financing, entrenched accountability issues in the public delivery system, and the persistent dominance of out-of-pocket spending. Introduced in 2005, the NRHM has led to several service delivery innovations and to significant, though still inadequate, increases in central government investments in health, especially for public health interventions and primary care. Since 2007, the new wave of Government Sponsored Health Insurance Schemes (GSHISs) has introduced a

new set of arrangements to govern, allocate, and manage the use of public resources for health, including an explicit (and delivered) package of services, greater accountability for delivering services, and a bottom-up design to reach universal coverage by first achieving coverage of the poor. Exemplified by the RSBY and RA, this new crop of GSHISs, over a dozen at last count, covers over 300 million Indians today, focused on inpatient care. The three schemes discussed in this case study were designed and implemented by different agencies almost in parallel, over the same time period, and used different financing and delivery approaches. Yet, they have a complementarity in the focus of their benefits package that seems to have been more by accident than design, possibly emerging because the need for additional coverage was more visible among, and more acutely felt by, the poor seeking inpatient care.

Consequent to a report by the National Commission on Macroeconomics and Health (MOHFW 2005b), which reemphasized the importance of investments in health toward achieving economic and social development, the MOHFW launched the first of these three programs, the National Rural Health Mission (NRHM), in 2005. The NRHM aimed at increasing investments in strengthening the public health care delivery system. The plan of action included (a) increasing public expenditure on health, (b) reducing regional imbalance in publicly operated health delivery infrastructure, (c) pooling of resources, (d) integration of organizational structures, (e) decentralization and district management of national health programs, (f) increasing community participation and ownership of assets, and (g) induction of management and financial personnel into the district health system.

NRHM is an umbrella program that has placed a major emphasis on the horizontal integration of hitherto vertical disease control and reproductive and child health programs. In addition to its efforts to pool and integrate the resources of these programs, it has also brought new investments in the publicly operated health delivery system. It has provided flexibility around hiring contractual staff for public facilities, promoted supply chain reforms, introduced a cadre of grassroots workers paid entirely based on performance, and introduced elements of financial autonomy at the health facility level. It has also innovated on financial flow mechanisms and introduced a conditional cash transfer scheme for improving institutional deliveries.

The second scheme in this case study, RSBY, was introduced by the Government of India's Ministry of Labor and Employment in 2008. In contrast to NRHM, this is a demand-side financing scheme that purchases health insurance coverage capped at 30,000 rupees (US\$600) per family per year, for inpatient treatment (primarily secondary care). By September 2012, RSBY had enrolled over 32 million families who became eligible for inpatient treatment in more than 10,000 hospitals across the country included in RSBY's network.

The third scheme, also a demand-side scheme akin to RSBY, was introduced in 2007 in the state of Andhra Pradesh in India. This scheme, "Rajiv Aarogyasri," focuses primarily on tertiary coverage, paying for the treatment of serious and life-threatening ailments for 20.4 million families across the state, comprising all poor families and a significant segment of the lower-middle class in the state. Over the last five years, several other states (including Karnataka, Tamil Nadu, Maharashtra, and Gujarat) have launched their own tertiary-care programs modeled on the Rajiv Aarogyasri scheme, with some state-specific differences in their design and implementation arrangements.

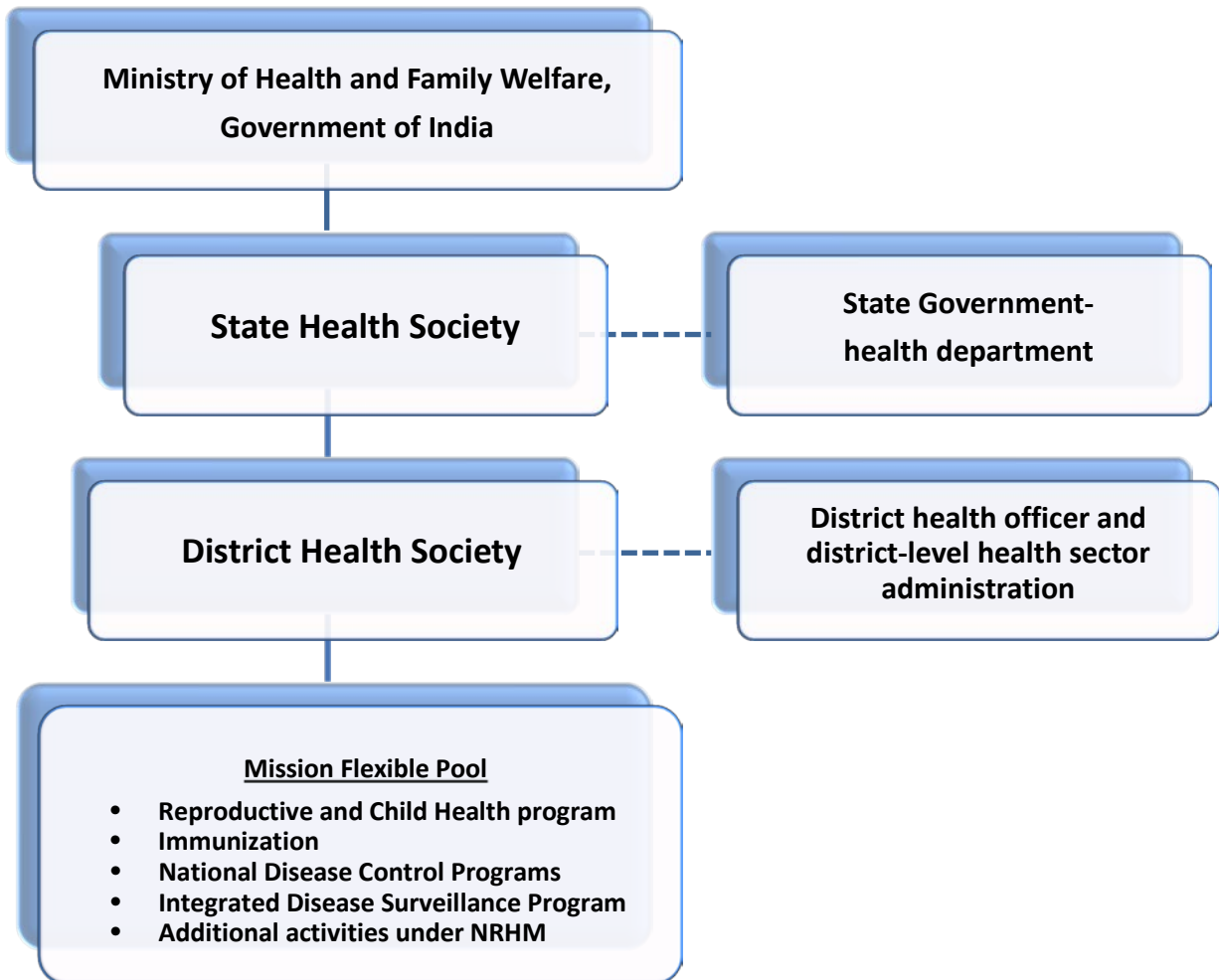
3. Institutional Architecture of the Programs

The **National Rural Health Mission (NRHM)** is the Government of India's umbrella health sector program, and it complements and works through the state government-run primary health care system. NRHM places a major emphasis on the horizontal integration of hitherto vertical public health programs as envisaged under the National Health Policy 2002. In a context where the country's constitution lays out health as being a subject for state governments, NRHM supplements and strengthens the state-owned public health systems by providing additional resources with a focus on primary care and public health programs. NRHM also leverages this financial support to facilitate the creation of institutional mechanisms that enable some degree of financial autonomy and a faster flow of funds.

Funds from the finance division of the central Ministry of Health and Family Welfare flow through a State Health Society⁶ created by the health department in each state, and onward to similar specially created district-level entities called District Health Societies (figure 1). The new investments in primary health have been through financing additional activities beyond those included in the previously existing vertical public health programs. While a major part of NRHM financing is not new money per se (being a continuation of several decades-old vertical programs now consolidated under one umbrella), the remainder is indeed new money, and that coupled with flexibility around hiring contractual staff, supply chain reforms, introduction of a cadre of grassroots workers paid entirely based on performance, innovative financial flow mechanisms, and an overall increased emphasis on public health expenditure, distinguish NRHM from the situation prior to its existence.

⁶ The State Health Society is an autonomous entity, which is the nodal agency for implementing NRHM in a given state. Although the officials of the state government are also the office bearers of the society in their official capacity, this mechanism provides considerable autonomy in decision making and financial flows.

Figure 1 Institutional Architecture of NRHM

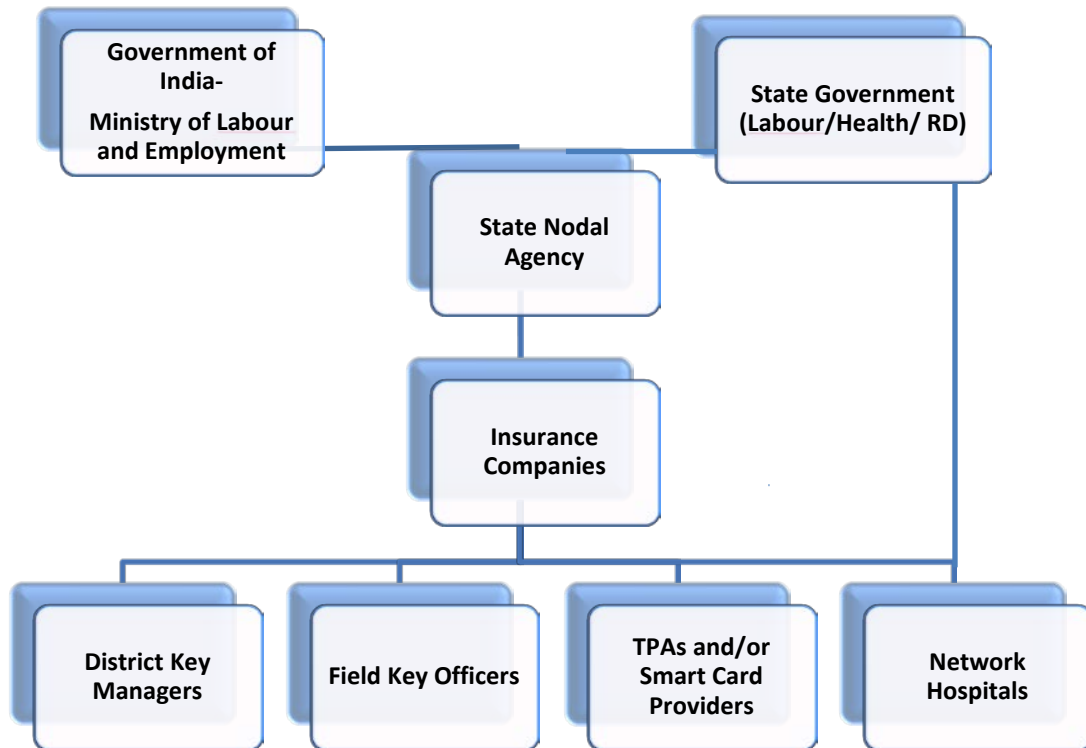


As mentioned, **RSBY** is a demand-side financing scheme that provides health insurance coverage capped at 30,000 rupees (US\$600) per family per year, for inpatient treatment (primarily secondary care). The coverage requires no premium contribution or copayment to be made by the beneficiary, and is “cashless”⁷ in more than 10,000 hospitals networked by the scheme across the country. The central coordinating and policy-making agency for RSBY is the Government of India’s Ministry of Labour and Employment (MOLE). MOLE plays a major role in decisions on scheme structure and implementation, and also drafts standard documents, defines operational processes, and monitors implementation. The scheme is implemented at the state level through a specially created entity known as the State Nodal Agency (figure 2), which is the main supervisory and implementing agency for the scheme at the state level and is involved in contracting and monitoring insurance companies in accordance with the guidelines issued by MOLE. However, human resource capacity constraints at MOLE and the State Nodal

⁷ “Cashless” means that the patient need not make any payments to the health providers when receiving services covered under the program, and all such payments are directly settled between the program and the hospital.

Agencies range from moderate to severe, and often the program functions with core staff numbering in the single digits, handling all the functions of a complex program that covers over 100 million beneficiaries.

Figure 2 Institutional Structure of RSBY

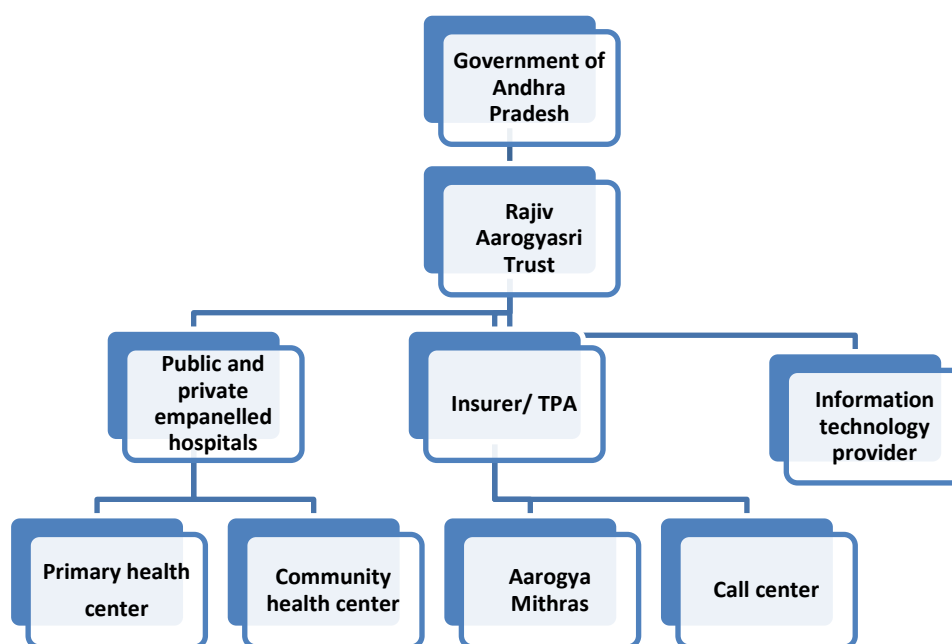


The **Rajiv Aarogyasri** Community Health Insurance Scheme provides tertiary-focused coverage for the treatment of 938 defined serious and life-threatening ailments for 20.4 million families across the state of Andhra Pradesh, comprising all poor families and a significant segment of the lower middle class. The Aarogyasri Health Care Trust established by the state government is an autonomous, nodal-implementing and oversight agency for this scheme. It is chaired by the chief minister and a separate minister, who serves as its vice chairman. The principal secretaries of several state government departments are members of the Trust, and the chief executive officer of the scheme is the Trust’s secretary. The chief executive officer is empowered by the Trust board through resolutions for making policy decisions and, based on these, facilitating implementation.

Until 2011, the insurance risk was partly retained by the Trust and partly transferred to an insurance company, chosen through a bidding process. In 2012, the scheme moved to a fully self-insured model, where it uses insurance intermediaries to manage the scheme but does not transfer the risk to a commercial insurer. The governing trust has well over 100 staff members

divided across functional lines, and the extended human resource count of the program, including its field functionaries, runs into a few thousand full-time staff, providing opportunities to undertake governance and implementation actions often not possible in other capacity-constrained GSHISs elsewhere in the country (figure 3).

Figure 3 Institutional Structure of Rajiv Aarogyasri



Source: La Forgia and Nagpal 2012.

4. Linkages of these Programs with the Country’s Health System

Several of these reforms have far-reaching effects. For example, the financial autonomy to receive additional funds at the facility level and to retain it for flexible spending by the facility, through the creation and funding of “Patient Welfare Societies”⁸ or *Rogi Kalyan Samiti*, in all public health facilities, has been instrumental in involving public facilities in public insurance schemes such as RSBY and Rajiv Aarogyasri. It is all the more commendable because such financial autonomy for government organizations is unprecedented in any other sector. Likewise, NRHM’s creation of a new class of village-level, community-based voluntary health workers paid only on a performance basis, called the Accredited Social Health Activist (ASHA), has been used by several health sector programs that provide incentives to ASHA workers for specific health promotion actions or for creating linkages between the community and health facilities. By strengthening infrastructure (such as creating 24/7 Primary Health Centres), and also providing demand-side incentives for institutional births under the Janani Suraksha Yojana

⁸ These facility-level societies commenced in states such as Kerala, Madhya Pradesh, and Rajasthan well before the onset of NRHM, pooling nominal fees levied on the nonpoor availing services at public health facilities and channeling the same to improve facility maintenance and drug supplies. NRHM institutionalized the mechanism across the country and instituted fixed, annual grants from NRHM for each facility, to supplement any income generated at the facility level and aimed at a similar eventual, flexible use.

(Maternal Safety Scheme), NRHM has contributed to a steep rise in the share of institutional births and thereby to improved reproductive and child health.

Results of initial studies reveal that schemes such as RSBY and Rajiv Aarogyasri do seem to make a credible contribution to the financial protection of their Below the Poverty Line (BPL) beneficiaries for the covered inpatient procedures, but they do not cover the frequent, ambulatory care episodes at all. In theory, the public health system, strengthened by NRHM, provides free or nearly free services that can partially fill these coverage gaps, and these two schemes also complement each other in their benefits package offerings. However, the links of the recent generation of Indian health insurance schemes, including RSBY and Rajiv Aarogyasri, to the public health system have been variable at best. Even within the health insurance schemes themselves, there exist situations where RSBY and the state-funded schemes operate in parallel, representing a missed opportunity to synergize and share resources.

It is important to emphasize that despite rapid expansion of population coverage in the last four years, these demand-side financing schemes are still small players in the country's health system. RSBY, for instance, constituted less than 0.3 percent of the country's health expenditure even in 2011. As such, their ability to bring about drastic changes in the incentive environment of the country's health system is still limited. However, at least in one state (Kerala), RSBY has managed to foster competition between public and private providers of hospital services for RSBY patients. The public hospital functionaries in Kerala receive a small proportion of the insurance payout as incentives, while the rest is used to improve the institution, which has translated into large incremental gains for some hospitals in Kerala. However, there is still some time before RSBY can similarly attain critical mass in other states and influence the health system in a big way.

In the Andhra Pradesh context, Rajiv Aarogyasri is a relatively large player in the health system, especially for the 300-odd hospitals in its network. Many of these hospitals have more than 20 percent (and for some even 70 percent) of all their inpatients being Rajiv Aarogyasri beneficiaries. This is understandable given the high share of the state's population (85 percent) being covered under the scheme. Anecdotal evidence suggests that the private health care sector has made substantial new investments in Andhra Pradesh in response to the business opportunity created by the scheme, with new hospitals, expansion of hospitals, and investments in medical equipment. As with other GSHISs, Rajiv Aarogyasri has increased choice for beneficiaries, and the continued and increasing use of public hospitals under the scheme may also suggest the strengthened ability of public hospitals (at least some tertiary-level public hospitals in the case of Rajiv Aarogyasri) to compete with private providers.

5. Targeting, Identification, and Enrolment of Beneficiaries

Targeting, Identification, and Eligibility

In India, the mechanism for defining the poor is housed in the Planning Commission of the Government of India. At the state level, the government lists of the poor, called the Below Poverty Line (BPL) lists, are established by revenue/food/civil supplies departments (depending

on the state) and are also updated by them. States may use more liberal criteria to define the poor, and often have larger lists than estimated using Planning Commission criteria.

Poverty is defined in terms of income, and a poverty line is set at the price of food required to provide standard caloric values. This varies by geography. These poverty lists established by the government are also used by the health schemes, although they do not have much control over the methodology or content of the lists. The system is primarily created for access to subsidized foodgrains and other supplies such as domestic fuel, and is used for determining eligibility for several social sector and welfare schemes, including health sector programs. Since several welfare programs are directed at the listed poor, inclusion in the list is desirable and thus little social stigma seems to exist on account of being classified as poor (though other stigma factors, such as caste, may be prevalent among the BPL population).

Still, these BPL lists are not without their problems, and incidence of false positives and false negatives may be high. Jalan and Murgai (2007) compared BPL classification with consumption patterns drawn from the household Consumer Expenditure Schedule of the National Sample Survey. They found that BPL scores misclassified 49 percent of the nonpoor as poor. The misclassification of nonpoor as poor is more prevalent in the richer states. Dreze and Khera (2010) performed a similar analysis based on the NSS 61st round (2004–05) and the third National Family Health Survey (DLHS-3: 2005–06). Based on a “Wealth Index” created by the authors, while only 53 percent and 39 percent of the poorest quintile had BPL cards according to the NSS and DLHS-3 data, respectively, so did nearly 18 percent of the richest. Targeting is, thus, not without its challenges, but is managed largely outside the domain and influence of these health programs.

RSBY follows the Planning Commission methodology and its estimates for the number of poor, to determine the number of BPL beneficiaries eligible under the scheme in each state. As of September 2012, the scheme covered about 100 million beneficiaries. In the case of Rajiv Aarogyasri, not unlike other state-level GSHISs, the scheme uses more liberal norms than the Planning Commission criteria to determine eligibility, and covers about 85 percent of the state’s population, amounting to 70 million beneficiaries.

Considering that none of their beneficiaries was covered under a health insurance scheme until 2007, RSBY and Rajiv Aarogyasri, along with the other recent government-sponsored health insurance schemes in India, have contributed to a massive scale-up of health insurance coverage for bottom-of-the-pyramid beneficiaries. The bottom-up design for expansion of health coverage, starting with coverage of the poor first, and the rapid scale-up of population coverage in a short period of time, are unique facets of the “India story” on beneficiaries.

The NRHM beneficiaries, in theory, can include anyone walking into a public health facility, regardless of income, geography, or other factors, so no specific enrolment is required to receive NRHM benefits. However, in practice, the scheme does strive to improve equity, and the focus is on the rural population and on primary care, irrespective of any economic, social, religious, or cultural barriers. The richer segments of the population are less likely to seek primary care from public health facilities (except from some prestigious tertiary institutions). However, some public health activities under NRHM can create their own community-level lists, such as lists of

pregnant women, children, tuberculosis patients, and couples eligible for contraception use, for implementation and monitoring of public health interventions. NRHM does not need or use any separate eligibility or enrolment system, except for certain schemes such as Janani Suraksha Yojana, which are aimed at the BPL population. For such cases, NRHM also relies on the standard BPL identification documents.

Enrolment

Of these three programs, enrolment particularly receives attention from RSBY, which requires its beneficiaries to be specifically enrolled, and has created a systematic, technology-intensive enrolment process. Village-level enrolment camps are organized by the program's insurance industry intermediaries over a period of three to four months every year, in each implementing district. The RSBY enrolment stations are a combination of enrolment, correction of personal information in the BPL lists (where necessary), photographing family members, registration of biometric information, and issuance of corresponding smartcards. The enrolment station is organized at a public location and a local health worker or other government official is involved in authenticating the issuance of smart cards. A token fee of 30 rupees (about US\$0.6) is also collected from each family every year, although this contribution does not accrue toward the fully government-subsidized insurance premium.

The smart cards are the identification documents required under the scheme for using hospital services, with no exceptions. Upon enrolment using biometric and photographic identifiers, each family receives a smart card, which encodes the biometric details provided by the enrolled members of the family. The entire enrolment process, however, may not happen exactly as envisaged. Small studies show that issuance of cards on-the-spot, as per scheme guidelines, is not universal, and as many as half of the cards may not be issued at the enrolment site and are issued and dispatched subsequently.

The insurance companies contracted to implement RSBY in the district (acting through their outsourced service providers such as third-party administrators or smart card agencies) are also tasked with enrolment, acting in close coordination with local health workers and district administration officials. Insurers have an incentive to enroll as many eligible families as possible because their premium-based income is derived from the number of cards issued. The insurers also do not have the flexibility to reject any eligible beneficiary who presents for enrolment.

In Rajiv Aarogyasri, the enrolment is automatic for the BPL cardholders of the state and for others who are similarly eligible, based on existing state databases of these beneficiaries. There is no specific enrolment process nor is any enrolment fee required. Any newly eligible beneficiaries can receive coverage through applying for the update of the BPL list (or other eligible lists). BPL identification cards and scheme-specific health cards issued by the insurer are equally valid as identification documents for the beneficiaries reaching out to the scheme health camps⁹ and networked hospitals.

⁹ Several government-sponsored health insurance companies organize 'health camps', which are outreach activities undertaken with support from hospitals and often also with support from the local government officials. These health camps involve free consultation and treatment of common health conditions, as also medical screening for

6. Innovations in Public Financial Management Associated with these Programs

NRHM is testimony to the fact that the Indian Ministry of Health has been able to convince the Indian Ministry of Finance to create significant flexibility in financial management rules for the public health system. As mentioned, the financial autonomy to retain and flexibly spend funds at public health facilities is unprecedented in the country's public financial management system. Creation of "health societies" bypassing the treasury mechanism, performance-based payments to ASHA workers, creating flexible pools of budgetary funds rather than strict line-item budgets, decentralized planning linked to budget allocation, and other such aspects of NRHM are also associated with a change in the usual public financial management practices. Historically, several of these innovations were tried earlier within the national disease control programs or at the state level, and NRHM deserves credit for identifying, mainstreaming, and upscaling these innovations on a large, national canvas.

The GSHISs take this argument for innovations in public financial management another step forward. Much of the eventual GSHIS expenditure is on private hospitals, based on actual outputs produced by them. This scale (millions of hospitalization episodes every year) at which GSHISs have enabled the purchasing of health services from the private sector is perhaps equally unprecedented in the health sector, where several partnerships with the private sector have not been successful in translating the achievement of public objectives through private providers. The shift from input-financing to output-based payments is no mean feat, either.

A lot more, however, needs to be done. Despite the financial innovations in NRHM, not much progress has been made toward performance-based payments or alignment of incentives for mainstream health sector workers, whose salaries and wages account for the largest share of the public health expenditure pie. Budgets bear little or no relation to volume, quality, or efficiency of care. Unless part of a GSHIS network, public facilities do not face potentially helpful market pressures, such as the need to be responsive to the demands of patients or to seek efficiencies. Staffing and budget norms restrict managers' freedom to take decisions aimed at improving quality or achieving efficiency. In effect, in such a system, hospital managers have little decision-making authority over inputs, including hiring, firing, rewarding, or disciplining of staff, while accountabilities for performance are diffuse at best (Das et al. 2012; La Forgia and Couttolenc 2008; Preker and Harding 2003).

As mentioned in the first section of this case study, a debate continues over investments in traditional input-based health spending for publicly managed health facilities versus demand-side financing, purchasing of care, and involving private providers and intermediaries in delivering services financed by public money. Related to the debate over demand and supply financing, an emerging issue involves linkages between these schemes and the public delivery system. The expansion of GSHISs has resulted in some friction within state governments regarding the expansion of the schemes versus investing in the public delivery system.¹⁰ Most GSHISs are

ailments that can subsequently be catered under the health insurance scheme. Increasing scheme awareness and utilization are the key objectives for these health camps.

¹⁰ NRHM financing is mostly directed to the primary care level, including small rural hospitals known as Community Health Centers. District-level secondary hospitals are mainly dependent on state financing, which has not been adequate in most cases.

only marginally linked to the public delivery system, which accentuates the dichotomy. Empaneled private facilities outnumber public facilities in nearly all scheme networks, and a majority of beneficiaries choose private facilities when seeking care (La Forgia and Nagpal 2012), even though the share of public facilities is not insignificant and appears to be increasing in several states.

7. Management of the Benefits Packages

Although the benefits package under NRHM is not explicitly specified, it is determined by what is funded under NRHM and to the extent it is augmented with state government's own resources. In theory, the public health system of the country does provide comprehensive, full-spectrum health services, and is open to everyone. However, it is also a fact that an overwhelming 80 percent of ambulatory care and as much as 60 percent of inpatient care continues to be obtained outside the public health system. In this context, the focus of NRHM funds continues to be on primary care and public health interventions, with some funding for secondary care and virtually none for tertiary care.

One of the largest (in terms of resources) components in NRHM is the Janani Suraksha Yojana, whose aim is to incentivize institutional births, which is a large component of the NRHM outlay. In addition to free institutional maternity services offered across the country, Janani Suraksha Yojana offers a conditional cash transfer to poor women, with incentives also provided to health workers, called ASHAs- Accredited Social Health Activists, accompanying the mother. The National Rural Health Mission also provides for capital investments to create and expand access to emergency obstetric care. A safe blood transfusion infrastructure is also being created under the National AIDS Control Program. Several state governments are investing their own resources in creating such infrastructure.

RSBY covers inpatient care episodes (except a specified negative list), limited only by its cap of 30,000 rupees per family per year, which essentially means that the focus is on secondary inpatient care. In contrast, Rajiv Aarogyasri covers a list of 938 hospitalization procedures, largely tertiary and some secondary, mostly surgical, as a positive list of services covered by the scheme.

The evolution of this prominence of inpatient care and other characteristics of this benefits package in the RSBY and Rajiv Aarogyasri programs responds to several factors (La Forgia and Nagpal 2012).

First, the health insurance sector, particularly insurers and large private hospitals in the insurer's networks, have considerable experience catering to insured patients for inpatient care. Second, hospitals and insurers were familiar with the "package rate" provider-payment mechanism for inpatient care currently used by all GSHISs. Third, preauthorization and other control systems for inpatient claims had already been developed by the private insurers, and the third-party administrators employed by them, mainly because private health insurance products were (and continue to be) focused predominantly on inpatient services. Fourth, inpatient care was seen as a major cause of financial burden for the poor, even when provided by public hospitals. Fifth, state policy makers who played an important role in the design of these schemes considered

purchasing surgical and tertiary care services from the private sector a priority due to limitations of public supply, particularly public hospital infrastructure and specialized human resources.¹¹

Sixth, some states (Andhra Pradesh, Himachal Pradesh, and other states currently in the planning stages) designed their tertiary-focused health insurance schemes in part to address equity and access shortcomings of the system of discretionary sickness grants provided by chief ministers of the states for high-cost health care. Finally, the potential moral hazard issues related to demand-side financing for ambulatory care (which the country's private health insurance sector is still struggling to cover) and the relative inexperience of both government and insurers in purchasing ambulatory care services have contributed to widespread reluctance to offer wider insurance coverage for primary care. Notably, the only two comprehensive health insurance schemes in India, the Employee State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS), deliver ambulatory care mainly through their captive facilities, partly to control utilization and also to serve as a gatekeeper for hospitalization.

Interestingly, the trio of schemes discussed in this case study has their areas of focus clearly marked out—primary care in the case of NRHM, secondary care in the case of RSBY, and tertiary care in the case of Rajiv Aarogyasri. Though this distinction in focus was due to their respective evolutionary factors, and did not happen in a planned manner, a very interesting complementarity exists. Thus, if these programs could further evolve to a state of close coordination and similarly defined populations to be covered, and with smooth linkages, they might actually contribute to more seamless, comprehensive coverage for primary, secondary, and tertiary care, drawing upon their respective strengths.

A related question is the priority of choice between investments in primary and inpatient care, especially when resources are limited. Although the inpatient schemes (RSBY and Rajiv Aarogyasri) reduce the financial burden for hospitalizations, whether they address the overall financial burden due to ill health experienced by the poor is an open question. Clearly, an inpatient stay would be a catastrophic event for most poor people. However, what would qualify as “catastrophic” for the poor household requires more precise definition. For example, ambulatory care constitutes a much higher share of overall health expenditure than inpatient care, and much of this continues to be out-of-pocket. A chronic ailment requiring regular treatment as an outpatient can involve higher expenditures than an inpatient procedure.

Finally, what should be the direction of expansion of benefits packages? As schemes evolve, they will face increasing pressure to deepen the benefits package. In Rajiv Aarogyasri (AP), for example, the scheme started in a small geographical area, with coverage for expensive, tertiary conditions that were among the most common causes for which patients approached the chief minister's discretionary “relief” fund for a grant to cover the cost of care. As the scheme expanded geographically, it also deepened the benefits package, adding several hundred new procedures, including some secondary procedures. Similarly, after a year of implementation experience, RSBY added maternity cover and removed the exclusion for HIV/AIDS. The evolution of benefits packages is an ongoing process in response to sociopolitical demands, claim experience (and ideally, actuarial analyses), and the availability of financial resources.

¹¹ Sufficient primary care was considered available from the public sector, including that supported by NRHM, but that is not necessarily so. Supply varies widely among and within states.

Choices will also have to be made between expansion of population coverage versus deepening of the benefits package. By restricting the number of BPL families eligible for enrolment to the number as per Planning Commission estimates, costs are again controlled by RSBY. The state of Andhra Pradesh, however, will soon face the evolutionary choice for Rajiv Aarogyasri between, targeted deeper benefits versus more universal coverage but with a more limited benefits package.

8. Information Environment of the Health Care Programs

All three schemes included in this study make extensive use of technology to improve their information environment, in terms of both collecting information for monitoring the scheme and of disseminating information to consumers.

Leveraging Technology for Information Management

Rajiv Aarogyasri makes such extensive use of IT (information technology) solutions as to set it apart from other health schemes in India. The scheme is largely paperless; all operational processes are electronic and integrated with a web-enabled management information system. About 5,000 users are on the system, and officials manage their roles using digital signatures. The information system is the only way to process every stage in the operational process—from document submission to internal processing and final payment of claims through electronic fund transfer systems. Operational process timelines are monitored in real time. These processes include internal controls and several innovations for fraud mitigation.

RSBY also ensures offline authorization of hospital admissions using information stored in a secure chip contained in the scheme's identification document—the smart card. The information subsequently travels to the servers of scheme intermediaries in batches, as and when connectivity is available.¹² Claims are similarly designed to be paperless, and claim information flows electronically from hospitals to insurers, and from them to the State Nodal Agency and the MOLE.

Though not as closely dependent on electronic flow and processing of data for its operations as the two programs described above, NRHM has also taken early steps toward automation of processes and reporting systems. It has facilitated electronic submission of performance data and financial reports by providing computer systems and human resources to run these systems at the district and block (subdistrict) level, and is rolling out a web-based Health Management Information System application software for online data capture at district and sub-district levels on RCH service delivery indicators. It also runs an IT-enabled mother-and-child tracking system pilot, besides using several innovations in the flow of financial management information at all levels. However, data flows continue to be scanty and not always used for planning or monitoring (Planning Commission 2012).

¹² This is usually required at least once in every 24 hours, which updates hospital transactions on the central server. Thus, hospital-level authorization can continue in an offline manner, even when there are expected or unexpected breaches in electricity and Internet connectivity.

Using Information for Scheme Evolution

GSHISs have also been able to use the information flowing to them for undertaking remedial actions. For example, claim systems of insurers serving RSBY compile utilization data and transmit it to the State Nodal Agencies and MOLE. Information mined from these data has been analyzed to monitor scheme performance and make midcourse corrections, such as:

- Hospitals showing unusual utilization patterns are kept under close watch or investigated.
- Change in scheme design features have been undertaken based on data analysis.
- Creation of new package codes for procedures hitherto unlisted and subject to case-to-case authorization.

Areas for Improving Information on Scheme Performance

There is no regular system of inspections or surprise visits in most schemes, although NRHM does conduct periodical “common review missions,” which also involve development partners. Hospital inspections are frequently undertaken by GSHISs in response to complaints, grievances, or unusual trends in data. While micro-studies exist for RSBY, Rajiv Aarogyasri, and NRHM, and a systematic impact evaluation is also ongoing for Rajiv Aarogyasri and is shortly planned for RSBY, no impact evaluation of any of these programs is presently available.

Consumer Awareness and Information Dissemination

An important institutional responsibility of these programs is to provide information to their beneficiaries to enable them to better manage their interactions with the scheme, and to take a more active role in their treatment and recovery. These interactions can include a number of areas, including enrolment, provider selection and access, treatment choices, access to follow-up care, dealing with illegitimate provider charges, and navigation of grievance and complaint processes.

Information disclosure is particularly relevant in the Indian context in which beneficiaries generally receive little information about providers, treatment options, and costs when involved in an illness episode or a care-seeking decision. This lack of information is compounded by socioeconomic, ethnic, and caste differences between beneficiaries and providers, leading to nearly absolute deference of patients to providers. The performance-based voluntary workers, ASHAs (under NRHM), and the specialized cadre of Rajiv Aarogyasri field workers, known as arogyamithras, are examples of efforts to provide beneficiaries with information on their benefits and to assist them in accessing providers in a timely matter.

HCPs need to strengthen and, in most cases, formalize, systems to help beneficiaries understand their rights and responsibilities within the schemes, access and navigate scheme providers, track and monitor member contacts, deal with routine issues (for example, change of address, lost cards, change of BPL or enrolment status, issuance or reissuance of identification cards due to new dependent or death), register complaints, and resolve problems and questions. Some of these best practices that could be adopted and/or strengthened by the HCPs include the following:

- *Outreach and member education.* Schemes need to provide general information on how the scheme works, what the benefits are, how beneficiaries can best use the scheme, and how to access information, and on other practical matters related to the insurance. Many schemes in India perform this function through camps. Other vehicles include village-based group information sessions, newsletters, websites, village theaters, and radio spots. Schemes can also launch a mobile-phone-based outreach program, which has the advantage of allowing beneficiaries to ask questions.
- *Routine access to and provision of information.* Beneficiaries need a “gateway” to the scheme to help them with any concerns or questions. In the Indian context, where mobile phone use is widespread, this is best achieved through a toll-free hotline. The Rajiv Aarogyasri call center handles millions of inbound and outbound calls every year, and is an important tool used for scheme information and communication.
- *Complaints, grievances, data collection, and analysis.* The consumer information department could also work in tandem with the existing grievance redress machinery of these programs and be responsible for the collection, collation, and analysis of all beneficiary contacts with the scheme including levels of satisfaction or dissatisfaction, complaints or compliments, and any problem related to a medical service or administrative process. This information can be complemented by beneficiary surveys to gauge patient satisfaction and dissatisfaction, and these inputs used to inform scheme design and evolution.
- *Quality-of-care measurement and dissemination.* Providing information on quality of care is arguably the most difficult task facing these programs due to the general lack of quality information in India and the absence of institutional arrangements to measure and compare quality across health care providers. In the absence of these arrangements in India, as mentioned, the schemes themselves will have to initiate their own programs to measure and disseminate information on the quality of care in their hospital network.

9. Putting it All Together – Fragmented Expansion or Promising Foundation

This section continues the discussion with a forward-looking perspective. It describes the specific challenges and opportunities facing these programs, and then discusses the issues around the apparent dichotomy of supply- and demand-side financing and how these programs can build better linkages with each other and the wider public health system, particularly with the aim of strengthening primary care.

The Nuts and Bolts: Operational Challenges and Opportunities

Programs such as RSBY have made a promising start, but they need to strengthen their managerial capacity at all levels, especially at the central level, and with a focus on better monitoring of the contracted insurers and hospitals. All the programs would need to focus on their service providers so that they are held responsible for productivity, efficiency, quality of care, and patient satisfaction. Further, the demand-side financing programs including RSBY and Rajiv Aarogyasri may need to revisit their benefits package and create and explore reforms in provider payment mechanisms.

Successful coverage extension requires robust enrolment processes and targeting mechanisms, and the latter are outside the control of the health programs in the Indian context. The targeting errors of the BPL lists, particularly in terms of leakage to unintended beneficiaries, combined with expansion of state-generated BPL lists to include the nonpoor, raise important equity questions about the allocation of scarce government resources. However, the National Commission for Enterprises in the Unorganized Sector (NCEUS 2009) estimates that 77 percent of the country's population is poor or vulnerable. Most of these vulnerable, non-poor households would be potentially impoverished by the need for expensive acute or chronic care. This may justify extension of health protection mechanisms to a wider group beyond the BPL population, within the country's fiscal resources.

Simple eligibility requirements, innovative outreach mechanisms, and use of smart technologies have facilitated enrolment, allowing schemes to better reach targeted beneficiaries. In the case of RSBY, which requires specific enrolment, intermediaries may still have a disincentive to enroll distant, hard-to-reach populations and BPL families residing in villages with low BPL density. RSBY can improve its enrolment performance by aligning incentives of enrolment intermediaries to reach out to more members per household (currently averaging about three members enrolled per family while the scheme provides for up to five members) and more households in each village (with current enrolment performance indicating that about half of the eligible families in the covered district were successfully enrolled). Lack of awareness and information about the programs remains a major impediment to enrolment in GSHISs, despite a number of outreach measures, and is another area where the programs can take due action.

Monitoring and evaluation is an area that needs focus by all three schemes. Rajiv Aarogyasri has an ongoing impact evaluation, as does RSBY in some states. The RSBY may need to revive its earlier plan to have a uniform nationwide claims data reporting and analysis system. Similar efforts by NRHM to improve the automation of data reporting and to undertake systematic impact evaluations of specific interventions would also be very important.

Gazing at the Crystal Ball: Fragmented Expansion or Promising Foundation

As mentioned in the section on benefits packages, the trio of programs discussed in this case study have their areas of focus clearly marked out—primary care in the case of NRHM, secondary care in the case of RSBY, and tertiary care in the case of Rajiv Aarogyasri. This distinction in focus was due to their respective evolutionary factors and did not happen in a planned or coordinated manner. Debate continues about whether the country can continue with expansion on both the supply and demand side in the long term, the prioritization of investments between primary and inpatient care, and between the extension of population coverage versus expansion of the benefits package, especially when resources are limited.

Despite the apparent dichotomy in financing as well as the apparent fragmentation among these three programs, the potential for an interesting complementarity does exist. Thus, if these programs could further evolve to a state of close coordination and with smooth linkages, they could potentially contribute to seamless, comprehensive coverage for primary, secondary, and tertiary care, drawing upon their respective strengths and synergies. There is considerable scope, for example, of NRHM-strengthened primary care facilities serving as effective gatekeepers for

the secondary and tertiary health insurance programs, and also contributing to effective follow-up care after these patients are discharged.

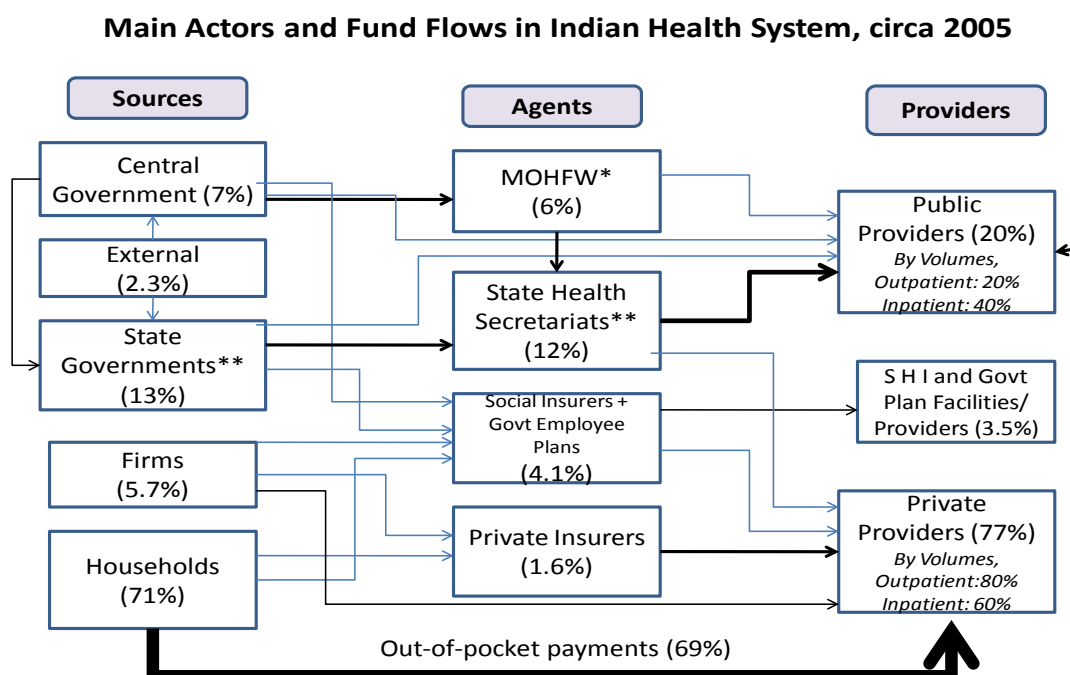
Further, preventive interventions and effective case management for noncommunicable diseases at the primary care level can contribute significantly to reducing the need for hospitalization, thereby simultaneously improving quality of life for the beneficiaries and containing the costs of hospitalization programs. Also, lessons from the demand-side financing schemes in aligning facility-level incentives for inpatient care can be used to introduce a performance-based remuneration system for public facilities providing primary care.¹³ If these programs can be coordinated in this manner for future expansion plans, their current configuration could be a promising foundation for a reformed health finance and delivery system, catapulting forward India's march toward Universal Health Coverage.

¹³ For further details on a proposed model to achieve such linkages, building upon the current configuration of the country's health system, see La Forgia and Nagpal (2012).

Annex 1 General Overview of the Health System and Health Financing in India

As discussed in the main text, public spending on health in India as a percent of GDP has varied little between 2000 and 2010, hovering at about 1 percent. Government (central, state, and local) has been the source of about one-fifth of spending, while out-of-pocket payments represented about 70 percent—one of the highest percentages in the world.¹⁴ Figure A1.1 depicts financial flows among major actors in India’s health service system according to the national health accounts classification, categorized by sources, agents, and providers. The bolded arrows show the main financial flows.¹⁵

Figure A1.1 Financial Flows in India’s Health System, circa 2005



Sources: National Health Accounts for 2004–05 (MOHFW 2009) and authors’ estimates from La Forgia and Nagpal 2012.

Note: *Includes spending by other central ministries. **Includes spending by local governments (1 percent of total spending).

The largest source of health financing in India is out-of-pocket spending by households (71 percent as a source of spending, and 69 percent as a financing intermediary for out-of-pocket spending). Nearly all this out-of-pocket spending is directed to fee-for-service private providers, but some is also spent for user fees and incidental expenses (for nonavailable drugs, for instance) at public facilities. This method of finance places considerable financial burden on poor

¹⁴ Among Asian countries, this was exceeded only by Pakistan, Cambodia, Myanmar, and Afghanistan in 2008 (WHO 2010).

¹⁵ The published National Health Accounts data contain certain inaccuracies, which has resulted in both an overestimate and an underestimate of spending. For example, social insurance was placed as a financing source rather than firms and households which actually contribute the financing for social health insurance. Also, some very small sources have not been depicted in this figure, so the totals for sources do not add up to 100 percent.

households, and is seen as one of the important reasons for impoverishment in India. As much as 80 percent of outpatient and 60 percent of inpatient care is provided by private practitioners (National Sample Survey Organisation, 60th round data) (MSPI 2004). This translates into a flow of 77 percent of total health spending directed toward private providers (including charitable and other nonprofit facilities).

Tax-financed, direct public delivery formed 20 percent of total health spending in the last year for which formal National Health Accounts are available. This public delivery of health services is, in principle, available for all of India's population at free or near-free pricing. Also, the share of public health expenditure has gone up to some extent in recent years with the introduction of NRHM (which is increasingly a large component of these funds), and estimates suggest that this may account for more than 25 percent of total health spending now, with out-of-pocket payments reduced to that extent.

Operated mainly by the states, the public delivery system includes facilities at primary, secondary, and tertiary levels, and accounts for about 20 and 40 percent of outpatient and inpatient utilization in the country, respectively. Considerable interstate variation exists, especially in inpatient utilization (Mahal et al. 2002) and there are significant subnational disparities across various dimensions of vulnerability. The publicly financed, owned, and delivered health service is also the largest health sector subsystem, where each state runs its own providers and infrequently purchases services from others. In theory, this system is available to all residents and is either free or at highly subsidized prices for health services. Public hospitals include Primary Health Centres and Community Health Centres at the primary level; Sub-District and District Hospitals at the secondary level; and Public Medical Colleges and their affiliated hospitals, and some autonomous specialty institutions, at the tertiary level. Though higher facilities are designated as referral facilities, the gatekeeping and referral systems are not strong, and even tertiary hospitals receive a large number of primary care cases in their outpatient facilities.

Social insurance schemes for formal private sector workers, civil servants, and military and railway employees constituted 4.1 percent of spending. These schemes are mandatory, and most are financed through employee and employer contributions via a payroll tax, but also receive partial government subsidies. Others are fully subsidized by the government (for example, military, railways) or public corporations (for example, coal and oil parastatals). Beneficiaries seek care in facilities owned and operated by the schemes or contracted out to the private sector. Private voluntary health insurance emerged in the late 1980s but has grown rapidly in the 2000s.

In 2004–05, (for which the latest country-produced National Health Accounts are available), private voluntary health insurance accounted for 1.6 percent of total health expenditure but, by 2008–09, it had reached an estimated 3 percent. Private insurance companies' health products emphasize inpatient coverage provided in networked private hospitals. The market consists of two, roughly equal-size components: a group market (catering to employers) and a retail market comprising individual and family plans. In 2010, private voluntary health insurance covered about 60 million people or 5 percent of the population.

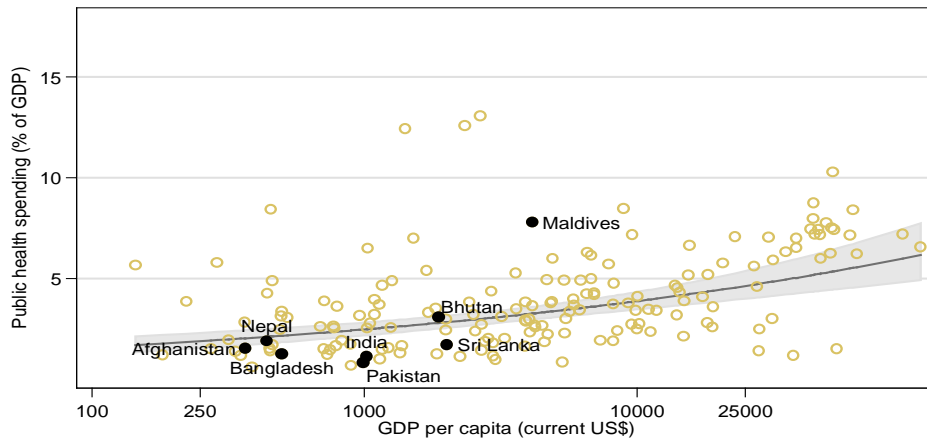
Annex 2 Evolutionary Context for the Indian HCPs: Health Impact, Public Health Expenditure, and Using Insurance Intermediaries

Health Outcomes and Public Health Expenditure are not Commensurate with National Income

India is significantly below its global comparators in terms of public expenditure on health as a share of GDP among countries with similar levels of income (GDP per capita in current U.S. dollars). At India's current income level, most countries exhibit higher public spending on health as a share of their GDP (World Bank 2010). Figure A2.1 illustrates this situation on a log scale in which each circle represents a country. The countries in South Asia have been labeled for ease of comparison.

Figure A2.1 India and Comparators: Public Expenditures on Health as a Share of GDP and in Relation to Income Per Capita, 2008

Public Health Expenditure as Share of GDP versus Income per Capita (2008)



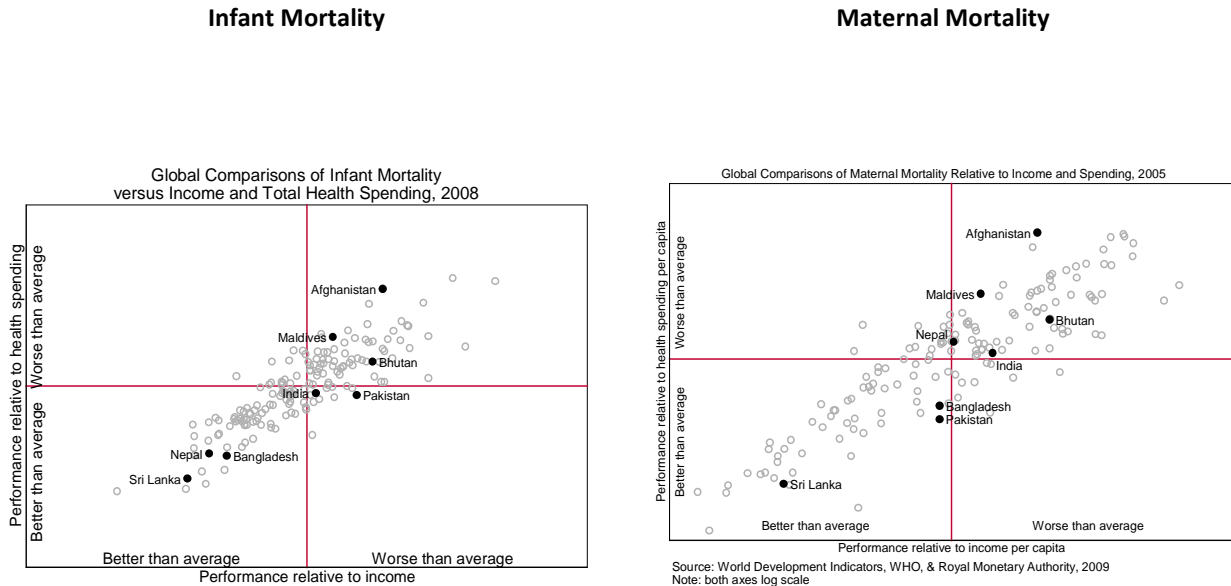
Sources: WDI; WHO
Note: x-axis log scale

Sources: World Bank 2010; WHO 2010.

Note: X-axis log scale.

India also falls short in terms of health impact, which also raises concerns around the effectiveness of its health expenditure. Although it has achieved laudable annual percent reductions in infant mortality over the last decade, some of its neighbors, such as Bangladesh and Nepal, have achieved steeper declines (Deolalikar et al. 2008). India has gained less ground in reducing malnutrition, maternal mortality, adult mortality, and prevalence of communicable diseases than its neighbors. In relation to its income level and total health spending per capita, India has not performed as well as its comparators on lowering maternal mortality, and its performance is just about average for infant mortality (figure A2.2) (World Bank 2010). Huge disparities in health outcomes are still evident across states and social groups (for example, scheduled castes and scheduled tribes), and improvements have not been shared equally.

Figure A2.2 India and Comparators: Infant Mortality and Maternal Mortality in Relation to Expenditures on Health and Income Per Capita, 2008

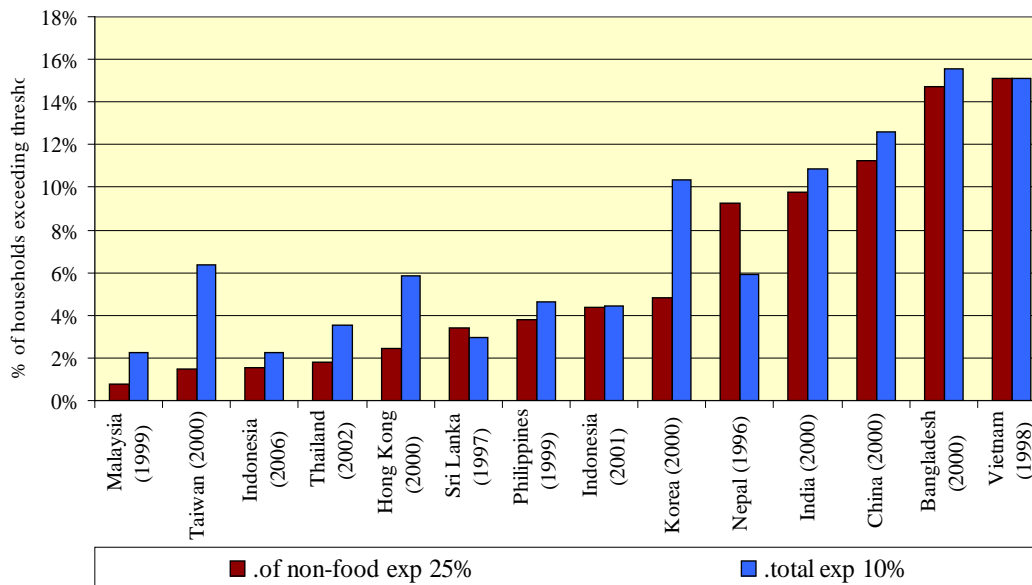


Sources: WHO 2010; World Bank 2010.
 Note: X-axis log scale.

Low public health spending, a high out-of-pocket share of 69 percent (MOHFW 2009), and the resultant health insecurity have been the main drivers of calls for government funding of health services for the poor. Selvaraj and Karan (2009), based on National Sample Survey Organization (NSSO) data (MSPI 2004), estimate that nearly 39 million people were pushed into poverty by out-of-pocket payments for health care during 2004 compared to 26 million during 1993–94. Applying a different methodology to the NSSO data, Berman et al. (2010) estimate that 63 million individuals (11.9 million households) were pushed below the poverty line by health care expenditure in 2004. These figures represented 6.2 percent of all households (6.6 percent in rural areas and 5 percent in urban areas).

Households, on average, devote about 5.8 percent of their total expenditure to health care. Health accounts for about 10.5 percent of nonfood expenditure. Approximately 14 percent of households in rural areas and 12 percent in urban areas spend more than 10 percent of their total annual consumption expenditure on health care (MSPI 2004). Countries such as Sri Lanka do much better, while China, Bangladesh, and Vietnam do worse than India on this count. A comparison of household spending on health for selected countries in Asia is shown in figure A2.3.

**Figure A2.3 India and Comparators: Household Spending on Health
(Percent of nonfood and total expenditures)**



Source: Van Doorslaer et al. 2005

In this context, the National Health Policy (MOHFW 2002), the report of the National Commission on Macroeconomics and Health (MOHFW 2005b), and the current coalition government’s framework for governance (“common minimum program”) (Government of India 2004), have all articulated the need for raising public health spending as a share of GDP, and catalyzed the introduction of the programs discussed in this case study. This commitment has been confirmed in recent government pronouncements related to the preparation of the 12th five-year development plan (2012–17) (Planning Commission 2011). However, the Government of India has yet to deliver on pledges for significant increases in public financing for health (aimed to be more than doubled to 2 to 3 percent of GDP), at least through the public delivery system.

The new generation (post-2007) of Government Sponsored Health Insurance Schemes (GSHISs), exemplified by RSBY and Rajiv Aarogyasri in this case study, and now comprising over a dozen such schemes nationwide, are a new form of mobilizing government resources in an underfinanced system while pioneering a new set of design features and institutional arrangements to govern, allocate, and manage the use of these resources. Though still small in terms of the share of public financing, these GSHISs introduced a number of significant changes in traditional government health financing and delivery arrangements in India. They have established a demand-side mechanism that mobilizes and channels additional public financing to health, introduced an explicit benefits package, pioneered cashless care (for example, there are no point-of-service payments or other forms of cost sharing required from beneficiaries and the hospital charges are directly settled by the schemes with their network hospitals), fostered public-private partnerships (with insurers and providers), and in principle stimulated competition among insurers (for government contracts) and providers (for beneficiaries, when ill).

Prior to the appearance of these schemes, nearly all public financing was directed to government-owned-and-operated service providers to support an implicit but irregularly (at best) delivered

benefits package. Although services were nominally free in most cases, users faced costs for unavailable drugs and consumables, transportation, diagnostics, and other services, as well as possible informal payments in some cases (La Forgia and Nagpal 2012).

The insurance intermediaries used by the newer GSHISs have provided an effective and transparent mechanism for these publicly funded schemes to buy services for their low-income beneficiaries from private health care providers, at a scale, amounting to a few million hospitalization episodes per year, which is also unprecedented in the Indian context. Prior to the evolution of this arrangement, purchasing of privately provided health services using public funds has been fraught with numerous hurdles, including leakages, delayed payments, and misaligned incentives.

The GSHISs are now deeply engaged with the network of private providers created by their insurance intermediaries from the private health insurance industry. This has allowed beneficiaries a broader choice of hospitals and also created some competition among providers, including public providers, with broader health sector impact, as has been discussed in an earlier section of this case study. Providers are held accountable for service provision (or they do not get paid). In theory, patient choice of providers further contributes to accountability. The explicit entitlement evident in the new generation of insurance schemes has established a new and more binding compact between government and citizens. Though limited in scope, benefits and the service delivery system to which they have access are clearly defined. In addition, the purchaser-provider split shifts provider payments from inputs to outputs and creates an enabling environment for increased accountability for results.

**Annex 3 Summary of Salient Characteristics
of the Government-Sponsored Health Insurance Schemes**

Factors	Rajiv Aarogyasri Community Health Insurance Scheme (AP)	Rashtriya Swasthya Bima Yojana, RSBY (GOI / MOLE)
Launch year	2007	2008
Geographic area	Entire state of Andhra Pradesh	Pan India: Currently implemented in 26 states
Target / eligible population	BPL or annual family income below Rs. 75,000	BPL families and other targeted groups
Number of beneficiaries	20.4 million families, 70 million beneficiaries	33.4 million families, 100 million beneficiaries
Unit of enrolment	Family	Family
Benefits package	Inpatient, tertiary focus; 938 identified procedures and follow-up packages covered	Inpatient lower-cost, secondary care focus; maternity also covered
Maximum insurance coverage	Rs. 150,000 per family per year plus buffer of Rs. 50,000 per year	Rs. 30,000 per family per year
Hospital empanelment, minimum beds	50 beds	10 beds
Number of empaneled hospitals (government and private)	275 private and 150 government hospitals	12,538 hospitals (8,546 private and 3,992 public)
Sources of funds	State government (100 percent, through the health budget and through a levy on alcohol sales in the state)	Central government 75 percent, state government 25 percent, but in some states, it is 90 percent from center. A contribution of Rs. 30 per family per year is collected from beneficiaries, which is used for administration and IEC expenses
Total expenditure, 2009–10 (millions of Rs.)	Rs. 12,000	Rs. 3,500
Premium price, 2009–10	Rs. 439 per family (varies between phases and districts)	Average: Rs. 540 per family per year including service tax
Number of hospitalizations per year	319,446, 2009–10	400,000, 2009–10
Hospitalization frequency (2009–10)	0.6 percent per beneficiary	2.5 percent per beneficiary
Governing agency / legal status	Aarogyasri Healthcare Trust / trust	State nodal agency (society/ trust)
Executing agency	Trust	State nodal agency with the intermediation of commercial insurer(s)
Number of staff in governing agency (2010)	117	~10 at center and ~100 at state nodal agencies

Annex 4 Spider Web

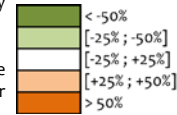
I. Outcomes comparisons: India and Lower Middle Income Countries



Note on interpretation:

In this plot 'higher' is 'worse' – since these indicators are positive measures of mortality / morbidity. Life expectancy is converted to be an inverse measure.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

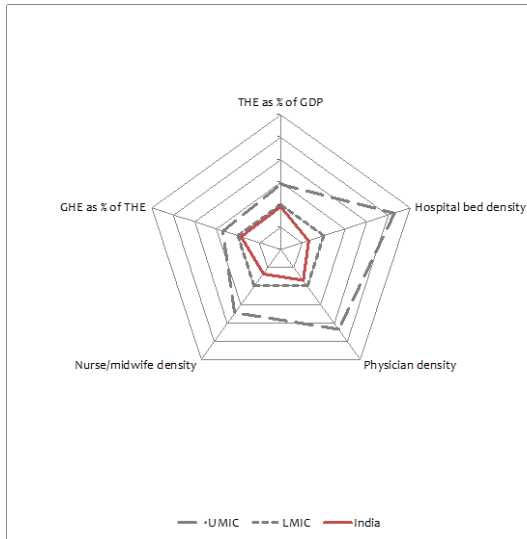


The table below summarizes outcome comparisons with the average lower middle income country (LMIC).

Country Data	India	LMIC	% Diff.
GNI pc (2000 USD)	445.7	592.4	-24.8%
IMR	48.2	50.3	-4.2%
U5MR	62.7	69.4	-9.7%
Stunting	47.9	29.7	61.3%
MMR	200.0	260.0	-23.1%
Adult Mortality	253.2	244.1	3.7%
100-Life Expectancy	34.9	34.6	0.7%
Neonatal Mortality	32.0	29.1	10.0%
CD mortality	47.0	47.0	0.0%

IMR: Infant mortality rate (2010). U5MR: Under-5 mortality rate (2010). Stunting: prevalence of low height-for-age among children under 5 (2010). MMR: Maternal mortality rate (2010) per 100 000 live births. Adult mortality: Adult mortality rate per 1000 male adults (2010). [100-(life expectancy)]: Life expectancy at birth (2010) subtracted from maximum of 100. Neonatal mortality: Neonatal mortality per 1000 living births. CD as cause of death: Communicable diseases as cause of death (% total). All data from World Bank's World Development Indicators. Income averages for stunting calculated by Bank staff and are unweighted.

II. Inputs comparisons India and Lower Middle Income Countries

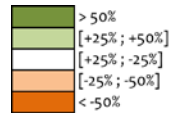


Note on interpretation:

This plot shows indicators which measure spending on health or the number of health workers per population.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

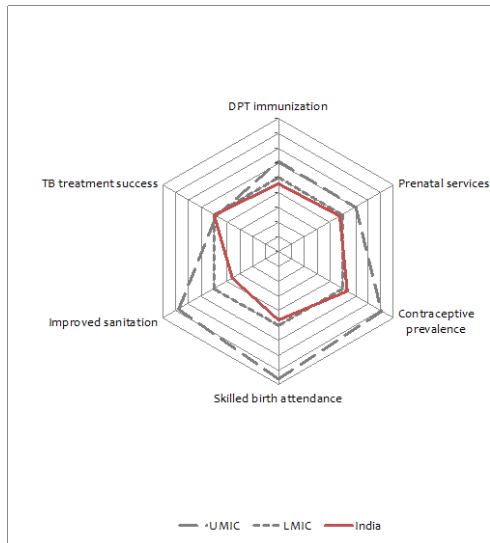
The table below summarizes inputs comparisons with the average lower middle income country (LMIC).



Country Data	India	LMIC	% Diff.
GNI pc (2000 USD)	445.7	592.4	-24.8%
THE %GDP	4.1	4.2	-4.4%
Hosp. bed density	0.9	1.4	-35.3%
Phys. density	0.6	0.8	-16.4%
Nur./midwife dens.	1.0	1.5	-34.1%
GHE %THE	36.9	40.2	-8.2%

THE as % of GDP: Health expenditure, total (% of GDP) (2010). Hospital bed density: Hospital beds per 1,000 people (latest available year). Physician density: Physicians per 1,000 people (latest available year). Nurse/midwife density: Nurses and midwives per 1,000 people (latest available year). GHE as % of THE/10: Public health expenditure (% of total expenditure on health) (2010). All data from World Bank's World Development Indicators.

III. Coverage comparisons India and Lower Middle Income Countries

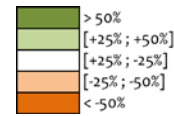


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures. In this case, all are percent of the population receiving or having access to a certain health related service.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

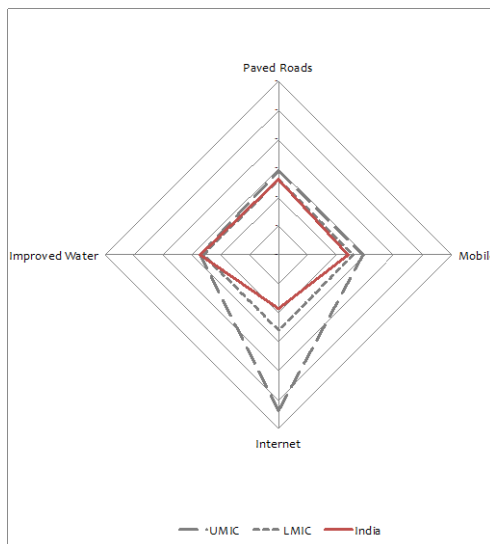
The table below summarizes coverage comparisons with the average lower middle income country (LMIC).



Country Data	India	LMIC	% Diff.
GNI pc (2000 USD)	445.7	592.4	-24.8%
DPT	72.0	78.7	-8.5%
Prenatal	75.2	78.1	-3.7%
Contraceptive	54.0	50.1	7.8%
Skilled birth	52.7	56.9	-7.4%
Sanitation	34.0	47.0	-27.7%
TB success	88.0	88.0	0.0%

DPT immunization: % of children aged 12-23 months with DPT immunization (2010). Prenatal services: % of pregnant women receiving prenatal care (latest available year). Contraceptive prevalence: % of women ages 15-49 using contraception (latest available year). Skilled birth attendance: % of all births attended by skilled health staff (latest available year). Improved sanitation: % of population with access to improved sanitation facilities (2010). TB treatment success: Tuberculosis treatment success rate (% of registered cases). All data from World Bank's World Development Indicators.

IV. Infrastructure comparisons India and Lower Middle Income Countries

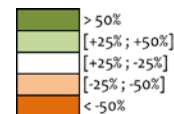


Note on interpretation:

In this plot 'higher' is 'better' – since these indicators are positive measures of provision of certain good / service, and a measure of urban development.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

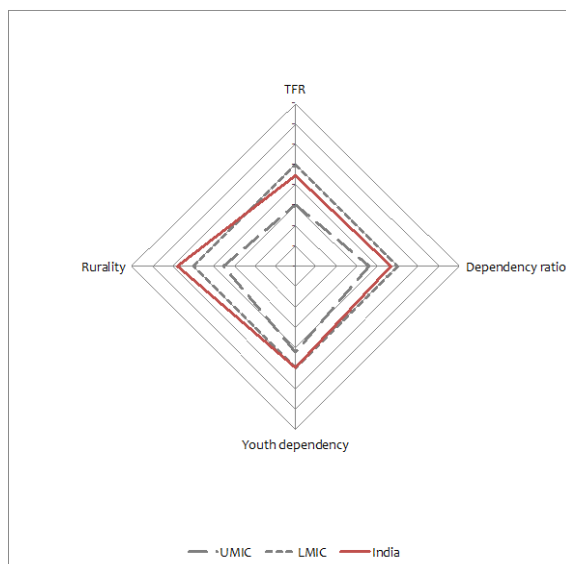
The table below summarizes infrastructure comparisons with the average lower middle income country (LMIC).



Country Data	India	LMIC	% Diff.
GNI pc (2000 USD)	445.7	592.4	-24.8%
Paved roads	49.5	49.5	0.0%
Mobile phones	72.0	79.3	-9.2%
Internet	10.1	16.0	-37.2%
Water	92.0	87.3	5.4%

Paved roads: % of total roads paved (most recent). Internet users: users per 100 people (2010, with some estimates from prior years). Mobile phone users: mobile cellular subscriptions per 100 people (2010). Access to improved water: % of population with access to improved water source (2010). All data from World Bank's World Development Indicators.

V. Demography comparisons India and Lower Middle Income Countries

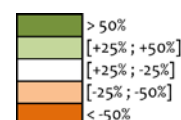


Note on interpretation:

Indicators here measure births per woman, the extent of rurality, and the number of dependents.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

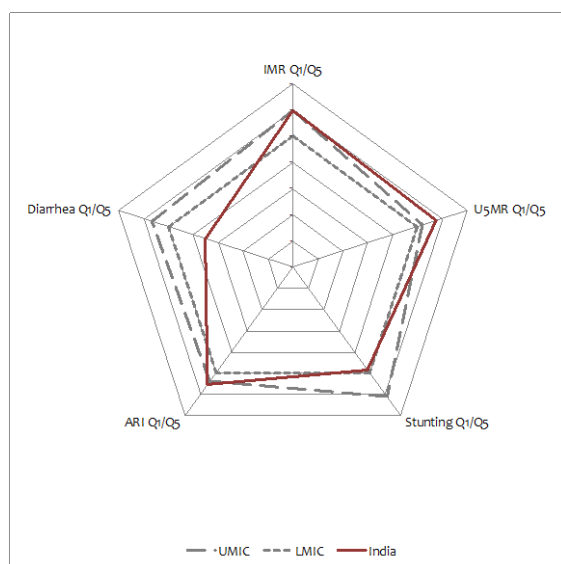
The table below summarizes demographic indicators comparisons with the average lower middle income country (LMIC).



Country Data	India	LMIC	% Diff.
GNI pc (2000 USD)	445.7	592.4	-24.8%
TFR	2.6	2.9	-10.2%
Dependency (Total)	55.0	58.8	-6.4%
Youth share	86.2	86.7	-0.6%
Rural pop.	69.9	60.6	15.4%

TFR: total fertility rate (births per woman), 2009. Dependency ratio: % of working-age population (2010) aged less than 15 or more than 64. Youth dependency: % of working-age population (2010) aged less than 15. Rurality: % of total population in rural areas (2010). All data from World Bank's World Development Indicators.

VI. Inequality comparisons India and Lower Middle Income Countries

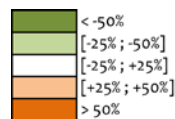


Note on interpretation:

In this plot 'higher' is 'inequal' and indicators here measure inequalities in selected health outcomes by taking the ratio of prevalence between Q1 and Q5.

The values on the radar plot have been standardized with respect to the average lower middle income country value.

The table below summarizes inequality indicators comparisons with the average lower middle income country (LMIC).



Country Data	India	LMIC	% Diff.
GNI pc (2000 USD)	445.7	592.4	-24.8%
IMR Q1/Q5	2.4	2.0	19.6%
U5MR Q1/Q5	3.0	2.6	14.8%
Stunting Q1/Q5	2.6	2.7	-3.0%
ARI Q1/Q5	1.4	1.3	10.7%
Diarrhea Q1/Q5	1.1	1.5	-29.3%

All indicators measure the ratio of prevalence between the poorest (in Q1, the first wealth distribution quintile) and the richest (in Q5, the fifth wealth distribution quintile). The data (latest data available) are taken from HNPstats (<http://data.worldbank.org/data-catalog/HNPquintile>).

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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