Swaniti Initiative

# Health Insurance Systems: Assessing India and Various Countries

*Global practices of healthcare coverage*

Healthcare spending accounted for **9.9% of world GDP** in 2014 according to the World Bank[1]. At the global level, healthcare spending by national governments as a proportion of their GDP stands at 5.84% as of 2015[2]. Healthcare expenses are prohibitive in most countries and only a small section of the population can afford it personally. This necessitates health insurance coverage for all, and one of the ways to maximise accessibility and assure quality of care is through government provision of health insurance.

Most national governments in the world run health insurance programmes as financial protection and to encourage healthcare seeking behaviour, for their citizens. Of this, the wealthier countries typically spend more on health insurance for their populations than the poorer countries. This skewed distribution of resources illustrates the gap in healthcare access across geographies. To acknowledge this, the Third Sustainable Development Goal (SDG), "*To ensure healthy lives and promote wellbeing for all at all ages*", has set out a target to achieve **Universal Health Coverage (UHC)**, financial risk protection and to strengthen the capacity of developing countries in dealing with the demands of their population. The theme for the World Health Day 2018, observed on April 7 annually by the WHO, was "*Universal Health Coverage: Everyone, Everywhere*".

Financial catastrophes arising out of hospitalisation episodes often prevent the poor from seeking healthcare, perpetuating a cycle of poverty, pushing them further into debt, as already discussed. It is in such a context that the Government of India has launched the comprehensive scheme to offer health insurance to about 40% of the Indian population, with an aim to achieve universal coverage in line with the SDG-3[3]. Christened **Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)**, it offers **INR 5 lakhs** per annum per family, with no restriction on family size. Secondary and tertiary care hospitalisations, except for a negative list, totalling **1350 packages for 1300 illnesses**, are fully covered. This scheme subsumes two existing schemes, Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizens Health Insurance Scheme (SCHIS). This convergence brings **13000 hospitals**[4] across the country as part of the AB- PMJAY infrastructure.

The Ayushman Bharat Scheme is a consequence of the adoption of the **National Health Policy (NHP) 2017**, which was released after a gap of 15 years. The NHP-2017[5] aims to set the ball rolling for ensuring access to quality healthcare, both preventive and curative. The ultimate goal to attain UHC remains central to the vision

[1] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?end=2015&start=2000&view=chart
[2] https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?end=2015&start=2000&view=chart
[3] https://mera.pmjay.co.in/
[4] http://pib.nic.in/newsite/PrintRelease.aspx?relid=183635
[5] http://pib.nic.in/newsite/PrintRelease.aspx?relid=159376

of the NHP-2017 as is reflected by the launch of the AB-PMJAY. The policy also emphasises on the necessity of strengthening secondary and tertiary health services through strategic purchase, highlighting the need for partnering with the private sector for capacity building, skill development and developing community networks. However, the role of government in providing public health services is to be prioritized and the policy provides a roadmap predicated on public spending and provisioning of a healthcare system that is comprehensive, integrated and accessible to all. On the whole, the **NHP-2017 aims to raise government investment in healthcare to 2.5% of GDP and 8% of GSDP in a phased manner**.

**Key Facts about the Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana**

- The AB-PMJAY is an **entitlement-based scheme** which targets beneficiaries on the basis of **deprivation criteria** in the SECC[6] database. This identifies families in both rural and urban areas.
- The **Ayushman Bharat National Health Protection Mission Agency (AB-NHPMA)** is the entity managing the scheme at the national level, while the states participating in the scheme have to set up a **State Health Agency (SHA)** in a Trust/ Society/ Non-Profit Company/ State Nodal Agency format. All states except Odisha, Delhi, Kerala, Telangana and Punjab are participating in the scheme, as these states already have comprehensive care schemes run by the respective state governments.
- Transactions carried out under this scheme are to be **cashless and paperless**; the beneficiaries will **not** incur any Out-Of-Pocket (OOP) expenditures for seeking treatment under the scheme. All pre-existing conditions are covered at empanelled hospitals upon production of ID.

## National Health Insurance Programmes in India and other countries

The preceding section summarised the newly launched social health protection scheme in India targeted at the population in the bottom of the pyramid. There are also various health insurance products[7] available in India, which are targeted at those employed in the organised sector (**Voluntary Health Insurance Schemes**). This includes both for-profit and non-profit schemes run by private entities. Additionally, there are government-run schemes that are mandatory, which address the healthcare needs of formally employed citizens, such as the **Employer State Insurance Scheme (ESIS)** and the **Central Government Health Insurance Scheme (CGHS)**.

These schemes involve the central government and the employer paying premiums jointly for the coverage of the employee. While the ESIS is for beneficiaries employed in the private sector, the CGHS is for employees and retirees of the central government, largely. In case of the voluntary health insurance programmes,

[6] https://www.abnhpm.gov.in/about-abnhpm
[7] J Anita, "Emerging Health Insurance in India- An Overview", 10th Global Conference of Actuaries: https://www.actuariesindia.org/downloads/gcadata/10thGCA/Emerging%20Health%20Insurance%20in%20India-An%20overview_J%20Anitha.pdf Accessed on 09 November 2018

ambulatory and outpatient consults are normally not covered under the packages. There is no coverage of pre-existing conditions and insurance companies can deny such individuals any scheme as well. Referred specialist consults, surgeon and anaesthetist fees, nursing expenses as well as charges for room and boarding for the patient, in addition to some implants, medical devises and artificial limbs or organs, are typically included in the insurance plans. The sum insured may be offered on an individual basis or on a floater basis to the family.[8]

The poor extent of coverage and the inefficient mode of claims processing are but two issues faced by the targeted beneficiaries of health insurance products in India, thus indicating that UHC is a distant dream for Indians. The government has used this experience to augment the AM-PMJAY for the impoverished, with emphasis on cashless treatment. There is much desired in the health insurance sector in India and it will be useful to examine certain international examples to understand what can be incorporated creatively in India. This section examines some international programmes which were selected on the basis of their servicing population, funding pattern, extent of healthcare coverage, public- private ownership, and geopolitical considerations which influence the construction of the model.

The assessment of the programmes can be carried out using a matrix devised to understand the logistics of the model along the levels of intervention, as summarised in the table below:

| Features of Scheme / Levels of Intervention | FUND SOURCE/ PUBLIC FINANCING | IMPLEMENTATION MECHANISM OF SCHEME | DESIGN OF BENEFIT PROGRAMME |
|---|---|---|---|
| **PROVIDER** (Both hospitals and insurance companies) | 1. How are the empanelled hospitals (private and public) reimbursed? | 1. How many hospitals are empanelled in the network? Are they connected across levels of care?<br><br>2. What does the scheme provide for hospitals to expand their infrastructure? | 1. What are the inclusions in terms of treatment and care packages?<br><br>2. How are independent, non-referred consults paid for? |
| **BENEFICIARY** (Income/ Social Class/ Age/ Employment & Marital Status) | 1. How is the co-pay from the beneficiary structured?<br><br>2. What is the cap on OOP spending? | 1. What is the insurance for private and unorganised labour/ vulnerable groups/ undocumented immigrants?<br><br>2. Can personal physicians' consultations be covered in the scheme?<br><br>3. What is the coverage of pre-existing conditions and prolonged illnesses? | 1. Does the scheme include specialist outpatient consultancy?<br><br>2. What are the provisions under the scheme for different groups of the populations? |
| **GOVERNMENT ROLE** (Welfare & | 1. How is the scheme funded/ budgeted? | 1. What is the extent of care coverage- Primary/ Secondary/ Tertiary? | 1. How are users registered in the system? |

[8] Handbook on Health Insurance, Insurance Regulatory and Development Authority; http://www.policyholder.gov.in/uploads/CEDocuments/Health%20Insurance%20Handbook.pdf Accessed on 08/11/2018

| | | | |
|---|---|---|---|
| Regulating Access) | 2. What is the role of private sector insurance? | 2. What type of care is covered? Ambulatory/ In-Patient/Out-Patient?<br><br>3. What is the implementation infrastructure- Arbiters and Agencies at National, State and Local level? | 2. How does the programme manage patient data? |

*Table 1: Assessment Matrix for Health Insurance Schemes*

This assessment matrix captures most of the crucial indicators that give an insight into health insurance programmes through the vertical and horizontal analytical categories. The vertical categories serve as criteria in understanding the nuances of the programme while the levels of intervention bring out the differences among the schemes of various governments. The verticals examine the funding source, implementation mechanism of the scheme, as well as the design of the benefit, while the cross-cutting categories highlight the impact of the scheme on the provider and the beneficiary, and the role played by the government in facilitating the programme.

The countries selected for analysis have been chosen on the basis of universality of coverage in their model, the sections of population covered, the types of care included, social safety nets for vulnerable groups, public-private provisioning, and the role of national government in ensuring equitable access to all citizens and visitors. Accordingly, a mix of successful models from England, Switzerland, Israel, Japan and Singapore have been chosen. The trailing paragraphs elaborate on the same.

| Country | Name of Healthcare Programme(s) |
|---|---|
| England | National Health Service (NHS) |
| Switzerland | Statutory Health Insurance (SHI) under FOPH- Swiss Medic |
| Israel | National Health Insurance (NHI): Four Plans- Clalit, Maccabi, Meuhedet, Leumit |
| Singapore | MediSave, MediShield, MediFund |
| Japan | Public Health Insurance System (PHIS) |
| India | Ayushman Bharath- National Health Protection Scheme (AB-NHPS), Central Government Health Insurance Scheme (CGHIS), Employer State Insurance Scheme (ESIS) |

*Table 2: Countries and their Healthcare Programmes*

## I. Fund Source

To understand the public financing of healthcare in various healthcare, it is important to understand the sourcing of funds, given fiscal capacity of the respective exchequers. This is reflected in the proportion of GDP allocated towards healthcare, and how much of the country's health spending is in the public domain. Additionally the mode of devolution of these funds to the care providers- public hospitals, ambulatory healthcare institutions and private facilities- is also worth examining.

A key aspect to be kept in mind here is that from the supplier end, both the sets of institutions- care providers and care financiers- are spread between the private sector and the government; this is crucial for price-setting, quality standards and efficiency of service delivery. Accordingly, public- private partnerships (PPP) in running healthcare facilities are encouraged under the new AB-NHPS in India. The policy regarding this varies between countries and is summarised as follows:

| Country | Dominant Insurance Model | Healthcare Providing Point of Service |
|---|---|---|
| England | Government- Sponsored | Trust or Non- Profit Foundation |
| Switzerland | Private but Government-mandated | Private |
| Israel | Government | Private and Public facilities |
| Singapore | Government & supplementary private | Predominantly private, and public facilities |
| Japan | Government & supplementary private | Government and Private hospitals |
| India | Voluntary Private & Mandatory Government | Predominantly private, and public facilities |

*Table 3: Countries and their Healthcare Insurance and Delivery models*

### Provider Level

In England, hospitals are either run through the NHS Trust or are non-profit Foundations themselves. The Trust hospitals contract with one of the 209 local Clinical Commissioning Groups to provide services and are later reimbursed at DRG rates, uniform across the country. This includes medical staff costs and account for about 60% of hospital income. In both Japan and India, the governments have instituted a policy of not paying at the Point of Service, thus providing cashless treatment to their patients. Insurance claims are filed and processed by legal entities who reimburse the healthcare facilities from the budgeted programme at the national level.

**Diagnostics- Related Groups (DRGs)** are an instrument that lie in the intersection of healthcare and health financing, and are an indispensable aspect of public health insurance policymaking. DRGs identify patients into various care groups depending upon their health conditions and hence, assist in the formulation of care packages. Therefore, DRGs determine the prices of such packages, and encourage hospitals to manage costs while providing adequate care to the patient. Overall, DRGs enhance efficiency by balancing medical requirements with health financing in the public health insurance sector.

The systems in Switzerland, Israel and Singapore diverge from this slightly in that the governments heavily subsidise the costs of healthcare and then later reimburse patients either directly or through an insurance agency. For instance, in Switzerland, where the provider end (hospitals and insurers) is predominantly privately held, 70% of the hospitals are publicly subsidised and the provider has the option to either bill the patient or the insurer directly. In Israel and Singapore as well, government-subsidized care is provided and the patients may be billed directly. They are later able to claim this as reimbursements from their governments.

## Beneficiary Level

There is global recognition for invested role of the government in providing healthcare that is equitable in quality and access. This helps in reducing disparity within the population and encourages healthcare seeking behaviour among the poorest and the vulnerable. The figure below illustrates the relationship between the proportion of public expenditure on healthcare in a country and the proportion of Out-Of-Pocket expenditures.

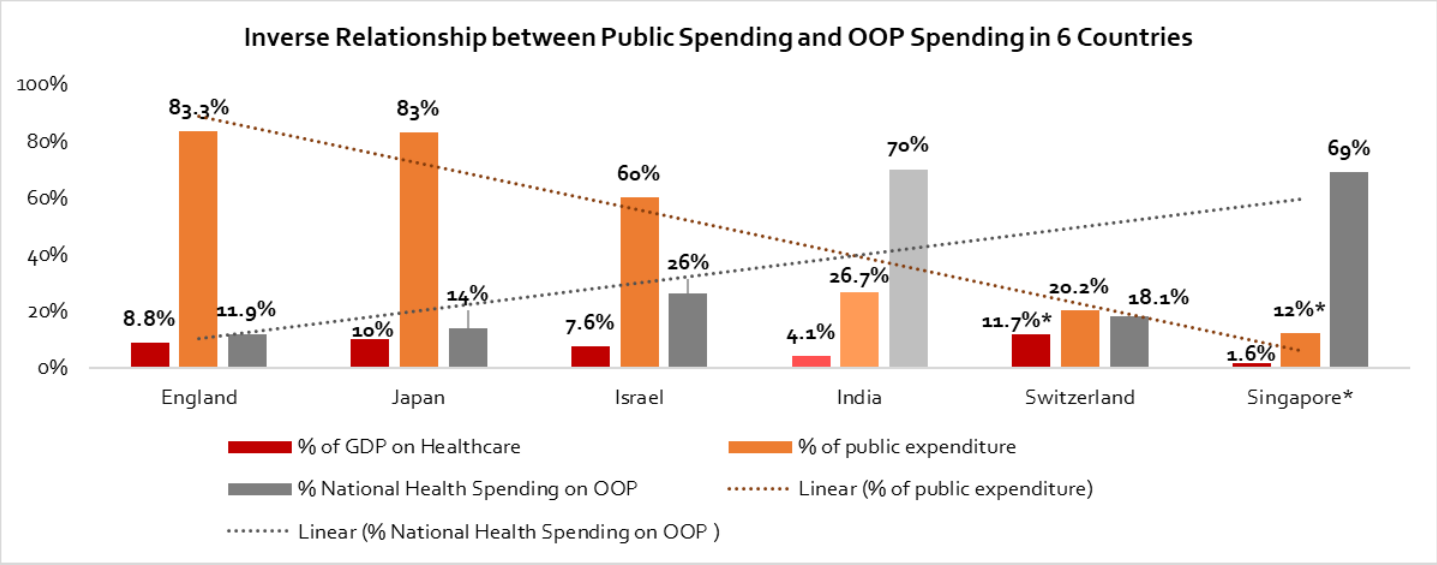


*Figure 1: Graph depicting how Increase in Public Expenditure in Health causes Decrease in OOP*[9]

The graph above shows the linear relationship between higher public spending on healthcare and lower OOP. With the exception of Switzerland, all countries exhibit a similar trend, in that where the OOP is high, public spending on healthcare is low. This is because of the unique model followed by Switzerland where the exchequer acts as the facilitator of service provision, by partnering with private insurance companies and hospitals, and providing 45-55% of services under the Statutory Health Insurance (SHI), leading to 32.1% of health spending in the country to be parked in the private sector. A similar trend exists between the proportion of GDP earmarked for health and the rate of OOP. On the other hand, there is no discernible commensurate relationship between the proportion of GDP and the proportion of public healthcare spending, as evident.

## OOP spending and co-payment structure in countries

In countries with very low OOP expenditure, such as England, Japan, Israel and Switzerland, the spending tends to be for special services outside of the programme. This may include some pharmaceuticals and medical appliances, equipment, implants, dental procedures, optometry and some elective procedures. Simultaneously, in countries with high OOP spending like India and Singapore, patients cover even crucial services such as primary care, diagnostics, prescription drugs and life-saving medication, among others. Therefore, high OOP is symptomatic of government attention wanting in healthcare in a nation.

[9] Source for asterisked values: WHO Global Health Observatory Data Repository: http://apps.who.int/gho/data/node.main.GHEDGGHEDGGESHA2011?lang=en

| Country | Structure of Co-pay |
|---|---|
| England | Limited cost-sharing for all public services |
| Switzerland | Pre-defined co-pay for adults with different rates for Outpatient and Inpatient treatment |
| Israel | Limited cost-sharing for all public services |
| Japan | 30% of the costs as co-insurance, and the annual co-pay under a specific bracket may be tax deducted |
| Singapore | MediShield and MediSave co-payments are matched by the employers for the benefit of employees |
| India | Varying degrees depending on employment status and income, AB-PMJAY has no co-pay |

*Table 4: Countries and their Co-payment models*

## Government Role

With regards to the funding of the plan itself, the NHS-England has its own NHS Budget funded through general taxation, under the Department of Health, as Health Act (2006) makes it the statutory duty of the Health Secretary of State to provide comprehensive health coverage. NHI- Israel also follows a similar pattern, funding its healthcare budget through income-based progressive taxation. This is in stark contrast to SHI-Switzerland which has no global healthcare budget, as the government aggregates private health insurers and pays premiums on behalf of vulnerable groups. Japan and Singapore use a combination of funding mechanisms including premiums, tax-financed subsidies and user charges, apart from a government budget. Singapore relies on very high co-pays and deductibles paid by the users to sustain its system. The AB-NHPS in India is targeted for the most impoverished of families in the country and hence is designed with no co-pays on the part of the beneficiaries.

This naturally prompts the enquiry into the role of the private sector in insurance provision. Voluntary Health Insurance (VHI) and Complimentary Health Insurance (CHI) are provided by private sector players; in NHS-England this is predominantly through employers while in NHI- Israel, a combination of Health Plan VHI and Commercial VHI exist to cover services not available under the NHI, such as care in a private hospital or premium care under the NHI etc. These VHIs tend to be operated by for-profit entities which are regulated by the markets authority of the government, like in SHI-Switzerland, where the VHI enables free choice of hospital apart from other services not available under the plan. In Singapore, the government funds care through private hospitals. In Japan, private sector insurance plays a complimentary, small role; these are lump-sum payments for hospitalisations, and other limited services such as orthodontics or traffic accidents. There are both for-profit and non-profit institutions providing insurance services, akin to the Indian system of optional private insurance for certain cases.

## II. Implementation Mechanism of Scheme

In the English, Singaporean and Israeli healthcare systems, universal health coverage is provided, with all three levels of care- primary, secondary and tertiary- covered under the programme. The Swiss and Japanese healthcare systems have non-universal coverage, with the former providing only secondary and tertiary support and the latter providing universal primary healthcare access alone. In Singapore, healthcare is seen as both a duty of the state and a responsibility of the individual, giving rise to a unique model of citizen-government partnership. The Japanese system is very similar to India's Ayushman Bharat, in that primary healthcare is accessible to all citizens regardless of income bracket. The extent of coverage and the type of care provided by the countries are provided in the table below.

| **Countries** | **England** | **Switzerland** | **Israel** | **Japan** | **Singapore** | **India[10]** |
|---|---|---|---|---|---|---|
| **Care Coverage** ($1^0/2^0/3^0$)* | $1^0$, $2^0$ & $3^0$ | $2^0$ & $3^0$ | $1^0$, $2^0$ & $3^0$ | $1^0$, $2^0$ & $3^0$ | $1^0$, $2^0$ & $3^0$ | $2^0$ & $3^0$ |
| **Type of Care** (Ambulatory/ In-Patient/ Out-Patient) | Ambulatory, In-Patient & Out-Patient | Ambulatory, In-Patient & Out-Patient | Ambulatory ($1^0$), In-Patient & Out-Patient | Ambulatory, In-Patient & Out-Patient | In-Patient & Out-Patient | In-Patient (for all) & Out-Patient (for the poor) |

*Table 5: Summary of countries and their extent and type of care coverage*

* **$1^0$ – Primary care; $2^0$ – Secondary care; $3^0$ – Tertiary care**

### Provider Level

A crucial aspect of healthcare provision lies in the dualism of spread of points of service and the continuity of care. In integrated systems like the NHS-England, NHI-Israel and PHIS-Japan the levels of care are all connected through the network, geographically. There are **gatekeeping mechanisms** that ensure that the higher level of care will be available only upon a referral system. This includes primary, secondary and tertiary care as well as mental care in the case of these countries. In SHI- Switzerland and the Singaporean system, there is no gatekeeping mechanism, given how the former does not cover primary care and the latter covers only outpatient consults. There is flexibility to choose hospitals, but at a premium charge in both the cases.

It is as important to understand the funding structure for the hospitals in order to ensure their smooth running and timely upgradation. Infrastructure expansion is a crucial aspect of the functioning of healthcare institutions, and sufficient funding for the same determines the availability of latest medical technology.

[10] Handbook on Health Insurance, Insurance Regulatory and Development Authority; http://www.policyholder.gov.in/uploads/CEDocuments/Health%20Insurance%20Handbook.pdf Accessed on 08/11/2018

| Country | Hospital Fund Source for Infrastructure Expansion |
|---|---|
| England | Hospitals provide care outside the NHS, generating income |
| Switzerland | Optional VHI forms a tiny supplemental income to hospitals in an otherwise expensive market |
| Israel | A dedicated head in the annual budget is allocated to introduce new technology |
| Japan | Hospitals are allowed to retain the subsidies generated through their operations |
| Singapore | Government strictly regulates the market to contain the costs |
| India | Annual budget has dedicated head for maintenance and equipment purchase in rural public health facilities |

*Table 6: Summary of countries and hospital funding mechanisms*

### Beneficiary Level

Considering that health insurance is essentially a social protection mechanism, it is crucial to ensure that the most vulnerable of the populations is covered. Under this umbrella, low income groups, undocumented immigrants, and the poorly educated are counted. The NHS-England has a universal coverage extending to low income groups, while 11% of the population is also protected by private employer insurance. In Israel, employers are required to enrol foreign workers in private programmes whether they are documented or not. But this does not absolve the government of all responsibility; the Singaporean government has the Community Health Assist Scheme and the Foreign Domestic Worker Grant to protect the unorganised labour in the country. Similarly, though PHIS- Japan and SHI- Switzerland does not extend to undocumented immigrants, the latter routes care for the vulnerable groups including children, the elderly and immigrants, through the Swiss cantons.

Various systems cover individual needs differently. To this end, there is a need to examine if personal physician consults can be charged to the scheme. In England and Israel, such exclusive consultations have to be purchased separately, while in Singapore, India and Japan this is simply not an option. As the Swiss system is one where the government has contracted with each private entity in the care system, all forms of healthcare is sought by users independently by private practitioners in private hospitals, which is significantly covered under the SHI. Country-wise coverage of chronic care is appended in the table below:

| Country | Long-term illness coverage |
|---|---|
| England | Only for low-income groups, with co-pay |
| Switzerland | Dedicated health plan to be purchased according to needs |
| Israel | Depends upon chosen plan, given healthcare needs |
| Japan | Case-by-case consideration |
| Singapore | MediShield and MediSave together, have provisions |

| | |
|---|---|
| India | Case-by-case consideration |

*Table 7: Do countries cover prolonged illnesses?*

### Government Role

Almost all the countries considered follow a hierarchy of implementation, with the exception of Singapore, where the small size of the nation-state has resulted in all responsibility of providing quality healthcare to be vested in the central government. Therefore, in Singapore, the Ministry of Health, through Statutory Boards like the Agency for Integrated Care and Healthcare Institutions, ensures healthcare access to citizens. Countries generally have a nodal agency at the federal level and implementing units at the regional level like in India and further decentralised at the local level like in England, Switzerland and Japan. The hospital managements themselves very rarely have governing authorisation or decision-making powers, but it is present in limited capacities in England and Israel. The assurance of health service quality in these systems happens through various monitoring mechanisms instituted at the hospital board level by the local government, in compliance with the policy framed at the national level.

## III. Design of Benefit Programme

While most programmes discussed here provide universal coverage of all conditions, there are still some exceptions and exclusions. These are not limited to elective non-medically prescribed surgery but also expand to private consultations and prolonged care, as already discussed. Therefore it is useful to examine what included under the packages, and for different groups of beneficiaries.

### Provider and Beneficiary Level

Some nations such as Israel, provide specialist outpatient consultancy, through co-pay and Fee-For-Service (FFS), with the specialists chosen as per the patient's health plan. However, this is not the case for England where this is available only through FFS. In Japan, the outpatient services of large-scale multispecialty hospitals are not covered; additionally, there is no gatekeeping, leading patients to move freely across all levels of care. Even primary care is provided upon FFS, although common prices are set, and extra allowances and fringe benefits cover these costs outside PHIS. The following table summarises such nuances.

| Countries | Inclusions under the Programme | Social Protection Provisions |
|---|---|---|
| England (UHC) | Preventive Services (vaccinations), in-patient & out-patient care and drugs, physician services, clinical dental care, optometry, mental, palliative and rehabilitation care, physiotherapy, community-based nurses, transportation costs for low-income groups. | Exception from drug co-pay for children under 16, full-time students of 16-18 years of age, those above 60, low income population, pregnant women, mothers with infants younger than one, disabled, people with cancer. |
| Switzerland (UHC) | General physician & specialist services, drugs, medical devices, home healthcare services through Spitex, physiotherapy, preventive services like | Mental illness, clinical psychotherapy, hospice care, dental care & optometry for children, palliative care, Spitex for the chronical out-patient. |

| | | |
|---|---|---|
| | vaccines, health exams, NCD screening among at-risk groups. | |
| Israel (UHC) | All inclusions are featured through either of the four healthcare plans. This includes mental healthcare and long-term care for elderly living in communities. | For children in-patient care, primary and specialty care, certain vaccines, mental care and dental care are offered. For adults, some dental care, optometry, palliative and home care are also covered. A quarterly ceiling for the chronically ill, discounts for the elderly based on income are allowed on pharma co-payments. |
| Singapore (UHC) | Cardiovascular care, nephrology care and NCD care are insured. Primary care and specialist care are covered, depending on plan. | MediFund is a safety net endowment programme by the government for the poor; ElderCare Fund provides grants to intermediate and long-term care facilities to subsidize care of lower and middle-income patients; ElderShield is for geriatric care. |
| Japan (UHC) | Primary healthcare, hospital charges, mental healthcare, pharmaceuticals, home care, hospice care, physiotherapy, dental care, preventive measures including cancer screening (delivered by municipality) | Little or no cost sharing for the elderly, poor, people with disabilities, mental illness, and chronic illness; Compulsory National Long-Term Insurance (LTCI) of the municipalities covers those over 65 years and the disabled. |
| India (no UHC) | Primary and Specialist (secondary & tertiary) care including hospitalisation, transportation charges, in-patient and out-patient care and drugs, pharmaceuticals, medical devices and implants except a negative list, follow-up care. | All benefits available only to those families identified as the bottom 40% of the population in the SECC- 2013. Some of the rest of the population is covered under VHIS or CGHS/ ESIS whose benefits are not as wide-ranging and not cashless. |

*Table 8: Depiction of how various countries provide benefits for various groups*

## Government Role

Access to healthcare is a spatial problem to many low income and vulnerable citizens; the costs of commuting to seek healthcare deter many individuals from visiting facilities, even when cashless treatment is assured. Hence it is worth examining if the government also covers the necessary costs of transportation of the patient.

| Country | Costs of Commuting Covered |
|---|---|
| England | Yes; for low-income groups |
| Switzerland | No |
| Israel | No |
| Singapore | No |
| Japan | No |
| India | Yes; for low-income groups |

*Table 9: Do countries cover transport costs for patients?*

### Enrolling People and Managing Patient Data

Most health programmes in the world are moving towards instituting systems that digitize and store the data in an electronic format, with provisions to access the data as required. Depending on the country, patients and healthcare providers can access the data to varying degrees, for the purpose of consults. Almost all countries assign a number to the patients to trace back the records.

| Country | Unique Identifier Artefact | Dedicated Health Data Management System | Usage of Existing Database for enrolment |
|---|---|---|---|
| England | NHS Number | NHS Choice with option for inter-operability | Lawful citizens are automatic members |
| Switzerland | SHI card | e-Health Suisse & a developing cancer registry | No interoperability between databases |
| Israel | Patient ID | Electronic Health Records | Information exchange system underway |
| Singapore | No dedicated health artefact | Integrated with other personal information of citizens | Master Index compiled from variety of databases |
| Japan | In development | In development | Social Security and Tax Number System |
| India | AB Health Insurance Card | Health Management Information System | RSBY, Ration Card database |

*Table 10: Data Management and Enrolment Methods in Countries*

## Conclusion

It is commendable that the central government is moving towards achieving Universal Healthcare for all Indians. However as previously stated, this is a rather ambitious target given the current status of infrastructure and OOP expenditure in the country. That said, a revamp in healthcare financing and comprehensive UHC is essential for improving curative health outcomes in the country. Some private facilities have joined hands with government insurance schemes to provide quality care. As UHC cannot be achieved in a single masterstroke, it can be approached in a phased manner in the following ways:

i. The emphasis should be placed on **strengthening healthcare institutions and according greater autonomy in their functioning**. Successful models like the NHS- England show how well-managed hospitals greatly improve the experience of seeking medical care[11].

ii. **Effective collaboration with the private sector needs to be forged in providing both insurance cover and medical treatment** as in Singapore and Israel. A complete disinvestment of the government from the healthcare sector will be ill-suited to the needs of a low-income country like India. Pre-identified, subsidised, packages (DRGs) can assure standardised rates across state lines and encourage hospitals to adopt efficient management practices. This will also be a move towards reducing the OOP expenditure in the country.

[11] Gerard La Forgia and Somil Nagpal, "Government Sponsored Health Insurance in India", The World Bank, 2012
http://documents.worldbank.org/curated/en/644241468042840697/pdf/722380PUB0EPI008029020120Box367926B.pdf

iii. **Competition among providers and product diversification are necessary**. A regulated marketplace, such as the telecom sector in India, illustrates how innovative products and pricing models can attract more consumers[12]. This not only inculcates a habit of saving for future healthcare expenses among the citizens, but also encourages the insurance companies- both private and public- to increase the services included under their products.

iv. **Expansion of frontline health workforce is needed to educate the masses about the benefits of being insured**. There is a painful lack of knowledge in the population regarding the necessity of health insurance given high costs of diagnosis and treatment in India. The coverage of health insurance for even the formally employed segment is very low, making some personal VHIS inevitable. Trained health workers need to take this message to increase awareness in this regard[13].

v. **Legislations need to be passed which make health insurance mandatory, and prohibit profit-seeking operations of hospitals**. This has proved tremendously successful in Japan, a country with great population density and a high degree of private sector participation in the healthcare scenario. This a necessary step towards achieving UHC[14], and defining a vast array of medical procedures under the ambit of mandatory healthcare can also provide avenues for hospitals to charge for services outside those prescribed, like in Israel and the UK.

[12] https://www.cppr.in/article/health-insurance-and-telecom-markets-a-comparative-study/ Accessed on 08/11/2018

[13] http://cprindia.org/news/7239 Accessed on 08/11/2018

[14] India Healthcare: Inspiring Possibilities, Challenging Journey, McKinsey & Co for Confederation of Indian Industry, December 2012 https://www.mckinsey.com/~/media/McKinsey/Featured%20Insights/India/India%20Healthcare%20Inspiring%20possibilities%20challenging%20journey/India%20Healthcare_Inspiring%20Possibilities_Challenging%20Journey.ashx Accessed on 08/11/2018

## Appendix

An important component of the implementation of the Ayushman Bharat- PMJAY scheme lies with the frontline health workers envisaged for the last mile delivery of the programme. **Pradhan Mantri Arogya Mitras** (PMAMs), as they are known, are the first point of contact for beneficiaries. They are trained to operate the Beneficiary Identification System to identify and verify beneficiaries under the PMJAY. They are also required to undertake transaction management processes like submitting requests for pre-authorisation and claims, and guide beneficiaries about the overall advantages of PMJAY. As of 22nd September, **3519** such individuals have already been trained across 20 states[15].

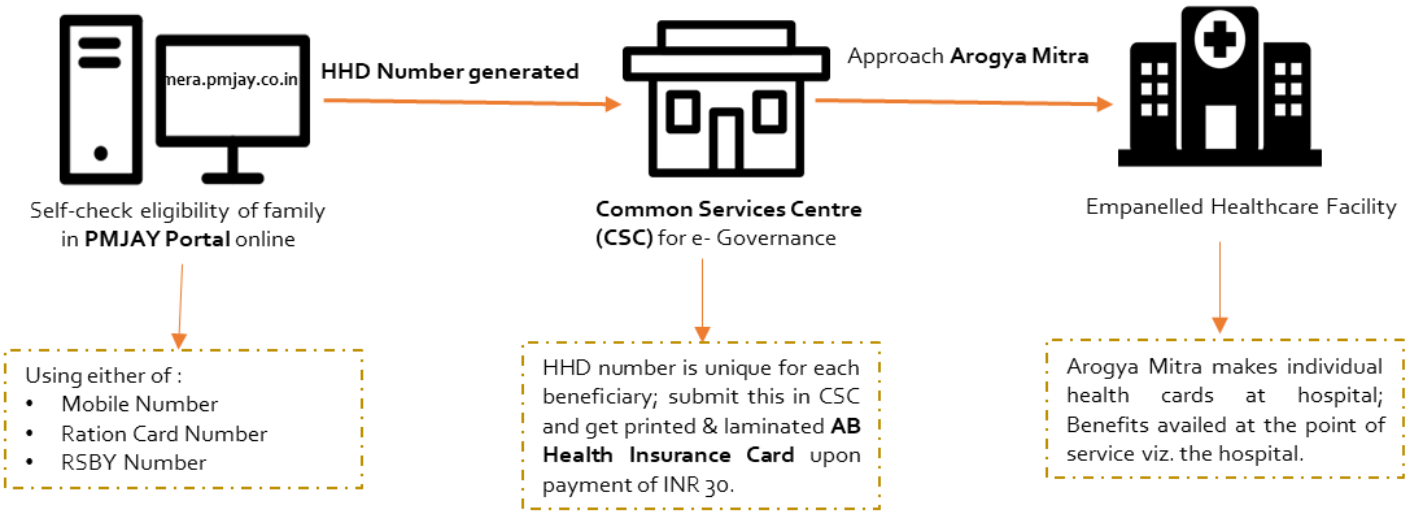


*Figure i: Steps to Obtain Ayushman Bharat Health Insurance Card*



[15] http://pib.nic.in/newsite/PrintRelease.aspx?relid=183624