

# Disappearing Dichotomies: New-generation government-sponsored health insurance schemes for the poor and vulnerable groups in India



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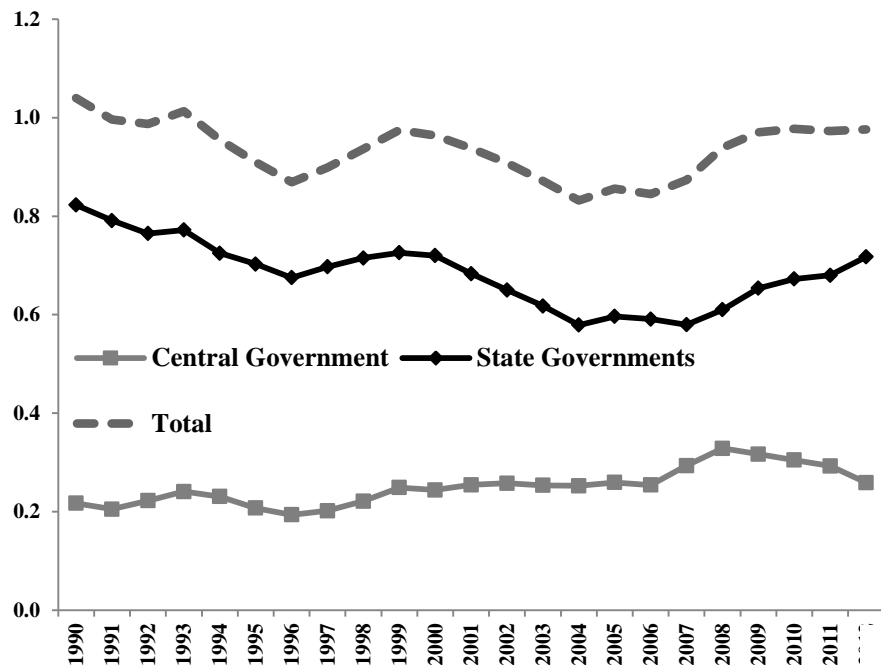
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# India's Health Financing Context

- India spent 4.1 percent of GDP (or US\$40 per capita) on health in 2008-09
- Over 17 percent of the world's population manages with less than 1 percent of the world's total health expenditure
- Out-of-pocket payments represent over 60 percent of the total health expenditure- common cause for impoverishment
- Even for India's income and health expenditure level, performance on health outcomes is below par- plus large disparities across states and social groups
- However, there are policy announcements to significantly increase public health spending in the near future



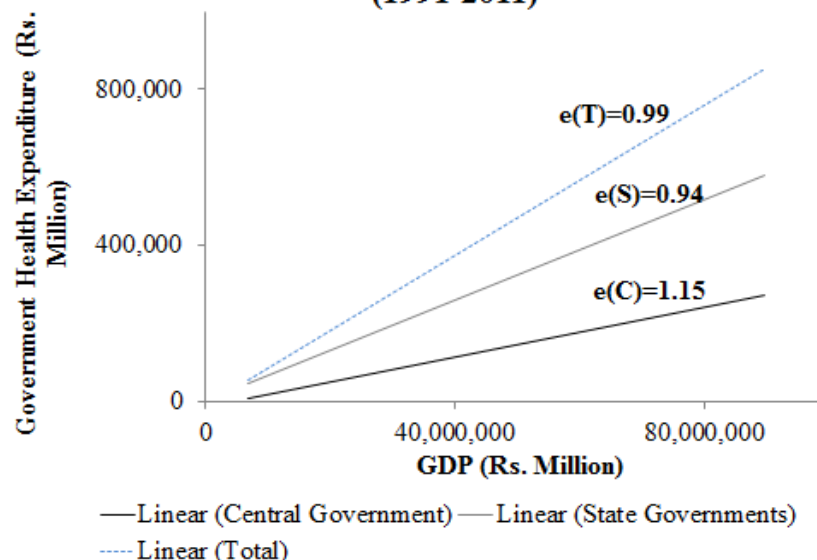
Public health spending, per cent of GDP



Public spending on health is hovering at about 1 percent - significantly below India's global income comparators

The share of total health spending has not kept pace with the country's dynamic economic growth and its income comparators (elasticity of 0.99, while comparators are at 1.15)

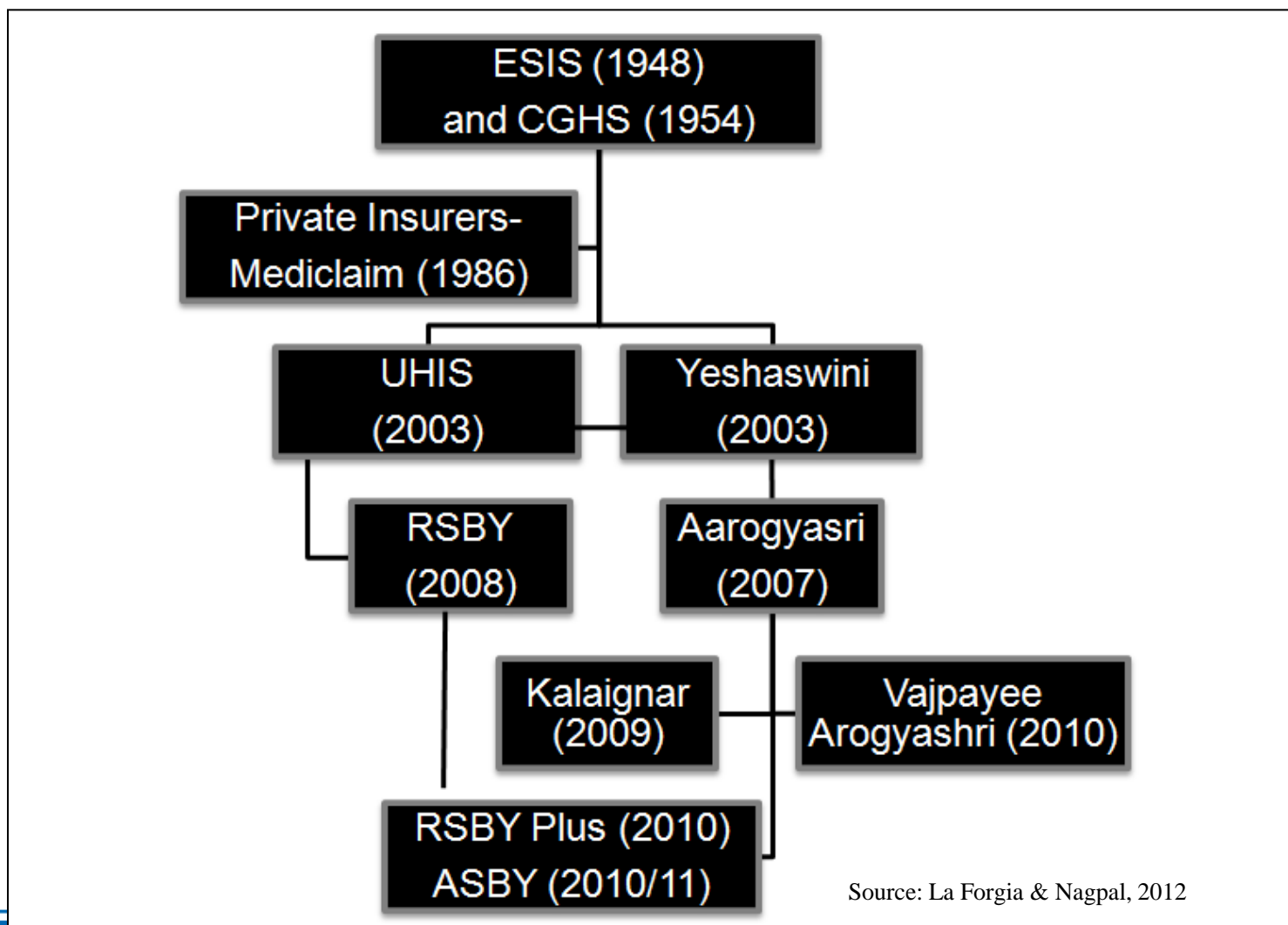
Income Elasticity of Health Expenditures (1991-2011)



# Contextual Factors/Building Blocks

- Introduction of limited financial autonomy in public hospitals: can retain and use funds at facility level
- Case-based package rates for inpatient care introduced by some early public HI schemes (CGHS, Yeshasvini)
- Rapidly growing, highly competitive private insurance industry:
  - Experience with “cashless” health insurance
  - Professional manpower, claim processing capacity
  - Primed private hospitals to join networks and receive third party payment
- Strong IT industry, relatively low-cost technical manpower

# A Genealogy of public health insurance programs in India



# Engaging with the private sector

- Contracting insurance intermediaries and private health providers
  - Transparent mechanism- competitive bidding by intermediaries for risk and/or administration
  - Enabled purchase from private healthcare providers at an unprecedented scale
- Spin-off effects
  - Allowed beneficiaries a broader choice - created some competition
  - For public hospitals, initiation of a broader health sector impact, results based payments
  - Explicit entitlements
  - A new and more binding compact between government and citizens
  - Though these programs are limited in their scope, the benefits and access are clearly defined.

The purchaser-provider split shifts provider payments from inputs to outputs and creates an enabling environment for increased accountability for results.

# IEC and Enrolment- illustrations from RSBY



Pre-enrolment IEC activities



Enrolment station, Gomati dist.

Enrolment stations in communities, using smart card intermediaries engaged by private insurers



Images courtesy RSBY Connect at [www.rsby.gov.in](http://www.rsby.gov.in)

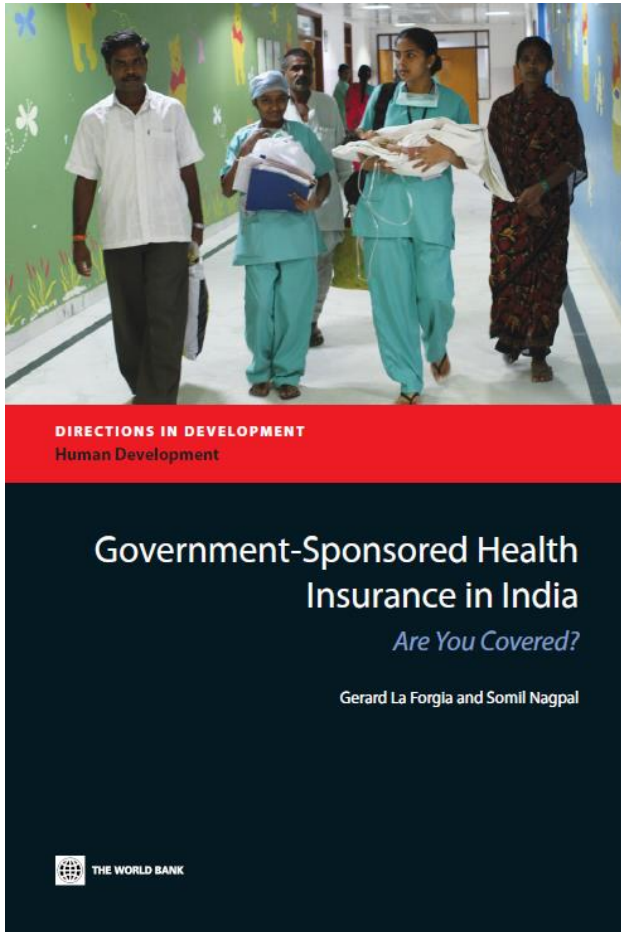
# Major challenges facing the GSHISs

- Limited Benefit Package with Inpatient/Surgical Focus that needs to be expanded-- has financial and operational implications
- Inadequacy of institutional architecture to conduct major governance functions -- most programs work with very limited institutional and human resource capacity
- No systematic attempt to cost services or collect market prices to improve case payments/ package rates – may not get the 'signals' to providers right
- Insufficient information for consumers on enrollment processes, benefits, providers and their quality etc.
- Monitoring and data analytics still in their infancy



# Thank you!

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