Chapter 2

Health Financing and Financial Protection

1. Introduction

India and other countries with relatively low per capita incomes can aspire to provide Universal Health Coverage (UHC) to their populations provided health financing arrangements are properly organized and managed. If not, healthcare costs can rise rapidly and make it very difficult to sustain UHC. It could even end up further exacerbating existing inequalities in access to healthcare.

Reforms of India's health financing and financial protection systems are critical for establishing UHC. In thinking of a new architecture, however, it is important to keep in mind that:

a) rising incomes and improved standards of living have been accompanied world over by increasing healthcare needs;

b) while advances in technology and medicine have improved health and enhanced life expectancy, costs of medical care have escalated sharply. Consequently, even in a high income country like the United States, cost escalations have put even basic healthcare out of the reach of several segments of the population, especially where carefully thought through financing arrangements have not been put in place; and

c) there doesn't appear to be a 'successful model' and universal method of financing and financial protection that assures guaranteed UHC in any country. Most nations are still trying to evolve a workable solution to financing and organising UHC.[1] There are, however, certain common features of countries that have done well with respect to ensuring UHC. These include: (i) a predominant role for public financing; (ii) related to this, coverage is compulsory (where linked to contribution) or automatic (where based on certain characteristics such as residence or citizenship); and (iii) universal entitlement without exclusion. In other words, UHC requires both (a) compulsion (no opting out) and (b) subsidization (enabling coverage for those too poor or too sick to pay for their own coverage). Finally, it is desirable to have large and diverse risk pools (that minimize fragmentation, and promote equity by not having, for example, separate pools for the poor) in order to provide UHC at a lower cost than would be the case if a country were to achieve it with lots of small, fragmented pools.

What we are proposing for India is somewhat unique - a hybrid that draws on the best lessons from other countries - both developed and developing.

While drawing on lessons from other developing countries, we should not forget that India's per capita income (around Purchasing Power Parity Dollars [PPP$] 3,250 in 2009) remains relatively low compared to that of China (PPP$6,890), Thailand (PPP$7,640), South Africa (PPP$10,050), Brazil (PPP$10,200) and Mexico (PPP$14,100) - countries that report better health outcomes than India. In other words, India cannot quickly match China, Thailand or Brazil in terms of per capita overall or public spending on health not only because of lower incomes and the consequently lower capacity to mobilize financial resources, but also because of the limitations of the health system to absorb additional financial resources effectively and efficiently without bringing about significant reforms of the health system.[2]

Moreover, we should be conscious that India's low levels of income and human development impose

several limitations. The problem is particularly severe at a time when the country has adopted a roadmap for fiscal consolidation to ensure overall macro-economic stability based on the recommendations of the 13th Finance Commission. In other words, we need to recognize the budgetary constraints, be realistic, and plan judiciously so that essential healthcare is made available to all Indians.

We present a brief analysis of the current state of health financing in Section 2 and list our recommendations in Section 3.

2. A review of health financing in India

Deficiencies in India's health financing system, to a considerable extent, are a cause of and an aggravating factor in the challenges of health inequity and impoverishment, inadequate availability, poor reach, unequal access, poor quality and costly healthcare services. Several well-known deficiencies characterise India's system of health financing and financial protection.

One, it would appear at first glance that India spends an adequate amount on healthcare. In 2009, India's total health expenditure as a percentage of the GDP was 4.2% - comparable to that of Sri Lanka (4%), Thailand (4.3%) and China (4.6%). The picture, however, changes dramatically when we examine levels of per capita health expenditures. At PPP$132 per capita, India's health expenditure is far less than that of Sri Lanka (PPP$193), China (PPP$309), and around a third of that of Thailand (PPP$345).[3]

Two, India's public spending on health as a proportion of the GDP - estimated at around 1.2% of the GDP in 2009 - is among the lowest in the world. The corresponding percentage is 1.8 in Sri Lanka, 2.3 in China and 3.3 in Thailand. The extremely low levels of public spending become even more evident when we examine per capita public spending on health. In 2009, the per capita government spending on health in India (PPP$43) was significantly lower than in Sri Lanka (PPP$87), China (PPP$155) and Thailand (PPP$261).[a]

The proportion of public spending on health by India is significantly low, not because India is poorer than these other countries, but principally due to the very low per cent of public spending that Indian governments devote to health – typically in a range of 3-4 % - is amongst the lowest of any country in the world. This reflects the very low priority that, historically, governments in India have accorded to the health sector.

Table 1 reveals that in 2009, total public spending in India was substantially higher as a share of GDP than in the other countries (33.6% as compared to about 22-24% in the others). So the government(s) of India had much greater capacity to spend, relative to GDP, than the other countries. But government spending on health as a share of GDP was much lower in India than these other countries. This was due to the dramatically lower allocation priority that Indian governments devoted to health.

[a] All data relating to 2009 are from World Health Organization database.

TABLE 1. LOW PRIORITY IN PUBLIC SPENDING ON HEALTH - INDIA AND COMPARATOR COUNTRIES, 2009			
	Total public spending as % GDP (fiscal capacity)	**Public spending on health as % of total public spending**	**Public spending on health as % of GDP**
India	33.6	4.1	1.4
Sri Lanka	24.5	7.3	1.8
China	22.3	10.3	2.3
Thailand	23.3	14.0	3.3

Source: WHO database, 2009[2]

Table 2 demonstrates what public spending on health as a % of GDP would have been with India's fiscal constraint held constant, but with each of the other country's allocation priorities. This demonstrates that public spending on health as a % of GDP is low in India because the state and central governments have chosen so, not because of fiscal constraints.

TABLE 2. PUBLIC SPENDING ON HEALTH - ACTUAL AND WITH COMPARATOR COUNTRIES' PRIORITIES			
	Total public spending as % GDP, India 2009	**Public spending on health as % of total public spending**	**What public spending on health as % of GDP would have been, given India's fiscal capacity but the other countries' public resource allocation priorities**
India	33.6	4.1	1.4
Sri Lanka's priority	33.6	7.3	2.5
China's priority	33.6	10.3	3.5
Thailand's priority	33.6	14.0	4.7

Source: WHO database, 2009[2]

Three, a consequence of the low public spending on health is the extremely high burden of private out-of-pocket expenditures. In 2009, private expenditure in India accounted for 67% of the total expenditure on health - comparatively higher than in Thailand (24%), China (50%) and Sri Lanka (56%).[2]

Two key features of private out-of-pocket spending are important to note:

- Out-patient treatment, and not hospital care, accounts for 74% of private out-of-pocket expenditures.[4]

- Medicines account for 72% of the total private out-of-pocket expenditure.[4] Largely contributing to the sharp increase in the costs of medical care has been the steep rise in the prices of drugs, which more than tripled between 1993-94 and 2006-07.

Four, there are wide variations in public health expenditure across states. In 2008-09, for instance, public expenditure on health was Rs. 498 in Kerala and Rs. 411 in Tamil Nadu as against Rs. 229 in Madhya Pradesh and Rs. 163 in Bihar. These differences in public spending explain, to a large extent, the differentials in the reach and capacity of the health infrastructure as well as in health outputs and outcomes across the states.

Five, state governments, primarily responsible for the funding and delivery of health services, bear close to two-thirds (64%) of the total government health expenditure. The Centre accounts for the remaining third. Though the Centre's financial contribution is relatively small, its influence is substantial. For instance, the mechanisms used via both the National Rural Health Mission and the Rashtriya Swasthya Bima Yojana (RSBY) strongly motivate increased contributions to health from State governments.

Six, states with low public expenditure on health typically find themselves fiscally constrained by two factors. The Centre's distribution of revenues across the states does not offset the fiscal disabilities of the poorer states. Further, there is less fiscal space for development spending in the poorer states, which incur a large share of obligatory expenditures (that include salaries, wages, pensions and interest payments).

Seven, many state governments do not accord high priority to health. Analyses of public expenditures show that: (i) levels of financial allocations by state governments to health are extremely low; and (ii) with the exception of Gujarat and Uttar Pradesh - and to a limited extent Bihar, the proportion of government development expenditures allocated to health in all other Indian states declined between 2001-02 and 2007-08.

Eight, financial protection against medical expenditures is far from universal. Expenditure on social insurance accounted for 1.13% of total health spending in 2004-05. According to the National Family Health Survey 2005-06, only 10% of households in India had at least one member covered by medical insurance.[4] India's medical insurance sector remains weak and fragmented even though there is a plethora of medical insurance schemes operated by the Central and state governments, public and private insurance companies and several community-based organisations. The benefits of traditional insurance coverage through Employees' State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) accrue only to a privileged few and mostly to those working in the organised sector. Despite the rapid expansion following the launch of Rashtriya Swasthya Bima Yojana (RSBY) and ot her state-sponsored insurance schemes over the past few years, coverage remains low with financial protection available only for hospitalization, and not for out-patient care.

3. Recommendations

As stated earlier, we envisage a Universal Health Coverage system that entitles every citizen guaranteed access to an essential National Health Package of primary, secondary and tertiary healthcare services (covering both in-patient and out-patient care that is available free-of-cost) provided by public sector facilities as well as contracted-in private providers.

For such a UHC system, we have identified three principal objectives of the reforms in health financing and financial protection:

- ensure an adequacy of financial resources for the provision of universal access to essential healthcare;
- provide financial protection and health security against impoverishment to the entire population of the country; and
- put in place financing mechanisms that are consistent in the long-run with both the improved wellbeing of the population as well as containment of healthcare cost inflation.

We believe that even within the financial resources available to India, it is indeed possible to devise an effective architecture of health financing and financial protection that can offer UHC to each and every Indian. Our key recommendations follow.

Recommendation 1: Government (Central government and states combined) should increase public expenditures on health from the current level of 1.2% of GDP to at least 2.5% by the end of the 12th plan, and to at least 3% of GDP by 2022.

Investing in health has both an intrinsic importance and an instrumental significance. Unless a person is healthy, he or she cannot enjoy the many opportunities and good things of life. At the same time, poor health conditions such as malnutrition and iron-deficiency anaemia directly impact labour productivity in the short-run.[b] In the longer-run, inter-generational issues such as low-birth weight have been associated with a number of poor health conditions that are particularly characteristic of the Indian population.[c] Also, India needs to prioritize and invest in health, especially if it wants to capitalize on the potential contribution of its large proportion (close to 40%)[4] of its children and youth.

Enhancing public expenditures on health is likely to have a direct impact on poverty reduction, if this increase leads to a reduction in private out-of-pocket expenditures. Financial metrics show that there is a significant imbalance in private spending versus public spending and in fact private spending is almost three times the amount of public spending. Our proposed increase in spending on health will greatly alter the proportion of public and private spending on health and, hopefully, correct the imbalance that exists.

Whereas the total per capita healthcare expenditure incurred by India is reasonable (around 4.5% of GDP), it ranks very low in the proportion that is financed through public expenditure. This imbalance needs to be corrected urgently. Financing the proposed UHC system will require public expenditures on health to be stepped up from around 1.2% of GDP today to at least 2.5% by 2017 and to 3% of GDP by 2022.

Increasing public spending on health, in our view, is essential for a number of reasons:

a) Healthcare provision has a large number of public and merit good characteristics that justifies the use of public resources to finance it.

b) The financing for the provisioning of the proposed NHP (that offers essential services only) requires the level of public expenditures to increase to 2.5-3% of GDP.

c) Prepayment and pooling provide a number of financial protection benefits. International experience has shown that this is best done through increased government expenditure rather than through the use of voluntary insurance arrangements.[7] Prepayment from compulsory sources (i.e. some form of taxation), and the pooling of these revenues for the purpose of purchasing healthcare services on behalf of the entire population is the cornerstone of the proposed UHC programme. Such an arrangement will provide a number of financial protection benefits. Both international experience and important concepts[d] in health economics demonstrate that voluntary mechanisms of paying for healthcare cannot be a basis for a universal system. This makes it critical for the government to directly expend resources and invest specifically in the provision

[b] Results of Weinberger (2004)[5], for instance, indicate that "productivity, measured in wages, is indeed affected by insufficient iron intake, and that wages would on average be 5 to 17.3% higher if households achieved recommended intake levels. The results demonstrate that enhancing micronutrient intake will contribute significantly to overall economic growth and development."

[c] According to Boo and Harding (2006),[6] for instance: "Many studies have provided evidence for the hypothesis that size at birth is related to the risk of developing disease in later life. In particular, links are well established between reduced birth-weight and increased risk of coronary heart disease, diabetes, hypertension and stroke in adulthood. These relationships are modified by patterns of postnatal growth. The most widely accepted mechanisms thought to underlie these relationships are those of fetal programming by nutritional stimuli or excess fetal glucocorticoid exposure. It is suggested that the fetus makes physiological adaptations in response to changes in its environment to prepare itself for postnatal life. These changes may include epigenetic modification of gene expression."

of primary healthcare and on a carefully designed healthcare system - and not merely include access to healthcare as a part of overall cash- transfer programmes.

d) Prepaid funding that is pooled on behalf of a large population is essential for ensuring that the system is able to redistribute resources and thus services to those in greatest need, given that the risk of incurring high health expenditures is often quite unpredictable at the start of any budgetary period. And as noted above, in both theory and evidence – no country that can be said to have attained universal coverage relies predominantly on voluntary funding sources – demonstrates that both compulsion (to avoid "opting out" as a result of the adverse selection phenomenon) and subsidization (to ensure that those too poor or too sick to contribute) are essential for universal coverage.

Hence, increased government expenditure on health is essential to ensure a leading role for compulsory pooling as the means to progress towards universal coverage.

Spent wisely, enhancing public expenditures on health is likely to have a direct impact on poverty reduction as it should reduce the extremely high current burden of private out-of-pocket expenditures. Out-of-pocket healthcare expenditure incurred by citizens at the point of care is an important source of financial catastrophe not merely for low-income households but also for those with higher incomes as well. Table 3 shows the indicative changes in the levels and shares of public and private expenditures that are likely to follow from the recommended increase in public spending on health.

TABLE 3. PROJECTED LEVELS AND SHARE OF PUBLIC AND PRIVATE HEALTH EXPENDITURES: 2011-2022

	2011-12	2016-17	2021-22
Total Health Expenditure as % of GDP*	4.5	4.5	4.5
Total public expenditure on health as % of GDP	1.2	2.5	3.0
Total private expenditure on health as % of GDP	3.3	2.1	1.5
Composition of Total Health Expenditure			
Private spending as % of total health expenditure	67	47	33
Public spending as % of total health expenditure	33	53	67
Per Capita Total Health Expenditure (Rs. 2009-10 prices)@	2,500	3,725	5,175
Per capita public spending	675	1,975	3,450
Per capita private spending	1,825	1,750	1,725

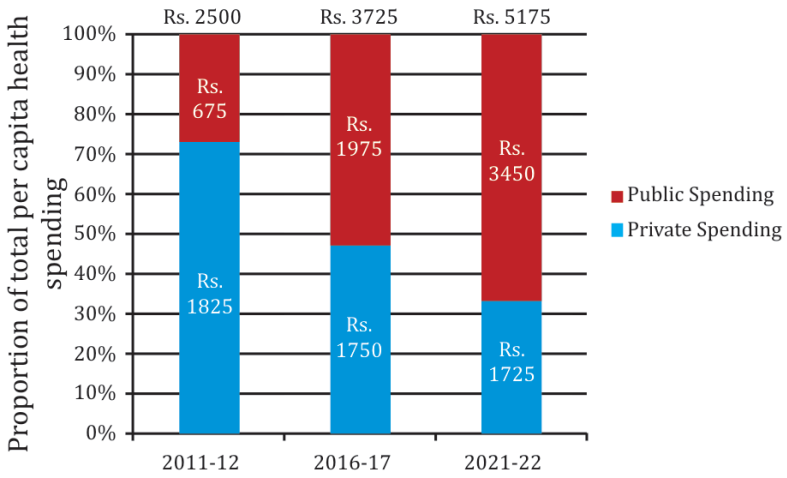
** Assuming that the total health expenditure in India (public and private together) will remain at 4.5% of GDP*

@ Assuming a real growth rate of GDP of 8% and projected population figures provided by the Registrar General of India.

[d] The phenomenon known as adverse selection is a particular type of market failure common to health insurance. Effective risk protection requires that the prepaid pool includes a diverse mix of health risks. Left to purely individual choice, however, healthier individuals will tend not to prepay, while sicker individuals will join (assuming that they can afford it). This leaves the prepaid pool with a much costlier population than the average in the population, and as a result is not financially stable.

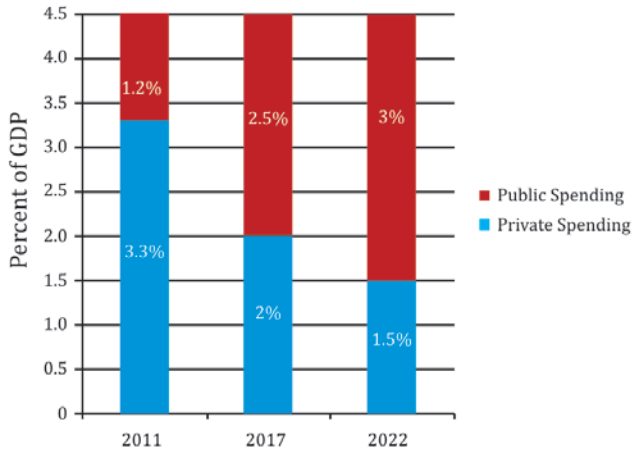
Even if we assume that the combined public and private spending on health remains at the current level of around 4.5% of GDP, this will result in a five-fold increase in real per capita health expenditures by the government (from around Rs. 650-700 in 2011-12 to Rs. 3,400-3,500 by 2021-22). There will also be a corresponding decline in real private out-of-pocket expenditures from around Rs. 1,800-1,850 in 2011-12 to Rs. 1,700-1,750 by 2021-22 (Figure 1).

FIGURE 1: PROJECTED REAL PER CAPITA HEALTH SPENDING IN INDIA AT CURRENT PRICES (2009-2010)



Such a planned expansion in public spending on health, if spent judiciously, could change significantly the patterns of public and private spending on health in India (Figure 2).

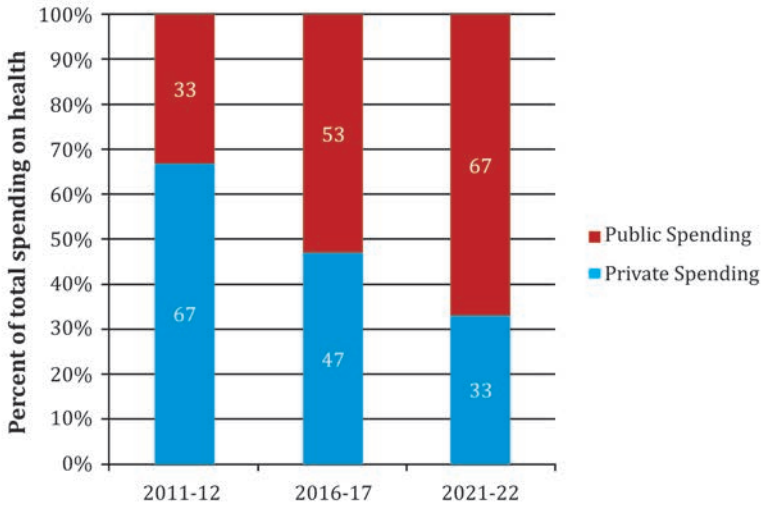
FIGURE 2: PROJECTED SHARE OF PUBLIC AND PRIVATE SPENDING IN INDIA



Note: Values in bars represent proportion of GDP assuming total health spending will stay at 4.5% of GDP.

Increased public expenditures, in our estimate, could potentially lead to a sharp decline in the proportion of private out-of-pocket spending on health - from an estimated 67% in 2011-12 to around 33% by 2022 (Figure 3) if the increased public spending is implemented in a way that substitutes for much of current private spending.

FIGURE 3: PROJECTED PROPORTIONS OF PUBLIC AND PRIVATE OUT-OF POCKET EXPENDITURES



The resulting impact of increased public spending on human poverty - in terms of transforming quality, improving access to healthcare and reducing sharply the burden of private out-of-pocket expenditures - is likely to be sizeable and significant.

Recommendation 2: Ensure availability of free essential medicines by increasing public spending on drug procurement.

Availability of most essential drugs in India is not a serious concern. India is also a global leader in the production and supply of generic medicines at affordable prices. However, low public spending on drugs and the consequent non-availability of free medicines in government healthcare facilities are major factors discouraging people from accessing public sector health facilities. Addressing this deficiency by ensuring adequate supplies of free essential drugs is vital to the success of the proposed UHC system. We estimate that an increase in the public procurement of medicines from around 0.1% to 0.5% of GDP would ensure universal access to essential drugs, substantially reduce the burden of private out-of-pocket expenditures and provide much-needed financial risk protection for households. Increased spending on drugs needs to be combined with a pooled public procurement system to ensure adequate supplies and rational prescription of quality generic drugs by the public health system. Distribution and availability of quality medicines across the country could be ensured by contracting-in of private chemists.

Recommendation 3: Use general taxation as the principal source of healthcare financing – complemented by additional mandatory deductions for healthcare from salaried individuals and tax payers, either as a proportion of taxable income or as a proportion of salary.

For a lower & middle-income country like India, with millions of self-employed and under-employed people working predominantly in the unorganised sector, general taxation is the most viable option for mobilizing resources to achieve the target of increasing public spending on health and creating mechanisms for financial protection for all. The conditions necessary for other methods of financing, such as payroll or social security contributions to generate sufficient revenues on their own (large formal sector employment, significant payroll or social security contribution and strong tax collections) are not present in India, and will be slow to emerge over the coming decade. Given the significant social benefits from healthcare, it would be appropriate to finance it through general taxation.

Special efforts should be made to increase revenues through tax administration reform and, in particular, improved information system for taxes at both Central and state levels. The tax ratio in India, at a little over 15 % of GDP, is lower than the average for countries with less than USD 1000 (18%) and substantially lower than the average for middle income countries (22% for countries with per capita income between USD 1000 and USD 15000). The enactment of a Direct Taxes Code (DTC) and the introduction of Goods and Services Tax (GST) could improve the revenue productivity of the tax system. Another important area for improving the tax productivity is to review all tax incentives and undertake measures to reduce arrears in taxes.

While improving the tax-to-GDP ratio is necessary, it is equally important to increase the share of overall public spending devoted to health. As noted, India devotes among the lowest proportion of total public spending to health – at or below 4.4% of total government spending between 1999 and 2009 according to WHO data, and in 2009. Only 9 countries (out of 191) devoted a smaller share of government spending to health than did India.

Moreover, looking into the future, given that (i) both the organised sector base and the tax-payer base are likely to grow; (ii) the efficiency of tax collections is improving; and (iii) the goal is to offer cashless healthcare to all sections of the society, it would be appropriate to complement general taxation with a specific surcharge on salaries or taxable income to pay for UHC. This will also obviate the need to levy user charges on the 'rich' at the point-of-care since they would have contributed to it through a pay roll or taxable income surcharge.[6]

This combines equity considerations with a feasible way of increasing the size of the prepaid pool, so that the final revenue mix would contain discretionary transfers from general budget revenues and also possibly earmarked funds for UHC coming from the payroll tax or surcharge.

Recommendation 4: Do not levy sector-specific taxes for financing.

Revenues from specific sources could be potentially earmarked to finance healthcare. These include, for instance, sector-specific taxes such as a yearly charge of 0.05% on the banks' balance sheets as in United Kingdom, a mineral resources rent tax as in Australia, a special VAT levy in Ghana, tobacco and alcohol taxes, or heavy taxes on petroleum products.

However, in our view, these options may not be appropriate for India for the following reasons:

a) None of these options is likely to meet substantially the financial requirements of Universal Health Coverage.

b) The practice of earmarking financial resources distorts the overall fiscal prioritisation.

c) Given that most public revenues are fungible, earmarking from a specific tax may not actually add to the health budget if the increased funds from the earmark are offset by reductions from discretionary revenues.

d) Though earmarking is not desirable, higher taxes on tobacco and alcohol have the public health benefit of reducing consumption of these harmful products, while adding to the general revenue pool. However, dependence upon revenue mobilisation from such sin and sumptuary taxes is fraught with perverse incentives. Securing more resources for health sector would, for instance, require increased consumption of alcohol and tobacco products both of which are undesirable.

We, therefore, recommend that additional resources for increasing public investments in health (and other social services) should be generated by enhancing the overall tax-to-GDP ratio by widening the tax base, improving the efficiency of tax collections, doing away with unnecessary tax incentives, and exploring possibilities of reallocating funds to health.

Recommendation 5: Do not levy fees of any kind for use of healthcare services under the UHC.[f]

We recommend that user fees of all forms be dropped as a source of government revenue for health.[g] This view is strongly endorsed by Jeffrey Sachs and others, including the authors of the Report of the Millennium Development Goals project who contend that ending user fees for basic healthcare in developing countries can guarantee a 'quick win'.[9] Recent global experience points to several drawbacks of user fees:

a) Imposition of user fees in many low and middle income countries has increased inequalities in access to healthcare.[10]

b) Modest levels of fees have led to sharply negative impacts on the usage of health services even from those that need them. For example, a full course of antibiotics may not be taken in order to save money, leading to avoidable illnesses and long-term drug resistance build-up.[11] User fees also deter consumption of medical care, without necessarily distinguishing between excessive and unnecessary medical care.

c) User fees have not proven to be an effective source of resource mobilization. The administrative costs of collecting user fees tend to be high relative to the revenues generated, especially when a significant share of users receive exemption due to poverty.[12]

d) There are practical challenges of means-testing and errors of inclusion and exclusion associated with identifying the economically weaker sections of society.

e) Given that people in India already pay a substantial amount out-of-pocket, whether to private providers or in the form of informal payments in public facilities, a differential fees model which charges different fees to people in different economic levels in a society was considered as an approach for leveraging user fees as a financing mechanism and improving the fairness and transparency by which people contribute. However, it would be very difficult to provide equitable services to all economic sections of the society through a differential fee arrangement

f) Limiting corruption and administrative costs associated with receiving payments at the point of care, makes it difficult to implement a program based on differential fees. That money may be charged from some people opens the room for rent-seeking (illegal under-the-table payments) at the point-of-care from the poor.

g) As a practical and political issue, increasing official user fees, when they are so low and yet impose

[e] Indian incomes are so low and so skewed that a large proportion of the population finds even routine healthcare expenditure "catastrophic" (defined by the WHO as more than 40% of net disposable income after meeting other essential needs).[7,8] It is not so much the absolute availability of financial resources itself, but the need to find money at the point-of-care that most often has catastrophic consequences.

[f] **One of the HLEG members differed with this recommendation, because he was of the considered view that persons who can afford to pay should be charged for tertiary care services.**

[g] This would include charges under the Rogi Kalyan Samiti scheme, voluntary donations directly made to hospitals and those levied for the use of improved facilities such as room and board.

financial barriers to access, would be politically and practically difficult to justify. The benefits of such an effort are unlikely to be worth the (financial, administrative and political) costs.

h) User fees can sometimes be employed as a means of limiting excessive consumption of unnecessary healthcare but there are other approaches such as effective triaging, providing preventive care etc. that are more effective in controlling this issue.

i) The implication of mandatory deductions to pay for healthcare from tax payers and salaried employees, over and above the general income taxes (which would be pooled along with the other tax resources) is that the non-poor will end up paying for these services in any case but will be insulated from the need to pay at the point-of-care.

j) Out-of-pocket payment at the point of care is the most important reason why healthcare expenses turn catastrophic for all healthcare users.[7, 8] As a result, user fees that tend to have an out-of-pocket character are not desirable even from even those that can afford to pay them.

Therefore overall, user fees would not be desirable for the proposed vision of the UHC programme.

Recommendation 6: Introduce specific purpose transfers to equalize the levels of per capita public spending on health across different states as a way to offset the general impediments to resource mobilization faced by many states and to ensure that all citizens have an entitlement to the same level of essential healthcare.

Improvements in health status depend critically upon augmenting public spending on health generally, and substantially in low income states. This is because analyses of public health expenditures and health outcomes reveal that:

a) health indicators are poor in low per capita income states implying that health expenditure needs in low income states are much larger than in states with higher per capita incomes; and

b) actual expenditures on healthcare in low income states are substantially lower than in high income states.

It has been the practice by the Central government to augment the financial resources of state governments through the modality of the National Rural Health Mission and RSBY. The fundamental rationales for the central transfers are to (i) ensure that all states devote sufficient resources to ensure the NHP for their entire population; and (ii) reduce inequalities in access and financial protection arising from the fact that poorer states have lower levels of government health spending than do richer states.

There is a strong case for augmenting specific purpose transfers from the Centre to states and designing an appropriate transfer scheme to reduce the disparity in the levels of public spending on health across states. The specific purpose transfer scheme by augmenting health spending should ensure that a basic package of healthcare services is available to every citizen in every state across the country. Moreover, ensuring basic healthcare services to the population, like poverty alleviation or universalising elementary education, has nation-wide externalities, and is also consistent with principles of equity. Therefore, although implementation of the provision of basic health services has to be done at sub-national (state) levels, a substantial proportion of financing of these services can and should come from the Central government. In other words, the Central government should (as in the case of Sarva Shiksha Abhiyan) provide adequate funding for provision of basic primary and secondary healthcare services. The extent of Central and state contributions should depend on the perceived degree of nation-wide externality versus state-wide externality.

It is, however, important while designing such a transfer scheme to ensure that states do not substitute Central transfers for their own contribution to health and continue to assign priority to health even as they receive Central funds. It would be necessary to ensure that states not only continue to contribute as much as they do now, but also increase these proportions

consistently over the years. In other words, the transfers received from the Central government along with the matching contribution by the states should constitute additional public spending on health - and should not be used to substitute spending from own resources by the states.

With states sharing two-thirds of the overall public spending in the country, this would be a necessary condition for reaching the target level of public spending on health of 3% of GDP across the country by 2022. If sharing of public spending by the States and the Centre continue in the ratio of 2:1, expenditure by the States and the Centre in per capita terms (in 2009-10 prices) and as a share of GDP are likely to be as follows (see Table 4):

TABLE 4. PROJECTED SHARE OF CENTRE-STATE HEALTH EXPENDITURES: 2010-2022

	2011-12	2016-17	2021-22
As % share of GDP			
Total Public expenditure on health	1.2	2.4	3.0
- Of which share of Centre (1/3)	0.4	0.7	0.9
- Of which share of States (2/3)	0.8	1.7	2.1
As % share of total public spending	4.1 (2009)	6.9-7.1	8.3-8.9
Total per Capita public expenditure on health (Rs. In 2009-10 prices)	675	1,975	3,450
- Of which share of Centre (1/3) (Rs.)	225	658	1,150
- Of which share of States (2/3) (Rs.)	450	1,317	2,300

Source: HLEG Secretariat

An equalization scheme for transfer of funds from the Centre to the states should be equitable, should ensure full utilization of the funds allocated, and should result in additional spending and not substitution of spending from states' own revenues. This is all the more important because, as noted earlier, the existing pattern of resource allocation by India's State and Central governments, collectively result in one of the lowest priorities given to health of any country in the world.

Box 1 presents an illustrative transfer scheme that is consistent with the overall level of public spending envisaged for the country and the cost-sharing ratio of 2:1 between the states and the Centre.

Box 1: An illustrative transfer scheme

1. Classify states into two categories:

   Category A:
   Non-high focus states as classified under the National Rural Health Mission (list of states in Table 3)

   Category B:
   High focus states as classified under the National Rural Health Mission (list of states in Table 3)

2. Estimate the incremental expenditures required for providing the basic entitlement package (of selected primary, secondary and tertiary healthcare services) to every citizen.

3. Preliminary estimates by the Public Health Foundation of India for 2020 suggest that the cost of providing the entitlement package (at 2008-09 prices) will be around: Rs. 1,500 per capita for general category states; and Rs. 2,000 per capita in special category states.

4. Cost sharing formula:
   Category A states:
   The Centre shall meet 60% of the incremental expenditures required for ensuring the basic entitlement package.
   Category B states:
   The Centre shall meet 90% of the incremental expenditures required for ensuring the basic entitlement package.

5. To be eligible to receive Central funding:
   - states with health expenditures, as percentage of their GSDP, less than the all-state average (separately for general category and special category states) will have to incrementally increase it to the average level;
   - states with more than average proportions should continue to maintain these proportions. Additionally, all states will have to increase their health spending by 1% of GSDP by 2020.

Table 5 shows (on the next page) the State wise distribution of funds for different states using the formula for transfers outlined in Box 1.

TABLE 5. ILLUSTRATIVE SPECIFIC TRANSFER SCHEMES ACROSS DIFFERENT CATEGORIES OF INDIAN STATES

States	Per capita public spending health 2019-20** (Rs)	Required per capita normative expenditure (Rs.)	Additional per capita expenditure required to meet normative expenditure	Share of State (%)	Share of Centre (%)	Per capita States expenditure required for meeting the gap from the norm (Rs. per capita)	Per Capita Centre expenditure required for meeting the gap from the norm (Rs. per capita)
GENERAL CATEGORY STATES (as classified under the National Rural Health Mission)							
Bihar	356	1,500	1,144	10	90	114	1,029
Uttar Pradesh	450	1,500	1,050	10	90	105	945
Madhya Pradesh	352	1,500	1,148	10	90	115	1,033
Assam	482	1,500	1,018	10	90	102	916
Jharkhand	468	1,500	1,032	10	90	103	929
Rajasthan	563	1,500	937	10	90	94	844
Odisha	590	1,500	910	10	90	91	819
Chattisgarh	656	1,500	844	10	90	84	760
West Bengal	522	1,500	978	40	60	391	587
Andhra	822	1,500	678	40	60	271	407
Karnataka	795	1,500	705	40	60	282	423
Kerala	1,061	1,500	439	40	60	176	264
Tamil Nadu	1,063	1,500	437	40	60	175	262
Punjab	953	1,500	547	40	60	219	328
Gujarat	1,104	1,500	396	40	60	158	238
Maharashtra	1,355	1,500	145	40	60	58	87
Haryana	1,226	1,500	274	40	60	110	165
SPECIAL CATEGORY STATES (as classified under the National Rural Health Mission)							
Arunachal Pradesh	3,563	2,000	0	10	90	0	0
Goa	3,148	2,000	0	40	60	0	0
Himachal Pradesh	1,845	2,000	155	10	90	15	139

Contd...

TABLE 5. ILLUSTRATIVE SPECIFIC TRANSFER SCHEMES ACROSS DIFFERENT CATEGORIES OF INDIAN STATES

States	Per capita public spending health 2019-20** (Rs)	Required per capita normative expenditure (Rs.)	Additional per capita expenditure required to meet normative expenditure	Share of State (%)	Share of Centre (%)	Per capita States expenditure required for meeting the gap from the norm (Rs. per capita)	Per Capita Centre expenditure required for meeting the gap from the norm (Rs. per capita)
J&K	1,160	2,000	840	10	90	84	756
Manipur	571	2,000	1,429	10	90	143	1,286
Meghalaya	979	2,000	1,021	10	90	102	919
Mizoram	4,500	2,000	0	10	90	0	0
Nagaland	N.A.	2,000	N.A.	10	90	N.A.	N.A.
Sikkim	3,049	2,000	0	10	90	0	0
Tripura	1,108	2,000	892	10	90	89	803
Uttarakhand	2,292	2,000	0	10	90	0	0
A & N Islands	N.A.	2,000	N.A.	40	60	N.A.	N.A.
Chandigarh	N.A.	2,000	N.A.	40	60	N.A.	N.A.
Delhi	2,855	2,000	0	40	60	0	0
Pondicherry	2,549	2,000	0	40	60	0	0

*** Assuming that until 2020, Gross State Domestic Product (GSDP) will grow at average real compound growth rate in the period 2004-05 to 2009-2010 and states will continue to spend the same share of GSDP on health in 2020.*

Recommendation 7: Accept flexible and differential norms for allocating finances so that states can respond better to the physical, socio-cultural and other differentials and diversities across districts.

A major factor accounting for the low efficiency of public spending has been the practice of the Central government to develop and enforce uniform national guidelines for similar transfers for health across all states. Such a practice fails to take into account India's diversity and contextual differences. It also fails to properly incentivize state governments to draw up their own health plans in keeping with the needs of communities. We, therefore, recommend that the Central government should adopt a fiscal transfer mechanism that allows for flexible and differential financing from the Central government to the states. This will also allow for Central transfers to better meet the diverse requirements of different states, and enable states to develop health plans that are consistent with the healthcare needs and requirements of their populations.

Recommendation 8: Expenditures on primary healthcare, including general health information and promotion, curative services at the primary level, screening for risk factors at the population level and cost effective treatment, targeted towards specific risk factors, should account for at least 70% of all healthcare expenditures.

We envisage a major role for primary healthcare in the UHC system. There are therefore a number of reasons for recommending specific earmarking of resources for primary healthcare:

a) The coverage of essential primary care services for maternal and child health, vision, oral health and hearing continues to remain inadequate.

b) The infectious disease burden continues to be very high in several parts of the country. Early identification and treatment of these diseases coupled with prevention at the community level are the only ways to reduce this burden.

c) The widespread burden of malnutrition including easily treatable conditions such as iron deficiency and anaemia can only be dealt with at the primary care level.

d) The surge in chronic illnesses, along with unipolar depression, cardio-vascular disease and diabetes are rapidly becoming dominant burdens of disease.

e) An ageing population will require home-based or community-based long-term care.

We, therefore, recommend earmarking at least 70% of public expenditures, both in the short-term and over the medium term, for preventive, promotive and primary healthcare. This is absolutely essential - especially if we want to offer the UHC system with modest levels of allocations of government resources and, as a nation, reap the full benefits of UHC.

Recommendation 9: Do not use insurance companies or any other independent agents to purchase healthcare services on behalf of the government.

Having recommended that (i) general taxation and other deductions from the non-poor would be pooled to provide UHC; and that (ii) private voluntary contributions and out-of-pocket expenditures or user charges should not be the means to finance UHC, this recommendation deals with how pooled funds can be used to provide and, if necessary, purchase healthcare. This is perhaps the most important determinant of long-term health outcomes and has several long-term and short-term cost implications for the country.

Indian states have experimented with several ways of providing and purchasing healthcare. In the context of delivering UHC, we have examined three options:

a) Direct provision: All the resources mobilised for the UHC system are transferred to the relevant Ministries and Departments of Health for the direct provision of all services.

b) Direct provision plus contracted-in services: All the resources mobilised for the UHC system are transferred to the relevant Ministries and Departments of Health which in turn offer services through a judicious mix of direct provision and purchase of services from the private sector.

c) Purchase by an independent agency: All the resources mobilised for the UHC system are transferred to an independent agency (such as an insurance company); or a government department (such as the Ministry of Labour); or a specially constituted Trust, with its own management structure, which can then purchase healthcare services from either the Ministries and Departments of Health or the private sector.

We have made the case for complementing the direct provision of health services by the government with the purchase of additional services from contracted-in private providers by the government. This, we have argued, is more practical and desirable than relying exclusively on direct provision of health services by the public sector.

Concerns are often expressed about the capacity of the Ministries and Departments of Health to either directly provide healthcare services or purchase them from the private sector. The use of third parties such as insurance companies to purchase healthcare services from both the government and the private sector and to allow insured-customers to freely choose providers from whom to seek services, therefore, offers an alternative model. This is demonstrated by the rapid spread of insurance schemes such as the Rajiv Aarogyasri Community Health Insurance Scheme or the Rashtriya Swasthya Bima Yojana (RSBY) across several states. However, in formulating our recommendations, we have kept the following design principles in mind:

a) Universal and easy access: There should be universal and easy access to high quality curative services combined with a full roll out of highly cost-effective preventive and promotive interventions at the primary care level.

b) Adequate supply: There should be an adequate supply of secondary and tertiary care services of sufficient quality to meet the needs of the population under the UHC system.

c) Well integrated care: The secondary and tertiary care that is provided should be well integrated with primary care to ensure careful management of the long-term wellbeing of the patient.

d) Cost containment: Secondary and tertiary care costs should be kept tightly under control so that they do not crowd out the rest of government health spending, especially given the importance of investing in primary care.

The use of insurance companies to expend government resources is an unusual model and there are very few examples of this globally. The key benefit of insurance as a mechanism to pool risks is not operative in this case since the use of tax based financing, coupled with a mandatory surcharge on taxable income, already effectively ends up pooling the contributions from the entire country with the richest and potentially the healthiest cohorts contributing the largest amounts. Without the risk pooling role, the principal tasks performed by the insurance companies are as follows:

a) Contracting-in of private and government hospitals.

b) Control of costs, through carefully designed fraud control and, with where necessary, pre-approval mechanisms.

c) Enrolment of customers, issuance of insurance cards to them and ensuring provision of services to them at the network hospitals.

d) Management of customer complaints and tracking of the cost and the quality of services that are provided by network hospitals.

The experience of RSBY has been that insurance companies, particularly those in the private sector, have performed these roles well and have gradually been able to address several of the lacunae regarding enrolment, utilisation levels and fraud control.

However, in our view, even though the use of insurance companies to purchase healthcare services does offer the possibility of addressing several of the capacity constraints of the Ministries and Departments of Health in the short-run, a continuance and expansion of this approach would, in the medium-term, lead to very suboptimal outcomes for the country. Our concerns arise due to serious design flaws:

a) The independent purchaser (in the case of most of these schemes, the insurance company) does not have any accountability for wellness outcomes of the overall population or at the individual level both in the case of infectious and chronic diseases. This accountability continues to rest with the Ministries and Departments of Health, which often have no role in the design of these schemes.

b) There is a serious danger that the overall health system will become excessively focused on

curative services especially as utilisation levels creep upwards and the supply of secondary and tertiary care facilities respond to the availability of money with insured customers. Since there will be no attempt to control the disease burden at the primary level, this could lead to rapid upward revisions in the underlying insurance premiums to the point of entirely consuming or even exceeding the total health budget of the country.[h]

c) Healthcare is a long-term service that needs to track and be responsive to very long-term outcomes, sometimes intergenerational. A standard insurance type purchasing mechanism which relies entirely on the customer to make all the healthcare decisions, is not well suited to do this.

d) There are strong linkages between curative, preventive, promotive strategies and systematic behaviour change efforts to reduce, for example, tobacco use and salt consumption and promote improved breast feeding practices. Here, while insurance companies could be persuaded to invest in some behaviour change communication messages (since there are no immediate benefits to the insurer of these strategies), in practice, the insurer tends to reflect the gradual increases in costs which are the consequence of dysfunctional behaviours in the form of increased premiums.

e) Chronic illnesses need long-term home or community based care and not necessarily at specific facilities. Traditional insurance type mechanisms (as opposed to Managed Care) are not well suited to purchasing and managing this type of care. They tend to produce excessive hospitalisation.[i]

f) Purchasing of healthcare services would need to be done at the district level on account of the wide variations in the healthcare status of individuals and associated causal factors. Insurance schemes that run on a state-wide basis do not take into account these differences and do not allow the district level health systems manager a sufficient degree of flexibility in managing budgets to respond to specific needs at the district level.

g) Insurance companies, given the short-term nature of the contracts that are necessary to exploit the benefits of competition for contracts, would have limited interest in investing in preventive-promotive services. Even where they do, they would focus on those aspects that reduce costs of care and not necessarily on those that improve the conditions of health and well-being.[j]

h) Moreover, we regard the underlying fee-for-service approach behind these models as a very important design flaw of this approach. It becomes necessary, therefore, to either explore a completely different approach towards the use of insurance companies and independent agents - more in the Managed Care Framework, where they take on explicit population level health outcome responsibilities or invest further in the capacity of the Ministries and Departments of Health to directly provide and purchase services from contracted-in private providers wherever necessary.[k] We favour the latter option.

[h] The HLEG's discussions with insurance companies participating in RSBY suggest that this is already starting to happen in states such as Kerala where utilisation levels are rapidly moving upwards.

[i] For example, Bachman et al (2008)[13] evaluate "a managed care model developed for use by community-based providers to improve healthcare outcomes for low-income Latinos with disabilities and chronic illnesses. Through this model, Medicaid enrolees with special healthcare needs were identified and received enhanced primary care, on-site mental health and addiction services, care coordination, and support services based on their levels of need. The goal of the demonstration was to determine whether capitation would be a catalyst to transform typical primary care delivery processes to provide enhanced, culturally competent care to patients with complex healthcare and psychosocial needs. Despite a significant investment in out-patient services, the intervention was cost effective due to a dramatic decline in in-patient care for a few enrolees. For most enrolees, care was slightly more expensive due to enhanced out-patient medical and mental healthcare. Enrolees expressed high satisfaction with the intervention."

[j] On this issue, Professor Anne Mills, in a discussion with the HLEG pointed, out that: "While one may expect the insurance industry to wish to control costs (since cost inflation would make insurance increasingly unaffordable), their record in doing this across the world is very poor, partly because the industry simply passes on the consequences to households, eg in co-payments, deductibles, etc."

Recommendation 10: Purchases of all healthcare services under the UHC system should be undertaken either directly by the Central and state governments through their Departments of Health or by quasi-governmental autonomous agencies established for the purpose.

We recommend that the Central and state governments (Departments of Health or specific-purpose quasi-governmental autonomous agencies with requisite professional competencies created by them) should become the sole purchasers of all healthcare services for UHC delivered in their respective jurisdictions using pooled funds from general taxation and other contributions. Provisioning of health services at primary, secondary and tertiary levels should be integrated to ensure equitable and efficient procurement and allocations. We believe that it is possible to substantially reform the manner in which Ministries and Departments operate so that they can become effective purchasers of healthcare services. District-specific assessment of healthcare needs and provider availability, communicated by the Director of District Health Services, should provide the basis for state level purchase of services. The example of the Tamil Nadu Medical Services Corporation, which has functioned as an efficient agency of the State in Tamil Nadu, could serve as a possible model.

Given the high levels of variation in the nature of the disease burden, we envisage, over time, a system where the responsibility for decision making is transferred to the level of the district within a state - with perhaps a few districts coming together to form a viable unit where the size of an individual district is suboptimal. Government should use, at the level of such a unit, (i) a combination of departmental and independent purchasing agents and (ii) contracting-in high quality care, such that users have an adequate degree of choice and national portability through the NHEC. State governments should transfer funds to the district and allow the District Health System managers to allocate the funds between public provision and purchase of services on a competing basis from contracted-in private providers, while tracking outcomes at the district level and holding these managers accountable for these outcomes. We recognize the limited capacity within government and envisage that, to begin with, purchases may need to be centralized at the state level. However, over time, it is possible to foresee a system where the district health system managers may eventually be able to purchase and enhance quality of care by using a variety of methods and also keep costs as well under control.

State governments should consider experimenting with arrangements where the state and district purchase care from an integrated network of combined primary, secondary and tertiary care providers. These provider networks should be regulated by the government so that they meet the rules and requirements for delivering cost effective, accountable and quality healthcare. Such an integrated provider entity should receive funds to achieve negotiated predetermined health outcomes for the population being covered. This entity would bear financial risks and rewards and be required to deliver on healthcare

[k] Hsiao (2007)[14] expresses the view that market based competition between health insurers does not improve outcomes (gives United States as the most celebrated example of its failure amongst OECD countries) but such competition for the provision of healthcare itself "may hold the potential for more efficient and high quality care" and strongly argues against the use of health insurance to purchase any kind of health services on four grounds: (a) risk selection and selective rejection of claims by insurers. Mandatory enrolment and technology based cashless policies issued under RSBY in India seem to have taken care of this issue - however it remains to be seen how are the premiums that need to be sustainably charged to make these schemes viable for insurers. He suggests that both United States and Chile have however ended up in this situation owing to their reliance on insurance companies as purchasers of healthcare; (b) high transactions costs implied by the use of insurance companies relative to other direct and indirect methods of purchase of healthcare by the government. He cites numbers as high as 31% for the United States which uses private insurance to purchase healthcare versus only 16% for Canada which relies on a single payer social insurance system; (c) very high healthcare cost inflation that in his view is the inevitable consequence of the use of insurance style purchasing - he argues that while on average growth rate in healthcare spending across developed nations exceeds average GDP growth rate by 2.08%, he shows that in countries such as the United States and Germany which rely on insurance companies this rate is far higher than in Canada and United Kingdom which rely on Single Payer models.; and (d) no incentives for investment in preventive promotive healthcare strategies.

and wellness objectives. Ideally, the strengthened District Hospital should be the leader of this provider network.

Recommendation 11: All government funded insurance schemes should, over time, be integrated with the UHC system. All health insurance cards should, in due course, be replaced by National Health Entitlement Cards. The technical and other capacities developed by the Ministry of Labour for the RSBY should be leveraged as the core of UHC operations – and transferred to the Ministry of Health and Family Welfare.

Smoothly transforming the RSBY over time into a universal system of health entitlements and building on its existing capacity and architecture to issue citizens with a National Health Entitlement Card with a minimum amount of disruption, would in our view be the best way forward to satisfy the social objectives of both NRHM and RSBY. A high level of capacity has been developed within the Ministry of Labour for the management of the RSBY. This capacity should be utilized for the roll out of the UHC system even if the functions performed by the insurance companies will now be performed by the Ministries and Departments of Health.

Moreover, effective triaging and management of patients can ensure quick treatment times. Traditional insurance schemes, including those being funded by the government (such as RSBY and the Rajiv Aarogyasri Healthcare Insurance Scheme) are entirely focused on hospital networks rather than primary care services. The advantages of such a network design for consumers are a large supply of hospitals in the network and short waiting times for hospital admissions. However, since there is virtually no focus on primary level curative, preventive, and promotive services and on long-term wellness outcomes, these traditional insurance schemes often lead to inferior health outcomes and high healthcare cost inflation.

We wish to clarify at this stage that though the proposed UHC system shares a number of features with what is traditionally understood to be health insurance, there are a few critical differences that are a deliberate part of the design. These, in our view, are essential for realizing better healthcare access and cost outcomes. It can be seen from Table 6 that:

a) the system of Universal Health Coverage has all the characteristics of traditional health insurance on the risk pooling dimension along with financial protection;

b) the UHC system underscores the importance of an extensive and high quality primary care network and believes that this will then reduce considerably the need for secondary and tertiary facilities. The traditional insurance schemes, including those being funded by the government (RSBY and the Rajiv Aarogyasri Healthcare Insurance Scheme) are entirely focussed on hospital networks. The differences are in terms of provider network design;

c) the advantages of such a traditional insurance network design for consumers are a large supply of hospitals in the network and short waiting times for hospital admissions. However, since there is virtually no focus on primary level curative, preventive, and promotive services and on long-term wellness outcomes, these traditional insurance schemes most often lead to inferior health outcomes and high healthcare cost inflation;

d) the focus here, is on reducing disease burden faced by communities and to identify and treat illnesses early in their cycle. This is why we emphasise investing in primary care networks and holding providers responsible for wellness outcomes at the population level. This design requires relatively fewer secondary and tertiary care hospitals. A potential consequence of this, however, could be that those customers who choose to by-pass their primary care physician and go directly to hospitals may encounter queues and waiting times. The expectation is that such queues would

only be for elective and non-emergency surgeries and would act to persuade customers to return to their primary care physician as the first point of contact.

Table 6 presents a comparative picture of some of the features of selective existing insurance schemes and the proposed the UHC system.

TABLE 6. FEATURES OF SELECTIVE EXISTING INSURANCE SCHEMES AND THE PROPOSED UHC SYSTEM

	Voluntary Health Insurance	RSBY[16]	Rajiv Arogyasri[17]	The proposed UHC system
Risk Pooling	Yes	Yes	Yes	Yes
Risk Pooling Vehicle	Insurance Company	Government	Government	Government
Purchase of Healthcare	Insurance Company	Insurance Company	Insurance Company	Government
Cashless	Yes	Yes	Yes	Yes
Hospital Network	Very large number of hospitals	Very large number of hospitals	Very large number of hospitals	Limited number of hospitals based on assessed need
Financial Protection	Limited to insured amount	Limited to Rs. 30,000 per year, per family upon hospitalisation only	Limited to Rs. 100,000 per year, per family upon hospitalisation only	No financial Limits. Covers all essential healthcare needs at all levels both in and out of the hospital
Primary Care Network	Limited to OPD at hospitals	Limited to OPD at hospitals	None	Extensive
Likelihood of waiting periods for non-emergency hospital admissions	Low	Low	Low	High
Integrated Care	No	No	No	Yes
Focus on Prevention and Wellness	No	No	No	Yes
Dominant Payment model to health provider	Fee for service[18]	Fee for service	Fee for service	Capitation[19]

Contd...

TABLE 6. FEATURES OF SELECTIVE EXISTING INSURANCE SCHEMES AND THE PROPOSED UHC SYSTEM				
	Voluntary Health Insurance	**RSBY[16]**	**Rajiv Arogyasri[17]**	**The proposed UHC system**
Regulation of Quality	Largely focussed on financial fraud prevention	Largely focussed on financial fraud prevention	Largely focussed on financial fraud prevention	Much more detailed input and outcomes based regulation
Private Sector Engagement	Yes	Yes	Yes	Yes
Primary Care	Extremely Limited	Extremely Limited	No	Yes. Unlimited
Secondary Care	Within Financial Limits	Within Financial Limits	No	Yes. National Health Package. No Financial Limits
Tertiary Care	Within Financial Limits	No	Within Financial Limits	Yes. National Health Package. No Financial Limits
Gatekeeping Function[20]	Third Party Administrator[21]	Third Party Administrator	Third Party Administrator	Primary care provider

The transition to the UHC system resulting from the above recommendations is captured in Table 7.

TABLE 7. TRANSITION IN HEALTH FINANCING AND INSURANCE TO UNIVERSAL COVERAGE			
	2011	**2017**	**2020**
Tax financing	Relatively low	Increasing	Relatively high
Private financing	Relatively high	Decreasing	Relatively low
Employer-employee contribution	Relatively low	Increasing	Relatively high
Coverage	Mostly rich and targeted poor	Expanded coverage to include poor and other targeted communities	Universal
User fees	Prevalent	Eliminated	Eliminated

TABLE 7. TRANSITION IN HEALTH FINANCING AND INSURANCE TO UNIVERSAL COVERAGE			
	2011	**2017**	**2020**
Central Government insurance schemes	Large numbers catering to different groups; little communality	Reduced in numbers; merged with the UHC system	None - and integrated fully with the UHC system (including CGHS, ESIS and other schemes for the railways and other public sector institutions)
State government insurance schemes	Option open subject to state government financing	Option open to top up Central Government's UHC-National Health Package (NHP) funding subject to state government financing	Option open to top up Central Government's UHC-NHP funding subject to state government financing
Private (including community-based) insurance schemes	Large variety with option to individuals to top up government coverage	Large variety with option to individuals to top up government coverage	Large variety with option to individuals to top up government coverage

Two final comments: ***One***, clear cut guidelines as well as adequate checks and balances should be developed for both public provision as well as the effective contracting-in for the provision healthcare at all levels. ***Two***, a common IT-enabled information gathering, monitoring and networking system is critical for the effective implementation of the UHC system. Both these are discussed in the chapter on Management and Institutional Reforms.

References

1. Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunid SM, Mukti AG, et al. Health-financing reforms in Southeast Asia: challenges in achieving universal coverage. Lancet. [Internet] 2011 [cited 2011 January 30] Available from: www.thelancet.com. DOI\:10.1016/S0140-6736(10) 61890-9.
2. World Health Organisation. World Health Statistics 2009. [Internet] 2010 [cited 2010 Dec 10]. Available from: http://www.who.int/whosis/whostat/2009/en/index.html.
3. Shiva Kumar AK, Chen LC, Choudhury M, Ganju S, Mahajan V, Sinha A, Sen A. Financing health care for all: challenges and opportunities. Lancet. 2011;377 (9766): 668-679.
4. International Institute for Population Sciences [IIPS] and Macro International. National Family Health Survey (NFHS-3), 2005-2006. Volume I. Mumbai: IIPS; 2007.
5. Weinberger K. Micronutrient intake and labour productivity: Evidence from a consumption and income survey among Indian agricultural labourers. Outlook on AGRICULTURE. 2004 [cited 2011 Apr 30]; 33(4):255-260. Available from: http://www.zef.de/module/register/media/1b99_Weinberger_2004.pdf.
6. Boo HA, Harding JE. The developmental origins of adult disease (Barker) hypothesis. Australian and New Zealand Journal of Obstetrics and Gynaecology. 2006 [cited 2011 Apr 30]; 46:4-14. Available from: http://www.hawaii.edu/publichealth/ecohealth/si/course-ecohealth/readings/Boo_Harding-2006.pdf.
7. Xu K. Understanding household catastrophic expenditure. San Francisco: World Health Organisation.[Internet} 2003 [cited 2011 Apr 30]. Available from: http://www.who.int/health- systems-performance/docs/IHEA_present/IHEA_catastrophic.pdf.
8. Xu K, Evans DB, Carrin G, Aguilar-Rivera AM, Musgrove P, Evans T. Protecting households from catastrophic health spending. Health Affairs. 2007; 26:972-983.
9. Millennium Project. The Full Report: A Practical Plan to Achieve the Millennium Development Goals [Internet] 2006. [cited 2011 Jun 30] Available from: http://www.unmillenniumproject.org/reports/fullreport.htm.
10. Yates R. Comments on the HLEG-UHC Recommendations submitted to PHFI, New Delhi; 2011.
11. Cohen J, Dupas P. Free Distribution or Cost-Sharing? Evidence from a Malaria Prevention Experiment. NBER Working Papers 14406. Cambridge, MA: National Bureau of Economic Research, Inc; 2008.
12. Masiye F, Seshamani V, Cheelo C, Mphuka C and Odegaard K. Health care financing in Zambia: A review of options for implementation', unpublished MoH report. Lusaka: Department of Economics, University of Zambia; 2005.
13. Bachman SS, Tobias C, Master RJ, Scavron J, Tierney K. A Managed Care Model for Latino Adults with Chronic Illness and Disability: Results of the Brightwood Health Center Intervention. Journal of Disability Policy Studies. 2008 Mar; 18(4): 197-204. doi: 10.1177/1044207307311304
14. Hsiao WC. Why is a Systemic View of Health Financing Necessary? Health Affairs. 2007; 26(4): 950-961.doi: 10.1377/hlthaff.26.4.950.
15. US Department of Health and Human Services. Accountable Care Organizations: Improving Care Coordination for People with Medicare | Healthcare.gov. [Internet] 2011 Mar 31. [cited 2011 Apr 30] Available from: http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html.
16. Rashtriya Swasthya Bima Yojana. RSBY. [Internet] 2009 [cited 2011 Apr 30]. Available from: http://www.rsby.gov.in/about_rsby.aspx.
17. Andhra Pradesh State Government. Aarogyasri Health Care Trust - Quality Medicare for the Unreached. [Internet] 2007 [cited 2011 Jun 30]. Available from: https://www.aarogyasri.org/ASRI/index.jsp.
18. McGraw-Hill Concise Dictionary of Modern Medicine. [Internet] New York: McGraw-Hill Companies, Inc; 2002. Fee for service. [cited 2011 Apr 30]. Available from: http://medical- dictionary.thefreedictionary.com/fee+for+service.
19. McGraw-Hill Concise Dictionary of Modern Medicine. [Internet] New York: McGraw-Hill Companies, Inc; 2002. capitation. [cited 2011 Apr 30]. Available from: http://medical- dictionary.thefreedictionary.com/capitation.
20. McGraw-Hill Concise Dictionary of Modern Medicine. [Internet] New York: McGraw-Hill Companies, Inc; 2002. Gatekeeper. [cited 2011 Apr 30]. Available from: http://medical- dictionary.thefreedictionary.com/Gatekeeper.
21. The Gazette of India. Insurance Regulatory and Development Authority - Notification. [Internet] 2001 Sep 17 [cited 2011 Apr 30]. Available from: http://www.irdaindia.org/tpareg.htm.