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Opportunities and Challenges in Health Financing in India

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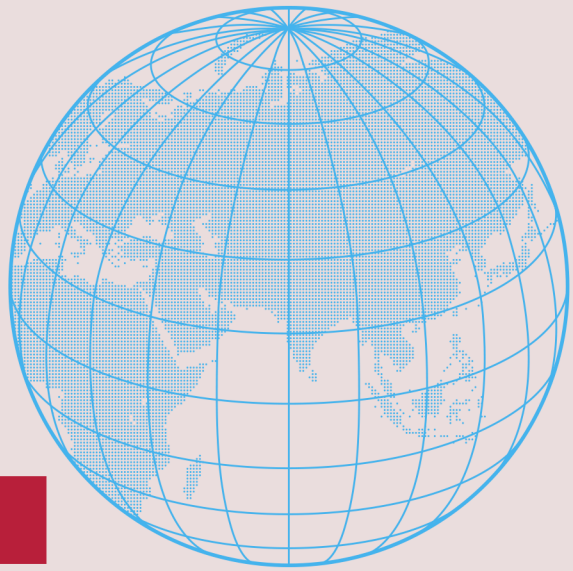

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Designed by Umesh Kumar

Opportunities and Challenges in Health Financing in India

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Abbreviations

AB-PMJAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
APL	Above Poverty Line
BHI	Basic Health Insurance
BPL	Below Poverty Line
CAG	Comptroller and Auditor General
CGHS	Central Government Health Scheme
CHE	Current Health Expenditure
CMCHS	Chief Minister's Comprehensive Health Insurance
CPR	Centre for Policy Research
DAU	Dana Alokasi Umum
DHS	District Health System
DRG	Diagnostic Related Groups
ECHS	Ex-Servicemen Contributory Health Scheme
ESIS	Employee State Insurance Corporation
ESIS	Employee State Insurance Scheme
FFS	Fee-for-Service
GFHIS	Government-Financed Health Insurance Schemes
GoI	Government of India
HAI	Health Accreditation Institute
HIF	Health Insurance Funds
HSRI	Health System Research Institutes
HTA	Health Technology Assessment
HWC	Health and Wellness Centre
ICMR	Indian Council of Medical Research
IEC	Information, Education, and Communication
IRDAI	Insurance Regulatory and Development Authority of India
JKN	*Jaminan Kesehatan Nasional* (National Health Insurance)
LMIC	Lower-Middle Income Country
MIS	Management Information System
MOHFW	Ministry of Health & Family Welfare
MOPH	Ministry of Public Health
NABH	National Accreditation Board for Hospitals
NHA	National Health Authority
NHCO	National Health Commissioning Office
NHI	National Health Insurance
NHM	National Health Mission
NHS	National Health Service
NHSA	National Healthcare Security Administration
NHSO	National Health Security Office
NRCMS	New Rural Cooperative Medical Scheme
NSS	National Sample Survey
OOP(E)	Out-of-Pocket (Expenditure)
PIB	Press Information Bureau
PM-JAY	Pradhan Mantri Jan Arogya Yojana
RSBY	Rashtriya Swasthya Bima Yojana
SARS	Severe Acute Respiratory Syndrome
SECC	Socio-economic Caste Census
SHA	State Health Authority
SHI	Social Health Insurance
SUS	*Sistema Único de Saúde* (Unified Health System)
Thai Health	Thai Health Promotion Foundation
TPA	Third Party Administrator
UHC	Universal Health Coverage
URBMI	Urban Resident Basic Medical Insurance
VSS	Vietnam Social Security

Executive Summary

This paper analyses the landscape of demand-side health financing in India, focusing on its progress, challenges, and potential pathways towards achieving Universal Health Coverage (UHC). Demand-side financing, which prioritises the population's healthcare needs, plays a role in ensuring equitable access to quality healthcare and providing financial protection against out-of-pocket expenditures (OOPE) on health. India's current landscape encompasses various government-financed and private insurance schemes. While there has been significant expansion in this regard in recent years, coverage gaps remain, in terms of population and services, slowing progress towards universal and equitable coverage.

Current Landscape of Health Insurance in India

Government of India's strategy to address its citizen's health rests on two main pillars: strengthening primary care through Health and Wellness Centres (HWCs) and expanding health insurance coverage through the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) for secondary and tertiary care. The Indian health insurance system is fragmented, with numerous schemes operating under different governance structures and offering varying benefits.

- **Social Health Insurance (SHI) schemes** cover occupation groups, managed by separate ministries (health, labour, railways, defence), with different networks of providers.
- **Tax-funded schemes** target the bottom 40 per cent of the population, primarily for inpatient services at secondary and tertiary levels, with lower benefits compared with SHI schemes. Implemented by individual States with varying coverage and benefit packages, often with deviations from the central PM-JAY model.
- **Commercial health insurance** caters to a small segment of the population who can afford premiums, characterised by high costs, market failures (like risk selection), and limited regulation.

This fragmentation leads to significant inequities in access to services and financial protection. While the combined coverage of various insurance schemes reaches a significant portion of the population, approximately 300 million people remain uncovered, largely comprising the informal workforce and the 'missing middle'—those who are not poor enough for targeted schemes but cannot afford private insurance. Moreover, existing schemes often lack coverage for outpatient care and essential diagnostics, which contribute significantly to OOPE, especially for lower-income households.

Challenges and Gaps

This paper highlights some of the gaps that remain to be filled within the Indian health insurance landscape:

- **Financial constraints:** Insufficient funding for PM-JAY, underutilisation of allocated funds, and varying State capacity to bridge financing gaps pose significant challenges to achieving UHC goals. Low package rates and delayed reimbursements discourage private sector participation.
- **Enrolment:** Inconsistent enrolment processes across States, low awareness of available schemes among beneficiaries, and errors in beneficiary registrations lead to lower than optimal enrolment rates.
- **Provider gaps:** Low private sector engagement due to inadequate package rates and delayed reimbursements, low quality of services in both public and private facilities, and instances of malpractice among providers affect both access and quality of care.
- **Institutional gaps:** Weak institutional mechanisms for quality assurance, transparency, accountability, and grievance redressal in many states undermine the effectiveness of insurance schemes. Limited capacity of purchasers, high claim rejection rates, and weak capacity of SHAs and district-level implementation units further exacerbate these challenges.
- **Outcomes:** Low utilisation of services in some states, inadequate coverage for primary prevention, limited focus on outpatient care, and persistent OOPE despite increased insurance coverage point to gaps in achieving desired outcomes.

Insights from Global Experiences

This paper draws insights from the experiences of select countries (particularly Brazil, China, Indonesia, Mexico, Thailand, and Turkey) that have implemented

health system reforms using demand-side financing and insurance models. Key insights include:

- **Revenue:** Increased government subsidies, often combined with voluntary contributions from the informal sector, have played a crucial role in expanding coverage. Countries comparable to India in terms of economic status have achieved greater progress towards UHC by allocating a larger share of government resources to health. Legislation mandating UHC has proved effective in ensuring budget allocation and consistent policy implementation.
- **Pooling:** Merging fragmented risk pools into larger, more inclusive pools has improved equity, efficiency, and risk management. This approach allows for cross-subsidisation across income groups and addresses the challenge of adverse selection. While a single pool is the ideal scenario, merging schemes with similar features can be a starting point.
- **Purchasing:** Strategic purchasing, involving the separation of purchasing and provisioning functions, has demonstrated its effectiveness in improving efficiency and ensuring accountability. Key elements of strategic purchasing include designing and costing benefit packages, empanelling providers based on quality criteria, and establishing performance-based payment mechanisms. Close collaboration with private sector stakeholders in package design and costing ensures their buy-in and participation.
- **Institutional reforms:** These proved crucial for supporting effective strategic purchasing. Creating independent purchasing agencies with clear mandates and responsibilities, strengthening regulatory frameworks for providers, and establishing robust quality assurance mechanisms are critical for success.

Potential Pathways for India

Based on the analysis of the current landscape in India and insights from global experiences, the paper proposes potential pathways for strengthening demand-side health financing in India:

- **Increasing revenue:** Raising government spending on health through increased tax allocation or earmarked taxes, mandating contributions from the informal non-poor population, or introducing voluntary co-payments under a basic benefit package are options to explore.
- **Consolidating risk pools:** Merging existing fragmented pools into a single pool or merging those with similar features would improve equity, efficiency, and governance. Introducing a tax-funded universal common benefit package as a subset of existing schemes or expanding existing schemes for the poor and informal sector with partial contributions and state subsidies are potential interim steps.
- **Introducing strategic purchasing:** Implementing a universal limited benefit package for high-cost care or primary care, offering a comprehensive package by merging existing schemes, and mandating health insurance for all, are potential options to consider. Tax-funded packages with differentiated costing rates adjusted to the local cost of living, with opportunities for voluntary co-payments by uninsured individuals proportionate to coverage tiers, can encourage participation and address equity concerns.
- **Strengthening payment mechanisms:** Moving towards output-based financing using blended payment methods such as DRG-based payments for secondary and tertiary care and capitation-based payments for primary care can improve efficiency and control costs. Integrating pay-for-performance incentives can enhance quality and accountability.

Organisational and Institutional Reforms

Consolidating purchasing functions under a single agency with a separate organisation (independent of both the purchaser and provider) for regulation, quality control, and policy research may further enhance governance and accountability.

Demand-side health financing offers a promising pathway to achieving UHC in India. However, realising this potential requires addressing the existing fragmentation, strengthening institutional capacities, and increasing the financial resources allocated to health. The PM-JAY serves as a foundation for many of these reforms but needs to be significantly strengthened and expanded in scope to achieve its full potential. Ultimately, the success of India's journey towards UHC will depend on the will to prioritise healthcare, the ability to build consensus among stakeholders, and the effectiveness of implementation mechanisms.

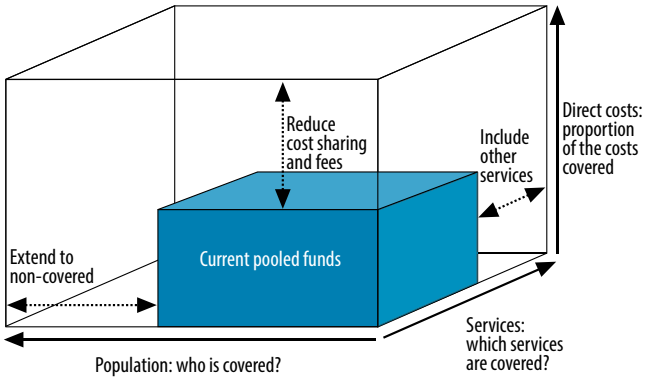
1. Introduction

The three dimensions of Universal Health Coverage (UHC)[1]—providing health coverage to all; reducing costs of health services and lowering Out-of-Pocket Expenditure (OOPE); and increasing depth of services provided (Figure 1)—constitute the main goals of most health systems. Financing health services, accordingly, becomes an important component of reaching the UHC goal. With health systems traditionally financed through supply-side financing of infrastructure, health workforce, drugs, diagnostics, and other inputs, financing that enables demand for services is often neglected.

Demand for health services, viewed in terms of health-seeking behaviour and utilisation of services, is a factor of several variables. Accessibility, availability, responsiveness of services, affordability, and quality constitute key determinants. Accessibility is not merely a physical attribute but equally a factor of socio-economic factors, education, cultural norms, health status perception, gender, and so on. Additionally, accessibility is both physical and financial, the latter determined by the cost of accessing services. Thus, enabling access requires financial support that can prevent people from forgoing care due to a lack of funds. Purchasing power given to people to seek services when required, in a controlled and regulated environment, alongside the availability of quality services, become the two critical components of UHC, through balancing supply and demand.

Accordingly, governments across countries have increasingly focused on demand-side financing[2] aimed at access and financial protection. Service coverage has been expanded through demand-side financing models, including publicly funded insurance schemes, cash transfers, and voucher schemes. These shifted supply-side financing models, with line-item budgets and health programmes, to a focus on population needs. They offer the potential of improving access and utilisation, as well as providing a choice of provider to people in some cases, enabling access to relevant health services. Evidence across countries suggests that expanding government-funded insurance results in increasing access to care and enhancing financial protection at the point of care (Parisi et al., 2023; Nandi et al., 2012; Das & Leino, 2011).

Figure 1: Three Dimensions of UHC



Source: WHO 2010.

Financing for UHC entails attention to the three aspects of revenue generation, pooling of funds, and mechanisms of purchasing health services (World Health Organization [WHO], 2010). A range of experiences are available regarding these, depending on country context. Revenue generation has ranged from tax revenue and employer-employee contributions to individual expenditure, driven by the composition of the economy and government priority given to healthcare. In contexts of high formal employment, a large part of revenue generation has been through mandatory employee-employer contributions, as in Germany's National Health Insurance, managed by private sickness funds. Contexts with large numbers of poor people have focused on models of tax funding. Even without a large poor population, countries that prioritise healthcare have allocated large tax budgets to healthcare, as in the United Kingdom's National Health Service (NHS), where 10% of the GDP is allocated to health[3] (Office for National Statistics, 2019), covering the entire population through general taxation. The presence of a significant informal workforce, as in many lower-middle income countries (LMICs),

[1] UHC rests on the idea that everyone, everywhere should have access to quality and affordable healthcare which ultimately will ensure healthy lives.
[2] A process of channelling public funds to citizens to enable them to access health services.
[3] Data for 2019-2020.

often makes the provision of UHC difficult due to limited space for social insurance and a low tax base. With those below the poverty line (BPL) covered by targeted welfare schemes and those in the formal sector by employer-employee insurance schemes, the informal sector falls between the cracks, remaining out of coverage.

Creation of large pools through aggregation of funds has been a strategy towards equity and efficiency; with pools often being a mix of tax and progressive contributions from the population. LMICs, with a low tax base and limited fiscal space, combined with a small percentage of the formal sector workforce, are often witness to multiple pools of funds, leading to considerable inequities.

Finally, the trend towards strategic purchasing of health services has contributed to control of costs and quality. While socio-economic and political contexts have driven the adoption of specific models, resulting in varying outcomes, reforms in each of these aspects have been undertaken in many countries and are acknowledged as the path forward towards UHC.

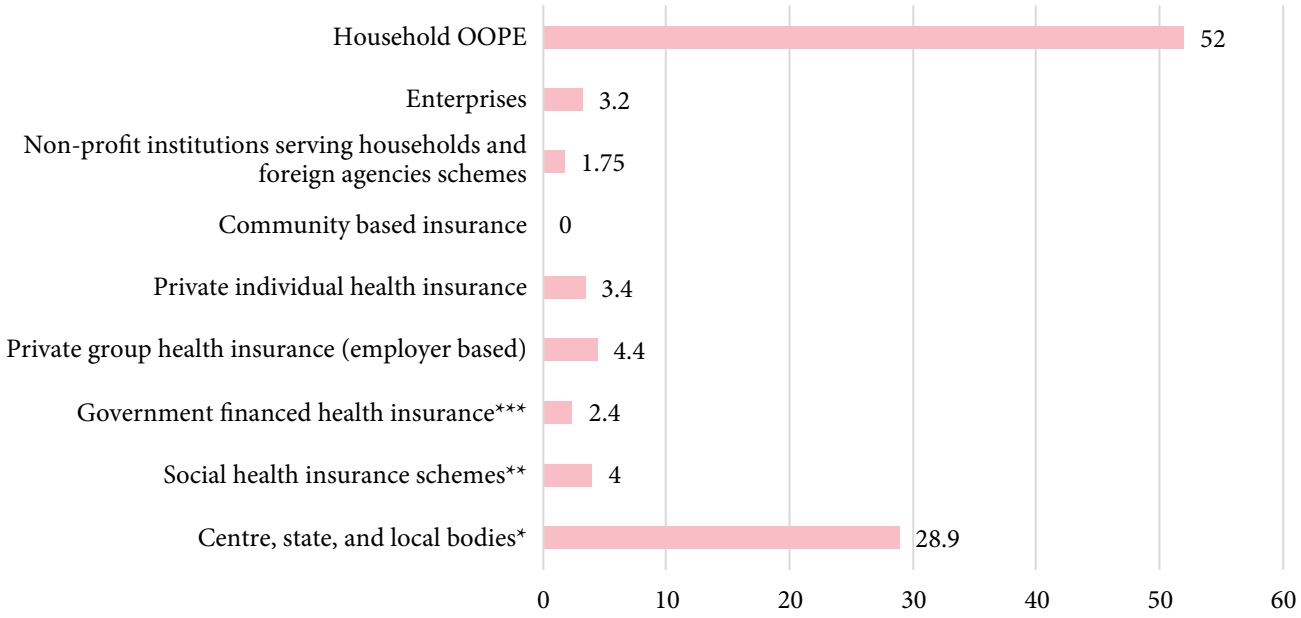
India's health financing landscape, too, has witnessed transitions in its recognition of the importance of demand-side financing and the consequent development of several health insurance schemes, both at the Centre and State levels. India also witnesses varying social health insurance interventions and a growing commercial insurance landscape. Combined, these target the poor, those in formal employment, and a small percentage who can afford commercial insurance products but leave out a significant population group from health cover, who then rely on OOPE for health-related needs. Despite the increasing attention to health insurance, gaps in coverage, gaps and inefficiencies in financing, and inequities mar the insurance landscape, limiting progress towards equity and comprehensive cover. Several countries have transitioned from where India is now, and this paper draws on the experience of their health system reforms to inform the pathways to strengthening revenue generation, pooling, and purchasing.

This paper maps the landscape of health insurance schemes with a focus on government-financed schemes (Section 2); discusses the challenges of the existing insurance landscape (Section 3); analyses insights from country experiences (Section 4); and then discusses the potential pathways towards greater and more equitable coverage in India (Section 5). The paper draws from six country analyses undertaken by the Centre for Social and Economic Progress (CSEP) to distil the experience of health system reforms in each. The countries included Brazil, China, Indonesia, Mexico, Thailand, and Turkey, selected for their comparability to India in terms of economic status, state structure, the share of informal employment, type of health system, and burden of disease (Venkateswaran, et al., 2023). Building on the UHC framework, which requires attention to revenue generation, pooling of funds, and mechanisms of purchasing health services, the framework for analysis of health financing used in this paper is built on these three components: revenue, pooling, and purchasing.

2. Landscape of Health Insurance in India

India is primarily focused on two pillars in its path towards UHC: strengthening primary care through the Health and Wellness Centres (HWCs) and health insurance through the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) for covering services at the secondary and tertiary levels of healthcare, launched in 2018. The last decade and a half witnessed a considerable increase in public health insurance, with the National Health Accounts (2019–2020) estimating financing through insurance (Figure 2) to be 14.2% of the current health expenditure. Of this, 4% is social health insurance; 2.4% is government-financed health insurance schemes (GFHIS); 4.4% is employer-based health insurance or private group insurance; and 3.4% is individual voluntary health insurance. Fifty-two percent of current health expenditure is out-of-pocket (OOP) expenditure (GoI, 2023a), reflecting the need and potential for increased pooling of resources.

Figure 2: Current Health Expenditure (2019–2020) by Health Care Financing Schemes (in percentage)



Source: GoI 2023a.

**Current expenditures on Defence Medical Services (Rs 14,690 crore), Railway Health Services (Rs 5,043 crore), and the rest is any reimbursements made by Union Government departments through central services (medical attendance) (for 2019–2020) or including expenditures on employees through medical allowance or reimbursements by State Government departments.*

***Including Central Government Health Scheme (CGHS), Ex-servicemen Contributory Health Scheme (ECHS), and Employee State Insurance Scheme (ESIS).*

****Including expenditures on PM-JAY, RSBY, and state-specific health insurance schemes.*

Insurance and other demand-side schemes have been numerous (Figure 3), including i) Employee State Insurance (ESI) Scheme, a contributory employee-employer mechanism for industrial workers; ii) Central Government Health Scheme (CGHS) for Central Government employees; iii) state health insurance schemes, emerging largely since the early 2000s; iv) the Prime Minister's *Jan Arogya Yojana* (PM-JAY),[4] a tax based scheme covering the bottom 40% of India's population. Initiated by different ministries, the fragmentation in the insurance landscape is evident from Figure 3. While several schemes merged with the Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018 (blue coloured boxes in the schematic), those that remain separate from PM-JAY (green) are not insignificant in number. Even for those that are merged with PM-JAY, the breadth and depth of coverage varies across states.

Thus, what stands out in the health insurance environment today is a fragmented landscape as a result of numerous pools, inequity through variable benefits across pools, and the need and potential to cover the large population that continues to spend significant amounts out-of-pocket on healthcare.

2.1 Breadth and Depth of Coverage and Exclusions

Accounting for data gaps in the Insurance Regulatory and Development Authority of India (IRDAI), it is estimated that approximately 1,150 million population is covered through some insurance, with around 300 million left out of any protection or coverage.[5] The IRDAI data aggregates individuals covered under State and centrally sponsored insurance schemes, employers, groups, and individuals that voluntarily purchase health insurance policies from public and private insurance companies. Data for 2021–2022

[4] PM-JAY was launched in 2018 as a targeted health insurance for those below the poverty line and is estimated to cover bottom 40% of the population. The scheme intends to cover hospitalisation services at the secondary and tertiary level for a sum insured of Rs 5 lakh.

[5] As per Mahal, et al., (2024), 550 million are covered under PM-JAY, 200 million are covered by states (extending to Above Poverty Line [APL] families), 149 million are covered under social insurance schemes (CGHS, ESIS, ECHS, etc.), and 252 million are covered under private insurance (both individual and group). Considering India's population of 1.43 billion, around 300 million–350 million will be uncovered (given the fact that there will be some level of overlap between the insurance schemes).

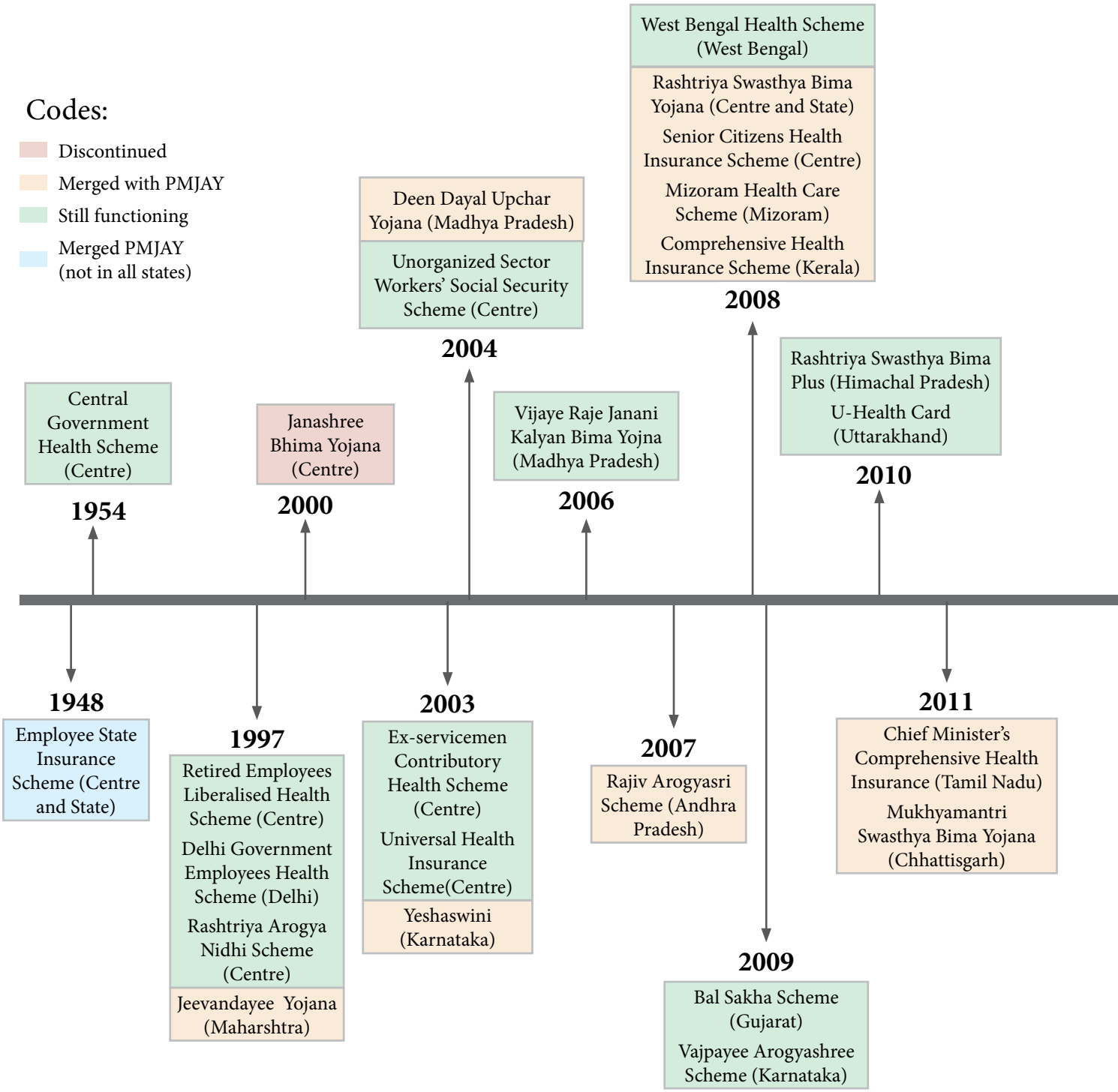
(IRDAI 2022) reveals that over 300 million people are covered under government-sponsored schemes; 51.6 million people are covered by individual schemes (voluntary health insurance purchased by individuals/families); and 162.3 million people are covered by group-sponsored schemes (insurance purchased by private or public sector enterprises for their employees) (IRDAI 2023). These combine to suggest that 36% of the total population is covered under some scheme.

IRDAI data, however, does not include the population covered under the ESIS, CGHS, defence health services, or railway employees, as these schemes are administered through separate agencies under their respective ministries (Nundy and Bhatt, 2023). They cover approximately 149 million of the population (ESIS, 2023; IRDAI, 2023; ECHS, 2022; Press Information Bureau [PIB], 2023; Government of India [GoI], 2023a) (Fig. 4), leading to 46% of the population being covered under an insurance scheme. Importantly, IRDAI data does not cover PM-JAY schemes in states that are administered through the trust model rather than insurance companies. Since 23 states have adopted the trust model, the 46% population coverage would be an underestimate (Nundy and Bhatt, 2023). Hence, an estimate of the actual proportion of the population covered by any insurance scheme to date would be difficult to calculate and could be in the range of approximately 1,150 Million[6] (Figure 4). Thus, about 300 million of the population remains uncovered, comprising the non-poor, typically informal workforce (considering overlap between private and social health insurance beneficiaries) (Mahal, et al., 2024).

Analysing some of the major insurance schemes in India, Table 1 underlines the fragmentation across governance, cover, and benefits. Social health insurance (SHI) schemes are managed across ministries (health, labour, railways, defence), have their own network of health centres and hospitals, are more comprehensive in the depth of services, and the health centres and dispensaries under these follow principles of gatekeeping and referrals (Ministry of Labour, 2023; Ministry of Health & Family Welfare [MOHFW], 2023; ECHS, 2022). The tax-funded schemes, on the other hand, primarily cover inpatient services, with lower benefits and lower expenditure compared with the SHI schemes. Expenditure across schemes is extremely variable, but per capita expenditures are not comparable due to different elements covered under the stated expenditure.

[6] Based on IRDAI and those covered by other national schemes such as CGHS, Defence Railways etc.

Figure 3: Demand-Side Health Financing Over the Years in India



Source: Dubey et al., 2023 (modified).

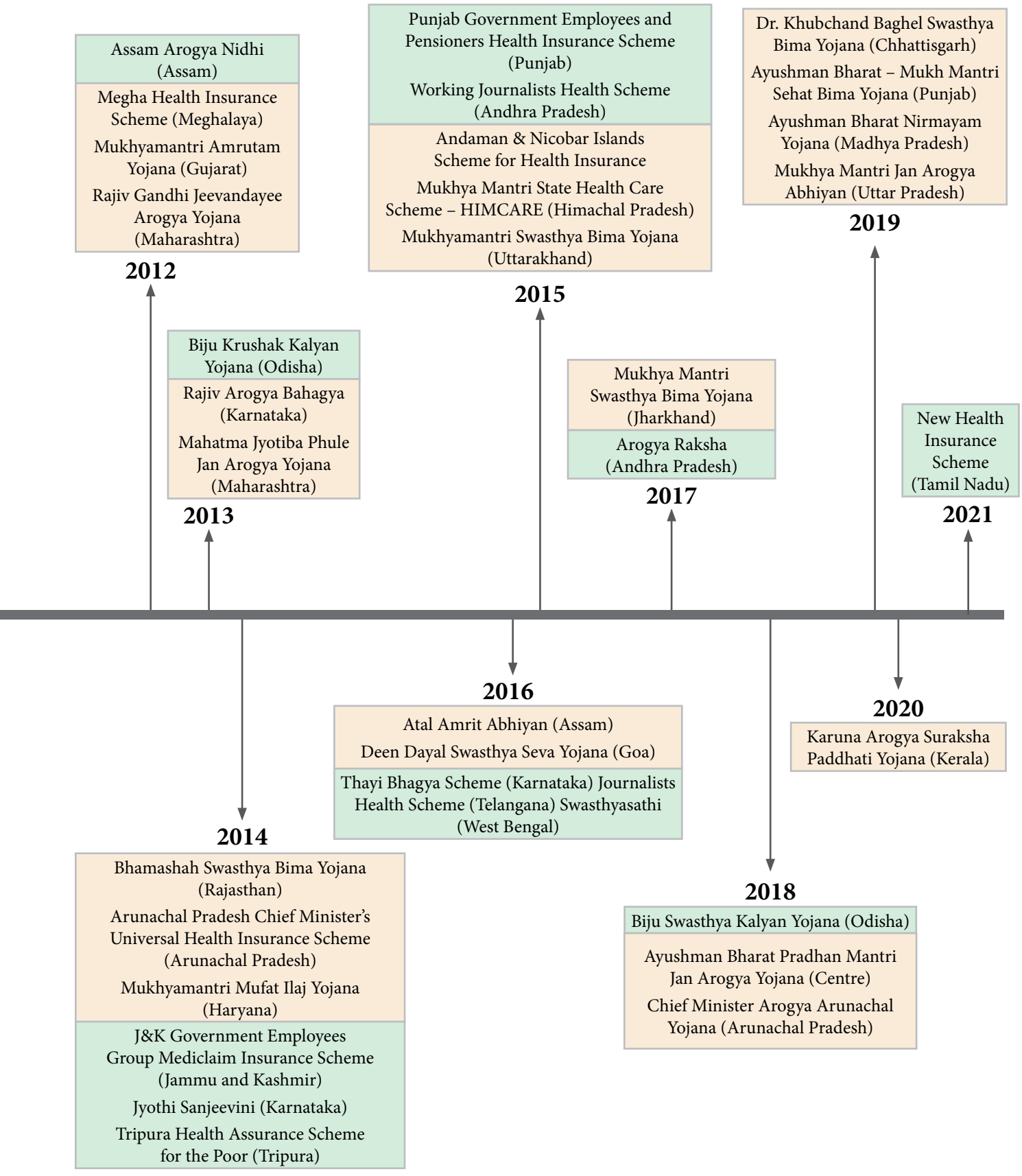
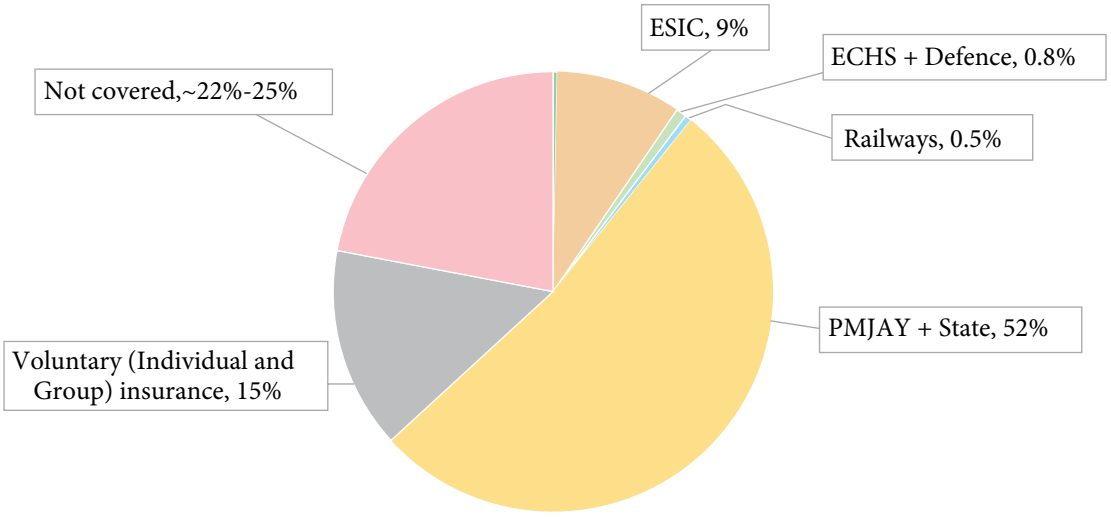

Assam Arogya Nidhi (Assam)
Megha Health Insurance Scheme (Meghalaya)
Mukhyamantri Amrutam Yojana (Gujarat)
Rajiv Gandhi Jeevandayee Arogya Yojana (Maharashtra)
2012
Biju Krushak Kalyan Yojana (Odisha)
Rajiv Arogya Bahagya (Karnataka)
Mahatma Jyotiba Phule Jan Arogya Yojana (Maharashtra)
2013
Bhamashah Swasthya Bima Yojana (Rajasthan)
Arunachal Pradesh Chief Minister's Universal Health Insurance Scheme (Arunachal Pradesh)
Mukhyamantri Mufat Ilaj Yojana (Haryana)
J&K Government Employees Group Mediclaim Insurance Scheme (Jammu and Kashmir)
Jyothi Sanjeevini (Karnataka)
Tripura Health Assurance Scheme for the Poor (Tripura)
2014
Atal Amrit Abhiyan (Assam)
Deen Dayal Swasthya Seva Yojana (Goa)
Thayi Bhagya Scheme (Karnataka) Journalists Health Scheme (Telangana) Swasthyasathi (West Bengal)
2016
Punjab Government Employees and Pensioners Health Insurance Scheme (Punjab)
Working Journalists Health Scheme (Andhra Pradesh)
Andaman & Nicobar Islands Scheme for Health Insurance
Mukhya Mantri State Health Care Scheme – HIMCARE (Himachal Pradesh)
Mukhyamantri Swasthya Bima Yojana (Uttarakhand)
2015
Mukhya Mantri Swasthya Bima Yojana (Jharkhand)
Arogya Raksha (Andhra Pradesh)
2017
Biju Swasthya Kalyan Yojana (Odisha)
Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (Centre)
Chief Minister Arogya Arunachal Yojana (Arunachal Pradesh)
2018
Dr. Khubchand Baghel Swasthya Bima Yojana (Chhattisgarh)
Ayushman Bharat – Mukh Mantri Sehat Bima Yojana (Punjab)
Ayushman Bharat Nirmayam Yojana (Madhya Pradesh)
Mukhya Mantri Jan Arogya Abhiyan (Uttar Pradesh)
2019
Karuna Arogya Suraksha Paddhati Yojana (Kerala)
2020
New Health Insurance Scheme (Tamil Nadu)
2021

Figure 4: Proportion of Population with and Without Insurance in India in Millions (percentage of population)



Source: ESIS, 2023; IRDAI, 2023; ECHS, 2022; PIB, 2023; GoI, 2023a.

Table 1: Design of Insurance Schemes

Scheme	Population covered (in millions)	Financing (Budget in crore)	Benefits covered	Sum insured	Governed by
CGHS (serving and retired + dependents)	4.3	Government financed-employee contribution (Rs 4,867 cr) Rs 11,318/capita	Limited preventive, Ambulatory, and inpatient services.	No fixed sum (rooms and wards depend on entitlements)	Ministry of Health
ESIS (workers + dependents)	132	Employee and employer contribution (Rs 15,349 cr) Rs 1,154/capita	Limited preventive, Ambulatory, and inpatient services.	No fixed sum (rooms and wards depend on entitlements)	Ministry of Labour
ECHS serving + dependents	5.5 (ECHS) + (1.4 million serving + dependents)	Employee and government-financed (Rs 5,185 crore for ECHS & Rs 14,690 cr for serving personnel)	Limited preventive, Ambulatory, and inpatient services.	No fixed sum (rooms, and wards depend on entitlements)	Ministry of Defence
Railways (serving, retired + dependents)	6.3	Government financed (Rs 5,043 cr) Rs 8,004/capita	Limited preventive, Ambulatory, and inpatient services.	No fixed sum (rooms and wards depend on entitlements)	Ministry of Railways
PM-JAY & other state health insurance	550 (BPL) + other states who have included APL (200)	Government financed (Rs. 13809 cr–including Rs 6,400 from Centre for 2019)	Only inpatient services. Over 1900 procedures. No outpatient or individual diagnostics covered.	Rs 5 lakh for hospitalisation	National Health Authority (MOHFW)
Private insurance (Group and individual)	212[7]	Premium contributions by group/individual (Rs 66,976 cr) Rs 3159/capita	Mostly indemnity inpatient services	Depends on the premium value (varies)	IRDAI, commercial insurance companies. Claims settled by TPAs.

Source: Ministry of Labour & Employment, 2023; MOHFW, 2023; ECHS, 2022; IRDAI, 2023; PIB, 2023; ESIS, 2023; GoI, 2023a.

[7] There are some differences in the coverage of voluntary health insurance (individual and group). As per IRDAI annual report 2022-2023, the figure stands at 212 million, and Mahal, et al. (2024) provides the coverage of 252 million.

2.2 Inter-State Variations in Insurance Coverage for Government Financed Schemes (PM-JAY and Other State Schemes)

PM-JAY is the largest government-financed scheme with a large risk pool aimed at covering the bottom 40% of the population. States, in implementing the scheme, have the flexibility to define the breadth and depth of coverage, resulting in a variable target population and benefits (Table 2). Most states are limited to covering inpatient services, with a few including reimbursements for some outpatient visits (see Appendix 1 for details). While states like Odisha, Sikkim, and Meghalaya have included limited outpatient visits in the insurance schemes, evidence on the direct impact of the inclusion of outpatient visits on lowering OOPE is limited.

States have attempted to cover the non-eligible through contributions, but with little success. In Andhra Pradesh, the Arogya Raksha Health Scheme attempted to cover 3.2 million APL families for hospitalisation expenses up to Rs 2 lakh per individual per year for an annual premium of Rs 1,200 per person for those who were not covered by any scheme (Nundy and Bhatt, 2023). The family (including spouse, parents, and two children) could be added with an increased premium of Rs 7,200. This was a voluntary scheme but had very few takers due to the high premiums and was hence unable to retain the few individuals who participated in the scheme (Mannuru, 2019).

Variations across states are inevitable in a federal structure, with higher capacity and better-endowed states more able to expand breadth and depth. Economically weaker states depend on the Centre's financial and technical support. What India's federal structure does offer in such a context is valuable learnings across states, which points to the need for robust implementation research across states to understand the impact of increasing the breadth and depth of cover for both citizen and state, and the processes that enabled these transitions.

Table 2: Inter-State Variations in Government-Financed Schemes

Government Sponsored Health Insurance	States	Variations in Benefits, Packages
States that have merged earlier insurance schemes with varying degrees of affiliation with PM-JAY	Karnataka, Kerala, Meghalaya, Punjab, Tamil Nadu, Telangana, Andhra Pradesh, Gujarat, Goa, Maharashtra, Uttarakhand, and Bihar.	Sum insured mostly Rs 5 lakh, but low in some states. Mostly inpatient services (number of packages vary). Some states like Andhra Pradesh and Meghalaya include some outpatient visits.
States with expanded coverage – covered or in the process of covering beyond PM-JAY guidelines. Use of SECC data, NFSA beneficiaries, MNREGA beneficiaries, registered senior citizens, street vendors, disabled, and those not covered can voluntarily join	Meghalaya, Maharashtra, Karnataka, Kerala, Goa, Andhra Pradesh, Himachal Pradesh, J&K, Assam, Arunachal Pradesh, Nagaland, Manipur, Punjab, Uttarakhand, Haryana, and Rajasthan.	Mostly inpatient services (number of packages vary). Some states like Andhra Pradesh, Haryana, and Meghalaya include limited outpatient visits. Sum insured varies across states.
States that have schemes separate from PM-JAY	Assam, Sikkim, and Mizoram	Sikkim allows seven outpatient visits. It has different schemes with different sums insured.
States that have opted out of PM-JAY but have their own schemes	West Bengal, Odisha, and Delhi (has Rs 5 lakh coverage for the needy)	Odisha covers limited outpatient visits.

Source: Various state websites.

2.3 Governance Structure Across Insurance Schemes

In India, multiple actors and agencies administer different insurance schemes (Figure 5). As highlighted before, the Ministries of Health, Railways, Labour, and Defence administer health schemes. Multiple authorities managing health insurance schemes have created multiple pools of funds and separate organisational structures governing these. The fragmentation is both horizontal and vertical—across ministries and within the Ministry of Health at the Centre level and between the Centre and State. Fragmentation has implications for efficiency, equity, and universality, as discussed in subsequent sections.

In summary, despite numerous insurance mechanisms, India is yet to achieve universal coverage through insurance, with an estimated 25% of the population left out of any cover. For those covered by public schemes, the shallow depth in coverage in many schemes has implied the lack of cover for specific conditions and needs, especially outpatient care, which contributes significantly to out-of-pocket expenditures. This is particularly so for the fully subsidised schemes, in a context of variable benefits, budgets, and governance across schemes, creating inequities and a fragmented landscape.

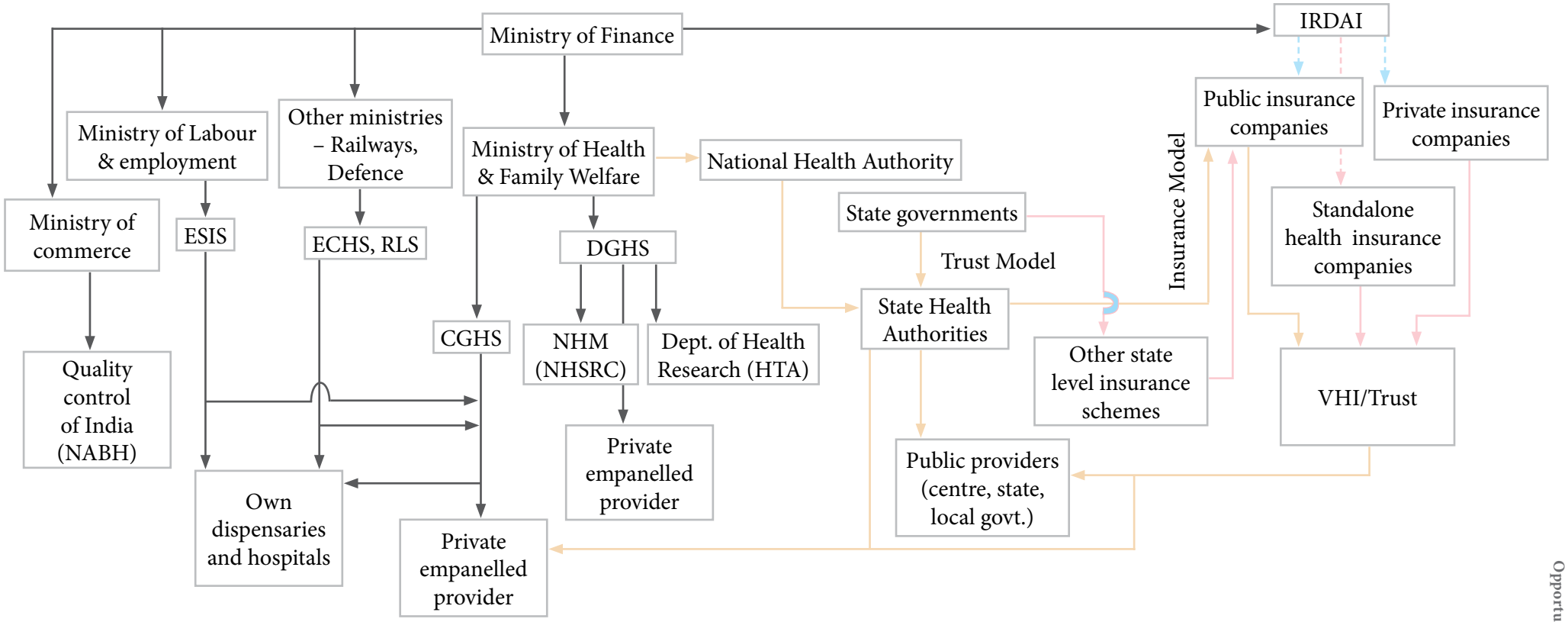
3. Achievements, Challenges, and Gaps

As outlined in the previous section, India's health system includes several insurance schemes, which expectedly demonstrate varied experiences with respect to enrolment, provisioning, and governance. This section discusses the experience of PM-JAY, CGHS, ESIS, and commercial insurance for individuals and groups.

CGHS and ESIS are comprehensive insurance schemes. CGHS covers a small population of 4.3 million and has a large budget of Rs 4,360 crore (per capita expenditure of Rs 10,139), highlighting the privileges of the scheme over others (MOHFW, 2023). The depth of services is comprehensive, but poor preventive outreach of the programme puts the burden on secondary and tertiary services. CGHS dispensaries are short-staffed with limited infrastructure, varying across cities (Vellakkal et al., 2010; Sarwal, 2015). Even though CGHS has a higher budget, the low cost of packages and delayed reimbursement results in low empanelment of private providers (Sarwal, 2015). In 2022, private hospitals wrote to the government regarding outstanding dues of Rs 500 crore (Sharma, 2022). In 2023, all package rates under CGHS were revised and enhanced to retain private hospital empanelment.

ESIS covers 132 million people with a budget of Rs 20,400 crore (Rs 1,545 per capita) (Ministry of Labour & Employment, 2023). ESIS has its network of institutions at all levels, additionally empanelling private hospitals for tertiary services. For many years, ESIS has maintained large financial reserves due to low expenditure. This is due to little expansion in infrastructure, poor maintenance of existing infrastructure, and a severe shortage of doctors (ILO, 2022). This has resulted in low utilisation by members and a poorly performing scheme. Aimed at improving utilisation and quality, ESIS underwent reforms post-Covid and has proposed to upgrade and enhance its infrastructure.

Figure 5: Multiple Actors and Agencies in India's Health Insurance Landscape



Source: Authors' representation.

It is being expanded to all 35 States and to 610 districts from the earlier 443 districts.[8] ESIS has converged with PM-JAY in 200 districts (eventually to be extended to all districts) where ESI beneficiaries can avail of all secondary and tertiary care from PM-JAY-empanelled hospitals on a cashless basis.

Private and commercial insurance targets individuals and groups who choose from policies offered by insurance companies (public or private). Group insurance is purchased by private or public sector enterprises and companies for their employees. Commercial insurance at the individual level has a small population base as few people can afford the premiums.

The IRDAI recently requested insurance companies to provide a standardised voluntary insurance scheme for the non-poor who are not covered by any scheme. *Arogya Sanjeevani* was introduced as a standardised health insurance policy available for purchase across insurance companies, but it has had limited takers given the high premium rates in absolute terms.

For commercial schemes, private and public insurance companies have established their practices to develop standardisation of treatment protocols based on categories of health conditions. This enables them to decide a standard negotiated cost for packages for health conditions (Nundy and Bhatt, 2023). Premium amounts estimated by companies are not regulated well, are based on age, and are regressive. The young and healthy pay less in premiums than the old; the latter pay more in the case of pre-existing diseases.

There is no standalone health insurance authority or agency responsible specifically for health insurance. The IRDAI is responsible for the overall oversight and supervision of the insurance sector, of which health insurance is one element. There is a growing case for the need to create a separate vertical for health insurance (Nundy & Bhatt, 2023). Perhaps due to the absence of a dedicated institution, health insurance data is not available at a granular level, inhibiting detailed analysis informing policy and its implementation.

PM-JAY is an ambitious programme that has faced some implementation and governance challenges in its initial years. It is one of the largest government-financed insurance schemes in the world, but with a mere 7.5% of the public health spend targeted to PM-JAY in 2022–2023 (Figure 6) (Dubey et al., 2023). At Rs 7,200 crore being the central budget for 2023–2024, it is estimated that government subsidies for government-sponsored insurance schemes like PM-JAY are very low (Gupta et al., 2019; PRS Legislative Research, 2022). A study conducted for the 15th Finance Commission (Gupta et al., 2019) estimated that the costs of full coverage of the targeted population for five years of implementation at 2019 rates could lie between Rs 28,000 crore and Rs 74,000 crore (Centre and State included). These costs could go up to between Rs 66,000 crore and Rs 1,60,089 crore in 2023 (accounting for inflation) (PRS Legislative Research, 2022). This would require a considerable increase or re-architecting of the overall central government budget on health. It has been found that even where government budgets allocated to health are high, UHC has been elusive, underlining the premise that the total quantum of resources allocated is not the only criterion of success. Mor and Shukla (2023) highlight that despite state differences in health budgets—where Bihar spends Rs 556 per capita (per annum) on health, while Arunachal Pradesh spends Rs 9,450—neither provides UHC. Not only does this underline inequities, but, more importantly, technical and allocative inefficiencies (Mor & Shukla, 2023).

Issues of resource adequacy and targeting are complemented with utilisation; underutilisation makes it difficult to justify additional resources. In 2021–2022, only Rs 3,115 crore were spent out of Rs 6,400 crore (TNN, 2023). The reasons would be several, but low awareness of the scheme and delay in the flow of funds are seen as key drivers (Bose et al., 2020).

Current challenges leading to inefficiencies have been pointed out in the Comptroller and Auditor General (CAG) audit report of 2023. The CAG report and other studies have highlighted the low levels of awareness of the scheme; cases of multiple enrolments against the same Aadhaar card and mobile number; enrolment of ineligible people (in Tamil Nadu alone, the expenditure for ineligible members accrued to Rs 23 crore [GoI, 2023b]); low interest from private providers in empanelling due to low package costs (15%–20% lower than the CGHS

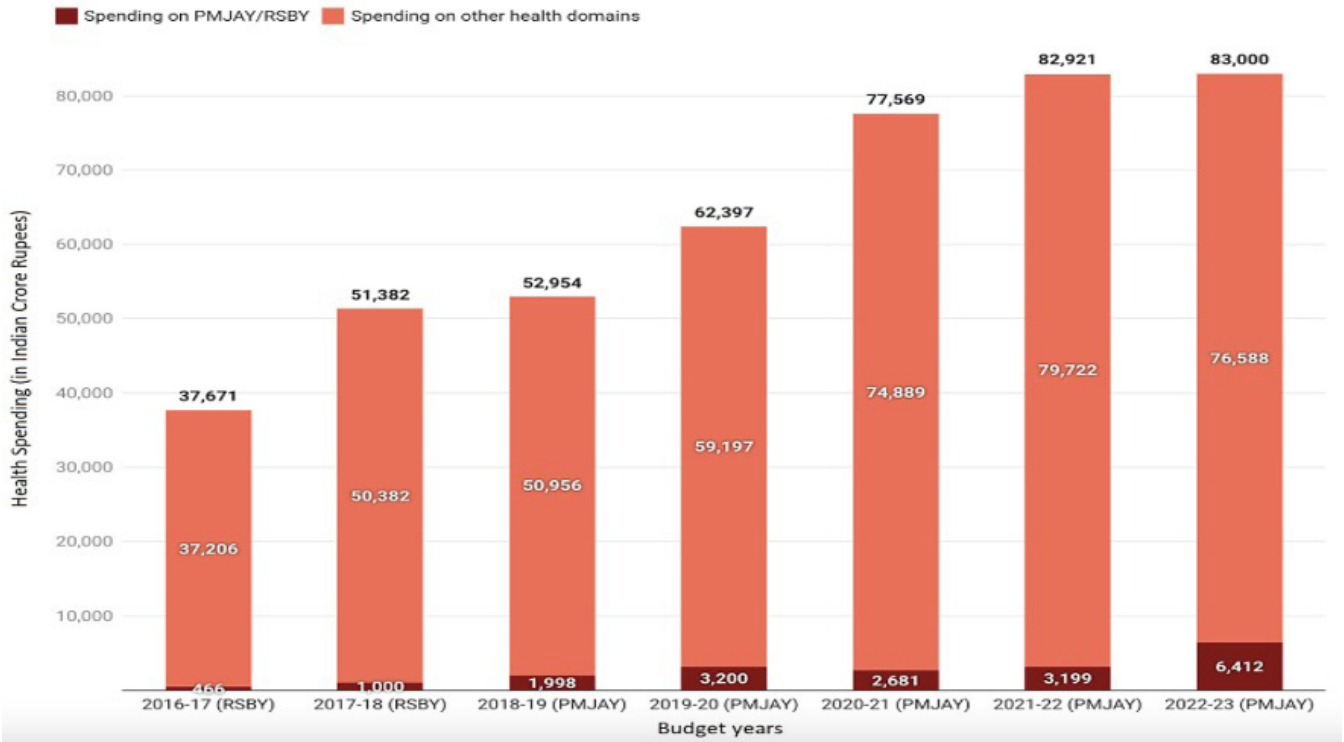
[8] The Ministry of Labour & Employment, under the initiative '*Nirman Se Shakti*', planned to modernise ESIC infrastructure—that is, hospitals and dispensaries—in a phased manner. '*Nirman Se Shakti*' includes the formulation of a standard design for 100/200/500-bedded hospitals with better modern facilities; an online, real-time dashboard for project monitoring or supervision; the adoption of new building technologies to ensure quality of construction; the elimination of delays and cost overruns; the digitalisation of land or property documents; etc. (PIB, 2023).

rates), leading to 46% of total providers empanelled being private (NHA dashboard, 2023); mostly small-sized private hospitals of poor quality (Sharma, 2022); private provider empanelment without meeting the criteria for infrastructure, human resources, and equipment; corruption in charging beneficiaries (GoI, 2023b); denial of treatment to beneficiaries by empanelled providers (Kaur, 2023); and several malpractices linked to providers (GoI, 2023b; Kaur, 2023) are some of the challenges noted. These issues reflect service quality and a lack of transparency and accountability with respect to empanelled providers (GoI, 2023b).

The CAG report (GoI, 2023b) points to the importance of governance in highlighting the absence of requisite structures (IT systems, organisational structures) in several states; constraints in workforce hiring; and integration of the state-run insurance schemes database with PM-JAY. Of the 29 states, only seven states formed an IEC (Information, Education, and Communication). Expenditure on IEC activities was well below the prescribed benchmark. The absence of state- and district-level grievance cells and the limited presence of Anti-Fraud Cells, Claim Review Committees, and Mortality and Morbidity Review Committees, etc., undermined the redressal process for beneficiaries. The lack of institutional processes to administer PM-JAY effectively has implications for low enrolment rates due to low awareness, lack of transparency and accountability, and quality of services, in turn impacting access and equity.

Challenges with respect to package costs merit discussion regarding costing. The case-based payment system is used by PM-JAY to reimburse providers for 1,574 medical and surgical packages, with rates based on a nationally representative costing study by a group comprising doctors, hospital associations, health economists, industry representatives, and others. While participatory in nature, the challenge lies in the absence of any single reference point for costs at the national level. While mark-ups exist for teaching hospitals and hospitals with quality accreditation, the heterogeneity of costs due to geographic location (Tier 1, 2, or 3), size of hospital, length of hospitalisation, and the annual number of hospitalisations are neglected (Prinja et al., 2023b).

Figure 6: Central Government Spending on Health (Proportion of Spending on PM-JAY vs Other Health Domains)



Source: Dubey et al., 2023.

Regarding the impact of insurance, it was envisaged that financial protection would increase access to health services and reduce OOPE. A systematic review concluded that there is no conclusive evidence of a reduction in OOPE under PM-JAY, but utilisation and access to services have increased (Reshmi et al., 2021). It is difficult to ascertain from state-level OOPE whether insurance has contributed to reducing OOP spending. A study in Chhattisgarh, however, found the mean OOPE to be similar for those enrolled in PM-JAY and those not enrolled in any scheme (Garg et al., 2020; Reshmi et al., 2021). Parmar et al. (2023) conclude that PM-JAY has increased access to private providers at secondary and tertiary levels that might have brought down OOP and catastrophic expenditure, which would have been high otherwise. However, given that maximum spending is on medicines and diagnostics at the outpatient level, there will likely be little impact of inpatient schemes on OOP spending. Studies show that patients paid OOP for services in private facilities that should be free of charge, mainly because hospitals felt that rates were low and that if rates were improved such payments would not be needed (Jain, 2021). PM-JAY is still new, and the impact of the scheme might take a few more years.

In India, we see the State Health Authorities (SHAs) taking up the role of the purchaser, but with a passive approach. While on paper there might be clear demarcations of the National Health Authority (NHA) and SHA roles, there have been gaps in implementing these, thus compromising accountability, transparency, and the quality of services. Passive purchasing is cost-inefficient and does not address the needs of the population (NITI Aayog, 2019). This has a bearing on the equity of services and supplies.

In summary, there has been considerable expansion of the health insurance landscape, primarily through tax-funded means. Coverage has increased, states have given priority to insurance cover, and flexibility through the central PM-JAY (the largest initiative) has enabled states to expand coverage in terms of people and benefits, and in terms of governance. These and other transitions point to overall progress. However, studies and audits suggest that the potential for improvement, with respect to access and financial protection, remains large. Universality, greater equity, comprehensiveness, and enhanced quality will require much greater attention to:

- Identifying mechanisms to mobilise those currently uncovered by insurance, estimated to be more than one-third of the population. These are individuals who are not classified as 'poor', are primarily outside of the formal workforce, and are not among the wealthy who can afford commercial insurance. Universal cover will require considerably greater resources allocated to insurance. Improving cover is not only about addressing those currently uncovered but also improving utilisation of insurance through increased awareness and quality of services.

- Improving accountability and reducing exclusions in insurance to provide effective financial protection for those who are covered, to address the current OOP spending among them. Quality and accountability challenges remain large in most schemes, particularly in PM-JAY, impacting the potential gains of access and financial protection.

- Leveraging the many pools in India for optimal benefits by aggregating them into one or fewer pools. The current fragmentation creates inequities with varying depths of services and also undermines the potential to control costs and improve quality through larger pools.

- Enhancing the gains from purchasing through introducing strategic purchasing. The current landscape of multiple purchasers across ministries plays a largely passive role. This results in varying efficiencies in maintaining quality, costs, transparency, and accountability of services rendered to the insured population.

Table 3: Gaps in Insurance Schemes in India

Challenges (Design and Implementation)	PM-JAY	CGHS	ESIS	Commercial Insurance (Purchased Directly from Public or Private Insurance Companies as Group or Individual Insurance)
Financial	• Attempts to cover a large population but with low investments. • Underutilisation of funds (of Rs 6,400 crore in 2021–2022, only Rs 3,115 crore were spent; Rs 140 crore unspent balance). • Varying state capacities to fill financing gaps. • Delayed fund flows from Centre to States (60% of funds).	• Small population covered, but budget much higher. • Preventive aspects of the programme are weak, and hence more burden on secondary and tertiary care.	• High financial reserves, poor claims ratio.	• Premiums are high, and there is much variation across companies; not standardised. • Arogya Sanjeevani premiums are lower but inaccessible for many. • Characterised by market failures—risk selection and those who can afford.
Enrolment	• Varies across states (from universal to targeted). • This means testing across states is different (SECC + other databases). • Low awareness among beneficiaries. • Errors in beneficiary registrations.	• Targeted towards serving and retired Central Government employees; hence, no challenge.	• Benefits are a statutory mandate under the ESI Act; hence, no challenges seen in enrolment.	• For individuals who purchase voluntarily or for private sector employer-based group insurance schemes. • *Arogya Sanjeevani* (a standardised insurance package with standardised costs across companies) was introduced as voluntary insurance for those who do not have any insurance. • Selects a younger, healthy population—many exclude pre-existing illnesses and people above 65 years.
Provider	• Low private empanelment due to low package rates and delayed reimbursements (12,165 private). • Low participation due to operational challenges. • Low quality of services (public and private) and high prices. • Co-payments made by beneficiaries (corruption); malpractices observed.	• Low empanelment due to low package rates; delayed reimbursements. • CGHS's own facilities are short-staffed with poor infrastructure.	• Supply-side issues and critical shortages in outpatient services (human resources, etc.) due to a lack of expansion of services. • Private provider empanelment started recently.	• Private providers are empanelled after negotiations with an insurance company regarding package rates, etc. • Many reimbursements are based on fee-for-service.
Governance	• Institutional mechanisms for quality checks, transparency and accountability, and grievance redressal are not active or in place for many states. • Low capacity of the purchaser. • High rejection rates for claims. • Capacities of SHAs and the District Implementation Unit are still weak.	• Lack of a robust MIS compromises ability to purchase effectively, control costs, and measure performance. • No separate autonomous fund manager for CGHS. Details of inflow and outflow of funds at all levels are not available.	• Limited health expertise on the ESI standing committee. Less representation from employers and employees.	• IRDAI regulates and licenses the entry of insurance companies into the markets. • TPAs work as intermediaries between insurance companies, providers, and beneficiaries. • The quality of services by providers is to be monitored by companies. Both are trying to profit, and there are tensions and conflicts between the two. • Overall regulations are very weak.
Outcomes, Gaps and Implications	• Utilisation of services is low in some states (Bihar, Uttar Pradesh—low capacity; lack of participation by private providers). • Utilisation has increased in private facilities with implications for the need to strengthen the public sector. • No significant reduction in OOPE.	• Low quality of services within the wellness centres. • Primary prevention is not covered, which puts a burden on secondary and tertiary care.	• Low performance in utilisation of services-weak supply. • Lack of data to conduct meaningful evaluations.	• Only inpatient services. • Co-payments are still made. • Accessible and available to few due to high premiums and selects healthy, younger people.

Source: CAG, 2023; MOHFW Annual Report, 2022–23; Ministry of Labour Annual Report, 2022–23; IRDAI, 2021–22; Gupta et al., 2019; Parmar et al., 2023.

4. Insights from Global Experience

As mentioned, several countries have moved to strengthening demand-side financing through the adoption and widening of health insurance. This section discusses experiences and insights from select countries that have used the insurance path of financing in their journey to UHC. The discussion is framed around the three key elements of resource mobilisation, pooling, and purchasing.

4.1 Revenue Mobilisation for Universal Health Insurance

It is well established that government spending on health as a percentage of current health expenditure is considerably higher in several countries in comparison to India (Table 4). Whether it be LMICs (such as the Philippines) or middle- to upper-middle-income countries (China, Indonesia, Mexico, Thailand, and Turkey), India's public expenditure on health is well below other countries (Table 4). Accordingly, OOPE in India is well above these countries (Table 4). The Philippines' economic status is not vastly different from that of India, yet its public spending on health is greater, and OOPE is lower.

Most of these countries reviewed gaps in health coverage and spending in the early 2000s due to high OOPE, leading to health system reforms and often increased budgets. The motivation and rationale for health system transitions are a larger discussion, but in summary, a combination of economic, social, and political factors led to increased priority given to healthcare (Table 5). A contracting economy, rising inequities, social unrest, public discontentment, and democratisation centred on social justice, all combined to create the rationale for prioritising healthcare, initiating reforms aimed at access, equity, and financial protection. Unemployment created by the East and Southeast Asian financial crisis prompted governments to roll out welfare measures to avoid social unrest and public discontentment. The democratisation processes in Brazil, Indonesia, and Thailand led to reforms in social welfare measures in the early 2000s. Turkey, Thailand, and China prioritised health as part of the political mandate in the early 2000s. Thus, a combination of political priority and socio-economic imperatives in the last two decades led to increased government health expenditure across several countries aimed at fulfilling the UHC mandate.

Table 4: Macro Indicators and Spending on Health (2020–2022)

Indicators	India	China	Indonesia	Mexico	Philippines	Thailand	Turkey
Per capita GDP PPP (US$) 2022	8,380	21,476	14,653	21,512	10,133	20,672	37,274
CHE as % of GDP (2020)	2.9	6.7	3	6.3	5.6	3.8	4.6
Govt health spending as % GDP (% CHE) (2020)	1.1 (37)	3 (54.7)	1.6 (55)	3.3 (53)	2.5 (44.4)	2.7 (70)	3.6 (79)
% OOP of CHE (2020)	50	34	32	42	41.5	9	16
Share of informal employment (%) 2021-2022	89.1	54.4 (2018)	80.2	56.6	40	65	29.9

Source: World Bank, 2020, 2022; UNDP, 2022; ILO, 2018.

Table 5: Why and How Did Countries Mobilise Domestic Resources for Health?

Context	China	Indonesia	Thailand	Turkey
Economic	Economic reforms not focused on social security but on growth, and the Party reviewed this gap in the early 2000s. SARS impacted the economy. The shift to market principles in the early 1980s undermined social security.	Economic crisis in the late 1990s fostered the process of increasing social security due to large-scale unemployment and social unrest.	Economic crisis in the late 1990s fostered the process of increasing social security.	Economic growth led to reforms in the early 2000s.
Political	Party leadership aligned to focus on human development.	Democratisation and social justice as a key element of the process.	Democratisation and social justice as a key element of the process.	Political stability over the years and addressing UHC helped in consolidating power and stability.
Social	Public discontentment due to high OOP.	Public discontentment and civil society movements.	Public discontentment and civil society movements.	Public discontentment due to high OOP.
How did They Increase Spending?	Increase in contributions from the formal sector and increase in government subsidies (Centre and Provincial)	Legislations on a national health insurance act to mandate UHC; increase in contributions from the formal and informal sectors, and an increase in government subsidies; Provincial Governments were to allocate 5%–10% to health.	Legislations on a national health insurance act to mandate UHC; increase in contributions from the formal sector and an increase in government subsidies for the rest.	Focus on providing for the most vulnerable and then universalising by increasing contributions from the informal sector and increasing government subsidies. A single pool helped in cross-subsidisation.

Source: Venkateswaran & Singh, 2022a; Nundy & Venkateswaran, 2022; Singh & Venkateswaran, 2022; Nundy & Bhatt, 2022a; Venkateswaran & Singh, 2022b; Nundy & Bhatt, 2022b.

4.2 Pooling (Increasing Breadth, Depth, and Merging of Schemes)

As discussed, India witnesses multiple risk pools with variable benefits on the one hand, and a significant proportion of the population lacking health insurance on the other. Merging pools and increasing the breadth and depth of coverage has been a strategy adopted by several countries (Table 6) to improve efficiencies, costs, quality, and equity.

Merging of risk pools

Country experiences show that a larger pool of funds, distributed equally across a large population base, is equitable, making the case for defragmenting pools. This offers the scope of cross-subsidisation across several income quintiles, addresses the challenge of adverse selection, and makes for a progressive system through redistribution of funds across income groups.

Turkey created a single pool by combining five insurance schemes under a single agency in its UHC reforms. "The political and economic stability post-2000 enabled the new government in Turkey to implement reform measures, with stability across the reform period enabling necessary legislative (General Health Insurance Act) and administrative initiatives (integration of insurance programmes under an umbrella institution)" (Venkateswaran, et al., 2023). Thus, the aggregation of pools (followed by a gradual enhancement and alignment of benefits) was legally backed with a legal framework for unifying schemes. Health financing became more equitable through larger contributions (as a proportion of expenditure) from wealthier households (Venkateswaran & Singh, 2022a). The creation of a single pool addressed overlapping roles in health policymaking and implementation (earlier, both the Ministry of Labour and the Ministry of Health were responsible for drafting policy) and inefficiencies (a single pharmaceutical expenditure tracking system that reduced health administration and governance costs).

In 2011, Indonesia enacted a law mandating the establishment of a Social Security Administering Body. The body consolidated pre-existing health insurance funds into a unified scheme, with the State responsible for covering the premiums of impoverished individuals. Mandatory enrolment was enforced for all formal sector employees in the public and private sectors. A unified insurance system improved equity in benefit packages and access, particularly benefiting the impoverished and those under weaker insurance schemes, and centralised beneficiary data, minimising duplications in coverage and membership. A standardised information system enhanced efficiency and facilitated smoother benefit transfers amid job changes in a dynamic labour market (Nundy & Bhatt, 2022a).

Thailand and China have insurance funds managed by a single agency but with multiple pools. Both countries have three pools (a reduction from the previous four)—one each for the informal sector and their dependents across rural and urban areas, and formal sector employees across the public and private sectors. Resistance from the formal sector employees prevented their merger with the larger population, with the former receiving better benefits. Despite this fragmentation, the pool of informal sector workers and dependents is a large risk pool, heavily subsidised by the government in China and fully subsidised in Thailand (Nundy & Venkateswaran, 2022; Nundy & Bhatt, 2023b).

Breadth of coverage

In terms of expanding the breadth of coverage and attaining universal coverage, LMICs, with lower fiscal space, have faced the challenge of expanding coverage to the non-poor informal sector. Turkey and Thailand provided coverage to their populations by providing subsidies (a full subsidy in the case of Thailand) to the entire population after bringing all schemes under one agency. China provided 85%–90% subsidies to the population not covered by the formal insurance scheme; the public contribution motivated greater uptake by people (Nundy & Venkateswaran, 2022). The remaining 10%–15% of the premium amount is managed by provincial officials through community-level campaigns. Indonesia, on the other hand, attempted to provide coverage to the missing middle through voluntary contributory enrolment with no subsidisation. While this increased coverage to some extent, voluntary contributions without government subsidies have seen few takers and have resulted in adverse selection, with people enrolling when they feel the need to access services and leaving when there is no need. Indonesia has yet to attain universal coverage, with 84% of the population covered (Nundy & Bhatt, 2022a).

Voluntary contributions can be seen as an interim step, as voluntary contributions have, for the most part, not worked for too long in the absence of government subsidies, especially in LMICs. Greater awareness of health insurance and its importance as a social security measure may increase demand for health insurance and willingness to contribute consistently.

Depth of coverage

High OOP spending is often seen alongside low depth in coverage, even where large numbers of the population may be covered, suggesting the insufficiency of universal coverage alone in addressing OOPE, the latter a factor of depth of cover. In India, people spend OOP mostly on outpatient services, including doctor fees, medicines, and diagnostics. As we observe, the CGHS scheme receives a larger share of funds while catering to a significantly small population base with comprehensive coverage, while PM-JAY has a much smaller share in the pie and aims to cater to a large population and provides limited coverage.

Country experiences show that providing comprehensive services through insurance that includes preventive, promotive, and curative services rationalises the flow of patients from outpatient to inpatient, with the potential to control costs through early screen-

ing of chronic diseases that can be managed at the primary level. Countries that introduced ambulatory services at the primary level, like Turkey and Mexico, saw an increase in the utilisation of services at the outpatient level, contributing to the control of chronic conditions at the outpatient level. Introducing a universal, comprehensive benefit package in Turkey led to OOPE reduction from 27% to 16% (Venkateswaran & Singh, 2022a). A comprehensive benefit package in Thailand resulted in a high level of financial risk protection, reflected by a low incidence of catastrophic health spending and impoverished households (Nundy & Bhatt, 2022b). All countries show that reducing dependency on facilities at higher levels is important for cost efficiency and OOPE reduction.

Countries prioritised breadth and depth of coverage depending on their priorities and allocation of budget to health. China, for instance, first attained universal coverage while providing shallow services and increased depth in the second phase of reforms. Working on merging pools, increasing breadth and depth through increased government expenditure showed a reduction in OOPE in all countries (Figure 7).

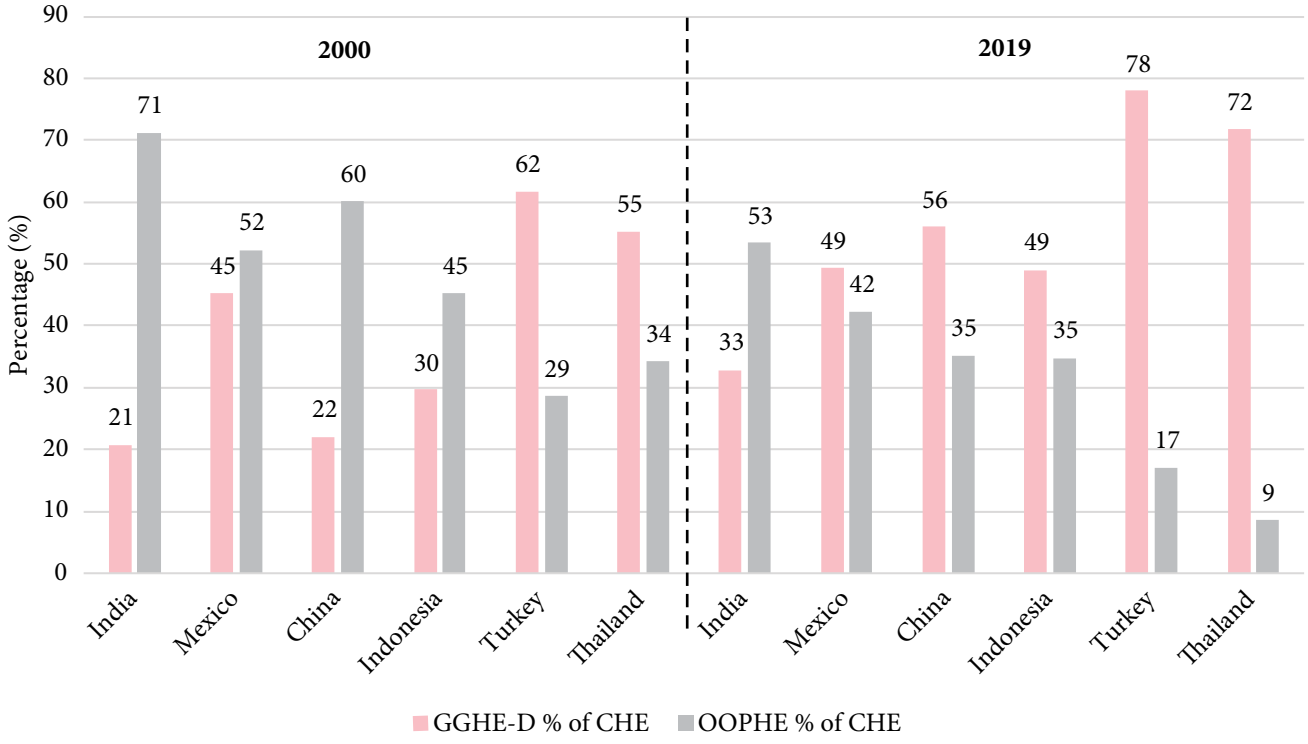
In summary, mobilising the revenue needed for UHC has been a function of the socio-economic and political contexts of countries, which motivated the prioritisation of health and allocation of tax resources. Recognising the equity and efficiency-related benefits of merging risk pools led to the consolidation of pools: a single one in some cases and three in others (differentiating the poor and the employed). Voluntary contributions are an option for countries with lower fiscal space, but experience suggests that motivation to contribute is driven by some subsidy from the government. Depth of cover is critical in both OOPE reduction and in controlling direct access to higher level facilities, the latter enabled by comprehensive cover across levels of care.

Table 6: Pooling Before and After Reforms

Countries	Before Reforms			After Reforms			Outcomes and Challenges
	Schemes + Population covered (%) (2000) -Breadth	Benefit Package–Depth	Financing	Schemes + Population Covered–Breadth	Benefit Package–Depth	Financing	
India	Multiple schemes before 2018	Varies in depth	Contributory for formal sector + government subsidies	Multiple schemes +PM-JAY (largest pool). 75% covered (approximately).	Varies in depth	Government subsidies have increased for poor + contributory (formal sector schemes)	Inadequate research on OOP or CHE, still low coverage and enrolment.
China	4 schemes. High OOP and rural resident scheme most disadvantaged–low quality and high co-payments. 20% covered.	Limited coverage and packages vary	Mostly contributions from formal and informal+ govt. subsidies+ high OOPE	3 schemes (merge rural and urban residents' scheme). 100% Provincial Governments to target full coverage of population	3 schemes have similar benefits (at all levels) (focused on breadth first and then depth)	Increase in government subsidies for informal sector + minimum contributions (mandatory from informal) + mandatory formal employer-employee contributions	OOPE reduced from 60% to 34%. Employee scheme and resident scheme still have funding gaps and vary in quality.
Indonesia	3 schemes. 50% covered.	Varying benefits of different depths	Contributions +subsidies by government.	One scheme (merged poor and informal sector + formal employees). 84% covered.	Same benefits (preventive, outpatient, and inpatient) Infectious diseases funded separately.	Increase in contributions (voluntary from informal) + govt. subsidies + formal employee/er contributions.	OOPE reduced gradually, utilisation increased Problems with voluntary payment from informal sector. Limited supply readiness
Thailand	4 schemes. 70% covered.	Varying benefits	Contributions (voluntary) + government subsidies	3 schemes (civil servants, formal sector, and the rest separate) 100%	Same benefits across schemes (comprehensive)	Increase in government subsidies (mandatory and no contribution from informal sector) Formal sector employee/ employer mandatory contributions.	Increase in utilisation; reduction in OOPE; No co-payments. Difference in quality and efficiency between civil servants' scheme, formal sector insurance and UCS for the rest. The former two have more funds available.
Turkey	5 schemes 70% covered	Varying benefits	Contributions and government subsidies	One scheme (all in one single pool) 100% Merged in phases	One standardised package (comprehensive)	Government subsidies increased + mandatory contributions	Reduction in OOPE; utilisation increased at all 3 levels Concern for fiscal sustainability of SHI, due to Turkey's comprehensive UHC package and aging demography

Source: Venkateswaran & Singh, 2022a; Nundy & Venkateswaran, 2022; Singh & Venkateswaran, 2022; Nundy & Bhatt, 2022a; Venkateswaran & Singh, 2022b; Nundy & Bhatt, 2022b.

Figure 7: Government Expenditure and OOPE Across Countries as a Percentage of Current Health Expenditure (2000–2020)



Source: World Bank 2001; 2020.

4.3 Purchasing Services

The active role of the purchaser is critical to the efficient and effective functioning of an insurance system. In India, each health insurance pool acts as a separate purchaser of health services, undermining its ability to leverage providers due to the size of the pool. Line-item budgeting still dominates the public sector, and fee-for-service is still the predominant payment method in the private sector. It is only with PM-JAY that case-based payment in the form of Diagnostic Related Groups (DRGs) is being considered. The private sector has been difficult to regulate, and financing, in many instances, has been the effective lever through which the private sector is regulated. Across countries, the government takes on the role of the strategic purchaser of services by empanelling the private sector, building in standardised treatment protocols, designing and costing packages/services, and determining payment mechanisms for providers.

Design and costing of packages

Defining the benefits package involves decisions about target beneficiaries; the extent and depth of benefits; and the levels of OOP contributions beneficiaries will need to make—decisions influenced by the economic, social, and political context of each country. Budget constraints in LMICs become binding at relatively low levels of expenditure per capita, leading to trade-offs: covering fewer people with a comprehensive package or covering a larger population with a less comprehensive package (Hsiao & Shaw, 2012; GoI, 2019).

"The definition of the packages and relative pricing require better alignment with the disease burden, as well as costing, market pricing analysis, and Health Technology Assessment (HTA)" (NITI Aayog, 2019), which determines the use of rational and effective technology given limited funds. Both Indonesia and Thailand leverage HTA for packages and their costs.

Including the private sector in the design and costing is challenging but imperative. In Thailand, decisions on standard procedures, diagnostics, and drugs are taken in consultation with private sector representatives, doctors', and nurses' associations. Through its Health Systems Research Institute (HSRI), the Thai system updates DRGs and develops new case-mix systems to refine standardised service levels in various sizes of hospitals (Nundy & Bhatt, 2022b).

PM-JAY uses a system of case-based payment methods to reimburse providers for a set of 1,574 packages. As observed, many private hospitals are unwilling to empanel. There is one reference point introduced for costs, and the heterogeneity of providers has been taken into account only recently by allowing mark-ups depending on the size of the hospital. But it has been observed (Prinja et al., 2023b) that the differential pricing has to take into account other aspects too—location and size of the hospital, and level of specialised care—highlighting the seven-time gradient in the cost of hospitalisation within public-sector hospitals. The inability to address this leads to the unwillingness of hospitals to empanel. Most developed countries have several gradients, and relative weights are used for pricing depending on geographical location, remoteness, recurrent procedures, and acute, specialised, and highly specialised procedures. India has yet to refine its costing process.

Consistency in costing across schemes is important. The IRDAI-NHA report (2019) shows "large gaps in rates of packages under different State and centrally sponsored schemes, such as CGHS, ESIS, PM-JAY and other programmes, often disadvantaging patients at private hospitals, which subscribe to more than one scheme" (Dey, 2019).

Provider empanelment

Empanelment of both public and private providers becomes critical in strategic purchasing to ensure standardised, quality services. A contractual arrangement ensures a minimum standard of human resources availability and qualifications; standard protocols and prescription guidelines; a standardised payment mechanism for providers; and potentially indicators to maintain performance standards (NITI Aayog, 2019). The contract lever could be used in India to integrate the public and private providers that exist in silos across levels. Contracts with differential pricing of packages across schemes undermine the monitoring of performance and quality (GoI, 2023b; NITI Aayog, 2019). One provider (a public or private hospital) deals with several insurance schemes with different standards and pricing that complicates its functioning, and the quality of services provided by the same provider varies for different schemes.

Indonesia assigns an identifier to every provider, who enters into a contract with the national purchaser. The capitation of private providers is double that of public providers to allow fair competition in the presence of government subsidies to public providers, and there is fraud prevention through reviews and inspections. In Thailand, the purchaser has its own contracting arrangements with private providers based on three levels of accreditation, which are utilised for measuring performance. Payments are adjusted upward as providers move up the three levels of accreditation approval (Nundy & Bhatt, 2022a; Nundy & Bhatt, 2022b). Additionally, Thailand has institutionalised annual negotiations between different interest groups/stakeholders of providers, doctors' associations, nurses' associations, pharmaceutical companies, and the medical devices lobby (Nundy & Bhatt, 2022b).

Provider payment mechanism

Countries have adopted varied provider payment mechanisms. Blended payments are used in most countries as a mix of case-based payments (mostly DRGs), capitation, and global budgets, with fee-for-service (FFS) in some cases. The DRG system is preferred over an FFS method to control provider motivation (especially in the private sector) to perform more inpatient procedures than required. "Almost every country has chosen to shift to a case-based system using several approaches: by classification categories (Japan, the Philippines, the Republic of Korea, and selected counties in China); by the nature of costs—i.e., salaries versus other types of costs (Thailand); and by participating hospitals (the Republic of Korea) or by disease categories" (Langenbrunner, 2015).

In most countries, the purchasing agency works around a global budget through which payments are made to the provider. These have an impact on sustaining insurance schemes and, in turn, UHC, but the budget needs to be expanded annually. Close-ended payments like global budgets may lead to issues of under-provisioning, but Thailand prevented this by unbundling some services from close-ended payment and paying for specific diseases according to an agreed fee schedule. Thailand and Turkey introduced capitation payments for primary care (outpatient services, including preventive and promotive services), with inpatient services paid by DRG. China's system of fee-for-service for each service has increased and inflated the budget, and the government has now introduced pilots on capitation and the DRG system of payments. In Indonesia, capitation for private providers was kept at double the rate for public providers to compensate for the subsidies that public facilities received.

Countries are moving towards performance-based payment systems along with DRGs, where incentives are given to facilities for quality services. These funds are used to maintain and upgrade the quality of public hospitals, as seen in Turkey (Venkateswaran & Singh, 2022a). PM-JAY is in the process of implementing value-based financing, in which empanelled hospitals will be measured based on beneficiary satisfaction, hospital readmission rates, extent of OOPE, confirmed grievances, and improvement in patients' health-related quality of life (NHA, 2022).

In summary, a standardised benefit package with consistent costs across schemes will help maintain equity. However, this has been a challenge in countries with more than one scheme. The packages are typically expanded gradually as increased funds are made available. Private sector empanelment has been defined by clear contractual agreements that include annual accreditation, quality checks, and rigorous audits. Private sector reimbursement costs and capitation are kept higher than those in the public sector—which receives subsidies—to allow fair competition. Provider autonomy is maintained by allowing providers to use the surplus to improve quality. The challenges observed with engagement with the private sector were low empanelment due to low costs in Thailand and misappropriation of funds. The DRG method of payment seemed the most efficient system of payment to providers in all countries due to greater cost efficiency achieved by containing costs.

4.4 Institutional Mechanisms for Effective Purchasing and Overall Governance

The policy instrument of strategic purchasing has been critical to financial reforms in the health sector in middle- and lower-middle-income countries. The concept of a purchaser-provider split is said to work well to efficiently purchase and enforce the accountability of providers (both public and private) to their beneficiaries through active purchasing. Strategic purchasing has the potential to increase provider competition, leading to greater efficiency. Institutions that govern and implement strategic purchasing are therefore key to the effectiveness of such processes.

In Thailand, the National Health Security Office (NHSO) plays the role of the purchaser, enforcing the accountability of public and private providers through active purchasing. The NHSO contracts the District Health System (DHS), which constitutes the cluster of services and functions as a unit at the district level. The contract is to provide outpatient services, including preventive and promotive services, to the district-level population based on an annual, age-adjusted capitation payment. As the purchaser, the NHSO has the monopsonistic power to negotiate with providers and suppliers of medicines and to assure quality (Nundy & Bhatt, 2022b). In Indonesia, the purchaser (the Social Security Health Agency) played a passive role, thus undermining its power and diluting its focus. Clear demarcations between the Ministry of Health and the purchaser were missing. The purchaser was not responsible for monitoring provider performance and quality and played a limited administrative role in processing claims and making payments. This undermined the purchaser-provider split in Indonesia (Nundy & Bhatt, 2022a).

Most countries have merged institutions to create the split and simultaneously created newer agencies to consolidate the roles of the purchaser and provider (Figure 8 i, ii, and iii). In China, insurance schemes were merged under one single purchasing agency, and provider agencies were merged under the National Health Commission. In Thailand, different agencies were institutionalised at the Centre, province, and district levels to work closely with the purchaser (the NHSO). These included the Health Accreditation Agency, the HTA agency, and the HSRI. Table 8 summarises the institutional mechanisms that existed before and after the reforms undertaken.

Table 7: Summary of Purchasing of Services by Countries

Countries	Design of Packages and Costing	Empanelment / Contracting Providers	Provider Payment	Outcomes (Achievements and Challenges)
India	• Different packages across different schemes and across same scheme (PM-JAY). • Benefits package focused on inpatient services in PM-JAY and includes infectious and non-communicable diseases. • Low cost of packages due to which low empanelment of private providers.	• Private sector participation has been low. • PM-JAY ensures pre-entry level accreditation by NABH. • Lack of continuity in quality checks, reviews, inspections.	• With PM-JAY key decisions initiated on benefit packages, costing and case-based DRG systems introduced. • Insufficient autonomy, limited financial planning, and management by public providers.	• Expanded benefits for in-patient, no pre-existing disease exclusions. • Lack of coverage for independent diagnostics and outpatient care. • Tamil Nadu and Meghalaya have more packages and consider the burden of disease specific to the state. • Low capacities on case-based and performance-based payments with both public and private. • NABH's role is the right step but inadequate quality checks after initial accreditation.
China	• Package initially designed to provide highly cost-effective health services, particularly for diseases that disproportionately affect the poor. • Coverage increased and included a wider range of interventions, as government spending increased.	• A growing private sector but mostly contracted public sector facilities.	• Different blended models at work–capitation at the primary, FFS at primary and other levels, DRG based payments being implemented in some provinces.	• Implemented and expanded insurance after piloting. • Public sector is autonomous commercially driven, reforms in pricing for insurance helped curb rising costs to some extent. • OOP still high due to overdependence on hospitals as co-payments are made here.
Indonesia	• A comprehensive benefit package by national purchaser (infectious diseases are funded separately). • Leverages HTA since 2017 to determine eligibility for appropriate diagnostics, payments for certain, expensive drugs, diagnostics, the benefits package.	• Contracts public and private sector equally. • Capitation of private provider is double that of public, to allow fair competition in existence of government subsidies to public. • Fraud prevention through reviews and inspections.	• Primary level funded by capitation and incentivised based on performance. • Hospital expenses reimbursed by purchaser by mix of case-based groups and FFS. • Capitation input based- does not consider regional epidemiological and demographic differences.	• Proportion of OOP spending in contracted facilities decreased but overall is still high. • OOP is still high due to supply-side issues (gaps in human resources, availability of drugs). • Policy experimentation at the local level.

Countries	Design of Packages and Costing	Empanelment / Contracting Providers	Provider Payment	Outcomes (Achievements and Challenges)
Thailand	• Comprehensive benefits for all including prevention and promotion for all citizens. • HTA for use of appropriate diagnostics for procedures integrated into the benefit package. • Decision on standard procedures, diagnostics, drugs taken in consultation with private sector representative, doctors, and nurses associations. • Calculation of costs done on a per capita basis, to include the cost of services, technology and human resources, and adjusted annually.	• Rigorous contractual agreements effective in ensuring mandatory infrastructure and quality standards. • Prior to contractual agreement, inspection unit assesses the applicants registering as main contracting units. • Three levels of accreditation utilised for measuring performance and payments are adjusted upward as providers move up the three levels of accreditation approval. • This measuring occurs every year.	• Capitation at the primary level. • DRG payment at secondary and tertiary under a global budget; FFS for some high-end specialisations. • Providers responsible for complying to standards and protocols like filing reimbursement claim forms within 30 days after discharge.	• Private sector empanelment limited despite large presence in Bangkok due to low-cost packages. • False billing by private sector which was caught in audits. • Provider autonomy–allowed to retain surplus and flexibilities in internal management of allocated resource. • Reduction in OOPE from 34% to 9%.
Turkey	• Comprehensive benefit package for preventive, primary healthcare, and inpatient services with no cost-sharing under UCS. • Collaborated extensively with global technical experts to craft intricate actuarial models, showcasing cost scenarios for various inputs, benefit packages, and service usage. • Meticulous evaluation of the budgetary implications and fiscal sustainability of proposed plans.	• Turkey has a small private sector. • Hospitals are contracted by the purchaser.	• Global budget for public hospitals for the treatment costs based on services provided in the previous year. • Performance based funds go into revolving funds of public hospitals and used to maintain and upgrade quality.	• Introducing comprehensive benefit package for all led to the reduction in OOPE from 27% to 16%. • The primary concern is maintaining the financial sustainability of the insurance scheme, due to rising costs stemming from the extensive coverage, shifting demographics, and diverse economic factors.

Source: Venkateswaran & Singh, 2022a; Nundy & Venkateswaran, 2022; Singh & Venkateswaran, 2022; Nundy & Bhatt, 2022a; Venkateswaran & Singh, 2022b; Nundy & Bhatt, 2022b; Marshall, et al., 2023.

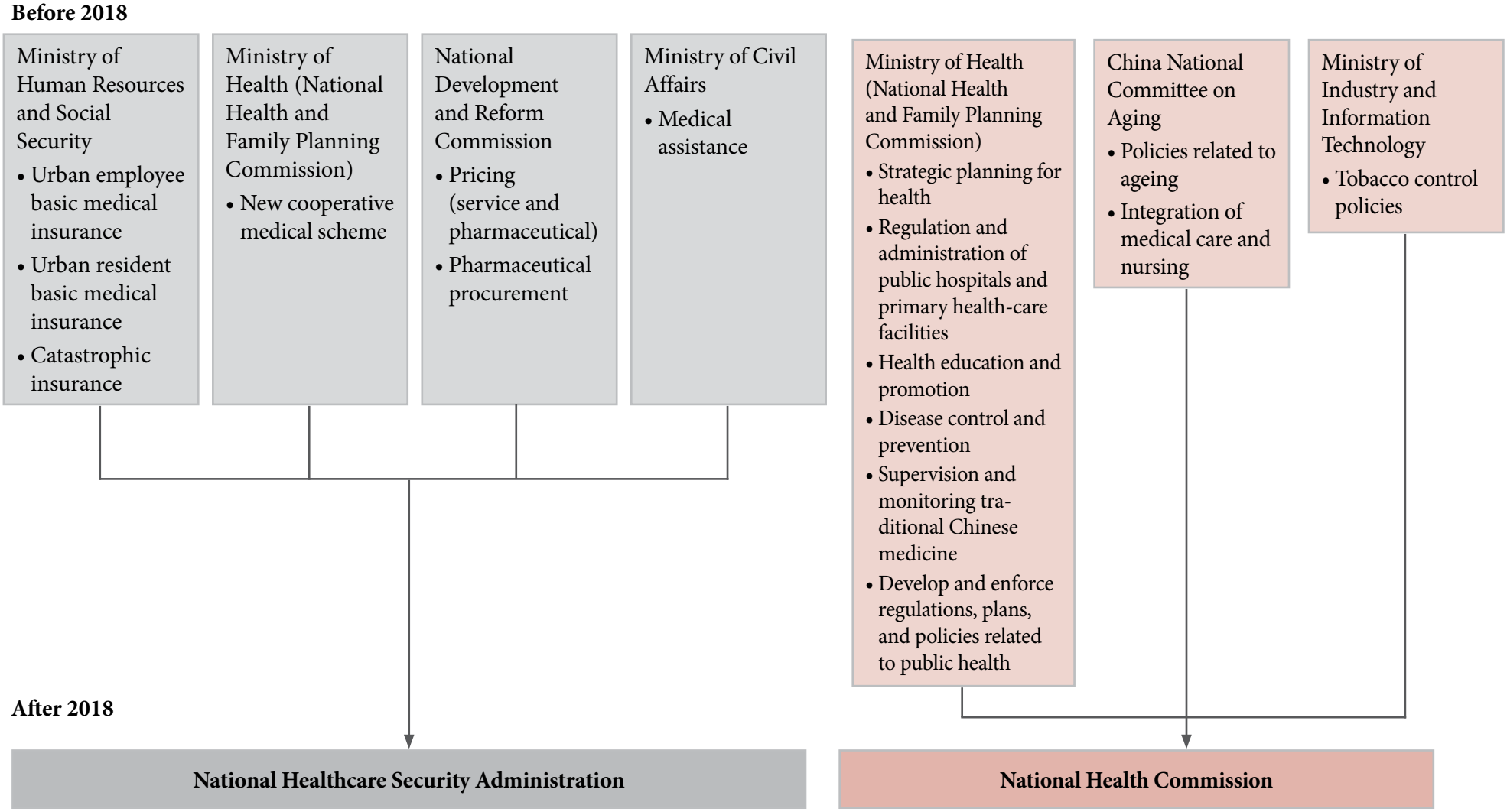
Table 8: Institutional Processes for Efficient Purchasing and Effective Governance

Countries	Institutional Processes		Outcomes and Challenges
	Before reforms	After reforms	
India	• Pre-PM-JAY, there were separate purchasers for schemes.	• Separate purchasers for separate schemes, and most play a passive role; the NHA was created for designing and administering PM-JAY. • PM-JAY, the largest scheme, has one purchaser (the SHA) at the state level.	• Different capacities of states. • Passive role of purchaser at the state-level.
China	• Multiple fragmentations—each insurance scheme was being managed by separate ministries.	• One single purchaser (NHSA) under which insurance schemes are managed. • Regulates prices of prescription drugs, medical and surgical procedures, and updates the national essential • reimbursement list for drugs and service items annually. • Fiscal decentralisation and autonomy to provinces.	• Ease in administration and greater efficiency at the Central level but these are not reflected in the middle and lower levels of governance. • Challenges of accountability and overlapping roles remain; purchaser-provider power conflict. • Interprovincial variations due to decentralised power and fiscal devolution. Poorer provinces perform less and need more Central support.
Indonesia	• Five separate insurance schemes under different ministries.	• Merged under a National Health Security Agency. • Devolution of administrative and fiscal roles and responsibilities • from the Central Government to local governments.	• Tensions between purchaser and provider affects governance and quality of services. The purchaser plays a passive role because of overlaps in purchasing functions of MOH and purchasing agency. • Interprovincial variations due to decentralised power and fiscal devolution. Poorer provinces perform less and need more central support.
Thailand	• Fragmented schemes under separate administrative agencies.	• Three schemes are governed by three laws. The NHSO, the largest scheme, was established under the National Health Security Act to govern UCS. • The MOPH and the NHSO are supported by the National Health Commission Office; the Health Systems Research Institute (HSRI); the Health Accreditation Institute (HAI); The Health Service Standard and Quality Control Board; the HTA; and the Thai Health Promotion Foundation (ThaiHealth). • The NHSO renews annual contractual agreements with private main contracting units, on the condition that they maintain NHSO standards and pass annual inspections. • The NHCO has citizen representatives and meets annually.	• Reforms resulted in recentralisation, NHSO had the financial power. • Accountability in governance was institutionalised and hence, effective due to representation from different sections and multi-stakeholder involvement. • National Health Assembly for public participation held annually. • The tensions between the NHSO and MOPH were prevalent due to the split between the provider and purchaser.
Turkey	• Three social security schemes. Funding for the three social security institutions came from a mix of payroll taxes, employer contributions, and general government tax revenues. • Each institution operated with its distinct set of benefits and payment procedures, resulting in variations in access, covered services, and co-payment requirements.	• Unification of the schemes was ensured through a passage of law. • All public hospitals were transferred to the MoH.	• Centralisation of the administrative and financial function, SSI has both fiscal and administrative authority. • Concern over the fiscal sustainability of the SSI. • The institutions at the three levels are not integrated, causing an overburden on the secondary and tertiary hospitals. It is a largely hospital-centric system

Source: Venkateswaran & Singh, 2022a; Nundy & Venkateswaran, 2022; Singh & Venkateswaran, 2022; Nundy & Bhatt, 2022a; Venkateswaran & Singh, 2022b; Nundy & Bhatt, 2022b; Marshall, et al., 2023.

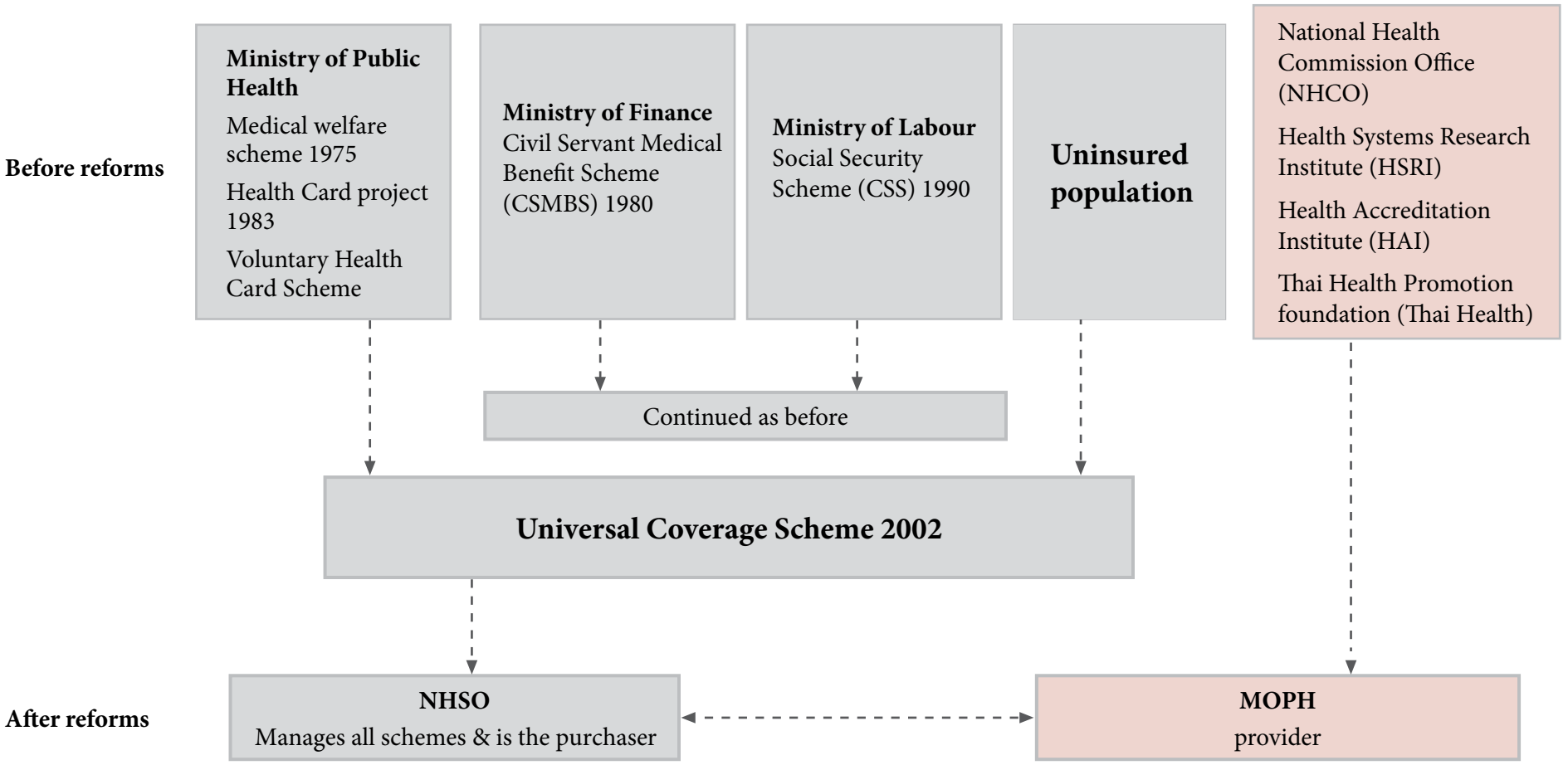
Figure 8: Merging of Institutions and Purchaser-Provider Split

i. China



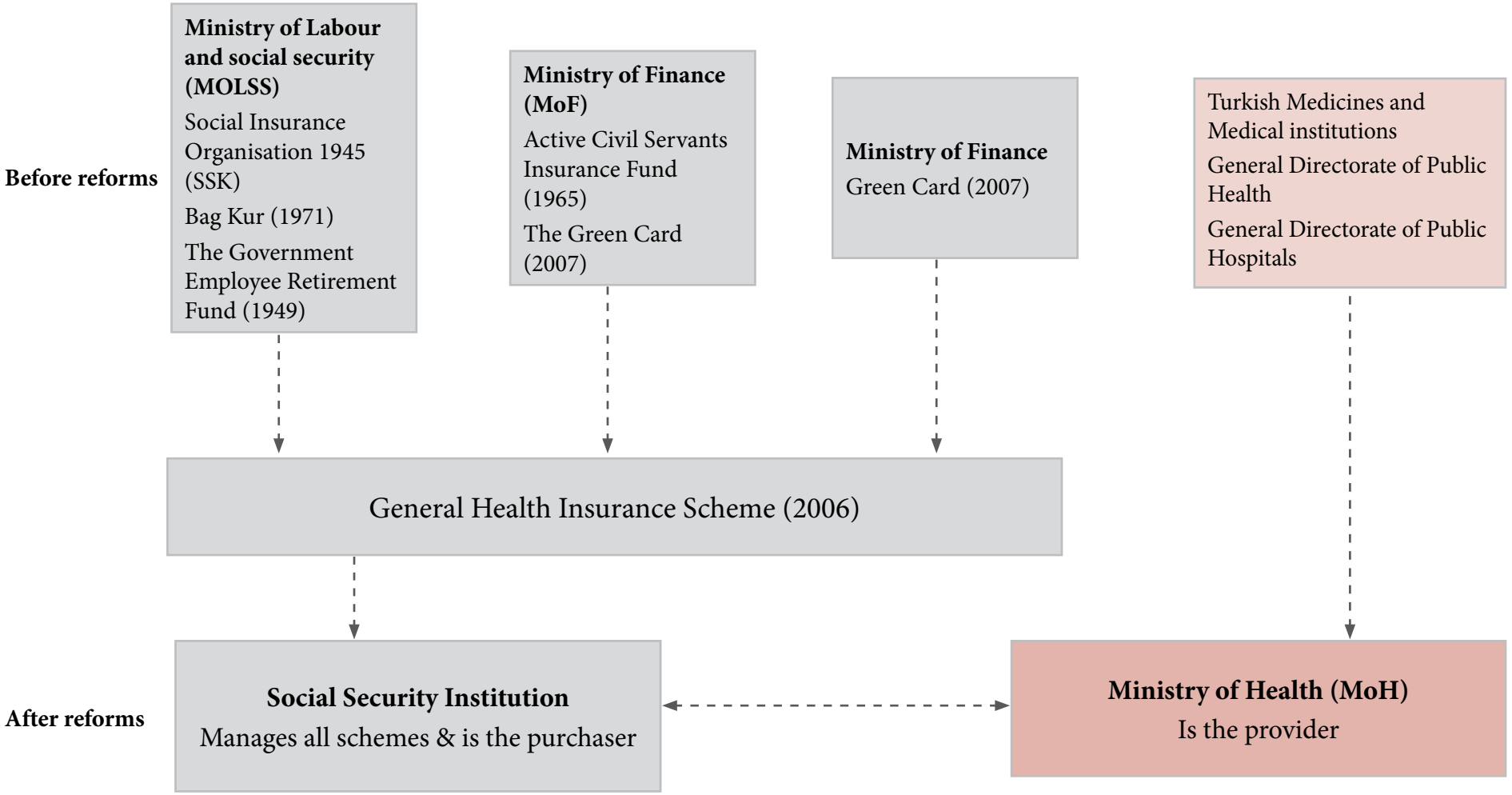
Source: Yip et al., 2019.

ii. Thailand



Source: Authors' representation.

iii. Turkey



Source: Authors' representation.

While the purchaser-provider split has been seen as an important component of UHC reforms, it comes with its challenges, largely emerging from power asymmetries. Tensions between the purchaser (a single agency created) and the provider (in most cases, the Ministry of Health, which regulates public and private provisioning) have been reported across countries. In China, tensions between the purchaser and provider, due to purchasing power transitioning away from the Ministry of Health, made coordination and negotiations difficult. Given that the purchaser-provider split is an effective way of financing and delivering services, these power asymmetries must be acknowledged and continuously addressed, and that is what is seen in most countries. There is little literature on how these have been directly addressed in the countries discussed.

In India, a purchaser-provider split exists with the new institutional mechanisms of the NHA at the Centre and the SHAs at the state level, but the demarcations are not yet clear. The split between the provider (MOHFW) and the NHA has to be made distinct. The extent of regulatory/financial oversight by the Centre and the states varies. With commercial insurance, IRDAI regulations plus TPA capabilities have helped bring in some initial accountability measures, such as regular audits, but these are mostly for fraud prevention and not a check on the quality of providers (Nundy & Bhatt, 2023).

According to the GoI (2019), both Maharashtra and Tamil Nadu "have implemented strong processes for provider accountability, as well as for preventing, detecting, and deterring fraud. Tamil Nadu's health insurance scheme regularly reviews morbidity and mortality outcomes across both public and private providers". The two states of Karnataka and Meghalaya, which have a history of managing health insurance schemes, are more attuned to strategic purchasing and have better experience with the split (GoI, 2019). There might be important lessons to learn from other states within India.

In India, agencies like the HTA, the National Accreditation Board for Hospitals (NABH), the Department of Research, and the National Health System Resource Centre (under the National Health Mission [NHM]) exist, but they fall under different departments/ministries with little coordination among each other and with the NHA.

In summary, institutional reforms—especially those that separate purchasing from provisioning—are an integral component of health financing strategies, though these do not come without institutional tensions. Countries have merged multiple purchasers and multiple provider mechanisms into single purchasing agencies and single provider institutions. These have led to ease of administration and increased efficiencies, though with an ongoing need for managing conflicts across newly created institutions. Additionally, countries have developed a range of other institutions for research, health technology assessment, accreditation, etc., to support the effective financing of healthcare.

5. Potential Pathways for India

Summarising insights from country experiences reveals patterns in the reforms. Some key observations are as follows:

- **Increased government subsidies** (often complemented with voluntary contributions from informal sector non-poor, near-poor individuals) into the risk pool. This increase in government subsidies required increased fiscal capacity along with political commitment to healthcare. Countries with GDP comparable to India's brought in UHC through higher health budgets as a result of increased priority given to healthcare. **Legislation was introduced in all countries to mandate UHC.**

- Most countries **merged risk pools** to either create a single pool or merged those with similar features to reduce fragmentation. Merging risk pools contributed to improved system outcomes, provider accountability, and autonomy (especially of public sector facilities) when complemented with performance-based incentives within strategic purchasing.

- **Empanelment through provider contracts** was a strategy to monitor and ensure regulation, accountability, and the quality of services, especially in the private sector. Accreditation was not a one-time exercise but an annual one. The breadth of coverage was increased to reach universal coverage, with countries subsequently working on improving depth.

- The majority of countries are moving out of line-item budgeting, thus reducing supply-side financing and moving instead to financing through the purchaser. The type of provider payments varies, but it is mostly through

blended payments (capitation, case-based DRG payments, and global budget). No one model is perfect, but FFS is seen to be regressive. Financing has therefore moved towards output-based reimbursement with performance incentives.

- There were key institutions critical to strong insurance systems: a purchaser different from the institutional mechanism for provisioning; quasi-independent agencies, like the HTA; accreditation and audit agencies (to check quality and fraud); and a national research institute that feeds into policy. The roles and responsibilities of central and state agencies (purchaser, provider, other autonomous agencies—for quality, managing fraud, and grievance redressal) have to be clearly defined to avoid overlaps and conflicts.

5.1 Increasing Revenue for Better Performance

It has long been argued that India needs to increase government financing in health, as recommended by most policy documents on health over the last two decades. Given the federal structure of how health services are governed and financed, legislation to mandate UHC is well-founded to establish uniform guidelines adhered to by states for UHC.[9] This may influence the prioritisation of funds towards UHC. However, in the absence of increased funds, re-architecting current health financing so that a greater proportion of existing resources are routed through the purchasing mechanism (rather than providing funds to providers through line-item budgets) could be another strategic direction to consider.

Several options can be considered for increasing revenue. These include:

- Increasing tax allocation to insurance to expand cover or increasing resources through additional taxes earmarked for insurance.
- Mandating contributions (from the informal, non-poor population).
- Voluntary co-payments for the informal sector (non-poor population) under a basic benefit package.
- Decentralising financing by empowering local bodies to raise more revenue and allocate as per needs.

Each of these has merits and potential challenges in the Indian context (Table 9). Countries that have introduced these options have experienced varied outcomes, which are also discussed in the table.

5.2 Consolidating Risk Pools for Better Performance

India has a fragmented health insurance landscape. Defragmenting this landscape by merging pools is an important and logical step towards UHC. While a single pool could be a long-term plan, given the federal system of government, merging some pools in the short term could be considered.

- The following options can be explored:
- Merging all existing pools into one.
- Introducing a tax-based universal common benefit package (as a subset of existing insurance schemes).
- Expanding insurance schemes for the poor and informal, non-poor population (through partial contributions from the latter, with a state subsidy).

The merits and potential challenges of these options are outlined in Table 10, along with relevant country experiences from those that have introduced them.

[9] It is recognised that institutional capacity will have to be built simultaneously.

Table 9: Increasing Revenue for Better Performance

Options	Advantage	Possible Concerns in the Indian Context	Country Experience
Increase tax allocation to insurance to expand cover. OR Increase resources through additional taxes earmarked for insurance.	• Linked with specific objectives and programme reduces the chance of mis-prioritisation. • Increased revenue for the specific target group or programme. • Financially sustainable. • Improve health behaviour among population (if earmarked as a health tax for unhealthy products).	• Increased allocation will require political will. • In India, the process of earmarking entails parliamentary intervention. For commodities under the Union list (e.g., tobacco), earmarked funds will be directed to the Consolidated Fund of India, subsequently transferred to respective states (creates administrative complexities with the possibility of either mis-prioritisation or not utilising funds at all). • For commodities (like alcohol) on the State list, the law varies by state. Currently, 16 states have increased taxes and excise duty (post-COVID) on alcohol. However, there is a wide variation in duty levied (6% to 75%).	• Thailand: Allocates 72% of total health expenditure to government health insurance (tax-funded). Indonesia (29%), China (28%), and Turkey (26.3%). • The Philippines: Earmarked funds for UHC from incremental revenue from tax on alcohol, tobacco, and sugar-sweetened beverages. Under the UHC Law passed in 2019, other funds were also earmarked. Since the earmarking was linked to specific objectives and programmes, the earmarks have provided a sustained, significant source of revenue, tripling resources for health between 2013 and 2018. • The Philippines had previously struggled to enrol informal workers in the insurance programme. Additional resources helped boost enrolment, but around 18 million people (mainly informal sector workers) are outside the system. The effective coverage is around 82%.
Mandatory contribution (from the informal, non-poor). Physical registration required, implemented through purchaser.	• Increased revenue for the insurance programme. • Reduced dependence on government revenue. • Since it is mandated, effective coverage increases.	• Implementation challenges due to difficulties in identifying people in the informal sector. • Mandatory contributions may be a burden for those just above the BPL (given that countries levy 10% to 13% of earnings for premium contributions). • With increased effective coverage, both primary care and hospitals will need more resources, which may cause denial of services due to low quality or the unavailability of services.	• Cost Rica (95% coverage under UHC) has mandated contributions (10.5% to 13.5% of earnings) for self-employed, independent workers. The benefits package is comprehensive, covering both inpatient and outpatient services. • Costa Rica extended social security benefits to informal workers through law (mandatory participation through contributions). Participation was ensured through (a) using trade unions or associations to collect contributions; (b) social insurance institutions employing specialised inspectors to oversee worker registration; and (c) self-employed workers being grouped into different contribution categories based on their income. However, the health system in Costa Rica is facing a financial sustainability issue due to over-reliance on employment-linked revenues. • Turkey (98.8% coverage under UHC) has mandated contributions (12% of earnings) for self-employed and independent workers. The government enforced contributions under the overarching framework of the General Health Insurance Act. The benefits package is comprehensive, covering both inpatient and outpatient services, as per the Social Insurance and Universal Health Insurance Law. Failure to pay premiums results in being excluded from availing of services and in being indebted, which may have wide-ranging implications.

Options	Advantage	Possible Concerns in the Indian Context	Country Experience
Voluntary co-payment for informal sector (non-poor) under a basic benefit package.	• Increased revenue and higher coverage. • Financially sustainable.	• Voluntary participation may not largely happen as evident form country experience. • Government may need to allocate more resources to conduct IEC to generate mass level sensitisation about the programme.	• China: Willingness to pay increased when there was no reimbursement ceiling, no deductibles, and no co-insurance (for out-of-pocket payments). People also participated because it covered high-cost illnesses. • Indonesia: The National Health Insurance (JKN) covered informal, non-poor individuals through voluntary contributions. Challenges with participation arose due to (1) higher premiums with no government subsidy; (2) the challenges associated with a floating population due to changes in employment from formal to informal work; (3) difficulties with the enrolment process; and (4) the provision that allows enrolment at any point during the year, which creates an incentive for households to delay enrolment.
Decentralise financing through empowering local bodies to raise more revenue and allocate as per needs.	• Less dependence on central transfers and simultaneous creation of fiscal space for the central government for other needs. • Reduced centralisation in financing and greater control for local governments over financing; fewer chances of misplaced priorities.	• Political economy issues (as state governments may not want to lose control over revenue generation through taxation). • Currently, the majority of local bodies (other than those in megacities) do not have adequate capacity to finance and govern on their own. • This may require a constitutional amendment. • May create inequities across municipalities. • Funds may be targeted to non-health areas.	• Brazil: Decentralisation (through devolution of power) occurred in a phased manner. Municipalities with greater capacity were allowed to manage their own financing and governance. Weaker municipalities depended on central and state transfers. The financing of health was distributed across levels of government, with states and municipalities required to allocate a minimum of 12% and 15% of their revenue, respectively, to the Unified Health System (SUS). • The health system is facing fiscal sustainability challenges due to the inability of local and central governments to raise revenue for the health sector. • Indonesia: Central, provincial, and district governments allocate finances to public health. Districts have autonomy to spend on human development areas. Intergovernmental financing relies on the General Allocation Grant (*Dana Alokasi Umum* [DAU]) for fiscal equalisation. The mandate is that the DAU pool should be at least 26% of the total net domestic revenue, of which 90% should be transferred to districts and 10% to provinces. Since 2001, DAU has constituted the major revenue source for districts. Despite decentralisation, health spending has been consistently low, with variations across districts. Weak monitoring and accountability mechanisms lead to mis-prioritisation.

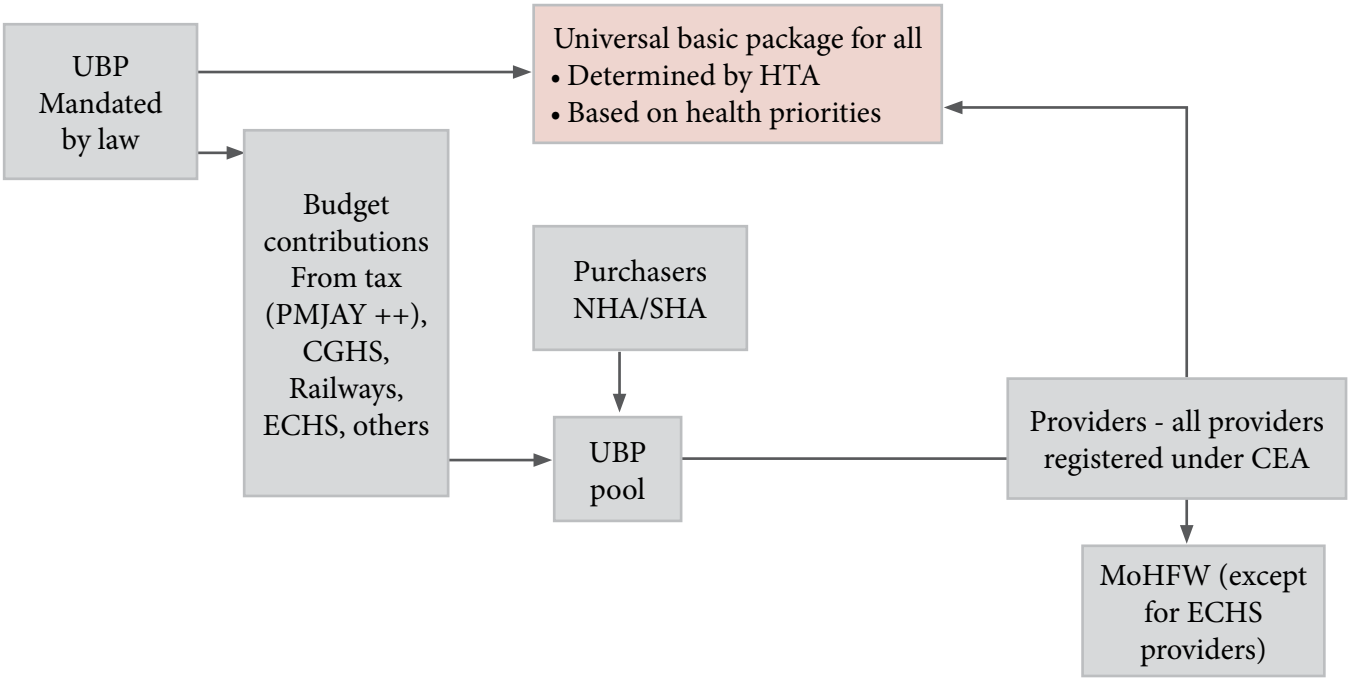
Table 10: Consolidating Risk Pools for Better Performance

Options	Advantage	Possible Concerns in the Indian Context	Country Experience
Merge all existing pools into one (including the civil servants' insurance scheme)	• Generating additional resources for cross-subsidisation. • Standardisation of the benefits package creates an opportunity for equity in financing, provisioning, and health outcomes. • Strengthens the governance process through defragmentation, leading to greater accountability (through a single purchaser). • With additional resources, effective coverage may increase, creating an opportunity to achieve UHC.	• Variable benefits and budgets make merging schemes difficult. • Even if all existing schemes are merged, it may not generate the required resources (at least double the existing expenditure on government insurance). • Due to the large percentage of the poor and informal sector population, it is fiscally challenging. • Since health insurance schemes in India are not mandated by an act, participation in the programme is voluntary (less obligatory for citizens to participate, therefore creating a risk of low enrolment and underutilisation).	• Turkey and Indonesia: Before merging pools, both mandated health insurance for all through an act. • Turkey is facing a fiscal sustainability issue, as the fiscal deficit of the SSI is growing annually (dependence on tax funding is increasing). • Indonesia: Created a single trust fund (Dana Amanat) comprising contributions from the entire population, and tax contributions are made for the poor. Despite this, the effective coverage is 82%, with considerably higher OOPE at 32%.
Introducing a tax-based universal common benefit package (a subset of existing insurance schemes with an extension to informal sector workers). Members of other pools draw from this for the universal common benefit and from their respective pools for benefits beyond.	• The minimum benefit package will essentially cover secondary or tertiary-level services with demand-driven payment. • Has the potential to address additional financial requirements through contributions by eligible people. • A standard rate for the benefit package is applied across all pools. • A consistent payment method is used across all pools. • Rationalisation of physical and human resources. • Potential for cross-subsidisation due to a lower chance of drawing on the pooled fund. • Reduces inequity in financing, provisioning, and outcomes.	• Identifying eligible people in the informal sector is a major challenge. • Generating additional resources outside the existing insurance schemes may be challenging. • The balance between a reduction in OOPE and catastrophic expenditure will depend on the benefits package. • A lack of state capacity to ensure the participation of informal workers. • The possibility of adverse selection due to the voluntary nature of the scheme.	China: The growing informal sector led the government to include informal workers under Basic Health Insurance (BHI) in the late 1990s. BHI covered both inpatient and outpatient services, and willingness to pay (premiums) increased due to coverage for large financial losses associated with catastrophic care. It was also found that government subsidies and changes in insurance attributes (e.g., including catastrophic care and portability) were effective in increasing coverage.

Options	Advantage	Possible Concerns in the Indian Context	Country Experience
Expand insurance schemes for the poor and informal non-poor population (through partial contributions from the latter with a state subsidy).	• Generating additional resources to extend medical benefits to the informal non-poor population. • Standardisation of the benefits package for both the poor and the informal non-poor population creates an opportunity for equity in financing, provisioning, and health outcomes. • Strengthens the governance process through defragmentation, leading to greater accountability. • With additional resources, effective coverage may increase and create an opportunity to achieve UHC.	• There are no existing separate insurance schemes for the informal non-poor population (states have extended PM-JAY for the non-poor population using tax funds)—fiscal sustainability issues. • Due to the large informal sector, identifying eligible people and motivating them to contribute is challenging, making it harder to implement contributory schemes for pooling purposes.	• China: Consolidated health insurance schemes by merging the New Rural Cooperative Medical Scheme (NRCMS) (for rural residents) and the Urban Resident Basic Medical Insurance (URBMI) (for the informal sector) into the Urban and Rural Resident Medical Insurance in 2016, aiming for equity in access to healthcare between rural and urban areas and efficiency in the operation of the schemes. Unified management was handled through a single purchaser, the National Healthcare Security Administration (NHSA). Despite merging pools, access remained lower than that for formal workers. • Indonesia: Reformed its social security policy in 2014 by merging all functioning health insurance schemes and extended healthcare benefits to the informal non-poor population (30% of the total workforce) through voluntary contributions. The poorest individuals are funded by government budgets, while informal workers must pay 100% of the premium. Because there is no penalty for non-participation, the scheme is de facto voluntary. • The Philippines: The National Health Insurance programme requires mandatory participation from informal workers, though premium contributions are voluntary. Informal workers are targeted through cooperatives or NGOs, with the government incentivising institutions to collect premiums. The public insurance corporation (PhilHealth) has sponsored member groups that receive full or partial government subsidies, which incentivise informal sector participation. However, problems remain, including (1) relatively unaffordable premiums for its target informal sector groups; (2) a lack of systems to verify membership with contributions, thus creating issues with authorisations at the time of use; (3) low levels of benefits and substantial OOPE; (4) a "learning by doing" approach that lacked consultation and evidence-based studies, which led to policy confusion; and (5) a complex financial management system that made tracking funds unwieldy.

Source: Cristina & Bautista, 2022; Bärnighausen, Liu, Zhang, & Sauerborn, 2007.

Figure 9: Universal Benefit Package—Single Pool, Single Purchaser, and Single Provider



The population that still lacks any kind of insurance can be brought into PM-JAY. PM-JAY could expand beyond the BPL and cover others who wish to join. Government subsidisation of this population (near-poor and non-poor individuals) to some extent could incentivise enrolment (as in China) and include progressive contributions from those who can afford to contribute. Methods of enrolment across states could vary, as is currently the case. Many states are providing coverage beyond the BPL and are utilising their own methods of expanding enrolment. This could progress to a mandatory insurance scheme. Given the low awareness of insurance schemes in India, awareness regarding insurance at the state level has to be strategised in a way that increases demand for health insurance, which should be viewed as a necessity.

5.3 Introduce Strategic Purchasing for Better Performance

Strategic purchasing has been adopted as a strategy for improving efficiency and effectiveness across middle- and lower-middle-income countries. India is already on this path but needs to increase its focus on processes and institutions. Options for consideration include:

- Universal access to a shallow benefit package (for high-cost secondary or tertiary care) from empanelled providers.
- A universal shallow package (for primary care services) targeted towards current PM
- JAY beneficiaries from registered providers.
- Universal access to a comprehensive package of services by merging all contributory and non-contributory schemes at the state and central levels for secondary and tertiary care, along with primary care services delivered free of charge through *Arogya Mandirs*. This option also includes mandatory health insurance contributions for taxpayers.
- Mandatory health insurance for all, along with expanding access to PM
- JAY benefits to everyone (without voluntary private health insurance) through empanelled providers.
- Providing a comprehensive benefit package only to the elderly population (all people above 60) from all registered providers, in addition to PM-JAY—catering to those in the BPL category.

On payment mechanisms:

- Tax-funded, DRG-based payments for secondary and tertiary care and capitation-based payments for primary care.
- Capitation payments would include the cost of services, excluding salaries and infrastructure.

- Pay-for-performance incentives for secondary and tertiary services and weighted capitation for primary care services based on the registered population.

Blended payment systems could be piloted (capitation, case-based payments [DRGs], and global budget) to compare efficiencies. Fee-for-service reimbursements could be minimised and selectively applied to cases where there is a risk of underpayment due to high-end specialist services. Provider funding, including incentives, could be linked to outputs and performance. Allowing the public to choose their provider would create a competitive environment across facilities (across and within the public and private sectors) to perform better to receive incentives and simultaneously give institutions the autonomy to utilise surplus funds to improve quality.

Gradually, public hospital financing could move towards a demand-side system, with minimal supply-side financing. Currently, much of the financing for public hospitals is still through supply-side mechanisms, and reimbursements through PM-JAY received by these hospitals represent surplus funds. Prinja et al. (2023a) observed that public hospitals accounted for 35% of the total volume of claim payments; therefore, the surplus amount per district hospital is substantial. They suggest using these funds to increase the quantity and quality of services in public hospitals.

On costing of packages:

- Tax-funded, with differentiated package costing rates: higher rates for contributory schemes and pricing adjusted to the cost of living at the point of care. There is an opportunity for uninsured individuals to participate based on a nominal contribution (co-pay) proportionate to the tier of coverage.

The merits and potential challenges of these options are outlined in Table 11, along with relevant country experience from those that have introduced them.

Table 11: Strategic Purchasing

Options	Advantage	Possible Concern in the Indian Context	Country Experience
Universal access to a shallow benefit package of high-cost secondary or tertiary care services (to be determined by HTA) from empanelled secondary or tertiary care providers.	• No risk of adverse selection—universal beneficiary pool. • Creates incentives for both providers and insurance companies to participate, since coverage is universal. • Low fiscal impact (since the population needing these tertiary services is likely to be small) • Politically attractive. • May motivate people to participate and contribute for top-up coverage if needed.	• The majority of services are outside the benefit package; thus, there is a low impact on OOPE, though the impact on catastrophic expenses varies (depending on the services selected). • Creates incentives for curative care rather than for prevention or health promotion. • Care for the better-off can crowd out care for the poor. • Fee-for-service payments can trigger supplier-induced demand. • Unless the shallow package is aligned with health needs, it will have little impact on health outcomes or equity.	• China and Bangladesh: Started with a shallow benefit package (basic health insurance in China covered primary, specialty, hospital, and mental healthcare, as well as prescription drugs and traditional Chinese medicine. Deductibles, co-payments, and reimbursement ceilings applied, but these covered both primary and inpatient services). • In general, universal coverage of priority services is recommended before expanding the package (JLN, 2020). It is better to include high-value services (that provide greater health value) and exclude low-value services that could crowd out or displace services that provide greater health benefits. • Vietnam: Found that disinvestment from inappropriate disease indications in its Vietnam Social Security (VSS) benefits package could save around US$150 million annually based on HTA, but this has not yet been implemented. • Adequate funding through full-cost subsidies in capitation payments for outpatient services and DRG payments for inpatient services prevents the under-provision of services and is necessary to prevent balance billing by healthcare providers (e.g., Medicare in the US).

Options	Advantage	Possible Concern in the Indian Context	Country Experience
Universal shallow package of defined primary care services (e.g., diagnosis and care for TB, diabetes, hypertension, anaemia, and mental health—corresponding to existing NHM disease programmes), in addition to current PM-JAY packages—targeted to the BPL population (current PM-JAY beneficiaries) from all registered providers.	• Shifts input-based financing for NHM programmes to output-based purchasing through the NHA. • Benefit packages are aligned to areas with a large burden of disease and to public health priorities. • Improves the efficiency of selective disease programmes. • Ensures appropriate follow-up and continuity of care.	• Difficult to maintain the quality of care. • No incentive for primary care providers to register. • May substitute the budget for health promotion and prevention with reimbursements for curative care. • Difficult to estimate the cost of primary care services—no existing costing packages are available. • Current selected disease programmes will be split, with curative elements included in the universal package and prevention and promotion remaining with the disease programme.	• Mongolia: Shifted from input-based budgeting to output-based funding for all levels of care from a combined pool of the state budget and health insurance funds (HIF). HIF covers all essential services, including intensive and emergency care and care for complicated deliveries, stroke, cancer, trauma, and burns. Core expenditures related to salaries and infrastructure remain part of the input budget. • China: The New Rural Cooperative Medical Scheme (NRCMS) caters to services needed in rural areas, including a mix of primary and inpatient services. Central financing provides subsidies, which depend on different economic levels, to cover 80% and 60%, respectively, of funds to the western and central regions, with subsidies to the eastern region provided according to a certain proportion. This may be relevant given the different state contexts and varying capacities in India. • The NRCMS has supervisory authority over medical establishments, but it does not have the right to penalise medical establishments for poor performance—those rights fall to the health bureau. This weakens the supervisory authority of the NRCMS. The financial base of the NRCMS is relatively narrow, with 80% of its funding coming from different levels of government. This may affect the stability and sustainability of fundraising in the future. Because it uses a flat premium rate for eligible people, the programme is reportedly pro-rich. Since the programme focuses on inpatient and catastrophic outpatient services, its impact on average OOPE has been reported to be insignificant.

Options	Advantage	Possible Concern in the Indian Context	Country Experience
Universal access to a comprehensive package of services by merging all contributory and non-contributory schemes at the state and central levels for secondary and tertiary care, along with primary care services delivered free of charge through *Arogya Mandirs* and existing CGHS, ESI, ECHS, and state or municipal facilities. Mandatory health insurance contributions for taxpayers.	• Achieving UHC is politically attractive. • Merging pools creates efficiency and facilitates cross-subsidisation. • Provides monopolistic power to state agencies as the only purchaser of all health services, drugs, and diagnostics. • Creates an imperative for private sector providers to empanel. • Improves the state's ability to regulate private providers. • Makes portability easier, which is especially useful in a country like India with high levels of internal migration. • Facilitates a shift in focus from curative care to preventive or promotive care. • Large impact on OOPE.	• Fiscally challenging. • Likely to be strongly opposed by the private sector and private insurers, since it will almost inevitably reduce their profits and market share. • Removes choice from the population. • The autonomy of CGHS, state governments, ECHS, etc., as purchasers will be removed. • Will not address geographical variability in the quality of care.	• Brazil: The SUS offers comprehensive services at the primary, secondary, and tertiary levels. Revenue is generated at all levels of government through increased decentralisation and the autonomy this provides. States and municipalities are mandated to allocate a minimum of 12% and 15% of their revenue, respectively, to SUS. Two quasi-autonomous agencies (ANVISA and ANS) were created to regulate the private sector, including pharmaceutical companies. Physician accountability is ensured by introducing pay-for-performance incentives in PHCs and by contracting services through private providers. Simultaneously, SUS has increased the density of public health facilities and physicians in poorer states. Brazil's health system architecture consists of three main subsystems: (1) the government as the main financer and provider of publicly delivered health services; (2) the government as the financer of privately delivered services; and (3) privately financed and delivered services. SUS remains underfunded due to its overall dependence on tax funding, with no concrete mechanism in place to increase government allocations for health, leading to still-considerable OOP expenses for households. Turkey: Merged all existing schemes under the Social Security Institution to offer comprehensive services, including preventive, inpatient, and ambulatory care. However, universal health insurance with a standard benefit package is leading to a growing fiscal deficit within the Social Security Institution.
Mandate health insurance, along with expanding access to PM-JAY benefits to everyone without voluntary private health insurance through empanelled providers.	• A large beneficiary pool that brings in uninsured individuals enables better price negotiation with insurance companies through monopsony. • Low likelihood of adverse selection. • Increases incentives for empanelment, especially for mid-size private providers. • Politically attractive.	• High fiscal burden. • Poor targeting. • May create separate markets with different qualities of care for the rich and the rest (inequitable quality of care). • Does not address the current fragmentation of health purchasing or provision and may even add to it.	Mexico: *Seguro Popular* had a nationally defined benefit package that included both low- and high-cost illnesses and provided services free of charge at the point of care. It increased the number of people covered substantially and reduced OOPE, but funding streams were variable, and both access and quality remained uneven. The purchaser-provider split, combined with inadequate monitoring of expenditures at the local level and delays in fund transfers from the central to state governments, severely impacted health financing and outcome goals. The failure to implement strategic purchasing (due to the inability of the government to negotiate with trade unions) led to a weak accountability mechanism.

Options	Advantage	Possible Concern in the Indian Context	Country Experience
Comprehensive benefits for the elderly population only, from all registered providers (all people above 60), in addition to PM-JAY—catering to the BPL population.	• Provides coverage to those who may not otherwise be covered—promotes solidarity. • Can facilitate cross-subsidisation across vulnerable populations for some secondary and tertiary care. • Likely to bring a substantial portion of the uninsured population under insurance cover. • Politically attractive.	• Premiums are likely to be expensive, since there is no risk pooling. • The availability of services for elderly people, including palliative care, is uneven. • Difficult to protect or regulate against the denial of care. • The size of the elderly population is likely to expand in the coming decades, which may create long-term financial obligations that may be too expensive to fulfil.	Thailand: Prioritised long-term care for the ageing population. 82% of older people (65+ years old) are covered under UCS, CSMBS, and other state insurance schemes; employee insurance funds cover 15%; and around 1.6% are covered by SHI. Home-based care for incapacitated elderly people is funded by UCS. The majority of the budget is transferred to local governments to support home-based care provision; the remaining funds are allocated to health centres and district hospitals to support capacity-building and volunteer caregiver training. Although the country's publicly run health insurance schemes cover all Thai citizens with comprehensive coverage, gaps remain in non-medical costs and social support to facilitate access to and the utilisation of healthcare services.
Tax-funded, DRG-based payments for secondary and tertiary care; capitation-based payments for primary care. Capitation payments to include the cost of services, excluding salaries and infrastructure.	• Fiscally efficient. • Less incentive to prolong care with unnecessary services. • Defined accountability for enrolled population at primary care level with greater likelihood of referral linkages. • Creates mutual dependencies across public and private sectors. • Allows provider to anticipate needs for drugs & diagnostics more accurately and increase efficiency through build procurement	• More incentive for under-provision, especially in crowded hospitals. • PHC of enrolment may not correspond to provider of choice–leading to low impact on OOP. • May be politically unpopular–beneficiaries may see it as an infringement of choice, providers may find costing to be too low or inflexible.	Thailand: Capitation for primary care units and DRG-based payments for inpatient care, determined using HTA (led by HiTAP). Capitation includes the full cost of services–salaries, materials, and capital depreciation–which is paid directly from NHSO to MoPH. There is no co-payment and extra billing is prohibited. But this kind of strategic purchasing has created tensions with hospitals and pharma companies and Thailand is now moving to a full cost recovery model. Indonesia: Capitation payments for primary care under JKN but this ends up being used largely only for curative care instead of the whole range of services as originally envisaged.

Options	Advantage	Possible Concern in the Indian Context	Country Experience
Pay-for-performance for secondary and tertiary services and weighted capitation for primary care services based on the registered population.	• Combination of P4P at the secondary or tertiary level with capitation at the primary level enables accountability for outcomes and improvements in quality. • Capitation payments support competition while allowing for investments in health promotion.	• Poor regulatory and M&E capacity dilutes the ability to implement P4P. • Lack of technical capacity to shift from input-based, public-sector budgeting to a capitation payment mechanism. • Capitation-based payments reduce patients' choice and creates difficulties for enrolling migrants. • Outcomes must be defined locally, create additional capacity demands on SHAs, which is uneven across the country. • Due to strong doctors' association, implementing pay for performance is a big challenge. • Absence of robust information system lead to weak accountability mechanism and poor track of programme objectives.	• Brazil's SUS uses pay-for-performance for services purchased from both the public and private sectors and capitation-based payment for primary care services. Line-item budgeting is used for most public sector hospitals. Pay-for-performance, along with appropriate M&E, led to an increase in the overall quality of care. The new PHC funding mechanism (*Previne Brasil*) is based on (1) weighted capitation payments—i.e., payment calculations that incorporate the registered population and their socio-economic vulnerability and geographic factors; (2) performance incentives linked to seven priority areas, mainly focused on maternal and child health and chronic diseases; and (3) incentives to improve overall primary healthcare by addressing issues in the identified strategic areas. Availability and quality of services remain uneven across regions. The development of health infrastructure has been marginal, with a trend towards a decline in hospital beds from 3.7 per 1,000 people in 1970 to 2.1 per 1,000 people in 2017. • Mexico: Decoupling the purchasing and provisioning of services without a "pay-for-performance" system undermined quality and created loopholes for inefficiencies and corruption. • Turkey: Performance-based supplementary payments are made under SSI at public hospitals and primary health centres (PHCs). These payments have been used for individual medical professionals at all levels of care in both the public and private sectors, which has reduced regional disparities and increased user satisfaction. However, it has also increased medical costs due to excessive numbers of diagnostic procedures performed to attract more funding, impacting the financial sustainability of the social security institution.

Options	Advantage	Possible Concern in the Indian Context	Country Experience
Tax-funded with differentiated package costing rates—higher rates for contributory schemes and pricing adjusted to the cost of living at the point of care. Opportunity for uninsured individuals to participate based on a nominal contribution (co-pay) proportionate to the tier of coverage.	• Private sectors are more likely to participate. • Creates incentives for voluntary enrolment.	• May create fiscal pressures. • May be administratively challenging to implement and will require federal coordination.	• Turkey: Has direct cost-sharing in the form of co-insurance for prescriptions and devices (at 20% of the price; 10% for retirees) and co-pays for outpatient department (OPD) visits at a fixed rate determined by the SSI. Co-payment exemptions are provided for primary care or family physician visits but not for hospital OPD visits to encourage the use of primary care as the first point of contact instead of strict gatekeeping. • Mexico: Centralised procurement enabled greater efficiency. It was mandated that state governments would pay a fixed premium per family on the premise that both the federal and state governments would share the costs. However, the requirement that states provide resources based on the number of beneficiaries enrolled per year turned out to be inequitable, with poorer states having larger uninsured populations and needing to pay more.
Voluntary Group health insurance for extended families (based on HUF rules) to divide risk across age-groups within families with 50% premiums subsidised by government.	• Mixed risk pools among beneficiaries leading to lower premiums. • Incentivises insurance coverage among the uninsured.	• Unless mandated by law, initial premiums are likely to be high creating disincentives for uptake–creating a vicious cycle. • Can lead to under-utilisation among some members of household such as women, elderly or disabled–inequity.	• There is no experience from other countries regarding the government-financed family group insurance model, but it is very common in the private sector. • In general, voluntary purchase of insurance has not been shown to work well, such as in China, unless government funding constitutes a significant portion of the costs, such as in Turkey.

Source: Venkateswaran & Singh, 2022a; Nundy & Venkateswaran, 2022; Singh & Venkateswaran, 2022; Nundy & Bhatt, 2022a; Venkateswaran & Singh, 2022b; Nundy & Bhatt, 2022b; Pengpid & Peltzer, 2022; World Bank, 2022.

5.4 Reforms on Organisation and Institutional Processes

Experience across countries has demonstrated efficiency gains from implementing a purchaser-provider split. In India, the NHA and SHAs already play the role of the purchaser, but the roles of the NHA (purchaser) and the MOHFW (provider) could be more clearly defined to avoid overlapping roles. Institutional options are outlined in Table 12.

- Consolidation of purchasing and provisioning functions under the NHA (in the immediate term, only for the universal common package) and the provisioning functions under the Department of Health and Family Welfare, also reinforced at the state level.
- Setting up an organisation equidistant from and independent of both the purchaser (NHA) and the provider (MOHFW) with responsibility for regulation, quality control, enforcement, fraud control, grievance redressal, and policy research.

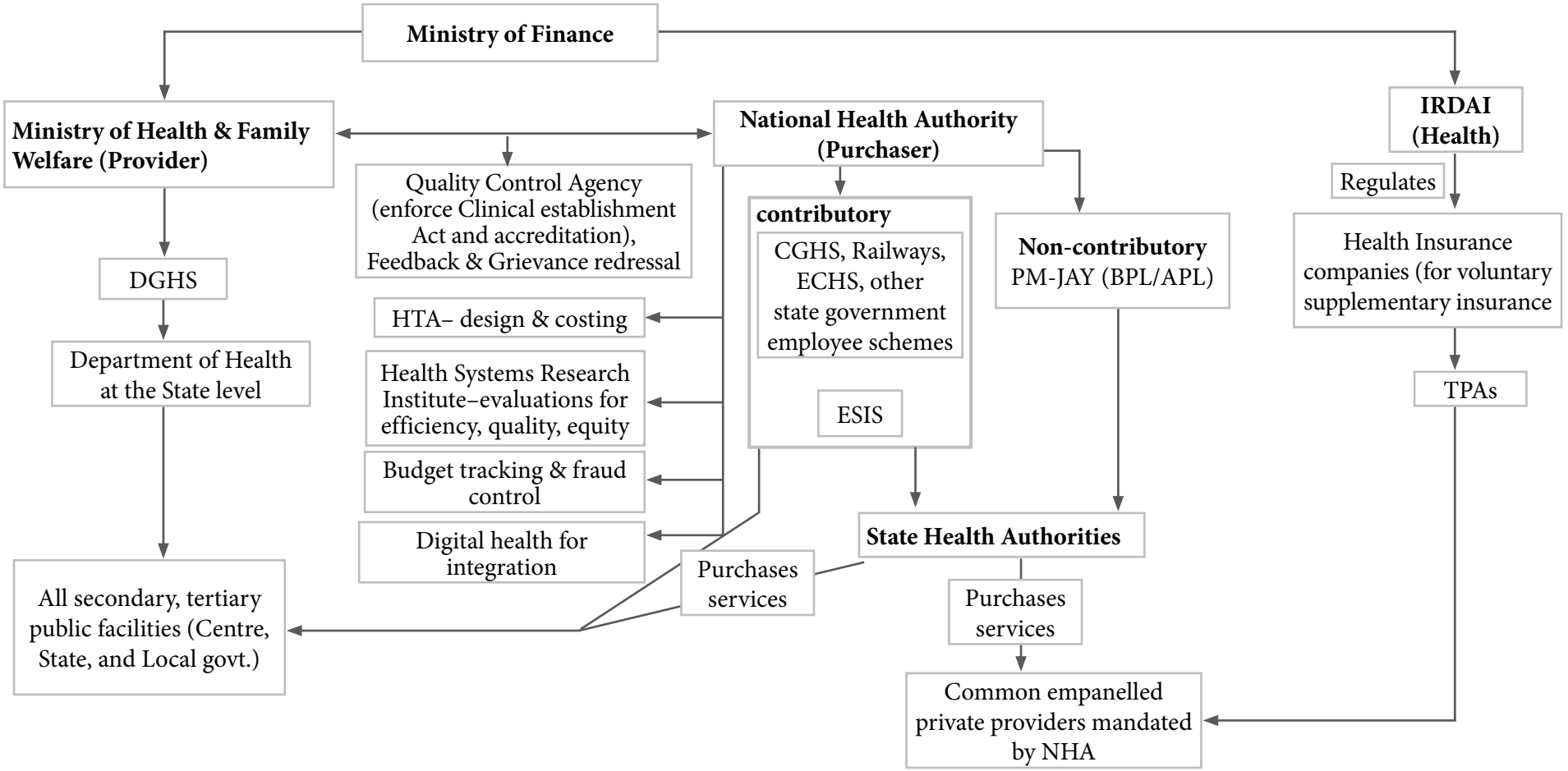
The merits and potential challenges of these options are outlined in Table 12, along with relevant country experiences for those countries that have introduced them.

Figure 9 suggests a possible governance structure after the merging of pools and the implementation of the purchaser-provider split—the MOHFW and the NHA as separate actors. The NHA would manage two pools—one for contributory schemes and the other for non-contributory schemes. ESIS (which is contributory) could be merged with either pool, depending on feasibility; hence, the two pools might not be distinctly contributory or non-contributory but a mix of both. All public facilities (even those managed by other ministries) would be merged under the MOHFW, the provider. The IRDAI could have a separate department managing all health insurance schemes and could include those private providers empanelled by the NHA to standardise providers across all schemes. The five technical agencies—quality control (including grievance redressal), health technology, health systems research, budget tracking and fraud control, and digital health integration—would work closely with the NHA and the MOHFW.

Table 12: Strategic Purchasing Organisation

Options	Advantage
Consolidating the purchasing and provisioning functions under the NHA (in the immediate term only for the universal common package) and the provisioning functions under the Department of Health and Family Welfare, also reinforced at the state level.	• Shifting away from the dual roles played by authorities such as CGHS, ESIS, and state authorities that perform both purchasing and provisioning functions. • Separating personnel and administrative functions between the national/state/district department of health functionaries and those at NHA/SHA.
• Regulation, quality control, enforcement, fraud control, grievance redressal, and policy research (like HTA) are to be strengthened under quasi-autonomous institutions that are equidistant and independent of both the NHA and the MOHFW. • Rigorous annual accreditation processes, along with audit processes conducted by independent third parties, can further help improve quality, accountability, and access to care across all providers (private and public).	

Figure 10: Possible Structure for Governance of Insurance Schemes



Source: Authors' representation.

5.5 Summing Up

In conclusion, country experiences indicate that improving equity in financing and access to health services universally was one of the main reasons for merging health insurance funds. Risk pooling, enhancing strategic purchasing, and increasing the efficiency of administration and cost control through institutional reforms were all seen as important reforms for achieving UHC. Progress towards UHC in India requires reforms in financing as the key lever through which UHC can be achieved. This includes increasing government resources allocated to health, expanding coverage to achieve universal healthcare, and consolidating pools and strategically and actively purchasing services from public and private providers. This would require certain enabling factors, as outlined below:

- Strengthening regulatory capacity, especially at the state level.
- Robust IT systems and data collection for monitoring.
- Implementation of a comprehensive package of services.
- Progressively strengthening health facilities and the workforce.
- Promoting digital literacy among healthcare workers.
- Identifying non-poor and informal workers for insurance coverage.
- Capacity-building and devolution to local bodies.
- Promoting social participation to raise awareness, support grievance redressal, and facilitate monitoring and evaluation.

These will require governance reforms with a clear purchaser-provider split. The reforms will also necessitate the institutionalisation of mechanisms for accountability, grievance redressal, and evaluations with citizen representation. PM-JAY represents a starting point for many of these reform processes, but the reforms must now be deepened to ensure universal and equitable coverage through this route.

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Appendix

Appendix 1: Table on Cross-State Variations of Health Insurance Schemes

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
Andhra Pradesh	Rajiv Aarogyasri (2007)	Rs 5 lakh per family (floater); an additional sum of Rs 50,000 is provided as a buffer.	All families with incomes under Rs 5 lakh are eligible under the new scheme. Permanent government employees and pensioners are not eligible.	Merged into PM-JAY as 'Ayushman Bharat-Dr. YSR Arogyasri Healthcare Scheme'.	Quality healthcare is already extended to BPL families, those covered under employee and pensioner health schemes, and participants in the working journalist health scheme. The 'Health for All' initiative will now include the remaining population of 3.2 million families, supplementing the existing coverage of 15.9 million families under state-owned programmes such as Dr. YSR Aarogyasri, the Employees' Health Scheme, and the Working Journalists' Scheme.	3,255 'listed therapies' are covered under inpatient services, along with treatment, which includes doctors' consultations and certain diagnostic tests.
Telangana	Aarogyasri Scheme (2007)	Coverage of up to Rs 5 lakh per annum.	BPL families (with incomes up to Rs 2 lakh per annum).	Ayushman Bharat has been integrated with the existing state scheme 'Aarogyasri', and this converged scheme is being called 'Ayushman Bharat PM-JAY Aarogyasri' (May 2021).		The scheme covers around 1,665 inpatient procedures, of which 1,376 are surgical procedures and 289 are medical procedures.

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
Gujarat	Mukhyamantri Amrutam (2012)	Up to Rs 3 lakh per annum for each eligible family; travel charges of up to Rs 300 per hospitalisation.	BPL and lower middle class (MAV).	MA and MA Vatsalya were merged with PM-JAY in 2020.		Up to Rs 5 lakh coverage for kidney and liver transplants and kidney + pancreas transplant procedures, along with other inpatient procedures.
Tamil Nadu	Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS) (2012)	Rs 5 lakh per family for every policy year.	1.57 crore families.	Pradhan Mantri Jan Arogya Yojana-Chief Minister's Comprehensive Health Insurance Scheme (PM-JAY-CMCHIS).		The scheme offers cashless treatment that covers almost every disease for its beneficiaries. In addition, it covers diagnostic tests and follow-up appointments.
Rajasthan	Bhamashah Swasthya Bima Yojana (2015)	Rs 30,000 for general illnesses and Rs 3 lakh for critical illnesses (both IPD).	BPL + APL under the NSA.	Mahatma Gandhi Rajasthan Swasthya Bima Yojana (2019) after merging with PM-JAY.		Pre- and post-hospitalisation expenses, transportation allowance, cashless treatment at the secondary and tertiary levels, coverage for pre-existing ailments, and coverage for critical diseases and general illnesses.
Goa	Deen Dayal Swasthaya Seva Yojana (2016)	Rs 2.5 lakh per annum for families of three or fewer members and up to Rs 4 lakh for families of four or more members.	Entire resident population who has been living in Goa for five years or more. (Rs 200–300 premium; 50% concession on premiums is given to those in the OBC, ST, and SC categories).	PM-JAY is integrated with the state's Deen Dayal Swasthya Seva Yojana, and it is now called 'Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY)'.		Cashless medical facilities are available, and medication for epilepsy, multiple sclerosis, and cerebral palsy is available for beneficiaries. During the pandemic, the scheme covered treatment for COVID-19.

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
Karnataka	Arogya Karnataka (2018)	Universal Health Coverage	Co-payment system for general patients and cashless for eligible households.	*Deen Dayal Swasthya Seva Yojana*. Integrated under a co-branded name called "Ayushman Bharat-Arogya Karnataka" and is being implemented in Assurance Mode (from October 30, 2018).	The population holding an AB-PM-JAY-ARK card constitutes only 27.1% of the targeted 51 million APL and BPL ration card holders.	• Treatment for COVID-19 is covered. • Financial support of up to Rs 5 lakh is provided for secondary, tertiary, complex secondary, and emergency healthcare.
Maharashtra	Rajiv Gandhi Jeevandayee Arogya Yojana (2012) renamed to Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY)	Rs 1.5 lakh per family member yearly.	Beneficiary is targeted through ration cards and identified as living in agriculturally distressed districts.	Integrated Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY) and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY) launched in the state April 1, 2020.		• 971 surgical procedures and 121 follow-up procedures are covered under the scheme. Up to Rs 2.5 lakh can be availed of for renal transplant operations. • Coverage is provided for pre-existing illnesses without a waiting period. Beneficiaries can avail of one health camp per year under the scheme. Post-hospitalisation expenses for consultations and medicines are covered for up to 10 days after discharge.
Haryana	Mukhyamantri Muft Ilaaj Yojana	Free services to all residents of Haryana.	All citizens (OPD included).	*Ayushman Bharat Pradhan Mantri Jan Arogya Yojana* (PM-JAY); Haryana Health Protection Mission.		Outpatient department visits, laboratory tests, surgical procedures, and other treatments are provided free of charge, along with dental treatment and ambulance services.
Punjab	Sarbat Sehat Bima Yojana (2019)	Rs 5 lakh per family per year.	Non-SECC and non-NFSA beneficiaries, such as farmers, journalists, and small traders.	Ayushman Bharat - Mukh Mantri Sehat Bima Yojana (AB-MMSBY) launched (August 20, 2019).	65% of the total state population.	• Pre-existing diseases are covered; treatment packages include three days of pre-hospitalisation and 15 days of post-hospitalisation expenses. • Cashless secondary and tertiary care treatment, which includes 1,579 packages, is available in public and empanelled private hospitals.

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
Himachal Pradesh	RSBY merged with PM-JAY Mukhya Mantri Himachal Health Care Scheme (HIMCARE) (2019)	Under PM-JAY: Rs 5 lakh per BPL family per year. Under HIMCARE: Rs 5 lakh coverage for those (BPL households) not covered under PM-JAY and APL households.	BPL population identified through SECC data and RSBY families. The scheme categorises beneficiaries into three categories, each with different premium rates. Category I includes BPL families not covered under Ayushman Bharat, registered street vendors, MNREGA workers, and senior citizens over 70 years old; Category II includes single women, disabled people, *Anganwadi* workers, ASHA workers, and children living in orphanages; and Category III covers beneficiaries not covered under Categories I or II and who are not government employees, pensioners, or their dependent family members.	HIMCARE is in addition to PM-JAY.	HIMCARE and PM-JAY together covers all the households in Himachal Pradesh.	Cashless treatment is available in public and empanelled private hospitals.
Uttarakhand	Mukhyamantri Swasthya Bima Yojana (2016)	Rs 50,000 (first phase) to Rs 1.25 lakh (second phase).	BPL and APL populations.	Merged into *Atal Ayushman Uttarakhand Yojana* (AB PM-JAY) (2018).	As of 2017, 52.4% of the rural population and 43% of the urban population were covered under this scheme.	High-end diagnostic procedures are covered on an outpatient basis, including transportation charges to empanelled healthcare providers, pre- and post-hospitalisation expenses, and follow-up care.
Jharkhand	Mukhyamantri Swasthya Bima Yojana and Mukhyamantri Gambhir Bimari Upachar Yojana	Rs 1.5 lakh, and a further Rs 2 lakh per family.	BPL households.	Merged into PM-JAY as 'Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) Mukhyamantri Swasthya Bima Yojana (MSBY)'.		

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
Chhattisgarh	Dr. Khubchand Baghel Health Assistance Scheme (2019)	Rs 5 lakh per family.	90% of the population covered.	'Ayushman Bharat PM-JAY/ Shaheed Veer Narayan Singh Ayushman Swasthya Yojana'. AB-PMJAY was incorporated.	Approximately 21.7% of the population is covered.	Treatment for liver and kidney transplants, haemophilia, and cochlear implants, among other inpatient procedures.
Madhya Pradesh	Deendayal Upchar Yojana (2004–2019)	Rs 20,000 per family per year.	BPL households.	*Ayushman Bharat - Niramayam Yojana* (2018).		
Uttar Pradesh	RSBY	Rs 30,000 per family per annum.	SECC and other poor individuals identified by the District Collector (DC).	*Mukhya Mantri Jan Arogya Abhiyan*, in addition to PM-JAY; 100% state-funded.	Up to 64 lakh beneficiaries, comprising the bottom 40% of the population, are covered.	The scheme covers 1,090 pre-determined diseases and transportation charges to the empanelled hospital.
Kerala	Karunya Health Insurance Scheme (existed before 2020)	Rs 2–3 lakh per year.	BPL/APL Households.	Karunya Arogya Suraksha Padhathi (KASP) (2020) incorporated AB-PM-JAY.		Medical examinations, treatment, consultations, pre- and post-hospitalisation care, and accommodation are covered.
Bihar	RSBY	Rs 30,000 per family per annum.	SECC and NFSA beneficiaries.	*Ayushman Bharat-Bihar*/ Mukhyamantri JAY.		
Jammu & Kashmir	AB-PM-JAY Sehat	Rs 5 lakh per family per year, on a floater basis.	All residents of Jammu & Kashmir.	AB-PMJAY Sehat scheme – merged with PM-JAY.		Medical procedures, including oncology, cardiology, and nephrology, along with three days of pre-hospitalisation expenses, are covered.
Assam	Atal Amrit Abhiyan (2016)	Rs 2 lakh per family per year.	BPL/APL households.	Implemented alongside Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) as 'Atal Amrit Abhiyan'.	Approximately 92% of the population.	Covers chronic, sudden, and acute health issues, including 3 days of pre-hospitalisation and 15 days of post-hospitalisation diagnostics and medicines.
Mizoram	Mizoram State Health Care Scheme (2008)	Rs 2 lakh per family per year.		Implemented alongside AB-PMJAY as 'Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY)' and *the Doctors in Mizoramscheme*.		Outpatient diagnostic services, surgical and medical procedures, and pre-existing conditions (covered from the first day of the policy) are included. Screening and follow-up care are also covered.
Meghalaya	Megha Health Insurance Scheme (2012)	Rs 2.8 lakh per family per year.	Families with an income of up to Rs. 5 Lakh per year.	Megha Health Insurance Scheme (AB-PMJAY + Universal Health Insurance Scheme).	Approximately 55% of the eligible population was covered under the scheme as of 2022.	

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
Arunachal Pradesh	Chief Minister's Universal Health Insurance Scheme	Same coverage as PM-JAY for residents excluded from PM-JAY.	All Arunachal Pradesh residents except employees of the Government of India (GOI), public sector undertakings (PSUs), and AB-PMJAY beneficiaries.	Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) & Chief Minister Arogya Arunachal Yojana (CMAAY), in addition to PM-JAY.	As of 2022, 709,000 families were covered out of a total estimated population of 1,825,000, representing coverage of 38%.	Cashless treatment for hospitalisations, prosthetic devices, implants, and pre-existing conditions. Three days of pre-hospitalisation and 10 days of post-hospitalisation care are covered.
Sikkim	Sikkim Manipal Swasthya Suraksha Scheme (2014)	Rs 1.5 lakh per year.	Those who pay subscriptions (Rs 500 and Rs 800).	PM-JAY was launched in 2018 in collaboration with the Mukhya Mantri Jeevan Raksha Kosh (2009) as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY).	As of 2020, 1,202 families and 4,900 beneficiaries were enrolled in this scheme.	Hospitalisation, hospitalisation expenses, and seven free outpatient department (OPD) visits.
Nagaland	Chief Minister's Health Insurance Scheme (CMHIS) (from October 1, 2022, for all residents)	Rs 5 lakh per family.	SECC and Rashtriya Swasthya Bima Yojana (RSBY) cardholders.			Inpatient hospitalisation, outpatient treatments (consultations and diagnostics), and preventive and primary care services.
Manipur	Chief Minister-gi Hakshelgi Tengbang (CMHT)	Rs 2 lakh per family per year.	Poor and disabled people.	CMHT, in addition to PM-JAY, supports beneficiaries not listed in the Socio Economic and Caste Census (SECC). PM-JAY is also listed on the webpage.	757,449 people were enrolled in the scheme, which constitutes 20.7% of the total population. The estimated population of Odisha is 3.649 million.	Secondary and tertiary care hospitalisation, transportation costs for beneficiaries and accompanying attendants for treatment outside the state, and outpatient services are covered.

State	Schemes	Sum Insured	Target Beneficiary	Merger in/Incorporation of PM-JAY	Population Covered	Packages/Benefits
West Bengal	Swasthya Sathi	Basic cover for secondary and tertiary care up to Rs 1.5 lakh per year in insurance mode.	All residents, irrespective of religious affiliation, caste, creed, or profession.	Not merged with PM-JAY.	5 million families (25 million people) are covered. West Bengal's total population is estimated to be 104.2 million, indicating that only 23% of the population is covered under this scheme.	2,092 packages are available under the scheme.
	West Bengal Government Health Scheme	Cashless treatment of up to Rs 1 lakh per eligible person.	Government pensioners, government employees, and their families.	Not merged with PM-JAY.		Off-state hospitalisation is permitted, and treatment coverage is provided at facilities that are not part of the empanelled provider network.
Odisha	Biju Swasthya Kalyan Yojana	• Up to Rs 5 lakh for illnesses like cancer, neurosurgeries, cardiothoracic surgeries, liver diseases, and blood disorders. • Cashless treatment up to Rs 1 lakh per eligible person. • Insurance coverage for medical treatment up to Rs 5 lakh for families and up to Rs 10 lakh for women when treated at health centres and hospitals across Odisha.	All Odisha residents.	Not merged with PM-JAY.	47.9 million people (9.909 million families) are covered, which amounts to 83% of the total population.	• Outpatient treatment (consultations, diagnostic tests, and medications) and coverage for Ayurvedic and homeopathic treatments in addition to allopathic treatment. • Off-state hospitalisation and coverage at facilities that are not part of the empanelled provider network are also covered.
Delhi	Delhi Arogya Kosh	The Delhi Arogya Kosh (DAK) provides financial assistance of up to Rs 5 lakh to needy individuals.	People with an annual family income up to Rs 3 lakh who have been residents of Delhi for the past three years are eligible.	Not merged with PM-JAY.		Free radiological and imaging facilities and free identified surgeries.

Source: State government websites on health insurance schemes & PM-JAY.

About the authors

Madhurima Nundy was a Fellow in Health and Human Development at the Centre for Social and Economic Progress, New Delhi and an Honorary Fellow at the Institute of Chinese Studies, Delhi. She holds a PhD in Public Health from the Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi. Her areas of specific interest include researching different health systems and health policies in a comparative perspective with a focus on inequalities in health outcomes. She has several publications to her name.

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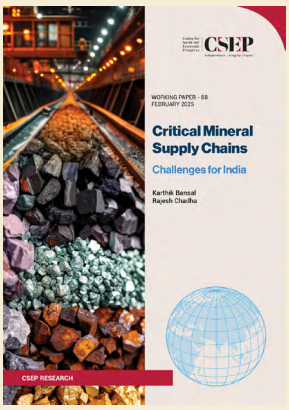
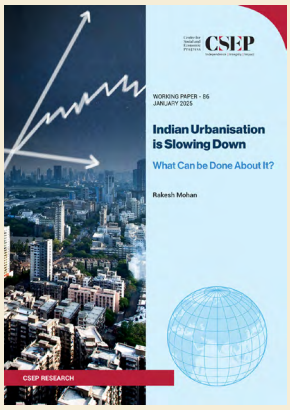
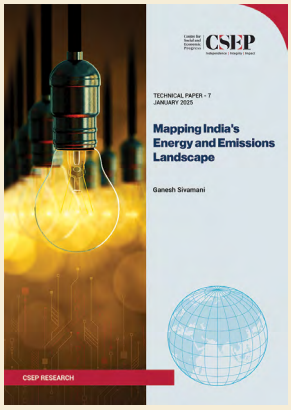
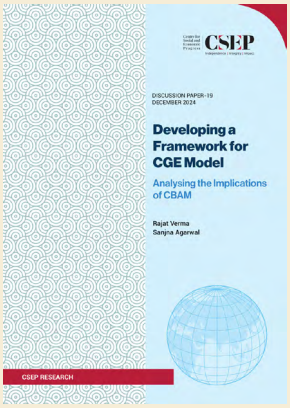
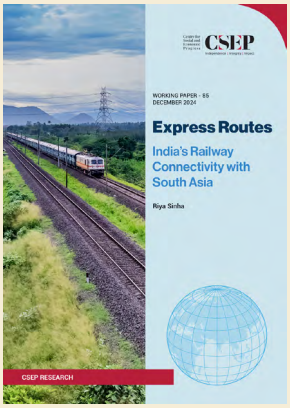
Other publications

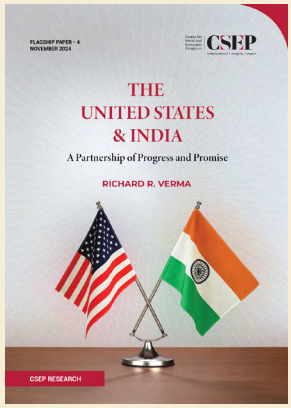


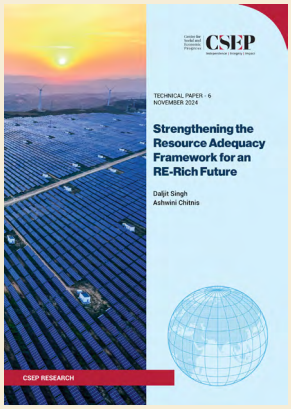


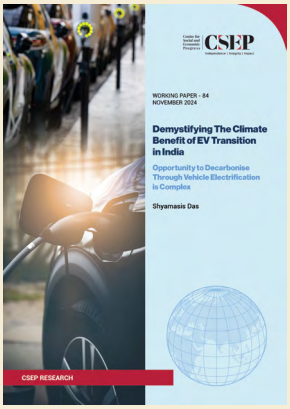


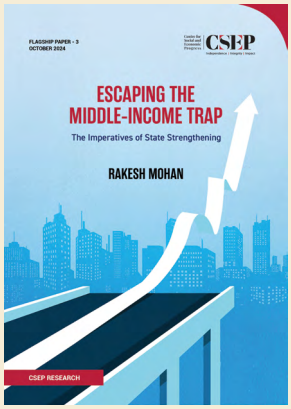


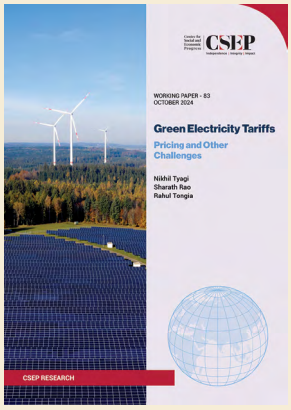


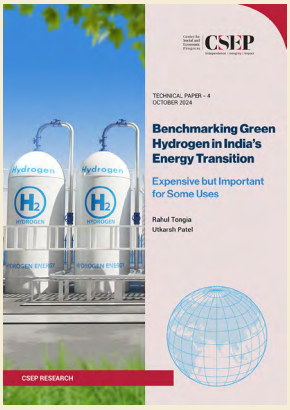


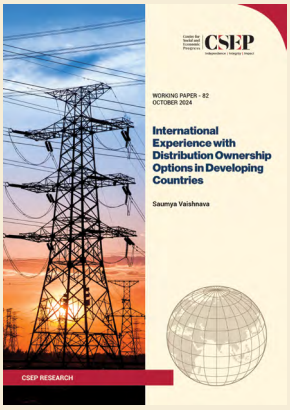


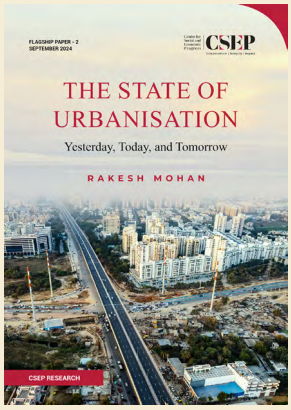












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