Social Protection in Action: Building social protection floors for all

Country Brief: India

December 2021

Extending Social Health Protection in India: Accelerating progress towards Universal Health Coverage

1. Introduction

Since the early days of its independence, India has recognized the benefits of ensuring comprehensive health care coverage for its population. As such, several official committees, expert groups and policy documents have reiterated the need for ensuring accessibility and availability of health care, and the country has taken incremental steps to establish and expand social health protection. This has been achieved across various targeted population groups through a range of mandatory social health insurance schemes, targeting industry workers, civil servants and low-income households, respectively. Despite advances made through these schemes, the social health protection system in India remains fragmented, with concerns expressed around the ability of schemes to provide effective coverage to beneficiaries. Moreover, such fragmentation has resulted in varying standards of quality of clinical care and levels of access, with implications for the efficiency of the system at large.

2. Context

Social health protection schemes in India have been operating since the country's independence in 1947. With limited economic resources to hand, the Government initiated a targeted roll-out of social health protection measures. Initially the entire population was entitled to affordable health care in public facilities through the national health service run by the Ministry of Health and Family Welfare (MOHFW), though the reach of this system remained limited in practice. Acknowledging the need for expansion, the Employees' State Insurance Scheme (ESIS) was launched in 1952 to cover factory workers and their families up to a certain income level. This was soon followed by the establishment of the Central Government Health Scheme (CGHS) in 1954, which aims to cover central government employees and their families. Both of these schemes are contributory and viewed as a means of alleviating the financial burden from the national health service to some degree. In 1997, the Railway Employee Scheme was established, and there are also smaller contributory schemes run by public sector enterprises, government departments and sectoral welfare boards.

Furthermore, a gradual opening of foreign investment in insurance products and increased economic liberalization led to the introduction of private health insurance markets.

From 2008 onwards, several states in India, acknowledging health care as an increasing financial burden on households, launched various health protection schemes which mainly provided coverage for costly inpatient services. At central level, the Government of India also acknowledged the need for such a scheme and launched the non-contributory Rashtrya Swasthya Bima Yojana (RSBY) scheme in April 2008, which covered families below the poverty line up to a certain financial threshold, mostly for inpatient and costly outpatient care (Karan, Yip, and Mahal 2017). After close to 10 years of implementation, the RSBY scheme was remodelled as PM-JAY, which consists of two inter-linked components: Health and Wellness Centres (HWCs), which aim to provide universal access to primary health care (PHC) and Pradhan Mantri Jan Arogaya Yojana (PM-JAY), which covers secondary and tertiary health services. The scheme increased the financial ceiling for inpatient services by more than ten times that of RSBY, and managed to consolidate the majority of smaller schemes run by state governments at the provincial level. This has facilitated the development of a large and common social health protection scheme, which aims to cover 500 million individuals across the country.

3. Design of the social health protection system

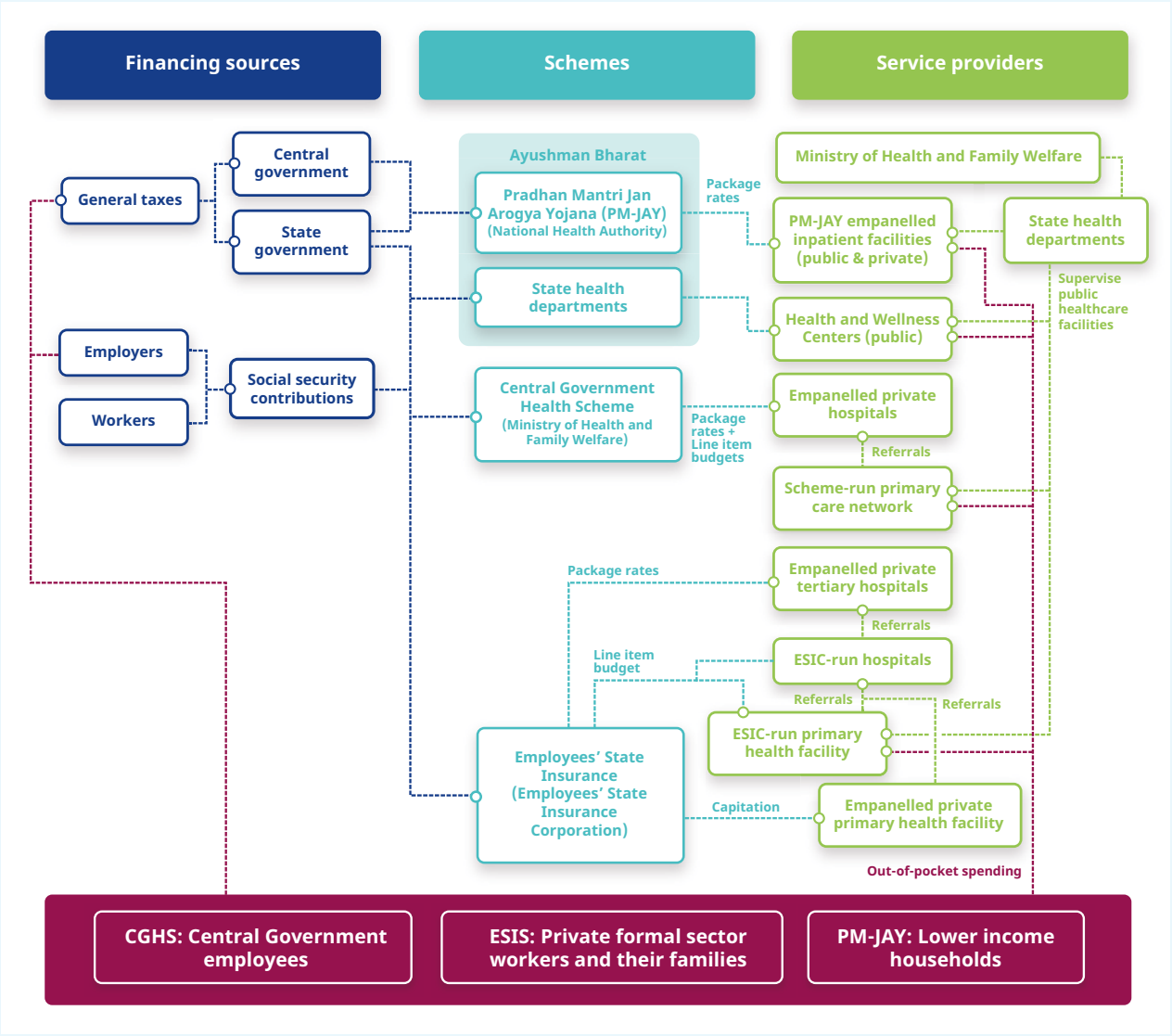
- Financing

Financing remains highly fragmented in India. Although public facilities receive general budget allocations from central and state governments and several contributory and non-contributory schemes exist, a large proportion of health expenditure in India is comprised of out-of-pocket (OOP) payments. According to the latest available data, OOP payments by households accounted for 62 per cent of health expenditures in 2017, while domestic general government health expenditure accounted for 27 per cent, and 10 per cent was attributed to other private sources (WHO n.d.).

The non-contributory PM-JAY scheme is financed predominantly through shared resources from central and state governments for supporting low-income households, mainly covering hospital level care. However, for outpatient care, a large proportion of financing is paid for directly by households, the costs of which are driven in large part by drugs and diagnostics (NHA Technical Secretariat 2019).

Figure 1 below schematically illustrates the structure of the overall system and the relevant financial flows.

▶ **Figure 1. Overview of main financial flows of the social health protection system in India**



Source: Authors.

- Governance

Parallel governance structures exist to oversee social health protection in India. The Employees' State Insurance Corporation (ESIC) is an autonomous body under the Ministry of Labour that oversees the implementation of Employees' State Insurance Scheme (ESIS). Policy level governance of ESIS falls under the oversight of three major committees, namely the ESIC, the Standing Committee and the Medical Benefits Council. In addition to government and ESIC representatives, these structures also include the participation of employer and employee representatives from covered industries and sectors. Representatives of insured workers and registered enterprises are involved in the overall stewardship of the scheme, as well as major policy decisions affecting the structure and operations of the ESIS.

The CGHS is governed by a dedicated department under the MOHFW, while the Railway scheme is governed by the Ministry of Railways. In the case of PM-JAY, the National Health Authority (NHA) takes on a stewardship role, providing necessary guidelines and policy decisions that inform the evolution of the scheme. Public facilities and

health service provision is stewarded by the MOHFW, though the majority of responsibility vis-à-vis governance and oversight is the purview of state health departments. While the MOHFW can provide guidelines, public health service provision in India is constitutionally decentralized, falling under the mandate of individual state governments. [1]

CGHS and ESIS have both set up dedicated grievance redressal mechanisms to ensure transparency and accountability. Moreover, ESIS has mechanisms in place for ensuring accountability among providers through use of regular monitoring processes, such as facility visits and reviews. In addition to these monitoring visits, a vigilance unit is in place at the ESIC headquarters to ensure that providers and ESIS officials are held accountable in the event of any transgressions. PM-JAY has also instituted a detailed transparency and accountability mechanism through a grievance redressal system with a chain of command that goes down to the district level. The scheme has also implemented anti-fraud units at Central and State level to ensure that providers and other PM-JAY officials are held accountable for their actions. Detailed medical and facility audits are also undertaken to monitor and oversee functioning and performance of empanelled hospitals.

- Legal coverage and eligibility

The social health protection schemes in India are targeted in terms of their beneficiary coverage and are predominantly mandatory for the defined target beneficiaries of each scheme, the scope of which have been mostly limited to the formal sector and the poor. While CGHS covers central government employees (targeting 3 million beneficiaries), the ESIS covers lower-income workers in non-seasonal enterprises, shops and establishments (targeting 135 million beneficiaries), with recent efforts to expand to the informal sector. Notably, through the new Social Security Code passed in 2020, the scope of coverage for ESIS has been expanded to cover some new categories of informal workers.

PM-JAY aims to cover 500 million beneficiaries, the majority of whom are lower-income households as defined by the Socio-Economic Caste Census (SECC) of 2011. While the scheme is not mandatory, individuals and households that are listed under the SECC 2011 are automatically enrolled into the scheme and can be enrolled at facilities directly after verification of their eligibility.

- Benefits

Benefits provided under each scheme vary. CGHS and ESIS aim to provide comprehensive health coverage, though the degree to which they effectively manage to do so is not clear. Maternity services are included under both CGHS and ESIS, together with other National Programme services such as treatment for HIV and tuberculosis, family welfare and immunization. In comparison, PM-JAY is more limited in the benefits it offers in terms of inpatient services. While pre- and post-hospitalization services are part of the package, unlike the other two schemes, PM-JAY does not include primary and general outpatient services.

- Provision of benefits and services

CGHS and ESIS differ in the network of providers they utilize to deliver services to their beneficiaries. However, neither CGHIS or ESIS implement a provider-purchaser split for the majority of service provision. CGHS provides primary care through its own network of clinics (through line-item budgeting) across selected cities in India. Inpatient services under CGHS are provided by a network of private hospitals empanelled under the scheme, and package rates have been established over time. However, the modes and frequency of formal costing or structured revision of these packages is unclear. A strict referral system is in place to regulate traffic of in-patients to secondary and tertiary public and private empanelled providers.

ESIS also provides primary care predominantly through its own network of facilities based on line-item budgets, and some private primary care provision is paid through capitation payment. Similarly, inpatient care is provided through own its internal network of facilities as well as through a pool of empanelled public and private providers. This internal network is managed and run directly by ESIC in some locations (model hospitals) and by state governments in other cases. In the case of specialized procedures (Super Specialty Treatment) and in areas where ESIS's own network is not present, ESIS leverages a network of empanelled private facilities (comprising 1500 facilities), wherein rates are on par with current CGHS rates. Referrals from primary to inpatient care are in place in principle, though the degree

[1] The Constitution of India 1949 (amended 2020), available at: https://legislative.gov.in/sites/default/files/COI_1.pdf

to which this gate-keeping system is effective is uncertain. However, there is a strict referral system in the case of utilization at private facilities to help ensure cost control.

In the case of PM-JAY, there is a clear purchaser-provider split, as public and private facilities are empanelled based on pre-defined criteria, with similar governance oversight and monitoring in place. Package rates were arrived at through expert consultations prior to the launch of the scheme, though it has often been claimed by the private sector that the rates provided tend to under-estimate the cost of provision in the private sector (Press Trust of India 2019).

India's social health protection schemes are all working towards developing robust IT and digital solutions to improve access and performance. While information on CGHS is limited, ESIS has developed an integrated IT reform through the initiative, Project Panchadeep, which implements various dedicated modules to address issues of inter-facility connectivity, patient medical records, data management and so on (ESIC 2020). PM-JAY has also been instrumental in pushing for a digitized social health protection eco-system wherein all aspects of scheme functioning, including beneficiary identification, transaction management and fraud detection are undertaken through elaborate IT modules devised for specific purposes.

4. Results

- Coverage

The social health protection landscape of India is made up of many fragmented efforts to cover specific population groups. Through the CGHS, ESIS and PM-JAY schemes, combined with several smaller schemes run by public sector units, it is estimated that close to half of the Indian population should be covered to some extent for utilization of health services (albeit in a fragmented manner) in the coming years. Among the contributory social health insurance schemes in India, the CGHS, ESIS and Railway schemes are among the largest in terms of coverage. The PM-JAY on the other hand is the largest non-contributory, tax-financed scheme.

At the federal level, ESIS and PM-JAY are the largest schemes in terms of coverage. ESIS covers 135,700,000 workers and their families, and PM-JAY covered 126,300,000 beneficiaries in 2020, representing about 10 per cent of the population, with rapid expansion towards its 500 million target. Within PM-JAY specifically, there is limited dynamism vis-à-vis ensuring effective coverage of potential beneficiaries due to the use of a retrospective database, which may not reflect changes in household economic conditions. Therefore, it is likely that several households who may have fallen down the economic gradient and are eligible for PM-JAY are excluded due to the reference database deployed for coverage.

While India has made great strides in expanding population coverage of health services, there remains a lot to be done in terms of further expanding scope and depth of coverage. With regard to the former, it is noteworthy that despite the large number of persons covered under each scheme, more than half of India's population still remains unaffiliated to a social health protection scheme. This is especially prevalent among the informally employed and self-employed, though policy discussions are underway as to how to reach this "missing middle" group.

- Adequacy of benefits/financial protection

As previously noted, sources of revenues for health in India are highly fragmented, with the largest share of health expenditures (around 62 per cent) comprised of OOP payments paid directly by households. Prior to the advent of PM-JAY, risk pooling was very low, with less than 35 per cent of the population participating in a risk pooling scheme and less than 10 per cent covered by a functioning risk pooling mechanism that provides effective protection against catastrophic events (NITI Aayog 2019). The high level of OOP expenditures reflects this lack of risk pooling, and the absence of a single monopsonic purchaser defining input and outcomes. This deficiency means that providers tend to have the upper hand vis-à-vis price setting and determining the level and quantum of care provided, with profit maximization prioritized, and non-coverage of post-hospitalization care the norm.

Each pool acts as a health service purchaser, and with this level of fragmentation, every pool has limited leverage with providers. With few exceptions, both public and private schemes in India use less effective provider payment mechanisms, with line-item budgets predominating in the public sector and fee-for-service prevalent in the private sector. Limited

leverage and the lack of performance/output-based payment mechanisms severely hamper the capacity of these pools to act as strategic purchasers. As a consequence, they behave mostly as passive payers. Ultimately, this situation impedes financial protection of beneficiaries.

In addition, the levels of financial protection offered by the existing schemes vary. In the case of PM-JAY, there has been a significant improvement in this regard compared to the previously implemented RSBY scheme, but some design elements traditionally associated with private commercial insurance (such as ceilings), persist (Dror and Vellakkal 2012). While ESIS offers high levels of cost coverage, in practice, beneficiaries have reported that financial protection is greater in ESIS facilities, while contracted facilities, especially those in the private sector, tend to charge more. Lastly while efforts have been made to reduce financial barriers to maternity protection, delivery in particular remains costly for most women in India. With financial barriers tending to have a gendered impact, efforts are needed to improve awareness and entitlements to RMNCH (Mohanty et al. 2020).

- Responsiveness to population needs

    o Availability and accessibility

Improving access to services in India remains a challenge (Ranga and Panda 2014). Overall, the fact that each scheme has its own provider network, does not result in optimal access for beneficiaries. Challenges in accessibility are evidenced by the very low levels of utilization witnessed across facilities under ESIS (0.37 outpatient visits per beneficiary as of 2017-18, compared with 5 per beneficiary in China) (ESIC 2018). This challenge may well relate to the lower number of beds and physicians available per capita, with ESIS providing only 0.6 doctors per 10,000 beneficiaries compared to an Indian average of approximately seven (computed by authors from ESIC Annual Reports). Furthermore, beneficiaries have reported that, while family members working in urban areas have access to ESIS or empanelled facilities, geographical access is much more limited for family members in rural areas, which is a very common situation among industrial workers. This was a concern raised by the results of ESIS beneficiary surveys (Verma et al. 2013). As for PM-JAY, empanelment and retention of private facilities remains challenging due to limited availability and involvement of facilities, which obstructs access to care.

There have also been concerns expressed around administrative barriers to accessing care, as evidenced by the beneficiary survey conducted by ESIS. These concerns relate to the ability of employers and employees to comply with the reportedly work-intensive, administratively challenging registration requirements and reimbursement procedures (issues that are currently being resolved as part of ESIS's transition to a more digitized process framework). Beneficiaries participating in the ESIS survey also reported gaps in knowledge of their benefits and how to avail of them in some cases. As a means of addressing this, ESIS undertakes a host of activities to increase awareness of the scheme among beneficiaries. This includes outreach and media campaigns (online and offline) as well as information provided at ESIS facilities. PM-JAY also carries out a large variety of communication and awareness activities for the scheme. In addition to using public sector front line-worker cadres to disseminate information on PM-JAY, the scheme also uses media campaigns, and has designated Pradhan Mantri Aarogya Mitras (PMAMs), who serve as provider level facilitators to inform beneficiaries of scheme details, and navigate them through the process of utilizing covered services. However, communication and awareness activities under CGHS remain limited.

    o Quality and acceptability

Some recurrent challenges in providing social health protection in India relate to quality of services (Central Bureau of Health Intelligence 2019). Concerns have been expressed regarding the lack of comprehensiveness of the schemes, namely the exclusive focus on inpatient services under PM-JAY, and concerns about adequate accessibility to and quality of health services offered under the formal sector schemes. Furthermore, over-prescription of drugs, especially antibiotics, as well as overtreatment (such as unnecessary injections) are rampant in both public and private sectors, and appear to be worse in rural settings and among private providers. Issues including supplier-induced demand for drugs and care, and a lack of standard treatment practices create an environment in which over-prescription and unnecessary treatments flourish.

To compound this, clinical protocols or guidelines are generally absent or unavailable, and even when they are available, non-compliance with diagnostic and therapeutic standards is high (Karan et al. 2019; Rao et al. 2011). This not only

impacts the quality of services provided, it also increases spending on health, including OOP spending among households and costs of the SHP schemes. While MOHFW efforts to increase regulation of private provision have been made, it remains difficult to control the majority of health care provision in India; the existence of many informal providers makes effective regulation of the sector particularly challenging (Kasthuri 2018; Roy 2021).

▶ 5. Way forward

Several changes are afoot in terms of increasing coordination between social health protection schemes and streamlining their operations. Most recently, ESIS and PM-JAY have agreed to align and share their respective networks of health service providers to enable greater access for beneficiaries of both the schemes, resulting in an overall increase in access to services (FE Bureau 2021). The need to expand health coverage to the "missing middle" in India and adopt a more universal approach to social health protection has also been widely acknowledged, as exemplified by the National Health Policy 2017. This may pave way for a potential convergence or even a merger of multiple pools to ensure uniform access and greater efficiency in purchasing decisions and governance flows. Better channelling of resources into formal risk pools (governed and operated by institutional purchasers), and better integration of such pools (through an aligned set of regulatory rules and/or a merger) would greatly increase leverage over providers, as well as facilitate the development of provider payment innovations. This development will be essential for setting incentives for provider integration and consolidation (NITI Aayog 2019).

While no specific laws have been conceived to promote progress towards universal coverage, other important legal precursors are in place, the implementation of which will influence the degree to which India can transition towards universal health coverage. Specifically, the pan-India implementation of the Clinical Establishment Act will help to regulate private sectors vis-à-vis their allocation of funds for infrastructure under the National Infrastructure Pipeline (NIP), outlined in the latest budget. However, a lot more investment will be required to truly bridge access and availability gaps (Roy 2021). Some key policy level steps are required to advance social health protection and improve efficiency and effectiveness of existing schemes, as follows:

i) Develop a vision and its implementation pathway to universalize social health protection coverage;
ii) Streamline risk pooling and strategic purchasing to de-fragment financial flows and build a pathway for expanding financial coverage for all;
iii) Organize the mixed health care delivery system into an accountable, affordable, high-quality system aligned with public objectives;
iv) Reimagine India's digital health landscape and improve availability of data, including analysis of existing data for clinical, epidemiological, financial and administrative improvement.

In addition to these measures, there is a need for social health protection schemes to adopt a greater focus on preventive and primary care, in addition to inpatient services. This is particularly important given that the prevalence of non-communicable diseases (NCDs) such as diabetes and stroke have substantially increased as drivers of mortality in the last decade. Moreover, ischemic heart disease (IHD) continues to prevail as the most significant burden of disease, with a substantial increase in its proportionate contribution to mortality (Dandona et al. 2017). All of these conditions could be handled and managed at the primary care level, through which active engagement with the community in prevention, management and treatment of risk factors would contain disease progression.

In addition to the clinical burden of NCDs, they also place a large economic burden on the country. It is estimated that, due to five NCDs alone, India will suffer an economic loss of US$4.58 trillion between 2012 and 2030, accounting for nearly double India's GDP in 2016 (Bloom et al. 2014). Despite a nationwide shift toward NCD treatment, in some states, especially those in the Empowered Action Group (EAG), the rapid increase in the prevalence of NCDs is coupled with an unfinished agenda in infectious diseases and maternal newborn and child health conditions. In this context, in addition to the focus needed to curb the NCD-related burden, it is important that efforts are made to sustain and improve maternal and child health outcomes.

Another important demographic consideration for the future is the ageing population of India. While a "demographic dividend" in India has been touted, declining fertility rates and an increase in life expectancy will result in an older population within a decade or two, which will require a substantially larger share of available health care resources. Today, 9 per cent of the population, accounting for over 116 million adults, are 60 years or older; by 2050, the population share of this age group will grow to 19 per cent. Furthermore, the proportion of adults aged 80 and over is projected to triple to 3 per cent by 2050, putting an additional strain on health protection schemes and the system at large to cater to the health needs of this large population group (Agarwal et al. 2016).

6. Main lessons learned

- To achieve the commitment of the National Health Policy of 2017 to increase government health expenditure as a percentage of GDP to 2.5 per cent by 2025, the Indian Government needs to take bolder steps towards increasing public funding of the health sector and improving health care service quality and access. The increased allocation to health of 1.8 per cent of GDP in line with the most recent budget announcement is commendable in light of the limited availability of fiscal space resulting from the economic impacts of the ongoing pandemic. However, there is a need to ensure sustained commitment to the health sector in the years ahead. Ensuring health as a central policy goal will help to ameliorate chronic issues around service quality, utilization and the high OOP financial burden faced by Indian households.

- Strong governance is crucial to enabling universal health coverage and achieving progressive realization of effective social health protection. Solid regulation, supervision, accountability and enforcement mechanisms at all levels are urgently needed to address the insufficient performance of the system and to facilitate the expansion of existing social health protection schemes so that they can effectively protect the population from the financial risks related to ill health.

- A rights-based approach needs to be prioritized. Currently, the PM-JAY Scheme and many other publicly funded schemes have only limited legal grounding and are insufficiently institutionalized, which could explain the weak regulation and enforcement of the benefits provided under these schemes.

- A solid social health protection system, which is an intrinsic feature of comprehensive social protection, can contribute to improving health outcomes while reducing the risk of impoverishment linked to catastrophic health care expenditures. This in turn contributes to increased economic productivity and national income. While different health protection options exist in India, there is considerable scope to expand upon ongoing efforts by increasing risk pooling across these multiple schemes. Reducing the fragmentation across pools and/or adopting common design features across pools would ensure: (i) greater leverage for price setting by a single purchaser; (ii) a uniform benefit package in the interests of equity; (iii) standardized quality of care tied to appropriate financial incentives; and (iv) increased access to care for the population in an equitable manner.

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