Sub-regional Conference: South-South exchange on strategies for universal health coverage

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Ouagadougou, Burkina Faso

India and Thailand: Country Case-Studies

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India

General information

Population	**1.2 billion** (UN Pop, 2011)
GDP	**4,195 billion** USD, PPP (WB, 2011)
	lower-middle income country
GDP per capita (PPP US $)	**$3,425.45** (WB, 2011)
HDI rank	**134** out of 187 (UNDP, 2011)

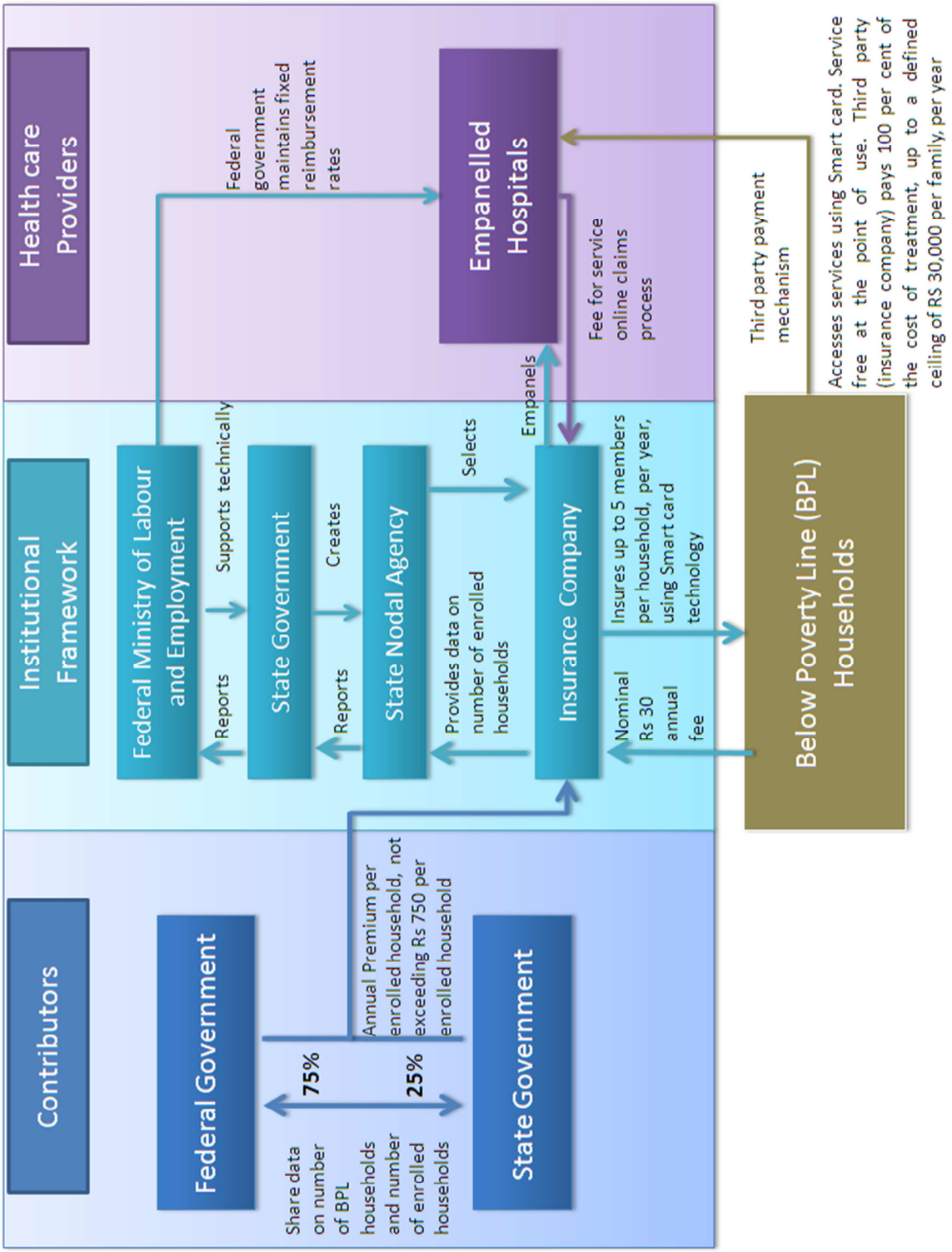
Non-wage workers in percentage of total employment	**54.1%**
→ *Wage workers in percentage of total employment*	*45.9%* *(ILO, 2010)*
Informal employment as a percentage of total non-agricultural employment	**83.5%**
→ *Formal employment as a percentage of total non-agricultural employment*	*16.5%* *(ILO, 2010)*
Health social protection coverage as a percentage of total population	**12.5%** (ca. 150 million people) (ILO, 2010)

→ Maternal mortality ratio (modelled estimate, per 100,000 live births)	200 (WHO, 2010)
→ Percentage live births attended by skilled health staff (%)	57.7% (WHO, 2010)
→ Total expenditures on health as % of GDP	4.1% (WHO, 2010)
→ Govt. expenditure on health as % of total govt. expenditure	3.6% (WHO, 2010)
→ Per capita government expenditure on health at average exchange rate	16 US$ (WHO, 2010)
→ Proportion of out-of-pocket payments to total health expenditure	86.4% (WHO, 2010)
→ Public social security expenditure (including health) as % of PIB.	2.31% (IMF, 2007)
→ Theoretical coverage gap due to health professional staff deficit (WHO Benchmark - 28)	44.5% (ILO, 2010)
→ Theoretical coverage gap due to health professional staff deficit, % (Benchmark relative 35.5 per 10000 persons)	*56.2%* *(ILO, 2010)*
→ Theoretical coverage gap due to financial resources deficit (Benchmark - 60USD MDG target for 2015 in low income)	65.1% (ILO, 2010)
→ Theoretical coverage gap due to financial resources deficit, % (Benchmark relative 272 USD per person and per year)	*92.3%* *(ILO, 2010)*

Source: ILO SECSOC statistics.

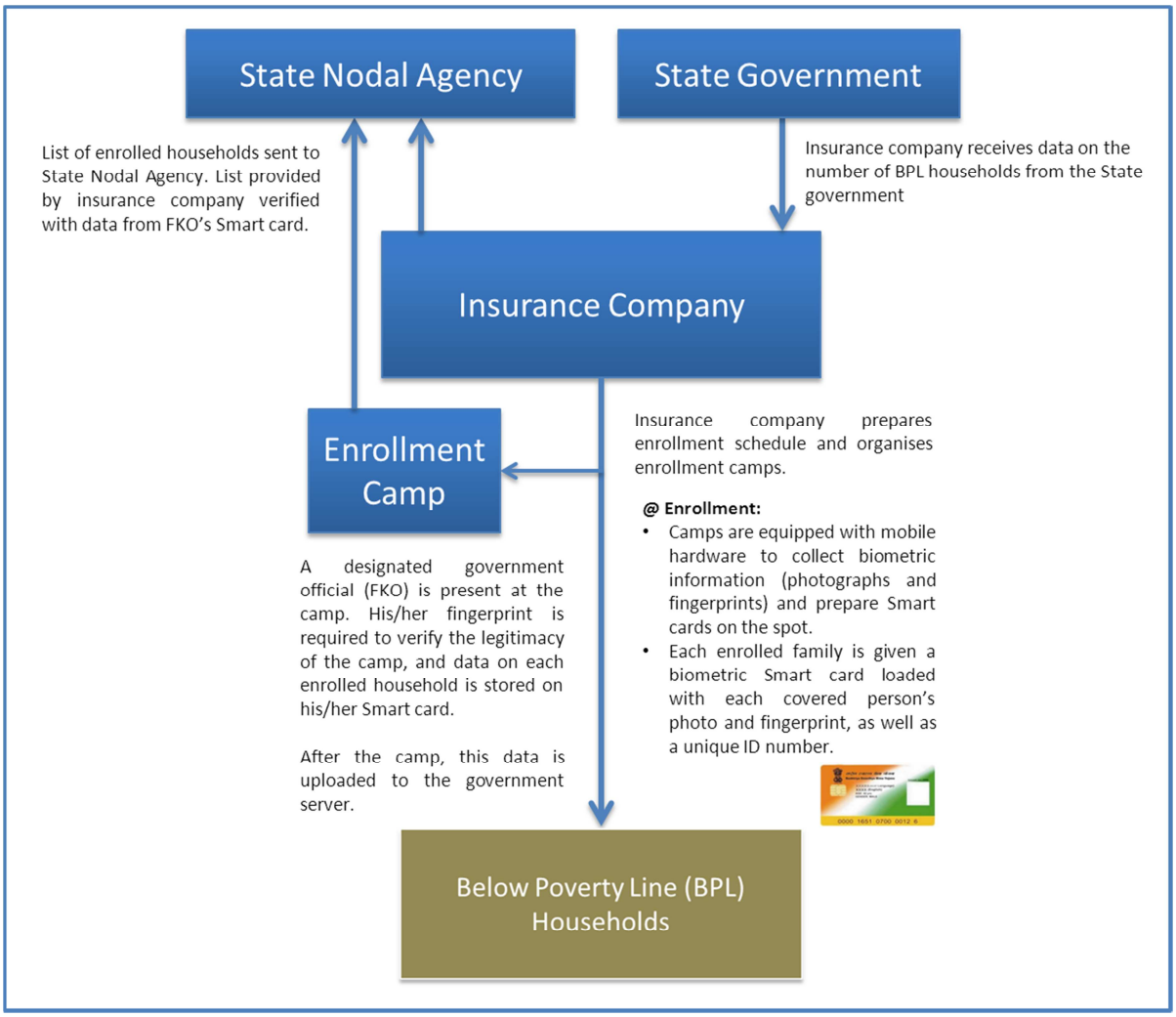
Scheme	Date created	Target population	Enrollment	Coverage rate (in 2012)	Benefit package	Funding Sources	Financing method	Cost
Rashtriya Swasthya Bima Yojana (RSBY)	2008	**Below Povert Line (BPL) households.** Poverty line set in 2011 at Rs 26 (approx.. US$0.53) per person, per day in rural areas and Rs 32 (approx..US$0.59) per day in urban areas.	• Organised at the state-level by insurance companies, in collaboration with local government and social partners	33,196,142 houesholds (50.41% of eligible households).	• **Not Comprehensive:** only in-patient hosptial treatment is covered.	• Insurance company selected at the state level through an open tender process	• **Third party payment mechanism:** Service free at the point of use for beneficiaries at empanelled hospitals.	Rs 9, 293, 437, 300 (0.037% of GDP), as of 31/3/2011, (Dror and Vellakkal 2012). Risk borne by the insurance company in exchange for the premium.
			• Facilitated through 'enrollment camps' in target towns and villages.	A total of 12,538 hospitals are empanelled. (8,546 private hospitals and 3992 public hospitals).	• Coverage up to a ceiling of Rs 30,000 (approx. US$650) per family, per year, for a family of up to five people for the cost of in-patient hosptial care.	• Insurance company receives an annual premium per enrolled household, up to but not exceeding RS 750 (approx. US$14) per household: 75% paid by the federal government, and 25% paid by the state government from general tax revenues.	• Hospitals claim a fee for service from the insurance company.	
			• No age limit, and pre-existing conditions are covered.		• Transportation covered, with a ceiling of Rs1,000 (approx. US$22) per family, per year, with a limit of Rs 100 per hospitalisation.	• Beneficiaries pay a nominal annual subscription fee to the insurance company of Rs 30 (approx. US$0.58) per family, per year.	• List of approved procedures and costings maintained by the Ministry of Labour and Employment at the Federal level.	
			• Up to five people per household are covered.		• Pre- and post-hospital costs incurred one day before and up to five days after hospitalisation.			
			• Using biometric smart card technology. Smart card issues at enrollment					

RSBY – Scheme Architecture

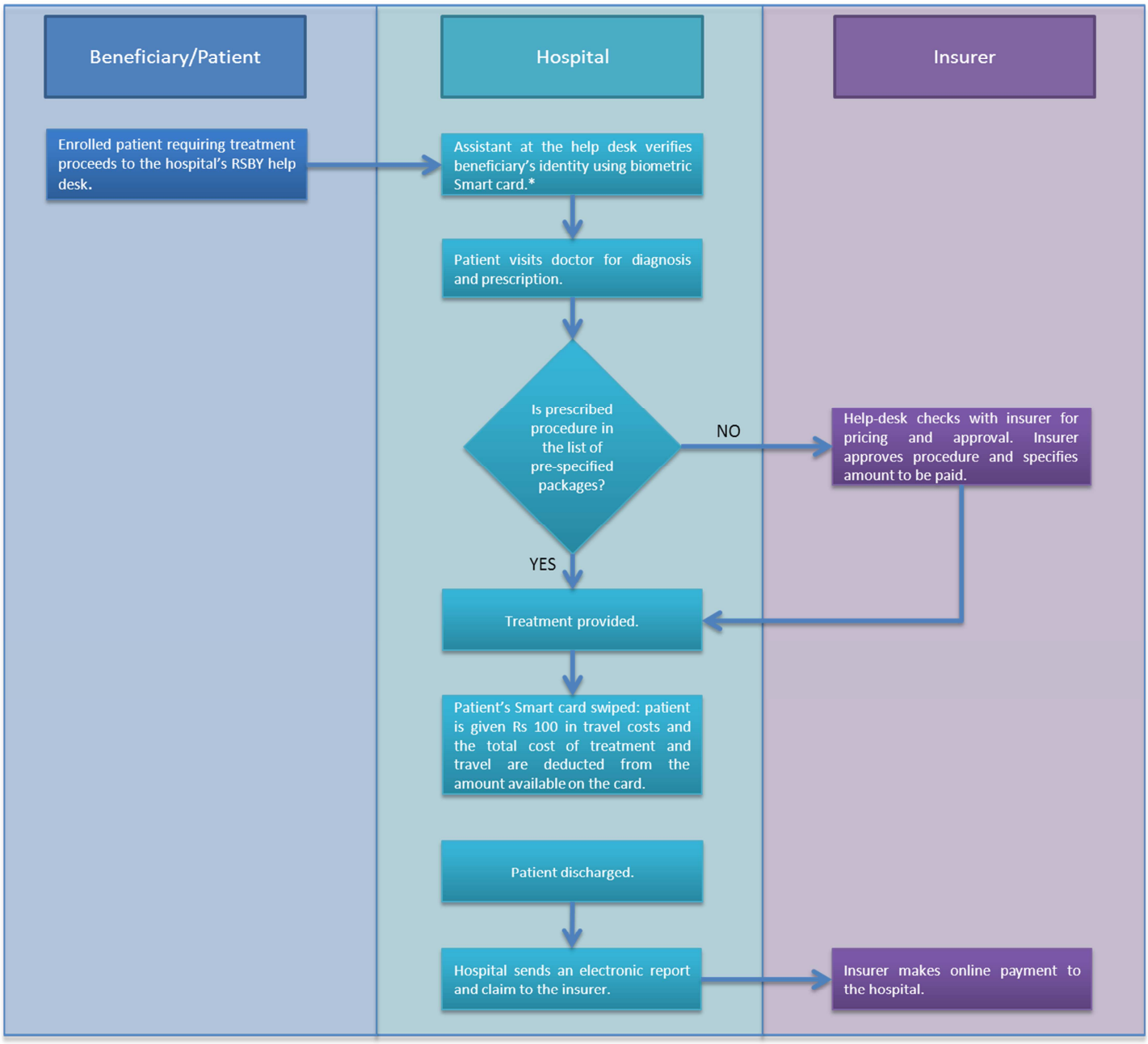


RSBY – Enrollment, Treatment and Payment Processes

Enrollment



Treatment and Payment Processes



*Generally, presentation of the Smart card is essential in order to access services. If the patient is not in a position to validate his/her identity with their own fingerprint, then their identity can be verified with the fingerprint of another family member who is registered on the Smart card. In exceptional circumstances, and where the patient's identity can be definitively verified by other means, and then only with the consent of the insurance company can treatment be given if the patient fails to prevent their Smart card.

⇨ Focus on *Rashtriya Swasthya Bima Yojana* (RSBY)

Universal Health Care in India: Historical Overview

Efforts to create a system of universal health coverage in India can be traced at least as far back as independence. Concerns about gaps in public health care provision actually pre-date it. In 1946 the Bhore Committee, established by the Government of India in 1943, insisted that "nobody should be denied access to health services for his inability to pay" (cited in Sen 2012: 46). Since then, successive committees, commissions, policies and plans have sought to extend health coverage to those individuals and households defined as living below the poverty line (BPL). However, as National Health Accounts data from 2004-2005 demonstrates, despite more than 50 years of attempts to extend public health provision, by the early 2000s, government (federal and state) spending accounted for only about 20 per cent of India's total expenditure on health. More than 75 per cent (as much as 86.4 per cent according to WHO statistics) of health expenditure comprised "un-pooled, out-of-pocket expenditures" (Swarup and Jain 2011: 260).

India is home to the largest absolutely poor population in the world (Pundir et al. 2012), and as Rajasekhar et al. (2011: 1) indicate, poverty and high health-care costs are "intimately" related. Out-of-pocket health care costs can often tip the balance, making the difference between a household falling either above or below the poverty line. Poor people themselves commonly list ill-health and health related expenses for their descent into or inability to escape from poverty (Krishna, cited in Ibid.).

With this in mind, *Rashtriya Swasthya Bima Yojana* (RSBY) was launched in April 2008 by the Ministry of Labour and Employment, with the aim of "provid[ing] protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization" (RSBY 2009). For an annual subscription fee of Rs 30 (approx. US$0.58), RSBY provides coverage of up to Rs 30,000 (approx. US$650) for a family of five for one year for the cost of in-patient hospital care. Transportation charges, up to RS 1,000 (approx. US$22), with a limit of Rs 100 (approx. US$2.2) per hospitalisation, are also covered. Pre- and post-hospital costs incurred one day before, and up to five days after hospitalisation are covered, though the cost of any on-going out-patient care is not. Unlike most health insurance schemes, there is no age limit, and pre-existing conditions are covered (RSBY 2012, Swarup and Jain 2011). The scheme uses biometric smart card technology to enrol and provide benefits to beneficiaries.

Technology: Biometric Smart Card

RSBY uses the following technologies:

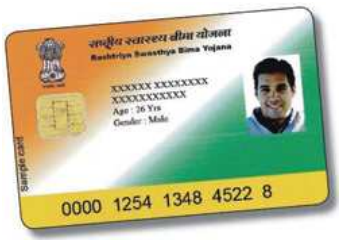
- Smart card Technology
- Biometric Technology
- Secure Key Management System
- Online data transfers

As Research for Development (R4D) (2010: 7) suggests,

> "The aim of the scheme is to use technology not only for controlling fraud and monitoring utilization, but also to find solutions to insurance related problems. For example, enrolment software has been designed to ensure that male heads of household must insure their spouses. In addition, since the scheme aims to provide quality treatment to all beneficiaries, technology has been implemented to ensure that every beneficiary receives needed treatment. For example, if a patient is not in a position to validate his/her identity at the hospital then any family member who is on the Smart card can validate the identity of the patient by providing his/her finger print".

The innovativeness of the information technology and information management infrastructure designed to support RSBY have been commended (Pundir et al. 2012). These systems offer scope for potential future expansion through, for instance, integration with mobile phone technology (Ibid.) or other government information management programmes, like that used for the NREGA (Gill et al. 2012). Recognising the effectiveness of the RSBY smart card system, the Government of India has taken a decision to expand the RSBY smart card platform to deliver other social security schemes including the life and disability Insurance scheme, *Aam Aadmi Bima Yojana* (AABY), and the old age and widows' pension scheme.

A biometric smart card is printed and given to each registered household at the time of enrolment, which is prepared and printed on the spot by the insurer. Enrolment stations are generally located in the field at the village level. The fingerprints of each registered beneficiary are collected and a thumb print of each registered household member is stored on the card. Once registered, beneficiaries are able to use the card to access services at any 'empanelled' hospital in India. A list of such hospitals is made available at enrolment. The system is cashless. Beneficiaries of the scheme are not required to make up-front payments to the hospital, and the hospital is paid directly by the insurance company (See RSBY 2012, Swarup and Jain 2011 and Rajasekhar et al. 2011: 3-5). Unlike other Government schemes which are available to the beneficiary only at the local level, RSBY members can access care at *any* empanelled hospital throughout India.



Achievements

In the four years since it was established, RSBY has become one of the largest Health Insurance schemes in the world. Some of the main achievements of the scheme are as follows:

Improvement in access to health care

RSBY has been able to improve access to health care for beneficiaries. The hospitalisation rate among RSBY members is more than 3 per cent, whereas for non-members it is only 1.7 per cent.

Reduced Out of Pocket Expenditure on Health

External evaluations of the scheme have shown that out of pocket expenditure on health for RSBY beneficiaries is considerably lower than that of non-RSBY beneficiaries in similar socio-economic circumstances.

High Satisfaction

Evaluations have also shown that there is very high level of satisfaction with the scheme. The satisfaction rating is between 70 and 90 per cent. More than 90 per cent of respondents said that they would renew their membership of scheme in the following year.

Challenges and Weaknesses

Benefit Package

Perhaps the scheme's greatest limit in terms of the government's stated aim of achieving Universal Health Coverage is that it covers only in-patient treatment and does not provide coverage for expenses related to out-patient care, which actually represents the highest component health-care cost. As Dror and Vellakkal (2012: 2) indicate, "in India, particularly rural India, the highest component cost is due to medicines, not hospitalisations". The Government of India is currently piloting schemes in select districts in five states where out-patient coverage is also being provided to RSBY members through the smart card platform.

Coverage

Coverage remains highly variable across and within states. Aggregated data belie enormous variance in the success of the scheme according to state and district. As with past schemes, problems of awareness of eligibility and accessibility of enrolment camps are prevalent (Rajasekhar et al. 2011). Currently, 50.41 per cent of the target population are covered under the scheme (RSBY 2012). The scheme is not enshrined in law, meaning that beneficiaries are not able to make rights-based claims to their entitlements (Dror and Vellakkal 2012).

Accessibility

Where households have enrolled, some have reported that they have not been able to access its benefits. Although cards are supposed to be issued at enrolment, in some cases, beneficiaries have reported this not to be the case. Further, empanelled hospitals tend to be concentrated in urban areas, whereas beneficiaries tend predominantly to be from rural areas.

Third-Party Payments

Some beneficiaries have complained that hospitals continue to charge up-front fees, while hospitals complain that processing claims with insurance companies is slow, time-consuming and that payments do not meet the full cost of the care provided (Ibid., Nandi et al. 2010)

Coordination

RSBY comes under the jurisdiction of the Ministry of Labour and Employment, causing potential conflicts of interest and a blurred division of labour with the Ministry of Health at the federal level. At the State level however, there is very good coordination and in more than half of States, the Department of Health is extensively involved in implementing the scheme.

Resources

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Thailand

General information

Population	**65.9 million** (Census, 2010)
GDP	**$345,649,290,737** US dollars at current prices (WB, 2011)
	Upper-middle income country
GDP per capita (PPP US $)	**$8,703** (WB, 2011)
HDI rank	**103** out of 187 (UNDP, 2011)

Non-wage workers in percentage of total employment	**54.1%**
→ *Wage workers in percentage of total employment*	*44.6%* *(ILO, 2010)*
Informal employment as a percentage of total non-agricultural employment	**42.3%**
→ *Formal employment as a percentage of total non-agricultural employment*	*16.5%* *(ILO, 2010)*
Health social protection coverage as a percentage of total population	**98.0%** (ca. 68.2 million people) (ILO, 2010)

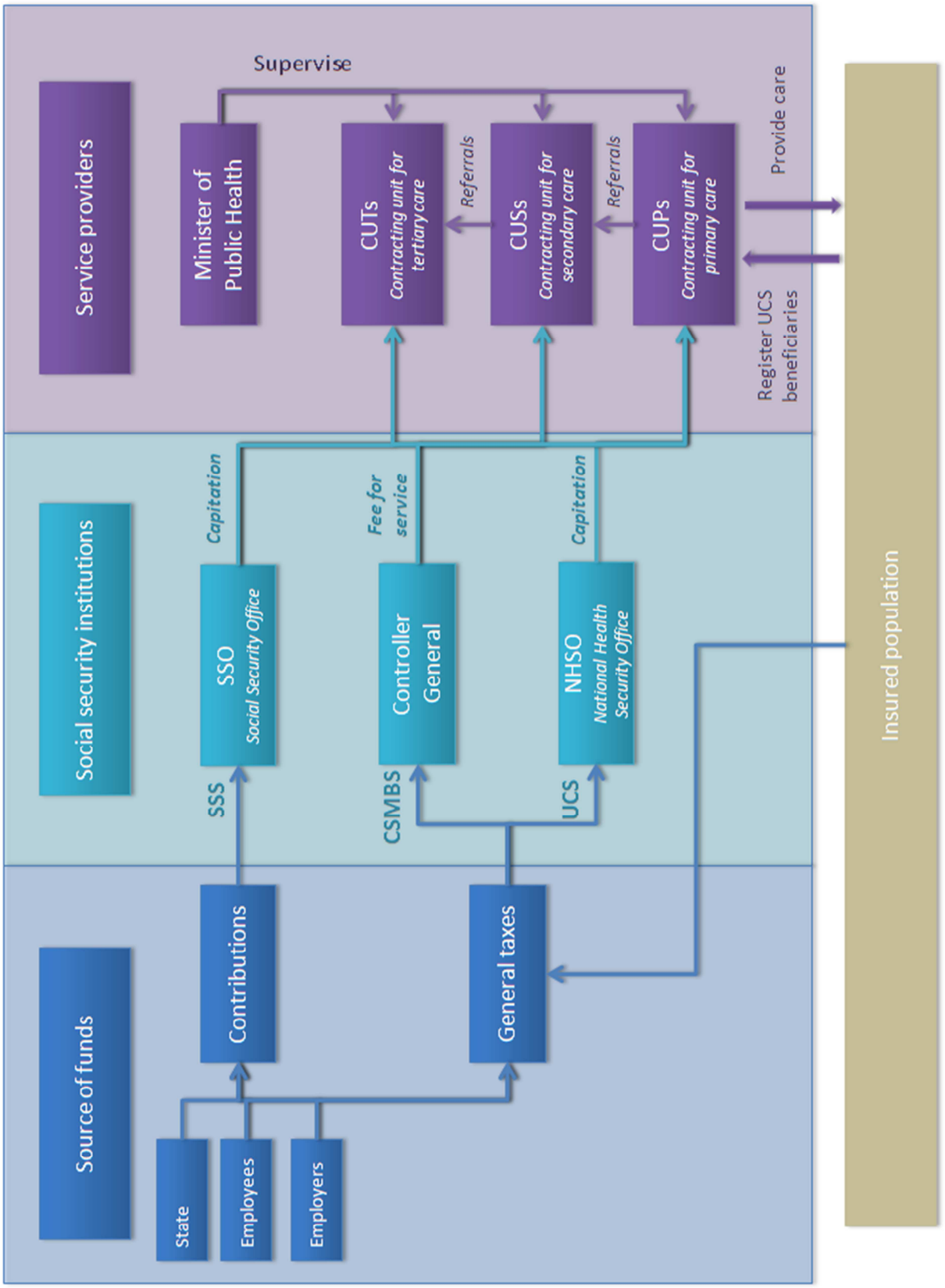
→ Maternal mortality ratio (modelled estimate, per 100,000 live births)	48 (WHO, 2009)
→ Percentage live births attended by skilled health staff (%)	99.4% (WHO, 2010)
→ Total expenditures on health as % of GDP	3.9% (WHO, 2010)
→ Govt. expenditure on health as % of total govt. expenditure	12.7% (WHO, 2010)
→ Per capita government expenditure on health at average exchange rate	134 US$ (WHO, 2010)
→ Proportion of out-of-pocket payments to total health expenditure	14% (WHO, 2010)
→ Public social security expenditure (including health) as % of PIB.	6.04% (IMF, 2007)

→ Theoretical coverage gap due to health professional staff deficit (WHO Benchmark - 28)	40.3% (ILO, 2010)
→ Theoretical coverage gap due to health professional staff deficit, % (Benchmark relative 35.5 per 10000 persons)	*52.9%* *(ILO, 2010)*
→ Theoretical coverage gap due to financial resources deficit (Benchmark - 60USD MDG target for 2015 in low income)	0% (ILO, 2010)
→ Theoretical coverage gap due to financial resources deficit, % (Benchmark relative 272 USD per person and per year)	*43.4%* *(ILO, 2010)*

Source: ILO SECSOC statistics

Scheme	Date created	Target population	Enrollment	Coverage rate (in 2008)	Benefit package	Funding sources	Financing method	Cost
Civil Servant Medical Benefit Scheme (CSMBS)	1963	Civil servants, retired civil servants, and their dependants.	Through employer.	16%	Comprehensive package with few exclusions (some organ transplants, cosmetic surgery, infertility treatments). Near-identical packages and unity of service providers for the three schemes. Through SSS beneficiaires can access some non-registered healthcare structures.	Non-contributory. General taxes.	Fee for service for outpaitent services, DRG payments for inpatient services	Around 440 USD /capita / year (2011).
Compulsory Social Security Scheme (SSS)	1990	Formal private sector employees.	Through employer.	7%		Contributory. Payroll tax tripartite contributions.	Risk adjusted capitation for inpatient and outpateint services where Adjusted Relative weight of DRG is <2. DRG for inpatient services when Adjusted Relative Weight is ≥2	Roughly 69 USD / capita / year (2011).
Universal Coverage Scheme (UCS)	2001	Rest of the population (mainly in the informal economy).	Register with a contracting unit (CUP) and receive a card for care in home area. *(When first implemented, potential beneficiaries were identified by health volunteers and medical personal, as well as through mass communications and media campaigns.)*	75%		Non-contributory: General taxes.	Capitation for outpatient care and prevention. Global budget for inpatient care. There is a 30 Baht co-payment for services, though this can be waived by the director of the facility where care is accessed.	Roughly 88 USD / capita / year (2011).

Global architecture



⇨ **Focus on UCS**

Institutional system

- Universal Coverage Scheme (UCS): created in 2001, people from the informal sector, replaced the Medical Welfare Scheme and the Voluntary Health Card Scheme. Covers about 74% of the entire population.
- Civil Servant Medical Benefit Scheme (CSBMS): civil servants, retirees, dependants.
- Social Security Scheme (SSS): contributory, private sector employees.

Thailand achieved a progressive extension of UCS to the national scale within a 2 years period (2001-2002). It was implemented in the period of economic crisis when GNI per capita is about $1,900 USD.

Benefit package

Almost the same benefit package for the three schemes.
UCS has a comprehensive benefit package (inpatient, outpatient, accidents, dental, etc.).
In addition to curative services (with some exclusions), UCS provides for preventive care for all Thai citizens, focused on health promotion and disease prevention (e.g., immunizations, annual physical check-ups, premarital counselling, antenatal care and family planning services, etc.). Recently, coverage has also been extended to ARV treatment for HIV/AIDs and renal replacement therapy.

Enrollment

To be enrolled in UCS, all members must register with a contracting unit (CUP) and receive a card for care in their home area. When first implemented, potential beneficiaries were identified by health volunteers and medical personal, as well as through mass communications and media campaigns.

Information System

The central registration database consolidates information on the entire Thai population, and includes registration information of the CSMBS, the SSS and the UCS. When patients seek care, their entitlements are checked with the centralized online database to ensure that they are enrolled in an insurance scheme. If the database shows that that are not members of the CSMBS or the SSS, they are asked to register for the UCS at that time.

Network of healthcare providers

All contracted public and private providers are bound to provide registered beneficiaries with these and other preventative services.
The UCS service delivery network includes both public and private health care facilities. Public facilities are automatically included. However, private facilities are first assessed according to a set of standards established by the National Health Security Office.

Reference system:

- Contracting unit for primary care (CUPs)
- Contracting unit for secondary care (CUSs)
- Contracting unit for tertiary care (CUTs)

Public hospitals are the main providers, covering more than 95% of the insured. About 60 private hospitals joined the system and register around 4% of the beneficiaries.

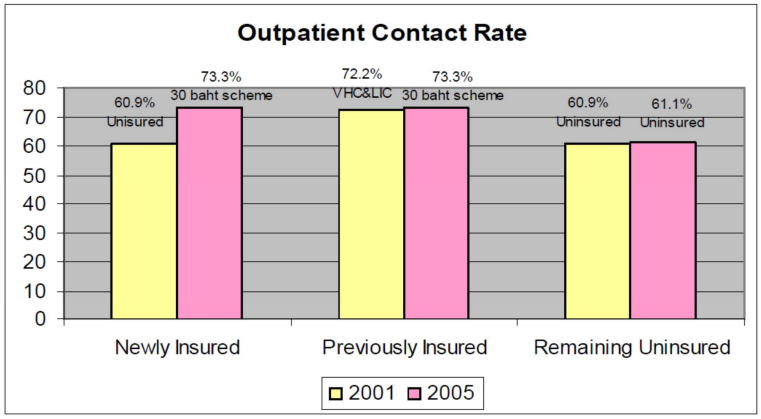
Financing

- UCS is financed through general tax revenues.
- Third party payment: The current payment mechanism for UCS is a mixed system of risk-adjusted capitation for primary care, a DRG-based capped global budget, and fixed rate fees for some services.
- The 30 Baht co-payment was abolished by the previous government in November 2006. The current government applies the 30 Baht co-payment again. However, flexibility applies so that directors of health facilities have the authority to exempt this co-payment.
- The UCS budget rose from 1,202.4 baht budget: (US$ 35.40) per capita in 2002 to 2,693.5 baht (US$ 78.80) per capita in 2011

A central administrative database capable of providing robust evidence on health-service utilization put the NHSO in a strong position to negotiate with the Budget Bureau. Introducing new service items into the benefits package, and thereby deepening financial risk protection, was another strategy used by the NHSO to secure a higher capitation rate

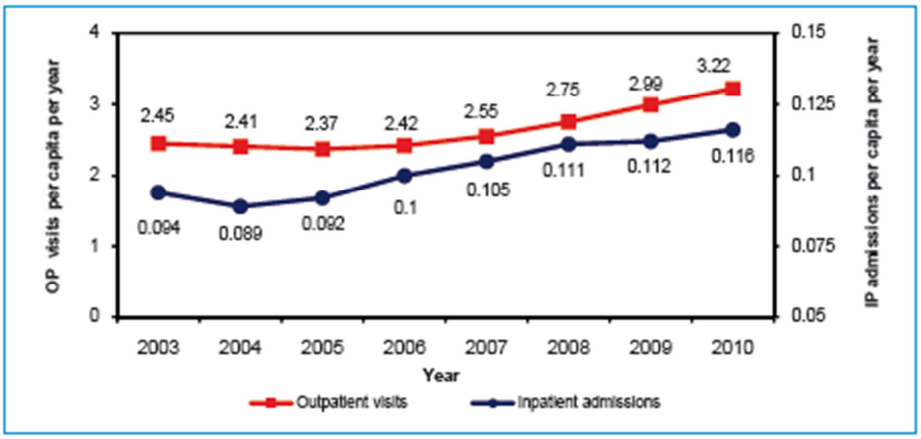
Access evolution

Outpatient contact rate (percentage of the ill who receive outpatient care)



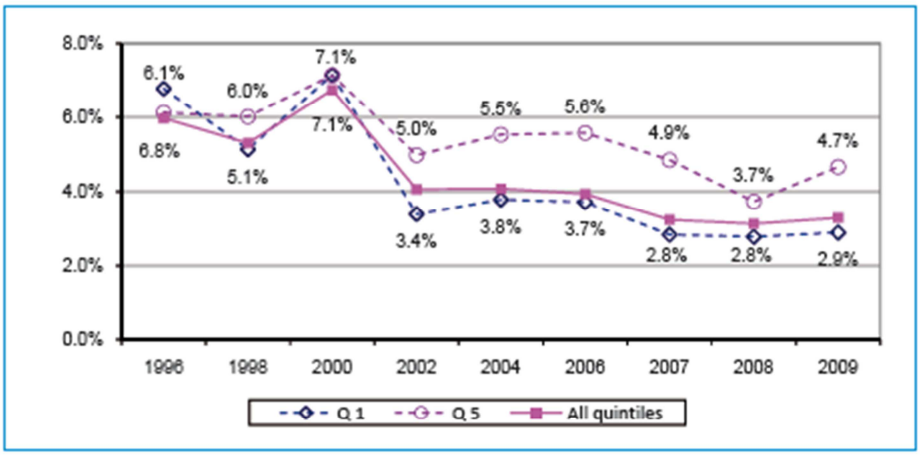
Financial impact on households

Service utilization rates among UCS members, 2003-2010



Source: NHSO annual reports 2009 and 2010.

Incidence of catastrophic health expenditure by wealth quintile, 1996-2009



* Catastrophic health expenditure refers to household spending on health care >10% of total household consumption expenditure.

Challenges

Although the original policy design called for a single fund, the decision was made to delay merging the public insurance schemes. This meant that universal coverage depended on a patchwork of the new and old schemes.

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