

**Reform Pathways for Healthcare Financing in India**

**A Dvara Research and IndiaSpend Webinar Series**

**Session 1**

**The Indian health financing landscape: what are the reform opportunities for this decade?**

**Monday, September 14, 2020**

**Introduction:**

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**Moderator:**

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**Panellists:**

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## PROCEEDINGS

**Mr. Ethiraj:** -- The reason we are embarking on this at this time is quite obvious. We are in the midst of a pandemic and also as we see from our vantage point, as journalists, “infodemic” [editor’s emphasis]<sup>1</sup>, and this is a good time as there is adrenaline pumping. People are thinking about responses, people are putting together, you know, ways and means to refashion organizations, refashion policy. So, it's a good time to look at healthcare as a whole and healthcare financing in specific.

The first one today is, like I said, the Indian health financing landscape. But there are three more and before I hand over to the moderator for this evening Bindu Ananth, let me tell you what the other three are. The next one is going to be about commercial insurance as financing, the one after that is going to focus on Employees’ State Insurance reforms, and finally the Ayushman Bharat scheme. So, in all, the idea is to get a composite overview on the various ways we can respond to not just the healthcare crisis in general, or at large, but also how do we address and make some fundamental changes in our health and public health policy approaches which use this as an opportunity to bring about fundamental or even transformational change.

So, on that note, I just -- also remind you that a lot of this is going to be found on Indiaspend in terms of our continuing coverage and the material that will emerge from this conversation and the ones ahead. So, on that note from me and my colleagues at Indiaspend, thank you very much for joining in today. Look forward to seeing you again on future conversations on this subject and more.

And let me hand over to Bindu Ananth who is the founder of Dvara Research.

**Ms. Ananth:** Thank you, Govind. I hope I am audible.

**Mr. Ethiraj:** Yes, go ahead.

**Ms. Ananth:** Thanks to all of you for joining us today.

I am delighted to moderate this very important conversation on health financing reform with three really outstanding speakers - Dr. Cristian C. Baeza, Executive Director, International Center for Health Systems Strengthening, Dr. Nachiket Mor, Visiting Scientist at The Banyan Academy of Leadership in Mental Health and Dr. Niranjan Rajyadhaksha, Research Director and Senior Fellow at the IDFC Institute.

So, I will provide some context briefly and then bring in the panellists for their remarks. Each of them will get a focus window of about 15 minutes for their remarks. Right at the end, we will have time, 15 to 20 minutes for Q&A. Please post your questions in the Q&A window and we will try to get to as many as possible. With that let me jump right into the conversation.

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<sup>1</sup> Text in [text] format indicate editor’s notes/insertions.

It is fairly self-evident that Indian health care is in dire straits. This has been made pretty obvious in recent months but is also the case that any meaningful reform is at the minimum a 25-year journey. So, one of the motivations of this webinar series is to make sure that as a country, as a health system, we are headed in the right direction and really have a good sense of the strategy to get there.

And so, what this series will do is really examine our health reform choices, principally through the lens of financing. There are other ways to approach it, but we feel that the financing lens has actually not received adequate attention in the Indian context. Financing, just to briefly set that up, looks at mechanisms to raise money. This could be general taxes, this could be payroll taxes, insurance, etc., thus determining what resources are available, the design of institutions that raise money, and importantly, the allocation of resources to different priorities. The end goals of course in all of this is to improve the health status of the population as a whole, preventing catastrophic expenditures that result in bankruptcy of households, something that we worry about greatly, and of course, delivering overall customer satisfaction.

Just to set some context here I want to share some financing-related facts. I would also encourage all of you to go through the background note for this session that's been made available to you I believe, that has been co-authored by Nachiket and one of my colleagues Hasna Ashraf.

So, fact number one, the largest share of spending for health in India is actually out-of-pocket by individuals. This accounts for about 65% of the total. So, in this conversation and I think in later sessions, it's helpful to acknowledge that in the current environment therefore health is largely a market provided or a private good. [Fact number two], the rest of it, the 35% of the pie is highly fragmented and comes from a number of central government, state government, and insurance companies and I believe Dr. Baeza has a wonderful graphic that we've all referred to extensively that will show you exactly what that split looks like.

Fact number three - this is emphasized a lot in the background paper. Even relative to what we are spending, and many people will argue to you, I think rightly, that we should be spending more as a country. In fact, that's sort of the dominant thing that you hear that public spend is only about 1% of the GDP [Gross Domestic Product]. It needs to be much more than that. But important again to acknowledge that even relative to what we are spending and using the metric of DALY which is disability-adjusted life years, you are actually not doing a good job at all. So, to give you a sense, currently, India has a DALY rate of more than 35,000. One DALY can be understood as one lost year of healthy life. So, to put this also in context, India's neighbouring countries, Sri Lanka and Bangladesh perform much better against this metric. So, the comparison is not with very sophisticated health systems. But even countries like us seem to be getting more value for money. Sri Lanka and Bangladesh being interesting examples right here in the subcontinent with DALY rates under 30,000.

So, as we think about the future, we believe there are four broad directions to go in over the next decade. Let me also say here that the four directions are not mutually exclusive but really represent different pathways and priorities and we will examine each of these in detail starting in today's conversation. The first one, and really the most dominant proposal I'm sure all of you have heard, -- that -- and thought about it, is to increase the total health expenditure, particularly the share of public spend on health care. Somehow find the resources to get this done because health is critical. In fact, recently Dr. Pramesh of Tata Memorial in one of his Twitter threads called for a doubling in two years and a quadrupling in five years of investment in public healthcare facilities and I think this is an argument you hear often.

The second sort of pathway broadly speaking is to increase the share of pooled expenditure, that is the share of money that's not out-of-pocket, the 35% sort of piece. For example, ESI [[Employees' State Insurance](#)], which is a scheme that we will look at in extensive detail in one of the future conversations, today covers only blue-collar workers in India. What if it were extended to cover all formal sector workers that would represent a significant broadening of the pool? So that's sort of pathway number two.

Number three is to increase the effectiveness of existing pools, which is to say, notwithstanding that the pools are not large enough etc. etc., can we get the pools to actually deliver more so that participants get -- experience -- more quality? What would that pathway look like?

And the final one is about increasing effectiveness of out-of-pocket expenditure. Like I said, 65% today is really out-of-pocket and even there I think there is a sense that people are not getting enough value. What would it look like if we really focused on, even if OOP [[out-of-pocket](#)] [[expenses](#)] would go down slightly over a period of time, but really also focus on the quality dimension?

So, these are the four sort of broad pathways, like I said, not mutually exclusive but I think force us to think about a different set of policy choices. Each of our speakers today will examine each of these directions in detail. With that, let me actually start with Niranjana who is the macroeconomist on our panel and requesting to walk us through the potential of pathway number one of increasing significantly the public expenditure on health in the next two to five years. How feasible is this, Niranjana, given our macroeconomic trajectory, and also if you can give us a bit of a basic sense of what are some of the key trade-offs from a public finance perspective? Niranjana, over to you.

**Dr. Rajyadhaksha:** So, thanks a lot Bindu and Govind for inviting me to this seminar. As Bindu said I am not an expert on health economics but more broadly a macroeconomist, but this is an issue which interests me immensely. So, I am going to give a bird's eye view of the health finance issue in India and especially the public funding of health care.

So, there are three broad overlapping themes which will be there in my talk over the next 15 minutes. One is the financial stroke - fiscal issue, the second is the constitutional issue, in sense of India is a federation so who does what, what is to be done by the state governments, what by the union government and third, I want to just tag some political economy issues because if we think about this meta goal of ramping up public expenditure in health, we can't ignore the political economy issues which face any government. So, these are the three broad overlapping themes which run through my remarks over the next 10 to 15 minutes.

So Bindu has already given you a view of how much or how poorly funded Indian health care is. Most of the money is out-of-pocket expenses. The state is not doing its bit. So let me start by making a broad statement of fact that India has traditionally had very low fiscal capacity, that the ability of the Indian state to fund its various requirements or its constitutional duties is very fragile, which is why we run up against this entire issue about a large fiscal deficit, that we have to borrow basically to even fund basic services.

So, the first thing we can look at is does India raise enough taxes to fund all the commitments of the Indian state, right? So, let's look at the tax to GDP ratio. And I look at it in three different ways and over the past two days I've been looking at the numbers again and again and these are standard statistical ways of looking at any data. The first is a cross-section which is at one point of time, how does India compare to other countries in the world? And one broadly sees that India's public health expenditure as a percentage of GDP is more or less predicted by its income level. So, given India's income levels, this is not very far from what you would get as a public health expenditure to GDP ratio. The other way is to look at time series data. Rather than look at different countries at one point of time, look at the same country that is India across time and you see that our tax to GDP ratio has been inching up over the past 25 to 30 years. I am saying 25 to 30 years because Bindu said it's a long-term game. So, the tax to GDP ratio was about 15[%], just using broad numbers, around [19]95, and today 25 years later it is about 18% which is not great but it's a three percentage point increase in the fiscal resources of the Indian state.

And the third is what you could call panel data which combines the cross-sectional idea and the time series idea. So, you look at how other countries were spending when they were at our level of development. So, I just took randomly a few countries like Korea. So, Korea in 1983 or Thailand in 1989, or China much later in 2008-09 were broadly at the income level that India is today and their public tax to GDP ratio also was similar. So, the point that I want to make is that this fiscal capacity problem or the low tax to GDP ratio is largely explained by poor income levels in India. So, we are officially called a lower-middle-income country but there is massive poverty still. So, therefore, the real goal or the real challenge will be that as India develops, as average incomes increase, can the state increase its fiscal capacity by raising more taxes per unit of GDP and therefore

release money or raise or get money for these ambitious social programs including health, education, and a lot of other things? So that's the first issue -- that -- do we have the money?

The second issue is that given the money we have, are we spending enough on health? It's a mixed bag here. If you look at countries which have similar income levels or similar tax to GDP ratios, at this point of time, a lot of countries like Vietnam, Bangladesh do spend more than us. So, therefore, I just have some numbers, you know, I can just share them here. So, for example, China's tax to GDP ratio is about 19.5%, but its public health expenditure to GDP is 3.1%. Vietnam has similar tax to GDP ratio, their public health expenditure to GDP is almost 3.8%. Brazil of course has a much higher tax to GDP ratio, and they spent about 4% -- health expenditure to GDP. This is public health.

India's tax to GDP ratio is about 17% but our expenditure, states plus central is only 1.4%. So even given the constraint of the fiscal resources, there is a case for, you know, -- given even this situation of [\[tax to GDP ratio\]](#) -- , increasing the ratio of public health spending to GDP. So, the question is that why doesn't this happen. And really this is the third point I mentioned, the theme, which is the political economy. Before I get back into more detailed data-based points on the political economy, let me make just broad sweeping narrative in the next two or three minutes.

So, it's going to be a brave narrative. Obviously, any narrative over three minutes is bound to have its simplifications which can be challenged but here goes anyway. I'll try to stick my neck out. So, the Indian state as I said, it didn't have enough fiscal resources. So, the first leg of our development story, say from 1950 to 1990, the idea was that the Indian state would use its fiscal resources and its borrowings to build physical capital. So, it was either infrastructure, like the famous Bhakra Nangal Dam or whatever you have it, or industrial investment through PSUs [\[Public Sector Units\]](#). So, it was focused on physical capital rather than human capital. So, most of the human capital spending really happened at the top end, which is science institutes at the IITs, the IIMs, etc. Similarly, just like education, public health was underfunded because it was a political economy call that we need to build physical infrastructure rather than human capital; physical capital rather than human capital.

Now, this switched in 1990 where the Indian state started withdrawing from the task of building the physical capital in the country. This is the reforms that the private sector would do, that part of it. So, the question says then fine, if you don't need all these industrial investments by the state what are you going to do? So, one obviously is tax cuts to transfer resources to the private sector to build this physical capital of the country. But what was leftover was very clear that it was going to be invested in health, education, and other forms of human capital. And if you read Manmohan Singh's early budget speeches it's very clear that the state will not be building the next steel plant but it will be building more schools, hospitals, public facilities, etc. Now, this was predicated on one very big assumption that India would follow the East Asian path and the private

sector investment would create jobs for large number of Indians who would move from farming to factory jobs.

Now that didn't happen and there were pressures then for subsidies etc. So, after 2008-09 the Indian state has moved into a third mode which my friend Ratin Roy calls the “compensatory state” [editor's emphasis]. So instead of a development state, we have a compensatory state. So, what the Indian state is now doing is saying that, hey we can't give you jobs, the economy is not delivering the jobs, we can't build your public goods, but we will hand you money. We have this JAM trinity which is Jan Dhan accounts, Aadhaar, and Mobile phones. So, we'll basically transfer money to you. So, this is the changing political economy of the Indian state and with that, there's a sub-narrative of how the Indian state has looked at social sector spending including health.

Now the third big issue is of fiscal federalism. That if you look at the public finance in India, India is a federation with union government, state governments, and after the 73rd and 74th Amendment to the Constitution we have a third-tier, which is the panchayats, the urban bodies, etc. But for now, let's just look at the state governments and the union government.

Generally, in India, the central government raises 60% of the taxes but the state government do 60% of the spending. So, there is a need to push money by the Centre into the states for the states to meet their commitments, because most of these local public goods which is policing, education, health are actually the task of the states according to the Indian Constitution. -- So now this fiscal federalism issue of how does money -- centre is collecting the money, it does spend on some health schemes, but it has to also transfer a lot of money to the states. So how is that money being transferred to the finance commissions? Is enough being transferred? And then what are the states doing?

So, I just want to share again some numbers for you. Indian government spends about 1.4% of GDP on public health. Out of that, about 30 to 35% is spent by the central government and about 65 to 70% is spent by the state governments. This is the data I've got from the *National Health Accounts* which the government releases. So actually, when we think about the public finance angle, we have to think of the states more than the Centre, the fiscal situation in the states.

So, it's interesting if you look at the gross budgets of the states, all the states together. It's from the rich states like Delhi to the poorest states like say Bihar, and you aggregate them. I find it interesting that in the states, health spending as a percentage of state GDPs is about 0.75%. But the spending on education is about 2.8%. So, this is again another issue which perhaps can be taken up later in this session or later sessions, that we have seen a greater acceptance of education as a public policy goal, and we've seen even private spending on education among the poorest families is rising. Health somehow does not tend to be resonant either politically or in social context.

So, this is a puzzle. I just want to take a little diversion. A few weeks ago, I heard a series of lectures by the economic historian Tirthankar Roy on *Epidemics & Indian History* and one of the issues discussed there was precisely this. We are in this pandemic, but India has had several epidemics of flu, of plague, of cholera but even the Indian national movement in the pre-independence era never made public health a central pillar of its critique of the colonial state. Education was always important. So why is social choice tilted towards education rather than health? Why is it more politically attractive to spend on education rather than health is the question I have, I don't have an answer but perhaps at some point it's worth discussing this.

I think that generally if you see, as India develops, my guess is that this simple line of best fit, if you follow that logic, it has its limitations, but that India's tax to GDP should gradually start rising and by the end of this decade, of course, the pandemic puts everything into question - all economic forecasts, but by 2030 if you have a tax to GDP ratio of about 20 or 22%, that's about 5%, four or five percentage points more and say we make a commitment that about a third of that has to be put into public health. So, at once you've doubled your public health to GDP numbers. So now we have to all make a case for this to happen. It has to be an intellectual case; it has to be a political case. But it can be done. So, I think that doubling over the next 10 years as a percentage of GDP is not unusually --

A second thing, I should have said this before when this number, public health spending to GDP, is discussed. One thing which strikes me is that only a certain type of things done by the health ministry is considered. I would ask this question that should the budget for water and sanitation also be included in the public health budget, when we think about it, not as a budgeting exercise but -- as a -- more of a policy framework because a lot of public health issues also arise because of poor water quality and sanitation.

I just want to end by looking at as I said, what does the Indian government spend on? So Bindu has obviously had asked that. What are the trade-offs? Like if you have to take money for public health where do you get it from? So, there are two points I want to make here. One is that the Indian government, a lot of its resources -- actually locked right. So large part, interest rates on old debt, salaries, pensions, we can add defence also, now given the situation, defence is something which cannot be touched. So, about 50 to 60% of the budget anyway is locked in. So, then the breathing room for the government or the scope for discretionary spending is much lower than what a lot of people think.

I was going through the latest budget numbers, the budget which the finance minister presented earlier this year [[Union Budget, 2020-21](#)], and it's interesting -- that it tells you some things. The *National Health Mission*, which is the flagship mission of the Indian government, I am

just rounding off the figures, it got a budgetary allocation of [Rs.] 34,000 crores. But two major transfer programs, the *PM Kisan* which is the transfer to the farmers, and NREGA [MGNREGA, The Mahatma Gandhi National Rural Employment Guarantee Act, 2005] which is basically a job guarantee in the rural areas which could now become a move to the urban areas as well, between them, they got an allocation of [Rs.] 1,35,000 crore. So, it's about four or five times higher. So, this is what I'm saying about the development state versus the compensatory state. Cash transfers have just exploded in the budget. Anyway, *National Health Mission* is [Rs.] 34,000 crores, the *National Education Mission* gets about [Rs.] 40,000 crores, the PM Gram Sadak Yojana gets about [Rs.] 20,000 crores. The metro projects and the *Smart Cities* projects get about [Rs.] 30,000 to 31,000 crores. So, you know, the way these allocations have been done, then, of course, the roads and national highways get about [Rs.] 80,000 crores.

The point of all these numbers is that it tells you something, it's like revealed preference that the government is not ignoring health, but health is not up there in the priorities. And a lot of money is actually being spent either on basic infrastructure such as roads etc., urban infrastructure or it is being spent on what I call these compensatory mechanisms to ensure that people who have not participated in the economic progress get some sort of social safety net and this again goes back to the lack of job creation in the economy.

So, I think you have to think about how these allocations are --, why are these made, and it again goes back -- just to reiterate to my earlier question -- that we can look at it as a pure fiscal issue and it is there, the tax to GDP ratio is low but it can be increased. But also given the current situation, why don't governments spend more on health? Why don't Indian citizens demand health as a basic service?

One last point before I wrap up is that this entire issue of, as I said, that the government strategy of saying that we can't build this, we will give you money. Now I am not completely close to that idea, I think for example education vouchers or health vouchers are an idea worth pursuing. But I am a little suspicious about solutions, one-shot solutions for the entire country. I think that these sorts of cash transfers or specialist vouchers work better when you have deep and well-regulated markets. But when you are in situations where there are single providers, so the markets are not developed, it can lead to monopoly pricing of these things or the option -- . It's simple. For example, in Mumbai, if I get a food voucher I can walk down the street and have 20 people who can sell me food. If I am in a remote village perhaps there's only one shop. So, the incentives of that guy is to just increase his prices because he has no competition. It can happen in education; it can happen in health care.

The other thing is, the government, given the flow of things these days, can say that we mandate the prices but then that destroys the idea of a market-based solution to this. I am not a health economist, but I feel that we need a more nuanced and a rich set of solutions which include higher public spending. I think higher public spending should be the linchpin of this entire strategy, but also, quasi-private sector solutions like health vouchers or cash transfers, or insurance. So, I'll stop for now and hand it back to Bindu and happy to take questions later.

**Ms. Ananth:** Thank you so much Niranjan. You raise many interesting issues that I would like our speakers to come back to towards the end but for now, let me move to Cristian.

Niranjan has very nicely laid out what are the kind of constraints of the fiscal strategy and so assuming, Cristian, that the public spend rises somewhat gradually, clearly it's not enough to produce dramatic changes, what are the other options available to us as a country? And in particular, if you can speak about the other risk pools which is not the government pools, and what are some of the opportunities for reform around those. Over to you Cristian.

**Dr. Baeza:** Thank you so much. So let me first thank you for the invitation. I feel really privileged and honoured to be here. I think I am the only international guest among very wise Indians. So, I apologize in advance for the things I may say that don't fit in the context. I am beginning to begin to know India and I'm fascinated by it. Second, I want to thank Nachiket Mor. I have a debt of gratitude to him and to Amrita who reintroduced me to India and by doing that really created a special place in my heart for India. So, thank you for inviting me.

So basically, I think there were four questions that you wanted me to address, and I will consolidate them. So, one is what are the health care financing options particularly given that the fiscal trajectory of India is going to be moderate -- way to be optimistic in the health sector. I will also throw in some discussion about the current landscape which is critical to understand my perspective later on.

A few guiding principles, it feels presumptive of me to have principles, but I think I have some learnings in the last three years that I'd like to share with you and what are the big shifts and I understand what are the big reform options particularly for the non-publicly financed pools. So as in any health system, India is funded by out-of-pocket and by fiscal funding. So out-of-pocket has non-pool and fiscal funding [has] labour taxation, and by contributions to voluntary insurance in general. And let me just bring up a graph that I think was distributed before to all of you. I hope you see it; I think you see it.

So basically, this graph from 2018, which has data from 2015 but the relative weights of the data are similar, shows the distribution of funding in India in 2015 across all the pools. The biggest elephant in the room by far is the out-of-pocket expenditures and it's the dominant factor. So similar to other countries, India has this blend, but uniquely to India, India has a very high level of out-of-

pocket and a very fragmented rest of the pooling which is around 35%. I personally believe that there is a significant underestimation of the out-of-pocket in India given two things. One, the levels of informality, second, the issue of robustness of data and third, an issue of supply-side constraints.

With that supply-side constraints, what you see is a less level of out-of-pocket, not [that] before [it] is not happening or it should happen, it's just because you cannot access services. So, these levels of out-of-pocket has been as stagnated for the last, I would say more than a decade if not 20 years, the rate of decline in out-of-pocket in India is around 0.4% annual, which is similar to other South Asian countries, but very different to countries with similar GDP per capita and even countries with the same tax collection capacity. So, there is an issue in South Asia and in particular in India that brings that.

-- So let me -- back to me-- . So, I believe that it is clear that there is a need to reduce out-of-pocket and shift the out-of-pocket to risk pooling, to the aggregation of this funding. Now as Niranjana said, I think very diplomatically and he's the macroeconomist, I am not, but I believe that the prospectus for significantly increasing fiscal resources for health in the next decade is pretty limited. And the reasons are -- the past -- so two decades of GDP per capita -- It's a GDP in health of around 0.7 to 1.4% depending on your source of data. So, I always tell my wife that, this year I will be running the Boston marathon, and you know what her answer is, yes dear, please, by all means do! And guess what happens. In 20 years I have not run it and so, yes, of course, we can expect and dream that there will be an increase. But if it is an increase, it will be very modest, and I have big doubts about that given the macroeconomic consequences of the pandemic globally and especially for India.

So, the second source of financing then would be labour taxation [the first being increasing the current level of fiscal allocation for health] . So, payroll tax. So, for labour taxation to happen you need two things. You need a formal sector, you need to be able to collect a labour taxation and if you look at labour formality in India in the last decade or more, India has one of the highest labour informality in the world. Very high in agricultural sector, which is not surprising for me, I used to work in ILO. But also, very high non-agriculture labour which is surprising to me given the trajectory of India. So given the current level of informality, -- the likelihood that -- the current labour formality is likely to be very labour tax elastic in terms of participation of labour. It seems to me that in India, going in and out of labour formality is easy or smooth and for households. And so, it's likely that there is a very high labour tax elasticity of participation in formal labour.

The third is, given the challenges of the current social insurer that Bindu very nicely hinted, and I've been working for years on that, the challenges that ESI has in actually giving value for money is also not an incentive for people to actually come into a labour taxation contribution more easily,

and finally, the global competitive implications of labour cost in India also are really significant. So, if I would have a conversation about labour taxation as the source of potential increase or shift from out-of-pocket to risk pooling, I would not only think twice but I probably would think 10 times, given the implications on formality, given implications on global competitiveness and given the reality of how do you actually collect taxes, labour taxation in a pool of 5 to 7% of labour which is formal.

So, in a scenario where more fiscal and more labour taxation is unlikely to happen, the only option is to channel OOPS [out-of-pocket spending] to risk pooling or other prepayment mechanisms through basically two mechanisms. And I come back --to do-- to that in a second once I visit the sort of my first impressions in regarding principles of the path in India. So, I see five principles. One is the need to focus on sustainable reducing but not eliminating out-of-pocket expenditures and expanding risk pooling. This distinction is important because there is no country in the world that is aiming to eliminating risk pooling [the panellist meant out-of-pocket expenditures] to zero. It would be not only inefficient for the country, it would be inefficient for the household. There are other options. Savings and prepayments or nothing depending on the size and the frequency and the predictability of the events.

The second principle for me would be that any reform solution will need to be pluralistic. India is as complex or more, much more complex than Europe as a whole -- [Europe] is really many Indias. And so, [first] it is likely to be plural in the source of financing. We just discussed that is unlikely to be purely fiscal, probably not only because of fiscal microeconomic constraints but also social contract issues about the financing of health in India. Second, it probably needs to be plural in terms of schemes. It will be a cohabitation of public and private and commercial for-profit and not-for-profit. It probably will be a need to be a blend of mandatory like ESI but also voluntary like commercial insurance. It will for sure, because of constitutional issues that Niranjana raised very clearly, -- it will -- be a blend of national and state-level financing and risk pooling and it will be probably a mixture of risk pooling as we know it, insurance, and also prepayment, which in my view, commercial insurance in India looks much more like prepayment than insurance today, given the regulatory challenges.

The third principle is that and this is one I'm going to get a lot of tomatoes for, but you know I will take the risk. So, although the reform is for universal coverage, [it] is likely that in the transition it will be a diverse transition and it will be an unequal diverse transition. And I mean by that, that likely for a long time in the transition not only the reality would dictate differential packages and differential financings but also the need for having incentives to bring in informal non-poor into the equation will dictate a need for differential benefits. Countries that have opted for equal benefits regardless of whether you contribute or not contribute have found themselves in pretty difficult

situations. You can look at Colombia and their fiscal impact now and 20 years ago.

My fourth principle is that and I really learned these by having India back in my heart now, thank you Nachiket for that, I said that. India can learn a lot from paying attention [to] international experience but it has to plough ahead with its own path. India is unique in many ways and in my need, India is unique in the starting point, in the social contract regarding public financing in health, in the labour market dynamics, and many others. And likely it will need to be unique in innovating ways to transition out-of-pocket into risk pooling with very unorthodox responses and I used to be the lead for the world bank in health and I'm sure many of my colleagues will not be happy [about] what I'm saying but probably, you need to be unorthodox in the way you use risk rating for contributions on informal non-poor and other ways to incentivize participation.

And finally, in terms of principles, I would say there is a urgent, a really crying demand for rebalancing supply and demand-side financing in India, particularly in the public sector. Today the public sector finance is almost purely traditional supply-side input funding and -- a very -- at the very least, [it] is crucial to for a responsiveness and also for an efficiency, both micro and macro allocative, to move at least to money follow the patient in the public financing.

Now regarding the question of necessary big shifts which I translate as path or potential options for reform, let me just use another little graph here that my colleagues and I prepared some time ago. This is a bit of a complex graph but basically on the left it tries to show the composition of out-of-pocket in India today and on the right it tries to show a significant reduction, a policy ambition to reduce out-of-pocket in 2040 could be 2050 could be whatever. And basically, what India is doing, and it seems to be need to do is a two-pronged approach to it. One is as Bindu suggested before and I call it the sandwich because it's up and down, basically needs to -- OOPS -- improve the effectiveness and the size of the current contributory health insurance pools today and have a more efficient growth of the well-functioning commercial and ESI insurance and it also needs to at the center of that improve the capacity for or the incentives for the informal non-poor to contribute to these schemes. In that sense, the efficiency and the expansion are closely linked. If I am a consumer, I can voluntarily decide to participate or not participate. Whether these things are working efficiently and there is consumer protection or not will make me choose or not to participate. So, this is very important.

The second issue is that moving the informal non-poor into contributory health insurance is essentially a voluntary issue. There is no country in the world that has been able to do it through a mandate. So, they need to be wanted to come and that means that these things, the contributory health insurance today, commercial and ESI need to be attractive for that. And then the second part of it is to improve the efficiency of the public sector allocation of fiscal resources through increased

targeted and fully subsidized, public subsidized, pooling and very likely, as I said before, in rebalancing the supply-side financing and demand-side financing, so providers in the public sector provision services have the incentives not only to be efficient but also to be responsive and to be actually reaching out to patients and populations.

India is moving in that direction with the NHA [National Health Authority] PMJAY [Pradhan Mantri Jan Arogya Yojana] scheme. I think the size, as we saw the PMJAY NHA scheme, is not what excites me. It is big because everything is big in India. But compared to the challenge in India, NHA is small. However, it is like an atomic ant, if I may put it that way because it has a tremendous potential for constructively disrupting what is happening in healthcare in India in the public sector and that is super exciting. Now more specifically regarding the path one, the improvement of the existing risk pools, and with this, I finish, so I don't take much time than I was suggested to. But basically, regarding the improvement of the current situation, there are two steps I would say, an immediate no-regret set of actions and a longer-term conversation about options. I have to confess to you and with this, I am with Niranjana that the political economy of India, the biggest democracy in the world, maybe [1] think that the long-term options will be a political idea, -- markets -- a solution rather than a plan solution but there is a lot of things can be done in the no-regret immediate and there are three buckets in that.

One is the national level, the second is the state level and the third is a combination of both. At the national level, there are two things that are crying to be part of the reform. One is to improve the performance of ESI. ESI is one of the two big components for path one which is the increase of risk pooling through contributory. ESI has tremendous challenges and is really not providing value for money, -- if I -- with a lot of love to ESI, I say that because I work closely with them. The second is to improve the performance of the commercial insurance market both publicly owned and privately owned. You know I work in health insurance all over the world and I work in regulation, and I believe that market failures in the privately-owned are significant and the regulation is not up to where it should be, and I can go deeply. And I think governance challenges in the publicly-owned are equally challenging and require very significant changes in governance, particularly in management of reserves and others.

At the state level, I think the biggest challenge is the consolidation of the de facto or de jure of multiple pools and fragmentation of the pool and ensuring portability of benefits and more efficient way of managing a more consolidated pool. At both levels, state and a national level, the innovations on bringing the informal non-poor sector likely in a combination of products that will make it attractive for them, but also will not shoot you in the dark. Because -- you -- if you have short-term consumer blindness products that will satisfy demand today, you are asking for risk dumping and a crisis 24 years ago in front of you as the Chileans had, as the Americans had, and so

on so forth. So let me stop here. Sorry for taking more time and thank you for the invitation.

**Ms. Ananth:** Thank you very much Cristian and I think it's not a coincidence, but all of our future sessions will exactly look into what you described as no-regret moves and things that are outside the fiscal but can really make a big difference in the next decade or so. So thank you very much for all your work on that. Nachiket let me turn to you next and I'm actually going to ask you to respond. I think Niranjana and Cristian have made very interesting, wide-ranging kind of observations and thoughts. Just your reactions and if we have time we will ask you more.

**Dr. Mor:** Thank you, Bindu for inviting me. It's wonderful to reconnect with Cristian and with Niranjana and to hear them once again share their wisdom about where the country is going, where the challenges are and clearly, there is not a lot that I can disagree with them on. I mean there is no question that there are a number of issues that are going on underneath that need to be addressed and that are puzzling. I mean, it's interesting what Niranjana said that the state has moved from a particular self-image of itself to another self-image of itself and maybe some of it is coming from what Cristian is saying, which is it pooled money, it put money into things, it didn't work, it didn't give the outcomes. It's an interesting perspective Cristian had to say that, is an entity like ESI acting as a barrier to formalization? Because if you're not getting value for money and yet you are charging people and only giving them half and you're charging relatively poor people, blue-collar workers, maybe you're signalling to them stay informal because if you come in here a reasonable portion of your money will get taken out even though you're outside the formal tax net into the informal tax net. Also, this issue that Niranjana said which I feel needs a little bit more, we may not have time today, a little bit more interrogation because I do believe that we have to go deeper into the state, at the state level rather than nationally and in some ways this notion that Niranjana had as incomes rise, these expenditures will rise. Well, we haven't seen evidence of that at the state level. Bihar, in fact, we've seen the opposite. Gujarat, Maharashtra, they are spending 0.5 or 0.6% of their GSDP [Gross State Domestic Product] on health. So, as they have gotten more money they have cut health expenditures or the proportion of money that they spend on health.

In fact, Kerala is amongst the richer states in terms of per capita income. It spends less than UP [Uttar Pradesh] does as a proportion of its GSDP on healthcare. So in some ways maybe I'm kind of making things a little bit less positive, less optimistic as to what is going on here because it seems puzzling that you are seeing this kind of trajectory of tax allocations going on. When there are several countries around the world and certainly our neighbour Thailand, our neighbour China, they didn't start out with such high allocations and Thailand switched its allocation towards health care significantly. Not today, at income levels that were pretty low 20 years ago and I think that -- be a real value to maybe separately having a conversation about, is there a political conversation to be had here, is there something there that is going on.

But there's also kind of a deeper issue which I think we need to interrogate a little bit and again Niranjana used the word public health and public expenditure in kind of one breath, but actually, there is a distinction in these words. There is core public health, essential public health which is what we call you know non-rival non-exclusionary public goods, merit goods, things with externalities, etc. Even Indian expenditures are more than adequate to fund those. They're not necessarily being funded fully because some of that money that should have stayed with public health like vaccinations, like vector control, like eradicating lymphatic filariasis, for example, have moved into setting up curative machineries and there's real value to thinking about something, for example, Jeff Hammer has been saying for a long time is that, first get the core public health work done and it's again an issue as to what is it that we can do there to finish that activity.

The second which I think is also another curious thing. I think the state was imagined in the 50s in a self-image of, I [the state] will comprehensively serve the entire population with full-service health care. So then it didn't matter whether I [the state] started with private curative or I [the state] started with public healthcare. But if we are indeed finding ourselves where both Cristian and Niranjana said, where there is a fiscal limitation and in the pandemic, there will be. What can we do? So one conversation to have is to say, why don't you [the state] allocate more? Another conversation, I think a more immediate conversation to have is to say, please accept that you [the state] will not allocate more and say it. Because then, I can sit with you [the state] and say, well sir, you're going to allocate less, can we debate how to spend that less? -- For example, why wouldn't you -- because as Cristian pointed out there's a lot of market failure in the commercial insurance market and we know from basic central limit theorem laws and law of large numbers that really expensive procedures can't be paid for by health savings accounts or loans and borrowings. You really need insurance to kick in. Why wouldn't you go to the government and say, well sir, why did you [the state] launch PMJAY for secondary care with five thousand, ten thousand, fifteen thousand rupees of expenditure? -- Why not do -- because in what Cristian pointed out that Indian insurance is more like prepayment. It really covers you up to a deductible, after that is your problem. Why not do the opposite and say, I [the state] will launch a high deductible health plan. Up to 2 lakh rupees, 3 lakh rupees you pay, beyond that you will never have to pay. The state will absorb all costs beyond 3 lakh rupees for the entire citizenry.

We have done an estimate of that. It will cost. It won't be free but it is well within government's current budgets to offer that kind of service and there are lots of spin-off effects of that. As soon as you enrol the entire population, the risk behaviour of the entire population become visible to you. The high-risk cases become visible to you. Much more targeted interventions and primary care can be done once you know the entire school. Also, you start to bring tertiary care costing under some sort of control because now you have a single-payer for the tertiary care market

which is the most expensive component of the market. So I would say they are clearly strategies within the current structure that are possible but unfortunately in any conversation I participate, I hear both things at the same time. We don't have enough money but we will run the system as if we have enough money and we will wait for "Godot" to show up because that's the mental frame in which we are actually built. And I see these conversations, this conversation today. I mean it boggles my mind, why ESI has not been doing more than it can? 45%, I don't know, Cristian has the exact number; 50% claims ratio. I mean if an insurance company did that kind of claims ratio there would be a hue and cry. People would say give us back the money.

In the U.S., the law is, if your claims ratio is below 80%, you give back the difference to the public. Here we're talking about 45%, 50% claims ratios and a cash balance of over [Rs.] 100,000 crores. So that's an unusual situation we find ourselves in. So my view would be a dose of realism, a dose of pragmatism, acceptance of our reality of where we are. There's a lot of room that can come forward. Even on out-of-pocket, if you look at Jishnu Das's work, you find that why it is true that there is a lot of price elasticity in primary care, because of hyperbolic preferences [there] is under consumption of primary care. Indians are spending a lot of money on primary care. They are not buying good primary care but they're spending a lot of money on it. Partly because they can't afford anything else, all they can afford is this. Can we get them more value for it? I've gone to rural NGOs again and again you'll find women that have spent Rs. 20,000, Rs. 25,000, and then show up at some facility which gives them reasonable care. I feel bad. She didn't have the money in the first place. Couldn't we have taken that money and given her more value for it? Is there another role? One thing that Kerala does beautifully according to me is the state acts as a benchmark competitor. It's small but it's like a powerful quality benchmark, it's a powerful price benchmark. So, it disciplines the private sector. Now is that an opportunity for us to explore more. So, I'm actually more pessimistic about perhaps the government side of the money portion because I do worry that states that have gotten richer have not allocated more. But a lot more optimistic that, given our current reality, we can actually find pathways that will converge over 15, 20 years rather than as we find them today, diverging further and further. More markets, more C-sections, 70% C-section rates, extremely high hypertension rates in rich states because there is no primary care. These are divergent pathways, not convergent pathways. Anyway, I'll stop here.

**Ms. Ananth:** Nachiket, thank you very much for reiterating, I think many of the previous perspectives around saying, let's get pools to work harder, ESI insurance deliver better value and that's linked to what Cristian was saying that will then draw in more of the informal sector non-poor. And also I think you raised the really important point around saying let's also look at the composition of public spend and is it possible to direct it towards things that may be more classically thought of as public goods. Particularly coming out of this pandemic, I think that is also very important

perspective. In the interest of time, I'm going to combine sort of my questions and those coming from the audience and maybe take another 10 odd minutes to get through them.

But Cristian, maybe you can take this question from Monika Halan. If you think about PMJAY as a risk pool that has been created, it has been created in some sense exclusively for the poor, defined in a certain way. Is it desirable, you know, why would we not open up that pool and that program also for the non-poor but on a contributory basis or do you think it makes sense to carve out a separate pool there. If you can just give us a quick sense of the issues involved.

**Dr. Cristian:** Thank you. Yes, yes, and no. So let me explain. In a steady-state where when a public insurer for the poor is well developed and has the capacity to really firewall the subsidies for the poor from undesired cross-subsidization to the new pool, there is some desire. You will need to probably subsidize the premium to bring the informal non-poor into the equation but for the time being it is, I think very dangerous for the poor in my view that you bring both together without having that firewalling. I used to be the CEO of the national health insurance in Chile. It's a tiny country. It's your census error, the size of the census error in India. But it functions and the national health insurance has three pools. One is the fully subsidized pool for the poor, the second is a missing middle, is a partially subsidized, and then the third pool is non-subsidized, completely self-sufficient. They are fully firewalled. You know what's happening in all of them and they have differential benefit packages. I think PMJAY, as I said I'm super excited about it. It might be very difficult to have differential packages for contributory and non-contributory at this stage of development and once you get it's a single equal package for contributory then you are in trouble in terms of incentives to participate. There is plenty of evidence about that. So I hope that I answered the question.

**Ms. Ananth:** There's also Cristian, a related question around -- from Piyush Sinha. What does an informal sector risk pool look like? From maybe from other countries who are participants. Is it all contributing, what might that look like?

**Dr. Baeza:** Yeah. It's a very good question, likely a loaded question. -- This is exactly why I welcome -- by the way, [it] is a good loaded question. This is exactly where I said India need to look at the world evidence but it will probably need to plough its own course. Because in most countries the only way the informal non-poor coverage had been solved is by growth and formality. Now that would mean probably for India to wait for 15, 20 years. So the question is, is there a way to innovate so you can actually create incentives for the informal non-poor to actually pool? And I think there are and I have seen discussions in the Indian government which are very interesting and exciting in that sense, the missing middle discussion.

It would need probably to be a value proposition for the informal non-poor that will probably do not reflect full actuarial cost of the coverage so you need to probably subsidize it to make it interesting. Second, it would require a very careful crafting of the package that balances the

need to have real insurance because if you do prepayment for things that do not really change your health trajectory, don't protect you, why are you having insurance? So a package that is attractive but at the same time, a package that actually provide coverage for catastrophic events and how you do that is complex for informal sector. The third, it would need to be a fully firewall from other subsidies that are not intended. Intended subsidy is fine but the implicit leakage of public funding for that could be a complication. Very difficult to do but I think the only path forward if you want to move in front of formalization as the only solution is to actually be able to create incentives to create this kind of schemes. I hope I answer the question.

**Ms. Ananth:** Yes, very much. Thank you. In fact, there's a recent, the labour code in India also talks about how even the so-called gig economy workers that employers, your Uber, etc. needs to start contributing to social security payments. So maybe those are different pools that are getting envisaged but really keeps coming back to the same question about how do you make sure that the pools are significant-sized, how do you make sure that they deliver.

We have quite a few questions on commercial insurance and let me make a plug here for our next panel which is entirely dedicated to this question about how do we expand, I mean commercial insurance in India is tiny relative to even the size of our well-to-do population. What's holding us back there? What are some regulatory issues? So please join us for that session. I want to take the broader question Niranjan raised, the whole theme around demand-side financing. Cristian also alluded to that to say that we may need to kind of rebalance the supply-side demand-side financing approaches. Nachiket, if you can briefly respond to that. What do you think are the limits in that sense to demand-side financing? If we did a DBT program purely for healthcare, put more cash in the hands of people, what is even theory in health suggest in terms of where does that take us?

**Dr. Mor:** See, we know from a lot of global experience and Cristian is the expert, so he may correct me if I misspeak. But that approaches that separate health care from health insurance are a recipe for high inflation because now what happens is that both sides are competing and this is the famous *Arrow-Pauly* dialogue. When at the point of consumption, the service is free, you get excess supply and excess demand and it produces high inflation.

The opportunity to me, which is one of the reasons why I continue to believe ESI is a powerful tool, ESI could be a *Kaiser Permanente*. It's a fully managed care organization. It has enough money, it has the ability to contract out health care, not simply hand over money to people. The other concern I have about demand-side, because if you had enough money to do full-service care, that's fine, but if you said to people, I will pay for hospital care, I don't have enough money to pay for primary care, you will end up in a situation which some states have ended up where haemodialysis becomes 70% of your insurance claims. It's already, I'm told, tracking 25%. Because

you don't have any hypertension control, you haven't thought about hypertension control at all, right. In fact, my instinct is, can the corporate sector under the commercial insurance market be permitted to launch managed care programs? This is something that we have sought Cristian's advice on in the past. Why can't a large hospital group like in the U.S. say, I will launch a managed care program myself, because one opportunity we have today, the corporate sector is tiny. It's 2% of the entire market. All the big names that we hear about are the tiny portion. They want to grow. Can we give them a good pathway of growth? To me, managed care is an attractive pathway of growth because now it brings insurance and health care into the same -- And I have used this analogy before, health insurance is half a car, health care is the other half of the car, and selling health insurance by itself, and I worry greatly about what Niranjana has been saying which is the compensatory state because we know markets fail in health care. They fail in education, they fail dramatically in healthcare. There's massive information asymmetry, massive uncertainties. You hand over money to people, they are not going to look after themselves well. You wouldn't even have obese doctors if it was so clear that people with money and people with knowledge can look after themselves. So I am nervous about the kind of silver bullet fixing. I think these all have a role, I think somebody Cristian or Niranjana said, we need to be plural in our approach. We need to unfortunately pursue six ideas at the same time and kind of build mass across the board rather than go one pathway.

**Ms. Ananth:** Right, and I think the point that Niranjana sort of alluded to in terms of price control, etc., we'll explore that more in future panels. But I understand from Nachiket that, that is not at all outlandish idea, in fact, most countries do heavily regulate pricing in the healthcare sector. So maybe we need to kind of think about these issues in a little bit more detail. But we are almost out of time. I want to give Cristian, Niranjana, Nachiket if you wanted to make any final comments. Otherwise, I will move to wrap up.

**Dr. Baeza:** Thank you very much. Just to say that I'm delighted, I am very excited about this kind of discussion in India. There are things in India that make it less constrained. So there are issues, for example, the fact that 70% of health care is provided by the private sector which is a challenge, at the same time is an incredible opportunity because in the country I come from, the region where I come from, there is no way you can begin from more greenfield discussions about how you do the public financing to private provision, that you have the opportunity in India. There is no way we can do. So thank you for the invitation. I will be watching with a lot of interest the other three sessions. They are very close to my heart as India is and I appreciate the opportunity. We continue to be connected. Thank you.

**Ms. Ananth:** Thank you Christian, Niranjana, any final comments?

**Dr. Rajyadhaksha:** No final comments Bindu but just thanks again to Govind and you for inviting me to participate and getting the opportunity to share the stage with Cristian and Nachiket and thanks a lot.

**Ms. Ananth:** I think it was wonderful to get your perspectives because even as we are approaching this from a financing perspective and sometimes there's no sense of what is a resource envelope and more money in the health pot means what are we taking it away from. So your remarks were really helpful. Nachiket, any final comments?

**Dr. Mor:** No, it's a great panel, good discussion. My only request to you and to the panels that you are developing is let's focus on the here and now and pathways that we can begin today. Somehow I've gotten too many conversations which are what we will we do 10 years later, 15 years later without clarity on what can we do today, so that the 10 years later. As you know I am a trader by my original background, the long run is a series of short runs. The long-run doesn't happen in a day. If you don't have a short run, there is no long run. And I like the fact that you're focusing on pools because I think they are key, they exist, the money is here. How can we use them better and then think about how do we grow them, what can we do more as we go forward. So thank you again for having me here. It's a wonderful listen to Niranjana and Cristian about what's going on. Thank you.

**Ms. Ananth:** Thank you very much and that's very much our goal to say over the next three sessions, can we develop some pragmatic proposals that at least set in motion the sort of changes that may take several years to play out but at least directionally adds more to the mix in addition to hoping and praying for additional fiscal space and so much to be done. But thank you, we couldn't have asked for a better overview session and all the future sessions will be far more narrow in scope and we hope to see all of you back there for those sessions. Let me also end by thanking the IndiaSpend team and the Dvara Research team for putting all of this together and for wonderful logistics. Thank you all, see you next time. Goodbye.

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