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Research Article

Reaching the Missing Middle: Ensuring Health Coverage for India's Urban Poor

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CONTENTS

Introduction

Health Financing Landscape

Growing Urban Poor Population in Need of Affordable Health Care

PHC Strengthening Initiatives for the Urban Poor

Government and Privately Sponsored Health Insurance

Schemes

National Health Protection Scheme

Health Insurance Aggregators

The Opportunity and Challenges of the NHPS

Discussion

Notes

References

Abstract—India has seen impressive investments in government-funded health insurance but still severely underfunds the health sector. The government of India has a critical role in ensuring effective health coverage to the “missing middle”: the urban poor. The urban poor have been excluded from benefits targeting eligible populations below the poverty line. Lack of access to public facilities and qualified primary health care providers in urban areas often results in treatment delays or patients relying predominantly on out-of-pocket payments to informal providers. The urban poor are also excluded from affordable health insurance markets. Illiteracy and poverty in the slums result in limited access to goods and services and unequal participation in social life, as well as in overall social exclusion. The government of India, in its 2018 union budget, announced a flagship National Health Protection Scheme (NHPS) that will provide health insurance benefits of up to INR 500,000 (7,692 USD) per family per annum. This article explores current and future opportunities to fill an important gap in access to health services, specifically targeting the urban poor by providing health insurance schemes that include primary health services for this population. Current public health insurance schemes providing exclusively hospitalization benefits are unsustainable; part of the solution is keeping people healthy and out of the hospital. Primary care integrated into health insurance improves population health management and is associated with higher patient satisfaction, fewer hospitalizations and emergency department visits, lower claim costs, and overall reductions in morbidity and mortality. There is no single solution to finance health services for the urban poor. This population mostly belongs to the informal sector, which encompasses workers whose jobs are not recognized formally and from whom no taxes are collected. However, the new NHPS could play a major role in expanding safety nets for the urban poor by providing financial risk protection and improving social inclusion. The government could use the introduction of the new scheme to shape approaches aimed at increasing opportunities for the urban poor through investing in public health facilities, subsidizing and fostering public–private affordable health insurance, and enhancing access to information, voice, and respect for rights.

Keywords: health insurance, health policy, India, primary health care, public and private, urban poor

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INTRODUCTION

Health care for the urban poor is emerging as a new priority in India, where economic growth has spurred rapid urbanization. The latest census¹ estimates an urban population of 438 million, 33% of the total population, and projects that by 2030, another 250 million people will migrate to Indian cities. It also estimates that about 27% of the urban population is poor, surviving on a daily consumption expenditure of INR 47 (0.72 USD)^[a] per person or less.

Urbanization in India is changing lifestyle, environmental, and other factors that affect health outcomes and shift the epidemiological makeup. For example, Anjana et al.² recently found that the prevalence of diabetes is higher in India's urban areas (11.2%) than in rural ones (5.2%). Noncommunicable diseases (NCDs) have surpassed infectious diseases as the main contributor to the burden of disease in India. NCDs currently account for about 60% of the burden, and NCDs and injuries together account for 72%. In urban areas of some affluent states such as Chandigarh, Maharashtra, and Tamil Nadu, diabetes prevalence is higher among people of lower socioeconomic status. Other issues in urban areas are vector-borne disease, malnutrition, and poor sanitation.

Despite the challenges fueling these trends, underfunded government health budgets place limits on the public-sector primary care infrastructure—preventive, promotive, curative, and rehabilitative services. A large proportion of outpatient care takes place in the private sector, but this sector is highly fragmented and consists of various types of providers. Some are informal providers and less than qualified.³

This reliance on the private health sector means high out-of-pocket (OOP) spending on health, which puts a financial burden on households, especially poor ones, and leads to inadequate health seeking. Some who seek care forgo other basic family needs such as food, clothing, housing, and education and, in some cases, health spending pushes the household into poverty.

The cooperative movement has played an important role in the Indian economy, especially in the development of the agriculture and rural sectors. India has a network of more than 600,000 cooperatives, with membership of 250 million and enormous potential to support the expansion of health insurance. These organizations combine the strengths of the public and private sectors, especially in supporting small and marginal farmers and vulnerable sections of the population. In fact, the cooperative sector is recognized by the government as a third economic sector that can provide balance between the private and public sectors.⁴

Government-sponsored health insurance schemes focus on the population that lives below the poverty line. But a

large segment of the population is the working urban poor, who remain without coverage and who risk worsened health if they do not seek health care or impoverishment if they do. The working urban poor represent “the missing middle,” a large percentage of the population that remains without financial protection, sandwiched between those who are affluent enough to afford health care and those who benefit from government-sponsored health insurance schemes. Those left out include people just above the official poverty line, members of credit societies, urban labor migrants, and workers in informal, micro-, small-, and medium-sized enterprises (MSMEs) who are ineligible for government-sponsored schemes. The role of the government and private sector in expanding health services to the urban poor is therefore critical.

To ameliorate inequity in access to health care, in 2005 the Indian government implemented the National Rural Health Mission (NRHM) to address health needs of the rural population. In 2014, the government established the National Urban Health Mission (NUHM) to focus on the urban poor and strengthen the health system in urban areas. The NUHM was subsumed into the existing structure and governance mechanisms of the NRHM to create the National Health Mission (NHM) in 2015. Among the NHM's objectives is to reduce household OOP health spending, in particular on medicines and diagnostics, and to support demonstration projects working toward universal health coverage.⁵

In addition, governments at the central and state levels have implemented various health insurance schemes for different segments of the population. Most of these schemes have focused on providing financial protection for hospitalization and curative care, with little to no coverage of outpatient care. For example, Rashtriya Swasthya Bima Yojana (RSBY), a health insurance program sponsored by the central and various state governments for families living below the poverty level, aims to reduce the financial burden of spending on hospitalization.

However, there now is interest from health sector stakeholders in enhancing these insurance schemes by integrating primary health care (PHC) benefits into them. They expect that such integration will improve population health management and health outcomes. By reducing hospitalizations, emergency department visits, and overall morbidity and mortality, PHC also is cost-effective.⁶ Incomplete or delayed treatment of NCDs leads to complications and more expensive treatments. Evidence from India shows low prioritization of PHC. For example, annual per capita expenditure on government-funded PHC in Uttar Pradesh in 2014–2015^[b] was extremely low, at INR 328 (5.04 USD).⁷

This article explores factors affecting health coverage of India's working urban poor. It assesses the adequacy of existing health financing programs, particularly health insurance.

HEALTH FINANCING LANDSCAPE

Though India has a fast-growing economy, tax collection has not kept pace, and health budgets at the national and state levels are limited. India has one of the world's lowest rates of public spending on health. The government spends about 1.15% of gross domestic product (GDP) on health, much less than the global average of 5.4%.⁸ Public spending accounts for 28.6% of total health expenditure on health—about INR 1,042 per capita per annum (16 USD) at current prices.⁹ Insufficient funding limits the government's ability to finance essential health services, including PHC. As a result, OOP spending by households represents the dominant proportion of total health spending, and this disproportionately affects the poor.

Findings from the most recent (2014) National Sample Survey Office (NSSO) household expenditure survey¹⁰ show that OOP spending on health is over two thirds (67.1%) of total health spending in India, one of the highest proportions in the world and far more than the global average of around 20%. Though this ratio has declined marginally from a high of about 70% a decade ago with the introduction of the NHM and government-sponsored insurance schemes, in real terms, there has been an increase in overall OOP spending between the 2004 and 2014 rounds of the NSSO.

The NSSO findings suggest that the increased OOP spending on health is fueled by spending on outpatient care. Data from Ravi et al. show that the bulk (63.5%) of OOP spending is on outpatient care (Figure 1). At the individual level, annual OOP spending on health has increased by 37%, from INR 799 per capita (12 USD) to INR 1,098 (17 USD), over the ten-year period from 2004 to 2014.⁹ At the household level, OOP spending on outpatient care is 1.7 times that for

OOP spending on inpatient care. Further, the data suggest that an overwhelming 75% of outpatient care is delivered in the private sector, where services must nearly always be paid for out of pocket.

At the same time, any comparison between OOP spending on outpatient and inpatient care should be done with caution, because actual OOP spending on all care may be lower than stated, and this is particularly true for inpatient care. This is because some households seek less (or no) care when they cannot pay or wish to avoid financial hardship.

GROWING URBAN POOR POPULATION IN NEED OF AFFORDABLE HEALTH CARE

The Tendulkar Committee's methodology¹¹ estimates the percentage of the urban population living below the poverty line at 13.7%. The Rangarajan expert panel's formula¹² estimates this percentage to be at 26.4%. However, data from the 2011 Socio-Economic and Caste Census (SECC) suggest that about 35% of urban Indian households qualify as poor.¹³ The SECC estimates of deprived or poor households are based on door-to-door enumeration of defined parameters of presence or absence of factors such as government employment, income tax status, ownership of motorcycle or refrigerators, and farming of at least five acres of irrigated land. The SECC data are thus likely to capture vulnerability much better than rigid poverty-line parameters such as monthly per capita consumption expenditure of INR 1,407 (21.61 USD) in urban areas (at 2011–2012 prices).

Using the Tendulkar poverty line estimation, the urban population below the poverty line in India will increase from 15.8% to 23.2% when health expenditures are included in consumption (Figure 2). This is a significant increase (47%), and it indicates that OOP spending on health has exceeded 10% of consumption in a significant number of cases.⁹

A large body of evidence shows that OOP health expenditure is responsible for making people vulnerable to poverty.^{14–16} OOP payments are considered “catastrophic” when they drive households into having to reduce expenditure on basic necessities. The proportion of households that incur catastrophic health expenditure in a country is widely used as an indicator of the extent to which the health system protects households needing health care against financial hardship. Offering such protection is a major goal of health systems and is a main purpose behind universal health coverage.

OOP spending per outpatient visit in urban areas is growing at a higher rate than in rural areas. In real terms, average annual urban OOP spending on health increased from INR

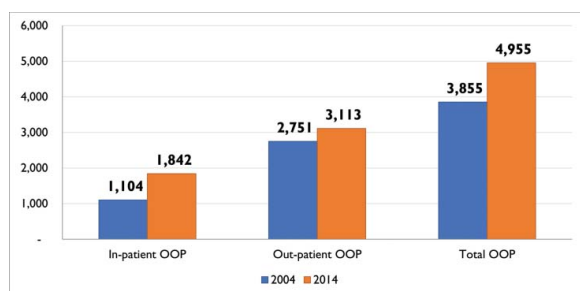


FIGURE 1. OOP Spending on Health per Household (Inflation-Adjusted). Figure Drawn Based on Data Provided in Ravi et al.⁹ (Color figure available online.)

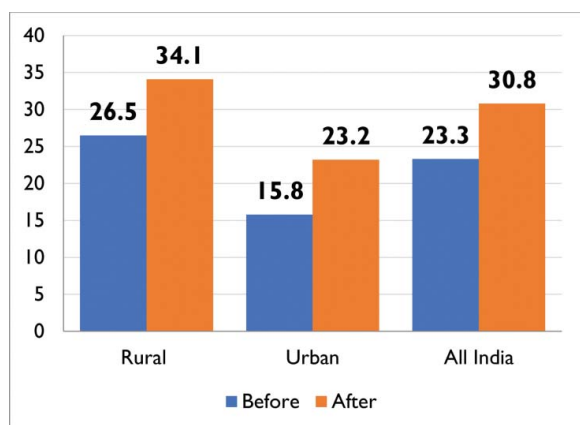


FIGURE 2. Percentage of Population below the Poverty Line before and after Deducting Health Expenditure from Consumption. Figure Drawn Based on Data Provided in Ravi et al.⁹

1,092 (16.77 USD) to INR 1,639 (25.17 USD) from 2004 to 2014 (Figure 3), an increase of about 50%, whereas rural OOP spending increased only 23%, from INR 699 (10.73 USD) to INR 866 (13.30 USD). In 2004, urban households paid INR 41 (0.63 USD) more per outpatient visit than rural households. Ten years later, they are paying INR 93 (1.43 USD) more per outpatient visit than rural households.⁹

More than 60 million persons in India are pushed into poverty every year due to health care costs.¹⁷ The NSSO data suggest that in urban areas, only 17.8% of residents were covered by some form of risk-pooling mechanism. Most of these were covered by a government-sponsored insurance program (11.9%), followed by private voluntary insurance (3.5%) or employer-sponsored programs (2.4%). (These data underscore the small proportion of the urban population currently covered by private health insurance.) The poorest were least likely to be covered: only 9.7% of people in the poorest quintile of income were insured,

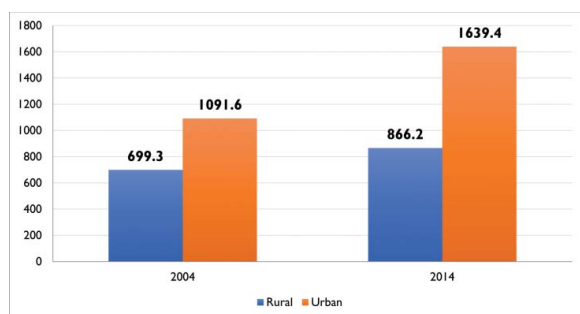


FIGURE 3. Urban–Rural Increase in OOP Spending on Health per Person at 2004–2005 Prices. Figure Based on Data Provided in Ravi et al.⁹ Exchange Rate on December 31, 2004: 1 USD = INR 45.13.

compared to 36.4% in the richest quintile.⁹ The data also show significant inter- and intrastate variations in insurance coverage as well as in OOP spending on health.

The health and financial protection of migrants is another major challenge. Urban labor markets have grown over the years. More than 100 million people have migrated to urban areas in various parts of the country. In seven million-plus urban agglomerations, migrants represent more than 40% of the population.¹⁸ Migration contributes significantly to filling gaps in labor supply and satisfying demand for workers and is a source of remittances to migrants' home towns. Return migration, which transfers knowledge, skills, and innovations, is an informal process of skill development. But urban planning often fails to provide for migrants' health and financial protection. Certain infectious illnesses are more common among migrants. Some of these illnesses, such as tuberculosis, require continuity of care.

PHC STRENGTHENING INITIATIVES FOR THE URBAN POOR

The government of India has implemented a spate of policy initiatives to protect urban households from catastrophic OOP health expenses throughout the past decade. The National Health Policy 2017¹⁹ proposes organized PHC delivery and referral support for the urban poor. It is also developing collaborative mechanisms with other sectors to address wider determinants of urban health.

Government-supported policy responses include the NHM, the largest public health program in India, with a central budget of INR 194.37 billion (2.98 billion USD). The NHM began with a focus on maternal and child health. Now, an important component of the program is strengthening the management and infrastructure of the urban health system. To expand access to PHC, the NHM has decided to invest in various types of PHC facilities and provider cadres over the five-year period 2017–2021. There will be:

- One urban primary health center for every 50,000 to 60,000 population.
- One urban community health center for every five to six urban primary health centers in big cities.
- One auxiliary nurse midwife per 10,000 population.
- One accredited social health activist or a community-link worker, for every 200 to 500 households.

The cost to NHM for the overall investment in PHC over the five-year period is estimated at INR 225 billion

(3.46 billion USD), funded mainly by the central government, with contributions from the state governments.²⁰

The Ministry of Health and Family Welfare also aims to implement the National Free Diagnostic Services Initiative under the NHM. This initiative aims to reduce OOP spending on diagnostic services. It also plans to start free health screening for key health risks and has identified a list of free essential diagnostic services for each facility level. The services encompass hematology, serology, biochemistry, clinical pathology, microbiology, radiology, and cardiology. States are allowed to augment the list based on epidemiological considerations and available financial resources.

The National AIDS Control Program and the Revised National Tuberculosis Control Program, both implemented by the central government, have a component for engaging with the private sector to strengthen service delivery at the PHC level.

The government's National Pharmaceutical Pricing Authority maintains a National List of Essential Medicines and price controls on cardiac stents. The authority plans to bring various other devices under price controls, such as pacemakers, lenses, catheters, implants, and valves. These controls have significant implications for reducing OOP spending for health. The government has also proposed to implement a policy that would require doctors to prescribe generic medicines.

The Delhi government started an ambitious PHC program in 2015, by setting up *Mohalla* (community) Clinics with the intention to eventually open 1,000 urban PHC clinics. *Mohalla* clinics offer a basic package of essential health services, including 110 medicines and 212 diagnostic tests free to clients. The government has empaneled private doctors, who are paid a capitation payment of INR 30 (4.60 USD) per person per year. Between April and December 2016, an estimated 110 clinics had treated 1.5 million patients.

The Urban Health Kiosk (UHK) is an initiative under the NHM in Punjab to ensure limited medical services for slum dwellers and the poor at their doorstep. Each UHK includes a prefabricated structure with a partition for auxiliary nurse midwives, privacy for an examination area and immunization cabins, a toilet and running water supply, and an electricity connection and power backup. A UHK is equipped with an examination table and basic equipment such as a blood pressure monitor, stethoscope, thermometer, weighing machines, vaccine carrier, hemoglobin meter, glucometer, needle hub cutter, and other test kits. The NHM builds and equips the UHK; its operating expenses are covered by the government of Punjab, which collects taxes for this purpose on each house that is constructed in Punjab.²¹

GOVERNMENT AND PRIVATELY SPONSORED HEALTH INSURANCE SCHEMES

The government of India at both the central and state levels has introduced financial protection measures for different segments of the population. The total number of persons covered under any type of insurance in India is nearly 552 million, 42% of the population. The NSSO survey estimates suggest that 18.1% of the urban population is covered by health insurance. Thus, out of a total urban population of 438 million, 359 million people lack financial risk protection for health. Moreover, assuming that 27% of the population in urban areas is poor, we estimated that at least 97 million people lack financial protection from catastrophic OOP spending on health.

Insurance coverage in India is mainly focused on hospital services but with growing recognition of the need to provide integrated PHC (Figure 4). Many schemes target a particular segment of the population based on eligibility criteria, outreach, cost, and other factors. A review of available health insurance schemes shows some relevant characteristics, as highlighted below.

Central Government Health Scheme

The Ministry of Health and Family Welfare started the Central Government Health Scheme (CGHS) in 1954 to provide comprehensive medical care to central government employees and pensioners and their dependents. The CGHS covers about 3.67 million beneficiaries. The scheme is financed mainly through central government tax revenues. Employees contribute a share of their salaries to the program, with contributions tied to their salary. However, these employee contributions account for only about 5% of CGHS revenue, whereas the government's contribution is 95%. The total expenditure on this scheme was INR 18 billion (276 million USD) in 2015, which translates into a per capita expenditure of INR 5,000 (76.78 USD).

Employee State Insurance Scheme

The Employee State Insurance Scheme (ESIS) is a flagship social health insurance program providing social benefits including health, life, and disability insurance, and pension funds to workers and their dependents. The ESIS is offered to workers in factories and other enterprises (including on construction sites) that have ten (in some states 20) or more employees earning wages of less than INR 21,000 per month. The scheme applies to 783,000 enterprises covering

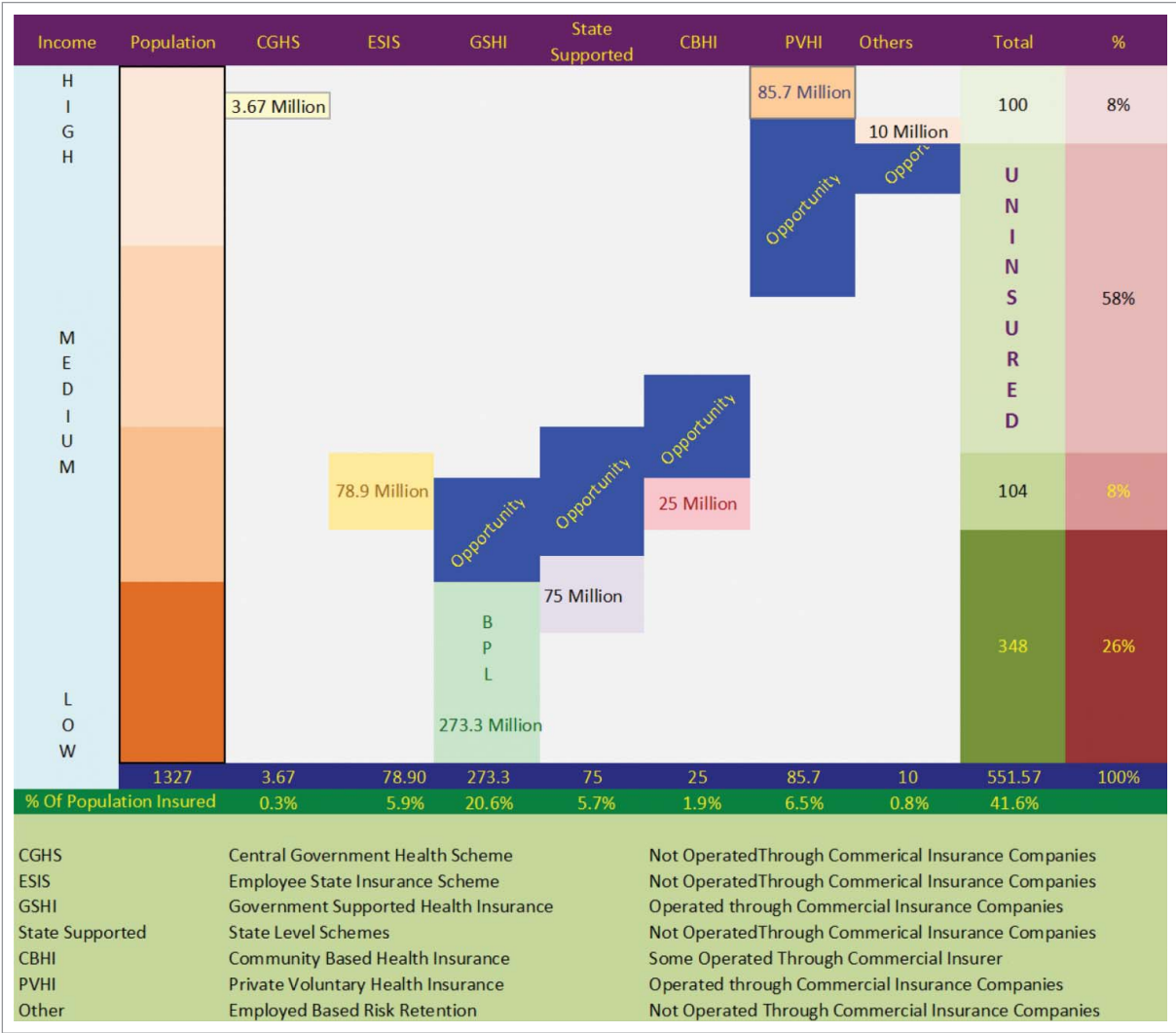


FIGURE 4. Health Insurance Landscape of India. OHI (in blue) = Opportunity to Expand Insurance

21.3 million families, with a total of 82.8 million beneficiaries. The ESIS is financed by contributions from employers (4.75% of the wages payable to employees) and employees (1.75% of the wage). Employees earning INR 100 (1.53 USD) per day or less are exempt from any contribution. State governments contribute up to one eighth of the cost, with a per capita ceiling of INR 1,500 (11.08 USD) per insured person per annum.

Government-Sponsored Health Insurance Schemes

The government of India and some state governments have launched publicly funded health insurance schemes targeting poor and vulnerable households. According to the Insurance Regulatory and Development Authority, 273.3 million

persons were covered by government-sponsored insurance schemes in the year 2015–2016. The government’s RSBY scheme, launched in 2008, represents one of the major initiatives in insurance and is by far the largest; other schemes include Arogyasri and the Tamil Nadu Chief Minister’s Comprehensive Health Insurance Scheme. The total premium paid to these schemes by the government was INR 24.25 billion (373 million USD) in the year 2015–2016. Most of these schemes were fully subsidized by the government. In the case of RSBY, it is important to note that the benefits are limited primarily to hospitalization, which occurs for less than 10% of the population each year; this percentage may actually be in the low single digits. Thus, the relatively low average annual premium of INR 88 (1.37 USD) per person reported above may be reasonable to cover expected

claims and other costs, given that outpatient care—including medicines that consume a big part of health expenditure—is excluded and lower utilization rates (resulting from various factors) have been factored in.

Insurance through Community- and Mutual-Based Organizations

Insurance regulations on microinsurance in 2005 referenced mutual aid cooperatives as partners in the growth and development of the insurance sector, particularly for more vulnerable populations and those who cannot afford the more expensive insurance products offered by private insurance companies. These groups usually share common characteristics such as geography or occupation. Some community-based organizations offer insurance directly to their members, using a community-based or mutual health insurance (CBHI) model, in which the scheme is owned and governed by its policy holders. Alternatively, community-based organizations may partner with a licensed insurance company to distribute insurance to members, using what is called a partner–agent model. These partnerships offer one way for health insurance companies to comply with regulations to spur financial inclusion for underserved populations. The regulations mandate the company to invest a portion of its profits to serve increasing numbers of vulnerable clients. Partnerships between insurance companies and community organizations also allow the community organizations turn-key access to insurance products where the financial risk and administration is borne by the insurance company. Broad estimates suggest that around 2% of the Indian population is covered by health insurance schemes that include a community organization as either an owner or a distribution partner.²²

Private Voluntary Health Insurance

Private voluntary health insurance (PVHI) is provided by public-sector non-life insurance companies, private-sector non-life insurance companies, and private-sector health insurance companies. A total of 85.74 million persons were covered under PVHI in 2015–2016, and total gross premiums were INR 220 billion (3.4 billion USD). Public-sector companies are market leaders, maintaining a market share of 64%. In contrast, the market share of private non-life and health-only entities was 22% and 14%, respectively, in the year 2015–2016. PVHI has registered a compound annual growth rate of 19% during the five-year period ending in March 2016. The majority of enrollment in PVHI (53%) is via group sales as opposed to individual sales. However, the

individual segment is growing at a compound annual growth rate of 22% compared to 18% for the group segment. Recent amendments to insurance legislation recognized health insurance as a class of business, enabling the incorporation of stand-alone health insurance companies. Based on premiums, the market share of stand-alone health insurance companies is increasing: in the last three years, it has increased from 11% to 14%.

Employer-Based Schemes

Many large public- and private-sector organizations in India have invested in their own health infrastructure and provide health services to their employees. Many other employers assume the financial risk of their employees' health and cover their health costs through reimbursement schemes. There are no estimates of how many individuals are covered directly by employers. We put a very broad estimate of such coverage in the range of around ten million individuals.

NATIONAL HEALTH PROTECTION SCHEME

The government of India in its 2018 union budget announced a flagship National Health Protection Scheme (NHPS) that will provide health insurance benefits of up to INR 500,000 (7,692 USD) per family per annum. The government has proposed an ambitious target for the NHPS to cover 100 million families (500 million individuals), approximately 40% of India's population, to protect them from hospitalization expenses. Whereas the earlier government-sponsored health insurance schemes focused on covering those persons below the poverty level, the NHPS will cover more of the poor and the vulnerable previously excluded from such schemes. This expansion of health coverage is seen as an important step toward UHC and, when implemented, the NHPS will be one of largest health insurance programs globally. Health insurance risk pools have remained extremely fragmented in India. However, the proposed NHPS will cover 40% of the population under one risk pool, with significant implications to improve risk pool efficiency and equity.

HEALTH INSURANCE AGGREGATORS

Health insurance expansion can greatly benefit from the structures, community outreach, and accessibility in every corner of the country of cooperatives and other community-based organizations. The government of Karnataka's health insurance scheme, the Yeshasvini Cooperative Farmers'

Health Care Scheme, is an example of a public–private partnership with a cooperative. There are important lessons from the CBHI scheme²³ offered by the Self-Employed Women's Association, a large multistate trade union based in Gujarat. The Self-Employed Women's Association's CBHI scheme reimburses hospitalization costs and is inclusive of the poorest; 32% of its rural members and 40% of urban members are from households below the 30th percentile of socioeconomic status. The main advantages of these aggregators who are trusted fixtures of their communities are lower distribution and servicing costs and the ability to promote or mandate enrollment and reduce adverse selection. Partnerships can address cooperatives' limitations, such as limited resources, poor technology, inefficiency, and weak human resource capacity.²⁴

The MSME sector has the potential to spread industrial growth across the country and can be a major partner in expanding inclusive health insurance. This sector contributes enormously to India's socioeconomic development and has emerged as an important part of the economy over the past 50 years. Thirty-six million MSMEs employ more than 80 million persons. Their production of more than 6,000 products contributes about 8% to GDP, 45% of the total manufacturing output, and 40% to exports.²⁵ The SME Forum has more than 76,000 MSME members and 270 sectoral and regional associations and partners with 35 major banks, corporations, and other organizations.²⁶ With its significant outreach, the MSME sector has great potential to enable health financing programs to reach many underprotected households.

Microfinance institutions (MFIs) provide access to much-needed savings and credit services to underserved low-income households. According to the directory of MFIs in India,²⁷ there are 268 MFIs. They operate in 28 states, five union territories, and 568 districts in India. Karnataka, Tamil Nadu, and West Bengal lead in client outreach and portfolio size. According to the Bharat Micro-Finance Report 2015, the total membership base of MFIs in India is 37 million;²⁸ of these, 21 MFIs serve 4.06 million clients. Together, Indian MFIs operate 12,221 branches, with staff of more than 94,500, of whom 16% are women.²⁹

Policy makers and regulators recognize the pivotal role that MFIs play in expanding financial inclusion to the unreached and underreached populations. With their ability to aggregate clients, MFIs can reduce the administrative costs of a health insurance program. However, Saha and Annear³⁰ caution that microfinance-based solutions cannot be seen as the sole contributor to poverty reduction or as an alternative to government intervention. MFIs such as

Annapurna Pariwar, Development of Humane Action, and Shri Kshethra Dharmasthala Rural Development Project have implemented CBHI programs for their community members.³¹

As a complement to insurance, extending health services through MFIs is associated with improved health awareness, behaviors, and health outcomes. Therefore, it is important to build MFIs' willingness and technical capacity to offer health programs as a complement to their core financial services. Their ability to reach the most remote areas is worth investment in capacity building.³² In addition to seeking health insurance programs that emphasize financial protection against catastrophic health events, MFI partners want to see improved health outcomes from their investment.³³ Consistent with this objective, about 45 MFIs are involved in preventive health care activities.

THE OPPORTUNITY AND CHALLENGES OF THE NHPS

To implement the NHPS, the central government needs to coordinate with 31 states and union territories and develop a comprehensive strategic plan. The government expects to roll out the NHPS during the latter part of 2018. Many state governments have been implementing RSBY and the National Institution for Transforming India, also called NITI Aayog, expects to leverage these experiences and assess the preparedness to scale up the proposed NHPS. The assessment will need to evaluate insurance functions and processes related to use of information technology, fraud detection and grievances, awareness generation and beneficiary identification, institutional arrangements (including provider empanelment), and quality of care.³⁴

The allocations announced in the current budget are preliminary as the scheme is in its initial stages of being rolled out. The central government expects to share costs of NHPS with states on a 60/40 basis. Regarding revenue for the NHPS, the recent 1% increase in tax on high-income taxpayers should generate adequate funding. However, given unfavorable health manpower and infrastructure constraints in the country, the availability of quality hospital care services remains a major supply-side constraint in the short run. The experience of earlier government-sponsored health insurance schemes in India shows that covering the target population has also been a major challenge. For example, the RSBY data suggest that in 12 states, family coverage is below 60% and in several states utilization of the scheme is low.³⁵ Given the limitations of targeting observed previously, one of the important challenges is in targeting the population

to be covered. Some of the strategies suggested in this article such as focusing on micro-enterprises; engaging cooperatives, MFIs, and migrant communities; and using technologies to integrate communities can help increase awareness of the scheme.

DISCUSSION

As policy makers develop innovative ways to provide affordable health care to the urban poor, they will require a two-pronged approach consisting of programmatic (supply-side) interventions and demand-side financing initiatives, primarily insurance.

The Insurance Regulatory and Development Authority facilitates collaborative arrangements among insurers, providers, and aggregators that are critical to fostering public-private partnerships and help resolve institutional and system issues. Such partnerships can provide affordable health insurance products and other solutions targeting the urban poor. The Government of India is committed to strengthening the public health system infrastructure and offering a low-cost package of services. To achieve this, the National Health Policy 2017 envisages increasing public health spending to 2.25% of GDP by 2025.

One of the major challenges in expanding health insurance coverage of the urban poor is to ensure that the process of reaching the target population and distributing the product is cost-efficient and cost-effective. To do this, the urban poor can be identified and targeted using several approaches:

- Focus on micro-enterprises and MFIs in urban communities.
- Organize communities for the purpose of distributing insurance.
- Use technology to reduce administrative costs.
- Better understand urban poor communities and their health-seeking behaviors.
- Develop innovative approaches to providing coverage.
- Ensure the affordability and economic logic of the programs and schemes.

Through efficient business models and through benefit packages and servicing tailored to suit client needs, health insurance programs can seek a balance between comprehensive benefits and affordability. It will be particularly important to address the issue of hours of service, because most urban poor are daily wage laborers, and to include more flexible premium payment options that accommodate the clients' irregular family incomes.

Technology can be used to develop and implement innovative approaches that will help increase coverage. Affordable technological innovations can help insurance providers pool their resources using a common information technology platform and even potentially share risk with each other. Use of technology can also play a vital role in building awareness and in marketing, enrollment, renewals, premium collection, and claim settlement. Though the extent to which technology can replace face-to-face interactions remains to be seen, technology presents significant opportunities to gain efficiencies and improve the quality of information and services. Clients have reported positive experiences with the use of mobile phones and automated teller machines used to collect premiums, with the added advantage of lowering transaction costs.

A beneficial impact of mobile-enabled health services has been observed in chronic disease management, showing improvement in symptoms among asthma patients, reducing hospitalizations and improving chronic pulmonary diseases symptoms, improving heart failure symptoms, reducing deaths and hospitalization, improving glycemic control in diabetes patients, improving blood pressure in hypertensive patients, and reducing weight in overweight and obese patients. Studies also showed a positive impact of short message service (SMS) reminders in improving attendance rates, with an impact similar to phone call reminders at reduced cost, and improved adherence to tuberculosis and human immunodeficiency virus therapy in some scenarios, with evidence of decreases in viral loads.³⁶

Technology can also contribute to preventing and treating NCDs. For example, technology can support positive lifestyle changes through use of text messages. Similarly, services of community health workers, nurse practitioners, or pharmacies can be enlisted to monitor hypertension and diabetes and provide standardized treatments for NCDs, as in Brazil.³⁷

In conclusion, the government can shape the implementation of approaches to increase access and provide financial protection using various health policy instruments: information, availability, pricing, and regulation. Information communication and social marketing strategies may be used to improve the awareness, literacy, and knowledge of various health and financial services, including health insurance. Similarly, capacity building among institutional structures can be used to strengthen the management of various schemes.

The role of aggregators in developing and delivering comprehensive health programs needs to be harnessed. The affordability and economic logic of the programs will be a key challenge, and government support through subsidies and other ways of ensuring the affordability of insurance

need to be effectively planned. Technology and lessons learned by insurance programs to develop and scale up sustainable programs can be used by the government and private sector to address many of these challenges.

Based on our assessment of challenges and opportunities, we suggest that improving overall health outcomes in India requires expanding access to PHC that is more fully integrated with financial risk protection schemes that cover the urban poor. India has a robust health insurance sector, with extensive expertise in insurance products and their design. The recently announced NHPS provides new opportunities for India, especially if central and state governments can leverage past experience. Data and pricing instruments are available to estimate and ensure a balance between coverage and premiums. Insurance companies have already collaborated with community-based organizations to offer insurance products. This health insurance knowledge and experience from across India can be tapped to increase affordable coverage—including of PHC—for the urban poor. In so doing, insurance schemes can reduce hospital costs, make health insurance more valued and efficient, and improve quality and health outcomes for the whole population of India.

NOTES

- [a] Exchange rate: 1 USD = INR 65.
 [b] In India, fiscal year 2014–2015 implies a period of 12 months starting April 1, 2014, and ending March 31, 2015.


DISCLOSURE OF POTENTIAL CONFLICTS OF INTEREST

Authors have no potential conflicts of interest.

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REFERENCES

1. Office of the Registrar General & Census Commissioner, India Ministry of Home Affairs, Government of India, 2011 [accessed 2017 Sep]. <http://censusindia.gov.in/>.
2. Anjana RM, Deepa M, Pradeepa R, Mahanta J, Narain K, Das HK, Adhikari P, Rao PV, Saboo B, Kumar A, et al., and the ICMR-INDIAB Collaborative Study Group. Prevalence of diabetes and prediabetes in 15 states of India: results from the ICMR-INDIAB population-based cross-sectional study. *Lancet Diabetes Endocrinol.* 2017;5(8):585–596. doi:10.1016/S2213-8587(17)30174-2. PMID:28601585.
3. Montagu D, Goodman C. Prohibit, constrain, encourage, or purchase: how should we engage with the private health-care sector? *Lancet.* 2016;388(10044):613–621. doi:10.1016/S0140-6736(16)30242-2. PMID:27358250.
4. Kumar A, Tripathy NR, Bhaskar A. Central government health services (CGHS) in perspective of beneficiaries' satisfaction. *Int J Health Sci Res.* 2016;6(1):401–409.
5. Ministry of Health and Family Welfare. National health mission goals. 2013. [accessed 2017 Nov 11]. <http://nhm.gov.in/nhm/about-nhm/goals.html>.
6. Friedberg MW, Hussey PS, Schneider EC. Primary care: a critical review of the evidence on quality and costs of health care. *Health Aff (Millwood).* 2010;29:766–772. doi:10.1377/hlthaff.2010.0025. PMID:20439859.
7. Berman P, Bhawalkar M, Jha R. Tracking financial resources for primary health care in Uttar Pradesh. A report of the resource tracking and management project. Boston (MA): Harvard T.H. Chan School of Public Health; 2017.
8. Ministry of Health and Family Welfare, Government of India. National health accounts technical secretariat and national health systems resource centre. New Delhi, India: Government of India; 2016.
9. Ravi S, Ahluwalia R, Bergkvist S. Health and morbidity in India (2004–2014). New Delhi, India: Brookings Institution India Centre; 2016. Brookings India Research Paper No. 092016.
10. National Sample Survey Organization. Household consumer expenditure: national sample survey; 2014 [accessed 2017 Nov 12]. <https://data.gov.in/catalog/household-consumer-expenditure-national-sample-survey>.
11. Government of India Planning Commission. Report of the expert group to review the methodology for estimation of poverty; 2009 [accessed 2017 Nov 12]. http://planningcommission.gov.in/reports/genrep/rep_pov.pdf.
12. Government of India. Report of the expert group to review the methodology for measurement of poverty. New Delhi, India: Planning Commission, Government of India; 2014.
13. Government of India. Socio-economic and caste census; 2011 [accessed 2017 Nov 12]. <http://secc.gov.in/welcome>.
14. Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. *Lancet.* 2011;377(9764):505–515. doi:10.1016/S0140-6736(10)61894-6. PMID:21227492.

15. van Doorslaer E, O'Donnell O, Rannan-Eliya RP, Somanathan A, Adhikari SR, Garg CC, Harbianto D, Herrin AN, Huq MN, Ibragimova S, et al. Effect of payments for health care on poverty estimates in 11 countries in Asia: an analysis of household survey data. *Lancet*. 2006;368:1357–1364. doi:10.1016/S0140-6736(06)69560-3. PMID:17046468.
16. Anil Gumber. Health insurance for the informal sector: problems and prospects. New Delhi, India: Indian Council for Research on International Economic Relations; 2002. Working Paper No. 90.
17. Government of India, Ministry of Health and Family Welfare. Situational analyses: backdrop to the national health policy. Mumbai, India: Department of Migration and Urban Studies, International Institute for Population Sciences; 2017.
18. Bhagat RB. Migration and urban transition in India: implications for development. Mumbai (India): Department of Migration and Urban Studies. International Institute for Population Sciences; 2017 [accessed 2017 Nov 13]. <http://www.un.org/en/development/desa/population/events/pdf/expert/27/papers/V/paper-Bhagat-final.pdf>.
19. Government of India, Ministry of Health and Family Welfare. National health policy; 2017 [accessed 2017 Nov 10]. https://www.nhp.gov.in/NHPfiles/national_health_policy_2017.pdf.
20. Government of India. Appraisal document of twelfth five-year plan 2012–17. Ahmedabad, India: National Institution for Transforming India; 2015 [accessed 2017 Nov 14]. http://niti.gov.in/writereaddata/files/document_publication/Appraisal%20Document%20Five%20Year%20Plan%202012%20-%2017-Final%20%281%29.pdf.
21. Maheshwari S. Innovation in urban healthcare: health kiosks. Ahmedabad (India): Indian Institutes of Management; 2017.
22. Bhat R, Menezes L, Avila C. Review of community/mutual based health insurance and their role in strengthening the financial protection system in India. New Delhi, India: Abt Associates India. Health Finance and Governance Project; 2017.
23. Ranson MK, Sinha T, Chatterjee M, Acharya A, Bhavsar A, Morris SS, Mills AJ. Making health insurance work for the poor: learning from the Self-Employed Women's Association's (SEWA) community-based health insurance scheme in India. *Soc Sci Med*. 2006;62(3):707–720. http://www.impactinsurance.org/sites/default/files/sewa_ssm_ranson.pdf. PMID:16054740
24. Vargas R, Torero HM. Innovations in insuring the poor. Washington, DC: International Food Policy Research Institute; 2010 [accessed 2017 Nov 13]. <https://books.google.com/books?id=8WY-KfrHcFQC&pg=PT28&lpg=PT28&dq=Verma+2009+aggregators&source=bl&ots=Qsd6T7gkyG&sig=aOCSt5oa0A6hRh2H4k1mYgO-4mM&hl=en&sa=X&ved=0ahUKEwiwzJuViL3XAhWC7IMKHT1XBJkQ6AEIQDAG#v=onepage&q=Verma%202009%20aggregators&f=false>.
25. Government of India. Ministry of micro, small, and medium enterprises; 2016–2017 [accessed 2017 Nov 13]. <http://msme.gov.in/relatedlinks/annual-report-ministry-micro-small-and-medium-enterprises>.
26. India SME Forum. Small & medium business movement; 2011 [accessed 2017 Nov 13]. <http://www.indiasmeforum.org/>.
27. Sa Dhana, Directory of Microfinance Institutions (MFIs) in India; 2014 [accessed 2017 Nov 11]. <http://www.sa-dhan.net/Resources/Final%20MFI%20Directory%20Report%2020%20Nov%202014.pdf>.
28. Sa Dhana, The Association of Community Development Financing Institutions. Bharat micro-finance report; 2015 [accessed 2017 Nov 11]. <http://sa-dhan.net/Adls/Microfinance/Sector%20Reports/The%20Bharat%20Microfinance%20Report%202015-Web%20version.pdf>.
29. India Microfinance. Bharat microfinance report; 2016–2017 [accessed 2017 Nov 12]. <https://indiamicrofinance.com/2017-2016-bharat-report.html>.
30. Saha S, Annear P. Overcoming access barriers to health services through membership-based microfinance organizations: a review of evidence from South-Asia. *WHO South-East Asia J Public Health*. 2014;3:125–134. doi:10.4103/2224-3151.206728. PMID:25685728.
31. Bhat R, Menezes L, Avila C. Community/Mutual Health Insurance Programme: a case study of Annapurna Pariwar, Maharashtra. New Delhi, India: Abt Associates, Health Finance and Governance Project; 2017.
32. Leatherman S, Metcalfe M, Geissler K, Dunford C. Integrating microfinance and health strategies: examining the evidence to inform policy and practice. *Health Policy Plan*. 2012;27:85–101. doi:10.1093/heapol/czr014. PMID:21343235.
33. Leatherman S, Dunford C. Linking health to microfinance to reduce poverty. *Bull World Health Org*. 2010;88:470–471. doi:10.2471/BLT.09.071464.
34. Indo-Asian News Service. Working groups formed to finalize contours of NaMo care scheme; 2018 [accessed 19 Feb 2018]. <https://www.thenewsminute.com/article/working-groups-formed-finalise-contours-namo-care-scheme-76608>.
35. Government of India. New Delhi, India: Rashtriya Swasthya Bima Yojana Programme [accessed 20 Mar 2017]. <http://www.rsby.gov.in/Statewise.aspx?state=16>.
36. Schmidt MI, Duncan BB, Azevedo e Silva G, Menezes AM, Monteiro CA, Barreto SM, Chor D, Menezes PR. Chronic non-communicable diseases in Brazil: burden and current challenges. *Lancet North Am Ed*. 2011;377(9781):1949–1961. doi:10.1016/S0140-6736(11)60135-9.
37. Marcolino MS, Oliveira JAQ, D'Agostino M, Ribeiro AL, Alkmim MBM, Novillo-Ortiz D. The impact of mHealth interventions: systematic review of systematic reviews. *JMIR Mhealth Uhealth*. 2018;6(1):e23. doi:10.2196/mhealth.8873. PMID:29343463