KPMG

Confederation of Indian Industry

Mandatory health insurance

A step towards Universal Health Coverage

July 2016

KPMG.com/in | cii.in

Foreword - KPMG

Currently, India's healthcare industry is at a very important juncture and vital decisions around the four pillars of healthcare — availability, affordability, accessibility and acceptability — need to be made to tackle contemporary healthcare challenges. Glaring challenges around high out-of-pocket spending, inequality of services and fragmented social and regulatory standards are forcing stakeholders back to the policy drawing board. Further, with the voice for Universal Health Coverage (UHC) gaining traction, it is becoming imperative for the government and other stakeholders to relook and redesign the current healthcare system.

As of today, one-quarter of the Indian population that lives below the poverty line and 67 per cent that dwells in rural areas[1], has limited access to affordable quality care. Additionally, about 60 million people have been forced below poverty line due to costs incurred while accessing healthcare facilities[2]. In view of these fiscal hardships and poor accessibility related to cost of care, it has become imperative for stakeholders to come together to provide financial security to all its citizens, especially to the more vulnerable sections.

The Netherlands model of mandatory health insurance has demonstrated that providing guaranteed quality and affordable healthcare is possible – an effort which has been praised around the globe This model can stimulate Indian policymakers to embrace a health security model that aspires to deliver healthcare without having one to suffer any fiscal hardship.

The report endeavours to focus on the current gaps that exist in financing healthcare in India. The report also provides a perspective into plausible solutions in the form of mandatory health insurance and innovative micro-health insurance, having the ability to safeguard the underprivileged section of the society from financial challenges.

Nilaya Varma

Partner and Head
Government and Healthcare
KPMG in India

1. "Rural population (% of total population)", The World Bank, http://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=IN, accessed 15 July 2016,
2. 'Financing Healthcare for all in India: Towards a Common Goal', OXFAM, May 2015, http://indiaenvironmentportal.org.in/files/file/Financing-Healthcare-for-All-In-India.pdf, pdf, page 3, accessed 15 July 2016

Foreword - CII

India has made rapid strides towards increasing access to health services in the past few years through a number of initiatives, including the flagship National Rural Health Mission (NRHM), launched in 2005. This was expanded to the urban population through the National Urban Health Mission (NUHM) in 2013.

To provide financial protection to targeted populations, including those below the poverty line, the government has implemented the Rashtriya Swasthya Bima Yojana (RSBY). It covers the cost of secondary-level hospitalisation.

In addition, there are a number of state-specific schemes. Some involve running free diagnostics facilities and offering free medicines; others are government-funded health insurance schemes in several states.

While these initiatives provide some financial protection to those seeking health care, tens of millions still fall into poverty after an illness or abstain from accessing the health services they need.

India will need to have a healthy population and address health inequities to sustain its economic growth. In this context, UHC can be the driver and benefit the entire population. Accelerating UHC is the key to successfully addressing the new public health challenges and inequities in health outcomes.

Despite remarkable achievements such as polio eradication and maternal and neonatal tetanus elimination, to name a few, there are several health challenges. The country is facing a double burden resulting from significant increase in non-communicable diseases (NCDs) associated with lifestyle and the pre-existing burden of communicable diseases.

At this juncture, the need of the hour is to scale up the public health services, increase the number of trained health professionals and augment public healthcare spending to determine adequate healthcare financing. Need for the universal health coverage has become imperative to counter the challenges of availability, affordability, and accessibility of healthcare services. India would not only require robust healthcare policies, but also a strong universal healthcare plan implemented through public as well as private sectors.

I am sure that this CII – KPMG report will serve as an intensive valuable tool for the participants to reach out for the best of the Knowledge concerning the healthcare sector.

Wishing all the success to the event.

Dr Dinesh Batra

Co-Chairman – CII NextGen Healthcare Conclave 2016
Co-Convenor, Services Panel, CII Haryana State Council and
Director & Group CEO
Cygnus Hospitals

Table of contents

Setting the context

Analysing the current challenging state in healthcare

Affordability concerns and healthcare insurance coverage

Concept of mandatory health insurance and micro-health insurance

Conclusion

Setting the context

India is on the threshold of becoming an economic power driven by its advantageous young demographic profile and developing service economy. These factors have the potential to propel the country even further on the trail of high GDP growth, necessitating that this young workforce remains healthy and continues to be extremely productive. Hence, the need to invest more into healthcare of its people has never been more imperative.

Since India's independence, healthcare has seen a positive evolution. The government has been a pillar of the developing healthcare ecosystem story. Despite progress across many parameters, the existing state of Indian healthcare leaves much to be desired. In the last two decades, the private sector has been the major contributor to healthcare infrastructure development in the country with public sector's contribution being limited.

Glaring challenges around healthcare financing, inequality of services, and fragmented social and regulatory standards have started to cripple the advancement in healthcare. India continues to have one of the lowest public health budgets in the world at just over one per cent of Gross Domestic Product (GDP) with out-of-pocket (OOP) spending contributing to the remaining share[1]. Increasing financial stress and inadequate care has been linked to higher share of OOP expenditure on healthcare, which is among the highest in the world. Approximately 60 million people[2], equal to the size of the United Kingdom's population, have already been pushed below the poverty line due to costs incurred while accessing healthcare. Further, one-quarter of the current population was prevented from accessing health services due to financial reasons[2]. This high ratio of OOP spending, coupled with a prevalent lack of adoption of health insurance, further adds to the complexities of the existing healthcare challenges.

As a result, health cannot be quarantined from financing for the population. The concerns need to be answered simultaneously to strengthen one another. India needs to design a healthcare structure that can provide access to affordable services to its population. The need for UHC has become imperative to the health needs of the population. Equity is key to UHC; every person must be covered and services must be allocated on a need basis, with the most vulnerable people being given the first preference.

Publicly financed healthcare insurance alone cannot answer the fiscal burden that the bottom of the pyramid faces while accessing healthcare services

On the path of achieving UHC, several state governments have introduced a number of publicly financed health insurance schemes not only to improve access to hospitalisation services, but also protect households from high medical expenses. Approximately two-thirds of the population covered under these schemes are those in the Below Poverty Line (BPL) category[3]. However, in spite of this progress, low awareness among the beneficiaries about the entitlement, and how and when to use these services have remained a challenge.

One option for healthcare financing that is receiving increasing attention in recent times is mandatory health insurance (MHI). Under MHI, an individual is required to maintain a minimum essential coverage for self and for his/her dependents. This equity option can act as an essential arsenal in helping India achieve UHC, emancipating the deprived sections of the society from this financial burden, and aiding in achieving an ideal healthcare state for the nation.

Another instrument of equity that is gaining traction is micro health insurance. The crucial features of micro health insurance premium are: (a) it is prepaid on a regular basis, and (b) it is affordable to low-income citizens. This instrument operates on the philosophies of equity, solidarity, risk pooling and community empowerment. These ideologies are necessary for running a successful and maintainable micro insurance scheme.

A dedicated approach encompassing public and private sectors, and leveraging emerging financial options are likely to play a disruptive role in the healthcare transformation in the future formative years of the Indian healthcare industry.

This report explores the current fiscal state of Indian healthcare and tries to contextualise the need to prevent the less advantaged from financial hardship while accessing healthcare. While the focus of this paper is on healthcare in response to current demand for UHC, KPMG in India recognises the importance of embracing a holistic approach to health financing through adoption of mandatory health insurance.

1. Healthcare Expenditure, Public (% of total)", The World Bank, http://data.worldbank.org/indicator/SH.XPD.PUBL?locations=IN, accessed July 2016,
2. Financing Healthcare for all in India: Towards a Common Goal', OXFAM, May 2015, http://indiaenvironment-portal.org.in/files/file/Financing-Healthcare-for-All-In-India.pdf, pdf, page 3, accessed 15 July 2016
3. National Health Policy Draft-2015', Ministry of Health & Family Welfare, http://www.nhp.gov.in/sites/default/files/pdf/draft_national_health_policy_2015.pdf, pdf, Page 8, December, 2014, accessed 15 July 2016

Analysing the current challenging state in healthcare

India needs to address the challenges around availability, affordability, accessibility and acceptability of healthcare factors to embark on the path of UHC

The Indian healthcare industry is at an intersection today. Health is progressively being perceived as a subject of development, rather than just a remedial one. The stakeholders need to relook at the architecture of the existing healthcare system. Important decisions around the four pillars of healthcare — availability, affordability, accessibility and acceptability — need to be taken into consideration to respond to the emerging healthcare needs of the nation.

Even though the last two decades have seen the Indian healthcare system emerging as a leading medical tourism hub, the gap in delivering quality and affordable health services to the bottom of the demographic pyramid has amplified.

The Indian healthcare system has made advancements across several dimensions. Life expectancy and infant and maternal mortality rates have improved noticeably. On the other hand, skewed availability of health facilities coupled with the issue of affordability have remained major bottlenecks to achieving universal access to healthcare in India. Availability of healthcare continues to be restricted by infrastructural inadequacies and lack of a structured delivery system.

Adding to these woes, regional distribution of infrastructure and human resources are better managed in urban India, which caters to only 33 per cent of the population[1]. Rural India, on the other hand, with 67 per cent of the population[2], continues to live with inadequate healthcare infrastructure and lack of manpower, resulting in large disparities in health outcomes across states. Further, inadequate healthcare spending by the government and poor uptake of health insurance by the masses have resulted in unreasonably high OOP spending. Also, an increasing number of people are choosing private healthcare facilities over government amenities due to easy accessibility to specialist doctors, diagnostic services and drugs, leading to challenges around affordability of these services.

Healthcare in India continues to remain more curative-oriented rather than preventive. Adding to this, the rapid upsurge in non-communicable diseases (NCDs) and the sluggish decline in the prevalence of communicable diseases (CDs) have challenged the healthcare system with a dual disease burden. These mega trends are anticipated to render the prevailing system unsustainable.

The current Indian healthcare indicators, when compared with peer group countries, expose the need to have a sustainable financial system

Current healthcare indicators highlight the gaps that exist in India's healthcare delivery system. India trails in healthcare indicators behind its economic peer group countries, such as Indonesia, Thailand, Brazil and China. There is a wide gap in healthcare delivery between the insured and the total population. With less focus by the government as reflected in public contribution to overall healthcare expenditure, coupled with the resulting high OOP spending, highlight the discrepancy in existing healthcare financing instruments.

1. 'Urban population (% of total population)', The World Bank, http://data.worldbank.org/indicator/SP.URB.TOTL.IN.ZS?locations=IN. accessed 16 July 2016,
2. 'Rural population (% of total population)", The World Bank, http://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=IN, accessed 16 July 2016

India's high out of pocket healthcare expenditure leaves much to be desired

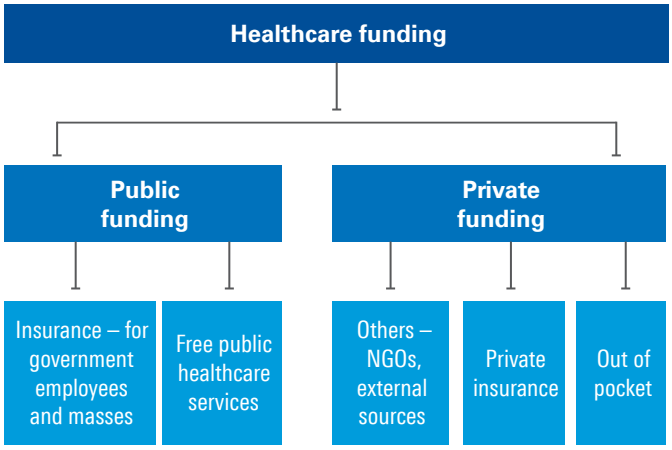
		India	Indonesia	Brazil	China	Thailand
Health indicators	Life expectancy, 2014	68	69	74	76	74
	Infant mortality rate, 2014	39	24	14	10	11
	Maternal mortality ratio, 2014	181	133	46	28	21
Healthcare expenditure indicators	Health expenditure per capita (purchasing power parity), 2014	75	100	948	420	360
	Public health expenditure, (% of total health expenditure)	30	38	46	56	86
	Private health expenditure, (% of total health expenditure)	70	62	54	44	14
	Health expenditure, public (% of government expenditure)	5	6	7	10	24
	OOP health expenditure (% of total expenditure on health)	62	47	26	32	8
	OOP health expenditure (% of private expenditure on health)	89	75	47	72	57

Note: Life expectancy at birth is in number of years; infant mortality rate is per 1,000 live births; maternal mortality ratio is per 100,000 live births; out-of-pocket health expenditure is the percentage of private expenditure on health.
Source: World Bank data, the World Bank website, http://data.worldbank.org/, accessed in 15 July 2016, KPMG in India analysis

Affordability concerns and healthcare insurance coverage

No increase in GDP share on healthcare spend for the past decade reflects the government's low emphasis on providing quality health

With health progressively being perceived as a GDP driver, rather than a social cost, the need to relook at various aspects of healthcare funding has never been more acute. Therefore, the current financing options and role of various stakeholders involved in supporting the expenditure related to illness need to be revisited.



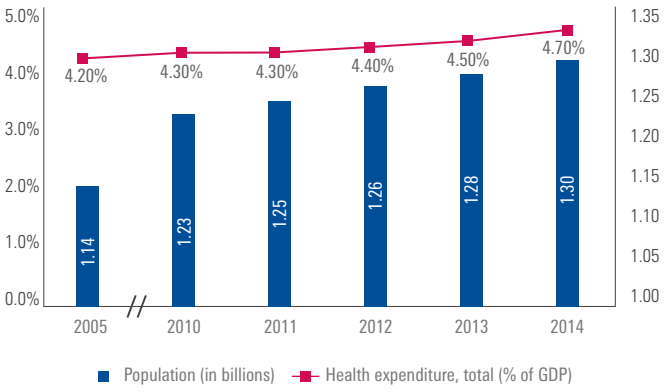
Source: Source: KPMG in India's analysis, 2016

GDP share of healthcare spending is not matching population growth

In the past decade, India's population has grown by more than 15 per cent[3]. This growth was not complemented by an equitable growth in the share of GDP spending on healthcare, which has remained flat at 4 per cent[4]. With more efforts needed on the part of stakeholders to increase this share, the aim to make healthcare affordable and accessible to all its citizens remains distant.

Currently, only USD75 is being spent per capita (purchasing power parity in 2014) on healthcare by India, a figure that lags behind several other developing countries.[5]

Healthcare expenditure share of GDP vs population growth



Source: "World Bank Data", the World Bank website, accessed in July 2016, KPMG in India's analysis, 2016

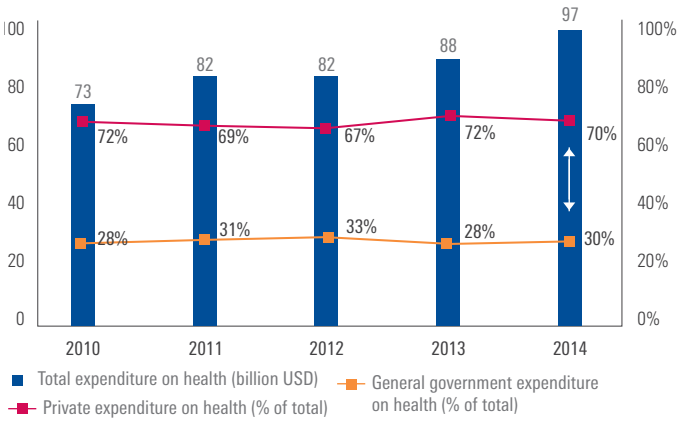
3. Population Total", The World Bank, http://data.worldbank.org/indicator/SP.POP.TOTL?locations=IN. accessed 16 July 2016,
4. "Health expenditure, total (% of GDP)", The World Bank, http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS?locations=IN, accessed 16 July 2016
5. World Bank data, the World Bank website, http://data.worldbank.org/, accessed in 16 July 2016, KPMG in India's analysis, 2016

The current healthcare challenges necessities that the government increases its focus on the sector to reduce the growing burden of OOP

The negative outcome of the low share of health spending in GDP is further intensified by low levels of public spending on health. The gap between the private and public source of healthcare funding has remained constant over the years.

The burden of expenditure incurred while accessing healthcare facilities can be calamitous on the less privileged not only in terms of cost related to hospitalisation, but also in terms of opportunity cost as a result of loss of daily wages. Due to lack of a comprehensive health insurance coverage and preference for private healthcare, close to 60 million citizens have been driven below the poverty threshold.[6]

Contributors to healthcare expenditure



Source: Global Health Expenditure Database", WHO, http://apps.who.int/nha/database, accessed 16 July 2016, KPMG in India's analysis, 2016

This gap between private and public expenditure has remained wide, and is a result of poor and inefficient public spending and high share of OOP in private spend.

Low government focus on healthcare: Public spending continues to account for only one-third of total healthcare spend. This has remained stagnant with no significant change over the past decade[7], reflecting low focus of the government.

In spite of targeting an increase in outlays for public health from 0.9 per cent to 3 per cent of GDP by 2012 through the National Rural Health Mission (NRHM) and expanding public health infrastructure considerably, public health spending lingered just above 1 per cent of GDP[8]. This has resulted in the shortage of 36,346 sub centres, 6,700 Primary Health Centres (PHCs) and 2,350 Community Health Centres (CHCs) in India[9].

Out-of-pocket spend has remained a major contributor to healthcare expenditure

Private spending has remained the main contributor to healthcare spending in India that continues to contribute to more than two-thirds of the spending pie[7]. Of this, the out-of-pocket expenditure of a household has remained the major source of funding. The health insurance sector in India, which is at a nascent stage, accounts for a minor portion of the overall market.

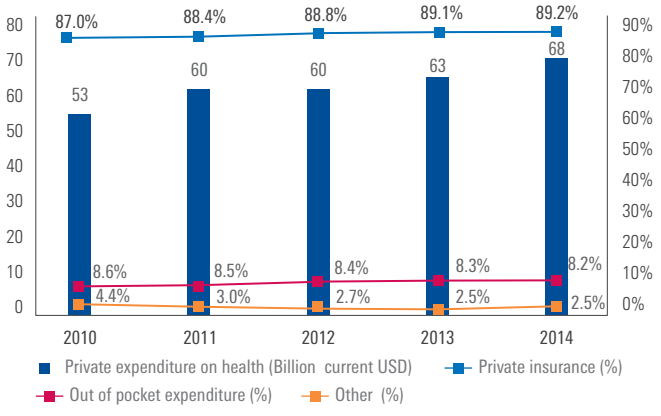
Higher financial burden on individuals due to higher proportion of OOP spending

This financial instrument option has increased the monetary burden on an individual with no social coverage from the government or any other form of insurance. OOP contributes approximately 86 per cent of private expenditure and 60 per cent of overall healthcare expenditure.[7] Further, one-quarter of the population has been prevented from accessing health services due to lack of any feasible financial source[6].

Additionally, poor uptake of voluntary health insurance by the masses has crippled the financial health of the system

Currently, less than five per cent of healthcare expenditure is being financed by insurances[7]. An unexploited potential demand exists for a well-designed health insurance product. Consolidated OOP payments accounted for USD61 billion in 2014[7], creating a significant untapped market by any standards. The private sector has recognised the potential of this segment. However, many corporate units are dealing with the high-end market, and their clientele are already well-protected.

Private spending on health and its contributors



Source: "Global Health Expenditure Database", WHO, http://apps.who.int/nha/database, accessed 16 July 2016,; KPMG in India's analysis, 2016

6. Financing Healthcare for all in India: Towards a Common Goal', OXFAM, May 2015, http://indiaenvironment-portal.org.in/files/file/Financing-Healthcare-for-All-In-India.pdf, pdf, page 3, accessed 15 July 2016
7. "Global Health Expenditure Database", WHO, http://apps.who.int/nha/database, accessed 16 July 2016, KPMG in India's analysis, 2016
8. Financing Healthcare for all in India: Towards a Common Goal', OXFAM, May 2015, http://indiaenvironment-portal.org.in/files/file/Financing-Healthcare-for-All-In-India.pdf, pdf, page 10, accessed 15 July 2016
9. Rural Health Statistics, Government of India, Ministry of Health and Family Welfare, Statistics Division, http://www.indiaenvironmentportal.org.in/files/file/Rural%20Health%20Statistics%202014-15.pdf, pdf, Page 52, , accessed 15 July 2016

With growing demand for UHC, the need to relook at financing alternatives that are universal and sustainable has become inevitable

The Government of India has launched various insurance schemes over the last decade with an aim to cover the health of masses. These schemes have been launched apart from the various insurance schemes covering government employees. Several schemes were launched, such as Rashtriya Swasthya Bima Yojna (RSBY) and Rajiv Aarogyasri Community Health Insurance Scheme, with an aim to provide health insurance to poor, domestic workers, Mahatma Gandhi National Rural Employment Guarantee Act 2005 (MGNERGA) workers, building and other construction workers, and many other categories as identified by different states. The population coverage under these various schemes increased from almost 55 million in 2003–04 to 370 million in 2014 (almost one-fourth of the population)[10].

However, due to low awareness among the beneficiaries about the entitlement, terms and conditions of usage and the benefits have crippled the intended outcome. Further, low participation levels have been a result of the low quality of services that are provided, coupled with cumbersome claims settlement process. Many of these schemes do not cover minor ailments, such as flu and malaria, which further reduce their appeal to policy holders.

To affect the health outcomes and achieve the state of UHC, insurance schemes could target the most vulnerable groups across the population pyramid. Further, to determine long-term sustainability, schemes need to be financially viable and not become a burden on the system. To address this, an amalgam of publicly-funded insurance schemes and private sector professional schemes is the need of the hour.

10. "National Health Policy Draft-2015', Ministry of Health & Family Welfare, http://www.nhp.gov.in/sites/default/files/pdf/draft_national_health_policy_2015.pdf, pdf, Page 8, December, 2014, accessed July 2016

Concept of mandatory health insurance and micro-health insurance

Sustainable equity in the form of mandatory health insurance can be seen as a pre-requisite for UHC

Realising UHC means executing strategies to ensure that every citizen receives uniform health services without suffering any financial adversity. To truly achieve this ideal state, India needs to create a new healthcare strategy encompassing not only adequate infrastructure and human resource, but also adequate financial options.

When executed accurately, UHC can radically improve health outcomes of a nation by reducing inequality and accelerating economic growth. It has been observed that for every 10 per cent increase in public expenditure, there is an average reduction of under-5 mortality by 7.9 deaths per 1,000 and adult mortality by 1.6 (women) and 1.3 (men) per 1,000, with major impact on the bottom of the demographic pyramid[1].

Thus, equity is the stepping stone towards achieving UHC. A thorough health coverage that covers the entire population, irrespective of economic status, can lead to improvement not only in access to necessary care, but also reduce financial hardship. A hybrid system of innovative public and private financing is required to develop such equity cover.

Currently, the liberated Indian market for health services is unable to deliver this type of a system. Mandatory health insurance can be one of the solutions to achieve this end – a system that covers the cost of accessing healthcare for those who are enrolled and in which enrollment is mandatory for every member of the population.

Mandatory car insurance: A different sector, but having a shared reasoning

Under the requirements of The Motor Vehicles Act of 1988, all vehicles in India are required to have a car insurance policy of a minimum coverage amount[2]. Penalties are levied on individuals who drive without minimum insurance coverage. The aim of the mandate is to mitigate risk. This form of compulsory insurance helps in spreading the cost of premium. The premium paid by an individual contributes to coverage for another individual who gets involved in an accident.

The idea behind making car insurance compulsory is to not only prevent unforeseen expenditure one has to bear in unfortunate circumstances of an accident, but also to keep the insurance premium within reach of all individuals. For instance, when a 'safe driver' is insured, it not only ensures that this individual is protected from unforeseen expenditure, but also the premium paid prevents the cost of insurance from rising.

Mandatory Health Insurance (MHI), such as car insurance, can not only act as a safeguard against financial hardship, but also help decrease the cost of health insurance

Similar to car insurance, mandatory health insurance could help cover all individuals of the society. Through this, the challenge of 'adverse selection', which is currently the state of health insurance in India, could be mitigated. With all members of the population covered by a mandatory equity instrument, irrespective of the risk one bears, the price of premium becomes affordable for the masses. This could further determine a wider uptake of health insurances.

While adopting MHI, a nation can aim to achieve the following common goals:

- Create a corpus of funds to pay for healthcare expenditure incurred
- Every individual should be able to access healthcare in an equitable manner without the fear of being pushed below the poverty threshold
- Help eliminate barriers to utilise healthcare services and protect households against incurring large medical expenditures.

Alternative options need to be explored by stakeholders to arrive at a sustainable health equity model. A mixed financing mechanism based on the criteria of pre-payment and pooling needs to be developed.

1. Broader health coverage is good for the nation's health: evidence from country level panel data' Royal Statistical Society, http://onlinelibrary.wiley.com/doi/10.1111/rssa.12048/abstract, Published 2015, Page 2 of pdf, accessed 16 July 2016;
2. "MOTOR VEHICLES ACT, 1988", Delhi Traffic Police, https://delhitrafficpolice.nic.in/wp-content/uploads/2014/11/motor-vehicles-act-1988.pdf, Page 40, accessed 16 July 2016

Health insurance mix

Health insurance models / H.I. Mixes	Tax-based health insurance	Social security	Private mandatory	Employer-based	Community-rated	Risk-related
Public–private mix	Public health insurance		Private health insurance			
Mandatory voluntary mix	Mandatory health insurance			Voluntary health insurance		
Policy relevance of the mix	Burden for public finances, financial sustainability, impact on labour market flexibility, extent of pooling					
	Extent of pooling, coverage					
	Solidarity and progressivity, degree of cross-subsidisation in the scheme					

Source: Adopted from 'Proposal for a taxonomy of health insurance', OECD, Page 13 of PDF, accessed on July 2016

To implement MHI successfully, all stakeholders need to work together and explore different innovative equity models

A robust MHI strategy needs to be collectively financed by three instruments: taxes, social security and mandatory private insurance. None of these alone can achieve the goal of UHC. For example, when the Indian government tried to embark on an ambitious healthcare plan for all using social security alone, the cost of USD18.5 billion over five years created a barrier that led to its non-implementation[3].

However, in its efforts to achieve UHC, the government had included a health cess in the National Health Policy Draft 2015; however, the implementation is awaited[4]. Further, in addition to current health insurance schemes provided by the government at different levels, a new health protection scheme that covers poor and economically weaker sections was announced in this year's Union Budget. Under the new scheme, a health coverage of INR1 lakh for a family is to be provided along with an additional benefit of INR30,000 to safeguard senior citizens of age group 60 years and above[5]. At the same time, there is low awareness among the beneficiaries about the entitlement, and how and when to use the benefits, which could continue to pose as threats to achieve success.

A mandatory private health insurance scheme financed by individuals can help overcome both the financial burden, which the public system faces and low awareness among the masses. It needs to be regulated to warrant equitable access and cross-subsidisation to all. The premiums of such insurance schemes need to be income-related with contributions calculated as the share of earned income.

Further, the role of private health insurance in relation to public health insurance needs to be clearly defined. The role of private health insurance schemes within the public–private mix, can be defined on two principal variables:

Entitlement to public health insurance: Certain sections of the population earning more than a threshold level of income might not be eligible for public health insurance support. For these individuals, health coverage would only come through private insurance.

Additional coverage for health services: Part of the population supported by government insurance schemes may opt for additional coverage to bridge any additional cost that may be incurred.

3. 'Exclusive: Modi govt puts brakes on India's universal health plan', Reuters, Februray 2015, Accessed 16 July 2016
4. "National Health Policy Draft-2015', Ministry of Health & Family Welfare, http://www.nhp.gov.in/sites/default/files/pdf/draft_national_health_policy_2015.pdf, pdf, Page 15, December, 2014, accessed 16 July 2016;
5. 'Healthcare Union Budget 2016, Post-Budget sectoral point of view, KPMG in India, https://www.kpmg.com/IN/en/services/Tax/unionbudget2016/Documents/Healthcare.pdf, April 2016, Page 5 of pdf, accessed 16 July 2016

Case study: Learnings from other countries

The Netherlands

The Netherlands continues to enjoy the position of being ranked the best healthcare system in Europe, according to the Euro Health Consumer Index 2015[6].

The healthcare system is characterised by the presence of mandatory health insurance. The Health Insurance Act, 2006, makes it mandatory for every person who resides or pays payroll tax in the country to be covered by a health insurance. Under the Act, every health insurer is required to provide services with a legal obligation to admit every individual who applies for insurance. The healthcare insurer may decide which qualified person or institution would provide the insured care[7].

Under the Act, all insured people aged 18 and above pay a nominal premium directly to the care insurers along with an income-related contribution, which employers deduct from employees' wages[7]. The price of premium is decided by the insurer. Financial reimbursement is provided to those who incur care expenditures due to chronic illness or infirmity, and are expected to pay the maximum personal excess structurally over time. This feature ensures that an individual does not pay more in terms of compulsory personal excess than an average insured person who receives no compensation.

Japan[8]

In Japan, every resident by law is required to be covered by public health insurance. Employed individuals are normally covered by a work scheme, and are required to pay 20 per cent of their total medical costs at the point of delivery.

The self-employed and unemployed are obligated to enrol under the national health insurance scheme. The premium of insurance is calculated on the basis of income, value of property owned and the number of dependents. Members are required to pay 30 per cent of the cost of inpatient and outpatient treatment — including emergencies — while the government pays the remainder. Individuals over 70 years of age are required to pay only 10 per cent of these costs.

6. 'Euro Health Consumer Index 2015', Health Consumer Powerhouse, http://www.healthpowerhouse.com/files/EHCI_2015/EHCI_2015_report.pdf, January 2015,Page 5 of pdf, accessed 16 July 2016;
7. "Health insurance in the Netherlands', Ministry of Health, https://www.government.nl/topics/health-insurance , pdf, March 2011, 16 accessed July 2016;
8. 'Health Care Financing And National Health Insurance, Section 2, NYU, https://www.nyu.edu/projects/rodwin/lessons.html, accessed 16 July 2016

Micro health insurance can provide people at the bottom of the demographic pyramid an opportunity to be a part of MHI strategy

Additionally, the micro health insurance option can be explored to aid the financially weaker sections of the society for adopting mandatory private health insurance. This is in addition to the government health coverage provided in the form of multiple schemes. Its adoption reduces catastrophic OOP health spending, and expands the access to quality care for those who are covered.

Micro insurance applies risk pooling as other insurance policies distribute risk across the covered population. It operates on the principles of equity, risk pooling and community enablement. These principles are essential to run an effective and sustainable scheme.

Currently, most of the 100 micro health insurance schemes active in India are operational in rural areas . With only 30 per cent of the schemes targeting the urban population[9] and still fewer targeting the urban poor population specifically, a strategy needs to be developed to provide the urban poor better access to healthcare.

The micro insurance solution could leverage public–private partnerships, combining the public sector's ability to source funding, pool large groups, and ease regulatory issues with the private sector's innovation, insurance expertise, efficiency and technology. It can be combined with other schemes launched by the Indian government, such as MNREGA and the Pradhan Mantri Fasal Bima Yojana, that targets rural and below poverty line population.

A way forward for successful mandatory micro insurance adoption to achieve UHC lies in the collective efforts of all stakeholders, namely policy makers and governments, insurers and reinsurers, and private sector actors, including technology firms, NGOs, and healthcare providers. government or any other form of insurance. OOP contributes approximately 86 per cent of private expenditure and 60 per cent of overall healthcare expenditure.[10] Further, one-quarter of the population has been prevented from accessing health services due to lack of any feasible financial source[11].

A community development financial institution[9]

A community development financial institution, works toward providing health insurance at a very nominal price. Currently it is active in five states: Odisha, Chhattisgarh, West Bengal, Maharashtra and Madhya Pradesh.

Its health insurance scheme collaborated with a leading Indian general insurance company to serve approximately 30,000 low-income women in Odisha and the other four states.

- Insurance package comprises hospitalisation up to INR10,000 for a family
- This facility is provided at a nominal premium of INR325 per family, per year
- The payment method used to settle the claims are cashless hospitalisation and reimbursement.

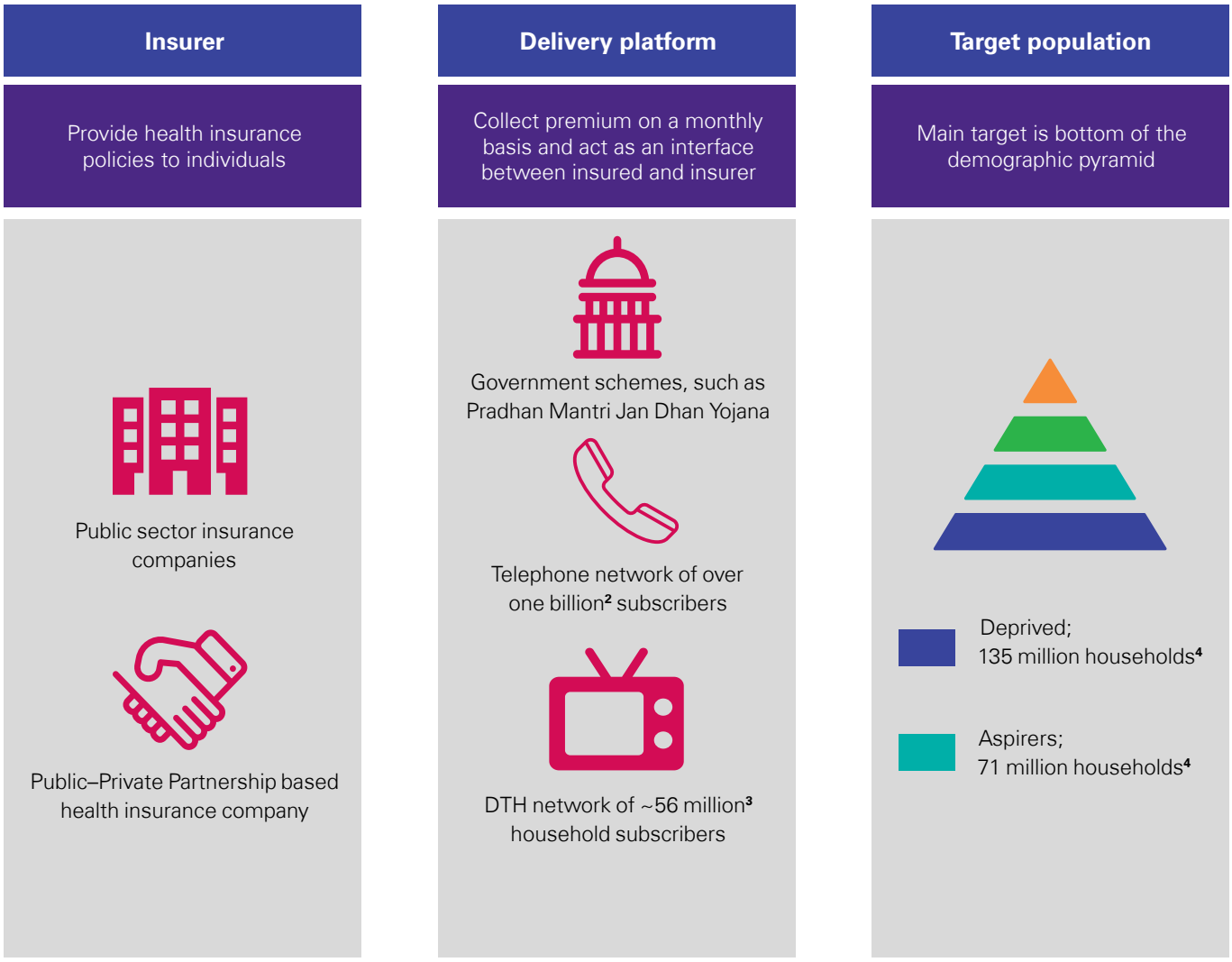
9. Micro Health Insurance Schemes in Urban India', Micro Insurance Academy, http://populationfoundation.in/wp-content/uploads/2015/09/Micro-Health-Insurance-Schemes-in-Urban-India.pdf, March 2012, page 15 of PDF accessed 17 July 2016
10. Global Health Expenditure Database", WHO, http://apps.who.int/nha/database, accessed 16 July 2016, KPMG in India's analysis, 2016
11. Financing Healthcare for all in India: Towards a Common Goal', OXFAM, May 2015, http://indiaenvironment-portal. org.in/files/file/Financing-Healthcare-for-All-In-India.pdf, pdf, page 3, accessed 15 July 2016

Innovative models for mandatory micro insurance

Various innovative models can be explored to deliver micro health insurance schemes to people at the bottom of the demographic pyramid. The central theme is to leverage a platform that has wider reach and can be trusted by individuals. Several such government and private platforms are available.

For example, at a nominal price of INR1 per day (i.e., INR360 per year) per telephone subscriber, a corpus of INR375 billion (USD6 billion) could be generated that can cover 200 million households that fall under the deprived or aspirer sections of the society. It is an inclusive model where even households at the bottom of the demographic pyramid are mandated to pay for their care, but at a very nominal price.

Proposed micro insurance model for India



Source: Source: 1 - KPMG in India Analysis, 2-' Highlights of Telecom Subscription Data as on 30th November, 2015', Telecom Regulatory Authority Of India, http://trai.gov.in/WriteReadData/PressRealease/Document/PR-TSD-Nov-15.pdf, January 2016, Page 1 of PDF, accessed in July 2016; 3- 'DTH Active Subscribers as on 31.12.2015' , Government of India, https://community.data.gov.in/dth-active-subscribers-as-on-31-12-2015/, Published on May 2016, accessed on 17July 2016, 4 - – 'Indias By Class: Economic Diversity of India' Learning India, http://learningindia.in/indias-by-class/ October 2013, accessed on 17 July 2016

Conclusion

A well-rounded financing strategy, keeping the demographic pyramid at the centre, and woven around by making health insurance mandatory, is a way forward for UHC

The stakeholders of India's healthcare sector need to work together to design a proactive risk management strategy. The strategy needs to provide a solution, which would protect low-income households against specific risks in exchange for a regular premium, whose amount is expected to be proportional to the likelihood and cost of relevant risks. The strategy needs to make insurance in any form mandatory, across all levels of population and supported by social security for the deprived sections of the society.

The strategy should determine the availability of equity instruments that every citizen is covered by. The demographic structure of the country has to be kept at the centre of planning while designing this new policy. The deprived (135 million households) and aspirers (71 million households) sections of the society (categorised as the section of the society whose annual income is below INR1.5 lakh and INR1.5–3.4, lakh respectively[1]), need to be covered extensively using innovative micro insurance schemes to prevent them from economic shocks of illness.

Further, the middle class (31 million households) and rich class (3 million households), (categorised as the sections of society earning INR3.5–17 lakh and more than INR17 lakh, respectively[1]) could be covered by mandatory private insurance. This strategy could determine not only the spread of risk, but also reduce premiums of insurance across the population pyramid.

Proposed Strategy to implement Mandatory Health Insurance

Source: KPMG in India's analysis, 2016, 'Indias By Class: Economic Diversity of India' Learning India, http://learningindia.in/indias-by-class/ October 2013, accessed on 17 July 2016

Note: **- For poor older generation and homeless people; * - To spread risk and decrease the premium for deprived and aspirers. Breakdown of broad economic wealth distribution as per the definition of National Council for Applied Economic Research

1. 'Indias By Class: Economic Diversity of India' Learning India, http://learningindia.in/indias-by-class/ October 2013, accessed on 17 July 2016

A robust healthcare delivery model is imperative to a country's evolution from a developing to a developed economy. India has come a long way in terms of healthcare outcomes — from where it was at the time of independence, but many challenges remain. With the increase in population, coupled with disease burden, India is facing a challenge of not only accessibility to quality healthcare services, but also of affordability at the bottom of the demographic pyramid. Allocating a higher budget to national healthcare expenditure alone cannot answer these issues. India needs to develop a long-term vision in order to provide financial security to the low-income section of the society.

This paper has attempted to identify gaps in the availability of sustainable financing options and put forth suitable recommendations. The promotion of mandatory healthcare insurance with the adoption of innovative insurance instruments, like micro health insurance, could help the government in crossing the barrier of managing vast health coverage for all citizens. These measures would need to be adopted soon to safeguard the health of the underprivileged.

Social and fiscal security can transform the way India delivers its healthcare facilities to its masses. With effective government policies and active participation from the private sector, India can achieve its dream of 'Healthcare for All'.

Abbreviations

BPL	Below Poverty Line
CDs	Communicable diseases
CHC	Community Health Centres
GDP	Gross Domestic Product
HIV	Human Immuno-deficiency Virus
INR	Indian Rupee
MGNERGA	Mahatma Gandhi National Rural Employment Guarantee Act
MHI	Mandatory Health Insurance
NCDs	Non-communicable diseases
NGOs	Non-government Organisations
NRHM	National Rural Health Mission
OOP	Out-of-pocket
PHC	Primary Health Centres
PPP	Public Private Partnership
RSBY	Rashtriya Swasthya Bima Yojna
UHC	Universal Health Care
USD	US Dollars

About KPMG in India

KPMG in India, a professional services firm, is the Indian member firm affiliated with KPMG International and was established in September 1993. Our professionals leverage the global network of firms, providing detailed knowledge of local laws, regulations, markets and competition. KPMG has offices across India in Chandigarh, Gurgaon, Noida, Ahmedabad, Vadodara, Mumbai, Pune, Bengaluru, Kochi, Chennai, Hyderabad and Kolkata. KPMG in India offers services to national and international clients in India across sectors. We strive to provide rapid, performance-based, industry-focussed and technology-enabled services, which reflect a shared knowledge of global and local industries and our experience of the Indian business environment.

KPMG International

KPMG International is a global network of professional firms providing Audit, Tax and Advisory services. KPMG member firms operate in 155 countries and have more than 174,000 outstanding professionals working in member firms around the world. The KPMG Audit practice endeavours to provide robust and risk-based audit services that address member firms' clients' strategic priorities and business processes.

KPMG's Tax services are designed to reflect the unique needs and objectives of each client, whether firms are dealing with the tax aspects of a cross-border acquisition or developing and helping to implement a global transfer pricing strategy. In practical terms that means, KPMG firms work with their clients to assist them in achieving effective tax compliance and managing tax risks, while helping to control costs.

KPMG Advisory professionals provide advice and assistance to help enable companies, intermediaries and public sector bodies to mitigate risk, improve performance, and create value. KPMG firms provide a wide range of Risk Consulting, Management Consulting and Deal Advisory services that can help their clients respond to immediate needs as well as put in place the strategies for the longer term.

About CII

The Confederation of Indian Industry (CII) works to create and sustain an environment conducive to the development of India, partnering industry, Government, and civil society, through advisory and consultative processes.

CII is a non-government, not-for-profit, industry-led and industry-managed organization, playing a proactive role in India's development process. Founded in 1895, India's premier business association has over 8000 members, from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 200,000 enterprises from around 240 national and regional sectoral industry bodies.

CII charts change by working closely with Government on policy issues, interfacing with thought leaders, and enhancing efficiency, competitiveness and business opportunities for industry through a range of specialized services and strategic global linkages. It also provides a platform for consensus-building and networking on key issues.

Extending its agenda beyond business, CII assists industry to identify and execute corporate citizenship programmes. Partnerships with civil society organizations carry forward corporate initiatives for integrated and inclusive development across diverse domains including affirmative action, healthcare, education, livelihood, diversity management, skill development, empowerment of women, and water, to name a few.

The CII theme for 2016-17, Building National Competitiveness, emphasizes Industry's role in partnering Government to accelerate competitiveness across sectors, with sustained global competitiveness as the goal. The focus is on six key enablers: Human Development; Corporate Integrity and Good Citizenship; Ease of Doing Business; Innovation and Technical Capability; Sustainability; and Integration with the World.

With 66 offices, including 9 Centres of Excellence, in India, and 9 overseas offices in Australia, Bahrain, China, Egypt, France, Germany, Singapore, UK, and USA, as well as institutional partnerships with 320 counterpart organizations in 106 countries, CII serves as a reference point for Indian industry and the international business community.

Acknowledgments

We acknowledge the efforts put in by:

Strategic direction

Mr. Nilaya Varma

Mr. Lalit Mistry

Mr. Amit Tandon

Mr. Mohit Bahri

Authors

Dr. Manav Dagar

Neha Noopur

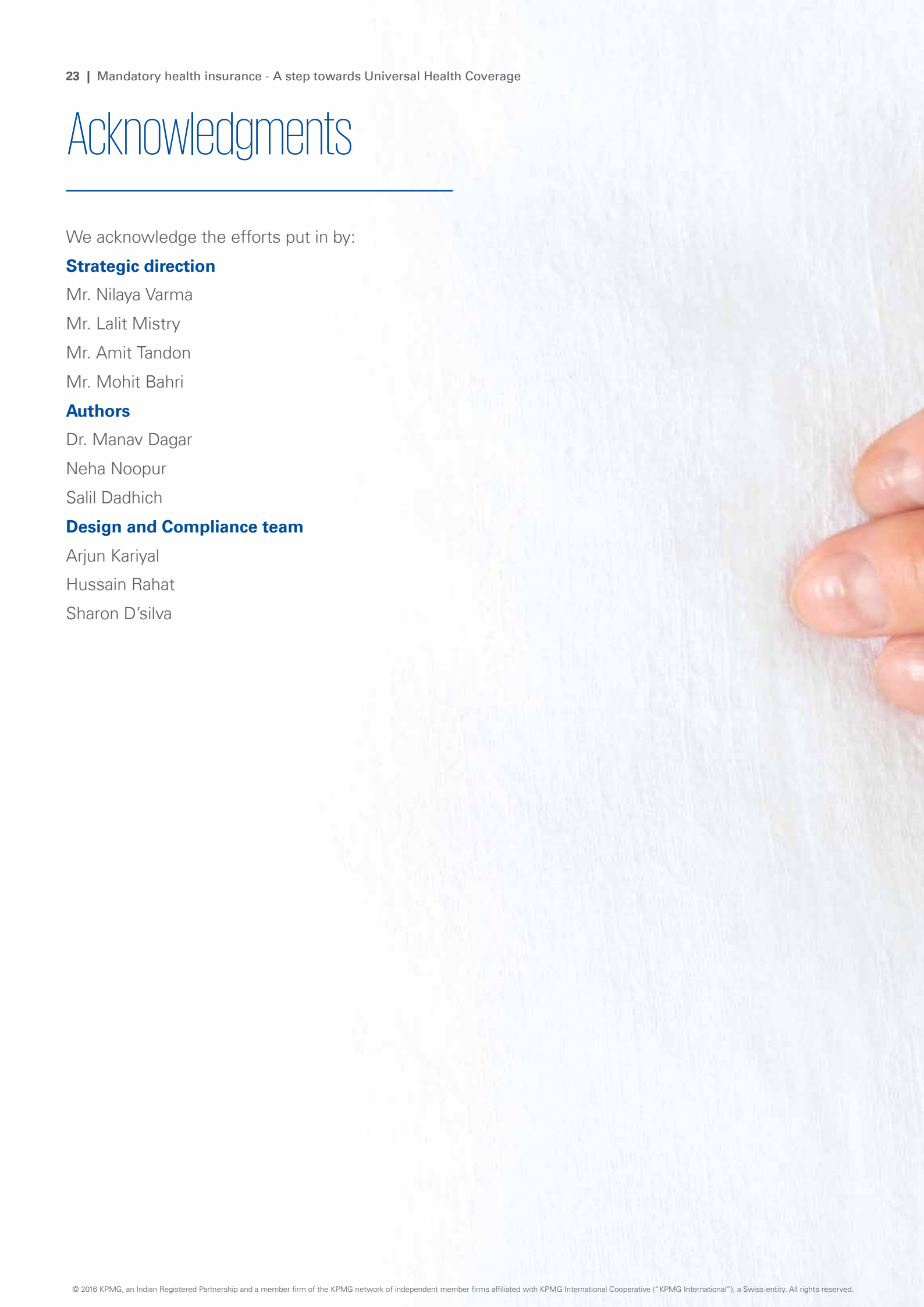
Salil Dadhich

Design and Compliance team

Arjun Kariyal

Hussain Rahat

Sharon D'silva



Notes

Notes

KPMG in India contacts:

Nitin Atroley
Partner and Head
Sales and Markets
T: +91 124 307 4887
E: nitinatroley@kpmg.com

Nilaya Varma
Partner and Head
Government and Healthcare
T: +91 124 307 4000
E: nilaya@kpmg.com

KPMG.com/in

Follow us on:
kpmg.com/in/socialmedia

Printed in India. (009_BRO0716)