CII Sub-Group on Universal Health Coverage

Report on
“Moving Towards Universal Health Coverage in India”
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1 Executive Summary

Universal Health Coverage has become an important aspect of public policy world over, especially for developing and underdeveloped countries which have been lagging their developed counterparts in providing this vital social security to their citizens. Some of these countries have experimented with demand side financing and other interventions in addition to traditional supply side mechanisms funded through taxes with reasonable success.

In the Indian context, low levels of Government spending in India (~1.1% of GDP and ~31% of total healthcare spend) has resulted in high levels of private spending and out of pocket expenditure. The functioning of the public health system and growth of Healthcare sector has been skewed with limitations to its access, availability and affordability for the people, notwithstanding the limited positive impact of specific Government programs like the NRHM.

After a lot of academic debate on Universal Health Coverage (UHC) for the past few years, ‘a financially sustainable and operationally feasible plan for UHC is an idea whose time has come. With the new Government showing keenness to improve healthcare, its availability, accessibility and affordability for all Indian citizens equitably, it is worthwhile to consider a model that is rooted in the Indian context - culture, resources, systems and that offers early take off to cover maximum population in the shortest period over 70-75% in a span of 3-4 years.

In the above backdrop, the Governments, both at Central and State levels have launched several health insurance schemes like the Rashtriya Swasthya Bima Yojna, Rajiv Arogyasri in Andhra Pradesh, Chief Minister’s Health Insurance Scheme in Tamil Nadu etc. which offer secondary and tertiary care to poor and vulnerable sections etc. This is an indication of a policy shift for Healthcare delivery in a “payer” model. These schemes have received good support from the insurance industry in operationalization and in improving access to healthcare.

UHC-Base Package and its delivery
The CII proposes a “composite” and “hybrid” model based on following tenets for implementing UHC in India in faster and efficient manner with utmost economy.

- The model aims at developing a basic and essential UHC package, consisting of primary, secondary and tertiary care, which would be affordable and accessible to every citizen, inclusivity all components of care - “Primary”, “promotive” and “preventive”.

- The model proposes to strengthen primary healthcare and other determinants of health like safe drinking water, sanitation, nutrition etc. by making it the core focus of the Government and public health system.
- It proposes utilization of health insurance for providing secondary care package of Rs.60,000 topped by tertiary care package of Rs.2 lacs to all

**UHC - Defining a Basic Package**

It is widely recognized that a basic package needs to be made available to all citizens. In addition to the basic cover, citizens can always take additional cover as per the requirement. An important question in UHC is the extent of basic coverage which should be provided to the population of India. Universal Health coverage package should be made available to all levels covering all segments and cover Primary, Secondary and Tertiary Healthcare. By its very nature, primary care is also linked with issues like safe drinking water, sanitation and nutrition which may not necessarily be made part of the basic package as the Government spends separately on these an arrangement of the same is organized at community level, not at individual level.

UHC scheme should mandatorily consist of primary health cover, a secondary cover (similar to the existing RSBY scheme) and a critical care cover (similar to state level schemes).

The provision for Primary care including outpatient (OPD) coverage is proposed to be included in the secondary cover which would help in reducing out of pocket expenditure by an individual. It would also help in providing for preventive and promotive care at primary health care level thereby reducing cases for secondary and tertiary care. The tertiary cover would only be utilized upon referral from a secondary cover hospital. The tentative contours of coverage for the proposed scheme are as follows. To keep the scheme affordable for the Government and available for all, limits to UHC package at secondary and tertiary cover are proposed, however with provision to replenish if need be. This would also ensure that over consumption of care at higher level shall be contained/ discouraged.

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<td>• No limit, to be organized by linking through public health facilities, government programs and community outreach.</td>
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| **Secondary care Cover (Outpatient and Secondary Coverage)** | • Hospitalization cover of INR 60,000 per annum for all common ailments including surgical interventions with minimal exclusions.  
• Outpatient cover (OPD) to include up to 10 free visits to a qualified doctor in a year. This shall cover consultations and medicines.  
• Pre-defined list of diagnostics (not involving high end diagnostics e.g. oncology, heart etc. which are covered in Critical Care cover) available for 5 times in a year  
• Pre-defined day care procedures  
• No co-payment  
• All pre-existing diseases to be covered  
• Transportation costs (actual with maximum limit of INR 100 per visit) within an overall limit of INR 1000 (this is excluding the visits for OPD) |
| **Critical care cover (Tertiary Coverage)** | • Cover up to INR 2,00,000 per annum  
• All inclusive package charges for medical and surgical interventions for only selected Critical Care tertiary procedures for Cardiovascular diseases, Cancer treatment, Neurological diseases, Renal diseases, Poly Trauma cases, Serious neo natal cases etc.  
• To include all pre-post visits related to the defined list and as referred by the secondary care cover hospitals  
• Include follow up treatments  
Diagnostics cover to include all relevant tests related to the defined list  
• Pre-defined day care procedures for critical care cover  
• Medicines included in the all-inclusive package charges for the listed disease  
• No co-payment  
• All pre-existing diseases to be covered |
| **Replenishment of the cover** | • In case the coverage amount is exhausted by the insured member(s) during the policy period, the total coverage amount can be replenished to the original coverage amount by paying an additional premium |
Financial implications

At present the Government of India and State Governments are running disparate schemes for healthcare e.g. RSBY, Arogyashri, Tamil Nadu Health scheme, CGHS, ESIS, programs like NRHM etc., all running parallel to each other, often duplicating efforts and scarce resources. It is necessary that all schemes are brought under one umbrella for efficient pooling and management. The proposed model fits quite well with Government of India’s intent to increase health spend from 1.1% to 3% over a period of 10 years. On a rough estimate, incremental expenditure for performance based primary care shall be around Rs.500 per family while the insurance premium per family for secondary + tertiary care package shall be less than Rs.900 per family if the entire nation was to be covered.

It is for the Government of the day to consider whether all citizens should be given free cover or those having the ability to pay, should pay self, albeit at much affordable prices than prevailing presently. The CII paper proposes funding of the base UHC package for poor/vulnerable entirely by the Government and part funding by self, for people having capacity to pay. The paper also suggests implementation strategies for various segments of the population. The CII Proposes a composite and hybrid model based on following tenets for implementing UHC in India faster and efficient manner with utmost economy.

To make UHC sustainable, the hybrid model proposes that people having the willingness and ability to pay should contribute/pay for the secondary and tertiary coverage. However with high degree of pooling and mandatory nature of cover for nearly 50% of population to begin with, it is expected that the insurance premium shall be more than affordable for self-paying people. The report suggests strategies, ways and means to enrol people on voluntary basis till the time legislative backing is available to enforce mandate for everyone.

Role of Insurance

Critics of insurance often cite imperfections of the insurance market as main reasons for opposing the insurance route. However, in the Indian context, the ailing public health system cannot be expected to achieve 100% efficiency and deliver results overnight. The use of Health Insurance would help in expanding coverage and large-scale operationalization, besides providing a financing mechanism. The technical, actuarial and operational capabilities of insurance industry in member enrolment, provider empanelment, controlling cost & fraud, abuse etc. are well established and must be utilized. It can supplement the Government machinery (as happening in case of RSBY and state government schemes), under the watch of a Regulator. Health insurance has already been brought under extensive Health Regulations by IRDA in 2013 to ensure fair play for consumers and all other stakeholders.
The advantages of hybrid model

- Better health outcomes with exclusive focus on primary care by public health system (roping in private practitioners/providers wherever need be)
- Rational and necessary use of higher care
- Advantage of pooled purchasing and lower costs
- Harmonization of disparate schemes, covers and private health insurance
- Leveraging operational capabilities of insurance industry and higher insurance penetration
- Investible funds and channelling of savings etc.

It will also help in driving quality of care as the payers will be able to set parameters and enforce them.

UHC – Success Factor

Needless to mention, for a successful roll out and for maximising health outcomes at low cost, the overall eco system has many other important pillars underlying the super structure. The success of hybrid model – on cost, outcomes and accessibility hinges on addressing certain critical issues:

- Cashless access to all care
- Free medicines/drugs for all, provided at Government outlets/empanelled pharmacies
- Oversight by Health and Insurance Regulators, Clinical Establishment Act, effective governance at joint level, Standard Treatment protocols, Clinical Pathways, Gate keeping and Referral Guidelines with alignment of incentives & payments
- IT enabled management and integration, Care Co-ordination, standard coded data exchanges, electronic health records, portability of cover across levels/providers/locations
- Pooled purchasing and uniform rational pricing of care with defined and measurable quality and performance parameters, alternate provider payment mechanisms – capitation, case based.
- Capacity building, community involvement, robust grievance redressal platform, dissemination of health outcomes and results.

For easy and accelerated rollout of UHC, it is proposed that the government makes use of existing governance and regulatory mechanisms, strengthening the same where needed.
Conclusion

The above proposed model of supply side funding along with demand side funding has been tried successfully in recent years in many countries at similar trajectory like Thailand, Philippines, Vietnam, China and Indonesia in Asia and Rwanda, Kenya and Ghana in Africa. The advantage of the proposed model is that without waiting for structural changes, Regulative and improvements in the healthcare systems, which need to be addressed simultaneously, hybrid model draws upon existing resources and capacities and stitches together the framework with necessary checks and balances. Based on these experiments and India’s own particular situation CII is confident that India, can implement its own unique low cost UHC model which offers best value for money for all stakeholders and the time is for the same right now.
2 Introduction

Over last several decades, most of the countries in Asian and African regions have been working towards providing healthcare provisions to the informal and poor segments of their population through supply side mechanisms. This has been considered as the standard approach where government sets up and maintains healthcare facilities and provides healthcare through them. This form of financing is basically tax funded.

However, during the past decade, a number of these countries have undertaken reforms which are aimed at expanding health coverage through “demand-side” (third-party) financing models. These countries are now utilising various demand side financing mechanisms like Health Insurance, Capitation Fee for service, etc. to provide health coverage to their citizens. Prominent among these countries are Thailand, Philippines, Vietnam, China and Indonesia in Asia and Rwanda, Kenya and Ghana in Africa.

In India, since independence, healthcare is financed through various sources, including individual out-of-pocket payments, Central and State Government tax revenues, external aid and employers. If we define it technically then till few years ago India’s health financing system could be categorized as supply side health financing where the Government was providing healthcare funded through general taxation. However, repeated studies have shown that in spite of free public health system, people are spending a lot from their pocket. This is also due to the fact that the share of Government in total health expenditure in India is very less. It is estimated that the Government spends accounts for about 22% of the total healthcare spend in the country. More than 60-70% of the health expenditure comprised of un-pooled, out-of-pocket expenditures. This compares adversely with the world average of 16% out-of-pocket expenses and 32% government spends within the total healthcare expenditure. India stands quite low when compared to both developed and developing countries.
To increase the share of Government spending in total healthcare and reduce the imbalance between Private and Public spending, the Government of India is targeting to increase its spending on healthcare from the current 1.1% of GDP to approximately 3% of GDP.

Though this ambitious target will result in significant increase in budget for healthcare, the increase in spending is not a solution by itself. There are indeed limitations in the absorptive capacity of the public healthcare system, and the concern that additional funds may get absorbed in the system without corresponding visible results. Although the Government aims to provide free healthcare services to India’s poor through Government-owned healthcare delivery chain, studies have shown that people continue to spend considerable amounts on treatment even in Government hospitals. People are often obliged to take out loans or sell assets to pay for the medical care they need, as a result many fall below the poverty line. NSSO and other surveys have shown that 64% of the poorest population in India gets indebted due to inpatient related expenditures at the hospitals.

### 2.1 Vision for Universal Health Care in India

With the above backdrop, the Government of India is now working seriously on defining a vision and roadmap for Universal Health Coverage (UHC) in India. If we analyze the draft version of the health chapter of the 12th five year plan and the High Level Expert Group (HLEG, set up by Planning Commission) Report on UHC, they have defined Universal Health Coverage as:

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1 Forbes November 2013
“Ensuring equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider of health and related services.”

To provide UHC to every citizen of the country by 2022 (in less than 10 years from now), HLEG Report has further given following vision of UHC:

*Figure 2.2: The vision of UHG as given by HELG Report*

Even before the 12th Five Year Plan document was unveiled or HLEG was set up, several Government health insurance schemes had been launched for the poor and vulnerable sections to complement (not substitute) public health system. The objective of these efforts was to test a demand side financing model to provide healthcare. We can, thus, see that there is a focus emerging on moving towards a demand side health financing system which is complemented by strengthening of the Government healthcare facilities. Whether established as stated policy of the Government or not, there appears to be a preference/intent on the part of Central and various State Governments to take the route of demand side financing for providing healthcare coverage to certain extent.

Currently several schemes are being run in isolation, and although successful individually, they are not able to derive synergies from each other. For example, schemes like Rajiv and Vajpayee Aarogyasri are providing assistance for critical care but only providing benefits in the states of Andhra Pradesh and Karnataka respectively. These schemes are working separately from national level schemes like Rashtriya Swasthya Bima Yojana (RSBY) which provides benefits more towards secondary cover. Schemes like Central Government Health Scheme (CGHS), Employee State Insurance Scheme (ESIS) provide coverage to Government employees and workers in the formal sector respectively. Thus currently we have a situation wherein some people are covered for some benefits, few others are covered for more liberal benefits, however, majority of population is still uncovered and there is practically no coordination among various schemes to draw pooling advantage.

In very simple terms, the move towards UHC from present status is depicted in following cube, developed by the World Health Organization (WHO). *(Adapted from the World Health Report 2008)*
Hence, there is a need to develop a cohesive strategy as to how best to cover the entire population and to develop a vision for Universal Health Care in India which builds upon current health insurance schemes and public healthcare system, to strategize about how each citizen of the country belonging to different segment of population will be covered under UHC, how best to finance the coverage, deliver healthcare in an efficient manner and define the requisite extent of coverage etc. based on the population segments. Understandably such a transition journey can neither be made in one go, nor by a single entity even if it is the Government.
To undertake this herculean effort many important decisions need to be taken by the Government, among which major ones are given below:

2.1.1 **From Voluntary to Mandatory Coverage**

At present Indian citizens do not enjoy access to health as a fundamental right and health insurance in India is purely voluntary for most of the categories of population. As India moves towards UHC, the position needs to change to mandatory cover irrespective of how the cover is organized, who delivers care and who pays for the cover. It can be the Government which pays for the poor or it is paid for by the citizens themselves who have the capacity to pay, etc.

Even though mandatory, it would not be easy to cover the entire Indian population as we shall examine in later sections; coverage in terms of population would only be gradual. However, it is possible to achieve near universal coverage in the next 10 years in India by adopting a hybrid model that builds on existing strengths, facilities, manpower, and infrastructure while simultaneously efforts need to be made to strengthen other areas, especially primary healthcare.

2.1.2 **Defining a Basic Package for UHC**

It is widely recognised that a basic package needs to be made available to all citizens. In addition to the basic cover, citizens can always take additional cover as per their requirement. An important question in UHC is the extent of basic coverage which should be provided to the population of India.

No country in the world can provide comprehensive coverage to everyone; however, to achieve true universal coverage, the package should make available all levels of care – Primary, Secondary and Tertiary. By its very nature, primary care is also linked with issues like safe drinking water, sanitation and nutrition which may not necessarily be made part of the basic package as the Government spends separately on these and arrangement of the same is organized at community level, not at an individual level.

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| **Secondary care cover**      | - Hospitalization cover of INR 60,000 per annum for all common ailments including surgical interventions with minimal exclusions.  
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2.1.3 Funding of UHC

The lessons learnt from other countries and also from the Indian context of limited resources and tax raising ability, very high share of informal workers/poor along with an increasing middle class, warrant that even though conceptually UHC ought to be free for all citizens, it is neither sustainable nor desirable. No country in the world has been able to do that, as it would have serious implications on cost escalations and over consumption of unwarranted care. It would much rather serve the purpose if healthcare funding remains affordable both for the Government and for citizens in both short and long term. Therefore, it is proposed here to make the UHC package mandatory, available and affordable to all citizens.

Thus, people above poverty line, self-employed and employed in the formal sector shall contribute/pay for secondary and tertiary level cover while the Government shall pay for providing cover to the poor and vulnerable sections. Primary healthcare shall continue to be available free of cost to all in public health facilities or facilities by empanelled providers. In the areas where Government facilities are not available or working properly, the Government can engage private healthcare providers and pay them for services.

Creating a self-paying segment alongside the Government funded segment is also desirable from the perspective of making the delivery system more accountable and responsive. A self-paying customer is always more demanding than a beneficiary who receives benefit free.

Adopting the above funding pattern for the universal coverage would ensure that the financing of UHC is affordable and within the budgetary projections, and high level of attention and funds are spent on primary care while cover for secondary and tertiary care is made affordable through insurance pooling. The Financing section of this report deals with projected costs for 3 levels of cover.

2.1.4 Leveraging UID enrollments to create a common data base

Currently there is no common database capturing health insurance/health schemes coverage for the entire population. However, going forward, a
provision for capturing health cover details can be done by linking this information with the Unique Identification (UID) database of Government. This would go a long way in implementing UHC as different agencies would be able to track the population without any health cover and extend the coverage to them.

To achieve creation of a common database, insurance companies may be asked to include the UID number in the health insurance schedule. This needs to be done at the time of enrolment of the scheme or at its renewal. List of health cover details along with the UID number can be forwarded to a proposed national level agency called Universal Health Care Agency. This agency, in turn will create a common repository of the population enrolled under health insurance/ schemes. This will also facilitate tracking specific segments of population which need to be provided a basic health cover on priority and may require significant Government interventions. Gradually this repository is expected to become a comprehensive database of the health coverage details for the entire population. In the long run, this would also be a crucial step in providing UHC as it would provide a single source for validating provision of health cover for entire population.

In addition, this mechanism will also facilitate creation of a robust technology backbone that will allow portability of the health cover benefits especially for those segments which are prone to frequent migration such as agriculture sector labour force.
3 Population segmentation towards operationalization of UHC

To ensure effective reach for UHC, it is important that the country’s population is categorized into identifiable and reachable segments. Segmentation is also the key to identify the categories for which costs would need to be subsidized by the Government. By the segmentation we can also identify sections of population, which are employed in the formal sector, are self-employed etc., which have the ability and willingness to pay. An effective segmentation will enable prioritization of those segments where access to subsidized health cover is urgent need of the hour. It will further help to build strategies to target penetration of UHC to more than 90% of the population in the next 10 years.

The method of segmentation, which has been adopted by most of the developing countries, is income based segmentation. However, only one criterion for segmentation may not be effective in a country of India’s diversity and societal dynamics. In India, employment provides another important metric for identifying the vulnerable sections of the society. Hence, a two-tier segmentation approach based on income and employment has been suggested for the Indian population.

The first level of segmentation is proposed to be conducted on the basis of income. The segment of society which falls below the poverty line (BPL)/poor is highly vulnerable and unlikely to afford the costs associated with medical treatments on their own income and as such should be covered by the Government at the earliest. In addition to the poor there are some other vulnerable population groups such as senior citizens without family and differently-abled people, which require support and should ideally be covered through some special funding means. For the group above poverty line (APL)/non-poor, a second level of segregation can be conducted based on their type of employment - into the Formal, Informal and Agricultural Sector employees. Their dependents can be further brought under the ambit of UHC ensuring an effective coverage of the employed labour force.

The breakup of the Indian population based on the suggested segmentation is shown in the following diagram.
Figure 3.1: Segmentation of Indian population (all segments include individuals and direct dependents except for Special Category)

For the purpose of analysis of various segments, an individual along with his/her direct dependents are considered. The direct dependents are defined as children and parents (if below the age group of special group category) of the head of the family and spouse. Additionally, individuals in Special Group category are excluded from being considered as dependents from this analysis since a specific strategy is being outlined to take care of this segment. As per the census data, average household size in India is 5.3\(^2\). In the segmentation analysis, family size of 5 is considered to exclude the effect of special group category.

The subsequent sections detail the possible strategies for covering each segment.

\(^2\) Census of India, 2011 data for total population 1,210,193,422; Indian Readership Survey data of estimated number of households at 228,183,000
3.1 Poor and Special Groups Categories

Current Status

With around 29.9%\(^3\) (35.6 crores) of the Indian population belonging to the BPL category\(^4\), the Government has already started providing health insurance coverage to them through Government sponsored health insurance called Rashtriya Swasthya Bima Yojana (RSBY) with INR 30,000 inpatient cover. At present, there are ~ 3.75 crore families\(^5\) enrolled under the RSBY scheme. The premium is subsidized by the Central and State Government. Each BPL family pays INR 30 per family per year as a registration fee with the premium amount subsidized by the Governments. Smart card-based enrollment has made benefits portable across India. There are few state-level schemes providing tertiary care cover to poor and defined vulnerable sections e.g. Rajiv Arogyasri in Andhra Pradesh and Maharashtra, Vajpayee Aarogyasri in Karnataka, Chief Minister’s health insurance scheme in Tamil Nadu etc.

Special groups include the senior citizens and differently-abled persons and they make up ~9.46%\(^6\) of the Indian population (excluding those who form a part of BPL category). Although vulnerable, they are currently not covered by any nationwide special health coverage.

There are a few schemes that provide health cover to senior citizens, however, such schemes are very limited for example, Gwalior Municipal Corporation (GMC) and Indore Municipal Corporation (IMC) initiated a special healthcare scheme (secondary care) providing for hospitalisation expenses of up to INR 20,000 targeting senior citizens from financially weak backgrounds (aged 60 – 80 years). The premium payment is fully subsidized by GMC/IMC.

3.1.1 UHC Strategy - Poor Segment

Providing fully subsidized health cover to poor segment through the Central Government scheme RSBY and few State level tertiary schemes is a step in the right direction. The proposed UHC package covering primary, secondary and tertiary care is next desirable step for this segment and focus should continue on increasing enrolment and increasing penetration of subsidized health cover in this segment. The primary care will continue to be provided free of cost through public health facilities and Government programs and its delivery will be ensured by strengthening Public health systems.

For enrolling this category, a process of identification and enrolment exists already under different schemes. These schemes should be synergized and

\(^3\) Household Consumer Expenditure Survey for 2009-10
\(^4\) As per the Planning Commission’s affidavit in the Supreme Court in October 2011 the BPL cap has been pegged at an expenditure of INR 32 per day and INR 26 per day by an individual in the urban and rural areas respectively at current prices in 2010-11
\(^5\) RSBY website: [www.rsb.gov.in](http://www.rsb.gov.in) accessed on December 01st 2013
\(^6\) CIA - World Factbook (2009 est.), News Articles, KPMG Analysis
coordinated with the UHC package thereby replacing separate standalone schemes.

3.1.2 UHC Strategy - Special Groups Segment

For the special groups like senior citizens and differently-abled persons, a separate fund could be created which will take care of the healthcare needs of this segment. This fund will directly pay for the healthcare expenditure to the healthcare providers and will focus on the disease management concept on the lines of managed healthcare. Alternately insurance companies can be supplemented for outgo above actuarial limits by the Government through special pool fund.

Moreover, this segment will be provided fully subsidized UHC package. A higher coverage limits may be considered keeping in mind the needs and higher risk in this group.

3.2 Non-Poor Category

Out of an estimated 60.64% of Indian population in the APL category, it is estimated that approximately 33.5% of Indian population are ‘dependents’/non-earning members in this category. Any effort to bring this category under the ambit of the UHC would require an effective coverage of the employed/earning members of the population in this category. Hence, a second level of categorization can be done on the basis of employment.

3.2.1 Agriculture Sector

**Current Status**

Although, this category makes up ~28.5% of the Indian population (34.19 crores), currently a concerted nationwide effort to cover the agricultural sector labour force is not in place.

Though there are State level schemes such as Yeshasvini in Karnataka that have been launched to reach out to the agricultural sector labour force, they don’t have extensive coverage due to various limitations. For example Yeshasvini requires that a person should be a member of Rural Co-operative Society of the State for a minimum period of 6 months.

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7 Report on Second Annual Employment & Unemployment Survey 2011-12, Ministry of Labour and Employment, Government of India
8 Report on Second Annual Employment & Unemployment Survey 2011-12, Ministry of Labour and Employment, Government of India
9 Report of the Committee on Unorganised Sector Statistics, National Statistical Commission, Government of India, February 2012 (About 99.2% of agricultural workers were reported to be unorganized and unprotected in Census of India, 2011)
**UHC Strategy**

People in this category can be classified primarily into owner cultivators and agricultural wage earners. Frequent migration of people in this category is a major challenge which has to be considered for the formulation of strategy for this segment. It is, therefore, imperative to increase the penetration of the health insurance in this segment through voluntary enrollment by creating awareness. Some of the possible mechanisms for covering this category are as follows:

- Various Co-operative Banks, Regional Rural Banks and Commercial Banks had issued ~10.4 crore Kisan Credit Cards (KCCs) cumulatively as on 31 March 2011. Banks are also working as distribution intermediaries of the insurance companies. Insurance companies have been asked to open branches in all areas with population more than 10,000. These banks, insurance companies and other intermediaries like NGOs, cooperatives etc. can act as agents for increasing penetration of UHC package. There could be innovative methods of implementation like bundling health policies with the KCCs, banking products for ease of execution.

3.2.2 **Informal Sector**

**Current Status**

As per the Report of the Committee on Unorganised Sector Statistics, the informal sector/unorganised sector consists of all unincorporated private enterprises owned by individuals or households engaged in the sale and production of goods and services operated on a proprietary or partnership basis and with less than ten total workers.

Informal sector comprises of informal employment encompassing all the jobs included in the concept of employment in the informal sector except those which are classified as formal jobs in informal sector enterprises. Such jobs generally lack basic social or legal protections or employment benefits and may be found in the formal sector, informal sector or households.

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10 Report on Trend and Progress of Banking in India 2010-11, Reserve Bank of India
11 Informal employment includes the following types of jobs:
   i. Own-account workers employed in their own informal sector enterprises
   ii. Employers employed in their own informal sector enterprises
   iii. Contributing family workers, irrespective of whether they work in formal or informal sector enterprises
   iv. Members of informal producers’ cooperatives
   v. Employees holding informal jobs in formal sector enterprises, informal sector enterprises, or as paid domestic workers employed by households
   vi. Own-account workers engaged in the production of goods exclusively for own final use by their household, if considered employed given that the production comprises an important contribution to total household consumption
The informal sector labour force along with their dependents comprises ~26.75\%\textsuperscript{12} of the Indian population and is the section of Indian society which is the hardest to reach and enroll and from which it is most difficult to collect premium. This sector can be again categorized into self-employed population and informal sector employees. Only a small portion of this segment pays income tax or makes contribution to provident fund and therefore is the most difficult segment to track.

At present, certain NGOs have been working in a few districts providing voluntary healthcare cover to informal sector workers such as Antodaya in Orissa and Arthik Samata Mandal (ASM) in Andhra Pradesh. The schemes are subsidized with a small contribution from the target group (ranging from INR 25 – INR 75). However, such schemes suffer from limited reach and dependence on financial assistance from funding agencies. In addition, the cover provided is fairly inadequate ranging from INR 1,000 – INR 2,000 for hospitalisation costs. Thereby, there is a need to provide mandatory UHC cover to such a segment through Government interventions.

The Central Government has recently extended RSBY scheme to cover families of persons working in unorganised sector such as Street Vendors, Beedi Workers and Domestic Workers, rag pickers, rickshaw pullers, taxi and auto rickshaw drivers, miners, sanitation workers and toddy workers in addition to Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) beneficiaries.

Currently there are 4.48 crores households\textsuperscript{13} enrolled under MGNREGA. Excluding the families in the BPL segment (which are already planned for enrollment under RSBY scheme), an additional ~ 12.4 crores individuals will be brought under the purview of the RSBY scheme.

There are various Boards under which workers in certain industries are issued identity cards, registered. There are more than 45 lacs beedi workers\textsuperscript{14}. The number of domestic workers has been estimated at 55 lacs\textsuperscript{15} while estimated figure of street vendors in India is over 1 cores\textsuperscript{16}. Building and other Construction Workers are also there in large number and it has been estimated that ~ 1.8 crores construction workers\textsuperscript{17} work in the informal sector.

**UHC Strategy**

A basic level of coverage including primary, secondary and tertiary care as proposed under UHC package should be provided for this section. Identification

\textsuperscript{12} Report of the Committee on Unorganized Sector Statistics, National Statistical Commission, Government of India, February 2012
\textsuperscript{13} MGNREGA Briefing Book, January 2013
\textsuperscript{14} Ministry of Labour, Annual Report 1999-2000; ILO ‘s Pilot Action Project for Beedi Men Women Workers in India, 2003
\textsuperscript{15} Report on Employment & Unemployment Survey (2009-10), Ministry of Labour and Employment; ILO analysis of the micro-data of the 2004-05 Employment and Unemployment Survey (61st Round), National Sample Survey Organization (NSSO) of India; KPMG Analysis
\textsuperscript{17} National Sample Survey Organization (2004-2005); Report of the Committee on Unorganized Sector Statistics, National Statistical Commission, Government of India, February 2012; KPMG Analysis
of beneficiaries is already done to large extent as explained above. This scheme can be gradually expanded to cover the persons working in the vulnerable occupation groups in the informal sector. The scheme will cover the person along with the family members (dependents) bringing in larger portion of the population under UHC.

- **For informal workers who are self-employed:**
  - Self-employed persons in the informal sector and their dependents form almost 11.08%\(^\text{18}\) of total population of India (13.29 crores). Their coverage under UHC can be increased through the enrollment process for Unique Identification Project (UID) where the details of the specific category of people are captured at the back-end. The data will be shared with the insurance companies which will be responsible for reaching out to this segment to create awareness and enrolling them for the UHC package.

- **For other informal workers:**
  - Efforts need to be made to include all informal workers under various welfare trusts and boards as explained above by the Government. These boards will act as facilitators between the beneficiaries and the insurance companies empanelled for UHC enrollment in particular districts.

In addition to above, this segment can be covered through:

- National Skill Development Corporation (NSDC) has a target of skilling/upskilling 15 crore people by 2022\(^\text{19}\). As most of the people that would be trained belong to this category, they can be made to enroll for a Government subsidized UHC package as part of the training program. This will facilitate provision of subsidized UHC package in the first year after which they can be enrolled under the mandatory health cover provided by the employer once they seek employment. The details of the trained individuals can be provided to the Health Sector Skill Council for tracking the administration of the base cover.

\(^{18}\) National Sample Survey Office (NSSO), KPMG Analysis

\(^{19}\) National Skill Development Corporation (NSDC) website, [www.nsdicindia.org](http://www.nsdicindia.org)
3.2.3 Formal Sector

Formal sector\textsuperscript{20} covers \(\sim 5.41\%\)\textsuperscript{21} of the population and depending on the ownership of the company this segment is also typically provided health benefits. For example, people working in the Government sector are provided health benefits under central/state health schemes while people working in the private sector may be provided health insurance plans for self and/or dependents. People working in the formal sector can be categorized into the following segments:

3.2.3.1 Government Sector

\textbf{Current Status}

Employees who are working in the Government sector along with their dependents form 3.4%\textsuperscript{22} of the population. They are at present covered with some kind of health insurance cover, although there are variations in the nature of coverage and quality of services provided. In most cases a small amount is deducted from the salary which goes towards the contribution of the employee towards the health coverage.

Following sub-segments can be identified for this category:

- **Central Government Employees** – Central Government employees and their dependents form 0.56%\textsuperscript{23} of the population. People working in the Central Government are covered by Central Government Health Scheme (CGHS) where they get a comprehensive coverage which includes both out-patient and in-patient benefits.

- **State Government Employees** – State Government employees and their dependents form 1.34%\textsuperscript{24} of the population. Every State Government provides certain level of healthcare benefits to their employees. E.g. Andhra Pradesh

\textsuperscript{20} Formal/organized sector covers those enterprises of work where the terms of employment are regular and where people have assured employment. It is registered, follows Government rules and regulations, and has employees and employers union. It offers job security, paid holidays, pensions, health, fixed working hours, extra pay for overtime work, medical and other allowances, gratuity, superannuation, provident fund, and various other benefits. Definition from Economics by National Council of Educational Research and Training (NCERT)

\textsuperscript{21} KPMG Analysis

\textsuperscript{22} Economic Survey 2010-11, Statistical Appendix

\textsuperscript{23} Census of Central Government Employees 2011; KPMG Analysis

\textsuperscript{24} Economic Survey 2010-11, Statistical Appendix; KPMG Analysis
Pradesh (AP) State Government provides Rajiv Aarogyasri Health Scheme for AP Government Employees and Pensioners in the State with no limit on expenditure through cashless model while Tamil Nadu (TN) State Government provides financial assistance up to INR 4 lacs per family through cashless model.

- **Government Companies** – Employees in Government companies and their dependents form 1.34% of the population. Employees working in Government owned companies are provided health coverage which is generally either through partner hospitals or through reimbursements.

- In addition, under Employees’ State Insurance Scheme of India (ESIS) people working in non-seasonal factories employing 10 or more persons, shops, hotels, restaurants, cinemas including preview theatres, road-motor transport undertakings and newspaper establishments employing 20 or more persons and having income level below specified benchmarks (INR 15,000 with effect from May 1, 2010 and INR 25,000 for an employee with ‘disability’ with effect from April 1, 2010) are required to be provided health coverage through employee and employer contribution (under present rate of contribution the employer’s contribution is 4.75% of wages payable to an employee while an employee’s contribution is 1.75% of the wages). A beneficiary can avail the medical benefits from any ESI dispensary/hospital across the country. As on March 31, 2011, 1.63 crores employees were covered under this scheme.

**UHC Strategy**

- As per the prevailing practices, varying level of health coverage is being provided to employees (along with their dependents) working in the Government sector. Current health cover schemes under CGHS and various State Governments which already provide comprehensive coverage can be retained. The Central Government is also proposing to introduce health insurance scheme for the central Government employees and pensioners known as Central Government Employees and Pensioners Health Insurance Scheme (CGEPHIS). It will provide coverage through a health insurance cashless model and will, in the long term, replace existing CGHS scheme for inpatient treatments. Existing employees and pensioners will be provided an option to switch from CGHS to CGEPHIS.

- The existing schemes should provide coverage as proposed under UHC package with secondary and tertiary coverage (if not included yet). Secondly, even though providing different level of benefits, ESIS and CGHS schemes need to draw upon each other’s capacity, facilities and infrastructure.

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25 Economic Survey 2010-11, Statistical Appendix; KPMG Analysis  
26 Employees’ State Insurance Corporation – Frequently Asked Questions on ESI Scheme  
27 Employees’ State Insurance Corporation of India website: [http://esic.nic.in/](http://esic.nic.in/)
3.2.3.2 Private Sector

Current Status

Employees in the formal private sector along with their dependents form 2.01% of the population\(^\text{28}\). People working in the private sector are not always provided with healthcare benefits. Even in companies where health cover is provided, the extent of coverage and the spectrum of associated benefits vary significantly between companies.

UHC Strategy

The UHC package defined by the Government may be mandated as the 'base-level' benefits which are mandatorily provided to all the employees and their dependents by the private sector. Ministry of Labour and Employment can issue the directive to make base level mandatory by the employers. Beyond the base level of the UHC package, companies may offer additional benefits to the employees as per their choice. The premium for this can be paid by employer and employee contribution.

The companies can provide annual disclosures to the Nodal Agency regarding insurance details of employees (including dependents) to track the coverage being provided to the employees.

3.3 Phased coverage of the population

Through sustained efforts, the coverage of India’s population will be increased in phases wherein the citizens will be covered under the proposed base-level UHC package. To cover such a large spectrum of Indian population it will be important to chalk out an implementation plan across different segments and enable provision of health cover to people.

Figure 3.2: Implementation plan for phased coverage of the population

Current State
~ 25-26% coverage

The current coverage includes the population covered by health insurance, RSBY, Government employee insurance, State insurance and ESIC.

After 2-3 years
~ 38-40% coverage

Increased penetration through mandatory health coverage in informal sector, poor category and formal sector including Government and Private sector. Special category segment will also start getting enrolled in the health coverage schemes.

After 5-6 years
~ 60-62% coverage

Increase in coverage by getting poor category under the fold of mandatory health cover; increase in the voluntary cover adoption by self employed people in informal sector and people in agriculture sector.

After 8-10 years
~ 75-77% coverage

Improved adoption of health cover by informal sector such as self employed people and people in agriculture sector. Reach will further be improved in special category segment.

Beyond 10 years
Over 90% coverage

With improved database capturing details of citizens and mass awareness and enrollment efforts, a large segment of India’s population will be covered with at least a basic health cover.

\(^{28}\) Economic Survey 2010-11, Statistical Appendix; KPMG Analysis
Insurance industry can be effectively utilized to increase coverage of the population, which has been demonstrated in implementing the RSBY scheme. In implementation of the RSBY scheme, there was a need for covering BPL population in rural areas at remote locations and on an immediate basis. A biometric smart card process provided an effective technology-based solution resulting in increased efficiency of enrolments. Experience and strategic planning of insurers in carrying out enrolment and innovations brought in by them in the process has resulted in enrolment percentage increasing from 44% in first year of RSBY operations to 70% last year as shown in the table below.

*Figure 3.3: RSBY enrolment conversion year on year*
4 Implementation Model

While there is a general consensus on the need to provide Universal Health Coverage to every citizen of the country, there is much debate and discussion on the route and model for its implementation. In the backdrop of partially effective functioning of the public health system and large presence of private healthcare providers, this paper proposes a hybrid model which on the one hand combines the resources and strengths of both to provide for the health needs of country and at the same time provide the most cost effective solution. The proposed hybrid model also takes into account that an implementation of this scale and complexity cannot rely on one agency, neither the public sector systems which are prone to inefficiency and other systemic issues nor the private sector which is prone to profiteering and sometimes questionable practices. It is to be noted that health insurance in Indian context is proposed as a means of extending coverage and not for the purpose of financing primarily.

At present, in addition to the public healthcare system and special programs like National Rural Health Mission (NRHM), Janani Suraksha Yojana (JSS) etc., the Government is also using insurance companies for implementing health insurance schemes of the Government like RSBY and State schemes of Tamil Nadu and Maharashtra. Barring a few issues, these experiments have been quite successful and the insurance industry has risen up to the challenge. It has partnered with the Government to make secondary and tertiary care accessible to poor/other defined segments of population.

In addition to providing health insurance coverage to the targeted population these schemes have also been able to improve quality of care through standard treatment guidelines, quality initiatives and scientific costing methods.

The proposed model builds further on the same and envisages delivery of primary health, primarily through public health system and secondary and tertiary care from both private and public health facilities under insurance mechanism.

4.1 UHC Package delivery – through public health system and health insurance

Though inadequately staffed and funded, public health system is present all across the country to offer first level of interaction and primary care services. There are issues of efficiency, lack of presence of doctors at PHCs, lack of all the necessary medicines etc. in the Government primary care providers. Therefore, it will be important to design appropriate incentive structures so as to bring pay-for-performance mechanism. Additional financial and non-financial incentives will need to be provided to make the system more effective and accountable.

Large presence of private providers in secondary and tertiary care makes a fit case for utilisation of such facilities alongside Government public healthcare facilities for primary care to offer complete continuum of care to population at
Due to principal agent relationship and business model insurance mechanism is most suited for delivery of secondary and tertiary care.

The table below is an indicative list of services which can be covered through insurance mechanism and those which shall be provided by the Government through public health facilities. *( Adapted from IPH UHC Operational Manual for the States in India)*

<table>
<thead>
<tr>
<th>Preventive Services</th>
<th>Provided by Government</th>
<th>Curative Services</th>
<th>Covered by Insurance</th>
<th>Promotive Services</th>
<th>Provided by Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal care</td>
<td>√</td>
<td>Outpatient care</td>
<td>√</td>
<td>Safe drinking water</td>
<td>√</td>
</tr>
<tr>
<td>Immunization</td>
<td>√</td>
<td>Emergency services</td>
<td>√</td>
<td>Nutrition services</td>
<td>√</td>
</tr>
<tr>
<td>Screening for specific diseases</td>
<td>√</td>
<td>Inpatient services</td>
<td>√</td>
<td>IEC services</td>
<td>√</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>√ √</td>
<td>Delivery services</td>
<td>√</td>
<td>Tobacco control</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CEmOC services</td>
<td></td>
<td>Sanitation</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ICU services</td>
<td>√</td>
<td>Counselling</td>
<td>√</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow-up Care</td>
<td>√</td>
<td>Anti-vector measures</td>
<td>√</td>
</tr>
</tbody>
</table>

A detailed illustrative list of Preventive and Public Health Interventions funded and provided by the Government has been given in the draft chapter on Health of the 12th Five Year Plan (refer to Annexure at the end). Assuming that the Government focuses its attention and resources on such services, the public health system’s capabilities, and delivery shall have far reaching positive impact on health outcomes.

The above UHC implementation model draws upon available capacities of:

- both public health systems and insurance industry in operational management of the scheme

- both public and private healthcare providers for delivery of health at different levels of care

for immediate roll out of UHC parallel to the process of revamping and building further capacities to meet shortages of beds/ doctors/ trained nurses and ancillary staff, technology and infrastructure etc. Not only is UHC about financing of healthcare but also about making efforts towards improving both quality and quantity of human resources for it. Together they will determine the success of this initiative in the long-term.
4.2 How will the scheme work

4.2.1 Covered Unit

Family shall be the unit of cover for the scheme and UHC package shall be available to the entire unit as a whole. Any of the enrolled persons in the family can avail of the benefits of the scheme. Once the family is defined as head of the family, spouse and immediate dependents, there is no need to define a family size for UHC. Those members who are not covered within the definition of family can be included in the scheme with the payment of extra premium.

The scheme will operate at all 3 levels of care, empanelling all eligible facilities in public and private sector. Though may be not in a very initial level, but eventually the 3 levels would act as gatekeepers and referral point for the next level of care. The incentives and protocols shall be aligned in a manner that over utilization of care at higher levels is avoided and it is expected that Government’s sole attention to primary health system, preventive and promotive care along with other determinants of health would lead to lower need for secondary and tertiary care and focus shall shift from inpatient care. Evidence from many countries such as Thailand and Turkey has also shown that with the successful implementation of UHC program, unnecessary movement towards higher level healthcare providers decreases and more people start accessing primary care centers as the first point of contact.

It is envisaged that with the roll out of UHC, existing disparate schemes and systems of the Government, various agencies shall merge into one model of organization and delivery of care. An overall view of the Scheme’s administration, care provisioning and fundamental governing principles at the back end is captured in diagram below:

![Figure 4.1: An overall view of the scheme’s programme](image-url)
Below is an example of referral from general hospital to tertiary care:

*Figure 4.2: An example of referral from general hospital to tertiary care*

```
Gatekeeper to prevent overutilization of secondary or tertiary cover

Insured goes for medical check up

Does check-up involve referral to speciality hospital?

Yes

Refer the case to speciality hospital

The base cover network hospital refers the case to the speciality hospital (part of critical care network)

Secondary cover is not utilized in this case

No

Trigger secondary cover

Available secondary cover to be utilized for outpatient services/day care procedures/hospitalisation of common ailments

(Involves OPD/secondary coverage)

Trigger critical care cover

Available critical care cover to be utilized for medical and surgical interventions

(Involves tertiary coverage)
```

Gatekeeping is an important aspect of unnecessary or overutilization of healthcare facility. It also pushes the population towards preventive aspects of healing and healthcare. In this regard we need to experiment with some private models of primary care which not only advocates preventive care but also serves as efficient gatekeepers. These models have outcome oriented goals for improving the health risk index of the population. If they prove to be successful, then such models should be encouraged in the longer term.

Through these models we need to experiment to arrive at the right design for the right incentive system to promote value driven patient centric healthcare.

### 4.2.1 Network providers, facilities and Hospitals

As discussed previously, given the magnitude and scale of Indian population, even partial roll out of UHC would necessitate utilizing all existing eligible facilities – both public and private. Use of private sector for public good is quite feasible. However, there shall be standard requirements for empanelment, categorization and rationalization for optimum use of each facility with right patient load and utilization of care at appropriate level through referral system and gate keeping. There are places in India where there are no private providers e.g. remote rural areas and there are places where the Government facilities are quite minimal or overcrowded e.g. urban areas. Hence, all available and eligible providers should form a part of the network. For primary care also, private/ general practitioners can be roped in by the Government to complement public health capacity. Also the facilities providing Indian system of medicine should be enrolled subject to fulfillment of laid down criteria for the particular line of treatment.
Not only that, under the insurance mechanism, Government facilities would also have the opportunity to earn from foot fall of insured members and utilize the additional funds for improving the facility, for buying equipment and providing incentives to staff, etc. Lastly a lower rate of compensation where there are too many providers and higher rate where there are none or few would help in driving a balance in supply and demand of care in all parts of the country and take care, at least partially, of the skewedness that currently exists. Facilities and capacity created under various existing schemes like ESIS, CGHS, Railway hospitals should form part of common pool, especially in areas where other facilities do not exist.

Consolidation of fragmented purchasing through the insurance mechanism will also help in improving the quality of care provided through grading of facilities based on quality parameters, standard treatment protocols and medical audits. This will improve the care provided and reduce costs and wastages.

4.3 Benefits of Hybrid model

4.3.1 Better accountability, transparency, focus and results

IT-enabled system combining the strengths of public and private providers with the oversight of medical regulator and insurance regulator and under the coordination of Universal Health Care Agency, is bound to yield a better accountable and transparent system than what exits today. More importantly, by freeing the Government system to focus exclusively on primary care, promotive and preventive care along with other determinants of health – clean water, sanitation, nutrition, the overall status of health shall improve for the population while the insurance industry shall manage secondary and tertiary care with optimum results. This way, all parties can build further on their respective strengths and manage the delivery span realistically.

There is a serious need to implement EMR (Electronic Medical Records) standards and seamless health data capture at the source so that patient records are available both for preventive, promotive and curative purposes.

4.3.2 Managerial and Technical Capability of insurance industry

The managerial, technical and operational capacity of insurance industry in member enrolment, healthcare provider empanelment, managing large volumes of transactions shall be effectively utilized for extending secondary and tertiary cover to the population which would otherwise be difficult to develop within the Government owned institutional framework which is already struggling. The actuarial capability of insurance industry to price the premium at affordable and appropriate level is the need of the hour. The IT-enabled delivery platform developed by schemes like RSBY can be utilized/ scaled up easily while learnings on fraud control, utilisation, awareness can be strengthened further to ensure better results.
4.3.3 Reasonable cost of care, higher efficiency and controls

The changing disease pattern with growing incidence of NCDs, chronic ailments and longevity of life are going to increase utilization of secondary and tertiary care where the insurance industry has considerable expertise. Schemes like RSBY, Aarogyasri and PPN (Preferred Provider Network initiative of public sector insurance companies) have helped cap prices of medical procedures to a large extent and have demonstrated the ability of ‘pooled’ purchasing to influence ‘price’ and quality of care, bringing the same to a fair and reasonable level which was hitherto considered impossible in a market driven healthcare industry.

Not only that, by capping outgo per procedure, somewhat on DRG pattern/case-based payment or to an all-inclusive room rent charge as compared to pure “fee-for-service”, the tendency of healthcare providers to go in for expensive tests, branded drugs etc. has been excluded to some extent. Though the tendency for unwarranted procedures, high-end surgeries is yet to be brought under ambit of medical regulation.

Government’s direct contracting/engagement with providers as done in case of CGHS is quite difficult to scale up for entire population and also cost of per capita for CGHS beneficiaries is approximately 3-4 times than that of beneficiaries covered under commercial insurance indicating higher degree of leakage and inefficiency in management that too despite extremely low rates and tariffs with contracted providers as compared to private insurers. Capital fee model which is not yet implemented at large scale by any significant payer also needs to be piloted to compare the overall cost implication and health outcomes..

4.3.4 Monitoring and control

For ensuring effective delivery of healthcare to the population, every mechanism requires appropriate surveillance, monitoring and control. It is observed that with the use of technology, online data exchange and trained manpower, it is easier to implement surveillance. Needless to mention, there is a need for greater focus on ‘outcomes’ and ‘outliers’ so that misuse is controlled. Greater monitoring would ensure that the pitfalls associated with ‘provider-induced demand’ leading to unnecessary procedures and hence excessive utilization are contained and ‘outcomes’ are tracked vigorously. The medical experts shall define medical protocols and clinical pathways, referral guidelines and strict enforcement of the same should be done under the provisions of law.

4.3.5 Higher penetration of insurance, increase in investible funds and Channelizing of Savings

Insurance penetration\(^{29}\) is quite low in India – 3.40% for life and 0.70% for non-life\(^{30}\) (health forms part of non-life business). Insurance cover as part of UHC implementation shall address this issue to some extent. Major share of funds

\(^{29}\) Insurance penetration is measured as a ratio of premium to GDP (IRDA Annual Report)

\(^{30}\) IRDA Annual Report 2011-12
collected through insurance premium are funneled back into economy through investment in Government securities and approved instruments – minimum 25% in Government securities, 10% in social infrastructure, 35% in approved securities, only 25% can be invested in unapproved securities. As of 2011-12, life insurers invested INR 15,81,259 crore and non-life segment invested INR 56,956 crore in different instruments. The growth of these investments would thus enable the Government and industry to access more capital without the risk of inflationary pressures, inequity, hardship or lop-sidedness. Since approximately 50% of population shall self-pay for the insurance premium, this means that higher percentage of household savings shall be channelized for economic growth while providing healthcare security.

Also Government facilities shall compete for patient foot fall and earn for the same similar to private sector. Thus part of Government funds paid as premium gets funneled back to public health system, making public health self-reliant to a certain extent.

4.3.6 Affordable Healthcare Insurance for all

Pooling of purchasing of care at secondary and tertiary level along with alternate payment mechanisms, and aligned incentives shall bring down the cost of healthcare. Enlarging covered population through mandatory cover would bring down insurance premium and make it affordable for those who shall pay self for the cover. The cost of cover for a secondary care package (INR 60,000) topped by tertiary care package (INR 2.0 lacs) is estimated to be, less than INR 3 per day per family. However, the low price would be possible only if the scheme is mandatory and major portion of population joins, with no risk of possible anti-selection. Thus, there would not be any risk of adopting an expensive health insurance model similar to the one in the USA, rather India can be the hub of low cost healthcare supported by affordable insurance.
Financing Projections

Financing projection for the two parts of hybrid model – primary health through public facilities (supplemented by private practitioners where need be) and secondary and tertiary through private/public facilities under insurance network fits quite well with the Government of India’s intent to increase health spend to 3% by the end of 12th Five Year Plan.

A World Bank study (Government Sponsored Health Insurance in India) released earlier in 2013, has estimated an amount of INR 500 per family for performance-based primary care in addition to current level of supply side funding. As regards the secondary and tertiary care cover, premium trends from current health insurance schemes can provide an estimate for the future projection though the same may currently be little underpriced due to stiff competition. However higher conversion and enrolment should help in settling the premium per family at low rates.

Health being a state subject, the funding pattern would also need to be shared between central and state Governments.

The intent of the Universal Health Coverage is to make base-level health package available to all the citizens in an affordable manner. As per the population segment analysis, it is imperative to provide full subsidy to certain segments to bring them under the fold of UHC.

In cases where subsidy will be provided by the Government for providing base-level cover, per family premium amount could be approximately INR 900 for coverage including a secondary care cover of up to INR 60,000 per annum and tertiary care cover of up to INR 2,00,000 per annum.

The total outgo for the Government per family for fully subsidized UHC package has been estimated to be in the range of INR 1500 which matches quite well with above projected cost.

The table below provides the financing mechanism across the population segments along with the quantum of subsidy required:

<table>
<thead>
<tr>
<th>Population segment</th>
<th>Segment Size</th>
<th>Financing mechanism</th>
<th>Central Government Share</th>
<th>State Government Share</th>
<th>Total Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>~35.6 crores individuals (~8.9 crores families)</td>
<td>• Premium to be subsidized by Central and State Government for UHC package</td>
<td>Premium amount of ~INR 500 per family for secondary cover</td>
<td>Premium amount of ~INR 400 per family for tertiary cover</td>
<td>Premium amount INR 900 per family</td>
</tr>
<tr>
<td>Non-Poor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agriculture</td>
<td>~34.19 crores</td>
<td>• Funding of premium is paid by the</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>No subsidy</td>
</tr>
<tr>
<td>Population segment</td>
<td>Segment Size</td>
<td>Financing mechanism</td>
<td>Central Government Share</td>
<td>State Government Share</td>
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</tr>
<tr>
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<td>------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>individuals (~8.5 crores families)</td>
<td>insured</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal Sector – Self Employed</td>
<td>~13.29 crores individuals (~3.3 crores families)</td>
<td>- Funding of premium is paid by the insured</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>No subsidy</td>
</tr>
<tr>
<td>Informal Sector – Working in other informal occupations</td>
<td>~18.80 crores individuals (~4.7 crores families)</td>
<td>- Premium to be subsidized by Central and State Government for UHC package</td>
<td>Premium amount of ~INR 500 per family for secondary cover</td>
<td>Premium amount of ~INR 400 per family for tertiary cover</td>
<td>Premium amount of Rs.900 per family</td>
</tr>
<tr>
<td>Formal Sector – Government Sector</td>
<td>~4.08 crores individuals (~1.02 crores families)</td>
<td>- Funding for Central and State Government employees and dependents to be funded through Government and employee</td>
<td>(Limited to the share in premium payment by Central Government)</td>
<td>(Limited to the share in premium payment by State Government)</td>
<td></td>
</tr>
<tr>
<td>Formal Sector – Private Sector</td>
<td>~2.41 crores individuals (~0.6 crores families)</td>
<td>- Funding through employer and employee contribution</td>
<td>Not Applicable</td>
<td>Not Applicable</td>
<td>No subsidy</td>
</tr>
</tbody>
</table>
### Table: Population Segment, Financing Mechanism, and Total Subsidy

<table>
<thead>
<tr>
<th>Population segment</th>
<th>Segment Size</th>
<th>Financing mechanism</th>
<th>Central Government Share</th>
<th>State Government Share</th>
<th>Total Subsidy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Special Groups</td>
<td>~11.4 crores individuals</td>
<td>• Premium to be subsidized by Central and State Government for UHC package</td>
<td>Premium amount of ~INR 750* per person for secondary cover (50% Higher rate than others for higher risk category)</td>
<td>Premium amount of ~INR 600* per person for tertiary cover (50% Higher rate than others for higher risk category)</td>
<td>Premium amount of Rs.1350 per person</td>
</tr>
</tbody>
</table>

At present Government is spending a little over 1% of GDP on health. If we calculate a premium of INR 1,400 per family per year for primary, secondary and tertiary care where INR 500 is for incremental performance-based primary care (in addition to the existing supply side spend) and rest for secondary and tertiary care and if the Government will subsidize 50% of the population then the Government will be able to cover the additional cost by spending only 0.35% of GDP. Since the Government is planning to increase health expenditure by 2% of GDP, this is a very small amount that will need to be paid for the UHC. From the above discussion we can see that financing for UHC is eminently possible from a fiscal perspective. Governments at both Central and State level have already shown their intent by funding different health insurance schemes. Funding for UHC which may need some additional funds, can be made available by Central and State Governments and some of the existing funds in the health sector can be reallocated for UHC efforts. The pooling of contributions from the employees and employers will also provide additional funds for this effort. To generate additional funds some countries have also used a provision of earmarked tax on certain items like tobacco, liquor etc. which goes directly into funding of their UHC efforts.
6 Recommendations and Way Forward

Hybrid model and demand side financing is not a new instrument and many countries are using it across the world. Countries like Germany, Thailand, and UK have almost reached 100% universal coverage. However, it is important to note that it took a long time for these countries to reach this stage. For example, while Germany took more than 100 years, Thailand took more than 30 years for the same.

There is a lot what we can learn from other countries which are working in this field and yet we cannot afford to take decades and thus need to develop our own path towards UHC which is rooted in the Indian culture, context, experience, fiscal ability and disease burden etc. Also different schemes are being designed and implemented in India – on supply side and on demand side by Central and State and Governments, which run in a fragmented manner. There is an urgent need to bring together these different initiatives in a UHC framework in a cohesive manner.

As experience across the world has also shown that UHC cannot be achieved in one go, this paper has thus suggested phased implementation starting with poor and vulnerable sections and people employed in the formal sector. It will need to be done with great deal of planning and preparation.  It is important is to start the journey on the right footing and the major steps towards are the same listed below.

6.1 Governance and Regulations

A big program like providing UHC to every citizen will be difficult to deliver without proper governance and regulatory framework. It is not only the scale but also involves co-ordination amongst multiple-agencies, multiple ministries and departments. Many countries, across the world have been able to move fast on UHC by setting up independent agencies. In the Indian context, we also need legal and regulatory agencies which should help strengthen and maximize delivery through existing delivery frameworks which have been developed with considerable investment and effort right up to village/ block level.

First and foremost in the Indian context, the urgent need of the hour is to:

- Implement Clinical Establishment Act
- Establish National Health Regulator

The above two requirements are critical foundation stones for improving the eco system of healthcare in India, with or without UHC. However, UHC implementation in an effective manner would be nearly impossible without above robust regulatory and legal framework. For converting voluntary cover to a mandatory cover, a legislative backing would be required.

The proposed model in this paper is to pool and purchase secondary and tertiary healthcare services through intermediation of the insurance companies.
Health insurance has a regulator in the form of Insurance Regulatory and Development Authority. IRDA has laid down detailed guidelines, issued Health Regulations and set up a multi-stakeholder Forum. Going forward, should the Government plan to implement UHC in the manner proposed, it would be advisable for IRDA to set up a Health Insurance Authority under its wing to deal, manage and coordinate in all matters connected with UHC. The Health Insurance Authority will understandably have a big say and sizable control over healthcare providers being the single largest purchaser of in-patient care.

6.2 Set-up National Level Institutional Structure
Besides Regulators there would be need to set up a National Apex Body for UHC in India. This body can be called National Universal Health Coverage Agency which shall be responsible for:

- Coordination with different schemes of the Government to bring alignment in the benefit package to UHC package
- Coordination between IRDA/ Health Insurance Authority and National Health Regulator
- Coordination with all the bodies for a centralised database for all the beneficiaries covered with UHC in India.

a. Linking with UID to identify the coverage level and target people as per priority and need
b. Establish Common IT standards, Data formats, exchange protocols
c. Develop common empanelment criteria, costing framework, package rates, quality standards, monitoring framework, evaluation design etc.

At the State level, there is a need to have similar agencies that will be responsible for implementation of the scheme. These agencies will be able to work closely with National Apex agency.

6.3 Challenges and way forward
The transition to UHC in India would not be without challenges and complexities. Once the Government makes decision to go for UHC, it will be critical to bring all the stakeholders together who are working in this field as they will need to participate in this effort.

Addressing other important issues relating to physical infrastructure and human resources shortages, medical education, quality and accreditation norms, capacity building and training, drug regulation and pricing, research and development, patient centric health administration enabled through IT architecture etc. is also critical. Some would be addressed by the Health Regulator, a few during UHC implementation, and rest would need interventions at other multiple levels. However, journey towards UHC must start in parallel to these initiatives and as explained in earlier sections, it is quite feasible to operationalize.
A large number of steps will need to be taken for design and implementation of the UHC program, some of the important steps are listed below:

- Discussion with all the existing Government funded health insurance schemes and relevant ministries and State Governments to agree on common understanding and agreements
- Legislation to make UHC mandatory, in the initial phase it can be mandated for the formal sector
- Design of detailed benefit package for primary, secondary and tertiary care
- Design and setting up of the governance, regulatory and institutional structures
- Design of common Information Technology System
- Preparation of detailed implementation plan
- Preparation of capacity building and monitoring framework

Countries across the world are moving towards providing UHC to their citizens. India cannot afford to lose on the momentum that has already begun in the country in the form of different initiatives by the Central and State Governments. At the current juncture, India stands in a unique position to consolidate varied programs, adopt an affordable and accountable UHC program within its budgetary reach. Not adopting one may not remain a choice for long as the cost of double burden of disease, escalating healthcare costs without corresponding outcomes and dampening impact of unhealthy workforce/ population on economic growth is going to increase by the day, every day.
7

Annexure

7.1

Illustrative List of Preventive and Public Health Interventions Funded and Provided by Government

1. Full Immunization among children under three years of age, and pregnant women.

2. Full antenatal, natal and post natal care.

3. Skilled birth attendance with a facility for meeting needs for emergency obstetric care.


5. Regular treatment of intestinal worms, especially in children and reproductive age women.

6. Universal use of iodine and iron fortified salt.

7. Vitamin A supplementation for children aged 6 to 59 months.

8. Access to a basket of contraceptives, and safe abortion services.

9. Preventive and promotive health educational services, including information on hygiene, hand-washing, dental hygiene, use of potable drinking water, avoidance of tobacco, alcohol, high calorie diet and obesity, need for regular physical exercise, use of helmets on two-wheelers and seat belts, advice on limitation on breastfeeding within one hour of birth and exclusively up to six months of age, and complimentary feeding thereafter, adolescent sexual health, awareness about RTI/STI; need for screening for NCDs and common cancers for those at risk.


11. Community based care for sick children, with referral of cases requiring higher levels of care.

12. HIV testing and counseling during antenatal care.

13. Free drugs to pregnant HIV positive mothers to prevent mother to child transmission of HIV.

14. Malaria prophylaxis, using Long Lasting Insecticide Treated Nets (LLIN), diagnosis using Rapid Diagnostic Kits (RDK) and appropriate treatment.

15. School check-up of health and wellness, followed by advice, and treatment if necessary.


17. Diagnosis and treatment of Tuberculosis, Leprosy including Drug and Multi-Drug Resistant cases.

18. Vaccines for hepatitis B and C for high risk groups.

19. Patient transport systems including emergency response ambulance services of the ‘dial 108’ model.
## 7.2 Summary Table for Segmentation

<table>
<thead>
<tr>
<th>Population Segment</th>
<th>Current</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Poor/ Below Poverty Line (35.6 crores)</strong></td>
<td>Government has started providing coverage to them through RSBY with a INR 30,000 inpatient cover</td>
<td>Premium is subsidized by Central and State Government. Each BPL family pays INR 30 per family per year as an enrollment fee. Smart card based enrollment makes benefits portable across India. Coverage may be increased to include tertiary care with enhanced limit for secondary care. The primary care will also be a part of the base cover which will be provided through Government programs and community outreach.</td>
</tr>
<tr>
<td><strong>Special Groups (11.4 crores)</strong></td>
<td>Fragmented schemes providing health coverage to senior citizens across the country. Differently abled population is not covered with any special health coverage.</td>
<td>Most of them pay out of their pockets for their medical expenses.</td>
</tr>
<tr>
<td><strong>Agriculture Sector (34.19 crores)</strong></td>
<td>Fragmented schemes such as Yeshasvini have been launched.</td>
<td>Most of them pay out of their pockets for their medical expenses.</td>
</tr>
<tr>
<td><strong>Informal Sector workers who are self</strong></td>
<td>At present no health coverage</td>
<td>Out-of-pocket expenditure for all healthcare.</td>
</tr>
<tr>
<td>Population Segment</td>
<td>Current</td>
<td>Proposed</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>---------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Coverage</strong></td>
<td><strong>Funding</strong></td>
<td><strong>Notes</strong></td>
</tr>
<tr>
<td>employed</td>
<td>costs</td>
<td>should be purchased</td>
</tr>
<tr>
<td>Informal Sector workers who are part of vulnerable occupational groups</td>
<td>Government has started the process of bringing different occupational groups under RSBY and is gradually bringing in more groups</td>
<td>Premium is subsidized by the Government</td>
</tr>
<tr>
<td>State Government Employees and Dependents (1.61 crores)</td>
<td>They are covered with a Government provided health scheme in most of the cases</td>
<td>Employee contributes a small amount for availing this scheme</td>
</tr>
<tr>
<td>Central Government Employees and Dependents (0.67 crores)</td>
<td>They are covered with Central Government Health Scheme (CGHS) Available for both in-service and retired people (pensioners)</td>
<td>Employee contributes a small amount for availing this scheme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population Segment</td>
<td>Current</td>
<td>Proposed</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Coverage</td>
<td>Funding</td>
</tr>
<tr>
<td>Government</td>
<td>Limited healthcare benefits provided by the employer</td>
<td>Funding is through employer and employee contribution</td>
</tr>
<tr>
<td>Companies’ Employees and Dependents (1.8 crores)</td>
<td>Healthcare coverage available in certain cases however, different level for different category of employees with huge variation in coverage</td>
<td>For certain segments it is out-of-pocket expenditure</td>
</tr>
<tr>
<td>Private Sector Employees and Dependents (2.41 crores)</td>
<td>Establishment having more than 20 employees deduct part of salary towards EPF. This channel can be utilized to deduct premium amount for the base cover</td>
<td></td>
</tr>
</tbody>
</table>
# List of Abbreviations

<table>
<thead>
<tr>
<th>S. No</th>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AP</td>
<td>Andhra Pradesh</td>
</tr>
<tr>
<td>2</td>
<td>APL</td>
<td>Above Poverty Line</td>
</tr>
<tr>
<td>3</td>
<td>ASM</td>
<td>Arthik Samata Mandal</td>
</tr>
<tr>
<td>4</td>
<td>BPL</td>
<td>Below Poverty Line</td>
</tr>
<tr>
<td>5</td>
<td>CGEPHIS</td>
<td>Central Government Employees and Pensioners Health Insurance Scheme</td>
</tr>
<tr>
<td>6</td>
<td>CGHS</td>
<td>Central Government Health Scheme</td>
</tr>
<tr>
<td>7</td>
<td>EPF</td>
<td>Employee Provident Fund</td>
</tr>
<tr>
<td>8</td>
<td>ESIS</td>
<td>Employees’ State Insurance Scheme of India</td>
</tr>
<tr>
<td>9</td>
<td>FI</td>
<td>Financial Institution</td>
</tr>
<tr>
<td>10</td>
<td>FY</td>
<td>Financial Year</td>
</tr>
<tr>
<td>11</td>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>12</td>
<td>GMC</td>
<td>Gwalior Municipal Corporation</td>
</tr>
<tr>
<td>13</td>
<td>IMC</td>
<td>Indore Municipal Corporation</td>
</tr>
<tr>
<td>14</td>
<td>INR</td>
<td>Indian Rupee</td>
</tr>
<tr>
<td>15</td>
<td>KCC</td>
<td>Kisan Credit Card</td>
</tr>
<tr>
<td>16</td>
<td>MFI</td>
<td>Micro Finance Institute</td>
</tr>
<tr>
<td>17</td>
<td>MGNREGA</td>
<td>Mahatma Gandhi National Rural Employment Guarantee Act</td>
</tr>
<tr>
<td>18</td>
<td>MoCA</td>
<td>Ministry of Corporate Affairs</td>
</tr>
<tr>
<td>19</td>
<td>NCERT</td>
<td>National Council of Educational Research and Training</td>
</tr>
<tr>
<td>20</td>
<td>NSDC</td>
<td>National Skill Development Corporation</td>
</tr>
<tr>
<td>21</td>
<td>NSSO</td>
<td>National Sample Survey Organization</td>
</tr>
<tr>
<td>22</td>
<td>OOP</td>
<td>Out-of-pocket</td>
</tr>
<tr>
<td>23</td>
<td>PF</td>
<td>Provident Fund</td>
</tr>
<tr>
<td>24</td>
<td>RSBY</td>
<td>Rashtriya Swasthya Bima Yojana</td>
</tr>
<tr>
<td>25</td>
<td>RWA</td>
<td>Resident Welfare Association</td>
</tr>
<tr>
<td>26</td>
<td>TN</td>
<td>Tamil Nadu</td>
</tr>
<tr>
<td>27</td>
<td>UHC</td>
<td>Universal Health Coverage</td>
</tr>
<tr>
<td>28</td>
<td>UID</td>
<td>Unique Identification Project</td>
</tr>
<tr>
<td>29</td>
<td>UIDAI</td>
<td>Unique Identification Authority of India</td>
</tr>
</tbody>
</table>
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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 7200 members, from the private as well as public sectors, including SMEs and MNCs, and an indirect membership of over 100,000 enterprises from around 242 national and regional sectoral industry bodies.

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