Should India Create a Single National Risk Pool?
Some Lessons from Thailand, Mexico, and Colombia

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The Issue and Overall Findings

Since 2007, India's health insurance coverage has grown from 75 million to an estimated 302 million persons insured in 2010. The lion's share of this growth is attributable to four new initiatives: Rashtriya Swasthya Bima Yojana (RSBY) from the central government, and three state-sponsored schemes—Rajiv Aarogyasri (Andra Pradesh), Kalaignar (Tamil Nadu), Vajpayee Arogyshri and Yeshasvini (Karnataka). These new plans added to the public insurance programs started in the 1950s with the Employees State Insurance Scheme (ESIS) and Central Government Health Scheme (CGHS) (Reddy, Selvaraj, & Rao, 2011).

As India seeks universal coverage, one of the major health financing choices facing the country involves risk pool consolidation. Should India seek to have multiple risk pools or a single national one? Should pools be organized at national or state level, or both? Should the country attempt to consolidate or merge some of the existing health insurance schemes or keep them separate?

At the request of Public Health Foundation of India (PHFI), the Results for Development Institute (R4D) carried out an initial analysis of these issues, drawing on the experiences of countries that have faced similar challenges. We adopted a special focus on three middle income countries that are highly relevant to India: Colombia, Mexico, and Thailand. In the last decade or two, each of these countries has brought a unique approach to risk pool reform in its pursuit of universal healthcare coverage. R4D will continue to review this topic of number/locus of risks pools in greater depth in the upcoming weeks, but created this note for PHFI on short notice in time for the April 2011 HLEG progress report.

There are pros and cons to having fewer, more centralized risk pools and corresponding insurance funds, as opposed to having a larger number of pools separated geographically or on other grounds. A single national risk pool has advantages in terms of efficiency and equity: the potential to lower administrative costs, better spread risk across heterogeneous populations, and increase fiscal and spending controls. However, there can be technical drawbacks to a single pool, as well as political reasons to believe that it may be difficult to achieve such a goal. The current health risk pools operating in India are very different from one another, and efforts to integrate or even harmonize them could be quite challenging. Add to this the fact that state-level risk pools would be easily large enough to spread risks and have the advantage of geographic proximity to the people they serve (and greater familiarity with local providers).

In such a context, international experience may be useful for Indian policy makers. In other countries, what were the drivers for risk pool restructuring? Did these countries combine and integrate risk pools and insurance funds, or did they keep them separate? What were the key

financial and political trade-offs made in the transition? What were lessons learned in the process?

Our research uncovered four major findings:

1. *Many other countries have achieved high levels of coverage, in terms of breadth (population enrolled) and depth (richness of benefits), without moving to a single national risk pool.* Medium sized countries have generally attempted to build on their legacy insurance systems, filling in the gaps so that other households are covered (Thailand); or to reshape and integrate existing risk pool sub-systems while expanding them for broader coverage (Colombia). Large countries with federal systems have also built on existing risk pools and insurance institutions, while developing new and expanded risk pools at the sub-national level (e.g., Mexico's use of the states for the Seguro Popular).
2. *Gradual integration of disparate risk pools may make reforms more viable:* Countries that have been successful in merging risk pools have taken a gradual, step by step approach that appreciated the needs (and fears) of stakeholders, effectively depoliticizing a potentially explosive topic. Consolidation is difficult if it is seen as "taking away benefits" or introducing long queues. Gradualism may mean allowing several risk pools to co-exist within the same geography, while moving to harmonize certain features of each risk pool such as enrollment processes and databases, provider payment methods, and provider accreditation standards and methods. This effort at harmonization occurred in the three countries we examined closely (Thailand, Colombia, and Mexico).
3. *Cross-subsidizing across disparate risk pools is a potentially effective approach when consolidation of existing and new schemes is not feasible:* While administratively demanding, creating a fund(s) to transfer money between pools on a risk-adjusted basis (Colombia) or requiring better off workers to pay for their own insurance via wage taxes, while requiring them to contribute to general taxation which is used to subsidize the poor (Thailand, Mexico), may be easier politically to do than to blend all pools into a single one for an entire country.
4. *In a large federal system, garnering strong sub-national support for new risk pools that expand coverage or extend or merge existing schemes is vitally important.* This was the case in Mexico, the support of state ministries of health was crucial for efforts to create and implement an insurance scheme for the poorest households and for those in higher income brackets. Without this backing from sub-national leaders and institutions, creation of state-level risk pools/insurance funds and implementation of cost-sharing between central and state governments may be jeopardized.

Background

Risk pooling is a way to decouple payment for healthcare services from an individual's health risks. The chief arguments for pooling are equity and efficiency. Often, those with the highest health risk are those least able to afford healthcare. Risk pools help to ensure that those with lower risks and health spending requirements subsidize those with higher risks and expenditures. On the

efficiency front, risk pooling can lead to large societal gains in productivity from decreases in morbidity and mortality (Smith & Witter, 2004).

There is a spectrum of risk pooling options from no risk pool in which all expenditure liability lies with the individual, to a single risk pool for an entire nation. The vast majority of countries lie somewhere in between, operating several large risk pools segmented on the basis of geography, occupation, income, etc. While in an ideal state, the integration of small risk pools can help to lower administrative costs, leverage monopsony buying power, and spread actuarial risk, it is not always feasible (nor is it necessary) to create a unitary risk pool. In post-reunified Germany, for example, the government added nearly two dozen sickness funds—instead of consolidating risk pools—in order to absorb the residents of former East Germany. This policy move was made on the basis of preserving the century-old sickness fund model of local risk pool administrative control (Radich, 1995).

In India, the existing risk pools vary substantially in their beneficiary strength, method of funding, provider payment, and benefit package (Table 1).

Table 1: Public Health Insurance Overview

Scheme	**Number Enrolled (millions)**	**Funding Source**	**Administrative Body**	**Benefits**
ESIS	55.5	12.5% State, 6.5% wages	Min. of Employment and Labour	Comprehensive
CGHS	3	95% Centre, 5% wages	Min. of Health and Family Welfare	Comprehensive (no gatekeeper)
RSBY	79	75% Centre, 25% State	Min. of Employment and Labour	Inpatient, Secondary Care
Aarogyasri (AP)	70	100% State	State	Inpatient, Tertiary Care
Kalaignar (TN)	35	100% State	State	Inpatient, Tertiary Care
Vajapayee Arogyasri (KN)	1.4	100% State	State	Inpatient, Tertiary Care
Yeshasvini (KN)	3.0	100% State	State	Inpatient, Secondary, Tertiary Care

Source: Reddy, Selvaraj, & Rao, 2011
Note: Private health insurance accounts for an additional 55 million covered individuals.

Broadly speaking, expanding coverage to a greater number of people could entail a number of possibilities including: increasing the memberships of the current schemes, creating more schemes, or consolidating schemes (Table 2). Each of these options has trade-offs.

Table 2: Range of Options for Reforming Risk Pools in Moving toward UHC

	Expand Membership of Current Risk Pools	**Increase Number of Risk Pools**	**Consolidate/Merge Risk Pools**
Benefits	-Technically simpler (preserves current infrastructure) -May spread risks -May reduce average administrative costs through economics of scale -Builds on political support for existing schemes	-May speed implementation by decentralizing control -May build local solidarity between municipalities, members, and providers -May increase choices for consumers	-Lower administrative costs -Possible optimization of provider networks -Lower health spending through monopsony buying power -Minimal adverse selection -Solidarity through common healthcare access
Drawbacks	-No gains in cross-subsidizing risks between informal and formal sector -Less opportunity to realign incentives for cost containment	-May increase administrative costs -May increase adverse selection, inequity across pools	-Harmonization of administration, benefits, provider payment methods is politically and technically difficult and takes time -Danger of system failure if "all eggs are in one basket"

To feed into the HLEG debate on the size and shape of health risk pools in India, we looked closely at a set of three countries that have undergone dramatic changes in their risk pools within the last two decades. While these countries differ substantially from India on a number of dimensions, their approaches to reform and outcomes can be instructive. The salient features of the three countries are shown in Table 3.

Table 3: Countries Extending Coverage Via Risk Pool Restructuring

	Thailand	**Mexico**	**Colombia**
Pre-reform Structure	Two main schemes: SSS (16% of population) for private, formal sector; CSMBS (8% of population) for civil servants	Two main NHI plans: IMSS (40% of population) for private, formal sector; ISSSTE (7% of population) for civil servants	Two schemes: ISS (15% of population) for formal sector; private insurance (15% of population)
Uninsured Before Reform	48million (75%)	50million (50%)	32million (70%)
Current Uninsured	<2%	30%	10%
Nature of Reform	Added a tax-financed comprehensive scheme for the poor and informal sector chiefly using public sector provision (UC Scheme)	Seguro Popular, which includes a new tax-based (central and state), voluntary social insurance scheme for the poor and informal sector leveraging public provision infrastructure; also, national-level high-risk pool	Contributory Regime (high-income risk pool) and Subsidized Regime (low-income, informal sector risk pool); choice between public or private plans
Relevance to the Indian Context	Added new risk pool for the poor and informal workers. No attempt so far to merge these pools. Gradually harmonizing benefits, payment methods, etc	Added new risk pool for poor and informal workers; high-risk conditions pooled nationally Left existing social insurance schemes intact. National framework, center-state fiscal transfers, state-based rollout of new scheme	Greatly expanded coverage via merger of social insurance funds and creation of new scheme for uninsured. Cross subsidization of risk for workers and others. Private and public plans compete for members within highly regulated framework.

Part I: Country Cases

Thailand

Drivers for Risk Pool Reform

The process of working toward universal coverage in Thailand began in 1975 but by 2001, 47 million people—three-quarters of the population—remained uninsured despite decades of experience with community-based and publicly subsidized voluntary health insurance. In 2001, there were two public insurance plans: the Civil Servant Medical Benefit Scheme, which covered 5 million people, and the Social Security Scheme, which covered the 10 million private sector employees. The CSMBS was funded by general taxation and SSS by payroll tax. Members of CSMBS had their choice of provider, who was paid on a fee-for-service basis (which tended to result in higher costs). SSS members had to register and seek care at first-contact facilities. Those bypassing the system had to pay out of pocket (The Joint Learning Network).

There were also two other public risk protection schemes: the low income card scheme and voluntary health card scheme. The former (also called the Medical Welfare Scheme) was a general tax-financed program that offered free medical services at public facilities. The voluntary health card scheme was publicly subsidized with only modest success in enrollment. Neither of these provided adequate financial protection and many Thai citizens were not covered by these programs.

Leading up the general election campaign of 2001, grassroots organizations and a respected policy expert, Dr. Sanguan Nittayarampong, advocated for universal coverage. The Thai-Rak-Thai Party took up this policy as part of their platform and subsequently won the election, launching a universal coverage effort the following year through the National Security Health Act (Towse, Mills, & Tangcharoensathien, 2005).

Summary of Reforms

Of interest to Indian policy-makers may be the fact that initially, some Thai government officials wanted to merge resources from all four existing public insurance programs into a single pool in order to eliminate overlap and improve equity. However, there was resistance from civil service and trade unions. Thus the government decided to leave the CSMBS and SSS intact, merging and re-engineering the Medical Welfare and health card schemes to form a new risk pool, the Universal Coverage (UC) Scheme (originally called the "30 Baht Scheme") that significantly extended coverage to the uninsured (Mills, 2007).

The UC Scheme is tax-financed, with benefits focused on prevention and primary care. The provider payment method is prospective and uses capitation to help contain costs. There is a purchaser/provider split in order to introduce limited competition and provider accountability, and hence better services. While private providers may vie for contracts if they earn accreditation, in practice, most services are from public providers (Manual of Universal Coverage, 2002).

Thailand Public Risk Pools

	CSMBS	**SSS**	**UC Scheme**
Population	5 million (8%)	10 million (16%)	47 million (75%)
Source of Finance	General tax	Payroll contribution from employee, employer, and government	General tax
Benefit Package	Comprehensive (no preventive)	Limited	Limited, focused on prevention, promotion
Providers	Public (private in emergency cases)	Public and private	Public and private contracting unit for primary care (CUP)
Payment	OP: fee-for-service IP: DRGs	Capitation	OP: Capitation IP: DRGs

Source: Winai Sawasdivorn, 2010 (www.jointlearningnetwork.org)

Financial and Political Trade-offs

It was not feasible to launch a contributory scheme for the new risk pool, as the poor would not be able to bear much of the premium, and the cost of collection from the informal sector would be high. Hence the decision to finance the UCS from general taxation. Moreover, the ruling party needed to show rapid gains towards universal coverage which a tax-financed system could more easily accomplish than one based on household contributions (Sawasdivorn, 2010). That said, the government understands acutely that the long-term fiscal capacity to sustain its UC Scheme benefits package will require cost containment discipline.

Even though Thailand has reached near-universal coverage by having three risk pools operating in parallel, rather than a single national scheme, there is a concerted effort to harmonize (where appropriate) across the three risk pools. The 2001 healthcare legislation created the National Health Security Office to administer the UC Scheme. While these three schemes still are funded and operate separately, NHSO has standardized a member registration database among the risk pools (Towse, Mills, & Tangcharoensathien, 2005).

Another effort is provider payment harmonization across the schemes for similar services. A standard fee schedule, systematic adjudication processes, utilization review, and medical auditing systems are being considered for implementation across all of the schemes. The SSS plans to move in the direction of the UCS and CSMBS by adopting DRGs for inpatient and risk-adjusted capitation for outpatient care.

Merging risk pools is still very politically contentious in Thailand, and it is unclear when this move might happen. Public officials are keen to allay fears from powerful constituencies while focusing instead on measures to improve benefits and contain costs (Sarnsamak, 2011). In this

regard, a new government panel headed by the prime minister will spend three years to find ways to boost health promotion and disease prevention and reduce healthcare worker shortages.

Key Lessons from Thai Reform
1. In the quest for UHC, it is very difficult to abolish or merge existing risk pooling schemes. 2. In such a context, it may be quicker and politically easier to create a new scheme for the uninsured (poor/informal sector). 3. When UHC is pursued through several parallel risk pooling schemes, it may be possible to harmonize benefits and operating modalities (e.g., payment methods) gradually. 4. Schemes for the poor and informal workers may be better financed through general taxation and subsidies from the middle class, rather than member contributions. 5. Health reforms are often triggered by major political change but require tactical compromises to be sustained over time.

Mexico

Drivers for Risk Pool Reform

Mexico, not unlike India, had a large uninsured population at the end of the last century. The single greatest driver for Mexico's sweeping healthcare reforms since 2004 has been financial protection for the fifty per cent of Mexicans who previously had no health insurance. The bulk of these uninsured had to rely on public facilities operated by the public sector, which offered widely differing services from state to state (Frenk, Gomez-Dantes, & Knaul, 2009). While the Mexican Constitution recognized each citizen's right to healthcare, this was an underfunded, unfulfilled mandate (Frenk, Knaul, & Gómez-Dantés, 2004). The World Health Organization 2000 health system report card ranked Mexico 51 out of 191 nations overall but 144th in terms of financial fairness (World Health Organization, 2007). Furthermore, there was a significant public health spending disparity between the states. More than half of health care expenditures were out-of-pocket, well above the level in peer Latin American countries.

Of the fifty million Mexicans who had insurance, forty million belonged to the IMSS, the risk pool for private sector salaried employees and their families. Another seven million civil servants received coverage through ISSSTE, the public sector worker insurance scheme. Both IMSS and ISSTE are social insurance programs funded through wage taxes. Roughly 3-4% of the total population subscribed to voluntary private insurance.

Ten years ago, the new President Vicente Fox brought urgency to the cause of national health system reform. In 2004, Mexico passed legislation which created a broad set of reforms including a new tax-financed voluntary public health insurance system (Seguro Popular) that would gradually extend insurance coverage to the poor and informal sector workers. The projected increase in public spending of 0.8-1.0% of GDP was to be phased over 7 years (after a pilot project in twenty states in 2002) (Frenk & Knaul, 2005). The uninsured not enrolling in the program would need to pay user fees at the point of service. Those enrolled would pay a yearly membership fee according to a sliding scale based on household income.

Summary of Reforms

Just like RSBY, Seguro Popular (SP) offers a variety of services, including tax-financed, voluntary public health insurance at the state-level and a national high-risk pool. Funding for the SP is shared between the federal government, the state ($130 per affiliated family), and the household through annual enrollment fees which average $113. The federal contribution consists of one component that is a fixed amount per family in each state ($261) and a second component that is redistributive and varies according to state income (average $391 per family) (Lakin J. , 2010). The goal of the initial rollout was to target the bottom two income deciles, for whom the enrollment fee is waived.

Mexican Public Risk Pools

	IMSS	**ISSSTE**	**Seguro Popular**
Population	40million (40%)	7million (7%)	20million (20%)
Source of Finance	General taxation Payroll contribution (Employee and employer)	General taxation Payroll contribution (Employee and employer)	General taxation (Center funds flow to state based on number of families affiliated) Enrollment (sliding-fee $0-$950)
Benefit Package	Primary, hospital care	Comprehensive	255 common services 18 high-cost services
Providers	Public	Public (some contracting with Private)	Public (some contracting with Private)
Payment	Move towards capitation for public sector primary care	Move towards capitation for public sector primary care	Move towards capitation for public sector primary care

There are three main components of Seguro Popular which are relevant to risk pool reform in India:

1. **Funds follow affiliates**: The allocation of monies to decentralized state ministries of health is based on two factors. First, there is an equalization formula that gives poorer states more central government resources than those given to wealthier states. Second, center funds go to states in proportion to the number of families enrolled in Seguro Popular. Enrollment must be renewed yearly. This mechanism gives states a powerful incentive to provide and sustain quality services to Seguro Popular members

– otherwise they will drop out or fail to enroll in the first place. States are given considerable latitude on how they structure their Seguro Popular program, within the boundaries set via national guidelines. For instance, states have elected to place an emphasis on providing access to pharmaceuticals (Barros, 2008). Since there is substantial aggregation of risks across each state, the threat of adverse selection, despite the voluntary nature of the scheme, is eliminated (Frenk, Gómez-Dantés, & Knaul, 2009).

2. **Benefits are explicit**: The program guarantees access to a package of 255 health interventions that comprise 90% of service demand (Frenk, Gomez-Dantes, & Knaul, 2009). By making the benefits explicit, Mexico has bolstered accountability through a tripartite social contract between taxpayers, SP affiliates, and the State Ministries of Health. Additionally, the package serves as a quality assurance tool to assure protocol compliance.
3. **A complementary national catastrophic health fund**: Eighteen high-cost, low frequency conditions not contained in the essential package (anti-retroviral therapy for HIV, childhood leukemia, cervical cancer) are included in a separate national risk pool. Mexican states are protected from these financial shocks. This component of the SP is similar to Andra Pradesh's Arogyashri focus on more costly tertiary services.

In 2007, the SP program cost US$377 per family (US$2.75 billion in total), of which the federal government bore 69% of the cost and the states and individual families (via annual fees) the rest (Homedes & Ugalde, 2009).

Financial and Political Trade-offs

By 2007—three years into the rollout of the SP—about 20 million persons had enrolled in the program (predominantly those in the bottom two decile, fee-waiver categories). There are still 35 million uninsured not yet enrolled – presumably they are deterred by the annual fees they would have to pay, though the existing literature is not clear on this point. Since quality services are not available in some localities, a portion of the uninsured may be questioning the value of paying the enrollment fees.

According to Homedes and Ugalde, some states have made little progress in implementing the SP because of weak political support for the program at local level. Without commitment from the state-level Ministries of Health, enrollment in SP has stalled. This suggests that as India looks towards expanding coverage to the above-the-poverty-level demographic, state and broad citizen commitment may be important.

Further hurting the SP has been the allegation that the formula for transferring federal funds to states has favored wealthier states, rather than compensating and lifting the poorer states. More recent analysis, however, shows that indeed the SP's equalization efforts are having a positive redistributive effect. This may be another lesson for India, regarding the challenges of equalizing resources for health across states that vary dramatically in economic and social development

Another difficulty in Mexico appears to be that some states have not paid their share of the costs of the Seguro Popular, failing to match the transfers from the center (Lakin J. , 2009). This can seriously undermine the credibility of such a program. India should be mindful of this potential issue, too, as it considers ways to expand health risk pools using a mix of central and state government budgets.

Key Lessons from Mexican Reform
1. It may be easier and politically more feasible to expand coverage rapidly by creating a new insurance scheme for uninsured poor and informal sector workers, rather than trying to merge or overhaul existing social insurance programs for the middle classes in formal employment. 2. In a large federal country, a new scheme involving tens of millions of persons may best be implemented at sub-national (state) level. 3. To get states on board is not easy. Political engagement and commitment are essential. Technical and oversight skills may not be adequate at state level. 4. Cost-sharing formulas between center and state must be fair and must be enforced in practice to remain credible politically. 5. If the risk pool schemes for the poor and informal sector are voluntary, it may be difficult to enroll the bulk of the population including those above the poverty line. Mandatory insurance schemes avoid this issue. 6. If the new risk pool for the poor and informal workers does not offer comprehensive benefits, it may be possible to create another complementary tax financed pool for high-cost, low-occurrence events.

Colombia

Drivers for Risk Pool Reform

As is the case in many Latin American countries, Colombia's Constitution guarantees healthcare as a social right, yet for much of the population, such care was historically not available or accessible. Prior to the 1990s, almost 70% of the population relied on the Ministry of Health's tax-financed network of public hospitals and clinics. Because of low coverage and quality, more than half of total health expenditures were out-of-pocket. While the public facilities were supposed to provide care for the poorest, those facilities favored the better off, with the bottom income quintile comprising only one-fifth of individuals receiving care from the public system.

Before 1993, about 15% of Colombians were covered by Instituto de Seguros Sociales (ISS), or Social Security Institute, through payroll contributions. Those in the public sector were enrolled in a large number of insurance funds that were exclusive to state-owned enterprises or particular government units. For those contributing to ISS through their private sector jobs, there was another separate fund. There was no risk pooling among these funds. Private insurance companies (to which 15% of the population belonged) did not participate in this obligatory health finance system.

Summary of Reforms

In 2008, after nearly 25 years of a major healthcare overhaul, Colombia was able to achieve near universal healthcare coverage. Law 100 of 1993 established the guidelines for the reform of the social security system in Colombia. The first change involved unifying the existing social security, public, and private financing institutions under the umbrella of the General System of Social Security in Health (SGSSS). The reform aimed to create quality-centered competition among service providers and insurers by allowing insurers to negotiate service rates with both public and private providers, for government-mandated standard packages of health services. As of December 2008, 90% of the population of 39 million was covered under the SGSSS.

Within the SGSSS, the reform created two parallel insurance schemes to target different sectors of the population—a Contributory Regime (CR), which, like ESIS, targets the higher income population in wage employment, and a Subsidized Regime (SR), which, like RSBY, targets the lower income population. As of December 2008, 39% of the population (17 million) was covered under the CR and 51% of the population (22 million) was covered under the SR.

The CR is mandatory for all formal and informal workers who earn at least one minimum salary per month— defined by the Ministry of Social Protection as US$223 per month in 2007. Payroll contributions are collected by 21 different Health Promoting Entities (EPS), which are either private (for profit or not-for-profit) or public insurers and are regulated in terms of benefits and financial standards. In 2007, 8% of the enrolled population was affiliated with a public EPS, while 92% were affiliated with a private EPS. The EPSs are responsible for channeling the payroll contributions to the Solidarity and Guarantee Fund (FOSYGA), where the funds are collected and pooled, making it possible to cross-subsidize care for the poor. Funds are then returned to the EPS in the form of a risk-adjusted capitation payment unit (UPC). EPSs act as purchasers, buying services from a mix of public and private providers.

The Subsidized Regime (SR) is targeted toward the lower income, informal sector, and retired populations. The insurer for those enrolled in the SR is known as a Health Promoting Entity of the Subsidized Regime (EPSS) and functions similarly to the EPS with the exception that it does not collect any contributions from those whom it insures. This target population is identified through the Selection System of Beneficiaries for Social Programs (SISBEN), which is a proxy-means test designed to identify the most vulnerable members of a municipality.

Colombian Public Risk Pools

	CR	**SR**
Population	17 million (39%)	22million (51%)
Source of Finance	Payroll contributions	Subsidies from the CR and from general taxation
Benefit Package	Comprehensive	Primary, Catastrophic
Providers	Public or Private	Public (some Private)
Payment	Capitation for primary care, fee-for-service for hospital care	Capitation for primary care, fee-for-service for hospital care

Of the 12.5% of wages paid by those in the Contributory Regime, the FOSYGA channels 1.5% into the Subsidized Regime (SR) as a solidarity contribution, while the remaining 11% stays in the CR. In this way, FOSYGA provides cross-subsidies between those in higher and lower income groups.

Since the benefits under the SR are broad but not comprehensive and a small number of Colombians are still not covered by the CR or the SR , the government also sponsors the Basic Health Plan (PBS), a safety net financed by general taxes that allows anyone to use public hospitals and health centers at no cost. In addition, public health interventions with high externalities, such as de-worming and the early treatment and control of contagious diseases such as tuberculosis and malaria, are paid for separately from the Ministry of Health budget.

Financing and Political Trade-offs

Colombia has made great strides toward its goal of universal health coverage. However, certain issues remain that will impact the future performance of the system. The country is grappling with equalizing benefits between the CR and SR. It has faced lawsuits from SR citizens demanding the same benefits as those afforded in the CR. Depending on how policy-makers in India design the risk pools and health benefits of various programs that can move the country toward UHC, they may wish to consider whether similar legal actions might complicate the task of expanding coverage.

While Colombia currently spends 7-9% of its GDP on health, expanding CR benefits to the entire population would significantly increase spending as a percentage of GDP, making it difficult for the government to afford a complete merger of the two schemes. Colombian officials recognize that a balance must be struck between the provision of comprehensive benefits and the financial sustainability of the system.

Key Lessons from Colombian Reform
1. Colombia has greatly expanded coverage in a short time using a mix of wage taxes and general taxation, centralizing revenue collections, but then transferring money to multiple competing fund holders (EPS) to purchase standard benefits packages from mostly private providers. 2. Risk pools of higher income households contributing wage taxes can subsidize risk pools for lower income populations. Thus, two pools can still achieve many of the same goals as a unitary pool. 3. In a managed competition model, multiple health funds can compete on the basis of quality and responsiveness even when the benefits package is fixed for everyone. A central agency can also redistribute premiums on a risk-adjusted basis. 4. Financial sustainability remains a challenge in a country where a large share of GDP and government spending is allocated to health, and where there are demands for additional services to be added to the guaranteed health benefits package. 5. In implementing its risk pools, Colombia uses a purchaser-provider split.

Part II: Options for India

Creating state-based risk pools. PHFI[1] has argued for the three central government insurance schemes (ESIS, CGHS, and RSBY) to be combined into a single national entity. Existing (and future) state-sponsored plans would serve as a top-up, supplementing the core benefits package of the national insurance plan with additional higher cost hospital services. Shiva Kumar and colleagues go further and support a single-payer system for India as a solution to pool risks across heterogeneous groups and to provide insurance for all citizens (Shiva Kumar, et al., 2011).

While fewer risk pools may confer certain advantages, there may be compelling reasons – both technically and politically -- why creating a single national risks pool may not be the only or the best solution for India. On technical grounds, India's population is so large that creating insurance pools at state level would still entail placing tens of millions of lives in each pool, thus spreading health risks widely enough to promote efficiency. Since health is legally the responsibility of states, rather than the central government, state-level insurance mechanisms might again make sense. State-based schemes might also help to increase accountability and dialogue among purchasers, providers, and patients.

Attempts to merge the national social insurance programs (ESIS, CGHS) with RSBY and other state schemes would also be politically contentious. Those receiving wide benefits at present under the national programs could feel that their health services would be threatened and undermined by a merger, as was the case in Thailand. As in Thailand, it may be easier politically and technically to work toward a gradual harmonization and equalization of spending, benefits, and processes (e.g., for enrollment and provider payment) across multiple schemes.

Expanding membership of existing schemes. Another option for India would be to increase the membership of existing risk pools and insurance funds. The HLEG Progress Report discusses the possibility of modifying the eligibility criteria for compulsory participation in the ESIS, so that it covers more workers in formal private sector employment including those with higher salaries. The political feasibility of such an action, and its financial impact, might be more carefully analyzed.

Another means for expanding membership would be to move RSBY from its original targeting of the poor towards enrolling the "above the poverty line" population (and potentially deepening RSBY benefits to include more outpatient and inpatient services). While difficult to achieve, technically and politically, such RSBY expansion would build political support for the program across a wider population base. To this end, state participation would be key.

Harmonizing across multiple schemes. While using a combination of consolidation and expansion of existing risk pools, Indian policy-makers could also adopt a variety of measures to

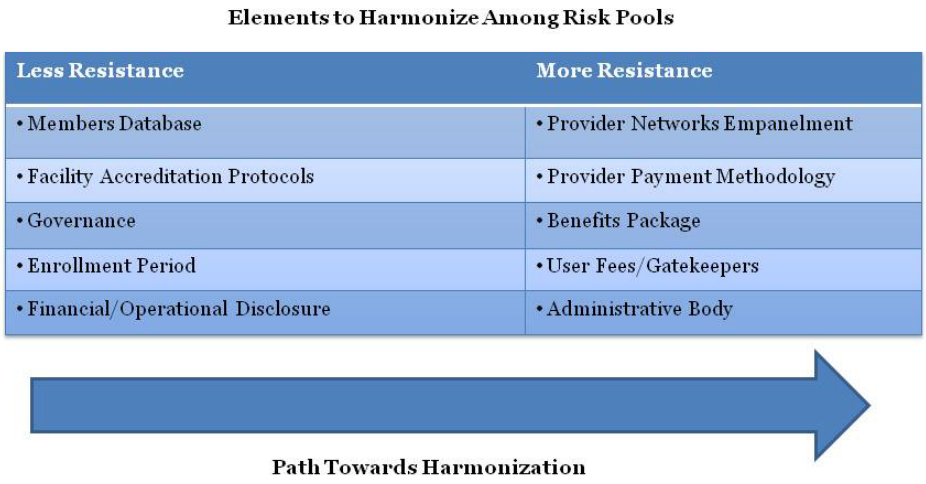
[1] In *A Critical Assessment of the Existing Health Insurance Models in India* 31 January 2011

help to improve the existing health financing schemes, make them more equitable and prepare the ground for a possible future merger.

One action would be to increase the benefits package under RSBY to include some of the services covered under ESIS and CGHS, especially outpatient care and drugs. Another action would be to encourage all of the schemes to use payment methods that better contain costs, including capitation wherever feasible. A third possibility for harmonization, along the lines of the Mexican experience with the Seguro Popular, would be to use differential central transfers to the states in order to ensure that benefits are similar across RSBY-type schemes. A further measure, building on the Colombian experience, would be to have a portion of ESIS's payroll tax transferred to the RSBY schemes in the form of a solidarity subsidy.

The experience from other countries suggests that some efforts to harmonize across multiple risk pools are relatively easier to achieve politically, while others that are more difficult sometimes need to wait until conditions are favorable (Figure 1). Staging of these changes may thus be required.

Figure 1: Path to Risk Pool Harmonization



Conclusions

While broadly speaking, fewer large risk pools have advantages over more small pools, international experience in this area is diverse and there are both technical and political reasons why a number of countries have kept multiple pools as they have moved toward UHC.

In making these difficult choices, it may be helpful for Indian policy makers to study the experience of their peers in other countries. Two key lessons that emerge from this experience are:

1. Focus on risk pool reforms that best achieve a country's underlying health policy objectives (e.g., financial protection, access to good quality services for all, cost

containment, adequate risk-spreading), rather than being attached to a particular structural feature of the system (single or multiple pools, central or state location of the pools, etc). Different countries have achieved these objectives in different ways in terms of their risk pools and health insurance institutions, so "one size does not fit all".

2. Build on what you have when you start – look carefully at your legacy risk pools and insurance funds and see if they can be strengthened and improved. Radical overhauls, mergers, and other such dramatic reforms should not be ruled out, but these may not be needed to achieve the underlying objectives.

The countries we examined for this paper have systematically and gradually staged their reforms, using a combination of (a) new institutions, (b) better oversight of existing risk pools, (c) harmonization of benefits and processes across multiple schemes, (d) carefully elaborated approaches to sharing costs and implementation responsibilities between central and subnational governments – and from time to time where appropriate and feasible, (e) consolidation or merger of existing risk pools. India may wish to consider all of these approaches as it searches for the optimal path toward universal coverage for its own citizens.

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