

Health systems dialogue: Health insurance for Universal Health Coverage

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Sandhya Venkateshwaran:

Good morning or good afternoon depending where you are. I am Sandhya Venkateshwaran, senior fellow at the centre for social and economic progress also called CSEP for short. It gives me great pleasure to welcome all of you to this dialogue today. Just a couple of words on CSEP. CSEP is a public policy think tank with research focused on growth, finance, development on energy and natural resources, on foreign policy. Very recently CSEP initiated a work program on human development with a particular focus on health. We are looking at human development both from the point of view of its intrinsic value and also its instrumental value in its contribution to a country's growth. We are specifically looking at policy for all of the areas that contribute to the development of human capital in a country. That is where health comes in. We have very specific focus on health. Our work program aims at analysing health policy and the system from the perspective of improved outcomes and reducing the financial risks associated with accessing health care. As part of this work, we have several strands to this work. But in the last few months we have been engaged in distilling insights from the health system across other countries. Particularly focusing on mechanisms of governments of financing or organisation to see in what way these aspects have contributed to improved outcomes and building resilient health system. These papers will be on our website very soon. Please look out for them. We are focused on six countries that are China, Thailand, Indonesia, Brazil, Turkey and Mexico. Having done the analytical work we have now developed a dialogue which basically examines different aspects of health systems. These dialogues, it is a series. These dialogues focus on the countries that we have studied specifically but of course they are broader looking at other countries as well. The dialogue today focuses on the possible pathways to provide universal access especially in resource constrained environments. This is a cross country dialogue. And today we are particularly drawing insights from Thailand, China, Indonesia and India. To draw these insights we are honoured to have a stellar panel with us. Prof. Winnie Yip, we have Dr Viroj, there seems to be some confusion. Madhurima will talk about him. He seems to be stuck on a flight. We have Dr Nachiket Mor and Dr Jack Langenbrunner. Each comes with experience in terms of designing or analysing of different ways of engagement with health systems and we are thankful to all of them for taking the time out to share their knowledge and their insights with us. So on behalf of CSEP once again a warm welcome to all of you. Madhurima, over to you.

Madhurima Nundy:

Thank you Sandhya. I hope everyone can hear me. Good evening, good afternoon and good morning. Thank you for joining us for this first dialogue on health systems organised by CSEP. I will straight away go to the focus of this webinar. The idea of universal health coverage better known as UHC is one of the sustainable development goals as envisaged globally for all individuals to receive health services which are comprehensive from preventive, promotive, curative to the rehabilitative services without suffering financial hardships. It also embodies within it the ideas of equitable quality and responsive health services. As Sandhya mentioned that here at CSEP have been analysing health systems of select countries and the health system reforms undertaken by these countries to attain UHC in order to draw insights for India. The countries selected are of course quite diverse given their political and socio economic histories but there are convergences and divergences across these countries in terms of dilemmas and the policy experimentations towards UHC. These really provide valuable insights. So today's discussion focuses on China, Indonesia, Thailand and India. And we focus on some of the key

issues regarding their journey towards universal access to health services. Before I get down to the questions I would like to introduce the panellists. We could not have had a better line up of panellists today because getting them together on the same day is quite a difficult feat. But we are lucky to have them together. But disappointingly Dr Viroj is unable to join us because he is stuck in a flight which is delayed and he hasn't yet landed. All four are renowned experts in the field of global health systems and health policy and have contributed not just to policy research and teaching generation of students, but also have been architects in designing health systems. Prof Winnie Yip is at the Global health policy and economics in the department of global health and population at the Harvard T H Chan School of public health. She serves as a faculty director of the school wide China health partnership and has recently completed her appointment as acting director of the Fairbank centre for Chinese studies at Harvard University. Doctor John C Langenbrunner better known as Jack is senior advisor for financing and health insurance. Jack is a health economist with both research and operations experience. He has worked in India since 2015 and was a senior officer with the Bill & Melinda Gates foundation from 2015 to 2018. He has also several publications and his recent book co-author was with NITI Ayog. November 2019 which was 'a health system for a new India building block'. And his other most recent book is 'health financing and universal health coverage in Indonesia'. Dr Nachiket Mor, within India probably doesn't need introduction. He is a visiting scientist, the Banyan academy of leadership and mental health. Senior research fellow at the centre for information and technology and public policy, IIT Bangalore. His current work is principally focused on the design of national and regional health systems. Dr Viroj of course is not here. But he is known as Master carpenter of the Thai health care. It is a real disappointment that he is not able to join us. But we still hope that probably he can make it if his flight lands in the next half hour or so. So it is a real pleasure to have you all. Thank you so much for agreeing to be here today. The format we are following today is one set of questions followed by a Q&A, then the second set of questions followed by another round of Q&A. We will get down to the structure now. We will have two rounds of questions. Each of these will be followed by Q&A, We are requesting the participants to please post your questions in the Q&A box. Let me start with the first question to our panellists. Despite variations across countries and attempts to provide universal access an important challenge has been of inadequate financing, sub optimal pooling. And there have been mixed sources of financing to pool resourcing. General taxation and there is a combination of insurance schemes like voluntary and compulsory, both. Sometimes supplemented by the government subsidies. So in a resource constrained environment what are the possible pathways to provide universal access? We recognise that voluntary health insurance is not the path to UHC since it could pose opportunities as well as risks for equitable progress. There is a viable possibility of making this an option in a resource constrained environment. Voluntary insurance as a share of total health insurance is growing in many countries. And one key factor has been, especially in the lower and middle income countries the emergence of the middle class which is willing to pay and purchase premiums. So which I would not mean only commercial insurance, but government managed schemes or as we see in Indonesia and China, how have China and Indonesia achieved universal access to VHI, voluntary insurance schemes and what has been the experience probably since Viroj is not there Prof Jack and Nachiket can actually give their inputs on Thailand in this regard. What has been the experience in these countries and what are the possibilities and challenges in the future of expanding the voluntary insurance for India? Winnie can you go first?

Winnie Yip:

Thank you very much. It is exciting to be on this panel. And I see a number of friends in the audience as well. So I look forward to interacting with other panellists and also the audience. Your question is given resource constraint what role can voluntary insurance play, what is China's experience, what might be the implications for India? First of all I want to clarify voluntary, because China actually has a social health insurance scheme that on paper is voluntary. And I would go into that. But I think we are more talking about voluntary in terms of private insurance. Let me start by just saying that we all know that voluntary private insurance cannot reach UHC and the key reason we have to keep remembering is that private insurance are for-profit. That is the key. For profit private insurance would only want to enrol healthy people. So let us put that aside. But remember that. I think this question of what role voluntary private insurance can play, we need to go back to a starting principle. The principle is for a country to think about how much priority it gives to equity. If equity is important then the government needs to play a big role in financing for health care. I just want to limit to financing for this session for this question. So let me just walk through with you what is China's experience and what China does. China makes it very clear that equity is important and therefore the government needs to put in money for financing health care and I have said many times that in a short period of ten years between 2008 and 2018 China actually quadrupled its spending on health care in real dollar terms. In real and not even nominal. So if equity is important that is a question that cannot be shied away from. We can't say that a country care about equity but not put in the money and ask what voluntary insurance can do. So let me just put that straight. And given that still not government can fund everybody and everything. So there still needs to be a question of what to prioritise. But given the equity priority what China has decided to do in the beginning is shallow coverage but for everyone. So everybody would be covered but the benefit package in the beginning is very shallow. There was a lot of criticism from international experts at that time. But I would say over time it was a right decision. It was a right decision because when you have everybody in a same program over time when there is money then everybody get lifted up together. You are not favouring any population against another population. And this has implication on purchasing which is the second question. I will come to that later. Over time China then was able to put in more money and the benefit package has been more generous. Actually recently China is only until the recent few years beginning to encourage private insurance. The fundamental question that China raises is that the government should be responsible for basic health care. And implicitly saying that non basic can be left to private. Now how to draw the line for basic is a much more difficult question. But at least in terms of principle that is what China is using. So what is non basic? At least at this moment some of the non-basic services are actually things that are rare diseases. So recently China is actually pushing out a class of private insurance to cover these rare diseases. But these private insurance is rolled out in a very... on one hand innovative but on the other hand remains to be seen empirically whether it works. The government actually help promote that. So it is not the private insurance company who promote that. The government help promote them to give people the confidence that these insurance is actually credible. And because they cover rare diseases, it means that a small share of the population would need to spend money on those health condition. And meanwhile they are getting almost everyone to enrol in it. Which means that the premium that people need to pay is really tiny. So the key is to get a lot of people to pay into that and the way the government is trying to do it is, the government itself is giving people the credibility and the confidence to encourage them to buy it. And therefore you are seeing a lot of program that say that they would cover a lot. If you do

have that condition, but you only need to contribute a small amount of money. And this is in a way trying to reduce risk selection. I think that this experience... so what I am trying to say is that the way that China has chosen to use its that is the government with the social insurance program is responsible to cover a benefit package what they call basic for everyone, leaving room for supplemental for the private. They haven't defined what is supplementary for the time being. I think this experience is, this principle is, quite similar to number of European countries. If you look at Netherlands and Switzerland, there is a uniform benefit package that is put on the public insurance program and then leaving room for private for a supplemental. But I think all these countries are using the principle of not slicing by population, but slicing by surface. Let me talk now a little bit about what do these have to do with India. India has decided by slicing by population already. Now there is question of will the government then still be paying for a public insurance for the missing middle for the time being... the missing middle... and then still have people buy some private insurance or pay contribution. My view is that there is a role for voluntary insurance but in the outpatient sector. The problem with voluntary insurance is risk selection. To reduce risk selection people need to see the benefit of it. If insurance only covers in-patient, you would definitely only be able to enrol those who are really ill. But if you would cover the outpatient services a healthy population would find it valuable and they would find it attractive to buy outpatient insurance. And there I think some of the US experience of managed care and also more population base kind of insurance schemes that get people to buy into some health insurance. It is almost a health benefit package. But encourage people to have early detection, early screening, early disease management, it is actually not a bad idea for India. But the question still remains how you then integrate this with inpatient services which is covered by the government. So we are not talking about perfection, we are talking about given your sighting point what you might be able to do. Here are some of the thoughts that are thrown around that we can discuss further. None of them is perfect. Because you still have to start with your starting point. The starting point is already slicing by population. And then for those poorest population of 40%, the focus has been on inpatient, which is again not really the right thing to do. China really paid a price for it because when you just focus on inpatient it actually gets the system a lot more expensive. So expensive now that I am not sure China can continue to pay for that continued increase in health expenditure. I am going to stop here so that we can have time for others to chime in and then we can have a discussion about that.

Madhurima Nundy:

Thank you so much Winnie. Jack, can you come in next?

John C Langenbrunner:

Thanks to the CSEP team. It has been great working with you and thank you very much for the opportunity to join today. So I am going to say a few things that are similar to what Winnie has said and also say a few things that are slightly different. Maybe that will be a little bit provocative for the audience and also generate some good questions. To recant as Winnie noted, universal health cover which requires pooling of funds and pooling of course allows funds to reach the rich and the poor, the old and the young, the sick and the healthy, but you can say voluntary public or private managed insurance might be a plus on the one hand. It covers health needs. But it is really not part of the overall pool which can hurt both efficiency and equity. Now Winnie emphasised equity but I will also emphasise efficiency. Efficiency in

that the pool is fragmented and purchasing has less leverage. Equity of course and the voluntary insurance is often the domain of the upper income and the healthy groups that Winnie eluded to. I think the US and South Africa are prime examples here. We can come back later to discussing some of these countries as examples. Now Indonesia, voluntary insurance is not really been a player in reaching UHC. Indonesia began with separate parastatal pools for the poor, the formal private sector, the military, the civil servants and the police. They are also a district based insurance pools, Indonesia is a very decentralised country with about 520 districts. So there were really over 500 various district pools with different benefit packages with different premiums and so on. All of these pools the five national pools and the district pools, are merged in 2013-14 to form a single payer. That was quite impressive on its own. Voluntary insurance does exist today in Indonesia for private enterprises. They buy insurance for employees and they buy insurance for families of workers. But it is duplicate coverage. It is duplicate coverage to the single payer and it does buy greater access to branded drugs, to more tests, to private providers, there is an emergence of big private provider networks in Indonesia especially in urban areas. But overall it is less than 10% of what we would call the insurance market. Insurance market being both public single payer and private insurance market. For me from my perspective if Indonesians were smart they would consider doing one or two things. The first option might be they could establish carve-outs for these enterprises buying private insurance. Whereby a) enterprises would pay into the single payer so that enterprises would pay into this overall national pool and b) they could receive back per capital rate which could be used to establish contracts with preferred providers for their workers. Now the single payer would both receive these funds and would reallocate them to the organisations, to the employers but at the same time the single payer would monitor performance. So these carve-outs would be dependent on performance year after year and if they don't meet the minimum standards in terms of quality and efficiency they could be reconsidered. The second option might be to develop a supplemental health insurance market where there would be a very clear demarcation of the basic package and the supplemental package. I think Winnie touched on this a little bit. If you are going to have a supplemental health insurance market, the first principle is really this clear demarcation of the package. What is in the basic package and what is in the supplemental package and consumers need to know that. Whether it is employers buying or whether it is individuals and families, they need to know where the line ends for the basic package and where the line starts with the supplemental package. So any individual or enterprise would pay into the single payer, but then also be free to buy additional services. Additional services that could be a private room, hotel services, it could be extra tests, it could be expanded drug package or things like that. As Winnie has also mentioned there are supplemental markets, there are variations in supplemental markets with some good models in the EU. Sometimes they are privately run, sometimes as in Croatia and Slovenia they are actually run by the single payer. You pay an additional three or four or five percent of the payroll and you pay into that and they provide supplemental services. There is variations across Europe in terms of these private insurance markets. But I think as Winnie mentioned the latest data I have seen suggested no more than 16 or 25 percent of the population will buy this supplemental package in the EU countries. So these two options I mentioned, either a carve-out or a new supplemental health insurance market, they need to be regulated, they need to be monitored, but neither option has occurred as yet. Thinking about India I think for various political and cultural reasons, here I am little bit different in my opinion than Winnie. But that is good for the discussion coming up. I believe India in 10 years might look more like Germany

or Switzerland or Netherlands. Now they have supplemental markets, they have supplemental private insurance markets but at the same time people do have a choice to purchase private insurance. But it would be mandatory basic package. The basic package that would be mandatory and everyone would need to have some sort of coverage. So you can join the PMJAY if you are poor, you could join maybe either publically run insurance or privately run insurance market. But at the same time it would be mandatory. It is not going to be voluntary. I want to say that however, I emphasise that however, these countries in Europe do manage and regulate these non-governmental insurers and they do so along certain lines. I think of it as at least in five areas they manage. They manage it quite closely, these non-governmental or these non-social health insurance markets. The first area the funds are pooled. The funds are pooled virtually. Perhaps you as an individual, family or an employer you pay into one pot and it is redistributed to an insurer. It is chosen by the individuals or by the employer. But nevertheless it is a kind of virtual pooling. A virtual pooling and then redistributed according to choice. Secondly the second principle is the benefit package is standard. So no matter which insurer you choose your benefit package is going to be clear. And it is going to be standard across all payers. There is not going to be any difference. Third principle is that the IT system. The IT infrastructure is standard across payers. So you have some level of interoperability. You have unique identifiers. And you can use that information later to pool in some information about performance and comparisons. Similarly the fourth principle would be the quality matrix would be standard across all payers, for performance assessments and comparison purposes. And fifth your payment systems would use essentially the same pricing, the same incentive structures. So for example if you are going to think about a DRG system as the national health authority is now thinking about, that DRG system with the same pricing structure would be applied across all of your payers, all of your insurer organisations whether you are social health insurance, whether you are government insurer or whether you are a private insurer. So this approach in these countries are variants of the so called 'managed competition' model. The 'managed competition' model is really the brain child of a Stanford professor Allen Enthoven. It is not a new model. I think he wrote his books in the 1980s. It really is a recipe for the disasters in the United States private health insurance sector. I think Obama care in the US did pick up some of its elements though not all of its elements. I also want to note that the colleagues in India at ___ research institute have been looking at this model and they have written a couple of very nice papers on its applicability to India. I am very pleased there is some interests already in India about the 'managed competition' model and some of the good things and may be some of the challenges that the European countries like Germany or Switzerland or the Netherlands are facing. So overall too in this managed competition model the system is governed by a sort of a governing board. Governing board to oversee the system, to update the system, every year the benefit package has to be updated, every year the prices have to be updated, every year the IT system may need some rethinking and the quality metrics. So there has to be a board to oversee the performance and also to update on a regular basis. For India would you have a board in each state where you could, but I would probably prefer to see a national board. A national board that would really allow comparisons and best practices to be recognised nationally. In the last point I will make before I turn it back to our moderator would be, would India need a new board and I would argue that now actually the national health authority could grow into this role over time. Say in ten years or even say sooner in 2030 this goal could be achieved. I don't think it is too early to start thinking about a timeline and even thinking about a step by step for doing this. Let stop here and back over to you.

Madhurima Nundy:

Thank you so much Jack. Very interesting insights from Winnie and Jack, both from the Chinese and Indonesian as well as some of the other countries which Jack mentioned in Europe regarding coverage, the mechanisms, how insurance works and the combination of insurance schemes. Like the voluntary itself is a very broad term in that sense. So it is a mix of... We would also talk about private insurance but also looked at what voluntary means when the government makes the voluntary schemes accessible to people. But of course the principles of equity and efficiency need to be definitely considered. I will move to Nachiket before I kind of make the other point. So Nachiket please if you could give your insights.

Nachiket Mor:

Thank you Madhurima, I am happy to be here. Most of the commentary that you got from Winnie and Jack is all very valuable and gives us very important perspectives. I am going to try to build a little bit from our perspectives. The Indian perspective and see what implications it has. Unfortunate reality we are facing in India is that the state of public finances in health care is in very, very poor shape both in terms of adequacy of financing. Less than 25% again state by state the number varies. But relatively small portion of money is coming from tax resources. Schemes like the ESI which is a social health insurance scheme which is a relatively large scheme has a claims ratio of 40 to 45%. So even the point that Jack named about efficiency, even a private insurance organisation has 60 to 70% claims ratios. Many state governments have launched, they call them insurance schemes but they are really purchasing schemes which they are using tax money already limited tax money. They further fragmenting it. But tiny amount like .02% or .05% of it and launching yet another purchasing package to try and see if they can somehow make that little money that is available spread out even thinner. While all other work that you all are doing in CSEP and other people are doing, there is continuing hope that this will change. The government will give us more money, that there will be ways to use the money better. But I don't see that happening. I in fact worry that somewhere near 70 to 80% of our population is going to be reliant on the most inequitable source of financing. I know Dr Yip is concerned, voluntary insurance is inequitable. But even more than that is out of pocket pay out. I think that is the dominant financing in this country. In fact I would argue in most developing countries. Therefore I don't see an alternative. But for us to really think about what can we do in an environment where the government will remain and public finances will remain a tiny portion of the solution and we are not talking about supplemental coverage. We are talking about basic coverage that is just not available to people. Even some of our richest states like Kerala while it spends a fair amount of money in terms of adequacy, 70% is out of pocket. Now the question is, there is no doubt, there is lot of empirical evidence that you cannot achieve universal health coverage with contributory or voluntary insurance. No country has done it and even countries that like the US etc. that do use insurance markets, a lot of it is mandated and a lot of it is like our ESI. It is really not that people go out and purchase schemes. There is some hope from the market places in the US that you are getting subscription. But if you look at the data post Obama care, much of it has been extension of medi-care and Medicaid that has brought new people under coverage. It hasn't really been people running out to buy a lot of voluntary insurance. But the question is in India we have even worse position. Even if I want to buy, let us say I am that unusual individual or unusual family that wishes to buy insurance, I have no choices. There is nothing available in the market. I do believe that while we will have to wait and see whether that will provide coverage to may

be 25% of the population or 30% of the population, can it at least add some additionality to what is available right now. There are many barriers in India that I would say prevent that from happening. For example commercial insurance in India the entry barrier is six times that of the European Union. You need to put up six times more capital in India to set up an insurance company than you need to do it in France. There is really no logic for something like that. And clearly moving in that direction could be helpful. The dominant form of insurance in India is indemnity insurance. Even the new schemes that have been launched by the government, various state governments have the indemnity character. Clearly there are number of issues with it that I would say we have to learn from medi-care and Medicaid experience that over a 25 to 30 year period. Is that really going to end us up in the same position as the US finding itself today where costs have just ballooned out of control? But there is an opportunity and the insurance regulator has made some moves now to help us think about managed care as a possible idea. Is it possible that if health care providers particularly the large well known health care providers start to offer managed care programs in which primary secondary and tertiary is covered as a part of a single package, would that lead to additionality that would be different from what other countries experiences. I think there is an opportunity in any case, I think it is an opportunity for us to move forward on moving from indemnity insurance. And finally the insurance regulator has announced some time ago a standardised insurance scheme that all insurers are required to offer. Unfortunately the pricing on that is in a sense almost designed for adverse selection. And you haven't seen much take up. Is there a real option for us to think about a public option? An option in which the government designs the program. The government offers it, government administers it. It doesn't just facilitate commercial insurance markets from coming in, but brings them all into a program managed by itself perhaps using a managed care type framework rather than the **Israeli** style management care framework rather than indemnity insurance. Again I think that would add some additionality. Dr Yip has been sharing with me some insights, I hoped she might mention it, maybe it will come later about how community based health insurance, how programs of mutuals and people coming together, there are existing trust based groups. Like self-help groups like credit cooperatives that already trust each other. Is it possible for us to imagine a contributory program from that that then indeed offers us an opportunity? While I am very much in agreement with our learned speakers that really voluntary insurance doesn't offer a pathway forward. But in a way I would say to them we have count of factual, yes in the ideal world the government comes up with the money and then we think about what to do with insurance. We are in a situation today where there is not enough money and there is a gap, enormous gap. The question is what additionality we can think about. And that is really where I would like to think about commercial or voluntary insurance. Thank you.

Madhurima Nundy:

Thank you so much. Yeah, Winnie. You have your hand raised.

Winnie Yip:

I thought it will be interesting for the panellists to have a little discussion before you take questions. Is that all right?

Madhurima Nundy:

Sure of course.

Winnie Yip:

I want to respond to both Jack and Nachiket in the following sense. And also given the audience whom I see the name list, I agree that in an ideal sense is that the government spend more money from both equity and efficiency perspective. But I also agree that we might have to face the reality that if that doesn't happen what would be the, not even the second best, maybe third best and fourth best compared to today. So I think a lot of time these discussion, the comparison point is not quite the same. We are often talking about an option compared to an ideal versus another option compared to the present. I think Nachiket is coming from (break in audio) and you can go through that employment channel to get employer employee contribution into the mandatory and if India doesn't have that condition satisfied that is formal sector employment and if the government doesn't put up the money that is needed to have that uniform mandatory benefit package is satisfied then I think we are going down the route of... unfortunately it is going to be a fragmented financing. So the question is... that is how I would think about it... among the different forms of fragmented financing what would be the least damaging. Every time I act on that, in that sense Nachiket and I have also had prior conversation, I do agree that there are opportunities whether it is government run or private run, should try out and I would like to use the word a piloting to learn the lessons of some form of managed care. But the key is it has include outpatient primary care. Because that is the only way to reduce adverse selection. That is the only way to try to... I am sympathetic to that is because that actually might also provide some health management rather than disease based insurance and so it is not a bad idea to think about it because that actually also do try to lead to some changes in the delivery system. We talk about financing, no financing is sustainable until you can change your delivery system. The only way you can change your delivery system I believe is that you have to go through the financing lever right, I mean providers unless the government can directly dictate them. Beyond that it is really the financing lever that can make them change. So I'm sympathetic to that idea and open to that idea but on a pilot basis because there are many mistakes that the United States have made. But that would still be moving India down a route of fragmentation. But that unfortunately and I think the thing we want to think about carefully is how can we do these kind of pilot that would reduce future fragmentation. Because we are saying that for the immediate term it is very difficult to see the government putting up more money. But at least we don't want to test out managed care in a way that create a situation that at the time when the government are able and willing to put in money it is not possible anymore. I don't know how I am saying it, but you know what I mean and in the rural area its some form of risk pooling scheme that draws on the self-help group and all of that and that is we can talk about separately. I think that for the conversation today, there is a question of... I think the big elephant in the room is, is the government going to put up more money and that is going to be two very different options that we are proposing.

Madhurima Nundy:

Thank you Winnie. Jack, please go ahead.

John C Langenbrunner:

Thanks very much. Couple of comments to follow up on Winnie's many good comments. I can't answer them all but I do agree with this issue of fragmentation and a scholar at the world bank from Osama state once said to me that the problem with India is that they have reform after reform, but they put each reform on top of the other. And they never quite rationalise the

entire system. So the fragmentation issue certainly rings true. Now I also like her ideas about piloting. And you know going back to my point about having a board, a board could oversee the piloting. The board could oversee the piloting and in China they have pilots that on-go all the time. In the United States we have at any one time over 200 pilots in the medi-care and Medicaid program alone. Some of these are county based, some of these are state based and some of these go beyond the state level but nevertheless the federal government says who has an idea, please come to us with an idea. Or maybe the federal government has an idea. The federal government puts some money into it. There is a design period, there is also an evaluation that is mandatory. There must be an evaluation. There are only two criteria that you really need to address when you develop a pilot. One is cost containment, is it going to cost the same or less than the way we do things now and quality, will outcomes change. If outcomes are going to not improve then you may not meet the threshold for putting together a pilot. These pilots run for three to five years typically. One of the interesting things about pilots is that some of them may not be so successful from a technical standpoint, but people like them. People like them, people say let's do it this way in the future and so they are integrated into legislation. In other cases you see just the opposite. They may be saving money. One pilot recently was a coronary bypass surgery where they paid for an entire episode. But they also had centres of excellence in only a few places in the country, let's say Texas and let's say Boston, let's say Los Angeles, people didn't want to travel. So they didn't really liked that idea. Anyway, these pilots could be done and they could be done through the national health authority. And that would be quite interesting. Now the public option and the issues, I like the public option idea. I also would say let's think about it in terms of the Chinese experience which is in the rural health insurance program, it was voluntary but at the same time the Chinese government put up something like a combination of national and state level and local level funding. But all together it was something like 90% of the premium. There were also targets in each county that leaders needed to reach in terms of the central and national level being happy. So county leaders told me they would go door to door, they would knock on the door, they would enrol people, if they couldn't pay their premiums initially they covered that ten percent. That wasn't a problem. So they were able to enrol a very large number of people in this rural health insurance scheme. I am a little out of date on what happened. I am sure Winnie can correct me. But I do think coming back to this public option there could be some public option. It would have to be subsidised, but there is money in the system now. The money in the system now is going to line items. Money is going to line items, it's going to supply side funding. What if you reallocated that money into pools that would subsidise premiums for the public option or say for another option that people could choose and that is where I think the politics create a huge barrier in India. But nevertheless. I think the NITI book in 2019 laid out step by step on how this could be done, on how the line items could be diverted into more of a pooling mechanism. Pooling mechanism could in turn then subsidise the premiums. So I think this public option is quite interesting. There could be some adverse selection. People might choose a private option but then get very sick and have to move to the public option where they would be very expensive. So I do think there could be some adverse selection issues but nevertheless interesting idea that's put on the table. Back over to you.

Madhurima Nundy:

Thank you. So given the interest of time, I will just take up one question probably from this particular discussion that we had. There is a question on given the evidences and experience a

supplemental role for the private health insurance is apparent. The continued exclusion of primary care from all types of insurance or negligible progress on it is worrisome. Prof Winnie touched upon it of course. But in reality government and insurers alike are risk averse to cover outpatient services. Government coverage of primary care is in the form of health and wellness centres as we see in India. But continuum of care is missing. So private insurer's outpatient services is poorly underwritten that costs a large fraction of the coverage benefit as the premium. So how do we see UHC progressing in this kind of an environment? Nachiket would you want to go?

Nachiket Mor:

There is a little bit of subtlety that I want to point to and maybe Jack and Dr Yip can comment on it. In an indemnity insurance environment which is where we are today primary care is not insurable. It doesn't have the volatility that is needed. So if you are going to deduct 30 or 40% of the cost from that to take care of your administrative and channel costs it is just unworkable. Which is why in an indemnity market one would talk about prepayment, one would talk about subscription, one will talk about other mechanisms that one could explore. I think in a managed care environment where you are now talking about a program in which health care is a part of the overall, there I think what Dr Yip said is a very valuable point that if you don't actually have primary care as a part of that overall structure, then what are you managing. The whole idea of managed care is that you are managing for early impact, you are managing for long term impact and you are not simply waiting for people to show up with advanced cancers and advanced cardiovascular situations. So that is I would say the subtlety if the question is why don't we add out of pocket insurance in the current indemnity environment, I just don't think that is an interesting idea because it is just... it is not consistent with the nature... I would go much more with what Dr Yip said earlier which to me has been an important kind of defining issue, a shallow universal coverage. For tertiary care, rare diseases, rare conditions, that meets the character because now you have got very high volatility and volatility reduction that you get through the insurance function allows you to pay for a large expense. I would go much more in fact almost in the opposite direction than in the direction of out of pocket payments for primary care in an indemnity environment.

Madhurima Nundy:

Thank you Nachiket. Winnie do you have any comments?

Winnie Yip:

Now I agree when we talk about outpatient it is not really like isolated outpatient services. It is really taking an advantage that there is a gap to try to introduce some new ideas into to really try to get people to enrol into health plans to make them happy. I mean to use the China experience, now that only has happened in the... I would say... richer middle income cities that are experience of these insurance plans selling. They don't even call it health insurance. They call it health benefit. It is very attractive because they tell people now when you have problems you can always come to this clinic, you don't need to go around and we can guarantee that the drug we provide you is not fake drugs. And they send out reminders that you have to come and do your health check up every year. And they enrol the parents, the children and the thing that they use to attract people is one is this prevention program. But it is also its nice ___ right? You go into the clinic, it is clean, it is orderly and so when you have that group once you

have an engaged population you can also do other things in terms of provider payment as well to change the behaviour of the provider. So that's relevant for the next question that you are going to ask. Because financing cannot be talked about in isolation with the service provision and the linkage is provider payment and purchasing. For as long as you do not have a capture population the kind of provider payment that you can use creatively, that is really encouraging people to keep themselves healthy is very limited.

Madhurima Nundy:

Thank you. Jack any views, very brief.

John C Langenbrunner:

I don't think so. I think you can either have managed organisations and you could do that through pilots or you could do that through aspiring employer organisations that might be interested to do that as we saw in California in the USA a hundred years ago. Or you can manage the market. You could manage the market so that over time you have to really start extending that benefit package and make it mandatory. Over to you.

Madhurima Nundy:

Thank you. Let me just quickly move on to the next question because we don't have much time left. Then we can come back to the questions in the discussion. So we have already in a sense addressed the second question also in many ways. But then this is more specific to do with strategic purchasing. Once the money is pooled and how does one spend the money to get more health for the given money. So strategic purchasing has been viewed as one of the key policy instruments to achieve the UHC. And many countries are moving towards this direction. So as we see in the case of Thailand, China and Indonesia the purchasers are typically public agencies who detail the core purchasing functions. They specify the benefits, contract, arrangements and provider payment and performance monitoring is being done by them. They have set up institutional mechanisms for these. So like Indonesia has the social security managing agency BPGS to implement their national health insurance, Thailand has the national health security office to implement their universal coverage service. And China has recently tried to institutionalise kind of the fragmented system that they have under the NHSA which is the national health security agency for purchasing services for implementing their rural and urban health insurance schemes. So what have been the experience of these agencies and purchasing comprehensive services, also the challenges in terms of the power dynamics between the ministry of health and these agencies? So Jack has already alluded to it, but can that NHA National health authority in India be seen as playing a similar role in India. And so can we get some insights. Also it would be good if some of you just allude to what experiences Thailand has gone through. Thank you. I think Jack would you want to come up first for this?

John Langenbrunner:

Thank you very much. I will do my... I know a little bit about Thailand I will extend the discussion and your point about governance is extremely important and I think this has been a challenge in Indonesia and I will sort of touch on it through this strategic purchasing discussion. First of all let me say, I am an enthusiast for the national health authority of India. They are off to a good start. They have had good leadership, they have had good experts and while it is a long journey in most countries, they have done some encouraging things. Now

Indonesia, yes they have merged funds as I mentioned earlier and they provide a single payer currently covering about 82% of the population. They have had great aspirations to be a strategic purchaser. And they have developed some good payment mechanisms. As you mentioned in your introduction when we are talking about this strategic purchasing we really look at the literature from say the EU observatory or the World Bank or other places and we see strategic purchasing is really embracing four or five main functions or what I call levers for efficiency and quality. One is the coverage or you know the shorthand might be the 'who'. The second is the benefit package. Shorthand might be the 'what'. Third would be the third lever might be contracting, the 'from whom', the shorthand. The fourth lever might be payment, 'how much' and at what price and the fifth lever and a very important lever is accountability or the quality assurance mechanisms, the 'how well' the purchaser and the payment models and the contracting is actually performing. So with coverage very quickly just a minute or two on each of these functional areas. On coverage I have mentioned they now pool 82% of the population. However public funding is fragmented with over half going to fiscal transfers. The fiscal transfers are really tied in some way but there is no reporting back. So it's really very... and they are often have different rules and regulations through these fiscal transfers. So the purchaser, the single payer only holds about half of total public expenditures and the leverage is diminished in this regard. Then this is probably lesson number one for the national health authority. And it comes as no surprise that pooling and leverage to purchase strategically is needed and they are only now pooling a small fraction of the funds. So this would be sort of lesson number one, I would put on the table for the national health authority. Second lever, the benefits package, Indonesians did a good job when they developed the benefit package. They had a positive list and a negative list. The PHC package the primary health care package was initially 355 discrete items. They put together provider teams. I was quite impressed in putting together this list. Not so good part was that the services came first and then they wanted the money to deliver it. I would say lesson number two for the NHA, I would recommend the other way around. Start with the money and then find the package of the most cost effective services. Because the way they did it in Indonesia services first, the package was too big and then out of pocket payments kicked in. Kicked in at the back and providers sometimes use out of pocket payments to improve their revenues. Third area contracting, I would say there has been some relative success in Indonesia. They have brought together public and private providers and over 50% of all utilisation is now in the private sector. People had a choice to pick their primary health care doctor or clinic in the beginning and then clinics could then refer although there were some patient choice in that referral as well. There still are issues. Supply side readiness is not always there in the private sector so the supplies, providers, equipment are better in the public sector. But people prefer the private sector for the usual reasons. I am glad Winnie mentioned it but the usual reasons of sort of clean environments, provider attitude and absence of queues. Still I would say the public sector is going to be absolutely essential in rural and underserved areas for years to come. I don't think the private sector is going to spring up in these underserved areas. Would be wrong but that would be my guess based on the first seven or eight years of experience. The fourth lever payment here I would say they implemented sophisticated models to begin with but implementation itself has been less than successful. One reason was IT. It wasn't fully developed in implementation. Though it has advanced over time and they do have now unique identifiers for every person and every provider. They did have a data dictionary but the data dictionary wasn't always complied with. So there were some good things and some not so good things there. On the primary care side they implemented simple

capitation but it wasn't adjusted for severity of the enrolled group. Typically you want to adjust for age and gender. Second there was no inflation updates and there has been no inflation updates for the last seven years. They are only now sort of thinking about it and of course that has had a negative impact. Third they haven't been fair to the private sector in terms of adjustment for capital or supply side readiness as I mentioned above. And fourth and last I would say gate keeping was more or less non-existent and that spilled over into hospital problems. On the hospital side they did insert a DRG system. But they used an old US software system from I think 2010 that reflected US protocols and US cost structures. Price did not match cost as you might imagine. Big surprise there. They are now after seven years adapting the Thai grouper. The Thai grouper is an offshoot of the Australian grouper. And inserting their own cost structures and so we do see progress today and I am very pleased to report on that. Here I would say with the national health authority they are moving to DRGs from their package payments. But I think very carefully and they are quickly learning best practices from many countries and so I have been very, very happy with what I have been seeing and hearing in terms of their step by step, in terms of moving to a DRG based system. Final function accountability or quality assurance mechanisms and this is really the saddest part from Indonesia. From the Indonesian story and that there has been little or no effort to monitor quality and performance. Only to pay claims. As a result there has been gaming such as up coding, it's been rather significant up coding. There has been unnecessary admissions. So there was one study that found that 16% unnecessary admissions in Surabaya, a major city in the Java island. But probably my guess would be that 16% is a sort of an under-value of what's going on nationally. I would probably put that number at, at least 20%, maybe higher in terms of unnecessary admissions. We see that overall expenditures for primary health care as a share for overall spending has gone down. It has gone down since the beginning of the single payer and we think it should be the other way around. It was a single payer reform that was intended to really centre on primary health care. But it's done just the reverse. I think this is in part the outcome of some poor payment system implementation. So coming back to some final thoughts. I think for the national health authority, looking at some of the webinars I have been attending I think the accountability measures have been there. And they are from the beginning. I think different states are really trying different things. I might be a little out of date but again I think there has been some initiative to have accountability measures built in and often the RSBY experience was very helpful in having the PMJAY payers think about accountability measures. So final thoughts for India, final thoughts for national health authority as we have talked about, they really need to move to some sort of primary health care benefit package. I think they initially need to develop a positive list. Positive list not just take what is available at health and wellness centres but really developing a positive list and then saying to providers both public and private, here is our package. And who is interested to contract with us. This is how much we are going to pay. So I think by doing that and may be a couple of iterations or may be a couple of rounds I think they can move to more of a unified package including both primary and secondary care. The second is pooling of funds. Again they really need... I have said this before but... they really need to the current line items going to public facilities and states to instead begin flowing to the national health authority. Once funds are more fully pooled and the primary health care package is developed, I think the mission and the real possibilities for the national health authority can be achieved. Now Thailand, they moved this supply side line item budget to the insurer to the purchaser and they did it overnight, from December 31 midnight it all went to the NHSO. How did they do it? They did it in a soft way.

In the sense that they kept their line items for people in public facilities. So you have your providers, your doctors and nurses. They maintain their salaries. And if you look at the budget of any hospital, public or private, 60 to 70% of the payment would be salaries right. The trick was they moved that money and they did a sort of no harm to providers by continuing that level of salaries and the same number of people over time they autonomized some of their public institutions so that there was more flexibility in terms of hiring and firing. But then the rest of the money let us say 30% of the action was really put into a performance based DRG system. So it was a bit of a compromise, it was bit of a soft reallocation of funds but nevertheless they did it. I am sorry that Dr Viroj isn't here today, but maybe you can bring him on at a later time. Let me stop there.

Madhurima Nundy:

Thank you so much. That was really insightful. Winnie can you go next?

Winnie Yip

Yes. In the interest of time I am going to focus on some big picture. One, you are correct that China established the national health security administration a few years ago NHA. One reason China established that was because previously the rural insurance scheme is run by and managed by the ministry of health. The urban scheme is managed by the human resources and social security, labour security. So in order to combine those, it is just politics, the government was not able to get the ministry of health to agree to give up rural or the labour to give up the urban, so they set up a new administration and combined them together. But it is not a bad thing. But because of setting up this new organisation agency it is possible to then integrate previously two separate program into one. I think that is important. Let me talk about a few things. It is a government department, this is the biggest difference between China and Thailand. Thailand's NHA is a public organisation outside the government. So it creates very different governance structure. Within China because it is a government department it is held accountable to a vice premier in the state council directly rather than to a board that with people representing them and all of that. So it is a very different accountability systems, government run. So far what is the experience? So far one of its greatest achievement is that it was able to launch a very effective bulk purchasing policy and program for drug. And the prices for the drugs for the basic services that are covered by the program, some of them have gone down by several hundred times. Just think about how much money is saved for the insurance program and for the people. The second category is about purchasing of equipment. Again the price has just come down huge and when you have a centralised purchaser who covers 90% of the population, I am sorry, the supplier do need to pay some attention to it. So this is really exercising market power in a very effective way. What it has not been able to do effectively is that I think the focus is too much on controlling health expenditure and not enough attention on what it is buying for people. So we actually run a number of training courses for them on value-based purchasing. But if you think about people's mind from their perspective, value based purchasing is cutting costs. And we keep telling them that value based purchasing also means increasing quality. And that just hasn't gotten into that mind-set. And that gives me, get me to my favourite point recently, it is about corporate culture. Because this group is started and NHS is staffed by a number of people who used to be managing social security, public security rather than health. Their perspective, they come with a culture and a priority of managing budget. And the idea that this is about health, you also need to be trading off about

quality and really value for people. They talk about it but it is just not in their head and therefore it is not there in their action. It is not in their decision. The next challenge that I see is that, you set up this new organisation, like India China is huge. Every province, every city has a parallel of that office. And the people that they can recruit to do the work that is required to design benefit package, to design payment method, to implement it and all of that is so thin. So it is really a large group of non-experts managing this big organisation in a decentralised way. I take my hat off to China to be able to do this very quickly because I do a lot of training for both the national and the local office. I know the capacity is very thin. So my one advice is that, I know NHA is doing quite well in India but it is important to strengthen its capacity to do things and design things well. It is not easy and rather than being ambitious, do things gradually but do it well. Rather than adopting a name and this is the problem with China. China said it is going to roll out the DLG. The DLG that it is rolling out is not done correctly, it is not estimated correctly, so in name it has done things, but in practice it is not done the right thing. Thailand, I think that the major lessons one should learn from Thailand is take that organisation outside the government, make it a public organisation that has a board that holds it accountable and the board is made up of people from ministry of health. So the health the delivery side. Because once you have this separation of purchasing and delivery, ministry of health become much more focused on really just the delivery side. And if they are at logger head which is China's problem, you can't even invite ministry of health and NHA to come to the same conference. You have to be able to have a board or some mechanism for the delivery side and the payer's side to come sit together and make them feel that they are at the table to be able to negotiate. Otherwise you are going to get the two sides to not talk, I don't see any health system that can produce any good things when the delivery side and the payer side really hates each other. So Thailand does that. And because by taking away from the government it is also able to allow it to have flexibility that is not tied by rigid government rules that are usually subject to much more bureaucracy. I see in Thailand also much more proactive in... they have a separate board for quality. They have a separate board and group that accredit the providers before they would purchase from them. And I think all those are important to learn. I think China is falling short in terms of those things. It just says on paper that it is doing selective contracting, I just haven't seen any provider that has not being contracted and if any provider is having fault, I just haven't seen their contract being discontinued. So you do need to have some, a little bit of a distance to exercise those power. But I think if you talk to the Thais they will tell you that, yes despite that effort to try to have ministry of health to have a say in the decision of NHA the relationship between them and ministry of health is still difficult. They will say that they are in a Yo-Yo situation. Sometimes they are better, sometimes they are worse. I think that is just the reality. I would not... those are the things that I wanted to say.

Madhurima Nundy:

Thank you. Jack can I come back to you later probably after Nachiket has responded?

John Langenbrunner:

Yes.

Nachiket Mor:

I am happy to but we are almost out of time right? We close at 7.30.

Madhurima Nundy:

We can extend it. That is okay.

Nachiket Mor:

Okay. I am happy to. It's been a wonderful conversation and really as Jack said the work that he did for NITI book, really laid out a pathway for strategic purchasing and strategic purchasing, one way to think about it is the way the NHSO, the dramatic move forward. But I think the point Jack has been making for a while is that, even reducing the number of line items could actually have a beneficial impact. Even if we don't actually end up with this big bang which I don't see happening in India. What is the value of it for India? I just want to put out a hypothesis that I am researching for a commission that I am a member of. So one of the ratios that we talk about when we say, is India spending enough money on health or not, is the national expenditure on health care divided by the GDP. And then we extend that to the state level and then we say we should look at the state expenditure and divide that by the state GDP. I am in one of the papers we are going to argue that it is a fundamental error. Because the reality is that the cost structures are not that different between the states. A nurse costs the same because of the slack labour market and because of free movement of people in a richer state as she does in a poorer state. Which means you should look at state expenditure as a proportion of national GDP. It turns out that many states have crossed 2% or 2 ½ % or 3% of national GDP as far as health expenditure is concerned. And of course it also means states like Bihar who look like they are doing better because they are doing 1.4% of their GDP actually turns out to be 0.4% of national GDP because actually they are not a very rich state. I think that presents some more accurate picture of the reality on the ground which then means that many states... we hypothesize that there are at least seven states in India... that today are spending enough money to offer universal health care to their people. Why are **they not able** to offer it? Because we think or we are going to argue if we get to this point, that there is massive inefficiency in expenditure. Massive inefficiency in expenditure. There is huge over utilisation of secondary and tertiary care. If you look at C-section rates in some of these states they have crossed 40-50-60% and in some states the government does more C-sections than the private sector at least in some districts. And primary care even if it is well equipped... there are states which do have well equipped primary care... is basically empty. One patient a week, one patient a month. Really not being utilised at all. Is it possible that a strategic purchasing type mechanism that either goes via the state health authority with all of the caveats Dr Yip had about local capacity or some other mechanism really unlocks this value. So that you are able to see gatekeeping implemented, you are able to see good electronics that moves back and forth. Currently there is no incentive. You go to these governments with training programs with ideas, so long as the donor is willing to pay for it they are happy to do it. But the minute you say – no, you have to pay for it because you should see value in it, the interest level just drops like a stone. So to me that is kind of the appeal of where a strategic purchasing could have a value, not necessarily across the country for all states. But in the spirit of piloting maybe not at the district level but maybe at a state level. Particularly the more high capacity states in the south or the smaller states in the north east all of whom seem to be spending more than enough money on health care. Is that something that could be explored as an idea? Now that we do have the NHA and the SHA and use that as a tool to do it. I will stop here. Thank you.

Madhurima Nundy:

Thank you. Jack you wanted to say something earlier?

John Langenbrunner:

I wanted to come back on the governance points that Winnie made and I didn't quite talk enough about Indonesia. So there is a governance challenge in Indonesia. The purchaser, the single payer, the BPJS reports to the president. Unfortunately the president doesn't have time to really manage the single payer organisation. But there is no direct linkage with the ministry of health. So the ministry of health and the single payer have sort of competed more than collaborated over these seven years. That's been a real challenge. So the benefit package, well they fight over that. The payment, well they fight over that. I think that this is a good lesson. The other thing is that they have a board at the single payer. But the board is under the CEO. That is just the opposite of what you want. You want a board that is over the CEO that can help the CEO and the organisation. So they have a board that is strictly sort of... well here is an idea or here is... but really not having any kind of weight. Any kind of impact. I think these are good lessons for other countries. I like Winnie's idea about somehow... you know in Philippines if you go to Phil health, they report to the president. But at the same time the minister of health of the department of health is the board chairman of that board of Phil health. I think those kind of things are very, very important to integrate these two organisations. I have seen fighting not just in Indonesia but in many countries. I have seen it in Russia and I have seen it in quite a few eastern European countries. This has wasted time and wasted money and wasted quality for consumers. Over back to you.

Madhurima Nundy:

Thank you. Winnie do you have a response here?

Winnie Yip:

Yeah. I think on this point that it is really not a small point about the relationship. The more powerful NHA grows to become a purchaser the more likely is going to become hostile with the MOH. Because MOH will see it as something to try to control that. Actually if you look at a number of the European, but also let me give you an example of Taiwan. When Taiwan set up its national health insurance there is a board and that board actually is responsible for deciding on benefit package. Deciding on provider payment. And based on what is the total budget that they have. And it has a really a combination of minister of health people and employer who pays into it and finance. In other words there is equal representation of the payer and the delivery side and also the patient as well. Also they have a few academics. What is the job of the academics? The academics job is there to be mediator and arbitrator. Because they are neutral. In a way this idea of taking it away from the government, I know it is a very big change but I do admire Thailand doing that. I am speaking on Viroj's behalf. You do take it away from some of the standard government bureaucracy and rules and things that you subject to the agency too, which China is not able to do that. It is still part of the government agency. And you are still subject to hiring rules, you are still subject to purchasing rules and all of that. In other words there are countries and their systems besides Thailand that have important and interesting lessons to learn from short of having to take it away from the government.

Madhurima Nundy:

Thank you so much Winnie. Okay, Nachiket.

Nachiket Mor:

Just a quick question to Dr Yip and maybe Jack. I see the point about the two collaborating but in some ways if the ministry of health defines itself as a provider unless we have also got some other mechanism that in some ways the purchaser is accountable to the consumer and not to the provider so that we don't have the prioritisation of the health of the public sector over the health of the public. Maybe the tension is good. Maybe the tension is inevitable and actually desirable. Because I don't think a ministry can say I want to be a policy making body and a provider. But I want to have control over people.

Winnie Yip:

Yeah. Nachiket, I think that theoretically is true. But I think by now we have observed in many countries that in practice ministry of health instead of saying that you and I can hold each other accountable we have seen many situations that the **minister decide** to say that if the terms are not what I like I am just going to block you. You do want to have some mechanism that they can negotiate before they go out and become a policy and they try to block each other. Jack.

John Langenbrunner:

Quick story. I was in a meeting with the ministry of health many years ago in Indonesia. They found that there was corruption in terms of how they sent in claims for their patients in public hospitals. A couple of big hospitals in Jakarta, the minister said – oh you know, we have to protect our public facilities and the CEO is a friend of mine, let us just drop it. So tension is okay. But a little bit of tension is okay. But it has to be less than competition and unwillingness to work equally with each other. Over.

Madhurima Nundy:

Ok. I will just quickly take two of the audience questions. One is of course directed to Jack from Dr Tanden. He says that Indonesia's BPJS is a bill paying agency and not a strategic purchaser, almost like a TPA. They don't determine the benefits package or the tariffs. So there remains confusion as to exactly the importance of their role in improving effective service coverage and financial risk protection. Especially given that lot of financing to public providers still comes via line items budgets from district governments and not via the BPJS. So has their role expanded recently to become more of a strategic purchase and being able to determine and negotiate prices and improve quality?

John Langenbrunner:

He or she is exactly right. They are more of a claims processor and less of a strategic purchaser. Now this is not gone unnoticed by the payer. They know that they are still a claims processor and not a strategic purchaser and there are over the last several months a new minister from the private sector who is not wedded to the public sector, the ministry of health. He has gone about first reorganising the ministry of health and secondly saying – let's start rethinking about who does what. So it's a slow process, a painful process. But with the benefit package we see some incremental movement and with things like actuarial analysis of new benefits. These have to come from the single payer. Things like a new technology. How much are they going to cost? Things like our new technologies being, even if they are in the package, are they being appropriately used? Only the single payer has the claims. They need to do the monitoring and surveillance. So some of these things need to shift back to a more equal relationship. But yes,

that work is still ongoing and I hope that at the next webinar we will have better things to say. But exactly right on the money. Over.

Madhurima Nundy:

There is another question. Probably each one can answer briefly. Primary care is critical or core in LMI __ in lower middle income countries. And health per capita is key and therefore we have seen how systems are worked during the covid-19 events and how systems have failed world over. Can we learn from technology e-governance systems and primary health? And what kind of transparency and last mile connectivity can be considered while providing primary care? Winnie can you go first?

Winnie Yip:

Maybe Nachiket would be the good person to answer this one.

Nachiket Mor:

I am happy to quickly comment. I know we are out of time. Clearly technology can play a role. No question. Clearly primary care has not worked as well. But you know, there are no panaceas here. You can't say that everything is broken, let's just add some technology and e-governance and then we get a smooth solution. Ultimately the discussion you have seen so far has spoken quite a bit about the power of financing. I would urge you to take a look at research by Jishnu Das, who does these very careful randomised control trials to show you that under a line item system the apparently highly trained is in fact the worst provider of the healthcare. But that doesn't mean, sometimes RCTs can conclude too quickly therefore that the market works, that doesn't necessarily mean that. But what it does tell you, incentives matter a lot. Sometimes if you have incentives that are poor adding technology can make it even worse. Because now you can, as you have seen in telemedicine in India, earlier you were forced to go to the same doctor not because you were loyal to him or her, because of no choice. It was in your neighbourhood and had to go there. That perhaps gave you better primary care than today in an environment you can dial somebody and I talk to somebody in Lucknow and then I talk to somebody in Delhi. Am I really getting good primary care? Even though I have got great technology now. Yeah, I mean technology I think can have an important impact. But I would hesitate to promote that as a panacea.

Madhurima Nundy:

Yes Jack.

John Langenbrunner:

I would say two things quickly. One is that... going to many webinars of course I had nothing else to do during covid. So I went to many webinars and I was impressed with how many innovations were coming out of India. These were often up-starts, small companies, individuals. In the US we like to talk about Steve Jobs working in his garage. Well I mean, I think these were innovators in India that really had ideas and really starting to develop them based on the covid and necessities. So I was impressed. But how appropriate they are going forward that is another issue and I think Nachiket has touched on that. The last comment I will make is the G20 discussions are moving to India next year. Use the opportunity to learn from G20 __primary care. Focus on primary care. This year in Indonesia there was a lot of focus on

resilient health systems. Very interesting but at the same time use the G20 forum, get many of the voices and thinkers from the G20 countries to weigh in on primary care and how it might help India. Over.

Madhurima Nundy:

Winnie any last words?

Winnie Yip:

I think we had a very rich discussion today. But many of them really can be taken into a bit more depth. Because obviously what can be done in India, international lessons are important. What can be done in India depends very much on two things. What is India's starting point because that really would have constrained us on where we go next so we can get to practical solutions. Two is, I do think that India has a lot of innovation if given time and the right environment. So the idea of whether you call piloting, demonstration, I know the word pilot people don't like it sometimes, but the idea of recreating the right environment for these new ideas to be tested out. Because India is complex to be tested out and draw lessons. But also building some mechanism for scaling. That would be a very important process moving forward. I just want to say that every one of us wants the government to put up more money. That would be the best way. But I think we are also confronted with the reality that in India and many other countries it is not going to happen especially after covid. Especially these few years. So we are back in a situation and even China, when I told you they increased four times of their spending that was when their economy is like growing very well. But that is going to be a different situation. The minister of finance has told everyone in health that no more new money. The best is to continue status quo. Even that is hard. Unfortunately we are in a different place and something that we haven't talked about is now there is a lot of political attention and movement to try to maybe put some money in covid related or pandemic control related initiatives. I think this question of where the health system and the public health system should really intermix, where they cross and not cross is a major question. Is it really distracting, driving resource from... is the pandemic public health system drawing resource from the health care system or is it a good opportunity to try to leverage the two of them to a better situation. I worry that the current conversation around the world is going to fragment it even further. And that would be unfortunate. I mean, we didn't cover it today. But I think it is important to bear that in mind.

Madhurima Nundy:

Thank you so much. This was a really valuable insightful discussion that we had today. I will just say that each of these we kind of understand the complexities of all health systems through these discussions and hopefully have more dialogues on specific issues in the future. One of course is there on the 25th of August which is on strengthening primary health care. And we hope all of you will join there. Each of these also can be conferences in itself, each issue, each topic that we take up. So we hope to have more dialogues with all of you and I really thank the esteemed speakers today for giving us their time, insights, analysis on the health systems, on the global health systems of countries under discussion. Indeed there is a lot to learn from one another and we hope to continue this conversation and organise further dialogues. Thank you so much.