Healthcare Payors and Providers Practice

Sustainable Health Insurance

Global perspectives for India

McKinsey&Company

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Foreword

India is on the cusp of becoming an economic giant powered by its favourable demographics. A young workforce and rapidly growing service economy have the potential to keep the country on the path to achieving high GDP growth.

Ensuring that our young population remains healthy and continues to operate at maximum productivity is an important imperative. Adequate and equitable healthcare financing is critical in meeting this imperative as most of the healthcare expenditure in India today is paid out of pocket by individuals, which too often results in either financial distress or inadequate care. Given the current financing mix, there is a clear need for a rapid increase in access to health insurance.

Rising affluence and urbanisation have also brought rich-world lifestyle diseases like diabetes, chronic heart disease, and cancer to India. This has resulted in a two-pronged healthcare problem for India. On the one hand, India has a long way to go in improving primary healthcare and tackling diseases such as malaria, tuberculosis and polio. On the other, a growing proportion of the population is showing alarming trends of lifestyle diseases. As a result, preventive care in plan design and chronic disease management techniques will play an important role in the sustainable development of the entire healthcare ecosystem.

Apart from improving coverage, we need to ensure that access to health insurance is inclusive. The recent announcement by the government in this regard is very encouraging, and private–public partnerships can play a significant role in improving access to the underprivileged.

While we focus on improving inclusive access to healthcare financing, we need to recognise that lack of customer and provider engagement, an inadequate regulatory framework and inappropriate plan designs have led to escalating costs in other countries and made their systems financially unsustainable.

As we look ahead, India has the opportunity to leapfrog and develop unique healthcare financing solutions which are inclusive, economically viable, and provide appropriate care to its people. I hope the FICCI Conference, "Sustainable Health Insurance - Need of the Hour," will help us find pragmatic solutions towards better health insurance access and broader coverage. I would like to thank McKinsey & Company for agreeing to provide thought leadership for this conference.

Shikha Sharma
Chairperson, Insurance and Pensions Committee – FICCI

New Delhi, 29 November 2007

Introduction

Policy makers and industry leaders agree that providing health insurance coverage to many more Indians than today is an important economic and social imperative. As income levels and awareness rise, the emerging Indian middle class will seek better underlying medical services and mitigation of the financial risks that come with the better, more sophisticated, but also more expensive medical care available today. At the same time, hundreds of millions of Indians at the base of the economic pyramid remain extremely vulnerable to unexpected healthcare expenditures, which often force them to sell the few assets they may have or push them deep into indebtedness.

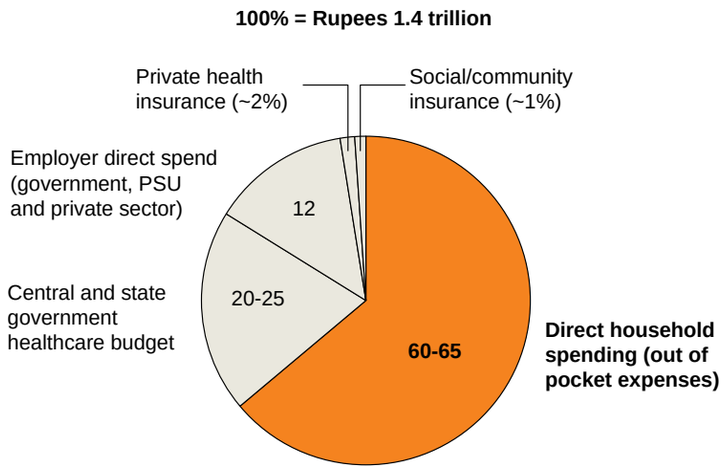
Today, only about 30 million Indians and an estimated 2 to 3 per cent of total healthcare expenditures are covered by some form of private health insurance (Exhibit 1).[1] Existing private health insurance is typically provided by large-group employers and focuses on hospitalisation benefits with a limited sum assured. To dramatically improve health insurance coverage, India will need to find financially sustainable ways to increase access for the majority segments of the population and develop insurance plans that cover preventive care interventions and drugs.

Given its size and stage of development, India faces both the opportunity and challenge to develop its own approach to providing health insurance coverage to a significantly larger number of people, learning from relevant international lessons, but also avoiding some of the costly mistakes made by others. To help advance the debate on potential solutions for the FICCI Conference on "Sustainable Health Insurance - Need of the Hour", we have assembled four background papers drawing on the expertise of our Global Healthcare Payors and Providers Practice. These background perspectives do not purport to have the answers for India, but are intended to provide helpful ways to think about some of the key issues the conference organisers have laid out in their agenda.

1 In addition, approximately 80 million Indians benefit from social welfare or healthcare directly provided by typically public sector employers.

Exhibit 1: Two-thirds of healthcare delivery spend is paid for by private households "out of pocket"

Break up of healthcare delivery* spend by source, 2006-07 (estimated)
Percentage of total spending



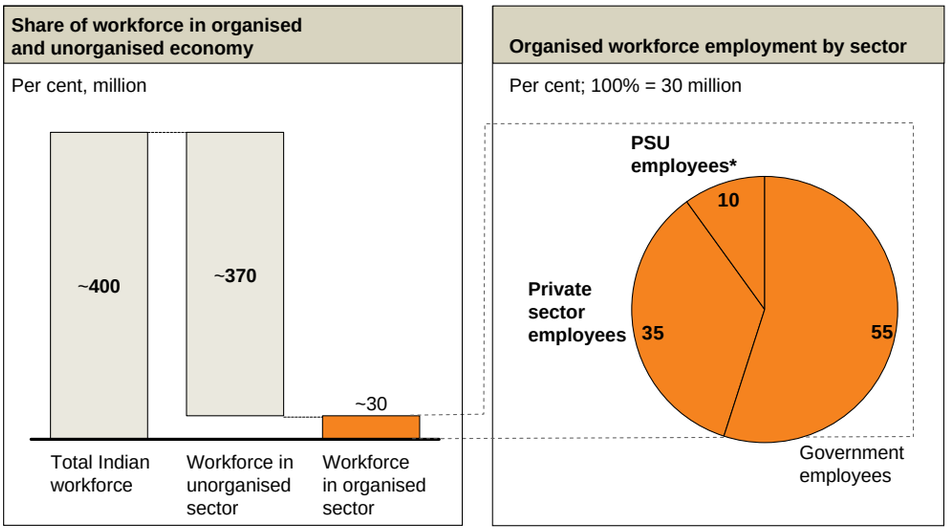
* Excludes pharma spends
Source: McKinsey-CII Healthcare Report 2001; WHO; National Accounts Statistics; annual reports; McKinsey analysis

1. OPPORTUNITIES AND CHALLENGES IN THE INDIVIDUAL HEALTH INSURANCE MARKET: LESSONS FROM THE U.S.

While relatively well penetrated, the employer-based group health insurance market is small, covering less than 10 per cent of the workforce and reflecting the small size of the organised economy in India (Exhibit 2). At the same time, government insurance coverage is limited and a planned expansion is focused on the poor at the base of the economic pyramid. As such, providing the growing Indian middle class with privately provided and individually purchased health insurance represents a big opportunity and challenge in expanding health insurance coverage in India.

Based on the experience of the U.S., the world's largest private health insurance market, our first background paper looks at the requirements for success in a retail health insurance environment and lays out a few design principles for market-based private health insurance. The key requirements for success in a retail environment include product innovations combining financing mechanisms, elements of managed care and advice; the ability to manage multi-channel distribution; and capabilities for risk-based pricing. To be cost-effective, market-based health insurance should focus on improving health status, engaging consumers, aligning funding instruments with health risk, minimising supply-side distortions, and allowing for value-based pricing.

Exhibit 2: In India, less than 10% of the workforce is in the organised sector



* PSUs are public sector units with majority government stake

Source: CSO; Planning Commission; NASSCOM; interviews; team analysis

2. HEALTH INSURANCE FOR THE POOR: LEVERAGING INDIA'S UNIQUE STRENGTHS

The Government of India has announced plans for subsidised health insurance for the country's poorest citizens in the unorganised sector. If successfully implemented, such a system could provide better access and a higher standard of healthcare to a significant portion of the Indian population.

Based on an analysis of global experiences and India's own experiments with grassroots micro-health insurance schemes, our second paper believes that a successful national health insurance model for India would proactively leverage three unique strengths of the country: its strong civic institutions, its active and entrepreneurial healthcare markets, and its tradition of decentralisation. In such a model, the government acts as a market maker and regulator. To lay the ground work for a dynamic, service-oriented model of subsidised health insurance for India's poor, the government would have to allocate appropriate funding and build the supporting institutional infrastructure critical to long-term success.

3. BEYOND HOSPITALISATION BENEFITS: THE ROLE OF PREVENTIVE CARE

Today, private sector group and individual coverage in India, as well as the Central Government's plan to subsidise health insurance for the poor, focus on hospitalisation benefits with a limited sum assured. While this provides valuable coverage, preventive care and chronic disease management techniques are important components of improving medical outcomes and the overall cost-effectiveness of healthcare provision and insurance. A number of these techniques fall into the domain of public sector and government health spending, but international examples suggest that private sector insurance can make important contributions.

Our third paper provides a framework as well as some basic facts about preventive care, screening and disease management programs adopted in other countries. The scope for improvements from relatively simple primary preventive healthcare measures in India remains huge and could prevent or delay millions of premature deaths every year. India's private sector can pick up a number of secondary and tertiary preventive measures such as screening for cancer or diabetes, and preventive health check-ups as well as disease management programs for conditions such as congestive heart failure or asthma.

4. EMERGING MEDICAL VALUE MANAGEMENT APPROACHES

The combination of rising income levels and awareness, increased access to health insurance, and broader coverage in India is bound to grow overall healthcare expenditure. This is the experience in nearly every developed country, where healthcare costs have been growing at a rapid rate for decades, for most years well in excess of aggregate inflation.

In the U.S., medical cost inflation has in the past led to a number of health insurance innovations such as the open-access Health Management Organisation (HMO). Our fourth paper describes how health insurers in the current era of rapid healthcare cost increases focus on an approach that integrates the formerly siloed functions of benefit design, network management, claims management, and care management. In addition, incentive structures are changing to shift decision making from centralised, payor-directed control to a consumer and provider self-directed approach. A number of the tools developed in this context, such as benefit and network tiering, consumer decision support tools as well as pay-for-performance and episode contracting for providers, appear relevant for an emerging market setting.

* * *

Dramatically expanding health insurance coverage in India is an important social and economic imperative. To do so, India needs to find financially sustainable ways to increase access for the large, emerging middle class in an individual market context and for poorer citizens at the base of the pyramid, and adopt health insurance plans that go beyond the currently narrow focus on hospitalisation benefits. While there are lessons from international experience, India will have to develop a unique approach given its huge size and stage of development. We would like to thank the FICCI Insurance and Pensions Committee and its Chairperson, Shikha Sharma, for the opportunity to provide our perspectives. We hope they offer a helpful background to advancing the debate on potential solutions at the FICCI Conference, "Sustainable Health Insurance - Need of the Hour."

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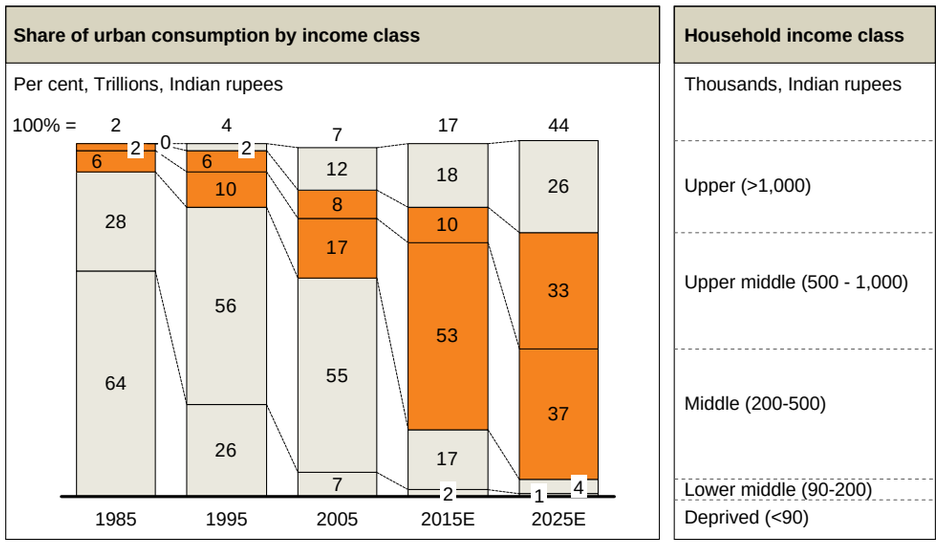
Opportunities and challenges in the individual health insurance market: Lessons from the U.S.

Opportunities and challenges in the individual health insurance market: Lessons from the U.S.

Shubham Singhal

India's accelerating economic growth is transforming the average Indian citizen into a discerning consumer with significant disposable income. In addition to substantially benefiting the country's poorest citizens, this growth will create a sizeable and largely urban middle class of over 500 million people by 2025. This middle class, with annual disposable household income of 200,000 to 1,000,000 Indian rupees ($25,000 to $120,000 at PPP), will control almost 70 per cent of India's urban consumption power in 2025 (Exhibit 1).

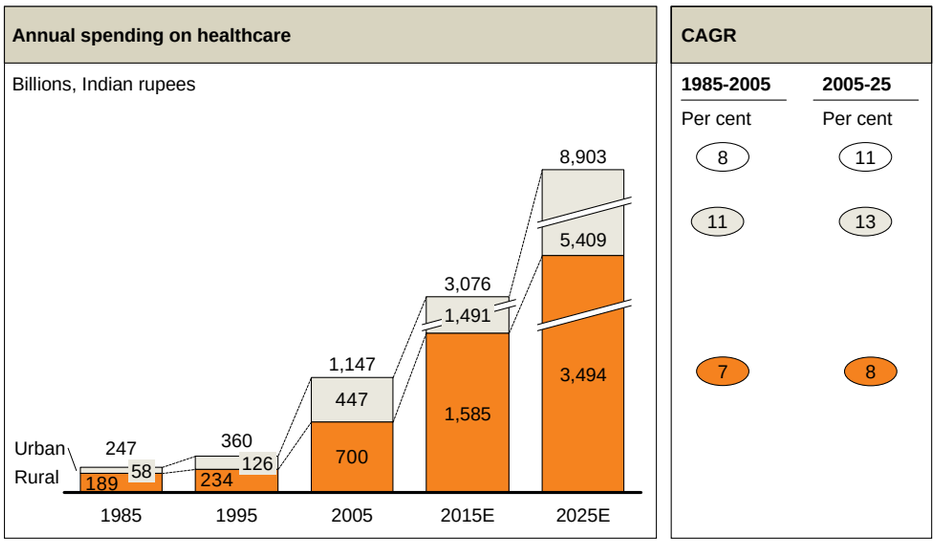
Exhibit 1: Rapidly growing middle class will represent 70% of India's urban consumption in 2025



Note: Figures are rounded to the nearest integer and may not add up to 100
Source: McKinsey Global Institute

As Indian incomes rise, the consumption of different products and services is likely to evolve. While consumption is expected to increase in nearly all categories, some will grow faster than others. Five product categories—food, transportation, housing and utilities, healthcare and personal products/services—will account for over 80 per cent of total cumulative spending in India over the next 20 years. Over the past 20 years, healthcare consumption has been growing rapidly at 8 per cent, faster than the overall consumption growth rate of 4.7 per cent. This strong growth trend is expected to accelerate over the next 20 years creating a nearly 9 trillion rupee healthcare market (Exhibit 2).

Exhibit 2: Healthcare consumption growth will be most rapid in urban India



Source: McKinsey Global Institute

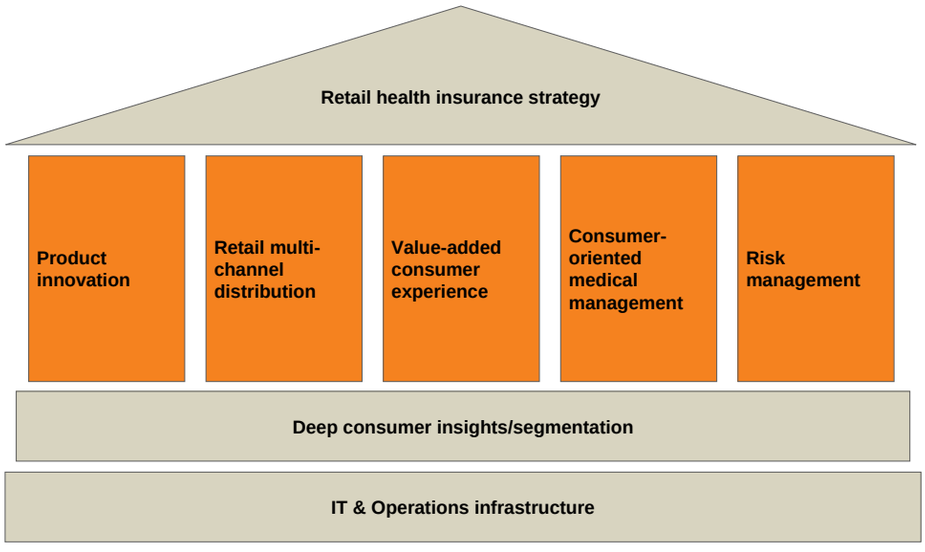
Today, healthcare consumption in India is largely funded by household expenditure. In 2005, the private consumption of healthcare represented more than two-thirds of total healthcare spending compared to 10 to 12 per cent in most developed countries. While relatively well penetrated, the employer-based health insurance market is small, covering less than 10 per cent of the workforce, reflecting the small size of the organised economy in India. Government insurance coverage is limited and any expansion is likely to focus on the poor at the base of the pyramid. As such, providing the growing Indian middle class with privately provided and individually purchased health insurance represents both a big opportunity and the main challenge in expanding health insurance coverage in India.

Based on the U.S. experience, we discuss below the key competencies and capabilities required to succeed in a retail health insurance market and lay out key principles for market-based private sector health insurance that might be helpful for the ongoing debate in India.

WINNING COMPETENCIES IN RETAIL HEALTH INSURANCE

Success in a retail health insurance world requires seven key capabilities and competencies. Crucial among them are product innovation, retail multi-channel distribution, value-added consumer experience (beyond just service), consumer-oriented medical management, and risk management. Each of these capabilities and competencies stands on a foundation of deep consumer insight and an IT-enabled administrative platform (Exhibit 3). In this section, we provide our perspectives on three of these competencies—product innovation, retail multi-channel distribution, and risk management—which seem particularly important in the Indian context.

Exhibit 3: Competencies required to win in retail health insurance



A. Product innovation

In a retail-oriented world, health insurers need straightforward, segment-tailored, quick-to-market products. Consumer industries gain only fleeting advantages from any single innovative offering, as rivals are quick to copy. However, competency in developing distinctive products faster than competitors delivers a substantial edge. To achieve leadership, health insurers must focus on building a broad product portfolio and managing products more effectively.

Broad product portfolio

Health insurers in a retail context need an innovative set of core health insurance products and an array of ancillary products and services. Breadth is important to realising economies of scope (e.g., in distribution) and covering the range of risks and expenses that consumers face. There are eight broad categories of exposures driven by health and health-related events and costs: low ticket-size expenses (e.g., for routine care), higher ticket-size discretionary expenses (e.g., for elective surgery), catastrophic expenses (e.g., due to major illness, accident), end-of-life care expenses (e.g., due to life-threatening illness), expenses related to chronic diseases and the related risk of becoming uninsurable, medical inflation risk, income risk (e.g., disability), and the risk of being unable to afford health services or insurance. Consumers have varying ability to bear these risks.

New categories of products combining three pillars of successful innovation—financing mechanisms, elements of managed care, and advice—will probably emerge to help consumers deal with the health risks and address these eight exposures (Exhibit 4). In the U.S., traditional products have focused on mainly providing insurance as the financial vehicle with select managed care elements. Recently introduced consumer-directed health plans combine savings and insurance vehicles. However, a significant gap remains in using financial mechanisms beyond insurance. Exhibit 5 portrays the full landscape of financial products that could help consumers address the exposures that they face.

A choice of financial mechanisms is essential to meet the needs of diverse consumer segments but also to exploit financing efficiency. For example, many consumers are unwilling to purchase long-term care insurance when they are young, as they view it as an unnecessary expense. Younger consumers are more concerned about meeting mortgage payments and expenses related to raising a family while the threat of long-term care seems distant. On the other hand, as consumers age and recognise the need for long-term care coverage, they often find the premiums unaffordable or are denied coverage due to medical underwriting. Products that combine investment with long-term care insurance could help.

Exhibit 4: Pillars of product innovation

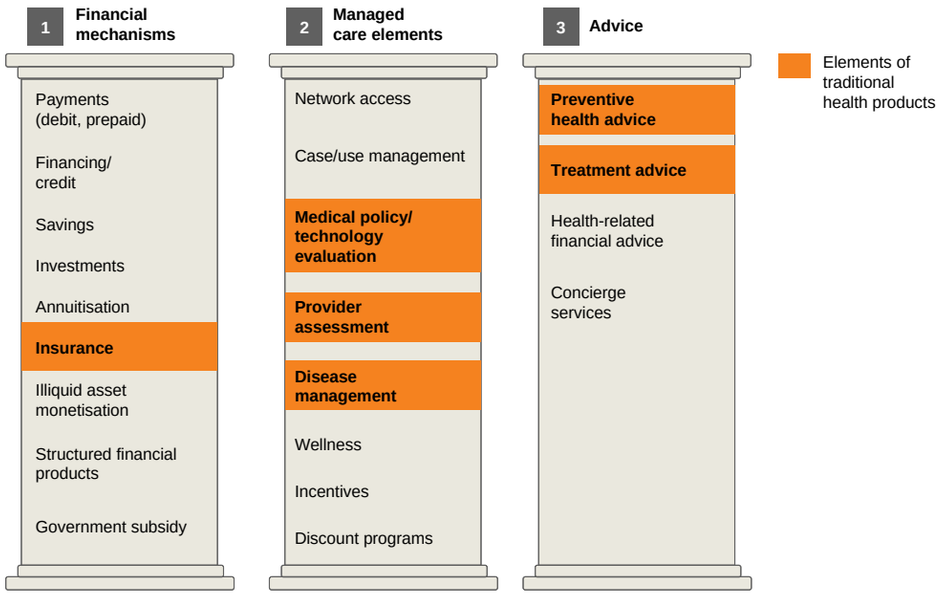


Exhibit 5: Aligning financial mechanisms with risks

US EXAMPLE

Points of alignment

Financial mechanisms \ Health-related financial exposure/risks	Low dollar expenses	High-dollar discretionary expenses	Catastrophic expenses	End-of-life care expenses	Chronic condition expenses	Medical inflation	Income risk	Unaffordability risk
Payments from current income	Debit, prepaid, discount/value cards				Debit, prepaid, discount/value cards			
Financing/ credit	Credit cards	Installment loans						
Savings								
Investments						Medical inflation indexed funds		
Annuitisation			Impaired risk annuity, accelerated benefit riders	Accelerated payout on annuity				
Insurance			Health, critical illness, accident, LTC insurance	Accelerated payout on life insurance, LTC	Chronic conditions	Level-term health insurance	Disability, income protection	Unemployment insurance
Illiquid asset monetisation			Reverse mortgage	Reverse mortgage, viaticals, senior settlements	Reverse mortgage			
Structured financial products						Medical inflation protection (derivatives)		
Government subsidy			Mandates with possible tax incentive		Subsidy, high-risk pools	Government-backed secondary markets		Subsidy

More effective product management

Health insurers in a retail context need to have skills to effectively integrate and bundle the different aspects of the product—financial and value-added managed care and advice services. A simple-to-communicate value proposition and product features will be critical to facilitate consumer sales. Sophisticated bundling approaches will be needed to combine product distribution synergies, consumer preferences, and ease of communication. One such approach is one U.S. insurer's attempt to bundle individual health insurance, dental, and life insurance. Insurers must design, launch, and manage products quickly, from concept through to commercialisation, in a way that satisfies the needs of all constituents. This will require a strong connection between efforts to gain consumer insights and the product development process.

B. Retail multi-channel distribution

Health insurers must build expertise in managing retail channels and bolster their approach to distribution by improving their branding and marketing. Whether they distribute directly to consumers or through intermediaries, they will also need distinctive brands and an overall brand communication strategy that gains the consumer's trust. A strong consumer brand can deliver significant value by way of price premiums, positive risk selection, and lower distribution costs. Insurers will also have to manage their marketing spend effectively because distribution approaches will become more complex and the amount spent could be significant.

Building and managing new retail channels

Reaching individuals requires a host of channels and sales approaches. Five types hold promise:

- *Direct-response channels.* These include a captive salesforce, call centres, the Internet, direct mail, and television commercials. Wellpoint primarily uses the Internet, for example, to sell a product aimed at consumers aged 18 to 29 ("young invincibles") who think they do not need health insurance. The online channel is also gaining in importance—web agencies sold roughly 10 per cent of new individual policies in 2006. Applications to eHealthInsurance.com, for example, grew by more than 30 per cent in 2005–06, with 80 per cent of their customers never requiring "live" help. The online channel has the added benefit of attracting younger and healthier customers.

- *Retail stores.* Health insurers are offering health benefit products through Costco and Wal-Mart, and pharmacies such as Walgreens. One of the biggest success stories for payors has been in selling Medicare-related products to the elderly through bricks-and-mortar retailers. Humana staffed kiosks in 3,600 Wal-Mart and affiliated stores to become the second-largest Medicare supplement player in 2006. Some 80 per cent of nearly 3.5 million members were voluntary enrollees.

- *Affinity-marketing relationships.* Health insurers that have used such relationships successfully include Humana (with Virgin) and United Healthcare (with the American Association of Retired Persons, or AARP).

- *Partnerships with financial institutions.* As consumers pay more for healthcare and health-oriented financial products (such as HSAs and health-focused credit cards), these two areas will naturally converge. Assurant, for instance, has employed partnerships with AXA, Lincoln Financial, MetLife, and State Farm, among others. Assurant derived about 20 per cent of its 2005 individual revenue from State Farm-sold business, suggesting that State Farm has accounted for as much as half of Assurant's net growth since 2000.

- *Worksites.* The worksite provides an attractive channel as it garners a natural trust among employees that the carrier has been vetted by their employer. In addition, it provides access to payroll deductions as well as opportunities to implement wellness programs. Individual insurance carriers are, for example, working to partner with small employers to offer individual products at the workplace, with or without financial contribution from the business.

Choosing channels

Different consumer segments have different preferences and attitudes, and payors must understand them. Some consumers, for example, want a trusted adviser who can make decisions for them, while others desire information and tools to make their own decisions. Preferences also vary by demographics; for example, most retirees like greater support. Understanding such preferences is important when companies decide whether to use direct channels or channels that provide for human intervention. Because a consumer's risk profile (that is, health status) is correlated with demographics, the choice of channels can be a significant driver of profitability.

Health insurers should look for opportunities to use channels and sales to build their brands. Offering a product through value-oriented retailers, for instance, may reinforce the perception that its cost is competitive, while offering it through a high-end financial adviser may support its positioning as a rich set of benefits with superior service.

Finally, health insurers face a strategic choice about whether or not to own direct relationships with consumers. In similar industries, such as asset management, many players that just create products thrive thanks to superior performance and brands. Retail distributors, by contrast, gain more power from the relationships they build with consumers. However, distribution and direct trust-based relationships with consumers are typically hard to create. Payors that want to follow this route should think about building a stronger captive salesforce; many companies that focus on health products for individuals already have one. Although a captive force can

come into conflict with independent agents and is often costly, it offers big benefits, including the alignment of incentives, superior pricing, a salesforce that knows a lot about products, and greater brand equity.

Stronger, consumer-oriented branding

Whether health insurers distribute directly to consumers or through intermediaries they will need to develop distinctive brands and an overall brand communication strategy. At a minimum, health insurers must gain the trust of consumers which frequently does not exist. If done well, a strong consumer brand can deliver significant value in the way of price premiums, positive risk selection, and lower distribution expenses.

Over time we expect many health insurers to develop multiple sub-brands under an umbrella brand to provide more targeted support to different products, channels, and/or customer segments. We also expect continued experimentation with affinity marketing and co-branding, both of which can be effective.

Building a new brand or strengthening an existing brand can be a long, expensive journey. Health insurers need to understand the time and cost required to develop or strengthen a consumer brand or brands. Given these requirements, many may decide to pursue niche strategies such as promoting a particular brand to a very well-defined segment of the population.

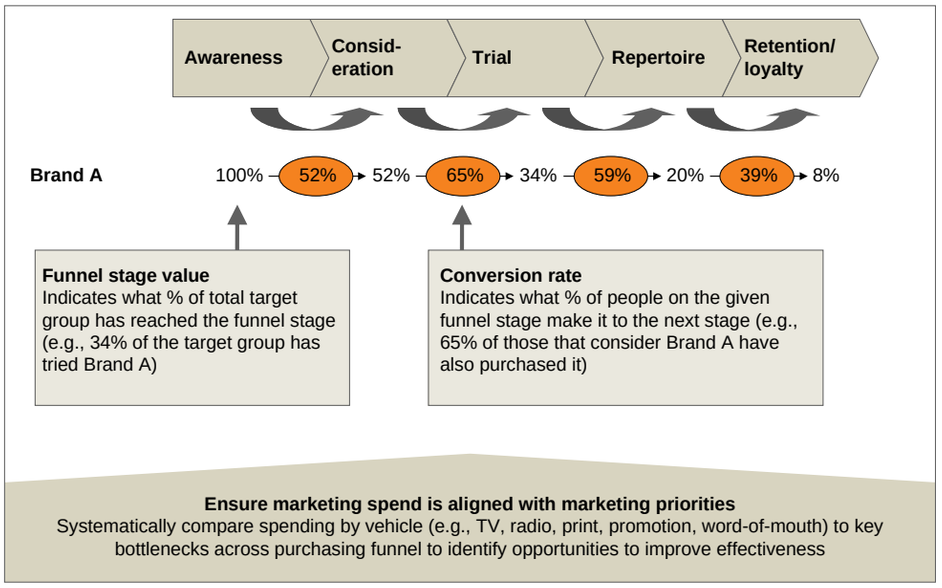
Marketing effectiveness

In a retail context, health insurers need to effectively manage their marketing spend because their distribution approaches will become exponentially more complex and the nominal amounts in play could be significant.

Health insurers will need to develop an understanding of the "purchase funnel" (Exhibit 6), a term that describes the path a consumer takes from being "aware" of a product, to "considering" the product, to "purchasing" the product, to "retaining" the product. Health insurers will need to understand the extent to which marketing levers affect each stage and the investment required. To this end, they will also need to improve substantially their ability to track and measure the performance of each marketing spend, such as the impact on the response rate of changing the type of envelope used for a direct mail piece.

Lastly, health insurers will need segment-specific targeting and positioning. Consumers have dramatically different needs and preferences and therefore will respond to messages, media, and positioning very differently. Health insurers will use deep appreciation for these differences to develop segment-specific approaches for each targeted consumer micro-segment.

Exhibit 6: Consumer purchasing funnel

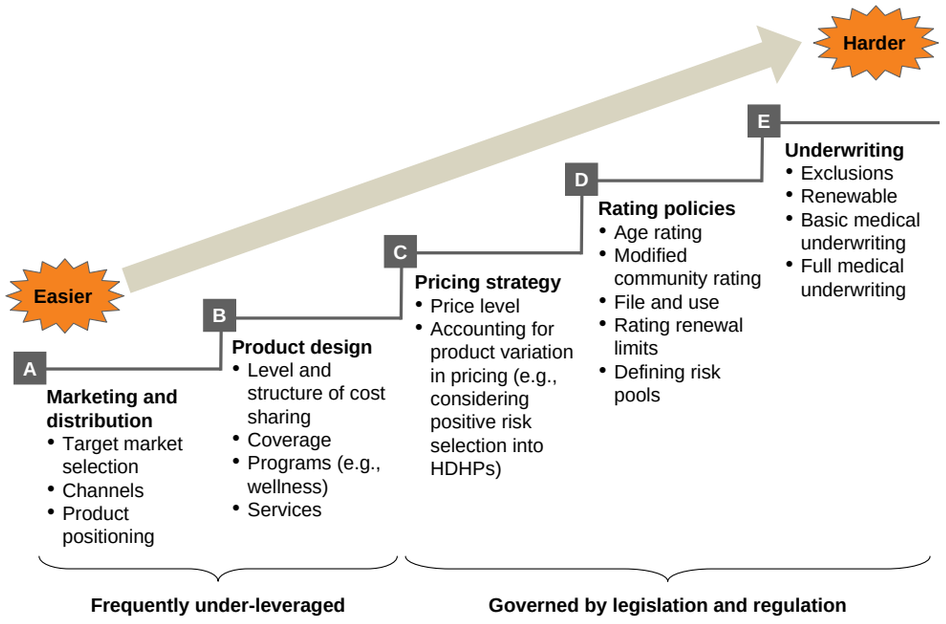


C. Risk management

Historically, most U.S. health insurers have relied on somewhat simple underwriting and rating approaches. Although the use of actuarial science and other more sophisticated approaches has grown in recent years, we believe that health insurers frequently leave a substantial amount of value on the table by pricing both too high and too low. In some states, the loss ratio for health insurers can vary by 30 to 40 per cent, indicating that some payors are maximising price much more than others. To price effectively in an individual market, health insurers need to understand not only the risk profile of an individual, but also their willingness to pay, which often varies by segment and channel. Marrying insights into consumer behaviour with actuarial science could create competitive advantage, if, for example, actuaries could recognise how consumer behaviour would change a priori and build that into product pricing rather than wait years to study observed behaviour. Progressive transformed the auto insurance industry by leveraging detailed data to build sophisticated actuarial models that are more powerful by a factor of over 1,000 relative to competitors. This allowed Progressive to gain share broadly as well as profitably play in high-risk markets (e.g., young drivers, motorcyclists).

We also believe that health insurers have not fully utilised all the levers available to grow and improve their risk pool. As illustrated in Exhibit 7, developing an attractive

Exhibit 7: Potential levers to grow and improve risk pools



risk pool starts by ensuring all marketing, distribution channels, and product designs target attractive segments. We also believe more health insurers should systematically work to shape the regulations and laws that govern technical elements of risk management such as underwriting and rating methodologies.

KEY PRINCIPLES FOR MARKET-BASED PRIVATE HEALTH INSURANCE

The U.S. is the largest private sector health insurance market in the world without government-mandated coverage, and thus provides relevant learnings for the development of India's market. However, the U.S. market is also evolving from its own legacy, for example, trying to instill more self-discipline on insured consumers who over decades had become accustomed to generous coverage of expenses with little skin in the game. India has the opportunity to put in place the right regulatory environment and competitive industry structure to allow for a well-functioning private health insurance market.

As industry participants, regulators and policy makers discuss the future evolution of the India private health insurance market, they may want to consider the some of the core principles for a market-based health insurance system:

1. *Make improving health status the system objective.* Underlying costs in the health system are driven by the health of the population. For health insurance to be broadly accessible and affordable, improving health status is critical. The U.S. life insurance experience has shown that a secular improvement in life expectancy has kept the market profitable. Improving health status would deliver the same in health insurance. Often the system's objectives centre on either returning people to good health or, increasingly, sustaining them while in poor health. Instead, the focus needs to be squarely on encouraging better lifestyle choices to maintain good health. An important aspect of such a system is that people who choose to ignore the message by putting themselves at risk of lifestyle-induced diseases should incur more of the related financial costs.

2. *Engage the individual.* The U.S. health insurance experience has shown that individuals with little skin in the game continue to make economically ill-informed and sub-optimal decisions. Optimisation requires two important elements. First, healthcare purchase decisions need to be squarely in the realm of other discretionary economic trade-offs. Second, once individuals decide to consume health services rather than another discretionary alternative, they should have the information and tools to evaluate a range of supply-market alternatives. In genuine consumer markets, suppliers strive to deliver segment-tailored value propositions leading to innovations that, at once, enhance benefits at one end of the spectrum and commoditise to reduce costs at the other. The result in both cases is much higher value per unit cost to deliver. Designing health benefit packages to encourage value consciousness is the starting point. Transparency of prices and benefits needs to follow quickly.

3. *Align funding instruments with health risks.* Insure only what is insurable: major healthcare expenses that are unpredictable in nature and outside the control of the individual, such as hospitalisation for random health conditions or critical care for costly diseases like cancer. Savings, rather than insurance, is the more appropriate funding source for more predictable needs, such as increased health expenditure in retirement or first-level routine care expenses. As we discussed in the product innovation section above, a range of financial mechanisms are needed to align with the different types of risks. Regulatory policy should encourage more innovation and better alignment in this regard. For example, reforms could include ways to enable or assist individuals in planning for predictable healthcare expenditures and beginning to save for health-related expenses earlier in life. Options for this type of savings plan include a wide range of approaches: from voluntary measures, to tax incentives, to compulsory savings programs. For example, in the U.S., the biggest beneficiaries of high-deductible health plans (HDHPs) and Health Savings Accounts (HSAs) have been the previously uninsured, who have flocked to these plans at a disproportionate rate (recent data suggests

that close to 40 per cent of all HDHP enrolment over the last three years has come from the ranks of the uninsured).

Of course, this system would only work for those with the means available to save, but that would include a large portion of the population—and steps could be taken to provide coverage for those with more limited means. Policy makers also need to ensure adequate incentive for the use of preventive care.

4. *Minimise distortions in the supply market.* The U.S. healthcare delivery system provides a case study in supply market distortions. It is riddled with overcapacity on the inpatient and outpatient side, although it varies greatly by geography. Many hospitals have high fixed costs but achieve only 55 per cent occupancy. However, this overcapacity does not exit the market as it should over time, given government and other interventions to keep capacity online (e.g., government loans and subsidies, community activism). In addition, the still predominantly nonprofit delivery system is often prone to irrational capital investment decisions. Policy makers in India must avoid these misaligned provider incentives (i.e., by avoiding subsidies or tax benefits) and instead subject the supply side to the force of market-based mechanisms.

5. *Foster value-based, dynamic pricing.* Pricing is the primary mechanism through which a market-based economic system best aligns supply and demand, and through signals the value ascribed by consumers to the services delivered by suppliers. As such, dynamic market-based pricing is often the key enabler of innovation in any given industry. In the U.S. healthcare system, this linkage of prices to value, and the incentives that should create for "productive innovation" on the services and/or product side of the supply market, does not really exist. For many covered medical services (as opposed to elective services like laser eye surgery or cosmetic procedures), the government essentially sets prices with little assessment of, or connection to, the actual value provided, as Federal or State governments buy roughly half of the total provider services delivered in the U.S. through Medicare and Medicaid. Their position allows them to define the prices at which providers sell their services to them—often based on a cost-plus philosophy. Many providers in turn negotiate their contracts with commercial payors indexing off the Medicare rates for many services—with a lag in when these rates are adjusted. In the U.S., largely "fixed" prices—combined with the aforementioned supply side distortions and a largely disengaged consumer—have arguably led to unnecessary growth in healthcare consumption while at the same time limiting innovation towards more cost efficiency. A well-designed system should encourage a more dynamic market of "free-floating" prices for all healthcare services, drugs, and devices, thus delivering a clearer linkage to value provided and rewards for productive innovation.

* * *

With a relatively small employer-based group market and Government intervention likely focus on the poor citizen at the base of the pyramid, providing the growing Indian middle class with privately provided and individually purchased health insurance represents both a big opportunity and the main challenge in expanding health insurance coverage in India. Experience from the U.S., the largest private health insurance in the world, suggest a set of competencies and capabilities required to succeed in retail health insurance and several key principles for a market-based private health insurance sector that might be helpful for the ongoing debate in India.

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Health insurance for the poor: Leveraging India's unique strengths

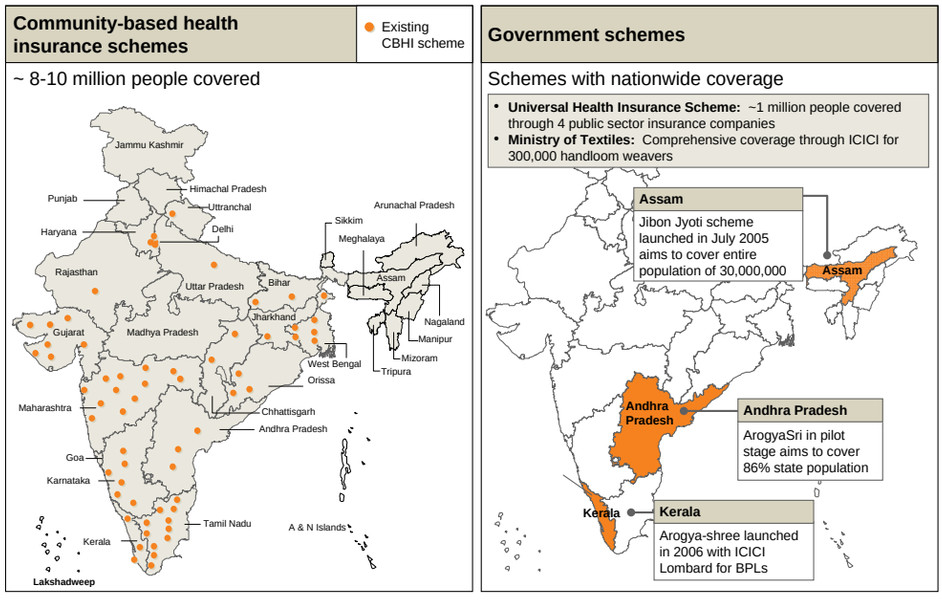
Health insurance for the poor: Leveraging India's unique strengths

Amanda Cowley and Tilman Ehrbeck

The Government of India has announced plans for subsidised health insurance for the country's poorest citizens in the unorganised sector. If successfully implemented, such a system could provide better access and a higher standard of healthcare to a significant portion of the Indian population.

Based on an analysis of global experiences and India's own experiments with micro-health insurance schemes that have sprung up around the country (Exhibit 1), we believe that a successful national health insurance model for India would proactively leverage three of the nation's unique strengths: strong civic institutions, active and

Exhibit 1: Many health insurance programs for the unorganised sector are spread across india today



entrepreneurial healthcare markets, and the tradition of decentralisation. For its planned health insurance scheme, the Central Government could engage NGOs, the private sector and states to build a system with the following characteristics:

- *Civic institutions act as social aggregators to educate, enrol and empower households in the healthcare marketplace.* India's active communities are uniquely capable of rapidly bringing large numbers of citizens into a health insurance system. They can act as informed consumers on behalf of their members, while simultaneously improving risk sharing and reducing the likelihood of fraud and moral hazard.

- *NGO and private sector players integrate risk management, administrative and provision services to offer complete insurance products to enrolled communities.* The NGO and private sector institutions active in healthcare and health insurance today are best positioned to deliver a health insurance product to India's citizens. They have the managerial and institutional capacity to most efficiently assemble the required risk bearing, administrative and claims management, and healthcare services.

- *State-based independent regulators catalyse NGO and private sector activity through positive incentives and targeted regulation.* The Central Government should define a set of limited national regulations, within which state-based independent regulators can manage local systems. These local regulators will use demand-side subsidies and targeted regulation to encourage competition in the provision of health insurance services and extension of services to lower income citizens.

- *A central data institution standardises, collects, analyses and publicises health information to continuously improve the system's performance.* Data will be essential to the future growth of India's health insurance and healthcare markets, as well as for ensuring well-tailored future government policies and investments.

Below, we describe the proposed model in more detail and propose steps the Central Government could take towards implementing such a model. For a summary of lessons learned from expanding healthcare coverage in other countries see Exhibit 2.

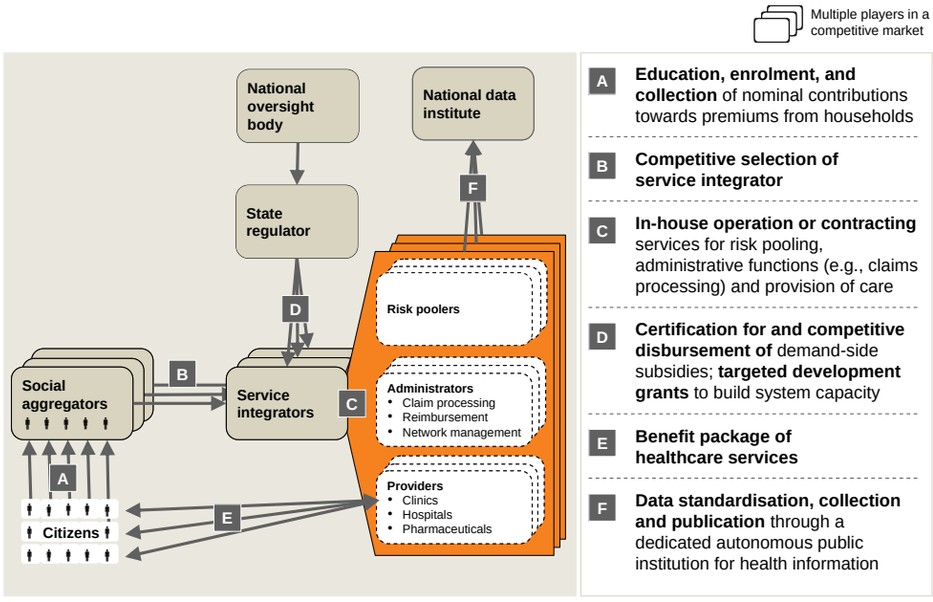
Exhibit 2: Lessons learned from experiences in health insurance system reform

Offering	1	Benefits package contents should be epidemiologically necessary, attractive to participants, and reduce impoverishment
	2	When access is equitable, competition between public, private and nonprofit providers improves overall quality of health services
Participation and risk sharing	3	Investments in education and mindset change are essential to enrolling the poor and disadvantaged
	4	Scale is critical for effective risk sharing
	5	Incentives encouraging near-universal coverage can reduce problems of cream skimming and moral hazards
Financing and contributions	6	In the context of a large unorganised sector, system subsidisation must avoid placing a burden on the organised sector
	7	Whenever possible, all enrollees should contribute, even if only symbolically, to premium and co-pay to increase perceived ownership and manage utilisation
	8	Demand-side subsidy levels must reflect varying cost of service for different populations, particularly the historically underserved
Administration	9	Reimbursement systems should be reformed and monitored to encourage efficiency and avoid over-utilisation
	10	Data collection systems are critical to long-term development of health markets and improvements in health services
Governance/ safeguarding	11	Regulation of minimum standards, in insurance and provision, is necessary to avoid fraud and improve outcomes
	12	Fraud control mechanisms should be commensurate with value of services

A UNIQUE MODEL FOR INDIA

In the proposed model, the Central Government would engage states, NGOs, and private sector players to build a system in which four key types of institutions interact to provide poor households with a choice of cost-effective health insurance and thus access to better quality healthcare services (Exhibit 3).

Exhibit 3: Overview of proposed model



Civic institutions to act as social aggregators

Civic institutions are an essential feature of India today. The proposed national health insurance model would leverage the considerable strength of thousands of these institutions to be 'social aggregators'—institutions charged with two critical activities. First, social aggregators lead education about, enrolment in and collection of symbolic premiums for health insurance. Second, they are responsible for the competitive selection of a service integrator to provide a complete health insurance product to their community.

1. *Education, enrolment and collection.* In the proposed model, social aggregators drive household-level enrolment in health insurance through active outreach to their members. International experience in both the Philippines (PhilHealth) and Tanzania (UMASIDA), as well as the enrolment experience of domestic micro-health insurance schemes such as SKS Microfinance's scheme, makes clear that local community organisations are best positioned to launch the education and enrolment campaigns essential for success, due to their unique trust-based relationships with the communities they represent.

   In addition to education and enrolment, social aggregators should also be responsible for collecting nominal/symbolic premiums from most participants, to build participant understanding of the full concept of insurance and lay the ground work for future contributions as both the households and the country grow in affluence.

2. *Competitive selection of insurance integrators.* In the proposed model, social aggregators will select a service integrator based on the quality of healthcare and insurance services delivered to their enrolled communities. Designating the service integrator for their community in a competitive marketplace, social aggregators purchase on behalf of the households they enrol. The ability of the social aggregators to select among integrators will limit profit taking and encourage innovation, as well as improve the access to, and responsiveness and quality of, healthcare.

   Such a choice does not exist for most civic institutions playing aggregator roles today, due to the limited number of active insurance service integrators. However, the advent of competitive subsidies from the government should stimulate new entrants and increase competition among integrators.

NGO and private sector players to offer a complete insurance product

As envisioned, service integrators are private sector or not-for-profit institutions responsible for the delivery of a complete health insurance product, by in-house operation or the contracting of necessary services, including risk pooling, administrative functions (e.g., claims processing, network management), and ultimately the provision of healthcare (e.g., through contracting public, not-for-profit and/or private sector healthcare providers). In this capacity, their primary activity resembles that of many community-based micro- and private-health insurers active today. However, under a national insurance scheme, service integrators would receive the majority of their payments via demand-side subsidies from the state-based independent regulators.

Delivering a complete insurance product requires relatively sophisticated and active operation or contracting of risk management capacity, administrative services, and healthcare providers. As independent not-for-profit and private institutions, service integrators will be able to make flexible and competitive choices about the most effective mechanisms to accomplish these tasks. On many occasions, this will involve contracting with other institutions, from large risk-bearing institutions with a national footprint to small, local healthcare providers. Occasionally, a service integrator may independently operate the full set of services. A diverse set of illustrations of this flexible model exist today in India. For example:

- SEWA contracts with a private insurance company for risk-pooling services as well as a network of public and private providers, but manages its own administration (Exhibit 4)

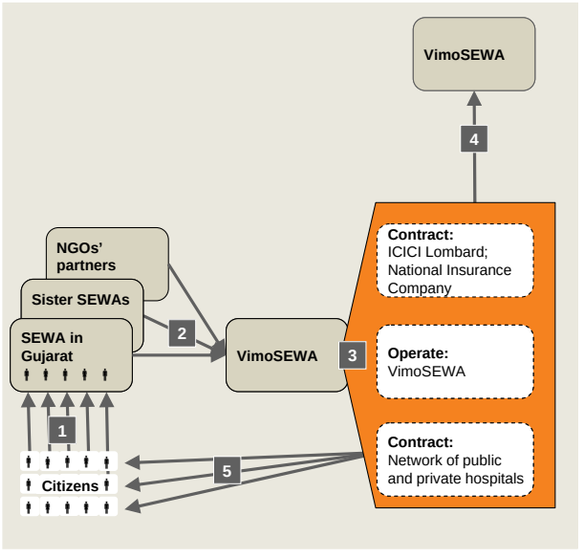
- Yeshasvini manages its own risk, but contracts with a TPA (Family Health Plan Ltd.) as well as a network of largely private providers (Exhibit 5)

- Arogya Sri contracts with an insurance company but manages a large network of providers on its own (Exhibit 6).

In exchange for work in compiling the essential risk management, administrative and healthcare provision services, service integrators are compensated through demand-side subsidies allocated through the state-based regulators.

Exhibit 4: Micro health insurance today: Vimosewa, Gujarat

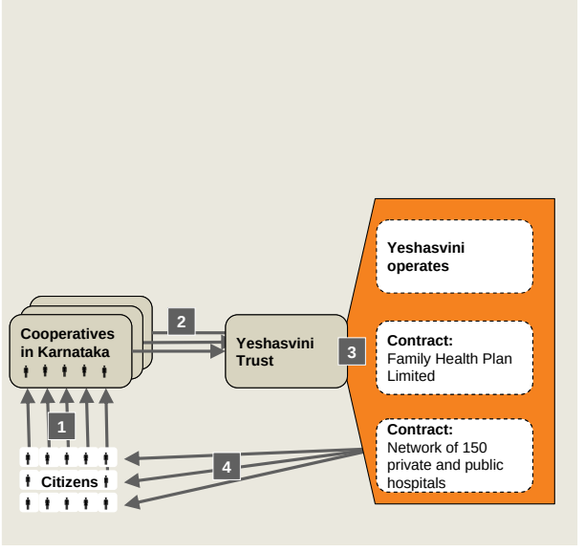
CASE STUDY



1. **Education, enrolment, and collection** occurs through community-based self-help groups in coordination with district teams
2. **Competitive selection of service integrator**is limited by exposure of SHGs to other players
3. **Administration** is managed by VimoSEWA so they are able to control costs and fraud, while providing better services. Bidding for re-insurer is conducted on a regular basis for exclusive rights to a specified region
4. **Provision of healthcare services** is handled through a network of private and public hospitals that VimoSEWA contracts with
5. **Data standardisation, collection and analysis** is completed centrally by VimoSEWA through self-developed software

Exhibit 5: Micro health insurance today : Yeshasvini farmers' cooperative, Karnataka

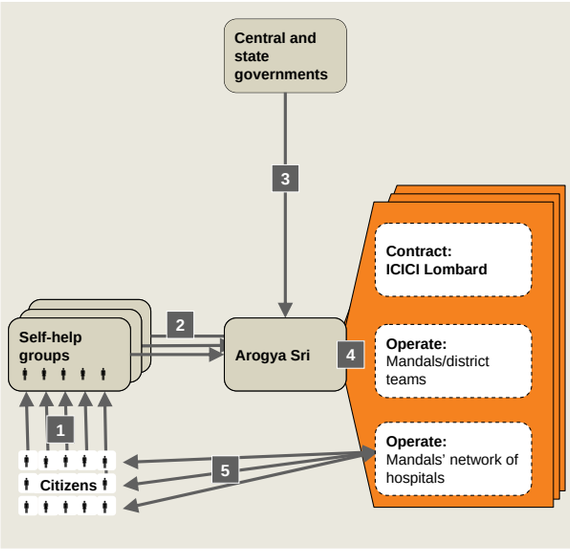
CASE STUDY



1. **Education, enrolment, and collection** occurs through established trade cooperatives
2. **Integrator selection** is limited by exposure of cooperatives to other schemes
3. **Administration** is managed entirely by Family Health Plan Limited. Yeshasvini self-insures through the Yeshasvini Trust
4. **Provision of healthcare services** is handled through a network of 150 high-quality private and public hospitals throughout the State

Exhibit 6: Micro health insurance today: Arogya Sri program, Andhra Pradesh

CASE STUDY



1 **Education, enrolment, and collection** occurs through community-based self-help groups in coordination with district teams

2 **Integrator selection** is limited by exposure of SHGs to other players

3 **Subsidy disbursement** on behalf of the state and central government is done by the insurance company

4 **Administration** is managed entirely by district teams or Mandals. Bidding for insurer is conducted by the State through a combination of an open tendering process and negotiation to get a competitive rate

5 **Provision of healthcare service** is handled through a network of private and public hospitals determined by each Mandal

State-based independent regulators to catalyse activity

State-based independent regulators should be created to oversee the implementation of the system, to catalyse growth by providing incentives to regulate the activity of NGOs and the private sector. While a central government institution will be essential for formulating broad guidelines and preventing fraud, state-based regulators will be responsible for the ultimate implementation of the scheme. They are responsible for three critical system activities: certifying service integrators and disbursing demand-side subsidies; defining the essential elements of the benefit package and symbolic premium levels; and targeting development grants to increase management capacity and enrolment in the system.

1. *Certifying service integrators and disbursing demand-side subsidies.* State-based regulators are the ultimate 'market maker' for the subsidised health insurance product. They are responsible for distributing these subsidies competitively to certified service integrators, based on the integrators' ability to cost-efficiently deliver a defined benefit package to enrolled households.

   Most significantly, state-based independent regulators must certify service integrators as fit for receiving government subsidies. The basic elements of certification for service integrators should include the ability to efficiently administer claims and payments, whether through its own operations or contractual relationships, and to deliver a basic package of health services to its enrollees. Additionally, regulators should be responsible for certifying that a service aggregator has achieved or will achieve sufficient scale and is non-discriminatory in enrolling (regardless of health status) any social aggregators within their geographic footprint.

Regulators are also responsible for setting subsidies at levels that most accurately reflect the costs required to serve households in a given region, and, ultimately, within given communities. Significantly, to ensure that social aggregators have choice, government subsidies must be allocated on a non-exclusive basis, e.g., integrators should not be granted exclusive rights to a given region.

While a number of approaches to setting subsidy levels are possible, auctions/ bidding are an efficient means to this end, particularly when the government has limited information about appropriate subsidy levels and costs of service are likely to vary widely, e.g., to populations in more impoverished and isolated areas. State regulators may auction off the right to serve a state (and access associated government subsidies) through a bidding process open only to certified service integrators. Regulators would select winning service integrators based on the size of the subsidy level that they would need to provide for a given population. Notably, the auction should offer only the right to compete for a certain portion of enrollees in a given geographic area, not exclusive rights of service. As an example of such a model, Chile's Sercotec program competitively allocates subsidies for providing microcredit through competitive, non-exclusive auctions.

Once sufficient data has been accumulated, the government must independently estimate appropriate subsidy levels to monitor the effectiveness of the auctions (e.g., for possible collusion).

2. *Defining the benefit package and symbolic premium levels.* State-based independent regulators are also responsible for defining the specific elements to be included in the subsidised health benefit package and the nominal/symbolic premiums to be charged to enrollees.

   Ultimately, this package should cover not only hospitalisation, but also essential primary and outpatient care as well as pharmaceuticals. While such a broad package is envisioned by the funding guidelines of the Central Government, it is ultimately very valuable because enrolment is more likely when non-emergent care is included, primary interventions are highly cost-effective, and global experience suggests that a broader, more continuous package is associated with improved satisfaction and outcomes. However, in most areas of India, such a package will only be possible after administrative systems, such as claims processing and fraud prevention, have significantly evolved.

   Simultaneous to defining the benefit package, the regulator should identify appropriate symbolic premium levels for the Below Poverty Line (BPL) community. These should not be based on the expected cost of the package, but, instead, set at a level that will encourage optimal levels of education, enrolment, and utilisation of services.

3. *Targeting development grants.* Finally, state-based independent regulators are responsible for releasing development grants to social aggregators and service integrators to increase enrollee education and build managerial capacity so they can deliver within the system, particularly in underserved areas.

Central data institution to standardise, collect, analyse and publicise health information

The data institute should be an autonomous public institution that helps ensure future market growth and government policy via the standardisation, collection, analysis and publication of health system data. In support of this objective, the institute may be involved in developing standards and software for accredited institutions. Regular collection and publication of system data will be an important tool for cost control, fraud reduction, and the long-term development of the health insurance and care markets in India. The data institute activities should also help set/increase standards for healthcare provision and introduce comprehensive criteria for provider accreditation in the long run.

In this way, the data institute will support the development of all other critical aspects of the proposed model: more effective service of enrolled communities by social aggregators; more efficient provision of offerings by service integrators; and increased transparency and accuracy of subsidies from state-based regulators.

STEPS TOWARDS IMPLEMENTATION

As the Central Government lays the ground work for a dynamic, service-oriented model of subsidised health insurance for India's poor, it will need to allocate appropriate funding; build new institutional infrastructure; test key elements by running pilots and reform supporting systems critical to long term success.

Allocate appropriate funding

Implementing and monitoring a successful subsidised health insurance scheme will require substantial financial support from the Central Government. Three separate pools of funding would need to be allocated:

- *Funding for subsidies.* Subsidy monies must be distributed to state-based independent regulators on the basis of local need. The current government proposal envisions relatively narrow hospitalisation coverage with a sum assured limit of Rs. 30,000 per family, and thus limits total costs to an initially estimated Rs. 10,000 crores to the Central Government. A broader benefit package, while considerably more expensive, would nonetheless be affordable to the government, given its stated objective to increase healthcare spending by 1 to 2 percentage points of GDP over the next five years.

- *Funding for capacity-building grants.* The government should also allocate a pool of funds to provide capacity-building grants for social aggregators and service integrators. In early years, these monies can be targeted at implementing system pilots, as well as managerial and administrative training and fellowships. Such a program is likely to require an annual minimum investment of at least Rs. 5,000 crores annually beyond subsidies.

- *Funding for data institute.* Finally, a dedicated pool of additional funds will be required for tactical investments and grants in developing common data standards, software and systems. The National Commission on Macroeconomics and Health (NCMH) estimates the cost for use of IT technology at ~Rs. 500 crores per year. This would cover not only hardware and software for patient record-keeping, inventory control, monitoring, data collection and reporting, but also potentially telemedicine and electronically linked facilities for training.

Build new institutional infrastructure

Essential to the success of a new subsidised health insurance system will be the creation of strong, independent institutional infrastructure for implementation:

- *National oversight body.* A small, independent and autonomous institution, the national oversight body should be responsible for crafting the broad guidelines for system management and liaising with the state-based independent regulators to ensure effective implementation and prevent fraud. Because its effective functioning will ensure the efficiency and integrity of the rest of the system, it should be staffed by a limited number of trained professionals, paid highly competitive salaries.

- *State-based independent regulators.* Similar to the national oversight body, these state-based institutions should be leanly staffed with dedicated professionals. Employees should be trained and on the payroll of the national oversight body to reduce incentives for fraud and encourage performance to a consistent national standard.

- *Data institute.* This institute must be independent from regulators to increase transparency, reduce fraud, and objectively demonstrate scheme effectiveness on improving health outcomes. It should employ a core group of statisticians and public health experts to measure and monitor health outcomes and scheme performance measures. In addition, they may choose to contract-in skills for data collection and analysis as needed.

Begin testing and pilots

Tailoring and testing any model will be critical to a successful rollout across diverse regions. To do so, the government should engage existing schemes as partners in pilots as well as define new pilots. Carefully selected pilots with established partners will allow the government to begin immediate monitoring and modification. New pilots offer a chance to experiment with a 'complete' version of the selected model.

Creativity and flexibility will be required in any model. In both pre-established and new pilots, the government should carefully monitor and seek innovations in delivering four specific features that are most likely to generate complexity and challenges in any national rollout:

- Subsidy auctions, specifically the creation of competitive risk-pooling markets
- Comprehensive benefit packages, specifically the administration of a package that includes primary and outpatient services
- Management capacity of service integrators, specifically the support that they require to effectively risk-pool and administrate their systems
- Fraud control, specifically those mechanisms that prove effective at minimising system leakage.

In addition, pilots should also be targeted at geographies requiring special modification or supplementation. (e.g., certain states may have limited aggregator and provider capacities and therefore require supplemental strategies and funding to formalise or establish community-based groups to serve as social aggregators).

Monitoring the results of such pilots will be critical. Key metrics to track during the pilots include: rates and levels of enrolment, effectiveness of education campaigns, efficacy of fraud control, health outcomes, enrollee satisfaction levels, and timeliness and accuracy of claims reimbursement.

With flexible partnerships and careful monitoring, the government can learn a great deal about the proposed model and its rollout in a relatively short period of time.

Launch reform of supporting systems

A number of supporting systems need to be changed for a subsidised health insurance system to be effective. Many of these supporting systems will require time and significant focus to reform. Therefore, as the government is building new institutional infrastructure and testing possible approaches to a health system, it must also begin long-term planning for the improvement of these supporting systems. Specifically:

- *Planning for coordination with other government insurance programs.* Today, a number of government-run programs exist to provide health insurance to specific groups of people. A long-term strategy for the coordinated governance and productive co-existence of these programs with the proposed subsidised health insurance scheme is necessary.

- *Improving quality and competitiveness of public healthcare facilities.* The Indian government has already established a vast network of public healthcare facilities to serve the rural population. However, to compete effectively in the health insurance scheme, currently underutilised public provider facilities will need to be reformed. In particular, the lack of accountability and responsiveness to the public, as well as the incongruence between available funding and coverage commitments, must be addressed. International experience has shown that the transformation of public sector providers into more flexible and responsive institutions frequently takes decades.

- *Gradually introducing minimum standards for providers.* Setting clear standards for the quality of care and service that providers are required to adhere to will improve consistency of healthcare delivery in the country—and will become increasingly important as the health insurance system grows. In India today, voluntary accreditation through the National Accreditation Board for Hospitals and Healthcare (NABH) has resulted in the accreditation of only 7 out of 15,000+ hospitals. Health insurance subsidies create the opportunity for the government to introduce and gradually raise minimum standards at provider institutions included in any service integrator network (e.g., requiring that provider networks have at least 50 per cent of their hospitals meeting minimum standards for service integrators to receive subsidies).

- *Identifying BPL households.* The greatest challenge to a demand-driven subsidy system like the one proposed will be appropriately identifying eligible participants. Identifying below poverty line (BPL) families today in India can be challenging and expensive. The effectiveness of a subsidised health system will ultimately require improvements in this area. Therefore, the government must begin the reforms as soon as possible: re-surveying the population, requesting income certificates as evidence, and distributing biometric or photo identification cards. In the medium term, as part of the health insurance scheme, social aggregators could be leveraged to assist BPL families in obtaining appropriate documentation.

* * *

The Government of India has announced plans for a subsidised health insurance scheme for the poorest citizens in the unorganised sector. By leveraging the country's civic institutions and vibrant private healthcare markets, and by building the right support infrastructure, the Central Government has an exciting opportunity to truly improve access to higher quality healthcare services for a significant portion of the Indian population.

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Beyond hospitalisation benefits: The role of preventive care

Beyond hospitalisation benefits: The role of preventive care

Viktor Hediger

Today, private sector group and individual health insurance coverage in India, as well as the Central Government's plan to subsidise health insurance for the poor, focus on hospitalisation benefits with a limited sum assured. While this provides valuable coverage, preventive care and chronic disease management techniques are important components of improving medical outcomes and the overall cost-effectiveness of healthcare provision and insurance. A number of these techniques fall into the domain of public sector and government health spending, but the private sector can make important contributions as well.

Below we provide a framework and some basic facts about preventive care, highlight select examples of screening and disease management programs adopted in other countries, and tee up some of the key questions to facilitate the debate in India on expanding coverage beyond the currently narrowly provided hospitalisation benefits.

A FRAMEWORK AND BASIC FACTS ABOUT PREVENTIVE CARE

In assessing the cost-benefit equation of a number of techniques and determining who is best positioned to provide these services, it is helpful to distinguish between three levels of preventive care:

- *Primary prevention* is the reduction of the level of one or more identified macro risk factors to reduce the probability of the initial occurrence of a disease. Examples include road safety, clean water, food fortification and vaccinations, which are typically government-led

- *Secondary prevention* aims at detecting a disease at a very early stage to prevent or delay its progression. Examples include screening programs for cancer and diabetes, which could be provided and funded by the private sector

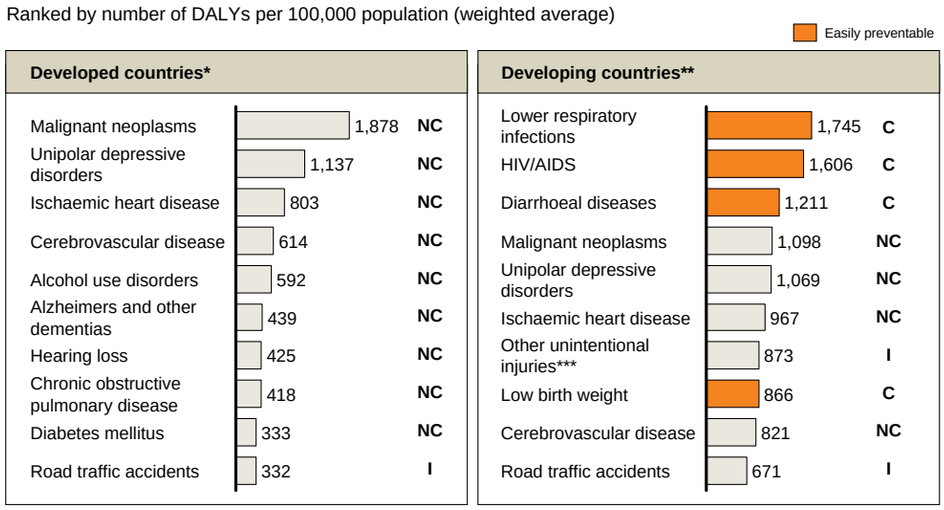
- *Tertiary prevention* consists of ongoing interventions aimed at decreasing or delaying the severity and frequency of recurrent events of chronic or episodic

diseases. Examples include family-oriented disease management therapies for cardio-vascular diseases, or disease management programs for diabetes patients, where again the private sector can play an important role.

Against this framework, the decision on where to focus healthcare resources will always be relative to what is technically possible. Healthcare professionals around the world typically use the potential positive impact on healthcare outcomes per dollar spent, where the health benefit is measured as disability-adjusted life years (DALY) saved through intervention.

Not surprisingly, types of the most costly diseases when measured by DALY differ across countries (Exhibit 1). Using data from the World Health Organisation we found that for a set of 30 developed countries, 9 of the top 10 diseases as ranked by DALY in 2002 were chronic non-communicable diseases, which require more sophisticated early detection and ongoing intervention to lower prevalence and costs. By contrast, for a set of 30 developing countries, the top 3 diseases ranked by DALY were communicable, which suggests that there remains significant potential to lower prevalence of the total number of diseases and overall healthcare costs via more elementary primary and secondary prevention measures.

Exhibit 1: Top 10 diseases in developed vs. developing countries, 2002

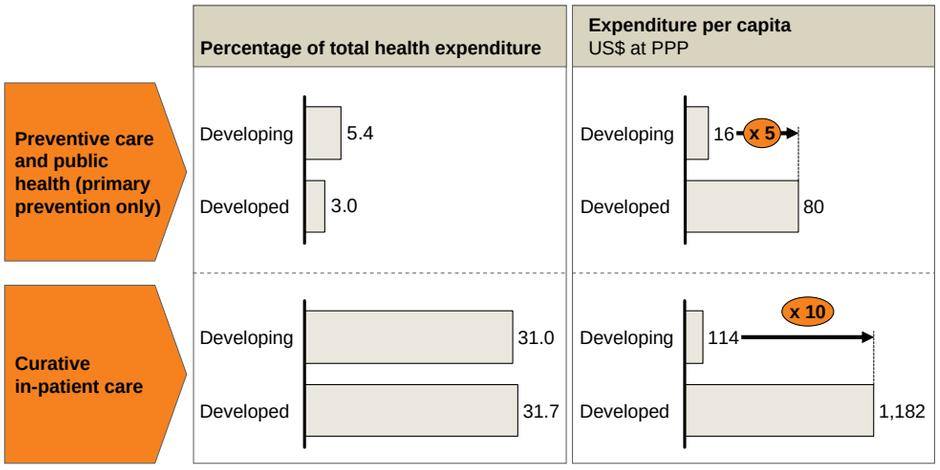


* 30 countries according to the IMF classification (excl. Hong Kong and Taiwan)
** All other countries, WHO members
*** Unintentional injuries excl. road traffic accidents, fires, poisonings, falls, and drownings
Note: C = communicable diseases, NC = non-communicable diseases, I = injuries
Source: WHO; McKinsey

Interestingly, developed and developing countries alike spend disproportionally on curative in-patient care versus preventive care. In both sets of countries, curative in-patient care accounts for more than 30 per cent of health expenditure. While the expenditure on curative care in developed countries is higher than in developing countries by a factor of 10 adjusted for purchasing power parity, the same ratio is only 5 for preventive care expenditures (Exhibit 2).

Exhibit 2: Expenditure on preventive vs. curative care, 2004

Comparison developing* vs. developed** countries (weighted average)

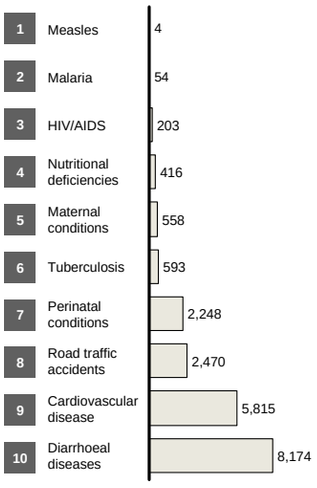


* Developing countries: sample of 30 countries
** Developed countries: 30 countries according to the IMF classification (data available for 23 countries)
Source: WHO; OECD; Global Insight; McKinsey

In India, we found that 8 million people die every year from diseases that are preventable by certain primary preventive measures. If preventive measures were in place solely for the top 10 diseases ranked by their cost-effectiveness in terms of U.S.$/DALY, more than 5 million premature deaths could be avoided or significantly delayed (Exhibit 3).

Exhibit 3: Top 10 primary prevention measures

Ranked by US$/DALY averted* (sum of measures)



Prevention measures**	Number of deaths in India, 2002 (est.)
• 2nd opportunity vaccination in a fixed facility	125,600
• Intermittent preventive treatment in pregnancy, insecticide treated bed nets, residual household spraying	9,400
• Education programs for high-risk groups, condom promotion and distribution, blood and needle safety	361,300
• Sustained child health and nutrition programs, food fortification	129,100
• Improved quality of comprehensive emergency obstetric care, increased primary care coverage and care quality	133,100
• BCG vaccine, management of drug resistance	364,900
• Family, community, or clinical neonatal packages	762,100
• Regulation of speeding (penalties, speed bumps), enforcement of seatbelt laws, random driver breath testing	189,000
• Legislation substituting trans fat with polyunsaturated fat, 33% price increase on tobacco (taxes), legislation with public education to reduce salt content	2,810,000
• Water sector regulation, construction and promotion of basic sanitation, breastfeeding promotion, cholera or rotavirus immunisation	456,400
	5,340,900

* Cost of intervention in US$ per disability-adjusted life year averted
** Measures as reviewed by DCP2 published by the World Bank and the Bank for Reconstruction and Development
Source: Disease Control Priorities Project (DCP2); WHO; McKinsey

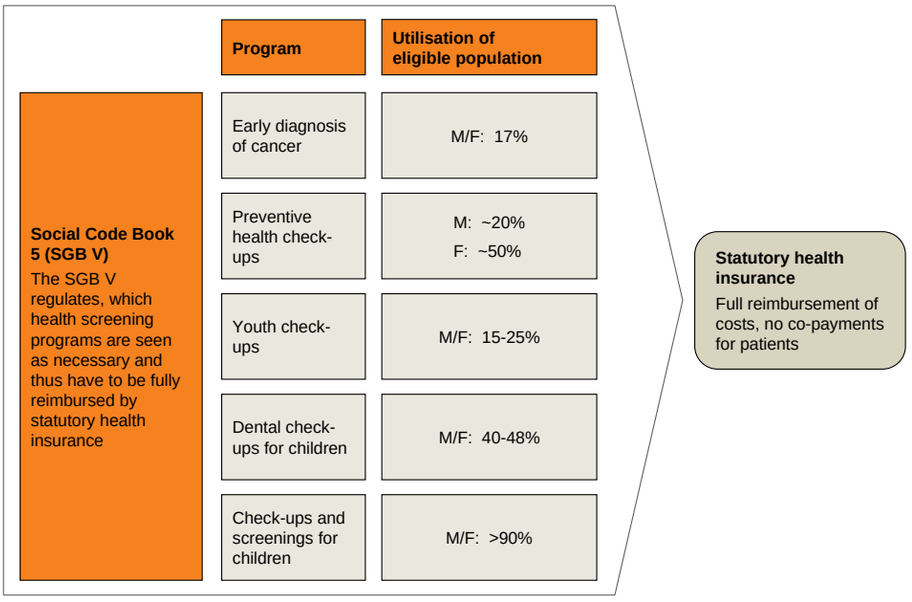
EXAMPLES OF SCREENING PROGRAMS

A number of countries have recognised the benefits of health insurance packages that cover not only acute, curative expenses but also focus on secondary prevention measures, such as health screening. Germany and the Netherlands are two examples of publicly mandated and largely publicly funded health insurance systems that are covering such preventive healthcare expenses and actively encouraging usage by insured members.

The extent of coverage and utilisation varies. In Germany, statutory health insurance covers 5 programs with utilisation relatively low for early cancer diagnosis (17 per cent) and highest for children's check-ups (more than 90 per cent) (Exhibit 4). The Netherlands provides for a more comprehensive set of screenings and check-ups across 6 programs that are paid for either by government funds to the ministry of healthcare, local government funds to local healthcare services, or through private healthcare insurance (Exhibit 5).

Private health insurers in Germany are complementing the statutory screening program. One of the leading German private health insurers, for example, offers a special tariff on prevention and screenings designed as supplementary non-obligatory health insurance for Statutory Health Insurance members. Policies cover up to 27 different screenings (depending on age) that are not already covered and cost up to €20.50 per month (Exhibit 6).

Exhibit 4: Screenings and check-ups: Germany



Source: McKinsey Research

Exhibit 5: Screenings and check-ups: The Netherlands

In the Netherlands, screening programs are coordinated by the National Institute for Public Health and Environment (RIVM). RIVM actively advises the target group to go to a screening at the recommended frequency

Government
PHI

Screening	Target group	Description	Funding
Breast cancer	F: 50 - 75 years	• Mammography • Every 2 years • At local screening organisations	US$ 53.5m
Cervical cancer	F: 30 - 60 years	• Cytological research, coloposcopy • Every 5 years • In GP offices	US$33.5m
Pre-natal/ newborn checks I	F: after 3rd month of pregnancy	• Blood type, infectious diseases, Down syndrome • Once • Three options: GP, midwife or gynecologist	US$22.3m
Pre-natal/ newborn checks II	F: within a few weeks after birth	• Heel prick, blood test to detect extremely serious diseases, e.g., phenylcetonuria • Once • Babycare clinic or midwife	US$22.3m
Flu prevention	M/F: 60+ years	• Injection against the flu • In GP offices	US$45.4m
Familial hypercholes-terolemia (FH) prevention	M/F	• DNA test • Once • FH prevention team visits the patient at home	n. a.

Source: RIVM; Dutch Association for Healthcare and Dutch Ministry for Healthcare

Exhibit 6: Private health policy for prevention

GERMANY EXAMPLE

Product	Supplementary health insurance for prevention/screenings not covered by SHI
Target group	SHI insureds (entering age up to 70 years)
Monthly payments	Children: €5.00-8.50, adults: €11.00-20.50

Birth–18 years

- Hardness of hearing for newborns: once within the first 3 months, €37.30
- Examination before entering a kindergarten: once, €20.98
- Lipid metabolism: once between 10 and 16 years, €4.69
- Skin type: once, €13.06
- Blood type: once, €35.67

18–35 years

- Pulmonary function: every 4 years, €35.94
- Skin cancer: every 3 years, €30.07
- Consultation on prevention and life style: once a year, €10.73

35–45 years

- Major health check-up: every 4 years, €131.57
- Cancer screening for women: every 3 years, €59.98

From 45 years*

- Glaucoma: every 3 years, €27.87
- Brain capacity: every 3 years, €5.78

9 screenings in total ⊕ **8 screenings in total** ⊕ **3 screenings in total** ⊕ **7 screenings in total**

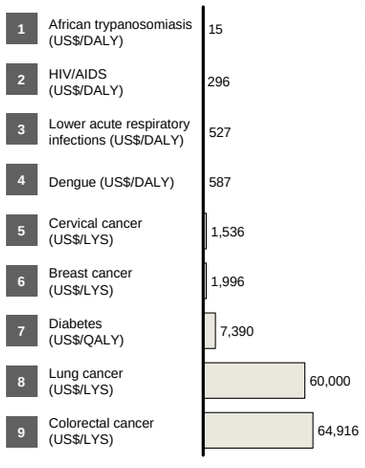
* Including 2 tests for people aged 55 and more

Source: Company website

For India, based on our analysis of publicly available data, 3 million premature deaths could be avoided every year via early screenings, most of them in diabetes and malignant neoplasms. Screenings for the top 10 diseases ranked by cost-effectiveness could prevent or significantly delay 1.9 million premature deaths in India per year (Exhibit 7).

Exhibit 7: A selection of secondary prevention measures

Ranked by cost-effectiveness* (sum of measures)



	Prevention measures	Number of deaths in India, 2002 (est.)
1	• Identification and treatment using the card agglutination trypanosomiasis test with parasitological confirmation	n.a.
2	• Voluntary counselling and testing, sexually transmitted infection diagnosis and treatment, mother-to-child transmission prevention	361,300
3	• Case management package at community, facility, and hospital levels	1,107,900
4	• Improved case management, e.g., early recognition of symptoms, supportive treatments include fluid replacement and electrolytic therapy	5,400
5	• Conventional or liquid-based cytology testing, nationwide pap screening program based on 5 year intervals, 1-visit VIA, 2-visit HPV testing, 3-visit cytology	74,600
6	• Clinical breast exam, screening mammography	57,300
7	• Annual eye examination, annual screening for microalbuminuria, screening	189,000
8	• Early detection screening	110,700
9	• Colonoscopy every 10 years, double-contrast barium enema every 5 years, fecal occult blood test, flexible sigmoidoscopy every 5 years	30,100
		1,936,300

* US$/DALY = US$ per disability-adjusted life year averted; US$/QALY = US$ per quality-adjusted life year saved; US$/LYS = US$ per life year saved

Source: Disease Control Priorities Project (DCP2), WHO, McKinsey

EXAMPLES OF CHRONIC DISEASE MANAGEMENT PROGRAMS

Disease management programs (DMPs) are for chronically ill patients and require patients to change their behaviour and the way they interact with providers. Key success factors for disease management programs include:

- Developing appropriate clinical guidelines based on the best scientific evidence, updated regularly as necessary
- Educating and involving physicians and other providers in the effective implementation of these guidelines
- Conducting repeated evaluations
- Sharing results with providers and patients
- Using incentives for patients and providers to participate in disease management programs
- (Co-)promoting local healthcare providers
- Leveraging medical information on computer systems to identify patients for intervention and measure clinical and financial outcomes.

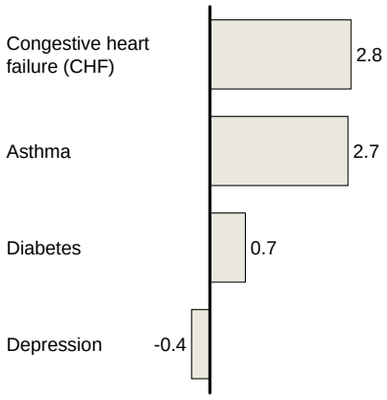
Germany introduced DMPs in 2002. These programs funded by statutory health insurance cover 6 diseases (type I and II diabetes, breast cancer, coronary heart disease, asthma and chronically obstructive lung diseases) and more than 3 million patients. To make these programs successful, a number of incentives were created:

- *Health funds* receive additional premium payments as financial incentives for each patient enrolled in a disease management program as part of the industry-wide risk-balancing scheme; these payments currently range from €2,300 for asthma at the lower end and €6,700 for breast cancer at the higher end of the spectrum
- *Patients* are given incentives through lower co-payments and reduced premium payments
- *Providers* get ongoing fee-for-service compensation. In addition, there are incentives to encourage enrolment and process efficiency, for example, €20 for consulting a patient and introducing them to the program, or a €200 one-time payment for investments into electronic data transmission from physician's office to data centre.

The cost-benefit equation from a long-term health insurance perspective is different by disease. A number of research studies suggest that the cost-benefit ratios are highest and clearly positive for diseases like congestive heart failure, asthma and potentially diabetes (Exhibit 8). A series of interventions for diabetic patients, for

Exhibit 8: Cost-benefit analysis of disease management programs

Medical costs only*



	Cost US$ per patient	Benefit US$ per patient	Comments on studies
Congestive heart failure (CHF)	1,399	3,884	• 12 studies, average of 170 subjects, 1 year
Asthma	268	729	• 12 studies, average of 449 subjects, 1.3 years • Findings not consistent
Diabetes	611	434	• 8 studies, average of 2,011 subjects, 2.5 years
Depression	1,479	-511	• 8 studies, average of 289 subjects, 1.1 years

* Direct savings from medical costs; other possible savings, e.g., through reduced absence and disability, reduced on-the-job productivity losses, are not considered

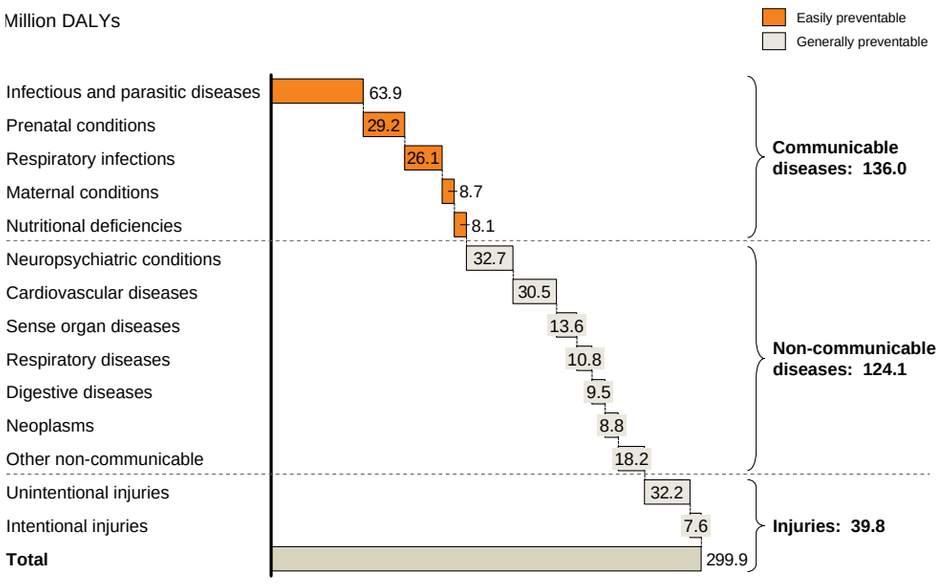
Source: Ron Z. et al. "Return on Investment in Disease Management: A Review" in Health Care Financing Review, Summer 2005, 26:4

example, can result in 10 to 15 per cent savings in the first year of implementation. This is only true if all possible levers are implemented at the same time. For other diseases like depression, the cost-benefit analysis is negative.

SOME QUESTIONS TO ADVANCE THE DEBATE IN INDIA

Clearly, public authorities have to play a critical role in providing and funding preventive healthcare measures. Forty per cent of the disease burden in India is caused by infectious and parasitic diseases, nutritional deficiencies, prenatal and maternal conditions, and respiratory conditions (Exhibit 9). These are relatively easily preventable and arguably a matter of public health programs. India's expenditure on primary prevention and public health is low by international standards (US$13 per capita on a purchasing-power-adjusted basis compared to, for example, US$17 per capita in Vietnam, US$22 per capita in Mexico, and US$25 per capita in Egypt) and can be significantly increased in line with the Central Government's declared intentions.

Exhibit 9: Disease burden in India by cause, 2002



Source: WHO; McKinsey

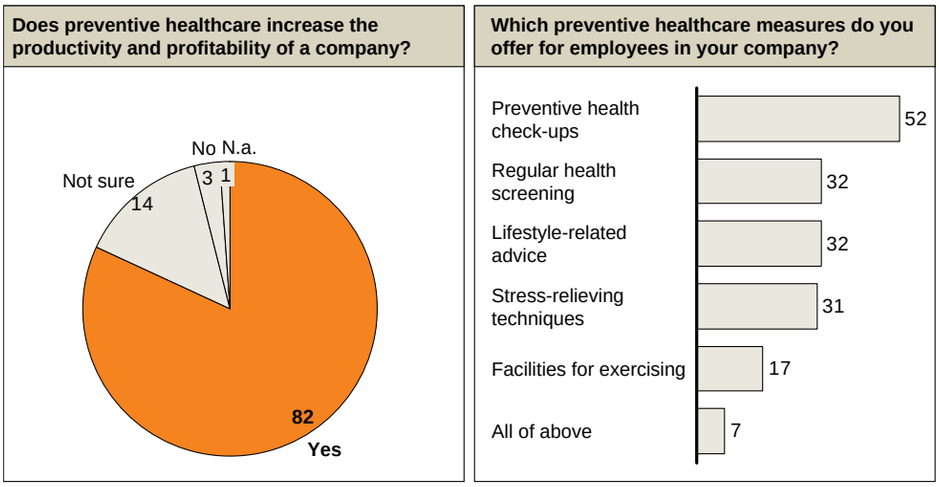
At the same time, India's private sector is more aware of the need and opportunity to step up their own contributions. Companies have recognised the importance of preventive care and the linkage between their employees' health status and company performance (e.g., through higher productivity, fewer sick days, lower medical costs). As a result, they have started to offer a number of preventive healthcare measures for their employees, including regular health screenings, lifestyle-related advice, and facilities for physical exercise at the workplace in addition to the traditional Mediclaim hospitalisation benefit (Exhibit 10). ICICI Prudential's recent diabetes and cancer care products are incorporating some of the leading-edge thinking in disease management. Patients will benefit from a holistic disease management program only if they stay with one insurer for a long period of time. This is not necessarily in the interest of the insurer, as the patient becomes much more expensive in later stages of a disease.

Key questions for debate include:

- What is the scope and depth of preventive care provision that can be realistically expected from public authorities?
- What can policy makers, regulators, and industry participants do, to increase the likelihood of success and benefits of more advanced preventive health measures (e.g., creating better publicly available data; funding joint development of clinical guidelines)?

Exhibit 10: Preventive care in the Indian corporate sector

In % of answers (n = 81 well-established companies*)



* Respondents included well-known different sized companies in manufacturing and services, e.g., Coca-Cola, Infosys, Sun Life, Tata Consulting Services

Source: Indian Council for Research on International Economic Relations (ICRIER), September 2007

- What screening and disease management programs can and should be insured?
- How can you give incentives to patients and health insurers to partner throughout the whole life cycle of a disease?

* * *

Preventive care and chronic disease management techniques are important components of improving medical outcomes and the overall cost-effectiveness of healthcare provision and insurance. A number of these techniques fall into the domain of public sector and government health spending, but the private sector can also make important contributions. We hope that the framework, facts, and examples provided in this paper can help advance the debate in India on how to expand coverage simply beyond hospitalisation benefits.

Dr. Viktor Hediger is a Partner in McKinsey & Company's Dubai office. *The author wishes to acknowledge the contributions of Uma Deepika Khan and Saule Serikova.*

Emerging medical value management approaches

Emerging medical value management approaches

Vishal Agrawal

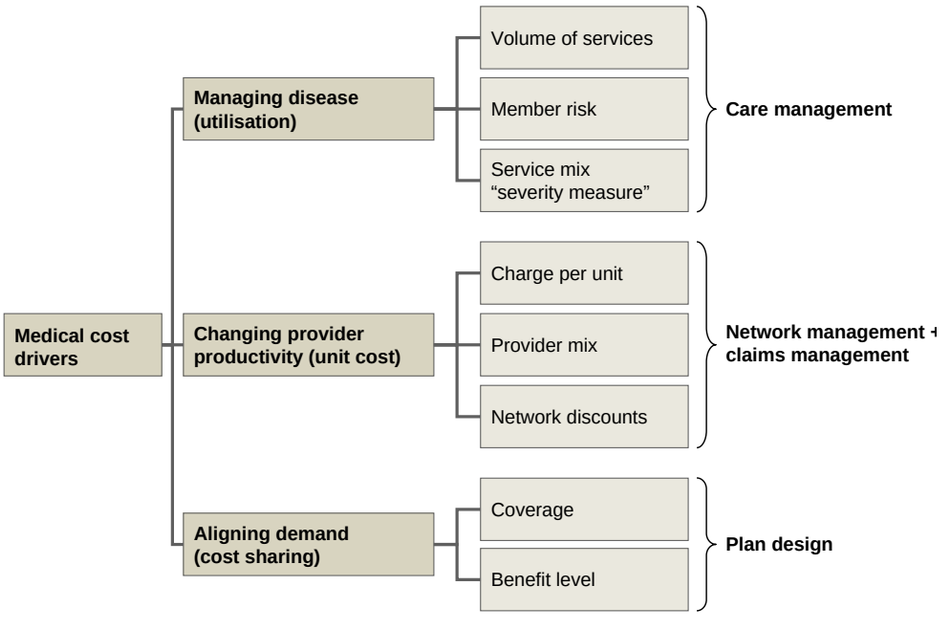
The combination of rising income levels and awareness, increased access to health insurance, and broader coverage in India is bound to grow overall healthcare expenditure. This is the experience of nearly every developed country, where healthcare costs have been increasing at a rapid rate for decades, for most years well in excess of aggregate inflation. Periodically in the U.S., when medical cost inflation accelerated, demand for new solutions emerged—often met by a wave of innovation from existing industry players as well as from new entrants. Today's open-access health maintenance organisations (HMOs) are the result of such periods; as was the earlier managed-care revolution (centred around point-of-service products) of the early 1990s.

In the current era of healthcare expenditure increases, a new approach is emerging. This time, innovation is focused on creating a holistic approach to manage medical value that integrates the formerly siloed payor functions of benefit design, network management, claims management, and care management. In addition, incentive structures are changing to shift the decision making from "payor-directed" centralised control to "self-directed" approaches that are initiated by consumers and providers. Here we provide an overview of the major medical value-management activities currently being deployed in the U.S. market, how these are evolving, and a set of "deep dives" into those that could have the greatest impact in an emerging market setting.

COMPONENT DRIVERS OF MEDICAL COST TREND

Medical cost trend is a function of utilisation volume and unit cost changes, less any member cost-sharing variance (e.g., benefit buydowns). Leading payors break down each of these variables into what underpins their operations, i.e., eight component drivers of trend, to understand how medical costs are changing (Exhibit 1). For example, a shift in the mix of hospital versus outpatient-based diagnostic imaging

Exhibit 1: Payors typically impact 8 component drivers of medical cost trend



will have a significant impact on unit costs given the three to five times dispersion in pricing across these settings.

Typically, U.S. payors are organised with different functional heads for each component of the payor value chain. The executive in charge of medical management is distinct from the head of provider networks who is different from the manager in charge of benefit design. Consequently, the operational objectives of managing disease (utilisation), improving provider productivity (unit cost), and aligning consumer demand (cost sharing)—all critical functions to managing medical cost—are fragmented across the organisation.

Realising the shortcomings of such a fragmented approach, payors are beginning to take a holistic, cross-functional approach to functional siloes from plan design, to network, claims, and care management (Exhibit 2). This type of integration enables consistent, reinforcing approaches across major medical cost drivers. For example, an approach like provider network tiering can be embedded in aligning consumer demand (e.g., reducing copays to steer members to top providers), improving provider quality and productivity (e.g., varying provider reimbursement levels), as well as managing disease (e.g., utilisation limits for inefficient providers). Typical and emerging medical value management tools are defined in Exhibit 3.

Exhibit 2: Activities span clinical and non-clinical approaches

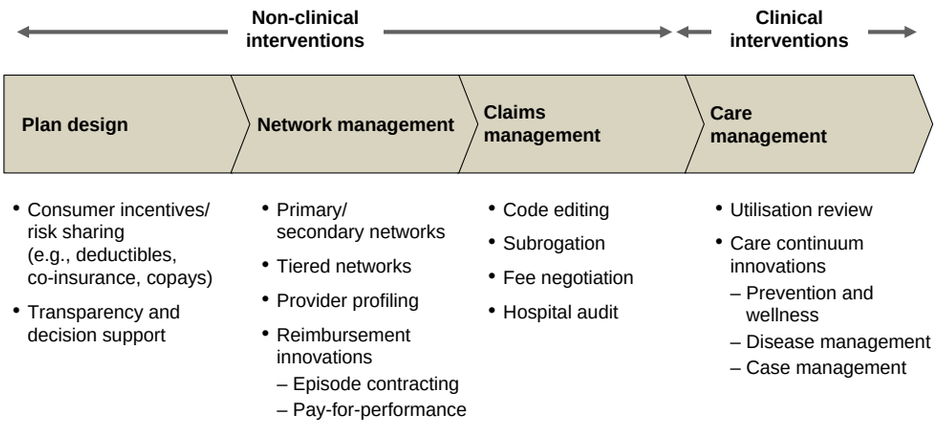


Exhibit 3: Description of medical value management tools

Cost-control approaches	Description
Consumer risk sharing	• Benefits that promote value-conscious utilisation (e.g., coinsurance)
Primary/secondary networks	• Provider contracts for preferred rates/discounts
Tiered networks	• Provider categorisation based on efficiency and quality information
Provider profiling	• Feedback evaluation for providers
Episode contracting	• Reimbursement model based on the estimated total cost of a health event
Pay-for-performance	• Financial or other incentives/based on provider performance
Code editing	• Pre-adjudication revision of claim codes (e.g., bundling of charges)
Subrogation	• Identification of third-party insurance liability (e.g., auto insurance)
Fee negotiation	• Negotiation of discounts with providers after services rendered/claims filed
Hospital audit	• Examination of billed charges with the provider to verify claim accuracy
Prevention and wellness	• Avoidance/hindrance of disease and promotion of healthy lifestyles
Utilisation review	• Examination of clinical services provided to assess medical necessity
Disease management	• Promotion of compliance with evidence-based guidelines
Case management	• Intensive support for high-risk, high-cost patients

CREATING A HOLISTIC MEDICAL VALUE PROGRAM

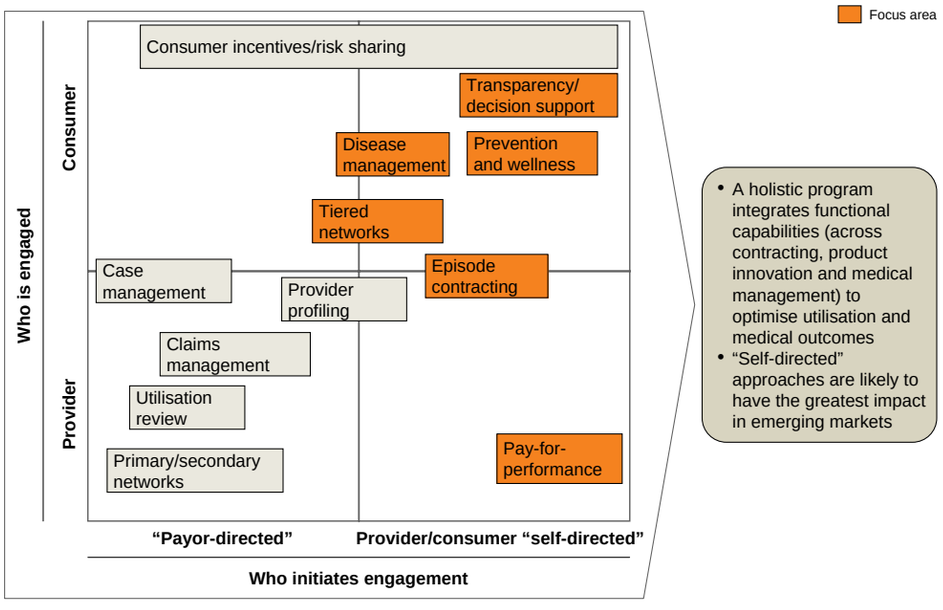
The approach to creating a holistic medical value program is likely to vary across developed and developing economies.

Developed economy approach

Leading U.S. payors create medical value by influencing provider and member behaviour through multiple approaches. These programs will vary by who is engaged: provider or member; and who initiates the engagement: the health insurer (i.e., "payor-directed") or provider/consumer (i.e., "self-directed") (Exhibit 4).

The historical emphasis in the U.S. has been on payor-directed approaches focused on engaging the provider (e.g., hospital utilisation review and case management). We expect that these approaches will continue to be predominant over the foreseeable future. However, a confluence of factors: 1) the failure of payor-directed approaches alone to manage trend; 2) recognition of broad disparities in provider performance; 3) the increasing proportion of chronic and discretionary care on total medical costs; and 4) new regulations and "ownership" mindsets, have led to medical cost-control innovations that are more self-directed. Given these factors, payors are supplementing traditional payor-directed approaches with those incentives that stimulate consumerism and provider-driven change. Over the long-term, self-directed

Exhibit 4: Holistic medical value program components vary along 2 primary dimensions



approaches will accelerate as individuals assume greater ownership and financial stake in their healthcare decisions and with greater accountability and transparency in provider performance (both efficiency and quality).

Likely approach in developing economies

We believe that self-directed approaches are also well suited for retail-oriented emerging markets. In fact, given widespread variability in coding and clinical standards, these may even create more value than more traditional payor-directed approaches. In many of these markets, consumers bear significant medical risk and providers actively compete for patients. Developing economies have the opportunity to leapfrog by deploying self-directed approaches that would promote competition, innovation, and ultimately higher quality care and greater market efficiency through appropriate stakeholder incentives.

DETAIL ON MEDICAL VALUE TOOLS

We highlight six specific medical value tools with a potential for strong impact in emerging markets to discuss in more depth. Two focus on influencing providers: pay-for-performance and episode contracting, and four focus on influencing consumers: network tiering, transparency/decision support, prevention/wellness, and disease management.

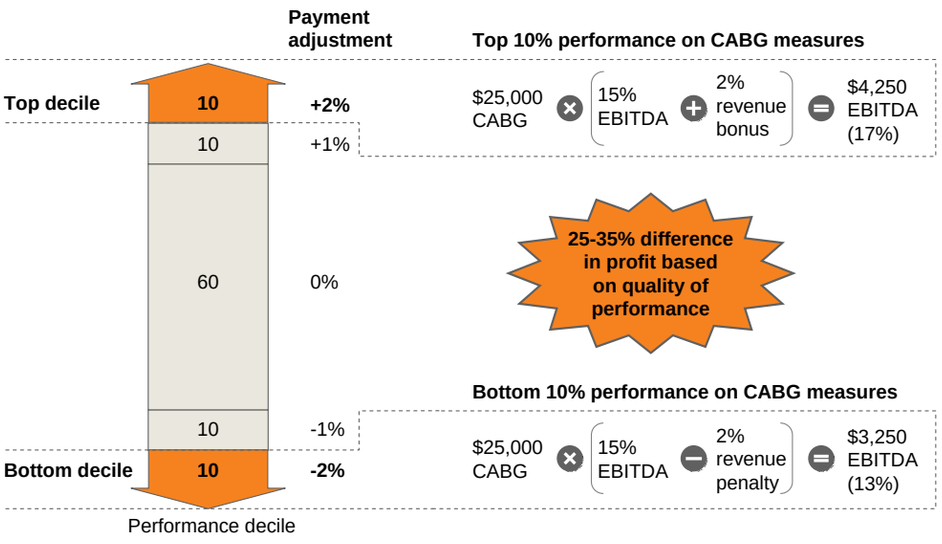
Influencing providers

The market is moving toward a more self-directed provider model, where providers are prompted to optimise medical outcomes and utilisation through increased transparency of efficiency/quality information and appropriate economic incentives. Programs to achieve this include:

- *Pay-for-performance:* Provide financial or other incentives to high-performing providers at the hospital and physician level. This tool requires cooperation and agreement between payors and providers on the key performance indicators that determine compensation for physicians and facilities. Initial experiments in place today are largely based on process metrics (e.g., did the heart attack patient receive an aspirin) with more true clinical outcomes-based metrics likely to emerge in the future (e.g., what is the morbidity rate after a heart attack). Given the small margins many providers operate with, even small revenue bonuses or penalties can have a strong material impact (Exhibit 5).

Exhibit 5: Pay-for-performance: provider reimbursement variation to prompt improved quality and efficiency

Medicare Pay-For-Performance Demonstration Project



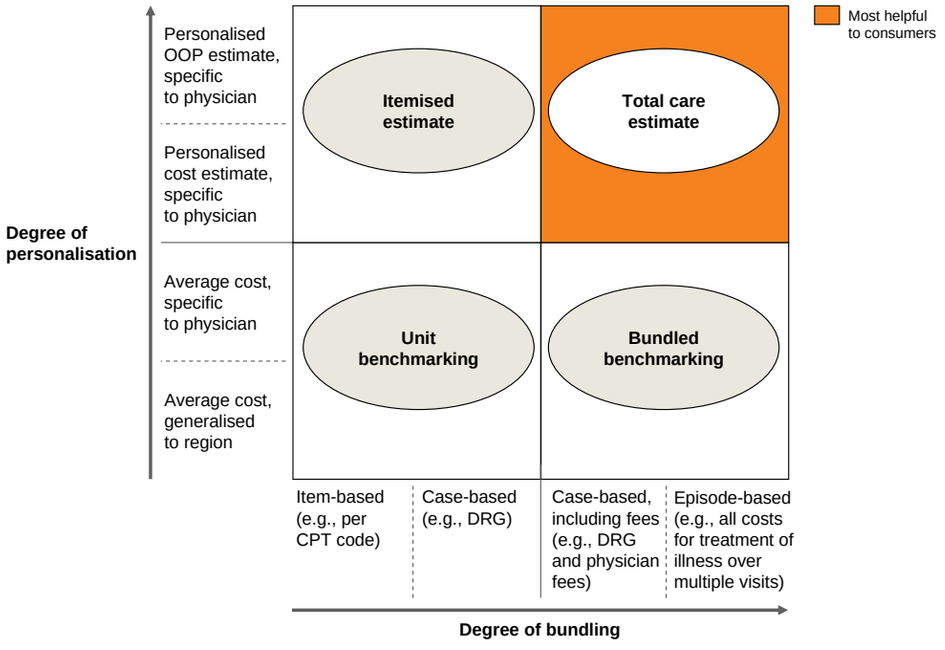
Source: Centers for Medicare and Medicaid Services (CMS)

- *Episode contracting:* Reimburse based on the estimated total cost of an end-to-end set of expenses for a clinical condition. Typically includes all inpatient, outpatient, drug, and diagnostic expenses and is risk-adjusted by several health and demographic factors (e.g., co-morbidities, age, sex). A total care cost estimate that is personalised to the specific consumer and bundles treatment costs over multiple visits for a given illness is the end-game for this approach (Exhibit 6).

Local market scale provides a strong competitive advantage in executing these programs. Indeed, many U.S. Blue Cross Blue Shield organisations are in the forefront of pay-for-performance. Medicare has pilot programs underway to test the effect and potential unintended consequences of episode contracting.

Both of these self-directed provider approaches essentially shift incentives away from a fee-for-service reimbursement model to one that is more value-based. Providers are more at risk for attaining results. In emerging markets, these approaches might help prompt provider optimisation in the absence of rigorous claims management protocols.

Exhibit 6: Episode contracting: greater personalisation and bundling of services to help consumers shop for value



Influencing consumers

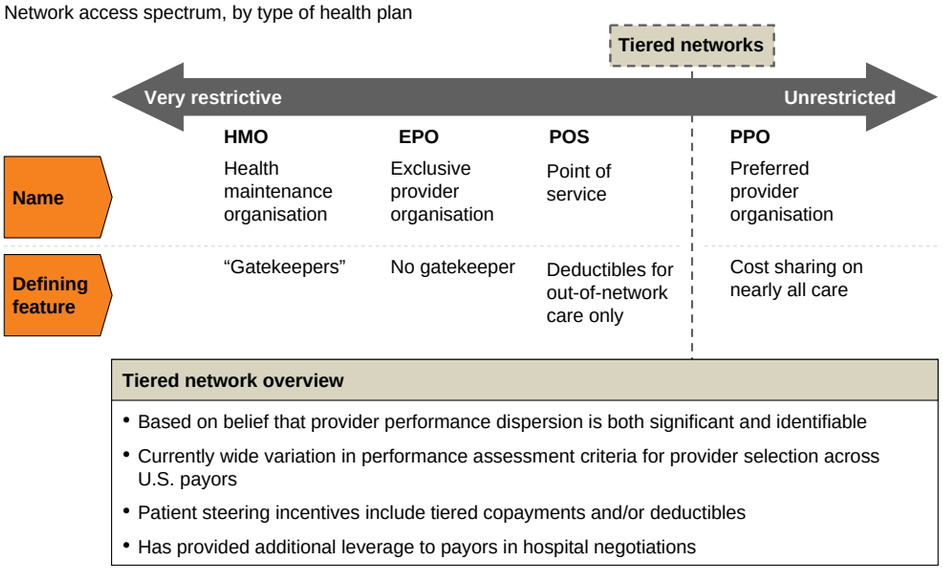
For consumers too, the market is moving toward a more self-directed approach whereby members are engaged and have greater incentives to make utilisation, cost, and quality decisions. This shift impacts how payors influence consumers and includes:

- *Consumer decision support tools:* Offer consumer tools to empower patients in healthcare decisions. When consumers have financial stake in their healthcare decisions, they will seek more information on their expected liability in advance of receiving care. Early evidence in the U.S. suggests that consumers prefer perceived better - value for money solutions.

- *Care networks/benefit tiering:* Select providers based upon efficiency/quality information (at the hospital/physician and procedure level), and develop incentives to channel patients to high-performing providers. These care networks are typically more restrictive than traditional PPOs but can create a “value-based” network based on performance outcomes versus simply seeking discounts in exchange for patient volume and prompt payment (Exhibit 7).

Exhibit 7: Care networks: network tiers that differentiate provider effectiveness to steer members to high value providers

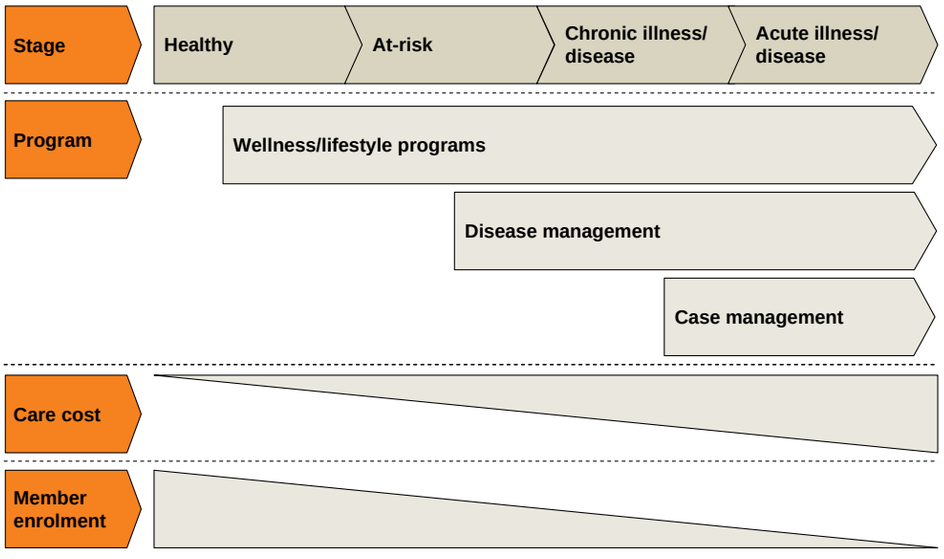
Network access spectrum, by type of health plan



Source: Literature review

Exhibit 8: Wellness/lifestyle: clinical programs across the full continuum of care to slow/prevent disease progression

Healthplan programs across the continuum of care



- *Wellness/lifestyle programs:* Prevent occurrence of disease through increased consumer awareness (e.g., general health education, health club memberships, health screenings, weight loss and smoking cessation programs) and point members toward healthier lifestyles. Shifting from "sick care" to true healthcare with programs and benefits across the entire care continuum can minimise downstream costs (Exhibit 8).

- *Disease management:* Identify and group patients with chronic diseases and prompt patient behaviour to comply with evidence-based guidelines. As the health burden increasingly shifts away from acute, random events to chronic conditions that are driven by member behaviours, low-cost programs to influence behaviours can have successful outcomes.

U.S. payors are actively pursuing programs to influence consumer behaviour, and some are supplementing traditional payor-directed approaches with a more consumer-directed mindset. For example, many are beginning to introduce tiered benefits, especially across specialty physicians, and several have recently expanded their wellness programs and consumer tools.

Consumer-driven approaches have the opportunity to be implemented effectively in emerging markets. These markets do not have the legacy of healthcare paternalism that we see in many developed economies and are therefore ripe for adopting such approaches. In addition, perhaps even more so than the self-directed provider approaches, these do not rely on sophisticated claims management protocols. In fact, many of the core skillsets to implement them could be leveraged from service vendors/carveouts emerging in other geographies.

QUESTIONS FOR INDIAN PRIVATE HEALTH INSURERS

In this context of a shifting medical value management emphasis in the U.S., India has an opportunity to leap ahead. It is unconstrained by a patchwork paternalistic health insurance legacy, and its reference point is already based on a deeply retail-oriented health economy. However, stakeholders interested in adopting these approaches must address several critical questions:

- Which component drivers of medical cost trend are the most important to medical value management in the Indian context?

- What is the right mix of payor-directed versus self-directed and provider versus consumer approaches?

- Which specific programs could be the most effective self-directed approaches?

- What are the pre-conditions for program success? What capabilities are needed to support these programs?

- How can Indian stakeholders best develop or access these capabilities?

* * *

The combination of rising income levels and awareness, increased access to health insurance, and broader coverage in India is bound to grow overall healthcare expenditure. In their attempt to manage medical costs, U.S. payors are increasingly focused on creating a holistic approach to manage medical value that integrates the formerly siloed payor functions of benefit design, and network, claims, and care management. In addition, incentive structures are changing to shift decision making from a payor-directed centralised control to self-directed approaches influencing consumers and providers. A number of these approaches could help improve medical outcomes and cost effectiveness in an emerging market like India.

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Healthcare Payors and Providers Practice

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