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Selection of Performance Measures in Context of Universal Health Coverage

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Abstract

There is an ongoing policy debate on the appropriate road map to universal health coverage. Two points of contestation are how selective should be the area of state assured services and whether the government should provide these as public services or purchase these from the private sector. This debate is both influenced and influences the selection of performance measures - not only in relation to choice of indicators but also with respect to the framework of analysis. We present a set of indicators from three contexts - of all India, and of its two most populous states Uttar Pradesh and Maharashtra from a nationwide survey. We also present contemporary discussions that have centered on these measurements. We show that these apparently technical discussions on performance measurement are essentially political choices that relate to the understanding of the role of the state and markets in health care and commitments towards equity and health as a human rights in public policy.

Key word: Health sector performance, financial protection

Introduction:

The emergence of universal health coverage as the dominant discourse in global health is quite dramatic. In the year 2005, the 58th World Health Assembly adopted a resolution calling on member states to achieve universal coverage which it described as: "ensure that health financing systems include a method of prepayment of financial contribution for health care, with a view to sharing risk among the population and avoiding catastrophic health care expenditure and impoverishment of individuals as a results of seeking care"(WHO 2005). In 2008, the World Health Report, the annual report of the World Health Organization, had the theme of Primary Health Care- Now More Than Ever, but it included a full chapter on the theme(Van Lerberghe 2008). Between 2008 and a 2012 a number of nations had expert committees or consultations leading to a policy recommendation for universal health coverage. In 2010 the World Health Organization's annual report was themed Universal Health Coverage and the same year the United Nations adopted a resolution endorsing Universal Health Coverage.

Universal Health Coverage defined simply is ensuring that all people receive the health services they need, of sufficient quality to be effective without facing financial hardship"(WHO 2015) Though official texts on UHC especially within the WHO reiterate that it is not prescribing any particular approach, in practice it is insurance schemes that get highlighted- and free or subsidized care by public health facilities gets either superficially touched on or ignored altogether(Cotlear et al. 2015). As UHC rolled out it includes a shift to seeing a greater role for private sector in provisioning of health services. The use of term "coverage" instead of "care" has also been interpreted as a shift from health system design towards insurance type financing(Sengupta 2013).

The dialogue of the desirable road map to achieve UHC spills over into the arena of measuring progress towards UHC as well(World Health Organization 2016; Rodney and Hill 2014). When recently the UN Statistical Commission proposed an indicator for measuring UHC "Number of people covered by health insurance or a public health system per 1000 population" the World Health Organization and World Bank took the unusual step of issuing a public statement addressing the Commission, criticizing the change. The statement in the form of a letter to the Commission, refuted the measure of people covered by health insurance as an indicator of financial risk protection, and asserted that "Beyond these measurement concerns, the indicator should be neutral with regard to specific policy instruments that countries use to implement progress towards the target. This is not the case with the existing formulation, which risks creating an implicit encouragement for countries to introduce or expand any form of health insurance." (Correspondence shared on People's Health Movement e-group). One reason for this clarification was strident voices from civil society that the UHC agenda was being used to push health insurance schemes across many nations (Laurell 2010).

In India, the last decade has seen a brisk political debate in the shaping of health policy (La Forgia and Nagpal 2012). Such debates take place largely in what we term a policy community viz. a community of experts, administrators and members of civil society, representatives of health care industry and what is known as development partners who are active in the creation and dissemination of policy statements and positions and who largely discuss health policy and design within an apparently non-political and technical framework. The members of this community are persistent across political regimes but dominance within the group and the broad directions is very much shaped by what we could term a policy environment that the political leadership sets. The larger electoral process and even popular organizations have relatively much less engagement with questions of health policy.

In the nineties the political directions of health policy had been shaped by the structural adjustment and the technical understanding of health sector reform that came with it, in a policy environment where liberalization, privatization and globalization were seen as key features (GHW4 2016). In brief these policies called for limiting government role to public goods and very limited range of health care services, largely related to maternal and child survival and three communicable diseases- and for the rest leaving it to the market. The policies that shaped the nineties were sharply contested in 2004 when after a surprise electoral victory a center-left coalition of political parties came to power. This government introduced a scheme called the National Rural Health Mission whose core was increasing public investment in healthcare with strengthening of public provisioning of health care services through more effective and responsive district health systems. A policy environment that favored re-distributive economics and recognized entitlement of people to basic services as a key to development and even as a pre-condition for economic growth. This period therefore saw the introduction of legislation of a right to employment , a right to education

and a right to forests of tribal communities, and a right to information all of which were accompanied by schemes that were meant to implement. With respect to the right to food and right to health, though these were strengthened by both Supreme Court rulings of this period, there was no separate legislation, but there was the launch of major expansion and strengthening of existing public services along with a substantial increase in investment.

However by 2009, this government has given way to a new regime with the same political leadership, but without the left. Internationally there had been a global recession, where healthcare remained one of the ever-green areas. The focus was back now on economic growth rates as the main measure of progress and increasingly re-distributive measures were characterized as 'populist.' In this regime, while increasing public health expenditure was still seen as a desirable there was a concerted push

Though there were continuity with most of the earlier programmes there was also a push in the period leading upto the finalization of 12th Five year Plan, to shift the role of government from provider to a purchaser of services and that too preferably from an integrated network of providers which was owned or managed by a corporate entity- similar in some ways to the Health Management Organizations. (JSA, 2012). The final 12th Plan that emerged was a compromise promising a universal comprehensive primary health care provided by the government with insurance mechanisms limited to secondary and tertiary care to fill gaps in government provisioning. The main vehicle of strengthening public provisioning which was the National Health Mission experienced a substantial increase in financing for this programme (Planning Commission 2013).

With the next shift of government in 2014, a new draft National Health Policy was put up for public discussion on December 31st, 2014 (NHP), and after two years of debate, this was adopted-

with more or less the same broad policy features as earlier. However there was a much more strident articulation of the government as mainly a vehicle of strategic purchasing- a term that was for the first time made it prominently into Indian policy discourse. There is now a decision to launch a nation-wide federal government funded insurance programme called the National Health Protection Scheme. In parallel over 8 states have already many state level publicly financed health insurance (PHFI) schemes. There are also strong moves to extend insurance-based purchases to primary health care. While the policy community has consensus on increasing public health expenditure it is divided on whether this is better achieved through strengthening public provisioning, or by shifting to public purchasing of health care or some combination of the two (La Forgia and Nagpal 2012).

Closely related to this debate, is another which centers around what services should be included into the package- a very selective package of the nineties which is sharply limited to some RCH services and three or four communicable disease control programmes, or a moderately expanded package that includes in addition some non-communicable diseases (NCDs), or a comprehensive package that allows only some exclusions like we see in Thailand or Brazil. In universalization is limited to selective services and UHC is interpreted to mean shifting to purchasing, in effect it would mean a form of privatization of existing services. If on the other hand purchasing is because a more comprehensive package requires to insource the required capacities from private sector partners the implications are different. Though policy statements call for a level of expenditure of 2.5% of the GDP which is required for an expanded package of services, the reality is that public expenditure hovers around 1% of the GDP and at this level of expenditure a shift to purchasing substitutes existing public services rather than supplementing it (Sundararaman, Mukhopadhyay, and Muraleedharan 2016).

To guide policy choices there is a need to develop a framework of measurement and analysis which is not only able to measure financial protection but also the level of equity with which such coverage is offered (Gwatkin and Ergo 2011) and further attribute effectiveness of such coverage or the lack of it to policy choices with respect to the government purchasing care from private providers through insurance mechanisms, or the government providing access to free or subsidized care in government facilities and various combinations of the two(Savedoff et al. 2012). Such a framework will go beyond measuring performance for the purpose of advocacy to providing context specific information that can be used to inform policy.

India has a national level demographic and health surveys once every 3 to 5 years (NFHS-3 in 2004, DLHS- 3 in 2007-08, DLHS -4 in 2012-13 and NFHS in 2015-16).

In addition India has the National Sample Surveys, which are annual surveys on different areas of consumption, poverty, and employment organized by a government organization called National Sample Survey Organization. Once in ten years this NSSO undertakes a survey called the Social Consumption of education and health services. The last four NSSO health surveys were the 71st round (2014), the 60th round (2004), the 52nd round (1996) and the 42nd round (1987)("Ministry of Statistics and Programme Implementation" 2016).

In this paper we present data from the NSSO 71st round to discuss key findings related to the coverage and effectiveness of both government purchasing through insurance and government provisioning of free or subsidised care as strategies of access to care and of financial protection. We then present how the same findings get interpreted in different frameworks of analysis. We then discuss how both choice of indicators and frameworks of analysis influence how we perceive health care performance and how this influences policy.

Methods:

One of the main sources of data we used for comparison is the National Sample Survey, 71st Round, 2014, the results of which are in the public domain. This survey covers 65932 households (rural: 36480, urban: 29452) and includes 3, 33,104 individuals. In the state samples, we have 7921 households from Uttar Pradesh state and 5403 households from Maharashtra, respectively. These two states are chosen because they are comparable in population, but at very different levels of economic and health sector development and have different types of publicly funded insurance programmes in place. This is shown in table 1:

Table 1: Different indicators in All India, Maharashtra and Uttar Pradesh

Health indicators	**India**	**Maharashtra**	**Uttar Pradesh**
Population in million (census 2011)	1221	112	199
Proportion of Urban Population in (census 2011)	31.6	45.23	22.28
literacy rates in percentage (census 2011)	74.04	82.19	62.17
Contribution to GDP- as percent of national GDP	100	23.2	7.8
Maternal mortality ratio(per 1,00,000 live births)*	167	68	246
Under-five mortality rates*(per 1000 live births)	49	26	64
Infant mortality rate (per 1000 live births) *	40	24	50
Total fertility rate*	2.3	1.8	3.1
Life expectancy at birth (in years)*	67.5	71.3	63.8

*Source: Sample Registration Survey 2013

To assess health sector performance with respect to financial protection, we studied hospitalization rates, choice of provider between public and private, insurance coverage, mean and median OOPE

with and without insurance in public and private provider, and the incidence of catastrophic health expenditure and its determinants and impoverishment rates with public and private healthcare providers. These indicators are also measured on different equity dimensions of gender, caste, income quintile, and geographical location. To understand the determinants of catastrophic health expenditure, we use binary logistic regression and to understand the impact of publicly funded health insurance we used propensity score matching.

We also compare the performance of these two states and the nation as a whole using the well-known National Family Health Survey- which is the more commonly used survey for commenting on health sector performance and which allows us some partial information on access.

Then we discuss how these numbers support the different approaches and could be interpreted differently in different discourses.

Results

From secondary data shown in Table 1 we see the divergences between the three contexts we have studied. Maharashtra and Uttar Pradesh (UP) are the two most populous states (provinces) of India. UP has a population which is 16% of the all India population and were it a nation, it would be the sixth most populous nation in the world. Maharashtra, the next largest state has 56% of the population of Maharashtra. Yet Maharashtra contributes close to 24% of India's GDP whereas Uttar Pradesh despite its population size contributes only about 8%. Maharashtra's urbanization rate is twice that of UP and much higher than the national average. And we see the same trend with literacy.

Not surprisingly therefore the health status indicators of the Millennium Development Goals are all clearly much better in Maharashtra. UP's maternal mortality rate is almost four times and its

under-five mortality rate is thrice and its infant mortality rate is twice that of Maharashtra. The total fertility rate shows that whereas each woman in her reproductive years is likely to have 3.1 children, in Maharashtra it would be only 1.8. Life expectancy at birth is 7.5 years more in Maharashtra. In each one of these figures Maharashtra performs better than the all India average, and Uttar Pradesh much worse.

However when we come to morbidity rates as uncovered by the NSS survey, we find that the Proportion of Ailing Persons (PAP) – which is the percent of individuals who reported having an ailment in the last 15 days in rural Maharashtra though more than Uttar Pradesh is less than the all India level. In urban areas, Maharashtra has rates which are less than even that of Uttar Pradesh. The intuitive interpretation that Maharashtra therefore has less morbidity is most unlikely – a fact accepted amongst those who study this data set. The responses are defined by the nature of the question placed for probing the illness as well as the contextual factors that determine perception of illness. All the states with better health status have much higher rates, and this is counter-intuitively indicates that when it comes to self-reported morbidity regions with better access to health care will detect and perceive morbidity more readily. Where primary health care is weak, chronic illness like hypertension and diabetes to take some examples will not be evident till it reaches a complication. The age pyramid also matters since states that have completed a demographic transition have a burden of senior citizens with much higher chronic illness rates.

Table 2: Morbidity Rates, Choice of Provider and Insurance Coverage – from NSSO 71st round.

Indicators	India	Maharashtra	Uttar Pradesh
Proportion AP (per 1000 no. of persons reporting ailment in last 15 days)			
Rural	89	80	68
Urban	118	70	91
Hospitalization (per 1000 no. of persons hosp.in last 365 days)			
Rural	44	53	34
Urban	49	47	40
Proportion of Hospitalization Care from Public Providers			
Rural	50.4	26.5	44.7
Urban	34.0	24.3	31.6
Proportion of Ambulatory Care from Public Providers			
Rural	28.3	20.3	14.6
Urban	21.2	14.5	16.1
Proportion of Institutional delivery services from Public Providers (as percentages)			
Rural	70.0	49.1	67.8
Urban	47.5	37.5	41.5
Proportion of Population who report being covered by a publicly financed insurance programme (as percentages)			
Rural	13.1	1.2	3.0
Urban	12.0	4.8	4.3

In hospitalization subjective factors matter less- but we still find that urban Maharashtra has much less hospitalization rates than the all India average, though it is more than Uttar Pradesh. We note that in the all India data set most other states with comparable levels of human development have much higher rates than the national average.

Part of the explanation lies in the choice of providers. The health sector of both these states are far more privatized than the all India average, and even within these two states it is Maharashtra which is apparently more privatized for both hospitalization and institutional delivery. But if we look at the home delivery rates we know that the proportion of choice of public provider is less because of an under-consumption of the services- many preferring to stay out of any care due to financial, social or cultural barriers.

Table 3: Average OOPE per hospitalization (in Rs- median and mean with 95% CI) by provider type and different insurance schemes

	Type of insurance coverage	Provider	OOPE						N
			Rural		Urban		All		
			Median	Mean	Median	Mean	Median	Mean	
India	Government funded insurance scheme	Public	1020	3302	600	2951	950	3204	4030
		Private	10200	17042	9150	18967	10120	17741	4235
	Not Covered	Public	1450	4241	1500	7026	1451	4919	21833
		Private	10500	20190	12900	26709	11300	22604	23025
Maharashtra	Government funded insurance scheme	Public	800	1494	510	4652	510	3470	63
		Private	16950	37751	6215	17074	7100	24088	113
	Not Covered	Public	850	3954	1310	3832	1000	3910	1195
		Private	10500	21723	15500	28447	12050	24198	3218
Uttar Pradesh	Government funded insurance scheme	Public	800	2819	1000	4248	800	3400	110
		Private	10700	20702	600	11425	5050	14916	2078
	Not Covered	Public	1100	4728	2000	14320	1200	6573	2078
		Private	12300	20397	14125	30097	12630	23144	3626

Source: Authors' calculation based on unit records of NSSO 71st round (2014)

In terms of financial protection what we find is that at the all India level, average OOPE per hospitalization in public sector is Rs 1380 (median) and Rs 4639 (mean) which is about 13% of median OOPE in the private sector and 21% of mean OOPE. In both instances mean is much higher than the median costs- as can be expected given that a few disease conditions and treatment are likely to be much higher than the average – and this would skew the mean considerably upwards, with median being more representative of general experience. But mean is also useful since from the view point of financial protection it is high end procedures that require more care. (Some of the high end expenditures are unnecessary over-consumption, but that is a separate issue, not explored in this study.)

When it comes to financial protection we find that publicly funded health insurance offers a modest degree of financial protection in the public sector. At the all India level, by both mean and median OOPE public sector averages are 65% of those without insurance. But in private sector neither insurance affords only a decline in median OOPE of 10% and of mean OOPE by a 22%. The corresponding figures for Maharashtra show a decline in OOPE in public sector with insurance coverage is a substantial 49%, if we take the median and only 11% when, if we use the mean average. In the private sector too, the declines are 41% in median OOPE in public sector and only 6% by mean OOPE. For Uttar Pradesh in the public sector with insurance coverage the median OOPE reduces by 33% and the mean OOPE by 48%. In the private sector of UP median OOPE declines by 60% with insurance coverage and only by 36% by mean average.

It must be remembered that all PHFIs are designed to provide cashless services. This is almost a myth if the provider is private sector. At the all India level only 8.1 % got services whose medical costs were less than Rs 500 (approximately $7) and the experience was similar in both prosperous Maharashtra (9.3%) and poor UP (12.7%). In public sector even without insurance 27% in all

India, and 37% in Maharashtra and 29% in Uttar Pradesh got services at less than Rs 500 and this rises with government insurance to 35% in all India,48% in Maharashtra and 40 % in Uttar Pradesh.

There are some important features that emerge about financial protection- firstly that the average costs in public sector without any insurance are much less than the private sector costs even with insurance. Secondly that in absolute terms median costs are about the same for public sector and private sector hospitalization in all contexts- but in Uttar Pradesh the poorest state, the public sector hospitalization costs for the insured and non-insured are much higher than the other states. Thus the effectiveness with which financial protection is achieved by free or subsidized care in the public sector is worse in the poorer state.

At first glance that figures appears to show, that insurance has a significant positive impact when it synergises with public sector provisioning. But there are many other features that also influence the consumption of health care and therefore the costs. A multiple logistic regression shows hospitalization rates increase with increasing educational status and income quintile (with hospitalization rates in richest quintile almost double that of the poorest in all three contexts). Social group, gender and even insurance coverage did not have much impact. (Alok, Sundararaman, Panel T17aP07, IPPA-3, 2017)

The accompanying paper to this one presents a multiple logistic regression that considers the determinants of higher incidence of catastrophic health expenditure and impoverishment due to health care costs (Alok, Sundararaman, Panel T17aP07, IPPA-3, 2017) co-relates with choice of a private provider, or belonging to a higher social group (by caste) or belonging to a poorer economic class. Of these it is choice of private provider which is most contributory as incidence of CHE 10 is almost 9.35 times higher for all India, 13.4 times for Maharashtra and 11.7 times for

Uttar Pradesh. In this analysis those having no insurance cover are more likely to face CHE 10- but the increase in likelihood is less than twice the rate.

To disentangle the contribution of insurance from many of these other factors we undertook a propensity score matching exercise where we matched for all the above characteristics and tested to see contribution of insurance to the reduction of catastrophic health expenditure. Propensity Score Matching, is a statistical technique described and presented in an accompanying paper. PSM shows government funded insurance schemes reduced CHE incidence for hospitalization at the 25% of annual income threshold (otherwise known as CHE 25%) by a meagre 6% in the all India level.

Whereas hospitalization rates consistently increased for higher income quintiles richer insurance did not have facilitating role in increasing hospitalization rates.

Discussion:

The making of policy is essentially a political process. Politics plays out in policy choice in two domains. One is the overt political domain as articulated in electoral manifestos and debates, and most important overall economic policies of the state- on whether it believes in redistribution of incomes and wealth as essential, or whether it believes that economic growth is all that matters and benefits trickle down to the rest. These are not necessarily separated into water-tight compartments. Re-distributive policies may be justified as populist sops required for electoral achievement or cynically used to stimulate market penetration into what has been hitherto public services – like health and education and food supplementation for the malnourished.

But the other domain is the epistemic community of policy makers and those engaged in shaping policy in a domain. These communities can be theorized as setting up a discourse within their

domains- a narrative of change and framework of analysis which is projected as politically neutral and purely technical- based on considerations of cost effectiveness. The articulation of rights in a political framework could be mirrored by an articulation of ethics in a framework of governmentality- a depoliticized approach to governance itself (Roberts et al. 2003). There is a dominant discourse within this domain which corresponds to the dominant economic and political philosophy and there are rival discourses which are subdued and which due to lack of patronage- research funding, peer review processes etc.- have a much more precarious existence. Thus even when political windows of opportunity open up for re-distributive policies as required by reasons of social justice and which see health as a human right, the dominant technical discourse can shape policies of even such a government in an iniquitous direction, because the discourse has established a hegemony over the ways of seeing and speaking about change. In this domain political choices with its inherent polarity based on who gains from the choices and who loses are now replaced by policy choices shaped by a neutral body of evidence that speaks its own truth and which by by virtue of being value-neutral imposes different consequences for different sections, which these sections must accept in the interests of the greater good. The measurement of progress and health sector performance is central to this project.

There are two levels in which measurement of progress and health sector performance is influenced by and in turn influences policy choice. One is the choice of indicators and the other is the framework of analysis in which the numbers are interpreted. After all is said "the numbers do not speak unless they are spoken for."

With the advent of the Millennium Development Goals, a choice is made for international measures and comparisons of a few very select indicators. In health it is maternal mortality rate and child mortality rates. An earlier discourse about the centrality of population control to health

had already established fertility rates as one of the global indicators of performance. Clearly Maharashtra is far ahead of Indian averages and of poor Uttar Pradesh by the MDG indicators. Life expectancy at birth was not a MDG indicator but the next most commonly used global indicator- but this indicator too though more holistic is overly influenced by the child survival rates. But is this is result of health sector performance or background variables. When it comes to recognition of all morbidity and hospitalization rates and financial protection, exposure to catastrophic health expenditures, the perceived positive performance of Maharashtra is considerably muted.

Other good performing states which have impressive MDG achievement but are challenged in other areas of health sector performance are West Bengal and Punjab. In West Bengal for most of its recent history was under a left government with a clear commitment to healthcare. The government did do very well in maternal and child survival and quite justifiably took pride in it. But as electoral time opinion polls showed, its performance in health sector was rated quite low.

This debate has played out intensively in the choice of indicators for sustainable development goals. A composite score like the HDIs was considered. But naming and shaming the poor performer or the public acclaim for the good performer wins has little positive contribution to make, especially since (a) the composite score is unlikely to be very different from say a single indicator like life expectancy at birth, or even under 5 mortality rate- and therefore not too much gains would be there in the ranking and (b) performance rank more often reflects the background demographic, social and economic characteristics than the health sector performance and (c) while a composite score can at best state where its comparative performance is, it cannot say why it is so- and therefore capable of being interpreted within different frameworks in diametrically opposite ways for the purpose of guiding policy. But then the SDGs for health alone have

developed such a wide range of indicators that it becomes equally difficult to see performance at all. This is not to make a case for reducing the indicators, since each indicator covers a different domain of health sector activity- and a focus on one area could very well lead to neglect of another. The draft national health policy document of the government of India confessed that the total health care needs that public health systems addressed were less than 12% of all health care needs- and while IMR has fallen, in many other areas, especially in deaths in young adult males rates or in impoverishment due to health care rates could have gone up sharply.

But it is not only the choice of indicators that are objects and subjects of policy choice. The framework of analysis – the discourse within which this is embedded, is even more important.

When the NSSO survey reports were released there was an active discussion on this in both academic journals dealing with public policy, notably the Economic and Political Weekly and in the press. The first paper on this titled "Falling Sick and Paying the Price" (Sundararaman 2015). It pointed out that the average costs of care in terms of out of pocket health expenditures had increased and though 300 million persons were said to be covered by insurance, actual coverage as reported by households were low and its impact on financial protection negligible. It pointed out that where government had invested in public systems – notably for care in pregnancy there had been a big improvement in public services and in financial protection for the same. But since public services are very selective in the care they provide, there is an enforced shift to private care, especially in urban areas where state intervention was negligible. In rural areas the previous decade had seen the roll out of a National Rural Health Mission, whereas the corresponding urban mission failed to materialize till just before the survey, and even then more on paper. It therefore made a case for further investment in public provisioning.

There was an immediate rejoinder in the same journal. Their paper (Jain et al. 2015)* disagreed with the conclusions that there was a need to strengthen public services. Instead they argued that a) that there was an active preference of the population for private health care- and for which they pointed to the higher private care preference even in a state like Maharashtra were the public sector performance was better. And b) that insurance cannot be lightly dismissed as the preferred option because it had not been invested on adequately and c) that it was unfair to compare the lower costs of care in public sector with that of the private sector, since it failed to account for the supply side subsidies that government spends in provisioning. Private sector they contended would be more efficient and its underperformance is only on account of under-investment. They dismissed the achievement of improved public sector performance on child birth services as due to incentives which were unsustainable. Their article was titled "same data, multiple interpretations." Typically such votaries of market based solutions have unlimited confidence in state capacity to purchase services, though they have little confidence in the ability of the state to provide improved public services. This was responded to by the first set of authors, in an article titled "Questioning Frameworks of Analysis" (Sundararaman, Muraleedharan, and Mukhopadhyay 2016).Here the authors contributed was that the public sector had been geared to provide only RCH care and therefore its performance should be measured against this.

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* Two of the four authors were from Niti Ayog. Niti Ayog is India's policy advisory institution and which is re-creation of the earlier Planning Commission with an even greater neo-liberal orientation and belief in market forces than earlier. This apex planning body Niti Ayog set up by the new government "has advocated a greater dependence on insurance based models with private sector playing a central role. It has said providing free treatment, diagnostics and medicines would be anachronistic at a time when the government was trying to rationalise and target the subsidy regime."

And secondly while the NSSO could comment on effectiveness of financial protection it cannot be used to discuss efficiency of financial protection using absolute outlays between provisioning and purchasing because there were many other public functions it performed and there was no reason to believe that after accounting for that public sector is any less efficient.

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What we have shown in this paper also is that a better performance in maternal and child survival goals as Maharashtra has achieved does not necessarily mean better access to health care or financial protection or even health outcomes across the entire range of services that are required in healthcare. And we also show that though NSSO cannot comment on the relative efficiency of subsidised care provisioning versus purchasing since the costs of public provisioning are not known, this paper uses the measurement of OOPE and CHE under different contexts, to flag the concern that if the objective is financial protection, then such a shift to insurance may, in the Indian context at least, not be the solution. Though investment in insurance is relatively low- those who are insured and are aware that they are insured do not get financial protection for what they are insured for- then the case to expand this is very weak indeed. This has been further substantiated by further papers using NSSO (Ghosh and Gupta 2017)and other primary studies (Verma, Singh 2017).

The recently national health policy of the government of India (NHP 2017) also discusses the options between government providing services and government purchasing services. The contestations are reflected in discordance within the document itself. In some sections it calls for strategic purchasing which would prefer purchase from public providers and then in order of preference non-for-profit private providers and only sparingly use private commercial providers. Yet in one divergent section (NHP para, 13.6.2) it calls for an understanding of strategic purchasing whose main purpose has been characterized as exploring opportunities for private healthcare industry in public investment in healthcare

The measure of universal health coverage if the proportion of those in need of health care services, who are able to access such services they need with adequate quality (which is effective) without financial hardship. This is a good definition, but as this paper shows neither nominal coverage with insurance nor the presence of a public provider in the area can be taken as effective measures of achieving universal health coverage. One would need to have data on utilization of a fairly wide range of services, not limited to where state intervention is focused, and good epidemiological data on the need of services and robust measures of community based measures of financial protection (as different from insurance data) to be able to measure progress towards UHC. It is our contention that at least in India with its robust data base this is possible to achieve in the immediate- if the necessary political and policy choices are made.

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