Transcript Begins:

Nachiket More: So, on behalf of the Lancet Citizens' Commission on Reimagining Health Systems in India, we welcome all of you —the panelists, as well as the audience and joined by Dr Atul Gupta who will start us off with the introductions and then I will talk to you a little bit more about the commission itself and why we have troubled all of you to join us this morning. Over to you, Atul.

Atul Gupta: Hi! Good morning, everyone. I'm sorry, I had some trouble joining. I'm glad that I could make it and I'm glad to see everyone who are here. So I will get started. We have a great panel for everyone today. Dr. John Gruber is the Ford Foundation professor at MIT, where he has been since 1992.

He's been the Director of the health care program at the NBER, which is the National Bureau of Economic Research. And he has extensive experience in policy and advising the government, specifically in health care reform. He was involved in integrating Massachusetts' healthcare reform, as well as the Affordable Care Act in 2009, 2010. So welcome, Dr. Gruber.

Next we have Dean Glied of the NYU, Wagner School of Public Service. She has been the Dean since 2013. Dean Glied has also been integrally involved in various aspects of healthcare policy. She was actually part of the Obama administration from 2010 through 2012 as the assistant secretary of planning and evaluation or ASPE, which is the office of research and strategic advice to the department of health, and human services. And prior to that, she had also served in the Clinton administration on the council of economic advisors.

We have Dr. Mike Chernew, who's also at Harvard at the School of Medicine in the department of health policy. Dr Chernew is the current chairman of the Medicare Payment Advisory Commission or MedPAC, which is the body of experts, which advises Congress on all policy matters related to Medicare. Welcome Dr. Chernew.

We have Philipa Mladovsky, who's the assistant professor of international development at the London School of Economics, LSE. She has extensive experience on healthcare, not just in Europe, but also in a number of developing countries around the world, including I believe in India, where she's been involved in various ways on expanding insurance coverage and the challenges that people face in enrolling in insurance.

Finally we have Dr. Dan Zeltzer, who is an assistant professor at Tel Aviv University, Department of Economics. Dr. Zeltser has very diverse research interests across the spectrum and its economics. And an important stand in his recent research centers around various issues in the Israeli healthcare system where he has studied extensively, not just a variation in spending in hospitals, but also the use of telemedicine and various other questions. So welcome to you all.

I'm looking forward, very engaging, exciting discussion thinking about the role of commercial health insurance.

Nachiket More: Thank you Atul.It's a real pleasure to have such a distinguished panel join us for the discussion today. I just wanted to briefly introduce the work of the commission and the broader set of questions that we are engaged with before turning it over to my colleague Hasna to take you through some of the hypotheses that we are exploring in the context of health insurance.

So the LANCET Citizens' Commission on Reimagining India's System is a cross-sectoral endeavor that aims to lay out a roadmap to achieve universal health coverage. This particular webinar is part of a series co-hosted with Dvara research, a Janai based research organization that is focused on the all important questions of healthcare finance.

And I just want to inform all of the panelists, all the viewers and analysts; there will be a short feedback survey at the end of this webinar, which you are requested to fill out, to guide us for the next set of seminars.

Just to give you a little bit of a background, India, like many other developing countries, largely relies on out-of-pocket payments from its citizens to finance healthcare. Other components of financing, such as contributions from state governments and compulsory insurance or mandatory insurance contribute only about a third of the tools we need.

We know that they represent the first best mode of financing for universal health care, and every effort needs to be made to grow both these components as well as the kind of health impact that they have. A lot of the work of the commission, particularly finance work stream will be dedicated to figuring this out, but it's also important to acknowledge that for the foreseeable future it is entirely possible that we may have to rely on out-of-pocket expenditures to fund our allocate, and it then becomes essential to explore what opportunities for financial protection are offered by voluntary insurance and other mechanisms.

And how can they be made consistent with universal healthcare. A broad question in front of this panel, therefore, leads to what countries like India can learn from how voluntary insurance markets in the rest of the world, including the United States. For this discussion. I want to emphasize that we have to work with the assumption that two legs of Dr.Gruber's famous three legged stool, which is the mandate and the subsidy, are currently not available. But what is available is the third leg, which is regulation and the possibility that India could take a different path from say the US.

But only after a long journey with indemnity insurance dominating the market. Has there been a gradual movement towards more hybrid managed or value based care models?

In India, such models of value based healthcare integrated care are currently prohibited by law with the belief that health insurance and organized health care need to be reviewed as entirely

separate markets and we should be required to compete only within the respective domain. With a fee for service link between them.

However, the emerging experience in the US with managed care models and the experience of countries such as the UK, Thailand, and Israel seem to suggest that there may be a real value in requiring healthcare providers to participate in risks and rewards of well-being of their patients. As Hasna Shroff will share in a presentation, the direction that insurance regulation should take on this and other things is the core issue that we wish to explore today with your help. So thank you again for participating in this discussion. I will turn it over to Hasna

Hasna: Thank you. Thank you, Dr. More, I'll be sharing a few slides here.
So as a part of the LANCET Commission's effort, we've been thinking of some of the questions around commercial health insurance in India. And to this end, we have produced a short concept note. The note itself has been shared with our panelists and participants. I'll take the next five minutes to present some of our key IBS that have been detailed in the note.

For conflicts like Dr. More said most of India's health financing comes out of pocket. Nearly 63 percentage of health spending is out of pocket. Health insurance, in fact occupies a very small portion of this health financing netscape, on seven percentage of health spending covering about 10% of the population to individual and group spending.

Well, this forms only small sliver. Commercial health insurance is also very fast growing segment. The last six years alone has seen a growth of about 20% annually. What is important to note here is that this particular commercial health insurance segment is currently dominated by hospitalization based indemnity insurance contracts.

And the question that we are trying to really understand is how much sense does it make to have a system based on indemnity insurance itself? So in theory India's indemnity insurance which is based on low-frequency high-impact events would seem to make sense, particularly in a world where consumers are rational, has knowledge about the health concerns, and in its varying capacities. And if they’re placed in a setting where the head has perfect information, using those two different stakeholders in what we expect. But as we know from canonical insurance theory and try and see the insurance market is in fact overlayed with the presence of information asymmetries between the different sets of stakeholders present in the market.

Which would then require the insurance designed to be with the problems with per selection. We argued that we need to go beyond the canonical model itself and also look at the consumer characteristics itself. Particularly when it comes to health insurance, we have a consumer who's rather far apart from the rational accurate.

For one people usually don't have a lot of information about their own health. And there is a range of behavioral factors that impede the seeking of very such knowledge. Now, even when that knowledge becomes available, the tendency to shop around for let's say a second or third

opinion is quite common, particularly in a, in a setting where the provider landscape is quite fragmented, which is pretty much the case in India right now.

And even if the doctor's diagnosis is trusted, it can't be taken for granted that consumers would then seek a combination of preventive care and insurances mechanisms. So these actual consumer characteristics then require an insurance system that would work towards two intertwined objectives. Good health outcomes, and adequate financial protection, which is not something India's current indemnity in insurance seems to focus on.

We believe that there is a very strong case to think of healthcare financing and provision together than a separate piece as it's happening in reality. And such an insurance redesign should factor into demand and supply side realities. And in the paper, we examined these to some detail.

Now based on the demand and supply conditions what we have done is we have arrived at five hypothesis, pretty much as starting points to reimagine the commercial health insurance space in India. So for one, we hypothesized that a model that integrated systems of care and insurance would be a way to minimize market distortions and redo a system of better health and financial protection.

The idea of being an integrated model, we believe would lead — align incentives and lead to efficiencies and with such an alignment we also hope that this would lead to a reduction in cost and improvement in quality due to internal accountability measures.

Second hypothesis is that say compared to a single large integrated system, a competing integrated system or competing integrated systems are more likely to lead to better cost and quality outcomes. When a single large integrator player providing care and insurance would hold the most power and have the maximum number of service providers at its disposal. It's also likely that such a system would have inefficiencies that come with it. In the form of say long wait times, reduced innovation, et cetera.

And this is where we feel competing systems are expected to have an advantage because in a competing model it's likely that consumers or say expert agents acting on behalf of these consumers will only reward those combined integrated plans that provide the most value for subscribers.

At situations where say full integration or vertical integration is not possible, we hypothesize here that it is still possible to design market configuration set, to mitigate some of the principle agent problems between say providers and payers. This can take the form of using pool money to pay primary care provider. Or direct acquisition of primary care providers for care provision. And we believe that such a focus on primary care sets a path to reducing future hospitalization, the savings that come from this can then be shared back with the primary care providers themselves.

We also look specifically at the demand equation here. See that simplification of plans and easy to buy can itself be a factor in fostering demand. Pricing quality comparisons are quite difficult to meet, especially in a product like health insurance and the presence of such high surge costs associated with this. Individuals may simply decide that that's it's not worth purchasing insurance. If I need to go through all of the costs.

In that context, if we make the comparison itself an easier process can have a positive impact on the demand for insurance. And finally, we hypothesize that regulatory enablers might have a very strong role when we reimagine a dual objective healthcare financing system. And basically the enablers can take the form of data portability, quality, transparency, standards, floor level requirements on insurance and providers for say, redressing consumer grievances.

All of this could then have a very critical role in how health systems are designed. The discussion today. I believe it will be a good platform to explore some of these in greater detail. I will now hand this away to Atul to lead the discussion.

Atul Gupta: Thanks Hasna. I'll start with Professor Gruber. I'd like to pose some questions to you and I'd love to hear your thoughts and then we can roll around the room. Given the interest, and short time that we have, we'll probably just have about 10 minutes for each panelist.

And then perhaps after that, we can have a comment discussion, probably that discussion cannot get into too many specifics. We've talked a lot about the supply side, but I thought I'll begin the discussion with the demand side, because you've done a lot of work thinking about how consumers choose plans and how they choose insurance and some of the problems that come up over there.

And so I thought we'd start by just getting your thoughts on, is there some trade off between offerings? You know, too much choice on insurance plans for consumers versus, perhaps limiting choices or limiting the variability that exists in the different types of bands that are available in the market.

Jonathan Gruber: That's a great question. Thanks Atul.. And thanks for inviting me to participate and I want to particularly thank Nachiket helping organize this care. That's a great example of someone who's realized that it's all about healthcare in the end, he came from banking and has increasingly realized that healthcare drives everything.

So it's great that he's continued to have his passion for improving the healthcare system in India. Atul you asked a great question. Economists; Econ 101 says that we should have choice. And why do we like choice? We like choice for two reasons. One is what we call consumer sovereignty.

The idea that if consumers have choices, we can better match their preferences for what they like the other's competition, which is about having choice. We induce efficiency on the production side by causing insurers to compete with each other. Unfortunately, in the insurance

context, both of these lead to problems on the consumer sovereignty side. There's a problem with the choice of health insurance, it is very complicated and consumers do very bad. No, there's a literature that's grown up in the US, I've done this work with my colleague, Jason Avaloq at Yale that shows that consumers are really bad at choosing insurance products. The typical individual choosing an insurance product on average, about 10 to 15% of consumers choose the lowest cost product available to them.

And typically about a third of the savings that could be available to consumers are left on the table because they don't choose the lowest cost plan available. And that's even controlling for, if you plan for risky or not risky. It’s not surprising. It's complicated. And we find the consumers over wait premium, which they can observe and understand and under wait out-of-pocket spending, which it's hard to predict and they don't understand on the supplier side.

The problem is competition can be good in that it can lead insurers to innovate, but they can also compete. Over things we don't want to compete about, which they can compete over, trying to get the healthiest risks and avoid the sickest station. So essentially insurers are very worried about adverse selection.

The problem is that the sickest patients will sign up with them and they can compete. In the famous story that's told in the US, to compete by having what we call the third floor walk-up HMO, which is an HMO on the third floor. And if you can walk up the stairs to get there, then they'll sign it.

But more realistically, there's an excellent work by Mark Sheppard at Harvard that shows how plans compete by leaving out, for example, the best cancer hospitals. So cancer patients won't want to sign up with that plan. So there's these two pernicious side-effects and competition of choice in health insurance markets. What’s ironic is they're both theoretically solvable.

The consumer problem is solvable with better decision support software. If we can help consumers decide better. Obviously India is a leader in software innovation. So you can help consumers choose better. Øn that front, there's just very little evidence that worked partly because consumers don't use the software that is available. Now, there is a possibility, in this front, my recent work with Ben Handel and John Kohlstadt at Berkeley has shown that if you combine better decision software support with agents, they can work together to help consumers make better choices, but that's a big step. On the provider side; on the supplier side, in theory, we could have risk adjustment and, you know, Mike Chernew has worked on this and his colleagues at Harvard have worked on this, but it just turns out it's very hard to make risk adjustment systems work well enough.

I think the upshot of my overly long speech is that we should not prioritize choice right now. As we move forward with developing insurance sector or commercial insurance sector, choice should not be high on the priority list, much higher on the priority list is making sure that there's a non-discriminatory comprehensive option available to consumers that can help them with their healthcare needs.

And eventually we'll move towards a more choice based system, but that should not be what we lead with. It should be as we give them more sophisticated system.

Atul Gupta: Thank you so much. No, I think that that definitely made a lot of sense and apologies for the limited time that we have. There's a lot to unpack there, actually, in what you said.

This is now getting a little bit into the supply side, it's kind of a segue from consumer choice. One aspect of choices, choosing which providers you would like to get your care at. And traditionally in the US, we've had these open networks, you had mentioned we had indemnity insurance and now we have managed care networks, but still the networks are pretty wide jetted. So, what do you think about the trade-offs between having these sort of standalone providers and insurers, where you are wide open networks through your insurance plan versus closed networks integrating providers with insurers. And we now saw the evidence on these closed network, integrated provider, it suggests that they do a good job of reducing costs while maintaining quality.

So in India, since we are still at a very nascent stage, do you think this could be an interesting model to encourage.

Jonathan Gruber: I think it's a really important model to encourage, I mean, couple of points. Your work has shown that choice is not good enough that we added the regulation to reduce readmissions that actually saved money. In principle, you wouldn't have had to regulate readmissions, as choice would have taken care of it. I think that integration can play a huge role in here. I come to the experience, I've done a lot of work with the new PMJY program. Thanks to Nachiket bringing me on board and help work in India.

And clearly the barrier to success at PMJY is hospital participation basically in a places like Bihar, something like 10% of hospitals are participating in the program because the good hospitals are all private and the rates are too low to risk. And so private hospitals won't. Clearly the answer is to have the narrower network, more highly, to really try to bring in high quality hospitals to reimburse them enough, but to make them compete off each other by structuring a narrow network. I think the trade-off there is because, as a good economist, I have on the one hand, on the other hand, the trade-off is in narrow network and deliver care more cost-effectively by getting hospitals to compete with each other.

The trade-off is, as Mark Sheppard's work has pointed out, is you don't want the networks too narrow or you exclude hospitals that are good and patients need to get the high quality care they need. So I think proper network construction is difficult, but I think it's critical.

I think that the struggle for India is how do you get these high quality private hospitals? How do you get people to have choices? And I think the way is to set up a system, which is a narrow

network, but which really rewards quality and uses competition to not just save money, but to bring out the quality options that are available through the night.

Atul Gupta: Thank you. There's multiple strategies that need to be followed and it's not just integrated providers with hands-off regulation, but some under regulation that's also going to be needed to encourage participation by certain types of providers.

Jonathan Gruber: Yeah. I think the bottom line is you need competition within a regulatory framework. Mike can talk more about this than I, but I think, Medicare advantage in the U S has shown a lot of positive signs of how that might work. I think you can get better, but I think if we can have competition within a more regular framework, that might be the right answer.

Atul Gupta: Perfect. I'll now move on to our next panelist and sort of continue the discussion forward. So Dean Glied I move to you. I'll begin with the same question that I have left professor Gruber off with. In India,if we're thinking about reimagining healthcare system, if we sort of say, we can start from scratch, you're not going to start from scratch, but if we could, we think about more integration would be providers and insurers. Then separately, imagining that if we have a hybrid system, what kinds of policies that have seemed to have worked in the US for providers and payers in alignment, that seemed to have worked.

Sherry Glied: Let me start off with your question about an integrated system. And I guess I am less enthusiastic about this than perhaps the other people on this call. I think what we know is that integrated delivery systems work really well. Kaiser record of success at Kaiser is tremendous, but what really strikes me is that for the past 50 years, United States has had a series of regulatory interventions and subsidies that have been intended to encourage the growth of integrated delivery systems. And nonetheless, I believe we have virtually no orchids in the United States that contain competing staff model, integrated delivery systems.

Kaiser has not successfully moved out of its base in California, their efforts to do so have failed. It is a great deal more difficult to build and compete, integrated delivery systems than economic theory would suggest. My view of why that is, which I think is actually important in the Indian context is that there are really important network externalities here around consumers. Consumers have views about who they like to see.

They get information about choices of providers from their friends and relatives and neighbors, and they are not apt to choose on their own network plans, if they think that they want to be seeing people who are outside of that network. Even in the marketplaces in the ACA narrow networks exist, they're important, but they certainly haven't taken over those marketplaces, even in places where the networks are good.

And we see evidence that the networks are good. People actually want and as you mentioned that people like to shop their doctors.That actually works completely against every principal that goes into the idea of an integrated delivery system, but also know that the integrated delivery

systems that have really thrived in the US are systems that began at the provider level and expanded into coverage rather than the other way around.

So that Aetna has built an insurance system. It's that Kaiser, which began as a healthcare provider, moved into the coverage world. And I see that you see that in other places, guys in there, for example, also start as a healthcare provider on an integrated delivery system. It is not clear that insurers are in a great position to build that kind of integrated delivery system from the bottom up.

And they don't have a lot of confidence of their patients, their consumers in doing so. The really strong forms of integrated delivery are very hard to build. Unless you start, for example, as John mentioned with those private hospitals and say to the private hospital, look, you have a great reputation. Why don't you recruit a bunch of primary care providers and create your own integrated delivery system and sell that product? Starting at the insurance side is really tough. So I think there is a model here. That's how Kaiser grew, that's all guys in Kaiser, right? You start with a high quality provider and get them to do the leg lift rather than trying to do it from the insurance side.

Let me just stop there.

Atul Gupta: No, thank you. I love that you had a different point of view. We certainly are not sold on this completely and we're trying to figure out what could be realistic. So let me move away from the organization structure to now thinking a little bit more about prices. You know, in the US we've had several concerns about escalating prices in healthcare. And part of the concern may be that this is the product of this market based system, where you have negotiation between private insurers and providers.

Insurers may not have enough market power, certainly nothing like a single payer. In India, we have a very similar situation where prices are basically a product of a market based system. So what kind of price regulation mechanisms do you think would be useful to put in place early, as we think about re-imagining India's healthcare system to avoid a situation 10 or 15 or 20 years down the line med prices are extremely high and somewhat out of control.

Sherry Glied: So a couple of things there. One important one is you actually say that perhaps the greatest innovation in US healthcare over the past 40, 50 years has not been the integration of care, but the practice of contracting between insurance companies and physicians. It is a form of integration, but it's very light, right? Very light touch integration. Prior to about 1995 insurance companies paid usual and customary rates, 80% of usual and customary rates — kind of indemnity insurance, not quite what you have in India. We can talk about that later. Right. But, after 1995, you actually started to see insurance companies negotiating with providers around rates.

And in places where provider markets are relatively competitive, that works not badly. I think that's actually a very good practice to put in place and not an enormous regulatory lift to try and

get the insurers to actually negotiate the rates with the providers and to require the providers to meet those contractual obligations. So I think that doesn't actually require a top-down regulation. It's more a matter of a more balanced regulation than an individual consumer having to try and deal with prices.

But I think it really doesn't work. I think the second thing to think about is actually that the US may not be the right comparison here because you were imagining a dual system where there is some sort of single payer underlying system, and there is a supplemental private insurance system that layers on top of it. We actually observed that in a lot of countries, the US is not one of them because we actually don't really have that because that's a small degree in Medicare advantage, but they have it in Australia, for example.
And then in England and in Germany and France, lots of places where you have this kind of framework. What we see in those frameworks is that if you regulate the prices of the single payer plan of the alternative plan. And this is true in Medicare advantage as well. You actually don't need a lot of regulation of the commercial.

Because the existence of this regulated market that's large on the outside actually does a lot to keep the prices down even when they are not regulated. So I think actually that may be the better model to think about how these two things fit together rather than to try and organize the price regulation separately in the private market.

I think the thing you really want to avoid is having your private market as side steps. So the problem is if you regulate private market too much, provider prices in the private market too much, wealthier people will simply sidestep the private market altogether and they will continue to pay out of pocket to the same providers.

It's sort of like a black market, but it either is, or is not legal. Right. But if you accessibly constrain the provider price in a market where there's that much out of pocket payment already. You're just going to basically cause this sector to just disappear, nobody is going to find it. So I think you need to let the market play out some before you impose a lot of regulation, but the extent of what you have to do, that will depend on the underlying market.

And this is true in Israel also, right? So Israel has this private supplemental market which is where the prices can be relatively high, but they're constrained by the fact that if the price is too high, you're just not going to do it. You're just going to go back into the regular market.

And this has to do with the gap between the two levels, which I think is also an issue that you want to think about.

Atul Gupta: So I completely agree. And we can talk about this later when we have a general discussion about if you have a large anchor or reference, like in the US we have by way of Medicare.

That can certainly make this whole thing a lot more streamlined and easier. not entirely sure in India, we have that sort of alternative right now, but perhaps that could be part of the architecture we suggest. Okay. So I will move on to our next panelist. Dr. Churn, most of your recent work has taught extensively about it. Not so much integrated provider insurers, but with the current organization structure that we have, how can we provide better incentives to providers to focus on population health? You know, whether it's ECO's, whether it's bundled payments, whether it's the kind of incentives that private insurance provide.

And so, I thought I'd begin by asking you about that. Which will be one or two of those policies that you think could be very promising and useful to sort of transpose to a developing country context when you think about payment systems for standalone providers.

Michael E. Chernew: Yeah. So first of all Atul, thank you for having me. I'm honored to be part of this group. I apologize to the audience for my lack of knowledge of the existing Indian healthcare system. I hope that will change in the future, but nevertheless, that's where I am right now. Let me make first, a broader, big picture point and then get to your question about payment.

Economists talk a lot about efficiency. I'll talk a lot about efficiency, but the distributional issues ends up being unbelievably important and what you do in a country that has say the income distribution and starting place at India and what you might do in a different country are just very different.

And understand that all the care that's delivered in India is going to be financed by people in India. It could be through taxes, it could be through premiums. It could be through out-of-pocket payments. And you need to think about the distributional consequences of all of that financing in terms of how to pay providers in this question of integration.

What we're really talking about is from a broader body of economic thought around the organization of the firm. What should the boundaries be of the firm? We were talking about integration between insurers and providers, but there's also integration across providers and a lot of discussion in the US about the integration of primary care doc specialist, hospitals, nursing homes, ambulatory surgery centers and any one of the other myriad of set of things, even in the pharmaceutical space between insurers and the pharmacy benefit managers, for example. So the main point that I'll make in the context of your question is that we should think of healthcare services as inputs, not outputs and efficiency requires some efficient use of those inputs.

And typical fee for service models impede the efficient choice of those inputs. And so a provider that choice of those inputs. And so a provider that avoids an unnecessary MRI or an unnecessary visit doesn't reap any of the savings and so broader types of payment models are useful. What arises in this whole discussion is the different layers of payment.

So for example, we often talk about there's one payment model. We'll remember most managed care plans in the US have some form of fee for service operating underneath them, even Kaiser,

which has salaried physicians will have bonus models that will approximate some aspects of fee for service underneath them. They'll have some aspects of episode based care. So there's what I would call under the waterline payment models where organization that's bearing some type of population-based risk is incentivizing the people that work with it.

And then, above the waterline payment models where the government, or maybe the insurer's deciding how the delivery system organization is paid. Not all providers are capable of bearing broad population based risk.

I generally think where organizations are able to do that, a model that gives them the maximum flexibility to combine inputs and to create the payment models underneath is generally valuable, but in systems in the US and again, I'll just speak about the US, in rural places in the United States, Arkansas, it's hard to impose population-based risk on a two person primary care group somewhere outside of Fort Smith, Arkansas, or something like that.

So you need to have different types of models that you layer in. The insurance companies are taking population-based risk. They manage the providers in a particular way. In some cases, increasingly in the US they find it's more effective to manage, to allow the provider systems when big enough to make those choices, because the way information flows across the firm makes that easier to happen at a provider level.

They're at an insurer level. So there's no really a correct answer about the best way to deal with payment is — it really depends on the scale and the nature of the production function and your ability to do this; I think is a principle allowing the delivery system to have some flexibility in how they combine inputs is a good thing.
But again, John spoke of chaos. When you impose that risk, you run the concern of integration, big scale, high prices, how you control prices and those types of things.

So it's difficult to answer your question of what's the best way to pay providers. And the answer is it's really going to be a hybrid based on where you are, the nature of the production function to the extent that you can allow flexible payment models and allow flexibility. I think you're better off to — don't think they're easy to do if you simply impose on the world and will automatically be wonderful.

Atul Gupta: Yeah, I'm sorry. I actually not realizing that was very unfair and an open-ended question. Perhaps a more narrow question is do you think that the role for performance pay incentive, whether it's quality or whether it's cost, do you think that is something that you foresee, that that's something that could lead to good outcomes? Or do you think that the evidence on that is that mixed? And we don't know where that's going to be.

Michael E Chernew: Again, so I think strongly some version of measuring outcomes, certainly quality outcomes and some ask, you know, fiscal outcomes can be dealt with in the market, but quality outcomes to make sure providers aren't stinting is really important. In systems like I imagine in India, and again, I apologize for my ignorance. You really have to worry about how

many tiers you want in terms of quality and fiscal output, right? So in the US, we've strived for literally decades to impose some sort of uniformity or at least minimum standards for everybody to have access into the same system. We haven't succeeded necessarily, but we've tried to make sure that people are kind of in the same system.

And that requires a lot of subsidies and cross subsidies in a whole range of ways. And that may work well in India. You have to make sure that the people that can't afford to buy into sort of the top tier system get into a system that you actually like, and you're comfortable with many countries have models where they provide a basic government provided floor, if you will, on the quality of care you get and they allow people to opt up and who opts up, depends on the income distribution and how you set up that system. And I think the challenge is do you set up a financing system to support access to everybody in the base model? And then you rely on the private market for all of the buy ups.

And you worry about the interactions between them, which is a model by the way, I basically like. Or do you try to have a model that imposes, I think the British word would be solidarity where everybody is sort of in the same system and you build that system and you try and limit the ability of people to move out.

Because if people siphoned themselves away the system underneath it might not work very well. How you get from here to there in India is difficult for me to know, because they don't know enough about the Indian healthcare system. The core question is, is your goal for people that otherwise might not be able to afford the best quality care from the best hospitals in India, to be able to do that. In which you need to think about the distribution issues in the cross subsidies. Or is your goal to provide a system for the bulk of folks to have good care? So is it a side? I'm the vice-chair of the connector in Massachusetts, just our ACA marketplace, which we'll give credit to John for. And John was both the founder of the former, Massachusetts, and then later ACA that Jerry really implemented.

But in any case almost all the plans we offer are narrow network. None of them involve the high prestige hospitals in our market, except for the ones that are sponsored by those hostels. But we're, just to be clear, we are perfectly fine with that because we believe that the care that people are getting outside of that system is actually completely adequate, if not in many cases, this is good.

And if you're okay with that, that system is fine. And if people want to buy up to the other system, they can. I should note, I also, I served nine years of a six year term as the chair of the benefits committee at Harvard. We don't have any narrow networks. A lot of the hospitals that are expensive, we actually are affiliated with and our workers very much want to pay for access to those facilities.

We have a different demographic at Harvard than say an insured on the exchange. So, you have to think really about what you're trying to do. Distributionally, I think that's important because solving the problem of how you have lower income people access high prestigious

hospitals is a different problem than making sure that low income people have access to good hospitals or good delivery system that they can get to and how you pay out of the delivery system.

I would like to see it paid depending on its scale and nature in a way that allows them to be efficient flexibly combine inputs, integrate with insurers and do a whole bunch of things like that. But, it might be that the first thing you need to understand is how much of this is a distributional issue versus an efficiency issue.

And if the distributional issue will cross subsidies, are you going to try and put in place as opposed to set up systems, will be the most efficient system. The problem in other countries that I know of is not a problem that they're spending too much and they have to be more efficient, which is what we spent a ton of time talking about here in the US. The problem is they have an income distribution that's challenging, and they're not sure how to build a system that allows the lower income people to access sufficiently high quality care.

Atul Gupta: I think in the interest of time I'll move on then and we can come back and discuss all of these very important questions about distributional issues and it's inefficiency. I think there's definitely a trade off there. I'd also like to get your thoughts on price regulation data but for now, let me move on.

So professor Mladovsky, I'd like to get your thoughts on, especially since you've done a lot of work on thinking about how people enrolled in insurance and some of the challenges that they face. They may not be necessarily institutional challenges, but other kinds of challenges.

So based on your experience, whether it's in developed countries or in developing countries, what are some of the models that you've seen that you know for expanding insurance coverage that you think could be good models for India to think about. As we think about expanding commercial insurance.

Philipa Mladovsky: Thank you for the question and for inviting me, I'm very honored to sit alongside these very distinguished panelists. So thank you. So my experience is really more with thinking about expanding coverage for the informal sector. So I have to say, I would sort of want to rewind slightly and just to gain some clarity on how you were envisaging the use of these mechanisms and voluntary private health insurance.

What segment of India's population are you imagining here, presumably you're thinking not about the population that was previously covered by RSBY, where with the new scheme that has replaced the below the poverty line population, presumably that's not the population you're thinking about. So maybe you could say something more about who you are thinking of when you're re-imagining India's health system. Who are you imagining? Which part of the population you're imagining to be taking up this insurance that you're talking about?

Atul Gupta: So I think, I think we definitely are thinking about both the middle-class, to the lower middle class, informal sector, as well as some of the people we have in the lower end of the force because the government schemes that we have in place currently are fairly narrow. So they don't really — it's like the Medicaid and the US. There's a lot of different eligibility criteria that you have to meet to be actually eligible for these kinds of programs. So I would be thinking about something that's a little bit more broad, lower income individuals and *Nachiket* and Tarun, please feel free to jump in, if I mischaracterized that or there's a better way to characterize it.

Tarun Khanna: No, I think you've said it accurately, Atul. The one thing that I point out is that the current government schemes are massively underfunded. And if they are to serve the people that they claim to serve that alone would eat up the entire health budget of the country. I think they're relying on the fact that, as Rupa pointed out that there are no hospitals in the places where people live.

If the hospitals did come about. The schemes run out of money. So in some ways I would assume for the moment that they don't exist in actual practice for the consumers that they are supposed to serve. So I would echo what Atul said which is we want to build something that people effectively left to their own devices.

How can they do better? And can we nudge the system in a direction that over 20 years gets better rather than gets worse for them as their incomes rise.

Philipa Mladovsky: I perhaps, I'm slightly misplaced on this panel because I fundamentally sort of challenge or question the premise that you pose there. I think the term re-imagining is misleading because it's borrowed from Paul Farmer, really is best known for using this term re-imagining and global health. And his idea of reimagining is in many ways, the very opposite of what this imagination — this imagining that is taking place in this panel involved. So he is talking about the way in which gadgets are assumed to be limited.

And then he points to say the case of antiretroviral rollout and how when at the beginning of the aids pandemic, it was believed so many of these barriers that you talk about — that the money simply isn't there, the resources simply are not there. Those were the arguments that were made by politicians, health economists at the beginning of the pandemic. And then you see with a whole range of different political reframing of the pandemic from securitization through to social movements on a Darity based reimaginings you suddenly see enormous amounts of resources being made available rolling out antiretrovirals.

So that's what Paul Farmer means by re-imagining. And so I would urge you to think of re-imagining that fence right. That not to accept the limitations that you started out with that we have to accept that mandating coverage,mandating insurance is not on the table, subsidies are not on the table. That's for me, not what reimagining actually means. I would encourage you to think sort of broader and bigger. And a way of doing that is to undertake a more political analysis to understand what the barriers are, where are the vested interests, where are the

political allegiances that mean that these broadly, internationally accepted foundations of universal health coverage, mandatory enrollment.

Even the world bank has come out and said that is the cornerstone of UHC and providing subsidies, which in principle, obviously India is already doing through schemes like the RSPY. So the principal has been accepted. Why are those options off the table? That's not entirely clear to me. I presumably — I'm not an expert on Indian politics and so I'm sure the reasons are obviously pretty clear to you. You are very well aware of the barriers, but what are the mechanisms for overcoming them?

So we have the increased awareness of the importance of politics in universal health coverage. We have people like Michael Reich and colleagues who are developing software, who have developed software that helps you to attempt to categorize, measure the different power relations between actors in the system.

It was used extensively in the US, and I'm sure us colleagues know about this to understand how to get care, previously Hillary Clinton's initiatives through. So I think those are the kind of political challenges that needs to be understood better and overcome firstly, and that's kind of politics.

In the sense of maybe high politics, one could say, and then I would really encourage you to also think about the micro politics. So, in my experience of looking at for example, community-based health insurance schemes in west Africa, looking at RSPY in India, looking at how at the politics, the kind of micro level politics of ensuring the informal sector shows the importance of — it's been mentioned — values like solidarity, understanding trust and relationships between insurers and providers.

So I'm sure you're aware of these kinds of issues that, for example huge amounts of gaming of the system in India, under RSPY with a third party administrators not providing accurate information about numbers of people within the family that could be enrolled. Private insurance really, their behavior risk selecting cream skimming and all those kinds of haters and market failures that one can expect taking what really were right with RSPY so then I also sort of at the micro level questioned why.

That is the foundation on which the re-imagining of India's health financing system is to be built. You know, that the experience that we have with RSPY has been, I would say negative, and not only because I think of the limited funds and possibly because of the limited budget that was made available, but also because of some of these difficulties on the ground in terms of enrollment and relationships between the different actors. And then, we also heard stories, in our research of patients being built up to the limits for reimbursement and a lot of fraudulent behavior among physicians as well.

So I think relationships between physicians, insurers, the administrators, the clients, or the patients need to be better understood. And the system designed around those real politics that

are on the ground at the micro level as well. And I think that those understanding of those politics may lead to the conclusion that going down this road of commercial, private, for-profit voluntary health insurance is not the solution that you're looking for if you look at the problems that you're seeking to solve.

Atul Gupta: Thanks. Tarun, did you want to say something?

Tarun Khanna: No. No, I'm just — thanks Atul. I'm just reflecting on Phillipa's comment. And so, my personal view, and I don't know if you agree with me, is that this is absolutely within the purview of reimagining, what you're saying. It's just that this exercise and the panel as constructed by Atul and Nachiket is perhaps a subset of the broader set of things that I would put under re-imagining. Right. Which is conditional on some kind of desire to have this commercial health insurance; what would be a sensible design for it? And the broader issue, of course, is there, when you think about a global optimum for redesigning the entire Indian health system, which of course is a Sisyphean task, that opens up all sorts of possible other things.

So my, my view is that, w hat you're suggesting is absolutely, uh, something that comes up repeatedly in the broader LANCET Commission.But perhaps less so in this immediate exercise. Nachiket or Atul, feel free to put me back in my box.

Nachiket More: I am very much with you there Tarun. Actually, what I tried to clarify in my opening remarks, because I was concerned that people might take you, is actually a substantial part of our work is political economy.

Michael Reich, Lewis Dylan. We are spending a lot of time on that. The question is, and this is really the key question. That a lot of the world has assumed we will solve that problem. Hasn't solved it for 70 years and has left the poor with no answers. Now, what if we do the best we can, but don't get any traction? In India the richest states are cutting health expenditure. So it's not as an income is giving the — of course we should fight that, we've got actually substandard parts of the commission's work in that direction. The issue is we must, I believe, have other ideas on the table as well, too many commissions have — I've been part of two — said government must pay, government must subsidized, government has said no. And 10 years have passed.

And the launch, these schemes, which are RSPY — 0.02% of GDP, BMJY — 0.05% of GDP, right? They say 40% of populations will be covered in this universal healthcare. I mean, it's a coat of paint. So what we need is what we are trying in the commission to do is to cover the landscape.

And to make sure we are looking under every stone while pursuing what you said ma’am as the principal goal, which is government financing, tax based financing. Other countries have done it. Why not us? But I am concerned that if we just leave it at that we will let down our populations once more.

Atul Gupta: Okay. So I think this is a great conversation to take ahead when we have our general Q and A, or general discussion. For now let me move on to our final panelist, Professor Zeltser or if I can call you Dan. You know, one of the models that we find quite interesting is this healthcare system model, where you had managed competition of integrated insurer Reuters.

So maybe first, just for the panel. You could tell us whether this thing seems to be working. If you look at outcome measures, it seems like it's there. Israel does pretty well on different types of health indicators. And in terms of the cost, as a proportion of GDP is also fairly reasonable.

So from the outside, it looks like it's a system that works pretty well. But maybe you can tell us more about the things that don't work so well in the system. For example, with managed competition, you sometimes worry about regulatory capture. Is there enough entry or threat of entry of new players to keep these firms in fierce competition? Or are they the sort laid back and consumers are worse off?

Dan Zeltser: Yeah! First, let me thank you for inviting me on this panel for this great opportunity to do this really interesting, international comparison and high level thinking about the organization. Let me spend maybe a couple of minutes just describing the basics of the system. Which is alluded to by the lead in my — it's a publicly funded universal healthcare system that essentially involves the basic tier that is fully funded and tightly regulated in terms of coverage. And this is in terms of. — maybe I should have begun with just saying that, Israel is a very small country, probably like one metropolitan area in India.

It has 9 million people, but it is similar in some dynamics. In the sense that it is fast-growing, it's very young, the median age is almost like India. It's 30 years old and we have this growing tension of inequality between sort of the region Tel Aviv center of Tech and other sort of highly educated populations and then the kind of periphery and the growing minorities of full orthodox and other minorities that basically create tensions when it comes to how you kind of set up a system.

So the system is, you know, starting from. Legacy of solidarity as this kind of mandated gear. And then to just kind of give people a sense of choice. I would agree with Dr. Gruber's remarks from earlier that, you know, essentially that's not the emphasis when our system was built, that was not choice, but to give people a sense of choice, you also have a supplementary tier. Which is a trait that then allows you to get some second opinion or choose your surgeon, or give you a little bit more choice, which is still contained within the public system.

So you have this kind of two tier, which is supposed to create this possibility of catering for different populations, but essentially 90% maybe by exploring value of care as providers with the basic tier and then there is this expert tier of private interests, which is much less regulated. And that's where people, may be above median or slightly more than that go to get more coverage.

And I think in terms of how the organization or managed competition works is that we have four health funds. it's by no means equally sized, and clearly the biggest one covers more than half, then the second largest cover is another quarter. And then the two smaller ones cover more and they basically receive risk adjusted, capitation payments from the government.

And then they kind of procure care from hospitals and contract with physicians in local networks and I think the it kind of is very different point in sort of the continuum. It's much more similar to single to single payer system. In some extent. It's about, 70% of it is publicly funded.

So it's really sort of the edge of having a nearly single payer system with some competition from the private sort of segment, which is relatively small. So I think what lessons can we learn from this organization? I think one thing that seems to be working well — so first of all, it's much more managed than competition.

Uh, in a sense that once you have this kind of setup does a lot of fact regulation of prices of contracting. For example, there's just a single hospital network. That's mostly owned by the government, uh, and that everyone sort of should contract with, and then you've basically eliminate a lot of the differentiation that has very low charge, very low switching rate. Then you kind of set coverage and set prices and basically what's left - it's just almost like a single payer. But at the same time you do leave some competition at the provider level physician and our patient providers and the nature of contracting is such that it's either full employment or flat capitation payments. The debt level as well, which I think creates good incentives for preserving health.

So once you have a system where people have a long horizon, because there's not much switching, so you have your pool of risk over the long run and the physician have a capitated payments, which means they understand as well that they better keep the patients healthy at home, but still attribute it to them because that's how they get the money for the patient. Then it creates I think, good systems for cost-containment. And on top of, of course, the direct regulation of coverage, which I think does most of the job.

I think in that regard one aspect of the system that seems to offer some of the positive example of how we're very far from fee for service. And that seems to be kind of working. I think where tensions arise is extending connection between public tier and then the private tier. Essentially when you rush and care in all sorts of ways you get the experience from a patient perspective.

I mean, there's a lot of efficiency. We have very low number of MRI machines.When my mom has to get an MRI, she gets it like at 4:00 AM in the morning in some remote locations. Efficient utilization of capital. When I just complained with low back pain to Princeton next morning, I had an MRI at Princeton, which is unbelievably less efficient. The MRI machine is a capital but at the same, but ultimately with all the efficiency gains you get people to be unhappy with the product. So the longer, some above some level of income, there's this tendency to want to move out of that into the private system.

And that's kind of a growing phenomenon in Israel, which we're seeing happening. So basically the situation is once we have tight control of what's basic tier, tt's still the largest tier. And I think it offers a very decent level of quality.

There are some other aspects that I haven't mentioned, but I mean, the risk adjustment is diverted towards the healthiest that we have and emphasis on primary care. This is not always good, but it has some advantages. So that's why, for example, I think we were very well set up for the vaccines because we're very good at primary care.

And that's where a lot of the focus of the residual competition exists. But essentially, what is the tension, that I I'm sure it would also exist in India and in a system is, this tension between the public, the basic tier and the kind of high-end tier. And I think what we're striving to manage is how to not make the system kind of break apart into a dual system where you have different care for the poor. Entirely different, care for poor and rich people.

I think that's always the tension involves trying to figure it out how to keep essentially providers working in both systems and not separate the delivery system into two delivery systems. So I think these are two. So just to recap, one aspect is that the fact that we're using — it's a form of integration, but essentially very large use of capitation payments and bundled payments and all these modes to reduce the incentives alongside regulation of overuse of care. Then the other aspect is this tension that I think is a point. So thinking we certainly don't offer clear lessons on that, but I think it's a constant tension between interior systems between the public tier and the private tier.

And the key challenge is how to make sure you kind of still get it. Decent quality in both tiers and not have this kind of separation of public tier. No one above some level of income wants to. We're not there yet, but I think that we risk getting there if they are sort of freshening or all the system continues in its current form.

Atul Gupta: So, one follow up on that is it’s almost like the price regulation could matter here a great deal if there is rationing of care. And if prices are set too low, then you may not have enough providers who would be willing to accept the basic insurance plan and would prefer to be in the private insurance plan.

So the price setting and how frequently it's updated — is that process somewhat flexible?

Dan Zeltser: So there's a lot of regulation, but there's also quite a lot of flexibility in this health fund tier. Basically manage most of the budget and contracts with physicians, there are some constraints and non-competitive behavior.
They can kind of sign exclusivity contracts with providers, for example. But I think that the way it looks, I mean, the way this tension looks on a daily basis in the hospital floor is that the public hospitals see all the specialists and all the surgeons. Still every respectable surgeon will work in the public system in the morning but then spend the afternoon in the ambulatory surgical

centers, kind of making money off the private interest. Which arguably is an okay solution because you get both systems to enjoy the same sort of human capital.

I think the challenge is how you manage the capacity and how you manage the budgeting and I think in Israel, the situation is that the treasury essentially is very worried about the fiscal aspects of the public tier. And there, I just went over the committee, of the 1000 different budgets sort of items that, if you want to change, move budgets between them, you have to get approval from the treasury.

So there's a lot of micromanagement, which is, I think the dark side of trying to set up a regulated sort of single payer or something like single payer system. So the challenge is how to make sure you're not running into this problem of very rigid system that prevents the dynamics, in that you want to kind of get into different preferences or new technologies, things like that.

Atul Gupta: I think I'm sympathetic to the concern that the bureaucracy might capture healthcare in India and then never let it go. So I think that we are good on the initial round of questions that we wanted to go through with the panelists. So now I just throw it open for general discussion.

So I'm trying to look at, if we have some questions from the audience

So I'll try to relate this as best I can. So the question is that there's obviously, and I think this has been discussed earlier as well. There's a lot of inequality and by distribution of incomes in India. So when we think about insurance, offering commercial health insurance as a product, how do we think about the pricing and premiums that's going to cater to all of these different tiers. And are we going to do to some sort of rationing of services where, in effect we offer different kinds of insurance products, some of the lower price products, which is basic, and then you have some more expanded products for people at the higher end of the income strata. Any thoughts on that? Professor Gruber, maybe I'll throw that to you since it's more related to how we think about the different types of plans?

And I guess in a way it's similar to what you guys did on the ACA exchanges, where you have more different tiers, different Metro tiers, and people can choose the plans that suit their needs.

Jonathan Gruber: Yeah, it's a great question. I think this has been a really helpful conversation. It's come a lot down to, once again, we think of public single payer options as not offering a lot choice and, we put that up with more choice based models. I think that the idea of the Affordable Care Act and the Massachusetts system was to try to essentially make all structurally choiced architecture.

So to basically say, look, we're going to allow choice, but within a set of tiers. So for example, a great example was in Massachusetts, we set up our plan. We had four tiers, or three tiers, I'm sorry. We had gold, silver and bronze.

But within each tier, all it meant is that we limited the actual value of the plan.
What does that mean? That means that for the typical person, what percent of cost does it cover? But there's many ways different plans at the same actual value by changing their out-of-pocket limits, their deductibles or co-insurance. And we ended up with more than a hundred different plan designs, which all met the actual value goals, but which were confusing.

So we went further and standardized and said, no, there's going to be six plans. You know, this deductible, this co-insurance this out of pocket maximum. Plans can differ in the breadth of the networks, which providers they include, but they can't differ on these confusing details. And it appears to have been a very successful move.

The evaluation suggested we really improve the process of choice on our exchanges. So once again, it's clear unfettered choice is not the right answer in such a confusing market. But I think what this conversation has really raised, is really comes down the challenge of matching care rate, which is, can you properly sort of set this tiered system up where you have universal — first of all, do you want it for any choice for the universal bottom plan and then will choice help attract people to a new middle to your plan?

And that really, I think is an interesting research question. Which is, if you offer more choice, will that bring more people into this new plan and that Nach gets this vision, there's this sort of new plan layered on top of the public plan and he talks about the difficulty of mandates, I don't quite agree that that subsidy so difficult.

I think those can be done a little bit better, but they're still challenging bureaucratically. You've done more than I certainly, but I'm just saying politically, I think they're possible. But the question is, is choice, something which makes this middle tier more successful. And I just don't know. I think that's something that we have to look for.

Michael E Chernew: Atul, I just want to add one thing. In Massachusetts, and I would argue in Israel, and in a lot of other places in the UK, there was typically a very strong delivery system. And the challenge was how to expand coverage, to get access to that delivery system and to build some subsidies around it in various ways.

That might be true in India, but that is not my sense. My sense in India is that the problem you're actually trying to solve is how to get money into the healthcare sector. So you can improve the delivery system in places where the delivery system is not so good. If that is the problem, that is a different problem.
And it requires a somewhat different discussion than what we had in the ACA or we had in Massachusetts, in my opinion.

Sherry Glied: My guess is that in India, there's a tremendous heterogeneity. So there are some places where you do have those delivery systems. And I would say if you have the delivery systems build out from the delivery system, rather than trying to encompass them.

And then there are other places where there is no delivery system. And we do not know whether simply building, actually, it seems impossible to build an insurance mechanism that will attract people to buy coverage. If there's nowhere for them to use.

Atul Gupta: No, I think both of those points are excellent points. So Dean Glied is absolutely correct. There's a lot heterogeneity. In large urban centers you have fairly high quality delivery systems, but in much of the rural areas and I would say in small towns delivery systems are fairly low quality and definitely access is a huge issue.

So I think that's definitely food for thought in thinking about how we move forward on the insurance side. At this point,I see that we only have 10 minutes left, so if there's anybody else who would like to make any comments or respond to any of the things that were said by any of our panelists, this would be a good time.

Nachiket More: Dean Glied, I want to ask you one question. What you say is right. In many parts of the country, we don't have a delivery system. The question is where do we start? Because to build one, you need money. Out of pocket payment because they don't go through insurance mechanisms, cannot actually help build hospital infrastructure.

They can do something for primary care, but without the aggregating influence of insurance most providers find that there isn't enough money on the table, even in cities. So in some ways, think of a 20 year trajectory. I'm starting today. I want to go somewhere 20 years later. The only thing I have, which is malleable, is money.

Sherry Glied: I'm just going to give you the historical story in the United States. So, I think what we know in the US is that at the margin insurance does drive investment in the delivery system. So when we raise payment rates in Medicare, there are more MRIs and at the average it doesn't do a whole lot.

So we have tried for decades to improve access to services in rural areas, and we've not succeeded at all. So, the existence of insurance has not on the whole been sufficient to do a lot. There it has propped up existing systems, but it has not generated new ones. The US built its delivery system through direct grants to hospitals in the 1950s, they did not do it through the insurance mechanism.

Now, there are lots of bad things about that. I don't want to, I mean, from an economic point of view, there are many challenges with that. But I think it is actually difficult. I mean, if you think about the problem of insurance and if you want to build hospitals, right, or even high price specialists, the number of people that you have to have holding commercial insurance in order to be able to write contracts that are going to bring enough money into those delivery systems seems enormous.

And how you're going to get those people to buy the coverage in the first place, if there's nowhere for them to use it. I think this is a real chicken and egg problem here. Right? Why have insurance, if there's nothing you can do with it? Now, this goes again to the redistribution point that Michael made.

I think one of the curious things in the Israeli healthcare system and it's such a small place is that there's actually supplemental insurance that's sold that allows you to get services outside of Israel. You could actually buy health insurance in Israel that pays for services delivered in the United States.

What you could imagine doing is building health insurance, but this is a very non-integrated model, right? In places that allow people to use services outside of their local area and hope that in that way, you're able to sell the coverage, build a market. And eventually somebody will say, Hey, why are these people driving three hours away?

If we opened a facility here, we can capture that market. But I think you have to start, I actually think in hospital at this point, right? In the beginning, you have to start with what people actually demand. You're not going to be able to create demand for insurance, such a hard product to sell, right? You're selling people a promise of something that happens when they get sick. Very difficult to sell this product. Tremendous concerns about fraud, about whether people are going to run off with their money. You really need to sell it based on something, some real delivery system that exists in front of people.

Dan Zeltser: I have one extra comment from a recent work on telemedicine that I think is kind of raising questions all over the world about the future of healthcare delivery. So this is definitely not about surgical care, but in a huge place like India, perhaps some reimagination of the definition of the market is required.

I realized the many barriers, people talk about the digital divide, even phone access, could have cultural barriers. I'm not used to this kind of interaction with providers, citizen. We see evidence from minorities.I think basically,just reimagining, what is the definition of the market that is potentially covered?

So maybe at least, care doesn't require physical contact. You could expand just by contracting with a much wider network initially, and then offer some access to specialized care that might not be available in remote and rural areas. This is one point to think about. I mean, I'm not sure how, how attuned it is to the actual needs of the population, but at least we know it's now a possibility that was not available before. So perhaps it's changes the calculus a little bit.

Jonathan Gruber: You know, if I can jump in and build on what both Sherry and Dan said and what Nach said about having a 30 year vision, you don't have to get there at once. And I think what Sherry and Dan are saying is that start with what the people want and move to what the people need.

And that could be a good principle for thinking about things like choice and subsidies and networks. And I think we know too little in India of what it's going to take to get people interested in buying insurance. We know what doesn't work. We don't know enough about what does work. And I think maybe starting with trying to see what does work and then eventually working towards the perfect system is a better sort of transition path that meets Natch's kind of 30 year mandate.

Philipa Mladovsky: If I could just also build on that, I think what you're talking about is such a huge effort. And the end result is so undesirable that you have a segmented market, escalating prices, inflated prices that I cannot see why you would make such a huge effort in terms of government effort to regulate and incentivize a market, which is ultimately not a desirable market to have.

I cannot fathom why a country would go down that road. And I also cannot fathom sorry to my US colleagues, why they would look to the US as the example to base your healthcare system on. Right. So there are countries that have done amazing work like the Thailand, for example, right where they have done amazing work in building up a primary healthcare out of hospital infrastructure.

Over these, what you call this 30 year period, this path to universal health coverage. It's very well-researched. You have amazing researchers and academics and policy makers and activists in Thailand who have so much to share that about that path and that journey that has absolutely nothing to do with commercial voluntary insurance.

So I would really urge you to look to countries like Thailand that have addressed really the problems that you're talking about. Because you're talking about infrastructure, you're talking about healthcare workers, you're talking about — those are the kind of core building blocks that you're talking about.

If commercial voluntary health insurance is not the route to build those, then let's look at countries that have built those and look at what they did. Right. And so I would really encourage you to look at countries like Thailand and maybe as a more useful model.

Atul Gupta: No, absolutely. I'd definitely be interested in the Thailand model and that's part of our thinking for sure. Thank you.

So I think we only have a couple of minutes and and all goods things have to come to an end. So I'll just request Tarun, who's one of the co-chairs of this Lancet Commission and also a director of the Mittal Institute to just offer some concluding remarks.

Tarun Khanna: I don't have too much value to add to this conversation to be entirely honest, but it's been a pleasure to listen to a lot of my colleagues in Cambridge, who I don't have the pleasure of seeing on a day-to-day basis.Thank you so much for responding to Atul and Nachiket's invite to come and join us.

And thanks also to Philippa and Dan for joining us from afar as we speak. I am very intellectually sympathetic to the idea that we should not be overly sanguine about learning from the histories of one set of institutional trajectories, so to speak, apropos, the last comments that were made.

It really is a daunting task when we set out to try to reimagine, and I hope that something productive comes out of it. But you folks have been very generous with your time and kind of you to spend time educating us. And we're very grateful for that. And I promise to bug you some more in the weeks and months to come.

Thanks again. Very grateful.

Oh, sorry. One last admin comment. There is a little bit of a survey for those of you who are on this webinar, if you don't mind taking a couple of minutes further at the end of this, we'd be grateful again. Thanks.