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Designing NHPS: lessons from the past

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There has been a highly contested debate on how India should move towards providing universal health coverage — via insurance or through the public healthcare system. The present government is keen to continue with the health insurance model. The National Health Policy 2017 reiterated the need to rely on health insurance programmes in the short-run till the public system is strengthened. The Centre recently announced the launch of the National Health Protection Scheme (NHPS), supposedly the world's largest health insurance programme, providing 500 million people with an insurance coverage up to Rs 5 lakh per family per annum.

Globally, about 100 million people are driven into poverty every year due to healthcare expenditure. The two common ways to address this is a public health system, similar to the National Health Service (NHS) system in Britain, or through an insurance-based system, similar to the Social Health Insurance System in Germany. Most low-income and middle-income countries are adopting hybrid models, that is, a combination of public system and health insurance. Should developing countries like India use the health insurance model?

On the one hand, health insurance programmes increase access to healthcare, utilisation, protection from catastrophic expenditure, but on the other, they drive unnecessary use of expensive healthcare, increase inequity and lead to corruption and inefficiency.

In India, every year, catastrophic healthcare expenditure pushes more than 40 million people into poverty. To address this problem, over the last decade, the central and various state governments initiated more than 15 health insurance programmes that cover some three million people below the poverty line. In 2014-15, the government spent Rs 2,500 crore on these programmes. What lessons can we draw from over a decade of experience in designing and managing health insurance programmes?

First, most of the schemes are funded by general taxes. Once instituted, these programmes are difficult to withdraw, however inefficient and costly they prove to be, imposing significant financial liability on the state. Therefore, in NHPS, commitments from the State need to be well thought-out. Populist approach must be avoided. The existing schemes cover more or less the same population groups, but differ regarding coverage of disease, rates paid to hospitals and purchasing agency even in the same

geography. This creates inconsistency and overlap that could be reduced by merging these schemes into a single pool at the district level, with a single purchasing agency and uniform rates. This would be an important milestone in moving from scheme-level mentality to sector-level thinking.

Second, most of the schemes target low-income families using Below Poverty Line (BPL) lists. However, BPL lists were prepared long ago, and studies suggest that they are full of errors. Estimates suggest that around 150 million families who are actually below the poverty line are not listed on BPL lists. On the other hand, about half of those on the list are not below the poverty line. It is

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the relatively well-off, educated and politically connected that have higher chance of getting enrolled in these schemes. Socially disadvantaged groups and poorly developed areas are left out by the enrolment agencies. Therefore, there is a need to improve targeting and states can learn from the success of Himachal Pradesh in enrolling 100% of the families in many villages and towns by frequently revising the BPL list.

Third, all schemes only cover hospital-based care, but ambulatory care accounts for more than 50% of expenses that people pay out of the pocket. As only hospitalisation is covered, there is limited focus on follow-up care for chronic diseases which now constitute a larger share of disease burden even among low-income groups. At present, the care provided under these schemes is curative, episodic and institutional rather than preventive, continuous and integrated care, critical for healthcare delivery to be efficient and effective.

Fourth, the objective of these schemes was to reduce healthcare expenditure. Generally, most schemes cover expenditures such as drugs, food and travel along with hospitalisation. Contrary to expectations, many studies reported no reduction in out-of-pocket healthcare expenditure and a few even suggest that it has increased among the enrolled population. One possible reason for the increase could be the higher utilisation of healthcare services and related incidental expenses. But a closer examination of the design and implementation process of these programmes suggests reasons for in-efficiency and wastage.

Quality neglected

Most of the schemes are designed to contain cost but ignore the quality. While awarding contracts or payment to agencies, only cost is taken into account, not quality. This has resulted in cost competition that has negatively impacted quality and incentivised fraudulent behaviour in the absence of robust monitoring. Insurance companies, hospitals and other partner agencies tend to engage in fraudulent behaviour and shed quality to sustain business and make profits.

In Rashtriya Swasthya Bima Yojana, the premium price that the insurance company gets to provide health insurance to a family has gone down to as low as Rs 200 per family per year. Out of this, Rs 80 goes to the enrolment of the beneficiary. The insurance company is left with only Rs 120 to provide health insurance coverage of Rs 30,000 for a family of five. Consequently, insurance companies try to reduce all those activities that could increase their cost. To control cost, they hire low-cost agencies and decline to pay hospitals for frivolous reasons.

Hospitals paid by fixed package rates cut costs by selecting the cheapest treatment plan, using low-quality resources and discharging patients prematurely. Given the challenge of monitoring, hospitals engage in fraudulent behaviours – charging patients for services covered under insurance, providing unnecessary treatments, claiming packages that provide more revenue and claiming for services not provided. The hysterectomy scandal in Bihar, which shook the nation in 2013, was only the tip of the iceberg.

Healthcare is very different from other services as patients do not know what service they need and are unable to judge quality. Insurance companies also lack information about the treatment provided by hospitals. Hospitals and insurance companies tend to exploit information advantages they each have. The complexity of health insurance demands a very high level of capability to design and manage it. The government needs to develop this capability and act proactively. Otherwise profit-driven companies and hospitals tend to take advantage of the complexity.

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ಅರಸು ಕಾಲೇಜಿನಲ್ಲಿ ೧೪ನೇ ಕನ್ನಡ ವಿಜ್ಞಾನ ಸಮ್ಮೇಳನ

ಕೋಲಾರ ಸೆ ೧೧

ಸ್ವದೇಶಿ ವಿಜ್ಞಾನ ಆಂದೋಲನ ಸಂಸ್ಥೆಯು ಬೆಂಗಳೂರು ಉತ್ತರ ವಿಶ್ವವಿದ್ಯಾಲಯ ಮತ್ತು ಶ್ರೀ ದೇವರಾಜ ಅರಸ್ ಉನ್ನತ ಶಿಕ್ಷಣ ಮತ್ತು ಸಂಶೋಧನಾ ಅಕಾಡೆಮಿ ಸಹಯೋಗದಲ್ಲಿ ಕರ್ನಾಟಕ ವಿಜ್ಞಾನ ಕಾಂಗ್ರೆಸ್‌ನ ೧೪ನೇ ಕನ್ನಡ ವಿಜ್ಞಾನ ಸಮ್ಮೇಳನವನ್ನು ಇದೇ ೧೫ ಮತ್ತು ೧೬ರಂದು ಅರಸು ವೈದ್ಯಕೀಯ ಕಾಲೇಜಿನ ಸಭಾಂಗಣದಲ್ಲಿ ಏರ್ಪಡಿಸಿದೆ.

ವಿಜ್ಞಾನ ಮತ್ತು ತಂತ್ರಜ್ಞಾನದಲ್ಲಿನ ಎಲ್ಲ ಆಯಾಮಗಳ ಪ್ರಬಂಧಗಳನ್ನು ಕನ್ನಡ ಭಾಷೆಯಲ್ಲಿಯೇ ೧೨ ವಿಭಾಗಗಳಲ್ಲಿ ಪಂಡಿಸಲಾಗುವುದು. ಈ ಸಂದರ್ಭದಲ್ಲಿ ಭಾರತರತ್ನ ಸರ್ ಎಂ.ವಿಶ್ವೇಶ್ವರಯ್ಯ ವಿಜ್ಞಾನ ಪುರಸ್ಕಾರ. ಭಾರತರತ್ನ ಡಾ॥ ಭೀಮಸೇನಜೋಶಿ ಸಾಂಸ್ಕೃತಿಕ ವಿಜ್ಞಾನ ಮತ್ತು ಭಾರತರತ್ನ ಡಾ॥ ಸಿಎನ್ ಆರ್ ರಾವ್ ವಿಜ್ಞಾನ ಪುರಸ್ಕಾರಗಳನ್ನು ಪ್ರದಾನ ಮಾಡಲಾಗುವುದು.