Modicare will find it tough to get out of the blocks

Soon after he announced the world's largest public healthcare scheme in the Union budget, finance minister Arun Jaitley termed it "Modicare" in a Doordarshan interview. This was not happenstance. Prime Minister Narendra Modi's electoral dance card is full. Taking ownership of a startlingly ambitious—in theory—programme aimed at the common man is apt messaging. But the problems faced by Modicare's namesake, Obamacare, in the US show how tricky the big questions in healthcare are.

India's perennial healthcare failure, with low government healthcare spending and high disease burden, make for predictably depressing outcomes. According to World Bank data, 62.4% of total health expenditure in the country was out of pocket (OOP) as of 2014, compared to a global average of a little over 18%. Shamika Ravi, Rahul Ahluwalia and Sofi Bergkvist have estimated in a 2016 Brookings Institute paper, *Health and Morbidity in India (2004-2014)* that this adds around seven percentage points to India's poverty figures. Modicare—or the National Health Protection Scheme—raises two questions. Is it the best long-term model to reduce OOP expenditure and improve outcomes? And judging by the performance of the existing publicly funded health insurance (PFHI) scheme, Rashtriya Swasthya Bima Yojana (RSBY), that it will subsume, can it be implemented effectively?

The evidence for the first question is somewhat ambiguous. European states have implemented government or government mandated insurance—first, in the 1920s, and then with a number of southern European countries following suit in the 1960s—to achieve coverage and outcomes that are among the best in the world. However, the various models used sit uneasily with India's governance realities. Germany's system, for instance, relies on high formal sector employment to partly fund government insurance managed by independent trusts. It is also placing an increasingly unsustainable strain on the exchequer. Switzerland has managed to avoid this, implementing arguably the most free market model in the world, with the government subsidizing private insurance on a sliding scale. But its per capita health expenditure is among the highest in the world. Besides, the system rests on an efficient state's ability to tightly regulate the private insurers. More recently, countries in the developing world like China have used publicly funded health insurance to achieve wide coverage. In the absence of the European states' governance capabilities, however, outcomes have been poor and OOP expenditure has not decreased.

Given this, the answer to the second question is unsurprisingly clear. RSBY has been riddled with problems. Implemented in 2008 by the United Progressive Alliance government, it aimed to cover Below Poverty Line (BPL) households, funding private insurance for inpatient coverage of Rs30,000 for five members per household. A comprehensive report by Soumitra Ghosh and Nabanita Datta Gupta, *Targeting and effects of Rashtriya Swasthya Bima Yojana on access to care and financial protection (Economic & Political Weekly, 2017)* found that the scheme had failed in both its primary objectives. It had misfired in targeting, covering only 12.7% of households among the poorest quintile at the national level. Little wonder that "almost half of the households enrolled in the RSBY actually belonged to the non-poor category." And while the scheme increased the number of admissions in insured households by 59% compared to mean inpatient care utilization among uninsured households, it failed to significantly impact OOP expenditure or reduce health-related poverty for the former.

Figuring out why the outcomes have been poor is not rocket science. At both the central and state levels, governments have lacked the capacity to regulate RSBY effectively. This has exacerbated the effect of the inevitable perverse incentives for various actors in the system such as the insurers and healthcare providers. The former, paid on a per household basis, have found it profitable to register less than the mandated five members per household or issue the registration

cards halfway through the insurance term. Effective targeting has also not been a priority. Doctors and hospitals, meanwhile, have fallen into the supplier-induced demand trap, recommending unnecessary procedures in order to claim reimbursements.

The lack of concrete information about Modicare makes it impossible to know if the design flaws will be addressed. The few details that have been released so far suggest that states will have the freedom to provide insurance via the trust model or the insurance company model. The former would perhaps be more effective based on global precedent. In theory, farming insurance out to private companies introduces competition that reduces costs, but this has not been the case in practice. On the other hand, if Modicare allows competition between private insurers and public trusts, it has the potential to improve outcomes.

Regardless, the larger problem remains. Government insurance works to improve healthcare access and outcomes—if the state has the agility, expertise and regulatory capacity to implement it effectively. India does not. This will not change by October when Modicare is launched. Healthcare lies at a confluence of inelastic demand, political sensitivity, economic consequences and ethical governance that makes the state's role crucial. With Modicare, the current government is attempting to create a narrative that gives due importance to this. That is to the good. And despite the inevitable criticism, public insurance need not cannibalize the public healthcare system. Both can function in a complementary fashion. The reality of state capacity in India, however, means that Modicare will be more about messaging than performance in the near future at least.

Should the budget have focused on upgrading the public health system instead? Tell us at views@livemint.com.

END