# Making health insurance work

It is unusual for a health programme to become the most prominent feature of a Union Budget. The previous government missed the bus when it failed to implement the recommendations of the High-Level Expert Group on Universal Health Coverage (2011). Yet, those recommendations resonate in the Budget of 2018, with commitment to universal health coverage, strengthening of primary health care (especially at the sub-centre level), linking new medical colleges to upgraded district hospitals, provision of free drugs and diagnostics at public health facilities, and stepping up financial protection for health care through a government-funded programme that merges Central and State health insurance schemes.

Whatever be the time and resources needed to fully implement these initiatives, the Budget sends a strong message that health is now in the spotlight of politically attractive policy pronouncements. From now on, no government can ignore people's legitimate aspiration to get the health services they desire and deserve. However, health care is not just a matter of health insurance, involving as it does many other elements such as the availability of a multi-layered, multi-skilled health workforce. Further, there is health beyond health care, dependent on many social determinants.

The scheme will provide cost coverage, up to 5 lakh annually, to a poor family for hospitalisation in an empanelled public or private hospital. The precursor of the National Health Protection Scheme (NHPS), the Rashtriya Swasthya Bima Yojana (RSBY), provided limited coverage of only 30,000, usually for secondary care. Though it improved access to health care, it did not reduce out-of-pocket expenditure (OOPE), catastrophic health expenditure or health payment-induced poverty. The NHPS addresses those concerns by sharply raising the coverage cap, but shares with the RSBY the weakness of not covering outpatient care which accounts for the largest fraction of OOPE. The NHPS too remains disconnected from primary care.

The NHPS will pay for the hospitalisation costs of its beneficiaries through 'strategic purchasing' from public and private hospitals. This calls for a well-defined list of conditions that will be covered, adoption of standard clinical guidelines for diagnostic tests and treatments suitable for different disorders, setting and monitoring of cost and quality standards, and measuring health outcomes and cost-effectiveness. Both Central and State health agencies or their intermediaries will have to develop the capacity for competent purchasing of services from a diverse group of providers. Otherwise, hospitals may undertake unnecessary tests and treatments to tap the generous coverage. The choice of whether to administer NHPS through a trust or an insurance company will be left to individual States.

Reduced allocation for the National Health Mission and sidelining of its urban component raise concerns about primary care, even though the transformation of sub-centres to health and wellness centres is welcome. If primary health services are not strong enough to reduce the need for advanced care and act as efficient gatekeepers, there is great danger of an overloaded NHPS disproportionately draining resources from the health budget. That will lead to further neglect of primary care and public hospitals, which even now are not adequately equipped to compete with corporate hospitals in the strategic purchasing arena. That will lead to decay of the public sector as a care provider. This must be prevented by proactively strengthening primary health services and public hospitals.

The NHPS is not a classic insurance programme, since the government pays most of the money on behalf of the poor, unlike private insurance where an individual or an employer pays the premium. However, the scheme operates around the insurance principle of 'risk pooling'. When a large number of people subscribe to an insurance scheme, only a small fraction of them will be hospitalised in any given year. In a tax funded system or a large insurance programme, there is a

large risk pool wherein the healthy cross-subsidise the sick at any given time. The NHPS will be financially viable, despite a high coverage offered to the few who fall sick in any year, because the rest in the large pool do not need it that year.

However, the NHPS will need more than the 2,000 crore presently allocated. As the scheme starts in October 2018, the funding will cover the few months before the next Budget. It is expected to require 5,000-6,000 crore to get it going in the first year and 10,000-12,000 crore annually as it scales up. It will draw additional resources from the Health and Education Cess and also depend on funding from States to boost the Central allocation. The premiums are expected to be in the range of 1,000-1,200 per annum. They may be lowered if enrolment is high but will rise if utilisation rates are high.

In all the excitement about the Union Budget's proposal of the NHPC, it is easy to forget that State governments have the main responsibility of health service delivery and also need to bear the major share of the public expenditure on health. The National Health Policy (NHP) asks the States to raise their allocation for health to over 8% of the total State budget by 2020, requiring many States to double their health spending. Will they be stimulated to do so, when the Central Budget has not signalled a movement towards the NHP goal of raising public expenditure on health to 2.5% of GDP by 2025?

The NHPS needs a buy-in from the States, which have to contribute 40% of the funding. Even with the low cost coverage of the RSBY, several States opted out. Some decided to fund their own State-specific health insurance programmes, with distinctive political branding. Will they agree to merge their programmes with the NHPS, with co-branding? Will other States, who will also contribute 40% to the NHPS, demand similar co-branding? In a federal polity with multiple political parties sharing governance, an all-India alignment around the NHPS requires a high level of cooperative federalism, both to make the scheme viable and to ensure portability of coverage as people cross State borders. For the sake of all Indians, let us hope an all-party consensus develops around how to design and deliver universal health coverage, starting with but not stopping at the NHPS.

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Marriage is a civil contract — adultery or divorce should have only civil consequences

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