Is India ready for NHPS?

The National Health Protection Scheme (NHPS) is based on four assumptions and one hope: One, creating an effective demand to trigger private investments in supply deficit areas, two, enabling tapping of the 30 per cent unutilised capacity in private hospitals for the poor, three, covering 10 crore families with Rs 1,200 per family is affordable, and four, strengthening Wellness Clinics at the 5,000 population level will reduce hospitalisation. The hope is that, in this process, impoverishment will reduce and premature deaths will be averted.

Positioned as the big idea whose time has come, the NHPS attracted attention and health was the breaking news of the day. The discourse, however, has centred round the gap between policy intention and actual fund allocation.
The first assumption will take over five years or more to fructify, but partially, since revenue centres for hospitals are diagnostics and drugs not inpatient treatment. More investment into health is required to enhance access, but if it is only in the private sector, it will also increase out-of-pocket expenses. Regarding the second assumption, the benefits will go to the urban poor. Evidence from the RSBY shows that 25 per cent of people who availed services got impoverished meeting the indirect costs of hospitalisation.

The third assumption requires closer analysis. The NHPS provides cover for services that southern states are already providing within an average per capita outgo of less than Rs 50,000 despite the ceiling of an assured sum of Rs 2 lakh. Offering a higher ceiling for the same set of services will only help the hospitals game the system and is no solution to the crisis of inadequate human resources that the private hospitals also face. Technology can help neutralise this factor somewhat but will entail costs. In this environment of scarcity, the “government” patients are already competing for attention with those paying two times more for services — domestic and foreign. In other words, maintaining uniform quality is emerging as an issue in the current multi-payer system running alongside conditions of scarcity and an absence of regulatory oversight.

Besides, uptake will be low as the northern states have severe supply deficiencies — so poor that Bihar and UP abandoned midway the modest RSBY that provided a Rs 30,000 cover for secondary care. Taking these factors together, the allocation of Rs 12,000 crore for the NHPS is ample in the short term, but will treble as supply and service utilisation increases and gallop when coverage extends to outpatient care as well.

As for the fourth assumption, indicating a commitment to primary health care is not enough. All governments since Independence have been doing so. The sum of Rs 2,000 crore for Wellness Clinics is peanuts and will help strengthen less than a fifth of the relatively better functioning ones of the 1.5 lakh facilities. Besides, the primary health care system also consists of primary health centres and community health centres. This three-tier system is expected to prevent disease, provide timely medical attention, treat and manage chronic diseases like hypertension, diabetes, mental health and old age diseases. But due to chronic underfunding, substantial vacancies and shortage in human resources, lack of infrastructure and the rapid decline in public health capacity to cope with the complexity of the infectious diseases, barely a fifth of the 30 and odd services are being provided, explaining for the community’s continued trust in quacks and their apathy to seek care from these centres.

Policy intention that prioritises comprehensive primary health care implies committing an investment of Rs one lakh crore for providing basic healthcare alongside its social determinants, namely water, food, hygiene, environmental sanitation and behavioural modifications. Countries like Brazil, Japan, China, Sri Lanka made such investments and have conclusively demonstrated a reduced disease burden, lengthened life expectancies, one-third reduction in emergencies and

hospitalisation and averting of avoidable morbidity. Clubbed together, they add up to huge savings. Besides the fiscal argument, such a strategy also makes sense for half the country's population, that accounts for 35 per cent of the deaths related to malnutrition, TB, neonatal causes and respiratory infections that are preventable and treatable at low cost.

The Burden of Disease Report of 2016 shows the wide disparities between the north and south. Kerala for example, has a female life expectancy of 78.7 while Assam has 63.6. Or the epidemiological transition ratio — the shift from communicable to non communicable diseases — is 0.16 for Kerala while it is 0.74 in Bihar explaining for the 33 per cent health loss in northern states due to communicable diseases. This is significant as only few suffering from communicable diseases need hospitalisation. Even in the south, the disease burden due to non-communicable diseases can be substantially reduced with lifestyle modifications. In other words, the incidence of kidney failure requiring dialysis can be reduced if diabetes and alcohol intakes are moderated. Credit, then, lies not in providing Rs 1.5 lakh per year per person for dialysis but not having such a high demand in the first place. The tragedy of India is that all this is known. Yet we continue to neglect building a robust primary health care system.

The NHPS, however, raises a more important issue: The decisive redefinition of the role of the state from being a service provider to a financier. Separating the provisioning and financing increases costs, but makes the service providers and the state more accountable. This is the theory. But if the internal dynamics, as mentioned briefly, are not stitched together, such separation can also end up with the private sector getting fatter (what with the rapid infusion of FDI in our premier hospitals) and more parasitical on government finances and undermining the public sector that is the recourse for the poor without necessarily enhancing welfare or social gain.

In other words, if shoddily designed and implemented, the NHPS can metamorphose into a situation of riding a tiger that government will be unable to dismount later. Future implications of pushing the country into such an irreversible situation that can entail high social costs require a serious discussion in Parliament. Can our politicians go beyond partisanship? Do they care?

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