National Health Protection Scheme will not help its intended beneficiaries

It has been a fortnight since the Union finance minister announced the government's vision of Ayushman Bharat, or the National Health Protection Scheme (NHPS), assuring 100 million families of coverage of up to Rs5 lakh for secondary and tertiary care.

Meanwhile, in a welcome departure from previous years, health has emerged as the central topic of post-budget analysis and critique. Media newsrooms have been brimming with policymakers, academics, industry executives and politicians explaining the details and mechanics of the NHPS. Valuable viewpoints, evidence and analysis have surfaced in plenty, laced with a mix of admiration and scepticism, and as a result, the NHPS has been labelled many things—visionary, populist, pro-private insurance market, suboptimal solution for universal health, scaled-up version of old schemes, pre-election gimmick, and more.

Conspicuous by its absence in these debates has been the voice of the customer—the reaction of those belonging to the 100 million households meant to be relieved by the NHPS of the financial hardship of paying for healthcare.

The National Council of Applied Economic Research labels them "Deprived Households". The annual income of these households lurks below Rs1.5 lakh. Their homes, whether urban or rural, are in locations defined by wretched living conditions. And the people who call them home float freely between carefully-combed poverty zones separated by invisible poverty lines. Some 135 million households fall in the deprived category, constituting 56% of the total households in India. And yet, there has appeared not a single report highlighting their opinion.

This article doesn't either. It is an attempt to zoom in on the lives of such "deprived" households and their surroundings. It is a theoretical exercise to predict their likely reaction to the NHPS, based on the established correlation between economic capacity, health-seeking behaviour, and the gamut of risk factors endangering well-being and health in the bubble of deprivation.

On an average, the medical expenses of such deprived households with low income capacity hover between 5-6% of total expenses. The pursuit of health may trap them in medium- or long-term therapy regimens, pulling this single-digit proportion into a catastrophic range of 10% or above. Hence, the majority of them do not report sickness, until rendered inactive to work and earn, either by injury or the flare-up of a chronic condition.

For rural dwellers, seeking health is not even a matter of choice if the nearest medical touch point (public or private) lies miles away. There are still others, who don't trust the quality of available care to be worth dwindling family finances. Will the NHPS announcement let such families shed these inhibitions and change their health-seeking behaviour?

In the last two decades, many states have seen an epidemiological transition, with non-communicable diseases such as heart problems, stroke and depression imposing a greater economic and human burden on society than infectious diseases and nutritional deficiencies. That said, whichever state the deprived households may be located in, it would be safe to assume that the epidemiological profile of the low economic strata will mirror that of the poorest states (Empowered Action Group or EAG states) due to similarities in environmental and behavioural risk factors.

The top ailments adding the maximum burden of disease in EAG states include ischaemic heart diseases, lower respiratory tract infections such as bronchitis and asthma, chronic obstructive pulmonary disorder, tuberculosis and diarrhoeal diseases. Most of these are chronic conditions

that require regular outpatient consultations to manage disease prognosis. Hospitalization is a one-off event.

Eighty per cent of the time, the out-of-pocket expenditure of patients within this strata is, therefore, on outpatient clinics that don’t come under the ambit of NHPS.

Therefore, for deprived households, the NHPS holds limited value. It cannot deliver on the grand claim of complete health for them. It will not reduce the ever-increasing monthly medical bills that go towards managing the chronic diseases they are most susceptible to. It will not bring an iota of change in their health-seeking behaviour. That can happen only if the expenditure on health, which has hovered around 1% of gross domestic product (GDP), doubles in the near future to improve access and quality of healthcare to the last mile.

No doubt, insurance of Rs5 lakh per annum would be a comforting thought if one needs hospitalization and surgical intervention (provided in-patient admissions claims processing and reimbursement-related processes do not themselves become added stress factors). Such events may be few and far between.

It might be too early for opponents of this scheme to lay a wreath at its funeral, but the lackadaisical thought that has gone into crystallizing it misses the point that the epidemiological profile of its target strata will most likely exclude a majority of them from benefiting.

The scheme must expand its scope to share expenditure on outpatient services for long-duration chronic diseases to achieve Ayushman Bharat.

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Comments are welcome at theirview@livemint.com.

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