Not a prescription for the poor

The National Health Protection Scheme (NHPS) is being hailed as the biggest takeaway for the aam aadmi in this year's Budget. Given the noise that is being made around it, one is led into believing that the government has brought the nation into the next generation of health security. Quite expectedly, the Opposition, led by the Congress, has dubbed it "as nothing but a pack of lies". As there are a few elections this year before the big and major one, the battle lines are being drawn. So, given this impasse in public discourse, how will anyone be able to judge it accurately? The only real way to judge the potential of the NHPS is to review the empirical evidence pertaining to some of the existing publicly-funded health insurance schemes, particularly the Rashtriya Swasthya Bima Yojana (RSBY).

At the outset, it should be pointed out that the RSBY was rechristened the NHPS in 2016. The Budget promised to provide insurance coverage to an estimated 50 crore poor beneficiaries through the NHPS. There are two problems with this claim. First, the RSBY which was launched in 2008, was initially designed to target only the Below Poverty Line (BPL) households. However, even after nine years of its implementation, only half the BPL families have been covered, according to government data. Further, there is a huge discrepancy between the coverage figures in government data and estimates from surveys. In the 71st round of the National Sample Survey (NSS), 11.1% of the population was covered by the RSBY and State health insurance schemes in 2014 but according to the Insurance Regulatory and Development Authority, the population coverage of these schemes was 16.4%.

A key reason for this discrepancy is the creation of bogus beneficiaries by insurance companies to earn premium subsidies from the government. Another reason is that while insurance companies have been given the premium subsidy for covering all eligible households in the respective States, the insurer reached out to only a fraction of the eligible population. For example, in 2016, only 2.45% eligible families were enrolled under Maharashtra's Mahatma Jyotiba Phule Jan Arogya Yojana (MJPJAY) in 2016. Enrolment was also found to be very low in the Chief Minister's Comprehensive Health Insurance Scheme, in Tamil Nadu, as shown in the NSS data.

The second problem is related to the identification of poor households. According to the NSS data for 2014, among the poorest quintile, 12.7% of households received RSBY coverage, which accounted for 25.9% of all the RSBY enrolled households. On the other hand, about 36.52% of households enrolled in the RSBY were actually drawn from the richest 40% of the sample households. Further, almost half the households enrolled in the RSBY actually belonged to the non-poor category. The targeting process in RSBY has been fraught with exclusion errors.

It is important to underscore the fact that insurance coverage does not automatically translate into utilisation. According to the programme data, the hospitalisation rate was found to be as low as 1% among RSBY-insured individuals, compared to a national average of 2.6% for the general population as of 2014. The RSBY is not an exception in this regard. The utilisation rate of other insurance schemes is also very low. For example, the MJPJAY recorded a utilisation rate (calculated as the proportion of eligible persons with at least one in-patient claim during the year) of just 0.12% in 2013-14 and 0.18% in 2014-15.

There is no evidence that the RSBY/NHPS has caused a reduction in out-of-pocket expenditure. Two very recent impact evaluation studies have reported that the RSBY has hardly had any impact on financial protection. Proponents of the NHPS might argue that the insurance coverage was limited in the RSBY, leading to patients incurring payments for hospitalisations. So, in

‘Modicare’, the benefit package has increased coverage substantially. However, the increase in allocations is unlikely to effectively address the problem of out-of-pocket expenditure.

There are two reasons. First, international experience in publicly funded health insurance in unregulated private health-care markets suggests that in countries where the benefit package was expanded by raising only the insurance limit, private hospital care providers responded by substantially increasing the price of services. So, this kind of increase would actually mean a larger transfer of public money into private hands. This was also evident in recent actions by many private hospitals which withdrew from the RSBY as they were apparently not happy with the package rates. Hence, it is just a matter of time before private hospitals empanelled under the NHPS ask for higher package rates as seen in Karnataka or Andhra Pradesh where private network hospitals have threatened to pull out if their demands for higher rates are not met.

Second, given the fact that out-patient care, the single largest contributor to out-of-pocket spending, is not included in the benefit package of the NHPS, the increase in the insurance limit will not be of much help. Moreover, in the absence of strong and effective government regulations for insurers and providers, well-recognised market failures such as supplier-induced demand will ensure that eligible families exhaust full coverage with little improvement in their well-being.

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

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