Follow the states

The National Health Protection Scheme (NHPS) was one of the two big bang announcements in the last full budget of the Narendra Modi government. It is being hailed as the world's largest public healthcare programme, which will cover about 40 per cent of India's population. While any public effort at providing free healthcare to the poor is welcome, this is not the first public health insurance programme in the country. Many states, including Maharashtra, Karnataka, Rajasthan, Andhra Pradesh, Goa and Tamil Nadu, have successfully implemented health insurance programmes, easily covering over 50 crore people.

In Maharashtra, the Congress-led government started the Rajiv Gandhi Jeevandayi Aarogya Yojana in July 2012. This is a universal coverage scheme that benefits 2.23 crore poor households (over 95 per cent of the state's population). An insurance cover of Rs 1.5 lakh per year is provided to each insured family. The public sector insurance company that was selected charged a premium of Rs 333 (plus taxes) per family. This was entirely borne by the state. Although the scheme was first notified in May 2011, it took over a year of intense preparatory work before it could be formally rolled out. Initially, only eight out of 36 districts were taken up. After one year of experience in these eight districts, teething troubles were sorted out, only then was it extended to the whole state. The end-to-end operations are completely online, for which special software was developed. Over 16 lakh patients have been treated since the programme's launch. The current government of Maharashtra has continued this hugely popular scheme, though they have dropped the name of Rajiv Gandhi.

Our experience in Maharashtra suggests that the NHPS will have to consider many critical aspects. The first is the total cost. There is a token provision of Rs 2,000 crore in the budget. However, the total cost is likely to be nearer Rs 20,000 crore per year. A new 1 per cent cess will make about Rs 11,000 crore available to the government in a year. Early reports indicate that the states will be asked to bear 40 per cent of the cost. Whether the beneficiary families would also be asked to contribute to the premium is not clear. And it is uncertain how the existing insurance programmes running successfully in many states are to be integrated into the central scheme. I would strongly suggest that the states should be given an option to continue their own schemes. The Centre should just give its 60 per cent share to the states.

In a partial roll-out situation, identification of the initial 10 crore families will be extremely challenging. Any criteria, other than family income, will cause a huge discontent. How will a village-level functionary select 40 per cent of the people and leave out the rest? Will these remaining families be covered later? The government could alternately consider a universal roll-out for all the poor households, even at a lower level of maximum insurance cover, depending on the resource availability (say Rs 3 lakh, Maharashtra initially had a maximum cover of Rs 1.5 lakh). After identification of the beneficiary households, each family is required to be issued a family health card, complete with personal details and the Aadhaar number for each individual member. A group photograph of the family is also required. These details are then entered in a master database.

Another critical decision is the list of medical procedures to be covered in the scheme. Disease profile varies across the country. Each state must be given the flexibility to curate its own list of medical procedures. For instance, Maharashtra had notified 972 critical secondary and tertiary medical procedures. The number and type of procedures selected will naturally have an impact on the insurance premium.

Selecting the insurance provider is an extremely complex process. Each step — such as the design of the tender documents, contracts and legal agreements, payment terms, penalties for

non-compliance, pre-qualifications of bidders, prior experience, e-tendering process, whether private sector companies would be allowed to bid, whether tenders would be called statewise or nationally — must be considered carefully. Otherwise, it could invite legal challenges.

The accreditation of participating hospitals is another difficult exercise. In Maharashtra, to begin with, we selected 492 hospitals consisting of 78 government institutions and 414 private institutions. If due care is not taken in selecting the right hospitals, it can derail the entire programme. The Rashtriya Swasthya Bima Yojana (RSBY) is a glaring example. Many private hospitals registered under the RSBY were reported to have indulged in malpractices such as prescribing unnecessary diagnostic testing and hospitalisation. The RSBY had enrolled 3.63 crore families across 14 states. However, between 2015 and 2017, five states had withdrawn from the RSBY, citing various difficulties.

Insurance-based intervention in the health sector can only be a partial solution. The government cannot, and must not, abdicate its responsibility of providing a high-quality and affordable public health infrastructure. The average Indian family is forced to pay two-thirds of its healthcare costs out-of-pocket because the total public expenditure on health in our country is merely 1.4 per cent of the GDP. This is less than what Nepal and Sri Lanka spend on their healthcare. The National Health Policy has set a target of health expenditure to reach 2.5 per cent of the GDP by 2025.

Our experience in Maharashtra has shown us that the implementation of such a large health insurance scheme requires humongous preparation in the creation of infrastructure such as central data centre, software development, data entry, issuance of health cards, call centers for pre-authorisation, and claims settlement, hospital accreditation and online accounting. Trained personnel (aarogya mitra) must be posted in each of the participating hospitals.

It is clear that the NHPS was announced hurriedly without adequate preparation or due consultation, as no implementation details were made available immediately. The post-budget press conferences made it clear that the Union health ministry was clueless and that the entire project was driven by the Niti Aayog. Keeping the line ministry out of the loop is unlikely to help in project implementation.

The announcement has created a huge hype and has raised the expectations of the poor. The government must now deliver. As we have seen in the case of GST, the central government's track record in implementing complex projects/schemes so far has not been very inspiring. One hopes it will consider the experience of the states that successfully run such schemes.

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