Is the National Health Protection Scheme good public policy?

India recently announced an ambitious plan called the National Health Protection Scheme (NHPS) to provide government-sponsored insurance to roughly 500 million people or nearly 40% of India's population. Since the announcement, there has been much debate about two issues. First, does this plan make sense? Second, if it is a good idea, what should the design of NHPS look like? In this op-ed we use insights from our prior studies and those of other experts to inform the debate on both of these questions.

So, is the NHPS a good idea? Definitely yes. There are several reasons. First, India under-invests in the healthcare of its citizens and this is affecting the health and financial well-being of Indians. Out-of-pocket payments for healthcare services are very high in our country (about 70%, according to the National Sample Survey Office, 2014), which causes impoverishment to nearly 7% of our population. Health-financing policy directly affects the financial protection of people when direct payments that are made to obtain health services do not threaten their living standards. So the NHPS should be considered a significant move towards universal health coverage.

Second, while not all insurance programmes are successful, there is sufficient evidence that if implemented well, insurance can save lives and improve financial well-being. For example, one study conducted a rigorous evaluation of the government health insurance scheme in Karnataka called Vajpayee Arogyashree Scheme (VAS). In February 2010, the state government offered VAS to below poverty line (BPL) residents only in the northern part of the state, the scheme was later implemented statewide. Researchers took advantage of the arbitrary boundary in early implementation of coverage to compare outcomes in neighboring villages on either side of the line. In particular, they conducted surveys and compared outcomes in neighbouring villages on either side of the boundary drawn between the communities chosen for early versus late implementation. Since the eligibility boundary is arbitrary, early and late implementation villages located just above or below the eligibility threshold are likely to be similar and differences in outcomes across these villages are likely due to differential access to VAS. The study found that VAS lowered mortality for covered conditions for BPL families and erased rich-poor disparities in mortality rates. Most of this reduction was due to fewer deaths from cancer and cardiac conditions, which account for the bulk of VAS claims. They found that people covered by insurance were more likely to seek healthcare for their health issues and symptoms (such as chest pain), had better access to tertiary care hospitals, and had better post-operative outcomes likely due to seeking care at higher quality hospitals. They also found that insurance lowered out-of-pocket medical costs and lowered the chances of having catastrophic expenditures that are likely to push people into poverty.

Third, existing evidence shows that providing insurance to the poor not only saves lives but is also "cost-effective". That is, it provides good value for money as the benefits of insurance far outweigh the costs. However, cost-effective health coverage must cover primary care. This is where the second feature of Ayushman Bharat Programme—creation of 150,000 wellness centres across the country—is a very significant and welcome announcement. Sub-centres (and primary health centres) are the first line of contact of citizens to the public health system in India. Strong primary care is fundamental to keeping overall access to healthcare equitable and affordable in the country. Our biggest constraint to making this happen is not shortage of capital or infrastructure, but an acute shortage of human resources. Most public healthcare facilities (primary, secondary and tertiary) have significant shortage of doctors, nurses and other health workers, often higher than 50%.

Now that we have established that NHPS is likely a step in the right direction, how do we ensure that the programme is a success? The devil is in the detail: we need to pay attention to both the

design of NHPS and its implementation. We offer some guiding principles.

Make insurance easy to use

Insurance that is difficult to use will not be used. Therefore, we need to streamline both the enrollment process and access to care once enrolled. The number of forms people face to enrol in NHPS must be minimized. Aadhaar makes it easy to verify eligibility and enrol. Maybe all you need is Aadhaar and no other forms or hassles to enrol. For this, Aadhaar should be made readily available to demographics where it does not exist. This would require continuous and active collaboration between ministry of health and family welfare and Unique Identification Authority of India (UIDAI). In the case of children, the UIDAI authorities should take a more proactive approach and increase their coverage—as of today, data shows that of all the Aadhaar numbers issued so far, less than 5% are for those under five years of age, which is a gross undercounting of children.

Once enrolled, access to care should be provided where people live. This is a challenge in rural India but can be addressed with innovative models. For example, In Karnataka, health camps organized by super specialty hospitals were successful in improving access to care. Hospitals in Bengaluru would send cardiologists and other specialist to camps in villages. Patients identified as needing additional care were offered free transportation for patient and companion in Bengaluru. Other models are also being piloted, such as telemedicine in Uttar Pradesh where patients at primary health centre are connected to specialist doctors in Andhra Pradesh for virtual OPD care.

Target low-income populations

A programme financed by public money needs to conserve resources. Therefore, we should provide government sponsored insurance only to those who cannot afford insurance on their own. Existing coverage data shows that while private health insurance is largely concentrated among the urban richest quintile in India, public health insurance is more equitable, covering bottom quintiles of urban and rural population of the country. “Mission creep” or mis-targeting, however, is a significant threat as we witnessed in the case of Aarogyasri, where nearly 80% of Andhra Pradesh‘s population reported having coverage while the scheme was exclusively aimed at population below poverty line. This is why the Aadhaar platform becomes fundamental to enrolment to the NHPS. Also evidence from prior studies suggests that insurance has much larger effects on health and financial well-being for the poor compared to the rich. In addition to targeting the poor, insurance should target health conditions where disease burden is high and effective interventions are available but underused.

Contract with private hospitals and clinics

Nearly 75% of out-patient department care and 55% of in-patient department care in India is exclusively from the private sector. Therefore, private hospitals and clinics provide care to a large fraction of the population and they need to be part of NHPS. Yes, private hospitals will try to exploit NHPS. But the solution is not to exclude them but to monitor them and create the right incentives for them. There are several options. First, not all hospitals should be eligible for NHPS. Only hospitals that meet certain quality standards should be allowed to serve NHPS beneficiaries. Quality should be measured not only by the infrastructure available at the hospital but also by actual patient outcomes achieved. Second, NHPS should institute prior authorization for expensive medical procedures and surgeries. NHPS doctors should review the medical records of NHPS beneficiaries to make sure that the surgery in medically warranted and meets evidence-based guidelines. Third, NHPS should reimburse hospitals using “bundled payment” so that the hospital receives a fixed amount per episode of care that covers all services provided by the hospital. This lowers incentives for the hospital to provide care just to make more money. The bundled payment can also be tied to quality metrics, creating further incentives to improve quality of care.

Use data to learn and evolve

The NHPS will have access to health information of 500 million people. This is an unprecedented amount of data and if curated well, it can have far-reaching applications. It can be used for comparative effectiveness research or understanding which treatments work in the real world rather than just in clinical trials. Treatments and interventions can be highly contextualized to local conditions. It can be used to advance personalized or precision medicine. That is, tailoring treatment based on individual genetic or other characteristics. It can be used to improve the health system and understand how different delivery and financing designs affect care outcomes and costs. It can be used to improve transparency by providing information on quality of care provided by different hospitals or clinics in India.

Tracking the NHPS will be extremely important to set priorities and shape future health policies in India. In a large and diversified country, health needs differ from state to state, and, within a state, can vary greatly from one district to another. Good disaggregated measures of health outcomes will become the basis of framing and assessing future health policy. In spite of the best efforts of previous governments, there is little or no evidence on whether past health policies have had the intended effects. There is little political pressure on elected representatives to address health issues, largely abetted by lack of good local health data. Of course, this disproportionately affects the weaker and vulnerable sections of society – women and children – far more. A well run NHPS has the potential to become the cornerstone of India's healthcare needs for several future generations.

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