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UNJOINED DOTS OF A SCHEME

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Planning to buy a mid-range smartphone? Honor 9N is the notched beauty you need

(Written by Jishnu Das, Yamini Aiyar and Jeffrey Hammer)

The Pradhan Mantri Jan Arogya Yojana (PMJAY) has now been launched. As the focus shifts from policy guidelines to implementation, sceptics may wonder if this time will be truly different. We have been here before. India has wide experience with running large health insurance programmes like the Rashtriya Swasthya Bima Yojana (RSBY) and state-specific insurance schemes. The one key lesson from these previous avatars was that even though the public sector has failed to provide quality healthcare, public funding for the private sector will be no panacea. Not because the private sector can't perform better, but because, in addition to the old adage that the private sector behaves like the public sector in direct proportion to the subsidies it receives, health insurance brings with it its own set of special concerns.

A functioning health insurance system must ensure that patients neither under-treated nor over-treated nor over-charged. Ensuring this requires adaptive price setting, third-party monitoring, strict regulation, and, quality improvements in public sector hospitals. All of which requires massive investments in state capacity.

Pricing: Getting prices right is an almost impossible problem. Prices need to fulfill the dual function of ensuring "neither too much, nor too little". But costs for the same procedure are likely to differ across hospitals because of quality, location and capacity. Therefore, a single price can never ensure that both constraints are effectively met, and in fact, it is certain that these prices — especially if they are the same for all hospitals in a state — will never be the "right" prices.

Price a service too low and the hospital will either choose not to enroll in the scheme or will deny services. Price too high and the hospital makes additional profits, or worse, provides additional services that patients don't need.

The fact that a stent will be reimbursed at Rs 40,000 but a heart bypass at Rs 1.2 lakh immediately highlights the problem. Even if administrators can perfectly determine what operation the patient received, there is nothing stopping a hospital from choosing the operation that grants higher profits. Why stop at a stent if the bypass nets additional profits? Complicated verification methods might help, but problems like "upcoding" (inserting a stent but coding a bypass) become more likely the greater the deviation in prices from each hospital's cost structure.

Getting prices right is the central dilemma in any insurance programme and one that all countries struggle to solve. But the one thing that countries implementing large-scale programmes have in common is a large analytical and data centre that continuously examines procedures, procedure coding and charges from the insurance scheme. Prices have to be frequently negotiated and updated based on the data. This is a job for specialised teams of hundreds in each state.

Third-party monitoring : Given the pricing dilemma, hospitals will almost certainly under-treat and over-charge. One of the trickiest problems in the Rashtriya Swasthya Bima Yojana (RSBY) was denial of services. In West Bengal, in a district one of us was studying, the private hospital would not honour the cards. Patients would turn up, and would be turned back. The reason was that

prices for some procedures were set too low for the hospital to make a profit on these cases, and therefore, it made little financial sense for the hospital to cater to these conditions. There were other cases where patients were turned back because hospitals were not being reimbursed for their claims on a timely basis.

A second problem is top-up pricing. Hospitals can increase prices of services and force patients to pay out-of-pocket. Subsidies to providers are shared among the provider and the consumer depending on demand and supply elasticities. If there is only one hospital in the district, the hospital knows that patients have little choice but to pay up.

The problem with denials and top-up pricing is that, unlike over-treatment, they do not show up in routine administrative data. Grievance redress and call centres, as envisaged in PMJAY, may prove useful but only if they can immediately influence the outcome for the patient. This problem requires an ecosystem of mediators and facilitators that will serve as a link between the scheme, third party insurers and the hospital. The proposed “Ayushman Mitras” are a step in the right direction, but will require both the authority and ability to guide patients through hospital care, occasionally in opposition to the hospitals’ own objectives. That the Mitras will be hired by the private hospitals themselves in several states sets up a direct conflict of interest and undermines their potential to be vigilant observers.

Regulation and insurance fraud: In tandem, PMJAY will require creating a strong regulatory framework for fraud control. India’s current regulatory environment is worryingly weak. Ajay Shah, Ila Patnaik et al have shown that all 17 insurance ombudsman offices in India are currently vacant with a backlog of 9,000 complaints. The current regulatory framework has no established procedure for settlement of claims, redress of consumer behaviour against the rejection of claims or even penalties for rejecting claims in violation of existing regulations. This, in turn, creates incentives for regular violation of norms by insurance companies. Not surprisingly, the complaint rate in India is orders of magnitude higher than comparable jurisdictions across the globe. The success of PMJAY is now intrinsically tied not only to the functioning of the health department, but also the criminal justice and court systems. The implementation of a stronger legislative framework for regulation and insurance fraud is urgently needed.

Improving government hospitals: Finally, there is no getting around the critical need to strengthen government hospitals. In the long run, well-functioning public hospitals will provide a much-needed backstop against predatory practices, denial of service and overcharging in the private sector. Especially in districts where competition is limited, public hospitals will limit the monopoly power of the private sector, flush with the new money from the scheme. Making sure that the scheme’s resources can be used in government as well as private hospitals to improve quality is crucial.

The only way to ensure that these conditions for implementation success are met is through massive investments in a skilled workforce. In the United States, Medicare employs 6,000 people to cover 44 million beneficiaries. These are all highly trained administrative staff handling insurance audits, pricing and medical records. They deal with anti-trust cases and fraud and examine billing issues. India’s staffing levels fall woefully short. UP, where the scheme may cover 50 per cent of the population, or 100 million people would requires 10,000 administrative staff; currently the RSBY headquarters in the state has 42. Across India, most state insurance schemes and the RSBY are run by trusts and offices that employ fewer than 100 staff. A scheme as complex as this requires people. Since the expertise currently does not exist (at least at this scale), PMJAY will have to both allow for this massive workforce and develop the necessary institutions to train an enormous number of professionals.

It would be a huge mistake to think that we can deliver care by devolving responsibilities to the private sector without improving state functioning. We can't. In fact, with a scheme like PMJAY, our state capacity now needs to go far beyond the health sector to complex regulation, industry practices, the police and the courts. This is a challenge for the entire country. And this is the metric against which the PMJAY should be monitored and the government should be held accountable for.

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