Source : www.livemint.com Date : 2018-09-21

OPINION

Relevant for: Health, Education & Human Resources | Topic: Health & Sanitation and related issues

The Narendra Modi government is better known for its economic programmes such as infrastructure and ease of doing business, than its social programmes. But two of its most ambitious programmes are related to health. The first is the Swachh Bharat programme, which the Prime Minister announced in his very first Independence Day speech. This programme, directed at eliminating the high incidence of open defecation, has been under implementation for nearly four years (Swachh Bharat Mission: A remarkable transformation). In contrast the Ayushman Bharat—Pradhan Mantri Jan Arogya Yojana (PMJAY), a health insurance scheme announced in the last budget, will only be launched on 23 September, towards the fag end of this government's tenure. It will take a couple of years before this programme can be objectively assessed. However, the promises and possible challenges deserve close scrutiny as it is arguably the most ambitious social health insurance (SHI) programme ever launched anywhere in the world. Such an ex-ante scrutiny need not be purely speculative as the main components of the programme are now known and there is a wealth of SHI experience from many other countries.

The significance of PMJAY has to be seen in the context of existing health conditions and health service delivery systems in India. Using life expectancy as a summary measure, health standards have improved enormously in recent decades. Despite this, with an average life expectancy of 68.3 years, India trails all its Asian neighbours barring Afghanistan, Pakistan, Myanmar and Laos (Fifty years of Asian experience in the spread of education and healthcare). Healthcare is one important factor among several that determine health outcomes along with income, nutrition, and hygiene. Regarding the former, the World Health Organization recommends that a country should spend at least 4% of its gross domestic product (GDP) on health (*Health Financing Strategy for the Asia Pacific Region: 2010-2015* by the World Health Organization). India's health expenditure at 3.9% of GDP is comparable to this norm. However, the health ministry's National Health Accounts show that total government health expenditure is only an appalling 1.1% of GDP. Thus, well over 70% of health expenditure is privately financed. More than 62% is, in fact, direct out of pocket (OOP) spending by patients as against the WHO-recommended OOP ceiling of 40%.

The allocation of public health expenditure is even more disappointing. Preventive health spending is more equitable and much more cost effective in improving health standards, a much bigger bang for the buck compared to curative care. But less than a quarter of India's meagre public health expenditure is allocated to preventive care. Hence the continuing high incidence of communicable diseases. Meanwhile, there is a rising incidence of non-communicable diseases with income growth, lifestyle changes and environmental degradation, resulting in a rising total burden of disease.

Despite absorbing the bulk of public health expenditure, the public curative care system has not managed to cope with this. Patients are faced with ill-equipped primary health centres (PHCs), run by poorly trained staff, a broken referral system and crowded hospitals. Overburdened and disgruntled medical staff, long treatment queues, touts and supposedly free but missing drugs have increasingly pushed patients towards private providers, who now account for over 70% of healthcare provision. However, private provision is expensive and unaffordable beyond a point except for the rich. Hence, patients turn to cheaper traditional treatments, live with their ailments or simply die prematurely.

It is against this grim background that we need to assess the PMJAY programme. SHI

programmes like PMJAY become necessary because consumers do not know in advance whether they will need treatment or not, but if there is a catastrophic health event, the high cost of treatment can impoverish families.

Of the high OOP payment by patients, the bulk is spent on out-patient treatment. However, compared to about 700 per episode of such treatment, in-patient treatment works out to 10,000-15,000 per episode, even more in the case of catastrophic illness. Such expenditure is unaffordable for most Indians, especially the most vulnerable. Risk pooling through health insurance addresses this problem. However, profit driven private health insurance leads to adverse selection. Those most likely to need treatment may be excluded from private insurance. Hence the urgent need for SI.

PMJAY will provide insurance up to 500,000 per family per year for in-patient secondary and tertiary treatment. It will cover over 100 million vulnerable families, which is about 500 million people, the poorest 40% of India's population. Treatment would be provided by empaneled public and private hospitals. A list of 1,350 procedures across 23 specializations, including pre- and post-hospitalisation, diagnostics, and medicines, has been prepared along with their rates. A performance-linked payment system has also been designed to incentivise hospitals to improve service quality and patient safety. The hospitals would be reimbursed through the appointed insurance agencies or assurance societies/trusts or some combination of the two.

A National Health Authority (NHA) has been mandated to roll out and coordinate the programme. NHA is itself a lean organisation consisting of a chief executive officer, a small management team and a handful of staff and consultants. But it will implement the programme through the state governments.

Memorandums of understanding (MoUs) have been signed with 30 states and Union territories. Discussions are ongoing with most others. The MoUs are flexible and allow states to fine tune the scheme to suit their own circumstances. The states are responsible for empaneling the hospitals. So far 10,000 hospitals have requested empanelment. States will also decide on the implementation mode—insurance agency or assurance trust/society or a combination—and choose the agencies.

PMJAY is actually the second tier of Ayushman Bharat, a two-tier scheme. It will ride on the first tier, a network of 150,000 health and wellness centres (HWCs) that will provide free universal and comprehensive primary health care. The HWCs will serve as the awareness, screening and referral link between patients and PMJAY. NHA has also signed MoUs with a network of common service centres (CSCs). They will implement a beneficiary identification system with the help of a cadre of some 300,000 village-level entrepreneurs.

A cadre of frontline health service professionals called Pradhan Mantri Aarogya Mitras (PMAMs) are being trained to facilitate provision of treatment to beneficiaries at hospitals. A capacity-building strategy has been launched under which a nationwide team of master trainers are also being trained who will in turn train the PMAMs and CSC operators.

As NHA will implement the programme through the states, it has prepared a set of model tender documents and multiple sets of detailed operational and other important guidelines. An information technology platform has been developed consisting of a beneficiary identification system, hospital empanelment module and a transaction management system, along with robust security systems to ensure data privacy.

Clearly, the architecture of the PMJAY programme has been carefully conceived and readied for roll out in a remarkably short time. If successfully implemented, it would be a game changer for

the 500 million or so beneficiaries who could not hitherto afford any secondary or tertiary treatment. However, a number of challenges need to be addressed before PMJAY can lead India into the era of universal SHI.

The most formidable challenge is the unknown financial cost of the programme. No actuarial database is available to yield a probability distribution of the expected number of different health episodes requiring different treatments at varying costs. Without such a database, insurance agencies cannot estimate the required premium to adequately cover the pooled risk —the ultimate cost of the programme. Depending on the nature of the contract between governments and insurance agencies, the actual cost of the programme could leave a deep hole in the finances of the insurance agencies or the central and state governments.

A second challenge is that of coverage erosion. A pattern observed in several countries is that when costs escalate, the package covered by SHI is shrunk and co-payments and coverage caps are introduced, thereby raising the burden of OOP spending. The third challenge is that of private providers pushing high cost treatments not covered by SHI to enhance their profit margins, thereby further raising the OOP burden on patients. This too is a well established pattern.

Another possible challenge is implementation failure. It was mentioned earlier that PMJAY will ride on the first tier of Ayushman Bharat, a network of 150,000 HWCs spread throughout the country. These will be souped up makeovers of today's PHCs, the Achilles heel of India's public health system. Can we assume that these modified PHCs will perform better tomorrow than they do today? Indeed, it is arguable that fixing this weak primary care foundation of India's public healthcare system is more urgently needed than providing insurance for secondary and tertiary care.

Finally, there is missing protection for the middle. PMJAY will protect the poorest 40%. Those at the top from the organised sector, government or corporate, also have access to insurance. But this excludes the 500 million people or so of the middle segment dependent on the unorganized sector. Universal SHI will also requires an insurance programme for them.

These challenges do not imply that PMJAY will fail but that it is only a first step on the road to universal SHI. As a follower country India can learn from the experiences of others. The Thai model with excellent SHI coverage and OOP spending down to 18% is increasingly seen as global best practice.

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Comments are welcome at views@livemint.com

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