More a private sector primer than a healthcare pathway

A new NITI Aayog report defies accepted logic that universal health coverage entails a strong role for the Government.

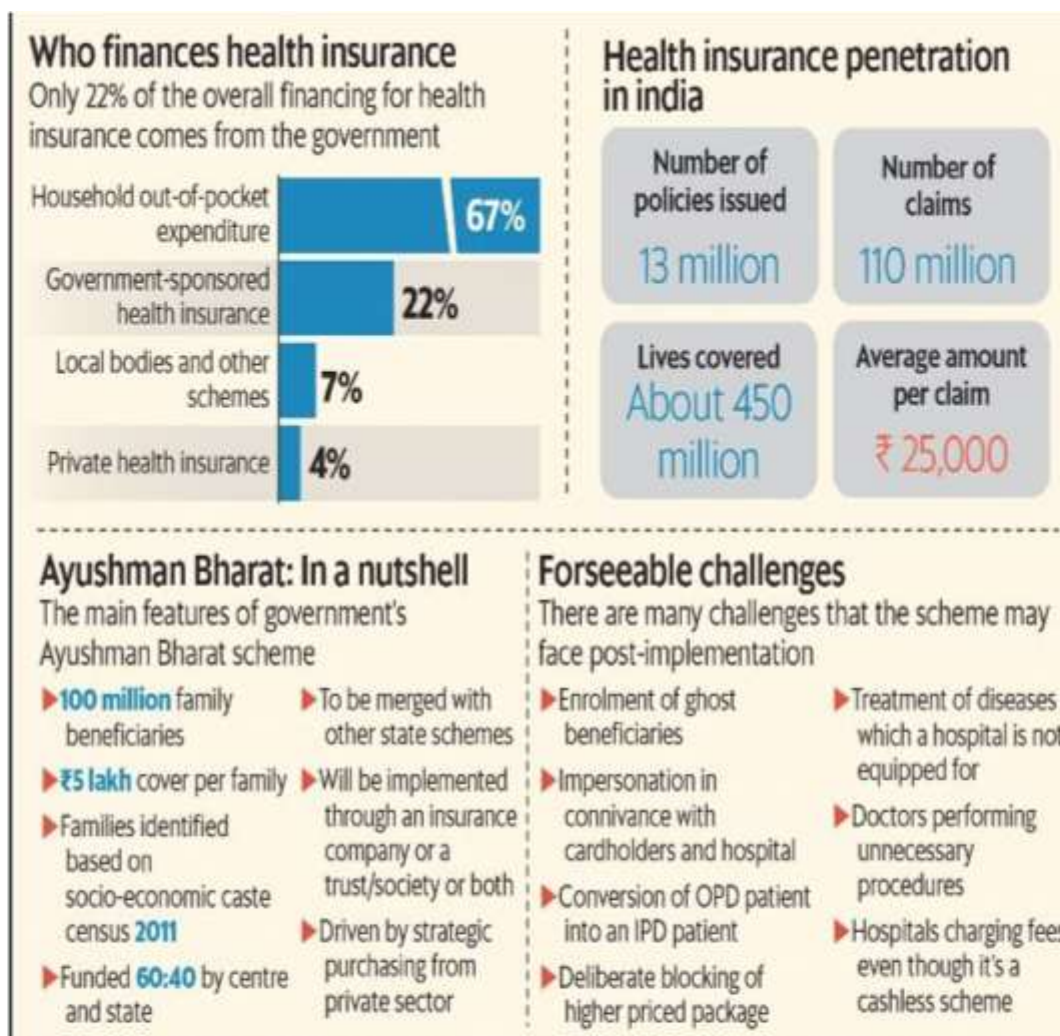
India's Missing Middle:

1. The central government's flagship health insurance scheme, the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), aims to extend hospitalisation cover of up to ₹5 lakh per family per annum to a poor and vulnerable population of nearly 50 crore people.
2. Apart from AB-PMJAY and State-level government health insurance schemes, small segments of the Indian population are covered under social health insurance schemes and private health insurance.
3. Covering the left out a segment of the population, commonly termed the 'missing middle' sandwiched between the poor and the affluent, has been discussed by the Government recently.
4. Towards this, NITI Aayog recently published a road map document entitled "Health Insurance for India's Missing Middle". However, to say the least, the report confounds all hopes and expectations of a credible pathway to universal health coverage (UHC) for India.
5. The report proposes voluntary, contributory health insurance dispensed mainly by private commercial health insurers as the prime instrument for extending health insurance to the 'missing middle'.
6. Government subsidies, if any at all, will be reserved for the very poor within the 'missing middle' and only at a later stage of the development of voluntary contributory insurance.
7. This is a major swerve from the vision espoused by the high-level expert group on UHC a decade ago, which was sceptical about such a health insurance model as the instrument of UHC and advocated a largely tax-financed health system albeit with private sector participation.

In-patient care

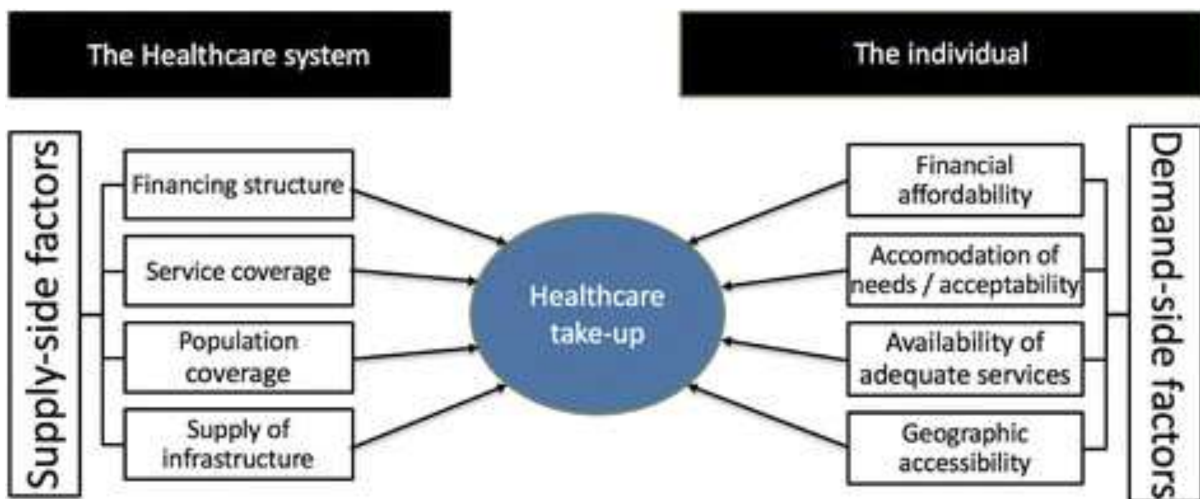
1. Those with even a rudimentary understanding of health policy would know that no country has ever achieved UHC by relying predominantly on private sources of financing health care.
2. Evidence shows that in developing countries such as India, with a gargantuan informal sector, contributory health insurance is not the best way forward and can be replete with problems.

3. But even when we look at international precedents of contributory social health insurance models, some very important traits stand out, for example, significant levels of government subsidy to schemes; not-for-profit mode of operation; and some important guarantees for health. The NITI report sweepingly ignores these fundamental precepts.
4. For hospitalisation insurance, the report proposes a model similar to the Arogya Sanjeevani scheme, albeit with lower projected premiums of around ₹4,000-₹6,000 per family per annum (for a sum insured of ₹5 lakh for a family of five).
5. There would be a standard benefits package for all, and the insured sum will be between ₹5,00,000 and ₹10,00,000. Insurance will be dispensed largely by commercial insurers who would compete among themselves.



Problems in the proposed scheme:

1. One can see how this model is vulnerable to nearly every vice that characterises conventional private insurance.
2. For instance, consider countries such as Switzerland. Despite relying predominantly on private insurers and a competitive model of insurance, certain important checks and balances exist: benefits are etched in legislation; basic insurance is mandatory and not-for-profit; cream-skimming and risk-discrimination are prohibited.
3. Such checks and balances are a long shot in the Indian scenario, neither have they been discussed in the NITI report.
4. Both these notions are likely to be far-fetched in practice, and the model is likely to be characterised by widespread adverse selection notwithstanding.
5. It is important to remember that even free-of-cost government health insurance for the poor has little penetration in the country, despite a nearly two-decade-long legacy.
6. The possible destiny of contributory private health insurance with modestly lower premiums, for a target group that is not significantly well-off, is obvious.



Out-patient care

1. An even more untenable case has been made with respect to out-patient department (OPD) care insurance coverage, which includes doctor consultations, diagnostics, medicines, etc.

2. The report rightly acknowledges that OPD expenses comprise the largest share of out-of-pocket expenditure on health care, and concomitantly have a greater role in the impoverishment of families due to health-care expenses.
3. The report proposes an OPD insurance with an insured sum of ₹5,000 per family per annum, and again uses average per capita OPD spending to justify the ability to pay.
4. However, OPD insurance is envisaged on a subscription basis, which means that insured families would need to pay nearly the entire insured sum in advance to obtain the benefits. This is the last thing one would equate with UHC.
5. Clearly, this route is unlikely to result in any significant reduction of out-of-pocket expenditure on OPD care, which beats the whole purpose of providing insurance.
6. Any cost savings or benefits that accrue would be due to using low-powered physician payment modes and a more integrated and coordinated pathway of care.
7. However, their contribution is likely to be nominal and at least be partially offset by the administrative costs involved in insurance. Individuals are likely to be largely indifferent to such an OPD insurance scheme, particularly if it restricts the choice of healthcare providers.

Wrong disposition

1. The NITI report defies the universally accepted logic that UHC invariably entails a strong and overarching role for the Government in health care, particularly in developing countries.
2. Rather than plot a pathway for UHC in India, the report is more about expanding the footprints and penetration of the private health insurance sector.
3. Further, the report looks to attain the elusive UHC with few or no fiscal implications for the Government, which is an absurd idea by any stretch of the imagination.
4. Such a disposition is highly dismaying in the aftermath of COVID-19. The National Health Policy 2017 envisaged increasing public health spending to 2.5% of GDP by 2025. Let us not contradict ourselves so early and at this crucial juncture of an unprecedented pandemic.