AYUSHMAN Bharat: Health Insurance Lessons from Recent Experiences

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AB Yojana – speed & ambition

- AB – launched in Aug – Sept 2018
- India's principal approach to achieving Target 3.8 on universal health coverage (UHC) of the Sustainable Development Goals.
- Expected to cover 100 million households (i.e. 500 million individuals) under a floating cover of Rs 500,000 per family per year.
- According to official AB website, as of 04 January 2019:
  - 16,227 hospitals empanelled
  - 45,11,770 e-cards issued
  - 7,24,901 beneficiaries admitted

Public – private mix

- Mix of public and private sector
- Two main segments
  - **Health and Wellness Centres** (HWC) - likely to be largely publicly run
  - **Pradhan Mantri Jan Arogya Yojana** (PMJAY) - insurance scheme that is expected to be largely based on private service provision.
  - PMJAY intended to be a centre-state collaboration in a 60:40 ratio
  - States free to run PMJAY through either an **insurance company or a trust**
  - Majority of states and UTs have opted for either a trust model or a mixed model (insurance cover up to Rs 1.5 lakhs, and reimbursement directly through a trust thereafter)

Private sector enthusiasm

- CEO of Max Bupa Health Insurance -
  - 2018 a “pivotal year for health insurance”
  - “Going into 2019, these measures and other emerging trends will unlock value for millions of customers, while simultaneously increasing penetration of health insurance in the country”
  - Predicts greater standardisation in health insurance policies across firms, driven by the regulator (IRDAI)
  - Also surge in the use of wearable technology (Internet of Things) - ‘tailoring’ insurance to customer specifics. (right to privacy?)

Major public and pvt health insurance cos.

- Public sector health insurance companies
  - United India Insurance, New India Assurance, Oriental Insurance, National Insurance, SBI General Insurance
- Major private health insurance companies
  - Star Health, Religare, Apollo-Munich, Max Bupa, Cigna TTK, ICICI Lombard, Reliance, Tata-AIG, Bajaj-Allianz among others

ICRA prediction – pvt hospital sector

- ICRA report on private hospital sector (September 2018) –
- Predicts recovery for the private hospital sector (sample of 6 publicly listed hospital chains - Fortis Healthcare, Apollo Hospitals, Narayana Hrudalaya, Healthcare Global, Max India, Shalby Limited)
- Profit margins and growth battered in last 5 quarters by demonetisation, GST, medical negligence cases, and regulatory control of the prices of medical devices, especially stents and knee implants
- “cardiology is the largest contributor to the revenues of most of the companies in ICRA’s sample set”

ICRA prediction contd.

- ICRA – “the introduction of NHPM is likely to improve the occupancies at implementing hospitals albeit with lower profit margins. The scheme is expected to be a major positive for hospitals in Tier II and III cities and smaller towns, particularly for healthcare facilities which have low occupancies and/or those that are positioned for affordable care. With an increase in patient volumes and occupancies, the viability of such private hospitals is expected to improve.”

Through the lens of recent experiences

- RSBY and state insurance schemes
- Objectives - Efficiency, effectiveness, equity and governance
- 4 issues –
  - financial and political viability
  - integration between primary, secondary and tertiary levels
  - financial risk-protection, and inclusiveness
  - corporate capture, regulatory capacity

Policy Questions - overarching

- Hlth system adequately funded publicly so as to avoid excessive burdens on households through out of pocket payments (OOPs)?
- universal or targeted?
- balance between primary and higher levels of care
  - ensures subsidiarity in service provision, along with effective gate-keeping?
  - different levels of care well-integrated to ensure effectiveness and economies in service provision?
- equitable access to services across and within households or regions?
- public, pvt or combination – provision or purchasing?
- governance / administrative capacity, including regulatory capacity, to handle combinations of public and private sectors with their different incentive structures, motivations and behaviours?

Caveat – micro questions

Examples:

- how well does the health insurance system pool risks? Already assumes that the purchaser-provider split has been approved as the best way forward
- does the publicly funded insurance system equitably reach all sub-groups in the population? Already assumes insurance

Such questions important for assessment, not for policy direction

Experiences of RSBY and state funded insurance schemes

- Patnaik, Roy and Shah (NIPFP 2018) – 48 govt sponsored health insurance schemes – major ones in south and west states
- Rajiv Arogyasri Community Health Ins Scheme
  - AP scheme
  - Launched 2007
  - trend-setter – access of 85% population to pvt tertiary care; empanelled hospitals; strong use of IT; package rates for 938 procedures incl cardiology, neurology, urology, oncology; Arogya mitras
  - Quick Invt by pvt hospitals (6000 additional beds, 29 new hospitals)
  - 75% services under scheme provided in pvt sector

Issue 1: Financial and political viability

- Rajiv Arogyasri spent Rs 1075 crores in 2009-10 (La Forgia &Nagpal 2012) against a budget estimate of Rs 925 cr.
- Total govt budget of Rs 105144 cr (BE) and GSDP of Rs 342571 (@ 2004-05 prices)
- Rapid uptake and growth of pvt sector – nervousness among bureaucrats at spending 25% of state's health budget
- AP asked GOI for a 70:30 split but was refused by Planning Comm – cash cow for private sector; doubtful compliance by pvt sector for unprofitable components such as free post-op care
- Ambivalence within UPA govt despite popularity of scheme and YSR sweep of next elections

Financial and political viability contd.

- Similarities between AP, Tamilnadu, Karnataka and other schemes but latter learned AP lesson about financing and funded less
- Challenge of cost containment with wide coverage (beyond BPL popn) – question of capacity to handle this through better institnal mechanisms, setting of package rates, incentives linked to length of contract
- moral hazard, adverse selection, balance billing (OOPs), provider-induced demand
- RSBY at 75:25 centre-state ratio of funding but much smaller benefit and narrower popn coverage
- Congress Manifesto for 2014 hardly claimed

Implications for PMJAY

- Wider the coverage, the more popular
- Clustering of previous schemes in south and west with stronger governance systems and capacity
- Serious questions for states and regions with less system capacity
  - Will cost containment and ensuring scheme requirements be met by pvt sector ?
  - Pvt sector capacity (ICRA predicts Tier 2 and 3 cities and towns – to be seen)?
  - IT as an important MIS and scheme control measure – highly uneven capacity across states?

Issue 2: universal or targeted?

- Universality typically viewed in UHC literature as having 3 dimensions – coverage of people, coverage of services, coverage of costs
- Most prior govt funded health insurance has been targeted, either to particular groups (CGHS, ESIS etc) or to the general BPL population as in RSBY and the state schemes.
- But both AP and Tnadu (Rajiv Arog; Kalaignar) covered beyond BPL to around 80% of the population – practically universal => risk-pooling efficiencies possible if recruitment is done by the insurer. However, since the hospitals conducted health camps for pre-screening, adverse selection was a serious issue at least in AP

Universal or targeted contd.

- Other major effect of universality is political economy based – the increase in ‘voice’ due to presence of better-off groups (e.g. NHS in UK). Voice imp for quality and accountability
- None of the schemes other than in AP and Tnadu (to some extent in Kerala) have this; neither does RSBY, as they all target BPL more strictly

Implications for PMJAY

- Risk pooling and avoidance of adverse selection will be difficult because PMJAY is also targeted to BPL only.
- In the poorer and more backward districts where PMJAY hopes to expand, the problem may be even more serious because of limited presence of competing health providers.
- Voice is also likely to be low.
- Absence of related effects through reduction of costs of drugs and diagnostics – weak links that pvt sector providers are likely to take advantage of.

Issue 3: Integration of levels of care

- Major weakness of previous schemes was their focus on secondary and / or tertiary care => fragmented care
- Absence of primary care => lack of subsidiarity in service provision, or gate-keeping; higher costs; poorer health outcomes – lower effectiveness

Implications for Ayushman Bharat

- In order to meet the challenge of fragmentation, HWC are meant to complement PMJAY
- Some budget provision has been made for this but it remains to be seen whether HWC receives the attention it needs.
- Challenge of two completely distinct institutional frameworks; thus far no clarity as to how the bridges will be built, either at the level of scheme admin or at the level of service provision.

Issue 4: Equity

- Major critique of previous schemes was that they did not really reduce catastrophic OOPs.
- Evidence also of more remote areas and groups such as tribals being excluded esp under RSBY
- Intra-household disparities in access affected girls and women, old people, etc
- Will this change under PMJAY?

Implications for PMJAY

- Given that PMJAY will have to operate in more difficult terrains with less literate populations, the problem of OOPs not reducing remains
- Also PMJAY does not cover ambulatory care whose expenses will have to be borne by patients; balance billing problem
- So also the problem of remote and marginal groups
- Intra-household disparity in access to services may be reduced by the absence of a limit on number of household members (vs limit of 5 under RSBY) – a lesson learned

Issue 5: Governance challenges

- Governance capacity was a major bottleneck even in better-off southern and western states
  - Low capacity to manage pvt insurers
  - Low capacity to handle large pvt hospitals and providers – cream-skimming, over-medicalization (over focus on cardiac surgery, hysterectomies, c-sections)
  - Non-transparency of swipe cards when dealing with semi-literate, poor and marginal populations – evidence for entire amount being swiped at one go
- Many lessons to be learned from NRHM in terms of Centre-state rels

Implications for PMJAY

- Governance problems in spades in poorer states and more backward districts
- Strong IEC essential to inform people of system's functioning and of their rights – done well under NRHM/JSY but that was much simpler
- Relation between Natl Health Authority and rest of MOHFW (pol econ of switch from Agency to Authority)

Summary of issues

1. Financial and political viability
2. Universal versus targeted
3. Integration of levels of care
4. Equity
5. Governance