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National Health Protection Scheme: Short-term and long-term challenges

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In the budget for 2018, the government of India announced the establishment of the National Health Protection Scheme.

The National Health Protection Scheme (NHPS), when fully implemented, will be the largest of its kind in the world. It will cover secondary and tertiary hospitalisation for a large section of the population with a limit of INR 500,000 per year per family. The scheme is likely to be a boon for Indian healthcare consumers, who have been paying out of pocket for over 60%[1] of their total healthcare costs for decades. As the scheme is expected to commence before the end of this year, the next few months are a critical time where all the scheme planning, monitoring, and implementation processes are to be finalised. The task is monumental, involving a wide range of mechanisms, from costing of benefits, to formulating stakeholder agreements, to developing strategies and a framework for managing the scheme. Multiple challenges will need important consideration before the scheme commences to ensure both its initial and long-term success and sustainability. The short-term and long-term challenges should be reviewed and tackled differently by each stakeholder—the central government, state governments, the provider community, and the insurer community. Short-term challenges include:

Costing of scheme: Getting accurate costing for the scheme is critical to its success. Costing calculations must be based on actuarial analysis of available data in the country. Current data sources include Rashtriya Swasthya Bima Yojna (RSBY), the Central Government Health Scheme (CGHS), the Employees' State Insurance Scheme (ESIS), commercial insurance, and various state schemes. Three key components for pricing—utilisation, claim costs, and administrative costs—should be calculated with informed assumptions and adjustments made based on the experience of different schemes and operating models throughout the country. This task is likely to be quite challenging, as the available regional or programme-specific experience may not be easily extrapolated to other regions or the NHPS specifications. Instead, a longer-term approach is recommended, involving an iterative framework where experience is carefully captured and analysed to test and refine assumptions. Over time, the experience and trends will strengthen the data, which will help in determining accurate costs.

Scheme administration: Administration of the NHPS will be the responsibility of each state. The individual states have the choice to develop a trust,[2] partner with an insurance company, or take assistance from an independent third-party administrator (TPA). These administrative models have been employed by different health insurance schemes in the past. RSBY was administered through insurance companies, while a state scheme such as Aarogyasri has been administered through a trust. The inpatient claims of the Gujarat's Mukhyamantri Amrutum scheme are administered by a TPA, while payments to hospitals are made directly by the state government. Each of these options has its own advantages and disadvantages and selection of a state's strategy requires careful consideration within the local context. The states should consider all types of schemes, including advantages and challenges, before choosing any particular model. In all cases, the states need technical capacity, expertise, experience, and guidance to help them evaluate their options and implement their preferred schemes.

Provider payment mechanism: The provider reimbursement system is one of the primary keys to the success of the NHPS. Providers must be paid rates that are commensurate with their expenses for a given treatment to ensure their participation in the programme. In addition to adequate reimbursement, the payment mechanism should address the unique concerns of different types of facilities and different regions, as provider costs, practices, and capabilities vary across the country. For example, smaller nursing homes, larger secondary hospitals, and tertiary care hospitals have different levels of expertise and expenses. Clear protocols for minimum provider infrastructure for procedures and package rates to reflect the expenses at each level of hospital and location are needed An example of such a rating system is the Chief Minister's Comprehensive Health Insurance Scheme of Tamil Nadu, which grades hospitals based on infrastructure and availability of medical personnel.

[1] World Bank Group (2018). World Bank Open Data. Retrieved 7 May 2018 from **https://data.worldbank.org**.

[2] As defined by the Indian Trusts Act, 1882.

Technology: The technology infrastructure should enable the scheme implementation. The platform for enrolment, preauthorisation, and registration of claims and payments must be efficient, able to handle large transaction volumes, and provide analytics to monitor the scheme performance. Establishing standardisation across states, leveraging past technology experiences, with minimum data standards enforced from the outset, will be very important.

In addition to these short-term challenges, which need to be resolved in the coming months, there are also long-term challenges to sustainable financing and achieving better health outcomes. Early preparation to meet these challenges is vital to the success of the NHPS.

Increasing the healthcare supply: An adequate supply of healthcare services is a prerequisite to meet the scheme's objectives. To support the benefit proposed under the NHPS, India must increase its healthcare infrastructure and resources including the supply of clinical professionals like nurses and doctors, as well as develop quality public and private hospitals. According to the World Bank data,[3] India has 0.76 doctors per 1,000, a rate less than one-half the world average of 1.8 doctors per 1,000. Similarly, India has 0.7 beds per 1,000, which is less than one-quarter of the world average of 2.9 beds per 1,000. Moreover, the supply must be distributed appropriately across all the states. While the government is taking steps to resolve these supply challenges—announcing in the 2018 budget the establishment of 24 new medical colleges, including one in every three constituencies—attention to provider quality and speed of deployment should be considered for developing the overall infrastructure.

Making the coverage comprehensive: While the NHPS offers enhanced coverage for secondary and tertiary hospitalisation, coverage gaps in primary care services remain. According to the estimates of the National Health Accounts,[4] primary care accounts for 45.1% of the total health expenditure, a bulk of which is general primary curative care and prescribed drugs. World Health Organization (WHO) studies show increased focus on primary care improves overall mortality rates and health outcomes.[5]

Managing quality of providers: In India, the National Accreditation Board for Hospitals and Healthcare Providers (NABH), which is a constituent board of the Quality Council of India, operates accreditation programmes for all types of healthcare organisations. The accreditation is provided for hospitals, clinics, blood banks, and others. The accreditation ensures good standards of quality, therefore providers should be encouraged towards accreditation. There are certain schemes that pay extra percentages in the package rates if accredited facilities are used.

In some other markets, such as the United States, provider quality is measured by comparing individual provider performance against established quality measures. For example, the U.S. Centers for Medicare and Medicaid Services (CMS)—the agency that regulates the two primary U.S. government-funded healthcare schemes—uses performance factors to measure and motivate improvements in provider performance against quality goals, which include: effective, safe, efficient, patient-centred, equitable, and timely healthcare services.

Use of standardised treatment protocols and a system for measuring provider quality will be fundamental elements for improving healthcare services in India. Benchmarks need to be developed and used to identify outlier hospitals in terms of both good and poor quality. This is achievable only if the right incentives and framework are in place to collect the data from the hospitals in the initial years of NHPS implementation.

Building a data warehouse: A comprehensive system to house healthcare information on all the aspects of NHPS will be crucial for programme management and evaluation. This could be accomplished by building a centralised data warehouse where information from all states, districts, and insurers are collected regularly to provide ad hoc reporting and analytics on a standardised format. Longitudinal data containing information from multiple years will be of great value for purposes such as:

- Providing a basis for pricing with insurers or budgeting by governments
- Studying the impact of including or excluding specific diseases, population, or coverages
- Studying improvements in the overall health of people and identifying potential areas for focussed interventions
- Conducting studies with longitudinal data such as examining the impact of certain interventions or diseases

Apart from the benefits mentioned above, a data warehouse would allow states and the central government to analyse operating efficiency, financial performance, and medical management effectiveness from a single platform. A data warehouse would specifically:

- Analyse cost and utilisation trends
- Develop future cost predictions and budgets
- Identify the drivers of cost and utilisation trends
- Benchmark a state's data with another state's or national data
- Measure and identify under-utilisation and over-utilisation
- Profile and analyse provider patterns and performance

[3] World Bank Group, ibid.

[4] National Health Systems Resource Centre (October 2017). National Health Accounts Estimates for India (2014-15). Ministry of Health and Family Welfare, Government of India. Retrieved 7 May 2018 from **https://mohfw.gov.in/**.

[5] WHO Regional Office for Europe's Health Evidence Network (January 2004). What are the advantages and disadvantages of restructuring a healthcare system to be more focused on primary care services? Retrieved 7 May 2018 from **http://www.euro.who.int**.

Minimising fraud

Fraud is a major concern for any health insurance scheme, especially one of the magnitude of the NHPS. The efforts to overcome fraud are not one-time strategies, but rather requires a continuous process of reassessment as new techniques evolve over time. The scheme administrators need to stay ahead in terms of knowledge, technology, and powers to curb fraud. Some of the most common types of fraud in this kind of scheme are:

- Billing for the package that has a higher rate than the actual package
- Performing surgeries that are medically not necessary
- Billing for diagnostics or procedures that were not performed
- Extended lengths of stay beyond what is necessary to meet the needs of the patient

Potential fraud could originate from any of the parties involved, including policyholders, intermediaries, or providers. However, there are ways to mitigate risks and a focused approach should be followed at inception to prevent fraud. The initiatives could be based on:

- Educating beneficiaries on benefits and possible misuse
- Enacting proper antifraud laws for the scheme
- Developing a dedicated pool of fraud investigators with appropriate training
- Creating effective information technology tools that can identify deviations from benchmarks and standard data

Final remarks

The NHPS is a very important step forward for India and the people who will receive coverage under this programme. However the challenges outlined in this paper and others that will develop over time, require careful consideration by each stakeholder. Studies could be initiated now to meet the potential challenges the scheme will face that are unique to India. Each of these challenges deserves an expert panel of its own to determine the appropriate steps and direction to mitigate the challenges in the best possible way. There can be inferences drawn from experience of other countries that have previously developed or are now developing healthcare schemes.

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