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Health Care for India's 500 Million: The Promise of the National Health Protection Scheme

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Abstract

India is the world's second most populous nation with an estimated 1.27 billion inhabitants. In 2018, the Indian economy was estimated to be the seventh-largest in the world by nominal GDP and the third-largest in purchasing power parity (PPP) terms. Although robust economic growth over the past two decades has contributed to a decline in mass poverty, gains in other indicators of "well-being" such as access to health care or education continue to lag behind. To address these "failures" the Indian government recently announced an unprecedented National Health Protection Scheme (NHPS), or in Hindi, the Ayushman Bharat Yojana *(popularly known as "Modicare"), designed to provide health insurance coverage to roughly 100 million "poor and vulnerable families" (or an estimated 500 million individuals) through reimbursements. This paper provides an overview of this ambitious plan, in particular, its strengths and weaknesses and the complex economic and political challenges it faces.*

According to a recent report from the WHO (World Health Organization) and the World Bank (2017), more than half of the world's more than 7.3 billion people do not have access to essential health services. Moreover, an estimated 800 million already financially vulnerable people spend at least 10 percent of their meagre household budgets on health care expenses either for themselves, their sick children or other family members. Often sudden and debilitating illness forces individuals and families to draw on their life savings, sell their assets, or borrow the needed funds — in the process comprising their futures and those of their families. The report notes that millions of families experience financial hardship every year because of "catastrophic expenditures" related to healthcare and about a 100 million people are pushed into destitution and "extreme poverty" because of the burden imposed by costly out-of-pocket health expenditures.[1]

Although good health depends on several factors such as income to buy nutritious food, access to clean drinking water, good sanitation and personal hygiene, access to quality and affordable health services is a key determinant. The recognition that lack of accessibility to basic health care and the

[1] The report defines "extreme poverty" as living on US$ 1.90 or less a day based on 2011 Purchasing Power Parity data.

prohibitive out-of-pocket expenses borne by poor families have direct bearing on poor health outcomes (especially among children and young mothers), including creating a vicious "poverty trap" as the loss of income from adult breadwinners unable to work only serves to further push individuals and families into impoverishment and extreme poverty (or prevent them from escaping it), and its adverse long-term consequences for economic development, has been the catalyst for the growing global support to address the problem. With the adoption of the United Nations "Millennium Declaration" in September 2000, the UN member nations, including various civil society and international organizations, unanimously agreed to make access to affordable health care one of the core "millennium development goals" with clear timetables and deadlines to assess progress in implementation and outcomes. With good and modest progress in only a few, weak progress in most, and growing concerns that countries' commitment to providing affordable and accessible health care was losing momentum, the United Nations General Assembly on 12 December 2012 unanimously adopted a resolution making "universal health coverage" (UHC) as an "essential element of international development," besides urging national governments to expeditiously implement measures to make universal health coverage a reality by providing "all people with access to affordable, quality health-care services." [2] In order to make universal health coverage a reality, all UN member countries agreed to do their best to achieve UHC by 2030, if not earlier.

Because UHC not only means that individuals and families should be able to receive health services without suffering undue financial hardship but also able to access the full spectrum of essential health services (from health promotion to prevention, treatment, rehabilitation and palliative, and curative care), there is broad consensus that as countries progress towards achieving UHC's, it will also help contribute towards progress in meeting their other health-related goals such as better health outcomes, including declines in overall poverty rates. Regarding how countries can best make progress towards achieving universal health coverage, there is a consensus that a "one-size-fits-all" strategy will not work. Rather, countries are free to adopt policies that suit their particular needs and circumstance – albeit, each can learn from common best practices and the experiences of others. For example, in all countries, individuals and families face financial hardship when confronted with the rising cost of health care. This burden is most acutely felt in low-income countries. This is because in many low-income countries health care is largely financed by direct payments, often resulting in excessive out-of-pocket expenditure. On the other hand, high and middle-income countries which provide some form of coverage via health insurance and prepayment plans are better able to insulate individuals and families from undue financial pressures associated with health care, including catastrophic health expenditures due to unexpected and terminal illness.

Towards Modicare

Joumard and Kumar (2015, 16) bluntly note that "when measured in per capita terms, India is 184th out of 191 countries in [in 2012] public spending on health." India's low public expenditure on health care (at around 1 percent of GDP) is not only dismal when compared internationally, but

[2] The resolution reaffirms that the WHO will play the leading role in supporting countries to implement universal health coverage.

it is also insufficient given the magnitude of the problem the country faces, let alone in meeting the goals of universal health coverage.

Table 1: Public Expenditure on Health, as % of GDP

Country	1995	2000	2005	2010	2014
India	1.22	1.27	0.93	1.18	1.4
China	1.79	1.77	1.83	2.72	3.1
Brazil	2.86	2.89	3.28	4.24	3.8
United States	6.09	5.79	6.70	9.49	7.0
World	5.48	5.34	5.70	6.52	6.5

Source: World Bank, *World Development Indicators* (various years)

In fact, India's low level of public spending combined with low coverage rates from both public and private health insurance (only about 15 percent of the population is covered by some form of health insurance) shifts the financial burden on individuals and families who are forced pay at the point of service for all types of health care most can ill afford. The high out-of-pocket (OOP) payments which accounted for 62.4 percent of total health spending in India in 2014 (compared to the global average of 18.62 percent[3]) is not only responsible for the country's poor health indices (and outcomes), but also for pushing individuals and families into a capricious existence, including falling back into impoverishment and poverty. According to the Ministry of Health and Family Welfare (GOI 2016), an estimated 50 million people fall back into poverty every year due to crippling medical expenditures.

Over the years several expert committees and panels have been established, including several plans, by the central government to address this pervasive problem. The "National Health Policy" of 2002 recommended greater role of the private sector in health care provision and "decentralization" of resources and implementation at the local (district) level. The Congress-led United Progressive Alliance (UPA) government that served two terms in office (2004-2014) made the provision of "accessible, equitable and affordable healthcare" a priority. The National Rural Health Mission (NRHM) established in 2005 (in 2013 the NRHM was subsumed under an umbrella initiative called the National Health Mission or the NHM), increased central government funding to the states with the explicit aim to improve health indicators such as child and maternal mortality as well as enhance the capacity of state governments to more effectively deliver health care.[4] The High-Level Expert Group (HLEG) report on "Universal Health Coverage" (2012),

[3] World Health Organization, 2015. "Global Health Expenditure Database.

[4] The UPA government was reduced its role (at least in financing specific schemes), and granted greater fiscal autonomy to the state governments, including giving them greater responsibility regarding "social sectors" such as healthcare. NRHM/NHM included several schemes such as the *Janani Suraksha Yojana* (JSY), which empowered village level workers called Accredited Social Health Activists (ASHA) and provided incentives for pregnant

recommended universal health coverage by merging central and state government health insurance scheme and strengthening primary health care. In 2017, the Modi government launched a new National Health Policy (NHP) with an explicit goal toward ensuring universal health coverage. Drawing on the recommendations of these earlier schemes and reports, on 1st February 2018, the Indian government under Prime Minister Narendra Modi announced its much anticipated plan to "fundamentally reform" the nation's health care system by improving access, quality and affordability to all Indian citizens, in particular, the poor and most vulnerable.[5] Under the National Health Protection Scheme (NHPS), or in Hindi, the *Ayushman Bharat Yojana* (popularly known as "Modicare") which the Modi administration proudly claimed would be "the world's largest government-funded health program," India would finally have a "National Health Protection Scheme" to provide quality health insurance coverage to roughly 100 million "poor and vulnerable families"[6] through reimbursements to an estimated 500 million beneficiaries (based on the assumption that an average family size consists of five individuals), of up to Rs.5 lakh (about US$7,845) per family per year for secondary and tertiary care hospitalization in an "empanelled public or private hospital," establish 150,000 health and wellness centers[7] to provide a holistic approach to care by focusing on both prevention and health promotion, and make "comprehensive medical care" accessible with free maternal and child health services, essential drugs and diagnostic services. Furthermore, to address the problem of shortage of qualified medical personnel, the NHPS proposes the establishment of at least one medical college for three parliamentary constituencies and one Government college per state, and further upgrading of the existing government medical colleges and hospitals.[8] Families and individuals covered under the NHPS will be able to access needed services from enlisted hospitals without upfront payments by providing their personalized smart card in the form of an "insurance card" that is linked to the national identity card (AADHAR) database.[9]

women to deliver babies in health facilities. As will be discussed later, the central government introduced the *Rashtriya Swasthya Bima Yojana* (RSBY) in 2008 to provide health insurance to the poor.

[5] In January 2015, when Modi announced its healthcare initiative called the New Health Policy (NHP), it was immediately criticized as there were no specifics on how to pay for the initiative, including, no increase in budget allocated to healthcare. In November 2015, the administration tried to remedy this by announcing the *Swachh Bharat Cess*, under which the government would charge a *cess* (or tax) of 0.5 percent on all services to pay for the Clean India initiative. On 17 March 2017, the government announced its plan to raise public health expenditure to 2.5 percent of GDP (from the current 1.3 per cent) "in a time-bound manner" to support "universal access" to good quality health-care services, including the provision of free medicines, diagnosis and emergency and essential health-care services such as mental health, palliative and rehabilitative care at the primary health-care level in all public hospitals. The latest healthcare scheme was announced by Finance Minister Arun Jaitley in his 2018-19 Budget.

[6] The beneficiaries of the health insurance scheme will be identified through the socio-economic caste census 2011 released by the Ministry of Rural Development.

[7] The Modi government also encouraged the private sector through their corporate social responsibility commitments and from philanthropic institutions to provide support or "adopt" some of the wellness centers.

[8] The NHPS provision of upgrading 24 district hospitals spread-out in poorly served areas (by hosting new medical colleges in these hospitals) will help improve the delivery of advanced care by making it more accessible to the rural populace.

[9] After the plan was announced, the prime minister tweeted (in Hindi) that "In poor people's lives, one big worry is how to treat illness…" The new program, he noted "will free poor people from this big worry."

By the government's own calculations, the NHPS will cost an estimated Rs.110 billion (US$1.71 billion) each year with funding shared between the central and state governments along a 60:40 ratio. Specifically, 40 percent of the cost is to be borne by the state governments and the remainder funded by the center through an additional 1 percent "cess" (or tax) on income tax and from the recently re-imposed tax on long term capital gains.[10] To underscore the Modi government's commitment, the February 2018 budget already allocated Rs. 20 billion to the NHPS, with an additional Rs. 50 billion once the details are worked out. Despite the scheme's scope and logistical challenges, the Modi administration remains optimistic that with effective cooperation between the Health Ministry and the state governments, the scheme's modalities can be worked out and the NHPS ready to be "rolled-out" on the auspicious October 2 — a public holiday in India marking the anniversary of the birth of Mahatma Gandhi. However, on 24 September 2018, the date that marks the birth of *Rashtriya Swayamsevak Sangh* ideologue, Pandit Deendayal Upadhyay, Modi formally launched the world's largest state-funded health insurance scheme, the *Ayushman Bharat-Pradhan Mantri Jan Aarogya Yojana* (AB-PMJAY)

India's Health Care System

India, like many other countries, is currently undergoing a health (or more appropriately an epidemiological) transition.[11] Although, infectious diseases such as tuberculosis, malaria, smallpox, dengue fever and influenza, among others, are under control as overall morbidity and mortality due to these diseases have been reduced (albeit, outbreaks remain a problem), non-communicable diseases, in particular, cancer, obesity, heart and respiratory disease and diabetes have been on the rise.[12] In the urban areas, non-communicable diseases are fast becoming the leading cause of mortality due to aging, physical inactivity and unhealthy diets and lifestyles, including excessive alcohol and tobacco consumption. However, India's aptly described "decrepit health-care system" is simply not up to task in addressing the country's myriad and complex challenges.

[10] In addition to the funds that have already been allocated by the central government, more resources will come from the increase of a health and education cess and from contributions from state governments. At present, a 3 percent education cess is levied on personal income tax and corporation tax. This cess will be increased by 1 percent and the existing education cess will now be replaced by a 4 percent "health and education cess" to be levied on the tax payable.

[11] The classical epidemiological transition model has three phases: the age of pestilence and famine, the age of receding pandemics and the age of degenerative and human-induced diseases (Phillips 1994; Porter 1997).

[12] "The contribution of cardiovascular diseases to total deaths has almost doubled since 1990. The number of Indians living with diabetes has grown from 26 million in 1990 to 65 million in 2016. The incidence of all cancers increased by 28% between 1990 and 2016, with new cases of cancer reaching 1·1 million. Those who suffer with chronic obstructive pulmonary disease have risen from 28 million (1990) to 55 million (2016). And while India is engulfed in this swirling epidemic of non-communicable diseases, the country is also in the grip of a mental health emergency. India could claim 18% of the world's population in 2016, yet it accounted for 37% of global suicide deaths among women and 24% among men. The death rates from suicide in India were 2·1 times higher among women and 1·4 times higher among men than global averages in 2016. Suicide is the leading cause of death among 15–39-year-olds." Richard Horton, 2018. "Offline: The new politics of health in India," Lancet, September 11, https://doi.org/10.1016/S0140-6736(18)32211-6 (accessed September 26, 2018).

However, this outcome was not expected to be the case. India's first policy paper on health care published on the eve of Independence (*TheBhore Committee Report of 1946*) laid out plans for an ambitious public health care system with both the central and state governments committing to work together to provide free "comprehensive basic health care services" to all based on the premise that "nobody should be denied access to health services for his/her inability to pay." The reality is sharply at odds with this goal. Not only is India's public health sector plagued with poor quality services in the dilapidated government-run hospitals stretched to breaking point with patients enduring long delays and perfunctory care, the problems are compounded with the lack of good public hospitals, inadequate basic health infrastructures such as medical clinics, pharmacies, diagnostic equipment, and essential drugs, including, acute shortage of qualified doctors and health-care professionals. The problem is particularly acute in the countryside where some 700 million Indian's live. Although, a large sprawling network of government-owned and operated primary health centers (PHCs) and community health centers (CHCs) have been ostensibly established to deliver primary health care to rural inhabitants, the reality is that rampant absenteeism (not to mention that many health professionals working in the PHCs and CHSs often run parallel private practice in the nearby towns) has resulted in an array of self-styled "doctors" (most who have no formal qualifications) filling the void and providing the bulk of outpatient care (Rao 2012). These problems are further exacerbated by very low public spending on health as a percentage of GDP. With public spending on health care in India remaining constant at around 1 percent over the past seven decades (despite the high GDP growth rates in recent years), and accounting for a mere 1.13 percent of the GDP in 2014-15 (which is amongst the lowest in the world, including China which spends about 3 percent of GDP), coupled with the reality that the vast majority of Indians (over 80 percent) do not have access to any form of employer-provided or state-funded insurance, many are forced to rely on their own resources to cover health care expenses.

The glaring inadequacies of India's public health sector, reflected in the widespread perception that government-run hospitals, health centers, and clinics are "where people go to die," has forced an every increasing number of people to turn to the more costly private health care providers. To meet this growing demand, the government, beginning in the 1980s liberalized the health sector by inviting greater private sector participation in the provision of health services. Exponential growth in private care occurred in the 1990s when India opened up its economy to global market forces. Soon the small private medical clinics were replaced by large corporate and multinational medical chains, with many of these facilities equipped with the latest state-of-the-art technologies such as high-end diagnostic tools like MRIs and CT scans and providing all manner of services from first-aid and emergency services to complex gynecology and pediatrics services, cardiac surgery, coronary bypass, liver transplants and orthopedic procedures, among others.[13]Sharma and Saha (2016, 7) note "that today the private sector has become the dominant healthcare provider in India. This privatization has grown from five to ten percent during the 1940s to 82 percent of

[13] For example, Narayana Hospitals is well-known for its world-class cardiovascular surgery at low cost and the Aravind Eye Care System for advanced cataract surgery. Not surprisingly, India has become a not destination for "medical tourism," with foreigners flocking in increasing numbers to avail themselves to the quick, efficient, and cheap services.

outpatient visit; 52 percent of inpatient expenditure; and 40 percent of births in private institutions by 2005." Similarly, the 71st National Sample Survey (NSS) conducted during January-June 2014 reports that 42 percent of the total hospitalization cases in the rural areas were in public hospitals and 58 percent in private. In the urban areas, 32 percent was public and 68 percent in private hospitals.

India's 2017 National Health Policy made the ground reality explicit by stating that the government would not only engage in the "strategic purchasing" of care from private facilities in order to improve access, affordability and quality of care, but that the private sector would also play an essential role in helping the country achieve its aim of "Universal Health Coverage." Yet the weak regulatory and enforcement regime overseeing private providers, coupled with the "profit motive of private sector" (Sharma and Saha 2016, 7), has meant that patients are often treated like cash cows and subjected to unnecessary (and costly) diagnostic tests and surgical procedures.[14] Not only private care can vary (sometimes dramatically) both in quality and cost, it remains unaffordable to the vast majority. Given that a brief 15 minute consultation with a physician at a private "five-star hospital" can cost over Rs. 1,500 rupees or more it is not an option for millions living on less than Rs. 80 a day and those compelled to seek private care, face high out-of-pocket payments, including bankruptcy if faced with a "catastrophic health care cost." In fact, with "out-of-pocket" expenditures accounting for some 70 percent of the country's total health expenditure (by contrast, OOP spending was estimated at 20 percent in the United States before passage of the Affordable Care Act), places a significant financial burden on individuals and families (GOI 2014). More broadly, the heavy out-of-pocket costs acts as a disincentive against preventive action as individuals and families may choose not to seek care (and in the process miss the early opportunity to manage health risks), which can ultimately lead to greater severity of disease and much higher costs for treatment.

Moreover, as the private health sector concentrate disproportionately on the more lucrative secondary and tertiary care and are mainly based in the major metropolitan centers, access to private medical care is simply out of reach of the vast majority of Indians.[15].The negative ramifications not only have direct and indirect economic costs (such as lower productivity and GDP growth), it is vividly (and sadly) also reflected in India's dismal health outcomes where more than a million children under five years old die every year from preventable illnesses such as diarrhea, dysentery and cholera. Sadly, more newborns die in India than in much poorer

[14] In September 2017, a private hospital Fortis Memorial Research Institute in Gurgaon (a Delhi suburb), slapped the family of a patient who had died with a 20-page itemized bill totaling around 1.8 million rupees (US$25,000). The hospital had not only over-prescribed medication, but also exorbitantly charged for basic items like band-aid and strips used to check blood sugar levels.

[15] In a scathing review of India's healthcare system, Nobel laureate Amartya Sen recently noted that "Money spent on public healthcare and education has gone down and the expansion has been for specialized healthcare. That helps only if you survive your childhood… India has come to rely on private healthcare even at the elementary level in a way no other country does, not even the United States. India has left it largely to the private practitioners, some of whom don't even know much medicine, and all of them know how to charge money. I think we have a most dysfunctional healthcare system." Quote in Elizabeth Roche and Sayantan Bera, 2017. "We have a dysfunctional healthcare system: Amartya Sen," February 25, *LiveMint*http://www.livemint.com/Politics/0YOsCib4VquFnSFgKWsxeN/We-h

neighboring countries like Nepal and Bangladesh. In fact, India's infant mortality rate remains much higher than the 150 middle and low-income countries, including its much poorer Asian neighbors. Overall, India's public health system has failed in its fundamental task — to protect millions of poor and vulnerable people from catastrophic illnesses and the spread of communicable diseases through prevention programs such as vaccination, immunization and control of influenza and virus epidemics.

Challenges to Modicare

A large body of research confirms that public health spending that is pro-poor or targets the underserved and the poor can have a positive distributional and health impact (Wagstaff et al, 2014). If on the one hand, inadequate access to basic health coverage can affect the overall health outcomes, on the other, the marginal benefit of health spending can be larger for the poor. Thus, providing affordable coverage for the poor, including targeting public health spending to the poor can help raise overall health outcomes. In part, this is because such reallocation of public spending will result in an increase in overall private health spending as the rich will increase their spending, and in the process offset the potential decline in spending by the poor. Moreover, cross-country evidence shows that increased government spending on health does lead to lower out-of-pocket expenses. Because poor households often fall into poverty because of the exorbitant out-of-pocket spending related to adverse and unpredictable health situations, public health coverage by reducing out-of-pocket expenditures not only limits such negative financial exposure, including freeing-up households from the need to engage in precautionary savings, but also increase household consumption and economic growth.

The NHPS as a publicly financed health insurance scheme whose key aim is to provide financial security against out-of-pocket and catastrophic health expenditure to poor and vulnerable households (as such expenses can constitute a huge financial burden for many, pushing individuals and families into debt and impoverishment), by raising the coverage cap will surely help alleviate the financial distress experienced by poor families. Furthermore, reduction in individual and household OOP health-related expenditure will allow for a broader use of one's disposable income, thereby boosting consumption and the economy. Yet the NHPS concentrates mostly on secondary and tertiary care rather than primary care such as outpatient treatment where out-of-pocket expenses for basic diagnostics and medicines is prohibitive and accounts for the largest part of OOP. In India (and many other countries) the cost of outpatient services account for the largest percentage of out-of-pocket expenses. Second, although the NHPS claim that hospitalization costs will be paid through "strategic purchasing" from public and private providers (certainly with a potential 500 million new "customers," private hospitals have every incentive to become competitive in order to attract these patients), it does not provide details regarding how this will be done. Specifically, without a precise enumerated list of what medical conditions, treatments and diagnostic tests are covered, including provisions to monitor quality, it will be a challenge to curb medical malpractice as the competing array of public and private providers could overcharge through unnecessary tests and treatments. Finally, the NHPS does not address the roots of poor health and sickness such as lack of access to clean water to vast numbers of people, worsening pollution levels, inadequate shelter, rampant malnutrition and poor sanitation. Given that there is

a direct correlation between India's weak national public health system and the country's extraordinarily high disease burden and poor overall "health outcomes" (which, as noted, are far below countries at a similar level of development) means that unless the problems with primary health care are not addressed, if will be difficult for India to make meaningful improvements to its overall health indicators.

The Political Challenge

Suffice it to note that much of the major determinants of public policy — in this case, health policy — lie outside the health system and in the realm of politics. In a federal polity like India with constitutionally demarcated division of power between the federal (central) government and the states, policymaking takes place in an environment characterized by overlapping and competing power relationships between the various levels of government. Under India's constitution, the "right to life" is considered to be "fundamental" and requires the central and state governments to ensure the "right to health" for all.[16] Yet India has a relatively decentralized public health care system.[17]. The central government collects and controls the tax revenues, is responsible for articulating and setting national health policy, including the regulatory framework, while the 28 state governments and seven union territories, which do not have taxing powers to meet their expenditure responsibilities, are responsible for the actual "delivery" or the implementation of health services.[18] Although, the central government with its tax-collecting powers (and greater financial resources), provides material support via a system of intergovernmental transfers to the states and other sub-national units and can compel (and often does) them to implement central directives, in reality, wide disparities in actual implementation remain and equity of access to healthcare varies greatly between the different states of the union (Joumard and Kumar 2015). Some of the variations in health care delivery are due to the sometimes wide disparities that exist in administrative, institutional and management capacities, as well as the geographic endowments and human capital that are inevitable in large continental polities like India. However, the size and scope of state budgets and political exigencies rooted in "competitive federalism" of multiple political parties and shifting political allegiances (not to mention the history of mutual suspicion and recriminations between the various levels of government) have made cooperation between the center and the states a challenge.

As noted, under India's federal system, much of the spending responsibility for "social welfare and development" falls under the purview of the states – albeit, the bulk of the revenue from taxation goes to the Central government.[19] Because the state governments have the responsibility for health service delivery, including bearing a significant share of the cost, they are not easy "buy-

[16] India's Constitution guarantees fundamental rights to its citizens. Article 21 gives the citizens "the Right to Life." As with all fundamental rights, the Right to Life is justiciable.

[17] The Indian constitution defines the distribution of power between the central government and the state governments under three categories: legislative, administrative and executive. The legislative section is divided into three lists: Union list; State list and Concurrent list. The Union list has 99 items, the State list has 61 items and 52 items are under Concurrent list – meaning they are under joint responsibility. Health care falls under the state list.

[18] On average, states raise about 40 percent of total current revenues, but incur about 60 percent in expenditures.

[19] The "social sector" includes health and medical care, education, water supply and sanitation, poverty alleviation, housing conditions and others that contribute to human development

ins" to the central government's plans and policies. However, the recent changes in the institutional architecture of Indian federalism may ease these tensions. Specifically, the Indian Constitution provides for tax devolution and block grant from the Union (Central government) to the States at the recommendation of the Constitutional body, the Finance Commission, appointed by the President every five years. The implementation of the recommendations of 14thFinance Commission increased the share of central tax revenues to the States from 32 percent of the divisible pool to 42 percent. Yet, even as this change increases the state governments share in the central tax revenue, it will also mean a reduction in the "direct" support the central government provides to "social sectors," Nevertheless, this change will not only help rationalize (and make more predictable) state government revenues, it will also give state (and local-level) governments greater autonomy in their budgeting and spending decisions, including aid state and local governments better plan and prioritize development and social-welfare programs on the basis of state and local needs. Of course, this does not necessarily mean that state governments will allocate more funds to healthcare and other social spending (rather, they may prefer to use the additional revenues to reduce budgetary deficits). Moreover, states with weak and inadequate capacities in physical and social health infrastructure, including the requisite administrative and technical skills may not gain much from financial devolution. Thus, it is important that the central authorities continue to aid and urge subnational units to devote the needed resources to essential social sectors and achieve the needed goals.

Yet, other tensions remain. Both the central and state governments have their own parallel health care programs – which do not always complement each other or duplicate each other in coverage. For example, in 2006, the central government, under the supervision of the Ministry of Health and Family Welfare launched the National Rural Health Mission (NRHM) to improve access to services in public hospitals and health centers, and in 2008, under the Ministry of Labour and Employment launched the *Rashtriya Swasthya Bima Yojana* (RSBY, the precursor of the NHPS), ostensibly designed to shield poor households from financial risk by offering insurance coverage of Rs. 30,000 (about US$500) per year for families living "below the poverty line" to help them meet their hospitalization expenses.[20] However, several state governments opted out of the RSBY on the grounds that they already had their own and more effective state-run health insurance programs, including concerns that the RSBY may not be effective in reducing out-of-pocket expenditure (also see Karan, Yip and Mahal, 2017), as it does not cover outpatient care which accounts for the largest part of out-of-pocket expenses (this concern seems to be been noted as the NHPS by sharply raising the coverage cap hopes to alleviate OOP health-related expenditures). Predictably, by September 2016, only 41 million families (about 150 million people) out of a

[20] The RSBY was ostensibly designed to reduce both out-of-pocket expenditure on health and expand access. Households who fall under the "Below Poverty Line" (BPL) are listed under a census conducted by each state under "poor households." Only these households are eligible to enroll in the RSBY. For an annual registration fee of INR 30, a BPL family (consisting of 5 members) receives a biometric-enabled smart card and an annual coverage of up to INR 30,000 for hospitalization-related expenses (including, preexisting conditions with no age limit) across both public and private RSBY "empanelled hospitals." Price controls such as fixed rates for various medical procedures help prevent cost increases.

targeted 65 million families were enrolled in RSBY.[21]Going forward, the RSBY along with another central government sponsored scheme, the Senior Citizen Health Insurance Scheme (SCHIS), will transition and eventually merge (or be "subsumed") with the NHPS. However, the future direction of state-level programs (currently 24 out of 28 state governments already have in place their own health insurance programs), remains unclear. State governments will have the option of running their own program parallel to that of the central government; merge state-level health insurance schemes with the central program; or as hoped under the current context, use only the NHPS. Yet, how the various parallel schemes run by state governments will be merged in to some type of a "single payer" mechanism under NHPS remains unclear. However, what is clear is that merging state-level programs into the NHPS will not be easy as states use an array of models ranging from direct reimbursement to beneficiaries; "trust" or where the government appoints a national health insurance company to provide medical coverage; and "awards contract" to an insurer with the lowest bid. Although, the NHPS allows the states flexibility regarding the model they select, each state must select an insurer. Of course, insurers will only agree to underwrite health policies if they are priced realistically. So far this has not been a problem, as under the RSBY, premiums are to be set through a competitive bidding between public and private insurance companies. For example, under the NHPS, keeping hospitalization costs low are to be met through 'strategic purchasing' from public and private hospitals. Yet, as noted earlier, to manage costs, there has to be clearly-defined list of conditions that will be covered, including cost guidelines for diagnostic tests and treatments. In addition, both the central and state governments must have in place competent bodies to monitor cost and quality standards. Equally challenging will be to get the private insurers as stakeholders. Not only is India's private healthcare system poorly regulated and prohibitive (as there are no limits of what private insurers can charge), it has never been "poor-friendly" — with no discounts for low income households, including setting aside mandated "cheap beds" for hospitalization.

Moreover, with their already established schemes, most states (including those affiliated with or aligned with BJP), are reluctant to abandon their health-care programs. This is particularly true in states ruled by parties who oppose Modi's BJP and have little incentive to give up their scheme to adopt the central scheme so closely tied to Modi. Some for political reasons may agree to co-brand, but others may not. For its part, the central government cannot do much if state governments refuse to pull funds out of their state-run health schemes to fund the NHPS. The proponents of Modicare claim that the beneficiaries under the state schemes will be happy to switch to the central program because of its higher insurance coverage (most state-level schemes provide coverage per family that is half of the NHPS). State governments, on the other hand, dispute this claiming (some correctly) that the state-level coverage is more broad and inclusive, while the NHPS is only designed to cover the most "vulnerable" as identified under the socio-economic caste census of 2011.

Furthermore, state governments are justifiably concerned that providing their share of the expense (40 percent of the NHPS's costs), they will not have the needed resources to fund or expand their

[21] There is broad agreement that although the RSBY improved access to health care, it has not been very effective in reducing out-of-pocket expenditures

health care schemes — as since 2007, several publicly financed health insurance schemes have been launched at the state-level such as the *Rajiv Aarogyasri*Health Insurance Scheme (RAS) in Andhra Pradesh, the *Rajiv Gandhi Jeevandayee Arogya Yojana* (RGJAY) and the *Mahatma Jyotiba Phule Jan Arogya Yojana* (MJPJAY) in Maharashtra, the *Bhamashah Swasthya Bima Yojana* in Rajasthan, the *Deen Dayal Swasthya Seva Yojana* in Goa, the *Chief Minister's Comprehensive Health Insurance scheme* (CMCHIS) in Tamil Nadu, among others. Running both schemes together will not only result in the duplicity of beneficiaries and services but also be an administrative nightmare. Given these, it is hard to imagine that the government of Andhra Pradesh will agree to scuttle its very popular health scheme (the Dr. N T R Vaidya Seva Scheme), to fund the NHPS-cum-Modicare. Although the Maharashtra government has stated that its residents are happy with the state-run health insurance, the reality is that the Maharashtra plan is quite modest when compared to the NHPS. The Maharashtrian authorities will be under pressure to revise their coverage upwards to meet the coverage provided by the NHPS, rather than joining Modicare. More bluntly, West Bengal chief minister Mamata Banerjee, an ardent critic of Modi's BJP-led NDA government has repeatedly stated that her government will not "waste" its hard-earned resources to contribute Modicare — which she has dismissed as a cheap political stunt aimed at garnering support ahead of the 2019 Lok Sabha elections. Banerjee has made clear that the West Bengal government already has enrolled some five million people under its own *Swasthya Sathi* program (under which hospitalization and treatment are free in the state), it makes no sense for her government to contribute funds to a lesser and vague scheme such as Modicare. Similarly, Karnataka, a Congress-ruled state has announced that it will also opt out of "Modicare" on the grounds that the state will soon unveil its own universal health insurance scheme under the name "*Arogya Karnataka Yojane*" and that this "state-level" program will be "a step ahead of the Modi plan."

Conclusion

The World Health Organization has long recommended that countries spend a minimum of 5 percent of their GDP on health to make "equity in access" and achieving universal health coverage a reality. Certainly, with the NHPS, the Modi administration is taking a bold step in providing India's poor and most vulnerable much need protection against financial distress resulting from medical expenditures. Nevertheless, the Modi administration is well aware that the NHPS is only part of the solution. To his credit, the Prime Minister has repeatedly stressed the importance of reducing air pollution and good sanitation and personal hygiene as a precursor to good health. No doubt, efforts to control and reduce air pollution via the expansion of the *Ujjwala scheme* (designed to replace wood and coal burning with gas connections for cooking), is a positive step.

Similarly, besides advocating yoga and traditional health practices such as Ayurveda and holistic living, he has been a staunch champion of his much-publicized and favorite initiative, the *Swachh Bharat* (or Clean India) program launched in October 2014. Under the initiative, the government has claimed that it built some 31 million toilets throughout the country by early 2018. Yet given the unsanitary practice of open defecation is a huge problem in India, rooted not only in poverty but also notions of ritual purity and caste status (Coffey and Spears, 2017), building latrines must

go hand-in-hand with large-scale socio-cultural and behavioral change that can best be achieved through access of good primary education — something India also lags far behind in.

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