

Ayushman Bharat: Hopes and Fears

Running Title: Ayushman Bharat

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The 2018-19 budget speech announced “*Ayushman Bharat*” but gave little information about the scheme or its funding details. As stated in the Finance Minister’s speech, this programme has two components viz. a National Health Protection Scheme (NHPS) and the establishment of Health and Wellness centers.[1]

There has been considerable publicity about the NHPS in the media as the political leadership declared it the largest healthcare programme in the world. Essentially, the NHPS is a Government-funded health insurance scheme that covers poor households. It replaces the currently existing *Rashtriya Swashtya Bima Yojana* from which it differs in including a larger package of secondary and tertiary care services, and increasing the sum assured from Rs 30,000 to Rs 5 lakhs. It does so in the hope that, access to secondary and tertiary care would greatly improve for about 50 crore population (10 crore families), and that financial hardship due to the costs of hospital care would be eliminated.[2] Many have expressed their concerns. There are a number of studies which show that the existing publicly funded insurance programs have not achieved the stated objectives- either of increasing access or of providing

financial protection.[3-5] Reasons for this poor performance include the multiple barriers to enrolment and to claiming the benefits when the need for hospitalization arises. It was found that not all private hospitals are empanelled. Moreover, even in these hospitals it was the provider who got to choose what services were covered and what were denied care, and where they could ask for co-payments, despite the provision being for cashless services. Additionally, patterns of healthcare consumption in existing publicly funded health insurance programmes did not necessarily match epidemiological patterns of needs. Thus, the concern is that, the care provided through the scheme would be so supply driven that health outcomes at a population level would not be assured.

The only real outcomes, then, would be to encourage the population to seek private health care, thereby undermining public provisioning of health care wherever public services are available.

The fear is that, though the stated rationale is to increase access for the poor, in fact the scheme is more driven by the needs of the healthcare industry. This industry has attracted

considerable investment, is over-capitalized, and therefore has considerable unused capacity. Consequently, it will encourage over-consumption of certain services. Anticipating this criticism, there are moves to reserve a number of services (procedures), like hysterectomy, for only the public sector. But it remains to be seen whether this technical advice on reserving some procedures would be followed during the process of implementation and whether it would be sufficient to safeguard public services. Another fear is that the already deprived areas at the periphery would be further excluded. Without increasing the availability of services, especially in remote areas, improving financing mechanisms alone will not help. Despite insurance schemes, private providers would be unwilling to operate anywhere beyond the tier 2 and tier 3 cities. The medical professionals in the public hospitals functioning at the district and sub-district level would now migrate to the re-invigorated private health facilities of the cities.

But there is also the hope that the NHPS could be used to strengthen the public hospitals, the not-for-profit sector and even the ethical providers in the private commercial sector. Public hospitals do have a major problem in receiving funds proportionate to the volume and variety of services they provide. If NHPS is used for a supplemental demand side financing of public hospitals, it would be a useful approach to ensuring adequacy and responsiveness of funding. Similarly, stricter monitoring of the private sector, to eliminate double charging, denial of care, unnecessary care, and kickbacks and commissions for referrals can provide an advantage for ethical private sector and non-commercial providers to thrive in

private markets. Community monitoring processes to review the implementation of such schemes would help. Quality of care can be positively incentivized through NHPS by a differential rate of reimbursement for quality certified hospitals. This is better than using the Clinical Establishments Act to set higher infrastructure and human resource standards for regulation and then closing down those hospitals that fail to meet these standards. The latter approach works against affordable care providers in low resource settings.

The Health and Wellness Center (HWC) concept flows out of the National Health Policy 2017[6] and the Task Force Report on Rolling out of Comprehensive Primary Health Care. The HWCs have been highlighted in both the 2016-17 and the 2017-18 budget speech of the finance minister. To quote:

“I am pleased to announce two major initiatives as part of ‘Ayushman Bharat’ programme aimed at making path breaking interventions to address health holistically, in primary, secondary and tertiary care system covering both prevention and health promotion.

The National Health Policy, 2017 has envisioned Health and Wellness Centres as the foundation of India’s health system. These 1.5 lakh centres will bring health care system closer to the homes of people. These centres will provide comprehensive health care, including for non-communicable diseases and maternal and child health services. These centres will

also provide free essential drugs and diagnostic services. I am committing Rs. 1200 crore in this budget for this flagship programme. I also invite contribution of private sector through CSR and philanthropic institutions in adopting these centres.”

The Health and Wellness centers are, in essence, upgraded and transformed health sub-centers. The earlier sub-centers provided a very select set of services- largely limited by policy- to immunization, ante-natal care, promotion of contraception, and including some elements of malaria, tuberculosis and leprosy control. These would hardly account for about 15% of healthcare needs.[7] The Health and Wellness Centers, if made functional as envisaged, could cater to over 70% of healthcare needs.[8] In particular, it would address a much wider spectrum of communicable and non - communicable illnesses. Recognizing that this is not a commercial proposition is an important component of the budget speech, where the only role envisaged for the private sector is through philanthropy.

There is enough evidence from international examples – like UK, Brazil, Thailand, Sri Lanka, that such an approach to universalizing primary healthcare is the most cost-effective way of achieving universal health coverage-. Thailand achieves UHC at levels of public health expenditure that are feasible for us.[9] We also have evidence from examples like Jan Swasthya Sahyog in the NGO sector and also some pilots launched by the State Government in Tamilnadu, that this HWC approach is feasible. The NHM has already made some significant advances in strengthening public health systems- but it was

sharply limited by its more or less exclusive focus on RCH services. The hope is that if the HWC strategy expands primary health care beyond RCH services, and takes it to scale, then we have defined a road-map to reach universal health coverage and could be speeding down that road.

But there are challenges. Firstly- such an expansion needs a long term well thought out expansion of human resources at the primary health care level. The Central Government has committed to supporting one mid level healthcare provider- but what is needed is a team of at least three or four health workers, suitably trained. Secondly, the cob-web of unhelpful rules about terms of employment and the level of medical care that different cadre of health workers are permitted to provide would need to be forded. We need to be able to recruit cadres from the local area who would be willing and happy to work there, and build the necessary skills amongst them. We need to be sure that they can prescribe the drugs and diagnostics that they are trained to provide, as part of the expanded list of services they have to deliver. Thirdly, there is the immense challenge of access to appropriate technologies. One part of this challenge is the logistics. The other part is the need for innovation to develop robust point-of-care technologies. Then there is the challenge of creating the information platforms and devices required to enable primary care providers, already over-loaded with recording and reporting RCH data, to now record and follow up all chronic illness in the community. Finally there is the big challenge of enabling continuity of care between primary providers in the HWCs and the doctors and specialists at the secondary and tertiary level. Without quality referral support from the latter, no primary health care effort

can succeed. This requires investment and design changes at the secondary and tertiary care centers also. There is, as yet, no talk of that.

The fear is that, despite the powerful articulation, the political will is inadequate. The technical problems can all be potentially overcome, if there is the political will. One indicator of political will is the budgetary allocation, which in the current year is a meager Rs. 1200 crore. Government guidelines project the costs per HWC as an additional Rs 17 lakhs per year in the first year and about 9 lakhs per year in subsequent years. This Rs.1200 crore allocation would pay only for about 8000 HWCs, which is only about 5% of the target. Furthermore, even this 1200 crore has to come out of the allocation for NHM. But since the allocation for NHM has not increased, the only way it can come out of it is by curtailing other necessary expenditures meant for strengthening health systems. It needs to be stated that this Rs 17 lakhs per HWC is a considerable under-costing. Though comprehensive primary health care is the most cost-effective way of approaching universal health coverage, the budget for HWCs would have to increase considerably to at least about 30,000 crore per year to make an impact. This would still be far less than the 2.5% of the GDP that the National Health Policy 2017 calls for.

In short, the big hope is that Ayushman Bharat could open the way to accelerate our progress towards providing universal health coverage. And the big fear is that, in the actual roll out, all the elements providing a sop to health care industry to recover its ill-advised investments and to increase its profit margins will trump the main objectives related to health outcomes and health equity. The

‘policy community’ and the ‘community of practice’ in public health need not be passive and helpless observers of this roll out. Through building capacity and shaping implementation of this program and through increasing the public understanding on these hopes and fears, there is considerable space to amplify the positive potentials and attenuate the negative.

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